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# Baseline Household Survey

# Dera Ghazi Khan District

May 2010





# **Family Advancement for Life and Health (FALAH)**

## **Dera Ghazi Khan**

**Baseline Household Survey**

**May 2010**

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## **Glossary of Terms**

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

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

## Executive Summary

The Family Advancement for Life and Health (FALAH) project conducted a baseline household survey for D.G. Khan, one of the 26 project districts.

The survey was conducted between February and April of 2008 in a probability sample of 520 households in 40 clusters in D.G. Khan. It included interviews with 669 currently married women 15-49 years ("married women of reproductive age" or MWRA), along with 200 married men, of whom 167 were married to women included in the sample. As a separate activity, a mapping study<sup>1</sup> was also carried out in D.G. Khan during the period between November, 2007 and February 2008. Selected data from that study are included in this report, although a separate report is also available. The FALAH project is primarily focused on birth spacing and family planning.

### *Household and Respondent Characteristics*

D.G. Khan is primarily a rural district in Pakistan; it ranks 53<sup>rd</sup> of 91 districts on the overall Human Development Index, according to the UNDP's Pakistan National Human Development Report 2003. The characteristics of our sample are generally similar to those found in other surveys; some key indicators are given hereunder in Table A.

**Table A: Selected key district characteristics from Dera Ghazi Khan household survey**

Variable	Value
Percentage of households in rural areas	87.8
Percentage of households with electricity	90.8
Percentage of households with indoor water supply	75.5
Percentage of households with flush toilet	55.9
Percentage of households with television	49.8
Percentage of literate female respondents	27.1
Percentage of respondents with literate husbands	61.0
No. of MBBS physicians per 1000 MWRA	1.2
<b>Total fertility rate</b>	<b>4.7</b>

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<sup>1</sup> Mapping Survey of Health and Reproductive Health Services.

D.G. Khan has a metalled road system. Electrification is complete (91 percent of sample households), and ownership of appliances that require electricity, such as television, refrigerator, washing machine, etc., were less common in D.G. Khan. A considerable majority of households (76 percent) had some indoor water supply, 56 percent had a flush toilet and 4 percent had latrine while 40 percent had no toilet at all. (According to the MDG report, D.G. Khan was ranked 26th nationally on sanitation.) On the other hand, education was relatively weak. Only 27 percent of females and 61 percent of husbands were literate. Thirty-nine percent of the respondents said they watch TV, 14 percent listen to the radio, and 9 percent read newspapers or magazines; whereas most women who heard of any FP message, heard it on television.

### ***Service Availability***

There was a wide range of health and reproductive health facilities in D.G. Khan district. Of the 2593 facilities in the district, 1191 were public while 1402 were in the private sector. These health facilities included health houses of Lady Health Workers and were widely scattered around the district, so the simple services such as antenatal check-ups, iron tablets for anemia, and non-clinical contraceptive methods were readily available in both public and private sectors. However, access to services requiring specialized care was difficult. For example, there were only 42 facilities – 2 public, 40 private – which were able to offer Caesarean section deliveries. There were 27 facilities which were able to provide female sterilization, but many of these could only provide the service occasionally, when an external sterilization team was present. Though services were spread throughout the district, there were some areas where access was relatively difficult.

### ***Fertility***

The crude birth rate was 34 per thousand population, and the total fertility rate was 4.7 children per woman. Fertility was higher for illiterate women and wives of illiterate men, and in households with a lower standard of living. Many births were spaced too closely for optimum health; for example, nearly 72 percent of closed birth intervals were less than 36 months. Among those who already had two living children under 5 years of age, 14 percent were currently pregnant.

### ***Maternal and Neonatal Care***

The household survey obtained data on selected key indicators of maternal and neonatal health from 406 sampled women who had delivered a child during the previous four years

Of these women, 75 percent had visited a health provider at least once for antenatal care; 48 percent had two or more tetanus toxoid immunizations; 24 percent were delivered by a skilled birth attendant; and 22 percent were delivered in a health facility, public or private. On the other hand, only 27 percent had at least one postnatal check-up, which has negative implications for family planning as well as for maternal and neonatal health. Exclusive breastfeeding was reportedly widespread; 58 percent of mothers reported breastfeeding their last child for at least four months without supplementation.

**Table B: Selected key MCH and family planning indicators from the D.G. Khan baseline survey**

<b>Indicator</b>	<b>Value</b>
Percentage of mothers with at least one antenatal care visit	75.4
Percentage of mothers with at least two tetanus shots	48.0
Percentage of most recent deliveries conducted by a skilled birth attendant	23.9
Percentage of most recent deliveries in a facility	22.2
Percentage of MWRA not wanting more children	54.6
Percentage of MWRA wanting to delay next birth for at least two years	24.1
Percentage of MWRA knowing at least one contraceptive method	99.7
Contraceptive prevalence rate	26.6
Percentage of MWRA who are past users of contraceptives	17.5
Percentage of MWRA with unmet need for family planning	41.7
Percentage of MWRA with unmet need for spacing	17.2
Percentage of MWRA with unmet need for limiting	24.5
<b>Total demand for family planning (CPR + unmet need)</b>	<b>68.3</b>

### ***Preference for Children***

The median “ideal” number of children according to the women respondents was 4 children. Regarding desire for more children in the future, 21 percent said they wanted another child soon (within two years), 24 percent said they wanted another child, but only after two years, and 55 percent said they did not want more children. The proportion wanting more children soon decreased rapidly with the number of living children, while the proportion not wanting more increased and the proportion wanting more children later was highest for women with one or two children. About 65 percent of women respondents said their husband wanted the same number of children that they did, while 16 percent said their husband wanted more children than they did.

## ***Contraceptive Knowledge and Use***

Nearly all currently married women (99.7 percent) knew of at least one contraceptive method. The contraceptive prevalence rate (the percentage of MWRA currently using some method of contraception) was 27 percent, lower than the average for Punjab or for Pakistan. The most commonly methods being used were the female sterilization (8 percent), withdrawal (6 percent) and condoms (5 percent). Past users comprised 17.5 percent of MWRA; injectables, pills, IUD, and withdrawal were all common past methods. Eighty percent of current users did not want more children, while 20 percent wanted more, but at a later time. Most users reported obtaining their supplies and services from health department outlets/LHW or their husband obtained the supplies.

## ***Experience with Contraceptive Methods***

Stated reasons for a respondent's choice of her current or past method varied by method, but commonly cited reasons included convenience of use, suitability for respondent and husband, easy availability, and no/fewer side effects. Costs were generally low (only 14 percent paid more than Rs.50 the last time they obtained their method) and did not appear to be a major obstacle contraceptive use. Thirty-two percent reported requiring more than 30 minutes to reach their service. Information provided at the time of acceptance of FP method often did not include information on side effects or what to do if experienced side effects. Clients generally reported being reasonably treated by providers and were often examined properly but some respondents were not happy with the attitude of staff. A considerable variety of side effects was reported by current users and past users.

## ***Reasons for Non-use***

Asked hypothetically about hindrances a couple might face if they wanted to avoid or delay pregnancy, women typically mentioned fear of side effects and problem of managing side effects, husband's disapproval, religion, and; less frequently mentioned were distance/cost, or that people might find out about contraceptive use. Past users were most likely to discontinue use because of experience of side effects, rest from method and desire for more children; their reason for current non-use was most often infrequent sex/ husband away. Other important reasons were fear of side effects and breastfeeding. Never users were most likely to say they were not using contraceptives for reasons like desire for more children followed by side effects, and husband's opposition. Knowledge of sources of contraceptive methods was noticeably lower among never users. A large majority of female current and

past users said they could discuss family planning easily with their husbands, but 67 percent of never users said they could do so. Forty percent of never using women expressed their intent to use contraceptives in the future. The information obtained in this study indicates that substantial numbers of women in D.G. Khan are willing to adopt birth spacing and family planning.

### ***Unmet Need for Family Planning***

A woman is said to be in “unmet need” for family planning if she says she does not want more children, or wants them later, and is at the risk of conceiving, but is not using any method of contraception. By this definition, 41.7 percent of the women in this sample were in unmet need, 17.2 percent for spacing and 24.5 percent for limiting. Unmet need for limiting was higher in rural areas, among illiterate women, and among women with lower standard of living. However, it is interesting to note that unmet need for spacing was higher among non educated women as compared with above secondary.

### ***Reproductive Preferences and Behavior of Men***

The findings reveal that all of the men knew at least one modern contraceptive method. Nearly 60 percent of the men did not want more children in the future or wanted to delay the next pregnancy. Thirty-one percent of the male respondents reported that they or their wives were currently using any family planning methods, and 25 percent were using modern contraceptive methods. Among the current users, 83 percent were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, only 16 percent reported that they were intending to use any FP method in the future. Of those who did intend to use contraceptives in the future, female sterilization and pills were their preferred methods. It would be important to include specific interventions aimed at influencing men’s attitudes toward their role and responsibility in the overall health of the family and in birth spacing and limiting needs.

### ***Conclusion***

D.G. Khan is characterized by a relatively less-developed district, a fairly low standard of living, a variety of public and private reproductive health facilities, and relatively fair maternal and neonatal health care. In this setting, knowledge and approval of family planning is high but contraceptive prevalence is 26.6 percent. Nevertheless, there is much

need for improvement; unmet need for family planning remains high at 41.7 percent. Among the important reasons that should be addressed in an improved program are husbands' attitude, husband-wife communications, fear of side effects, and knowledge of contraceptives sources. Also, the concept of birth spacing needs to be stressed to lengthen birth intervals, which are often too short.

# Chapter 1

## Introduction

### Background

#### The FALAH Project

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

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

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

The aims of the FALAH project are:

- a) To increase demand for and practice of birth spacing;
- b) To increase access to and quality of family planning services in the public sector;
- c) To increase the coverage and quality of family planning services in the private sector;
- d) To increase the coverage of social marketing of contraceptives, and provide support to the commercial sector for marketing contraceptives to strengthen contraceptive security.

At the district level, FALAH 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 D.G. Khan, district-level activities are being coordinated by Save the Children (US) and RSPN, with Greenstar providing information and services through social marketing and other partners supporting specific activities as needed.

### **Dera Ghazi Khan District**

District Dera Ghazi Khan is a mainly rural district of Punjab province. The overall population of the district is estimated to be 19,97,600 in 2008, with a population density of 168 people per square kilometer. Geographically D.G. Khan is bounded on the north by Dera Ismail Khan district of Khyber Pakhtunkhwa and its adjoining tribal area, on the west by Musa Khel and Barkhan districts of Balochistan province, on the south by Rajanpur and on the east by Muzaffargarh and Leiah separating the latter two districts by river Indus. The inhabitants of the district are predominantly Baloch belonging to various tribal groups (Population Census Organization, 2000).

Migration trends are important to analyze the economic and social development of communities. According to the 1998 census, 1.5 percent of the district population consisted of lifetime in-migrants, 52.4 percent of whom came from Punjab and 31.9 were from Sindh, Khyber Pakhtunkhwa and Balochistan, while 15.7 percent were Pakistanis repatriated from other countries.

According to the Pakistan National Human Development Report 2003<sup>2</sup>, D.G. Khan stands 53<sup>rd</sup> among 91 districts in Pakistan, and within Punjab, 28<sup>th</sup> of 29 districts (UNDP, 2003). In its Millennium Development Goals report of 2006 (United Nations, 2006), district-level data (based on the Pakistan Social and Living Standards Measurement Survey 2004-05) were shown for various measures of education, gender equity, infant mortality, and environmental sustainability. In these comparisons, D.G. Khan ranked below average in

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<sup>2</sup> In 2003, the districts of Pakistan were ranked according to a Human Development Index, consisting of: Literacy Rate; Enrolment Ratio; Immunization Ratio; Infant Survival Ratio; Real GDP per capita; Educational Attainment Index; Health Index; and Income Index.

most measures of education and literacy, immunization and water supply, and very low – 78<sup>th</sup> nationally out of 98 districts – in sanitation (Planning Commission of Pakistan 2006; Government of Pakistan, 2006).

## **The D.G. Khan Baseline Household Survey**

In D.G. Khan (as in each of the 26 FALAH focus districts) Population Council implemented a baseline sampled 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 D.G. Khan 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 D.G. Khan district regarding reproductive health, so as to meet their needs more effectively;
- More specifically, to obtain information needed to improve reproductive health services and to design appropriate social mobilization activities.

### **Methodology**

#### **Study Population**

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

## **Sample Design and Size**

The systematic stratified sample technique was used to select a representative sample of the district. The universe consisted of all urban and rural households of the district. A total of 40 blocks/villages were selected, with 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 then selected. The maps of these circles were obtained from the Population Census Organization which were already divided into blocks of approximately 250-300 households depending upon the number of households in each circle. Next, one block was randomly selected from each circle. The household listing of each randomly chosen block was then carried out by the enumeration teams before selecting the sampled households. A fixed number of 13 households was drawn from each sample enumeration block by using systematic random sampling.

### **Rural Sample**

The 1998 Population Census list of villages was used as the sampling frame for the selection of 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 were selected from each sample enumeration village by the systematic random technique.

### **Selection of Respondents**

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

Table 1.1 presents the enumerated number of households and eligible women of reproductive age in D.G. Khan.

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

<b>Result</b>	<b>Rural</b>	<b>Urban</b>	<b>Total</b>
Number of blocks/villages	34	6	40
Households contacted	488	90	578
Households refused	1	1	2
Households locked	45	11	56
Households replaced	46	12	58
Eligible women identified	594	75	669
<b>Total women's interviews</b>	<b>594</b>	<b>75</b>	<b>669</b>

### Questionnaire Design

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

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

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

### Hiring of Interviewers and Supervisors

Since the respondents in the baseline survey were currently married women and their husbands, female interviewers were hired to interview female respondents and male interviewers were used for male respondents. The 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 session of the D.G. Khan 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 criteria for 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 was also available to provide on-the-spot guidance to interviewers in the event that any part of the questionnaire was unclear to them. This ensured the completeness and accuracy of each questionnaire.

## **Data Entry and Edit Procedures**

Data processing was initiated in the field with the checking of the questionnaires. Each team leader completed on-the-spot checks and preliminary editing of questionnaires during the enumeration period. Team supervisors were provided with editing instructions emphasizing the importance of completing each questionnaire, correctly identifying each eligible respondent, and the completeness of household composition. Each team leader engaged in preliminary editing of completed questionnaires during the enumeration period. On receipt of the questionnaires at the Islamabad office, a special team of experienced staff edited the completed questionnaires. After the completion of the editing and coding process, the questionnaires were dispatched to a data entry center. The data were then analyzed using SPSS for Windows.

## **Fieldwork**

Fieldwork for D.G. Khan district was carried out between February 28 and April 16, 2008.

# Chapter 2

## Household Characteristics

### Geographic Distribution

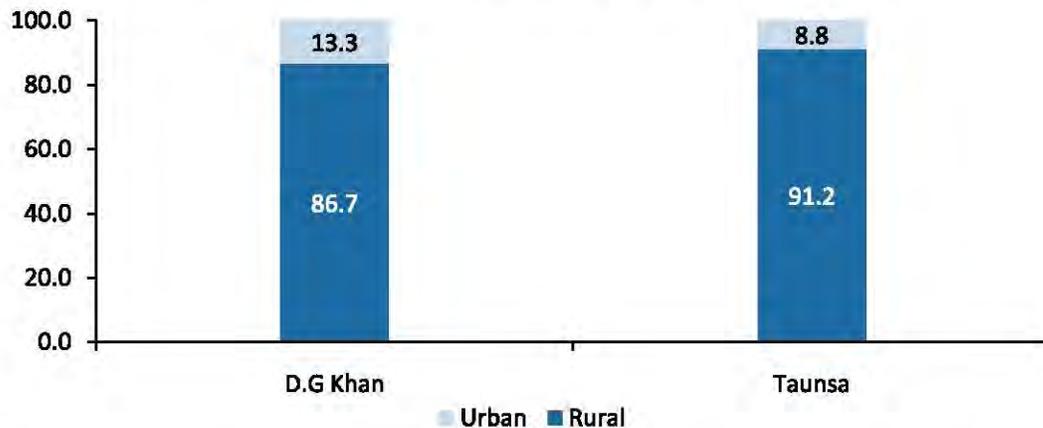
D.G. Khan district comprises two Tehsils: D.G. Khan and Taunsa, both of which are primarily rural. Table 2.1 and Figure 2.1 show the distribution of the population of sample households according to residence (urban and rural) and by Tehsil, with comparisons to the population distribution of the 1998 National Population and Housing Census.

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

Tehsil	Rural			Urban			Total	
	N	%	Census %	N	%	Census %	N	%
DG.Khan	2897	86.7	83.4	444	13.3	16.6	3341	100.0
Taunsa	991	91.2	89.5	96	8.8	10.5	1087	100.0
<b>Total</b>	<b>3888</b>	<b>87.8</b>	<b>84.9</b>	<b>540</b>	<b>12.2</b>	<b>15.1</b>	<b>4428</b>	<b>100.0</b>

As Table 2.1 shows, the distribution of the population of the 520 households in the sample by urban-rural residence and tehsil closely follows the distribution recorded for the whole district in the 1998 Population Census (Population Census Organization, 2000). D.G. Khan is about 88 percent rural, 12 percent urban. About 75 percent of the sample population is in D.G. Khan tehsil, while about 25 percent resides in Taunsa Tehsil.

**Figure 2.1: Rural- urban distribution of population in sample households**



The mother-tongue of 89 percent of the sample households is Saraiki, reflecting the dominant ethnic group in the district.

## Age-Sex Distribution

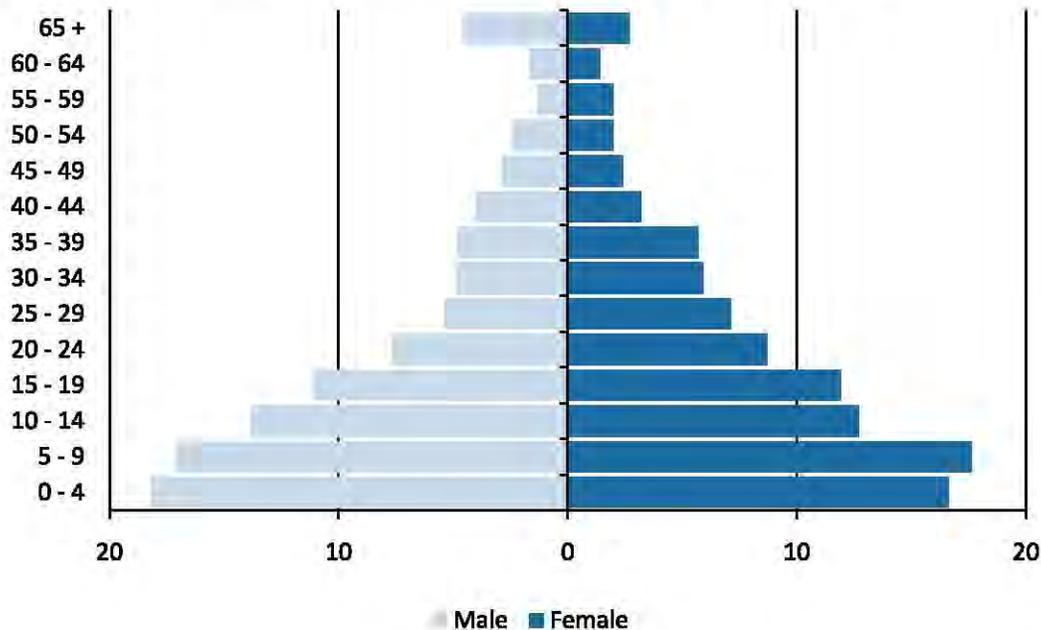
Table 2.2 shows the population of the sampled households by age and sex; Figure 2.2 shows the same information in the form of an age-sex pyramid.

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

Age group	Male	Female	Total
0 - 4	18.2	16.6	17.4
5 - 9	17.1	17.6	17.4
10 - 14	13.8	12.7	13.3
15 - 19	11.1	11.9	11.5
20 - 24	7.7	8.7	8.2
25 - 29	5.4	7.1	6.3
30 - 34	4.9	5.9	5.4
35 - 39	4.8	5.7	5.2
40 - 44	4.0	3.2	3.6
45 - 49	2.9	2.4	2.6
50 - 54	2.4	2.0	2.2
55 - 59	1.3	2.0	1.7
60 - 64	1.7	1.4	1.5
65 +	4.6	2.7	3.7
<b>N</b>	<b>2175</b>	<b>2253</b>	<b>4428</b>

The population is typical of a society with high fertility, with sharply declining percentages by age; the median age is 19 years old.

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



Of the total population of the sampled households, 23 percent (out of 4428) consists of females 15-49 years of age while 17 percent are children under 5 years old. These, and their husbands/fathers, comprise the population of primary interest to the FALAH project, and most of the analysis in this report will focus on them.

## Marital Status

In D.G. Khan (as in Pakistan generally) women tend to marry men older than themselves. Therefore, as table 2.3 shows, higher proportions of women at younger ages are married than men. Also, significant numbers of women are married, even at ages 40-49; such women are usually at a disadvantage for raising children, as in other ways. The singulate mean age at marriage for women, using the method of Hajnal (Shryock and Siegel, 1976), is 20.

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

Age group	Marital status of household members					
	Married		Widow/divorced/separated		Never married	
	Male	Female	Male	Female	Male	Female
15 – 19	12.1	38.7	0.0	0.4	87.9	61.0
20 – 24	47.3	66.3	0.0	1.5	52.7	32.1
25 – 29	66.9	90.1	0.8	3.1	32.2	6.8
30 – 34	92.5	92.4	0.9	3.8	6.6	3.8
35 – 39	97.1	96.9	1.0	3.1	1.9	0.0
40 – 44	96.5	97.2	2.3	2.8	1.2	0.0
45 – 49	100.0	81.1	0.0	17.0	0.0	1.9
50 – 54	98.1	80.0	1.9	20.0	0.0	0.0
55 – 59	93.1	82.2	6.9	17.8	0.0	0.0
60 – 64	80.6	65.6	19.4	28.1	0.0	6.3
65 – 69	84.6	70.4	12.8	25.9	2.6	3.7
70 – 74	92.3	46.7	7.7	53.3	0.0	0.0
75 – 79	77.3	50.0	22.7	50.0	0.0	0.0
80 +	92.9	28.6	7.1	71.4	0.0	0.0
<b>All ages</b>	<b>65.9</b>	<b>72.5</b>	<b>2.5</b>	<b>6.8</b>	<b>31.5</b>	<b>20.7</b>

## Household Characteristics and Wealth Indicators

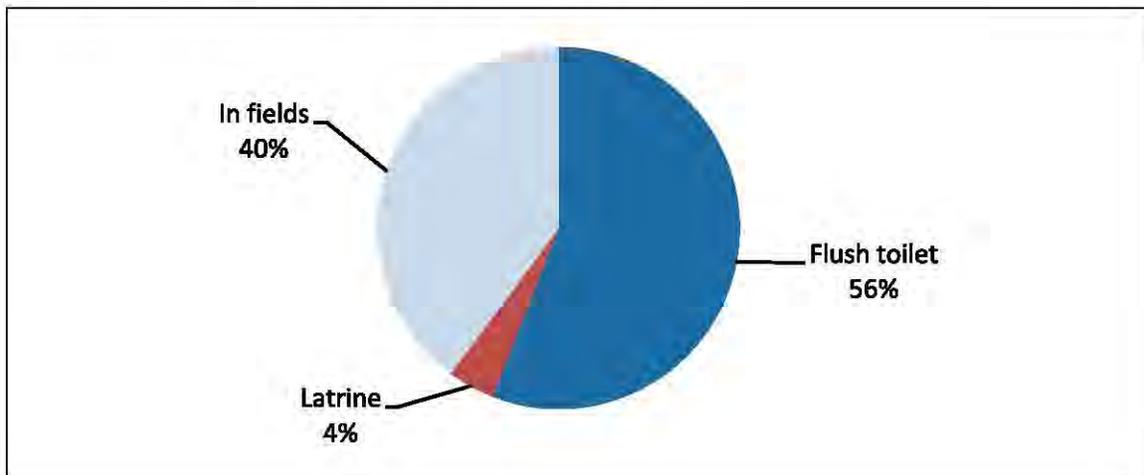
Several household characteristics were assessed that bear on the wealth and well-being of its inhabitants. Some of these may have direct bearing on health; for example, a clean indoor water supply and flush toilets are important for hygiene, and access to radio and television can help in learning about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

## Physical Characteristics of Households

Table 2.4 shows selected physical characteristics of the sample households. A considerable majority of households have an indoor water supply (76 percent). The point pertinent to note is that though about half of rural households have some type of flush toilet but 47 percent of rural population still goes to fields. Figure for raised or pit latrine is quite low, 2.7 and 2.3 respectively for rural population.

While most households (79 percent) particularly in rural areas (92 percent) use firewood for cooking, small proportions use gas. All household in urban areas enjoy electricity while vast majority of households in rural areas (89 percent) have electricity. Majority of the houses are roofed with wood/bamboo or Guarder T-iron while very few (3 percent) have concrete roof. About half of walls are of burnt bricks or cement blocks, and half of mud or mud bricks.

**Figure 2.3: Toilet facilities for D.G. Khan households**



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

<b>Characteristic</b>	<b>Rural</b>	<b>Urban</b>	<b>Total</b>
<b>Main source of drinking water</b>			
Govt. supply (tap water inside)	18.6	21.8	19.0
Govt. supply (communal)	2.9	3.8	3.1
Motorized/Hand pump (inside)	64.3	12.8	56.5
Motorized/Hand pump (outside)	10.9	11.5	11.0
Pure water supplies at homes	0.0	50.0	7.5
Others	3.4	0.0	2.9
<b>Sanitation facility</b>			
Flush to sewerage	0.7	5.1	1.3
Flush connected to septic tank	35.7	76.9	41.9
Flush connected to open drain	11.8	17.9	12.7
Raised latrine	2.7	0.0	2.3
Pit latrine	2.3	0.0	1.9
In fields	46.8	0.0	39.8
<b>Main type of fuel used for cooking</b>			
Fire wood	91.6	3.8	78.5
Gas cylinder	1.6	2.6	1.7
Natural gas (Sui gas)	1.6	93.6	15.4
Dry Dung	4.3	0.0	3.7
Others	0.9	0.0	0.8
<b>Electrical connection</b>			
Yes	89.1	100.0	90.8
No	10.9	0.0	9.2
<b>Main material of the roof</b>			
Concrete	0.7	15.4	2.9
Iron sheet	0.2	14.1	2.3
Guarder and T-iron	45.7	56.4	47.3
Wood/Bamboo and mud	53.4	14.1	47.5
<b>Main material of the floor</b>			
Earth/Sand/Mud	66.5	2.6	56.9
Chips/Ceramic tiles/Marble	2.7	33.3	7.3
Cement	12.0	32.1	15.0
Bricks	18.8	32.1	20.8
<b>Main material of the walls</b>			
Burnt bricks/Blocks	41.0	97.4	49.4
Mud bricks/Mud	58.8	2.6	50.4
Wood/Bamboo	0.2	0.0	0.2
<b>N</b>	<b>442</b>	<b>78</b>	<b>520</b>

## Ownership of Household Assets

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

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

Item	Rural	Urban	Total
Wall clock	56.1	97.4	62.3
Chairs	22.9	71.8	30.2
Bed	28.5	78.2	36.0
Sofa	13.2	64.1	20.8
Sewing machine	56.1	93.6	61.7
Camera	5.7	25.6	8.7
Radio/tape recorder	36.0	69.2	41.0
Television	43.0	88.5	49.8
Refrigerator	26.0	85.9	35.0
Land line telephone	4.8	42.3	10.4
Mobile phone	53.2	88.5	58.5
Room cooler/ air conditioner	11.5	67.9	20.0
Washing machine	32.8	93.6	41.9
Bicycle	49.8	51.3	50.0
Motor cycle	19.2	48.7	23.7
Jeep/car	1.8	21.8	4.8
Tractor	2.7	1.3	2.5
Computer	1.8	12.8	3.5
<b>N</b>	<b>442</b>	<b>78</b>	<b>520</b>

The distribution of these items appears to show the expansion of consumer purchasing that has characterized Pakistan in recent years. Several items requiring electricity are available in substantial proportions of households, even in rural areas. About half of all households have television sets, a figure of particular interest to communications specialists. The recent expansion of information technology in Pakistan is reflected by ownership of mobile phones by 59 percent of all households. It is more common in urban areas (89 percent) than in rural areas (53 percent). D.G. Khan lags behind in computer ownership, only 4 percent

households had computers. Four wheel motorized transport remains fairly uncommon, suggesting difficulties in arranging for transport in health emergencies. However, motorcycles are with 24 percent households, which is an encouraging point of view particularly in emergency.

### Standard of Living Index

It is useful to use the above data to get an overall index of the economic well-being of a household, both for general estimation of economic development for an area, and for use in investigating the relationship between household wealth and reproductive health behavior. One such index is the Standard of Living Index (SLI), developed for international comparisons with data from the Demographic and Health Surveys. 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 is 5 while it is 4 for rural households and 8 for urban households. About 62 percent of all households fall in the range from 3 to 8. This index will be used later in this report to examine differences in reproductive health knowledge and behavior.

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

Standard of living index	Rural		Urban		Total	
	N	%	N	%	N	%
1	34	7.7	0	0.0	34	6.5
2	82	18.6	0	0.0	82	15.8
3	50	11.3	0	0.0	50	9.6
4	58	13.1	2	2.6	60	11.5
5	49	11.1	0	0.0	49	9.4
6	49	11.1	12	15.4	61	11.7
7	45	10.2	11	14.1	56	10.8
8	28	6.3	16	20.5	44	8.5
9	33	7.5	26	33.3	59	11.3
10	14	3.2	9	11.5	23	4.4
11	0	0.0	2	2.6	2	0.4
<b>Total</b>	<b>442</b>	<b>100.0</b>	<b>78</b>	<b>100.0</b>	<b>520</b>	<b>100.0</b>
Median	na	4	na	8	na	5

# Chapter 3

## Respondent Characteristics

The primary source of data from the Household Survey is the interviews conducted with 669 currently married women of reproductive age. The background characteristics of these respondents are described in this chapter.

### Age

#### All Respondents

Table 3.1 shows the age distribution of the female respondents for rural and urban areas. Since many younger women are yet to be married, the number at age 15-19 is relatively small. It is high in the age group of 25-29 as by the time most of the women get married. At older ages, the number declines because of the overall shape of the age pyramid, and because significant number of women are widowed after age 40. About half of the sample female respondents are under age 30.

**Table 3.1: Age distribution of female respondents by residence**

Age group	Rural		Urban		Total	
	N	%	N	%	N	%
15 - 19	83	14.0	5	6.7	88	13.2
20 - 24	107	18.0	10	13.3	117	17.5
25 - 29	119	20.0	9	12.0	128	19.1
30 - 34	97	16.3	20	26.7	117	17.5
35 - 39	111	18.7	8	10.7	119	17.8
40 - 44	53	8.9	10	13.3	63	9.4
45 - 49	24	4.0	13	17.3	37	5.5
<b>Total</b>	<b>594</b>	<b>100.0</b>	<b>75</b>	<b>100.0</b>	<b>669</b>	<b>100.0</b>

## Education and Literacy

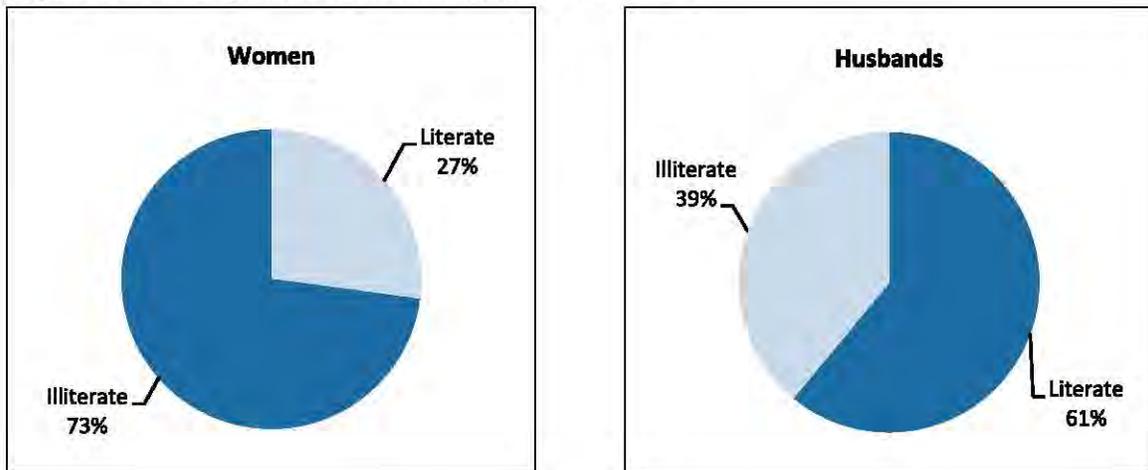
Levels of schooling completed and literacy rates for the respondents and their husbands are given in Table 3.2; literacy rates are also shown in Figure 3.1. The literacy rate of female respondents was 27 percent, compared with 40 percent for Punjab as a whole and 36 percent (at that time) for Pakistan as a whole (Government of Pakistan, 2005; Government of Pakistan, 2006). Similarly, only about 13 percent of the female respondents reported being educated up to primary level and only 5 percent had above secondary level education. For the husbands of the women as well, literacy (at 61 percent) was lower than the rest of Punjab in 2004-05 (63 percent), as well as the national average (63 percent) (Government of Pakistan, 2005). Table 3.2 also shows that younger women aged 15-24 years and 25-34 years were significantly more literate than older women 35-49 years old.

For women respondents and their husbands, literacy is higher in urban areas. As regards education, women education is also higher in urban areas. However, for husbands, it is interesting to note that primary education is higher in rural areas while education up to secondary and above is higher in urban areas.

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

Variable	Age of respondent			Residence		
	15 - 24	25 - 34	35 - 49	Rural	Urban	Total
<b>Literacy (respondent)</b>						
Proportion literate	33.3	29.5	18.7	21.8	69.3	27.1
<b>Education level (respondent)</b>						
No education	64.7	68.9	81.3	76.9	30.7	71.7
Up to primary	17.6	11.1	10.0	12.7	13.3	12.7
Up to secondary	12.3	13.5	5.5	7.9	30.7	10.5
Above secondary	5.4	6.6	3.2	2.5	25.3	5.1
<b>N</b>	<b>204</b>	<b>244</b>	<b>219</b>	<b>592</b>	<b>75</b>	<b>667</b>
<b>Literacy (husband)</b>						
Proportion literate	69.2	60.6	53.9	57.4	89.3	61.0
<b>Education level (husband)</b>						
No education	30.8	39.0	45.2	42.1	10.7	38.5
Up to primary	15.9	12.0	15.2	15.4	5.3	14.3
Up to secondary	38.8	33.6	27.2	32.2	40.0	33.1
Above secondary	14.4	15.4	12.4	10.3	44.0	14.1
<b>N</b>	<b>201</b>	<b>241</b>	<b>217</b>	<b>584</b>	<b>75</b>	<b>659</b>

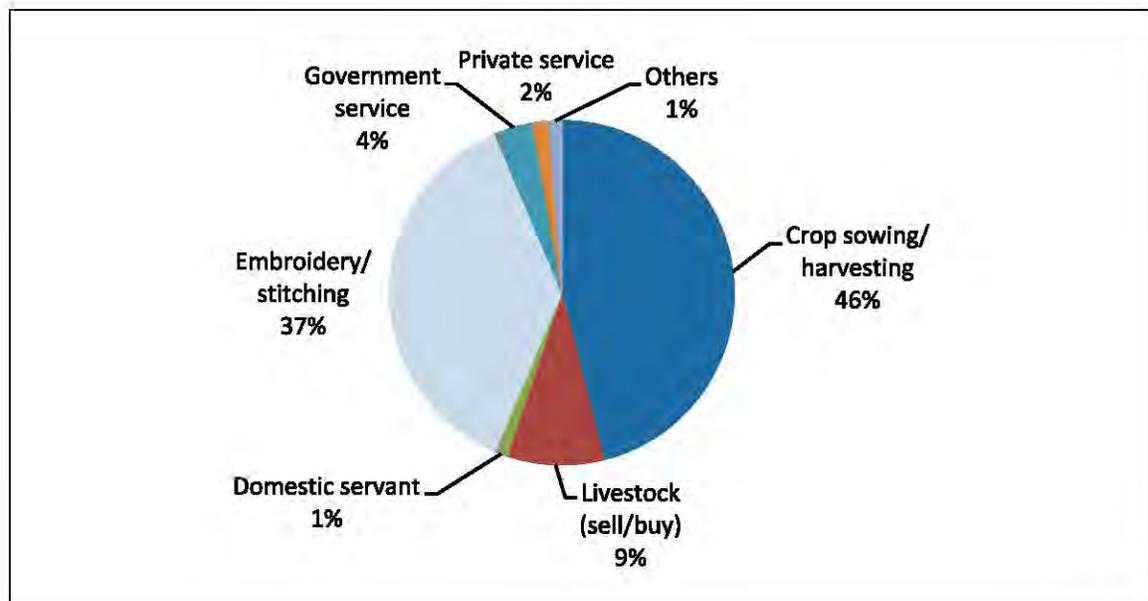
**Figure 3.1: Literacy status of women and their husbands**



## Occupation and Work Status

For men, occupation is both an economic and social classification; some occupations usually indicate higher income levels than others, while at the same time may represent social status and life style. Women’s work, whether for necessary income or for career fulfillment, is likely to compete, at least to some degree, with time spent on household management and child care. Therefore it is worthwhile to examine men’s and women’s work separately. Women working for money are shown in Figure 3.2.

**Figure 3.2: Type of work of women working for pay (n=330)**



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

<b>Occupation/economic activity</b>	<b>Rural</b>	<b>Urban</b>	<b>Total</b>
Agriculture/livestock/poultry	26.6	1.3	23.8
Petty trader	7.7	8.0	7.8
Labor (daily wages)	23.6	8.0	21.8
Government service	11.1	17.3	11.8
Private service	7.4	21.3	9.0
Own business	6.1	30.7	8.8
Working abroad	11.4	5.3	10.8
Unemployed	5.4	6.7	5.5
Others	0.7	1.3	0.7
<b>N</b>	<b>594</b>	<b>75</b>	<b>669</b>

Table 3.3 shows that 24 percent husbands of respondents earn their living through agriculture/livestock/poultry as a major occupation but mainly in rural areas followed by labour and Government service. Eleven percent husbands worked abroad. This is equally important for the prosperity of the families and health in the perspective of birth spacing. Unemployment rate is fairly high (5.5 percent). Health of such families is relatively at more stake.

## **Female Mobility**

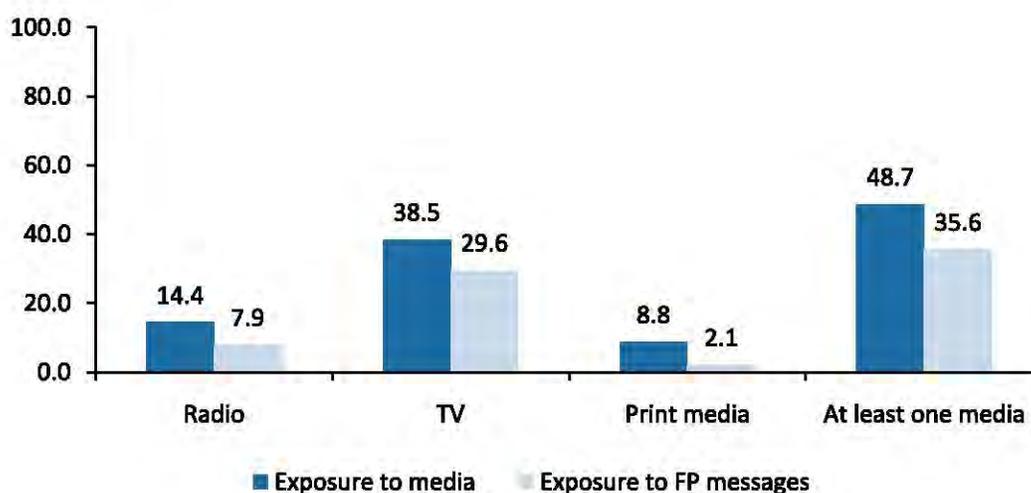
Women respondents were asked about their ability to go to places outside their homes, and what degree of permission was required (Table 3.4). Only a few women reported being able to go to any of the places named without permission except relatives/friends for which number is high (25 percent); on the other hand, few women reported not being able to go at all to any of the places, and the market was the only place where relatively high number of women – 13 percent – said “They do not go”. For each of the named destinations, a fair enough number said they could go with permission, whereas majority said they could go along with someone.

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

Destination	Degree of permission				Total	
	Without permission	With permission	With someone	Can't go/ Doesn't go	%	N
Market	6.9	21.8	58.1	13.2	100.0	669
Health center	7.3	19.7	71.9	1.0	100.0	669
Relatives/friends	25.4	22.6	51.4	0.6	100.0	669
Out of village/ town	2.1	20.5	69.5	7.9	100.0	669

## Mass Media Access and Exposure to Family Planning Messages

For the development of communication activities, it is important to know which mass media are available, and to what extent they are used by various segments of the population. Table 2.5 showed that 50 percent of households own a television, while 41 percent own a radio. Figure 3.3 shows the proportions of women who report that they watch TV, listen to the radio, or read newspapers or magazines. Television is the most commonly accessed medium followed by radio and print media. This is indicative of fairly typical situation in much of Pakistan.

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

Furthermore, women who reported an access to any sort of media were asked if they had ever seen, heard, or read any message about the methods of family planning through these mediums. This time again more women said that they had seen/heard about family planning messages on television (30 percent) than radio (8 percent) and only 2 percent reported reading it from print materials.

# Chapter 4

## Service Availability

Health status and practices in a district can only be understood in the context of the health facilities and trained personnel available to the population of that district. As a companion activity to the D.G. Khan Household Survey, the FALAH project undertook a mapping of health and reproductive health services study in the FALAH districts. The fieldwork in D.G. Khan was carried out from November,2007 to February,2008. 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-D.G. Khan district”. Some basic results are provided to give an overview of the context in which the knowledge, attitudes and behavior of the men and women of the household survey sample can be understood.

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

## D.G. Khan District Data

There are total of 2593 health facilities in D.G. Khan district, of which 1191 are from the public sector and 1402 from the private sector (124- Greenstar Social Marketing; 1278- other private facilities). Some facilities provide only limited care, such as the LHW health houses and dispensaries in the public sector and traditional practitioners in the private sector.

## Reproductive Health Facilities

The distribution of reproductive health facilities in the public and private sectors per union council is shown in Maps 4.1 to 4.3. Map 4.1 shows the distribution of government static facilities by union council population density. Similarly, Map 4.2 shows the availability of LHWs; the variation is considerable as 28 union councils have more than 20 LHWs, while only 8 have fewer than 10 LHWs. Moreover, there is one union council having no LHW in the area. On average, there are 19 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: 29 union councils have more than 50 reproductive health facilities, while 5 union councils have fewer than 25 facilities. On the whole, however, there do not appear to be any union council for which no reproductive health services are available. On average, there are 52 reproductive health facilities per union council.

## Family Planning Facilities

By and large, family planning services are available in two-thirds of the facilities in D.G. Khan district. However, the availability of clinical methods, with the exception of injectables, is quite limited; IUDs are available at one-tenth of the facilities, while Norplant and female and male sterilization services are hardly available at public or private facilities. In contrast, non-clinical methods, particularly condoms and pills, are available in almost all public facilities, and LHWs are the main contributing factor. These methods are less available at private facilities. Emergency contraceptive pills are not often available; however, their provision is mainly from the private sector. Generally, the choice of permanent methods is limited in D.G. Khan district.

**Table 4.1: Number and proportion of facilities providing specified family planning services in D.G. Khan district, by sector and MWRA per facility**

Service	Sector										MWRA per facility
	Government		LHWs		Private GSM		Private others		Total		
	N	%	N	%	N	%	N	%	N	%	
Injectables	88	78.6	230	21.3	97	78.2	308	24.1	723	27.9	499
IUD/Copper T	74	66.1	na	na	81	65.3	93	7.3	248	9.6	1456
Norplant	6	5.4	na	na	2	1.6	1	0.1	9	0.3	40120
Female sterilization	8	7.1	na	na	12	9.7	7	0.5	27	1.0	13373
Male sterilization	6	5.4	na	na	4	3.2	3	0.2	13	0.5	27775
Condom	90	80.4	1069	99.1	75	60.5	252	19.7	1486	57.3	243
Pills	94	83.9	1077	99.8	94	75.8	318	24.9	1583	61.0	228
ECP	8	7.1	0	0.0	68	54.8	66	5.2	142	5.5	2543
<b>Any FP method</b>	<b>96</b>	<b>85.7</b>	<b>1079</b>	<b>100.0</b>	<b>103</b>	<b>83.1</b>	<b>410</b>	<b>32.1</b>	<b>1688</b>	<b>65.1</b>	<b>214</b>
<b>Any clinical method</b>	<b>89</b>	<b>79.5</b>	<b>230</b>	<b>21.3</b>	<b>102</b>	<b>82.3</b>	<b>323</b>	<b>25.3</b>	<b>744</b>	<b>28.7</b>	<b>485</b>
<b>Any non-clinical method</b>	<b>96</b>	<b>85.7</b>	<b>1079</b>	<b>100.0</b>	<b>94</b>	<b>75.8</b>	<b>361</b>	<b>28.2</b>	<b>1630</b>	<b>62.9</b>	<b>222</b>
<b>Total facilities</b>	<b>112</b>	<b>100.0</b>	<b>1079</b>	<b>100.0</b>	<b>124</b>	<b>100.0</b>	<b>1278</b>	<b>100.0</b>	<b>2593</b>	<b>100.0</b>	<b>139</b>

**Note:** Multiple responses possible. Clinical method include; injectables, IUDs, Norplant, female sterilization and male sterilization. MWRA; married women of reproductive age ECP; emergency contraceptive pills na; not applicable

The geographic distribution of these services is as important as the number. Maps 4.5 to 4.7 show the availability of female sterilization, IUDs and injectables, as illustrations. Female sterilization is available in 15 union councils, while IUD services are available in all but 5 union councils. Availability of injectables is more widespread than other clinical methods; this service is available in all union councils. Methods like pills and condoms (not shown in the map) 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 services are shown in Table 4.2. Anemia treatment is the

most frequently available service, followed by antenatal check-up, both in public and private facilities. Service availability for tetanus protection is generally low, but it is higher in public facilities than in private facilities. Normal delivery services are available at one-tenth of the facilities, but mainly from the private sector. Overall, one normal delivery facility is available for every 1427 married women of reproductive age. On the other hand, Caesarean section, an important element of comprehensive obstetric care services, is available in only 2 public facilities; however, 40 private facilities are providing this service.

**Table 4.2: Number and proportion of facilities providing specified maternal health care services in D.G. Khan district, 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	105	93.8	1031	95.6	109	87.9	203	15.9	1448	55.8	3439
Anemia treatment	111	99.1	1075	99.6	124	100.0	1041	81.5	2351	90.7	154
TT injection	60	53.6	334	31.0	83	66.9	159	12.4	636	24.5	568
Normal delivery	49	43.8	na	na	86	69.4	118	9.2	253	9.8	1427
Caesarean section	2	1.8	na	na	23	18.5	17	1.3	42	1.6	8597
<b>Total facilities</b>	<b>112</b>	<b>100.0</b>	<b>1079</b>	<b>100.0</b>	<b>124</b>	<b>100.0</b>	<b>1278</b>	<b>100.0</b>	<b>2593</b>	<b>100.0</b>	<b>139</b>

**Note:** Multiple responses possible. MWRA; married women of reproductive age na; not applicable

Along with the sheer number of facilities, their geographic distribution is of critical importance. Map 4.8 shows the distribution of essential obstetric facilities in each union council of D.G. Khan district. There are only 4 union councils with no obstetric care facilities, while there are 52 union councils that do have facilities providing these services. Map 4.9 shows that 23 comprehensive emergency obstetric care (EmOC) services are available in 10 union councils.

## Service Providers

The number of service providers of different categories and number of women per provider are shown in Table 4.3. There are a total of 433 MBBS doctors; only 23 percent of these are women. There are 354 female paramedics to serve the entire female population of the district; 66 percent of the female paramedics are LHVs.

The number of married women per provider or facility is a good indicator of the status of health in the district. Table 4.3 shows that, overall, there is 1 MBBS doctor available to serve 834 married women of reproductive age. Since women usually prefer female service providers, especially for their reproductive health needs, this burden increases to 3575 MWRA per female MBBS doctor, indicating a serious dearth of female doctors. For female paramedics, there are about 1020 MWRA per female paramedic. Map 4.10 shows the availability of MBBS doctors by gender in each union council. There are 2 union councils where male doctors are not available, while in 28 union councils there is no female MBBS doctor.

**Table 4.3: Number of reproductive health care providers in D.G. Khan district, by sector and category, and MWRA per service provider**

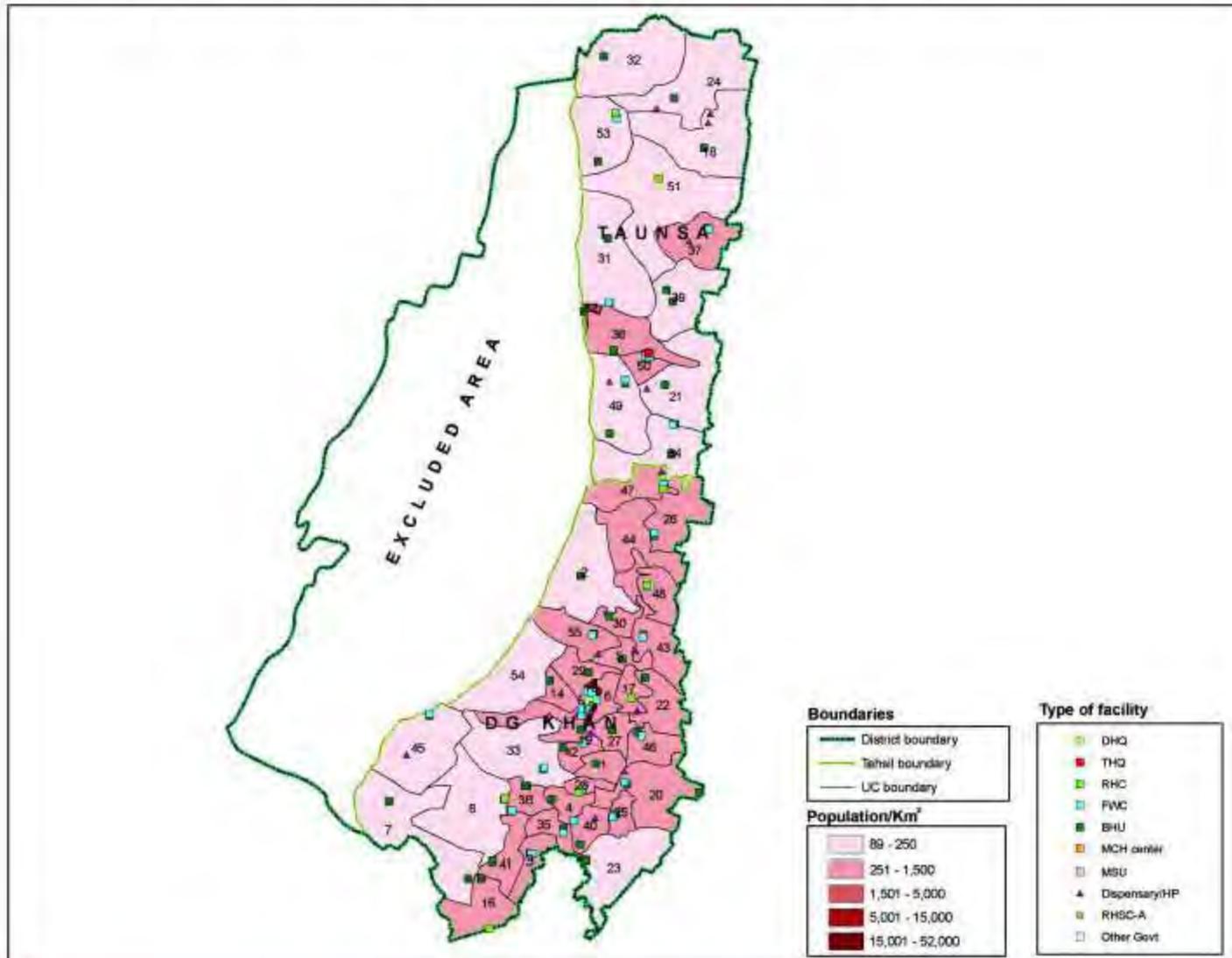
Provider	Sector								MWRA per provider
	Government		Private GSM		Private others		Total		
	N	%	N	%	N	%	N	%	
<b>Doctors (MBBS)</b>									
Male	88	73.3	72	66.1	172	84.3	332	76.7	1088
Female	32	26.7	37	33.9	32	15.7	101	23.3	3575
<b>Total</b>	<b>120</b>	<b>100.0</b>	<b>109</b>	<b>100.0</b>	<b>204</b>	<b>100.0</b>	<b>433</b>	<b>100.0</b>	<b>834</b>
<b>Female paramedics</b>									
Medical assistant	2	1.8	0	0.0	3	2.6	5	1.4	72216
Nurse	44	40.4	31	23.7	25	21.9	100	28.2	3611
Medical/ health technician	7	6.4	6	4.6	4	3.5	17	4.8	21240
Lady health visitor	56	51.4	94	71.8	82	71.9	232	65.5	1556
<b>Total</b>	<b>109</b>	<b>100.0</b>	<b>131</b>	<b>100.0</b>	<b>114</b>	<b>100.0</b>	<b>354</b>	<b>100.0</b>	<b>1020</b>
<b>Male paramedics</b>	<b>48</b>	<b>100.0</b>	<b>19</b>	<b>100.0</b>	<b>88</b>	<b>100.0</b>	<b>155</b>	<b>100.0</b>	<b>2330</b>

MWRA; married women of reproductive age

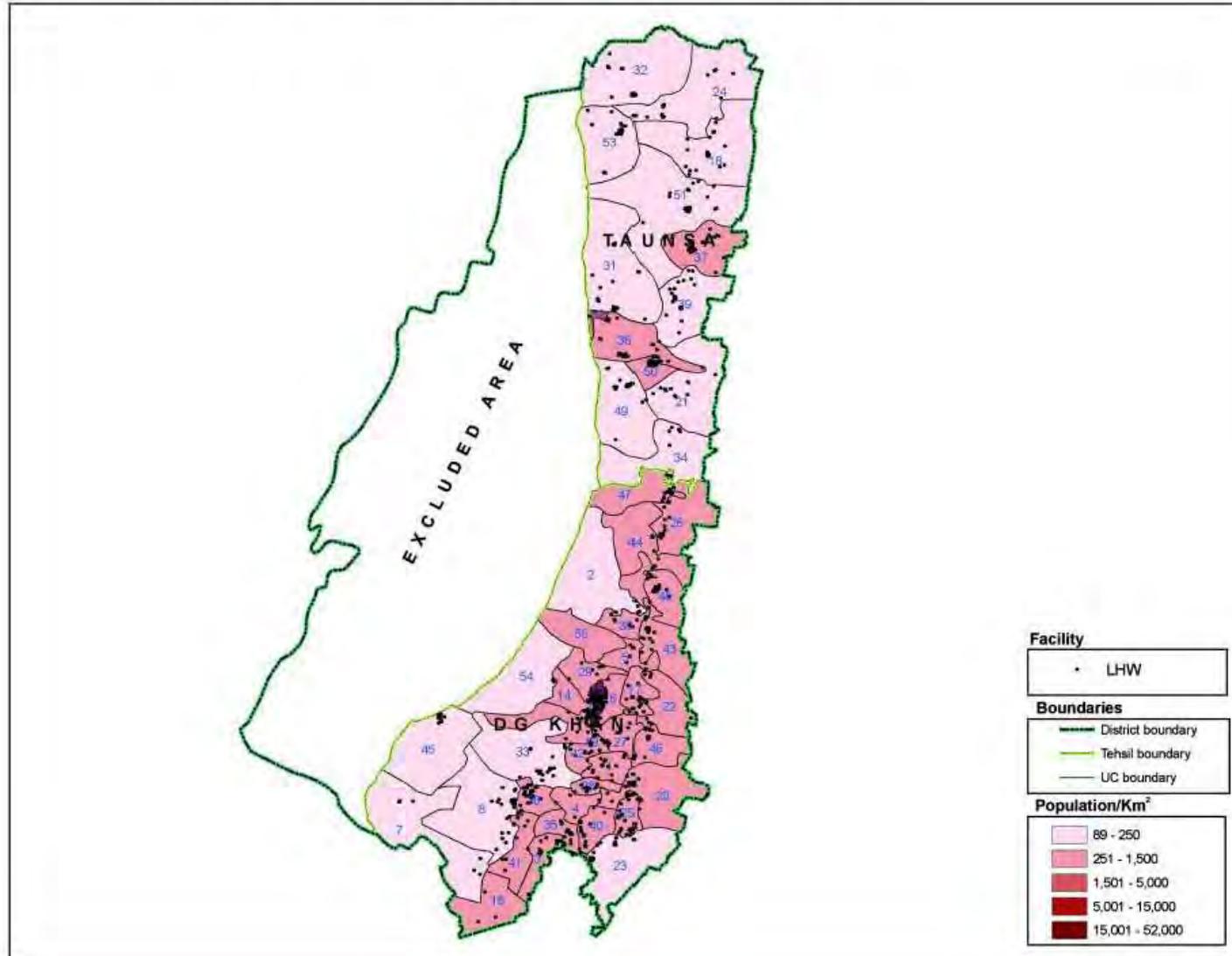
### List of Union Councils

1	Ali Wala	29	Kot Haibat
2	Bahadar Garh	30	Kot Mubarak
3	Basti Fauja	31	Kot Qaisarani
4	Basti Malana	32	Lakhani
5	Chabri	33	Mahmori
6	Chorota	34	Makwal Kalan
7	Choti Bala	35	Mana Ahmadani
8	Choti Zareen	36	Mangrotha
9	D.G.Khan 01	37	Morjhangi
10	D.G.Khan 02	38	Mutfariq Chahan
11	D.G.Khan 03	39	Narri Shumali
12	D.G.Khan 04	40	Nautak
13	D.G.Khan 05	41	Nawan
14	D.G.Khan 06	42	Paigan
15	D.G.Khan 07	43	Pir Adil
16	D.J.K Gharbi	44	Ranman
17	Drahma	45	Sakhi Sarwar
18	Fateh Khan	46	Samena
19	Gadai	47	Shadan Lund
20	Ghousabad	48	Shah Sadar Din
21	Hairosharqi	49	Sokar
22	Haji Ghazi Gharbi	50	Taunsa
23	Jakar Imam ShaH	51	Tibi Qaisarani
24	Jallowali	52	Tuman Qaisrani
25	Jhok Utra	53	Veho Wa
26	Kala	54	Wadoor
27	Khakhi	55	Yaru
28	Kot Chhutta		

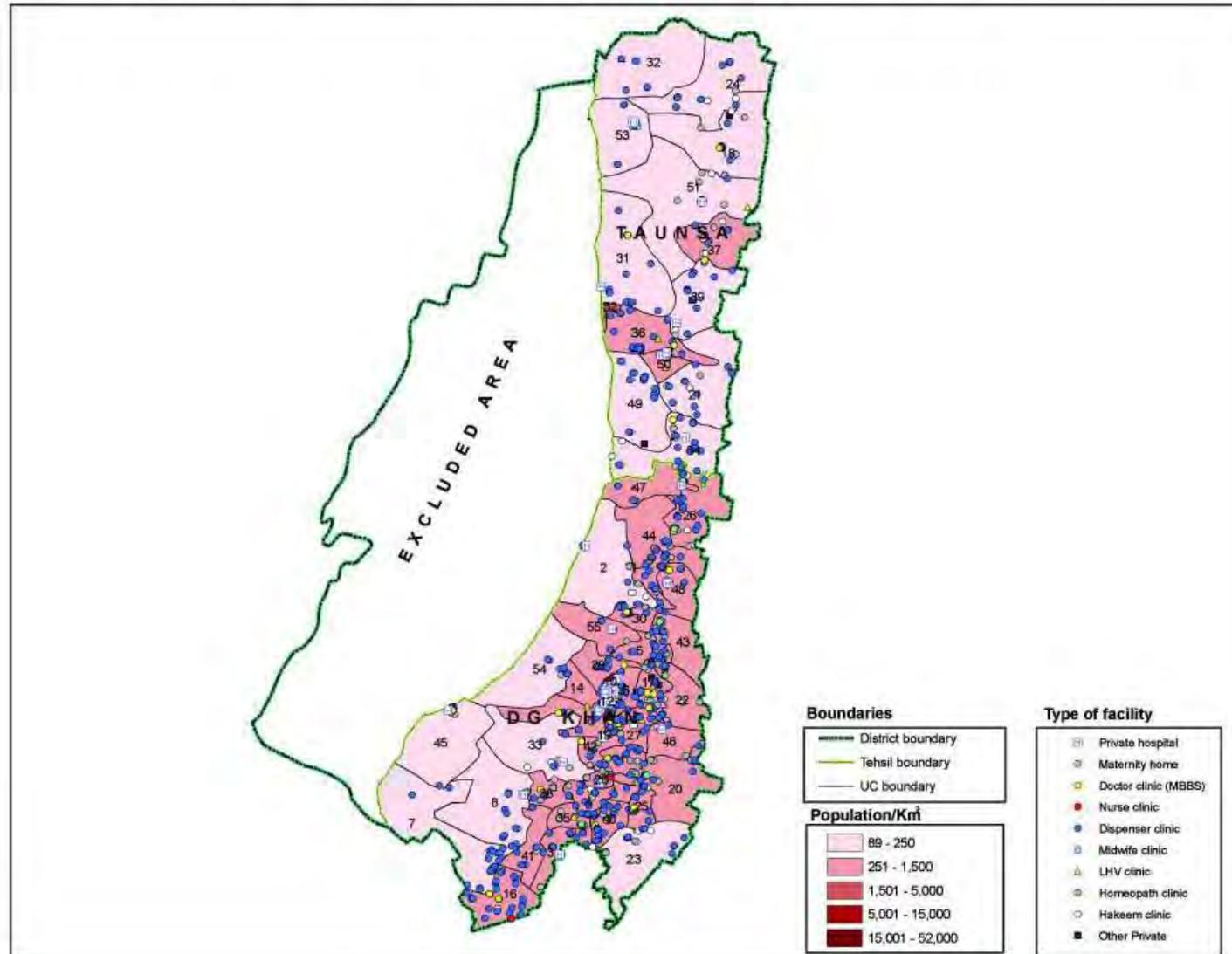
**Map 4.1: Location of government facilities in D.G. Khan district, by population density of union council**



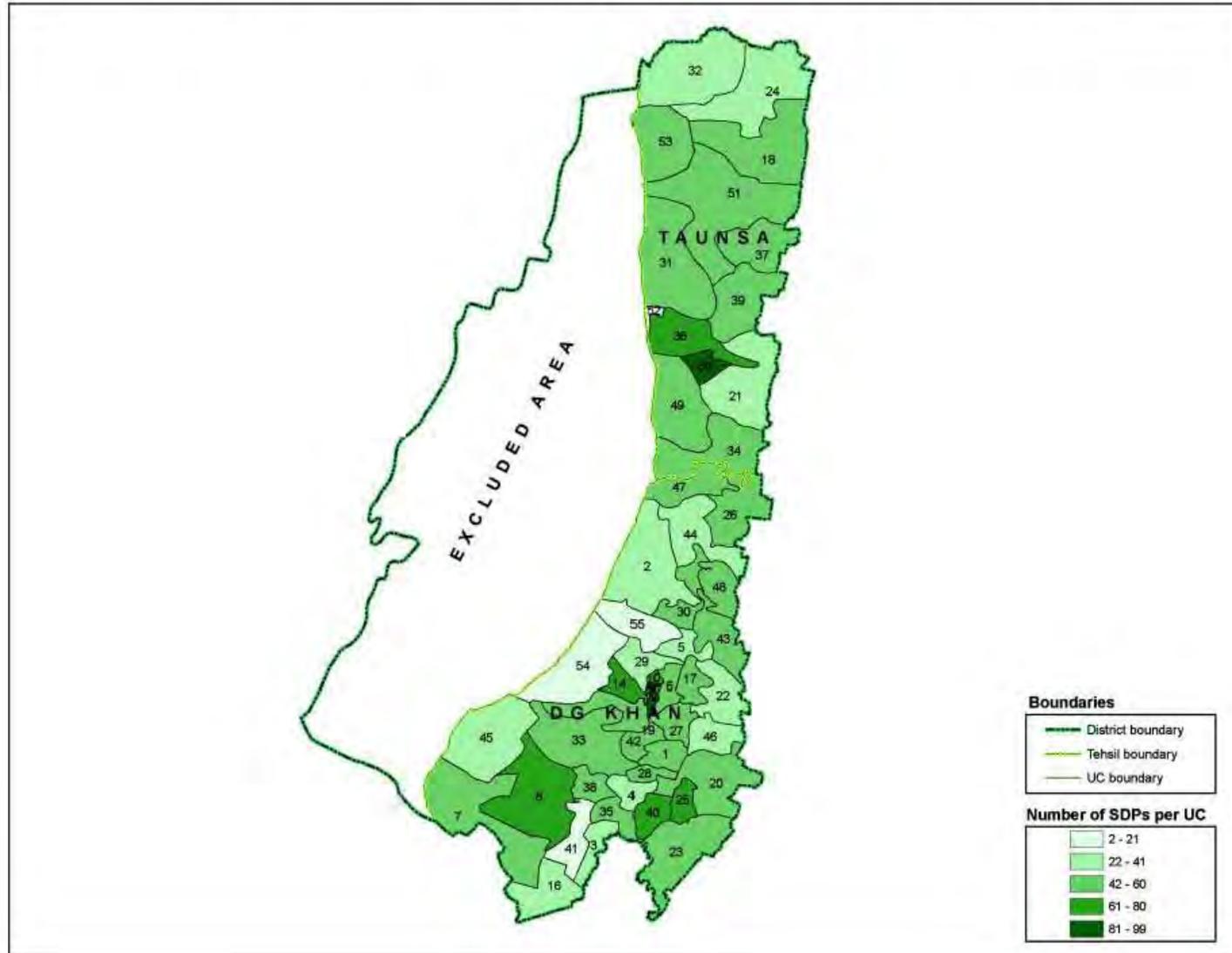
**Map 4.2: Location of LHWs in D.G. Khan district, by population density of union council**



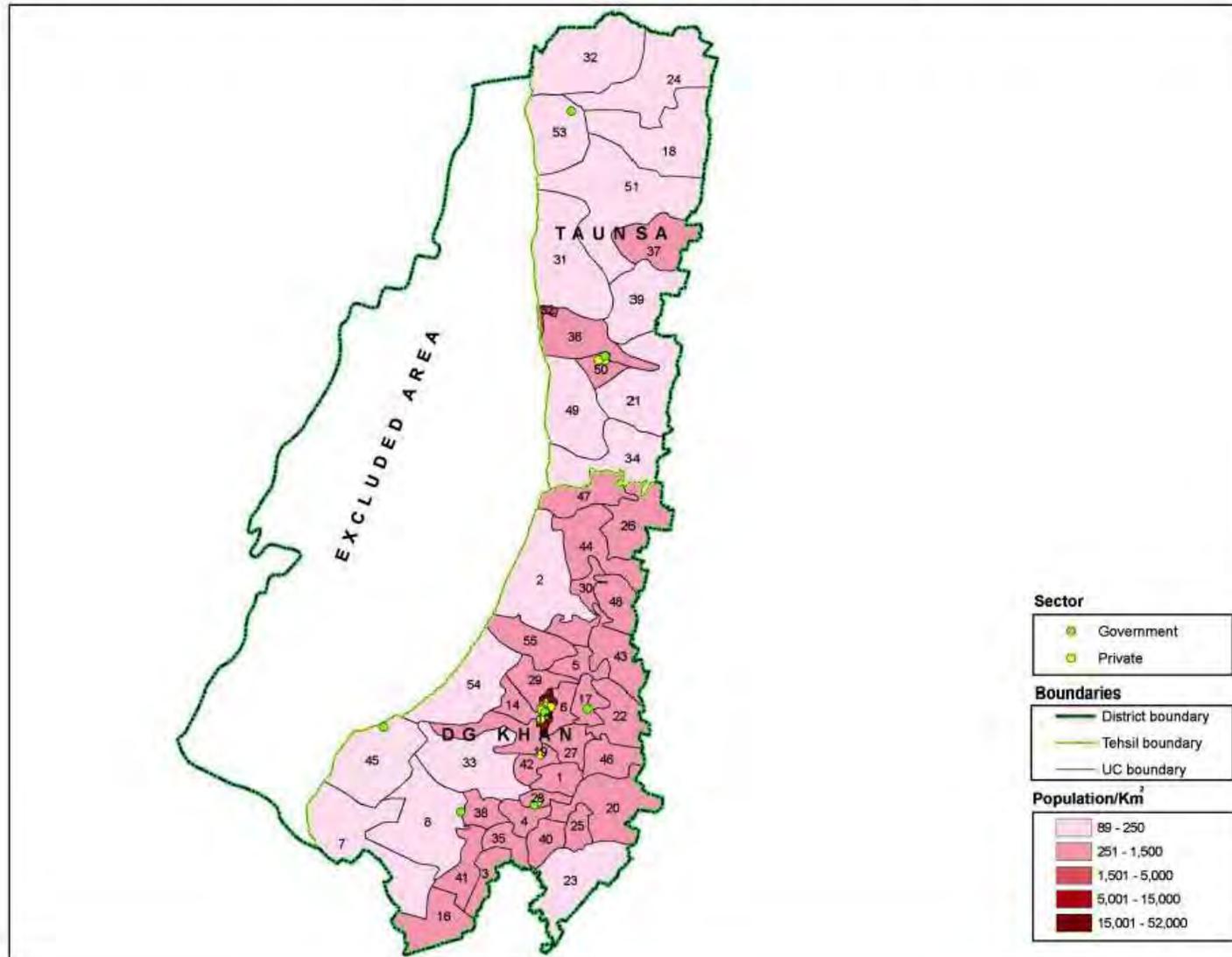
**Map 4.3: Location of private facilities in D.G. Khan district, by population density of union council**



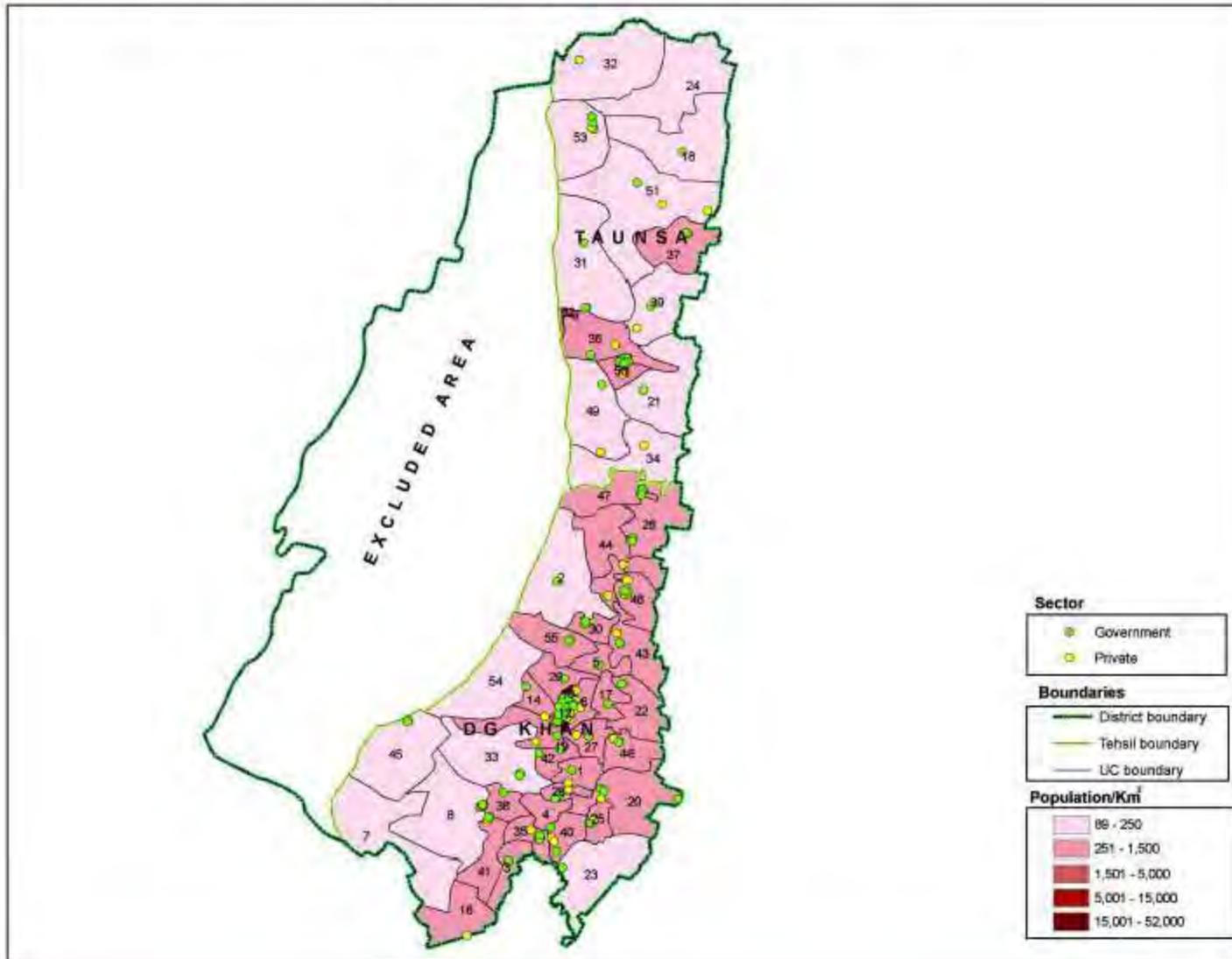
**Map 4.4: Total number of reproductive health service delivery points (public and private) in D.G. Khan district, by union council**



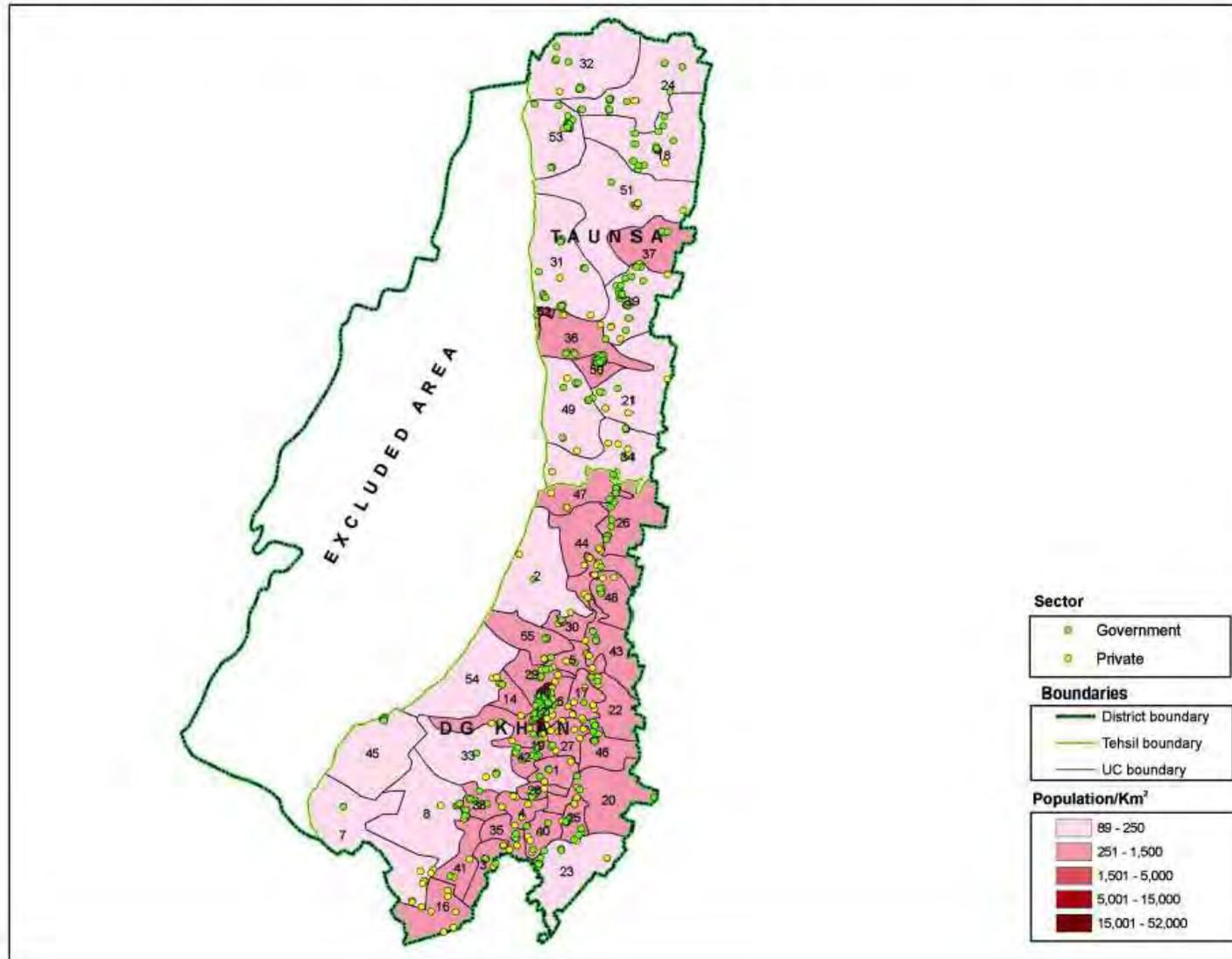
**Map 4.5: Location of female sterilization facilities in D.G. Khan district, by population density of union council**



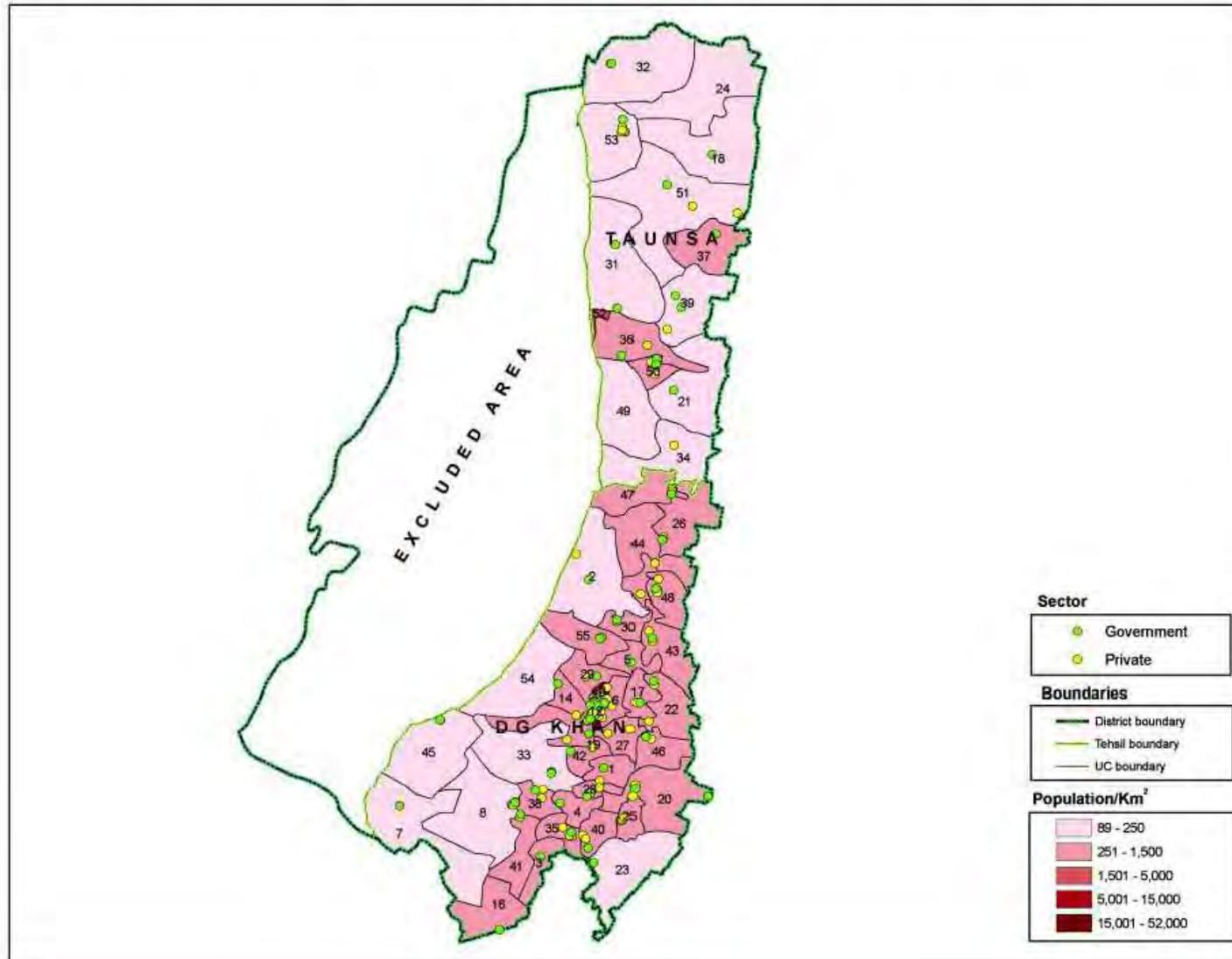
**Map 4.6: Location of IUD facilities in D.G. Khan district, by population density of union council**



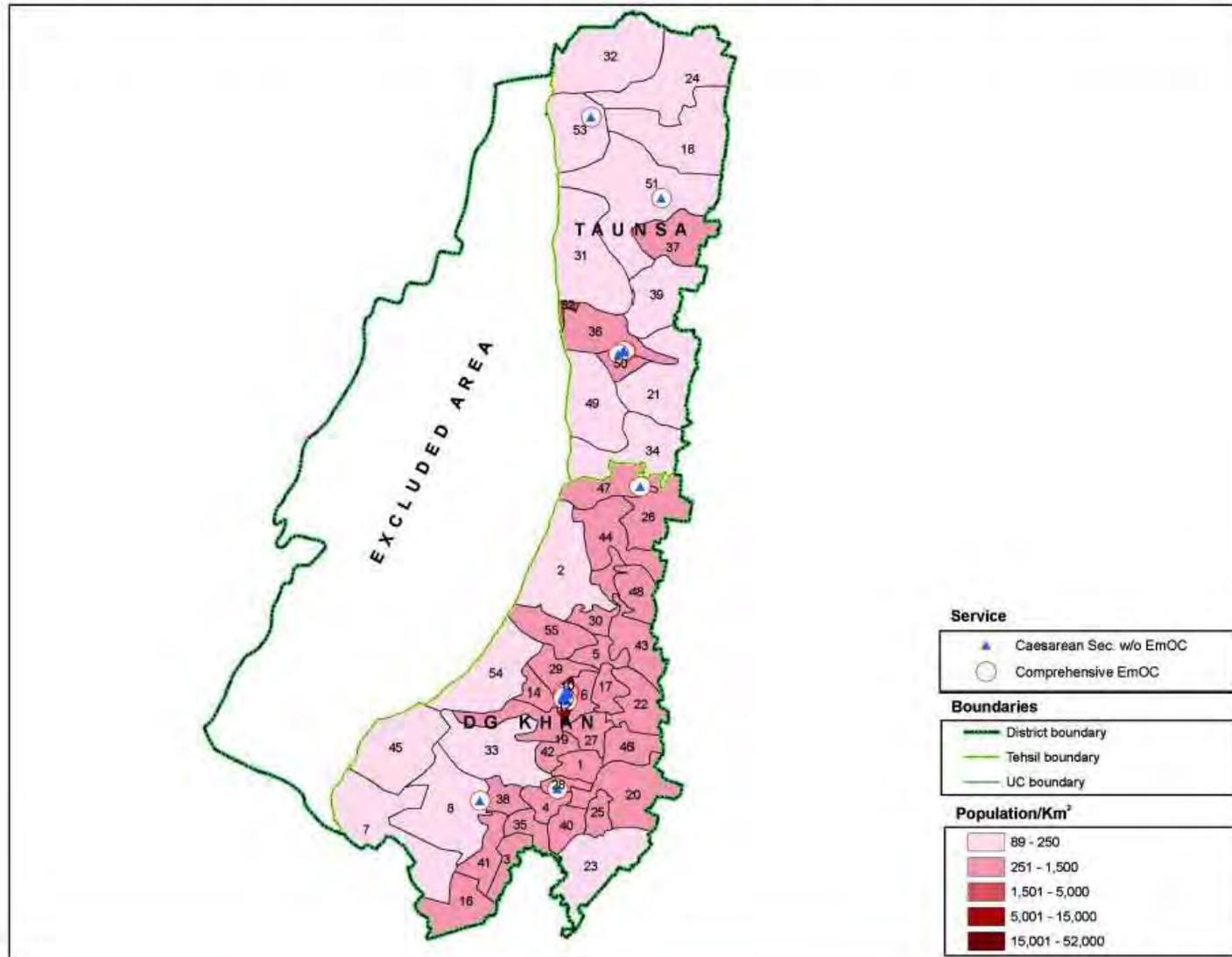
**Map 4.7: Location of injectables contraceptive services in D.G. Khan district, by population density of union council**



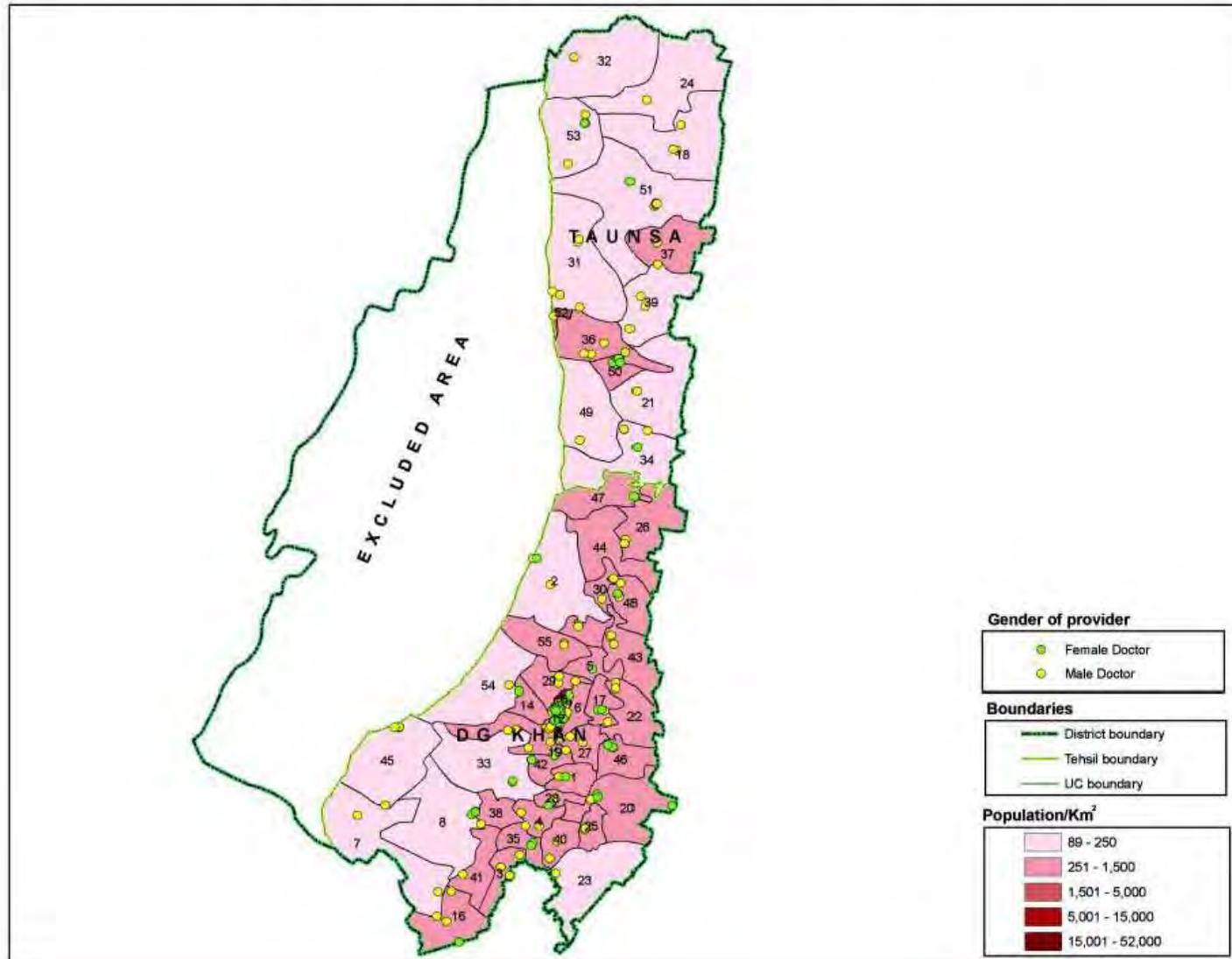
**Map 4.8: Location of essential obstetric services in D.G. Khan district, by population density of union council**



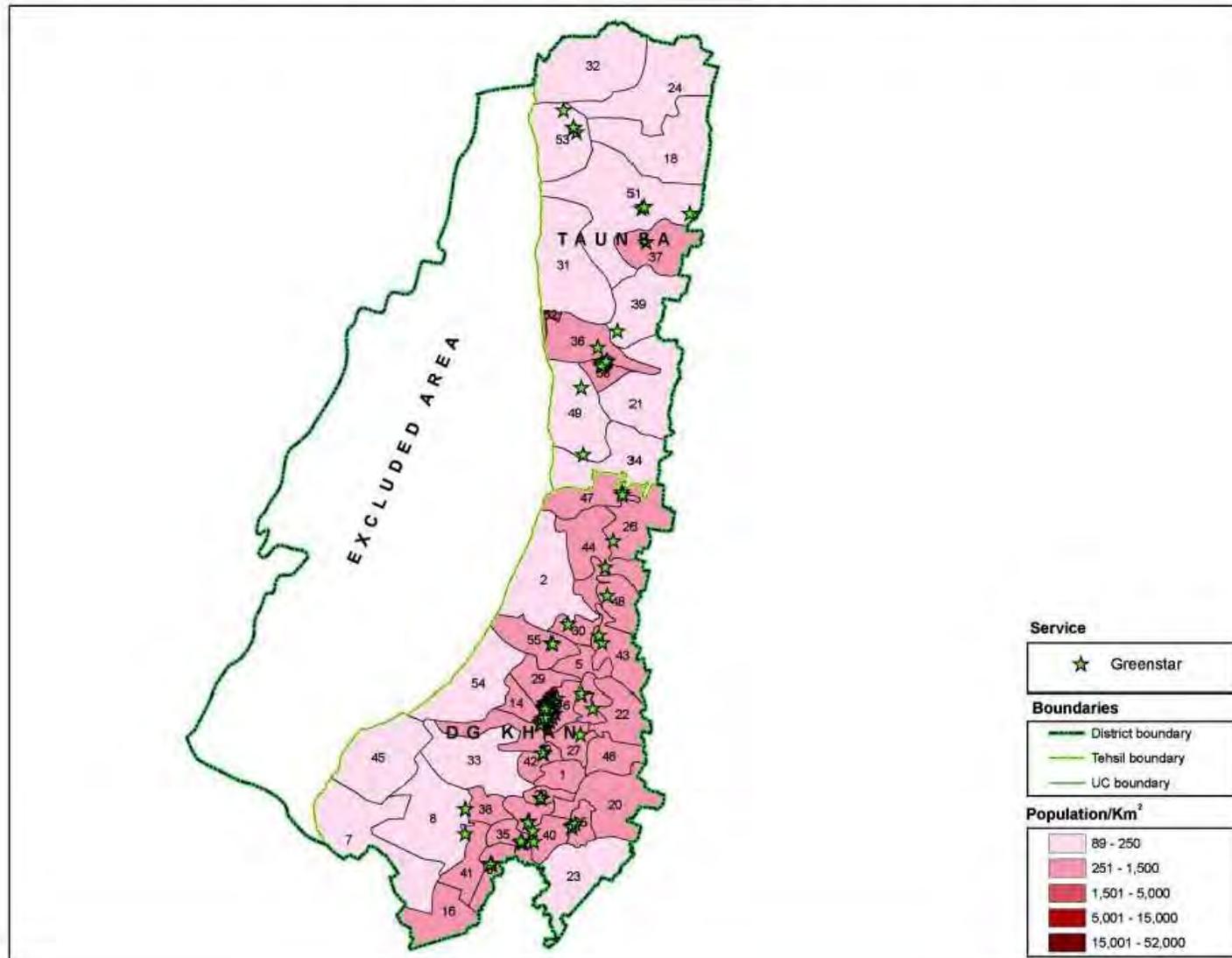
**Map 4.9: Location of emergency obstetric care facilities in D.G. Khan district, by population density of union council**



**Map 4.10: Location of doctors in D.G. Khan district, by gender and population density of union council**



**Map 4.11: Location of Greenstar Social Marketing SDPs in D.G. Khan district, by population density of union council**





# Chapter 5

## Fertility

The main objective of this baseline survey was to seek information on the level of knowledge and acceptance of using birth spacing methods to improve maternal and child health. Some information on fertility such as the number of children ever born and living children was collected from the currently married women. This information is used to obtain the level of cumulative fertility.

Other information collected through this baseline survey included the date of birth of all the live births and whether that child was still alive at the time of the survey. In case the mother did not recall the date of birth she was asked "How long ago was her live birth?" From those responses births which occurred during the last three years were ascertained. The number of births sought through this procedure is used to analyze current fertility. For a family planning program, it is essential to know about fertility to understand couples' responses to family planning.

## Cumulative Fertility

### Children Ever Born and Living

The number of children a woman has ever born 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 percent distribution of all currently married women by the number of children ever born (CEB). The table shows these distributions by the age of the woman at the time of the survey.

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

Age group	Children ever born					Mean CEB	N
	None	1 - 2	3 - 4	5 or more	%		
15 - 19	46.6	52.3	1.1	0.0	100.0	0.7	88
20 - 24	9.4	50.4	31.6	8.5	100.0	2.3	117
25 - 29	7.0	20.3	37.5	35.2	100.0	3.7	128
30 - 34	2.6	10.3	28.2	59.0	100.0	5.0	117
35 - 39	1.7	3.4	12.6	82.4	100.0	6.8	119
40 - 44	0.0	3.2	9.5	87.3	100.0	7.7	63
45 - 49	2.7	8.1	2.7	86.5	100.0	7.7	37
<b>Total</b>	<b>10.0</b>	<b>22.7</b>	<b>21.1</b>	<b>46.2</b>	<b>100.0</b>	<b>4.5</b>	<b>669</b>

The table shows that early childbearing is fairly common in D.G. Khan. The table, as expected, shows that the mean number of children ever born (Table 5.1) and living children (Table 5.2) increases with age of mother, as would be expected in data of good quality. Table 5.3 shows the mean number of sons and daughters, which also shows the quality of data. The mean number of children ever born increases from 0.7 in age group of 15-19 years to 7.7 in the age group of 45-49. Among women aged 15-49 in D.G. Khan, the mean number of children ever born is 4.5 for currently married women. The mean number of children ever born increases steadily with age, reaching a high of 7.7 children women aged 45-49. On average these women also have 6 living children marking the net loss of 1.7 children in their reproductive life.

**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	48.9	51.1	0.0	0.0	100.0	0.6	88
20 - 24	11.1	52.1	29.1	7.7	100.0	2.2	117
25 - 29	7.0	22.7	43.0	27.3	100.0	3.3	128
30 - 34	3.4	11.1	30.8	54.7	100.0	4.5	117
35 - 39	1.7	5.0	21.8	71.4	100.0	6.0	119
40 - 44	1.6	4.8	11.1	82.5	100.0	6.3	63
45 - 49	2.7	8.1	5.4	83.8	100.0	6.0	37
<b>Total</b>	<b>10.9</b>	<b>23.9</b>	<b>23.9</b>	<b>41.3</b>	<b>100.0</b>	<b>3.9</b>	<b>669</b>

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

Age group	Ever born			Surviving			N
	Boys	Girls	Total	Boys	Girls	Total	
15 - 19	0.3	0.4	0.7	0.3	0.4	0.6	88
20 - 24	1.2	1.2	2.3	1.1	1.1	2.2	117
25 - 29	1.9	1.9	3.7	1.7	1.6	3.3	128
30 - 34	2.4	2.6	5.0	2.1	2.4	4.5	117
35 - 39	3.6	3.3	6.8	3.1	2.8	6.0	119
40 - 44	4.0	3.7	7.7	3.3	3.0	6.3	63
45 - 49	3.6	4.1	7.7	2.7	3.3	6.0	37
<b>Total</b>	<b>2.2</b>	<b>2.2</b>	<b>4.5</b>	<b>1.9</b>	<b>1.9</b>	<b>3.9</b>	<b>669</b>

Table 5.1 also shows that more than 50 percent of married women 15-19 years of age have already had a child. Women age 45-49 have virtually completed childbearing. Among currently married women in this age group, 13 percent have reached the end of childbearing with fewer than five children ever born and 87 percent have five or more than five children ever born. Data show that 97 percent of women aged 45-49 had at least one live birth in their reproductive period, while 3 percent were nulliparous. The sex ratio at birth was 100 males per 100 females, the sex ratio of children living was also 100.

### Differentials in Children Ever Born and Surviving

Table 5.4 shows that differences in mean number of children by literacy and educational level of currently married women are pronounced. On average, 1.9 fewer children were born to literate women as compared with illiterate women. Also, fertility declines conversely with the level of education. Those who had “up to primary” education had on the average 3.6 children ever born as compared to 5 born to women who had no schooling. Those who had “up to secondary” education had 2.8 and those educated in college had 2.1 children ever born.

Differentials are also observed on the basis of literacy and economic activity of husbands. Those who had literate husbands had 4 as against 5.1 children ever born to those who had illiterate husbands. Women with illiterate husbands have slightly higher number of children ever born (5.1 children) compared to the women who themselves are illiterate (5 children). After this in that respect the occupation of agriculture falls with the highest number of children as 5.1. Women with husbands who have private service have the lowest number of children ever born (3.8 children). Comparison of mean numbers of children ever born and

surviving children shows that survival of children increases with literacy and educational level of mothers. The survival of children is also higher if husbands are literate.

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

Characteristic	Mean number of CEB	Mean number of LC	Proportion dead	N
<b>Literacy (respondents)</b>				
Literate	3.1	2.8	0.08	181
Illiterate	5.0	4.3	0.14	486
<b>Schooling (respondents)</b>				
No education	5.0	4.3	0.14	478
Up to primary	3.6	3.3	0.09	85
Up to secondary	2.8	2.6	0.08	70
Above secondary	2.1	2.1	0.04	34
<b>Residence (respondents)</b>				
Rural	4.5	3.9	0.13	594
Urban	4.0	3.6	0.10	75
<b>Literacy ( husbands)</b>				
Literate	4.0	3.6	0.12	402
Illiterate	5.1	4.4	0.14	257
<b>Schooling ( husbands)</b>				
No education	5.1	4.4	0.14	254
Up to primary	4.9	4.2	0.14	94
Up to secondary	3.9	3.4	0.13	218
Above secondary	3.6	3.3	0.08	93
<b>Standard of living index (respondents)</b>				
Low	4.9	4.2	0.14	212
Medium low	4.5	3.8	0.15	145
Medium high	4.2	3.7	0.11	145
High	4.1	3.6	0.10	167
<b>Economic activity/occupation ( husbands)</b>				
Agriculture/livestock/poultry	5.1	4.3	0.15	159
Petty trader	4.1	3.5	0.13	52
Labor (daily wages)	4.5	3.9	0.12	146
Government service	4.4	3.9	0.11	79
Private service	3.8	3.4	0.11	60
Own business	4.0	3.6	0.09	59
Working abroad	4.1	3.5	0.14	72
Unemployed	4.8	4.0	0.16	37
Others	5.2	4.6	0.12	5
<b>Total</b>	<b>4.5</b>	<b>3.9</b>	<b>0.13</b>	<b>669</b>

Table 5.5 further explains the relationship between age of mothers and literacy with mean number of children ever born and their survival. It is evident that the mean number of children ever born to literate mothers was lower (3.1 children) compared with that of mothers who were illiterate (5 children). Similarly, the survival of children with literate mothers was far better than with illiterate mothers. The mean number of children ever-born to younger literate mothers was lower and their survival was better than children born to mothers in older age groups. Literate mothers were younger than illiterate mothers. In the below 30 age group, 58 percent were literate, as compared to 47 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	0.5	0.4	26	14.4	0.8	0.7	62	12.8
20 - 24	1.6	1.6	42	23.2	2.7	2.6	74	15.2
25 - 29	3.2	2.9	37	20.4	3.9	3.5	90	18.5
30 - 34	3.6	3.5	35	19.3	5.6	4.9	82	16.9
35 - 39	5.4	5.0	24	13.3	7.2	6.2	95	19.5
40 - 44	6.0	5.3	12	6.6	8.1	6.5	51	10.5
45 - 49	5.8	4.0	5	2.8	8.0	6.3	32	6.6
<b>Total</b>	<b>3.1</b>	<b>2.8</b>	<b>181</b>	<b>100.0</b>	<b>5.0</b>	<b>4.3</b>	<b>486</b>	<b>100.0</b>

## Current Fertility

### Crude Birth Rate (CBR)

The Crude Birth Rate though a crude measure of fertility is the most widely understood and used fertility measure. In this survey, it is calculated from the number of births occurred during the last three years before the survey and the mid-period total population in the sample households. The baseline survey provides an estimate of 34 births per thousand population (Table 5.6).

## Age Specific Fertility Rates (ASFRs) and Total Fertility Rate (TFR)

The TFR is a more refined measure of fertility than CBR. 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 lower number of births in the sample during the last three years. Rates rise rapidly up to age 20-24, then decline with increasing age. It is lowest in the age group 40-44. The point noteworthy is that no birth has occurred during the last three years in the age group of 45-49; reasons are not known. A TFR of 4.7 for the period of 2004-2007 is obtained from the set of ASFRs calculated from the data presented in Table 5.6, compared with 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	269	56	69.4
20 - 24	196	139	236.4
25 - 29	161	110	227.7
30 - 34	132	83	209.6
35 - 39	128	57	148.4
40 - 44	72	11	50.9
45 - 49	53	0	0.0
<b>Total</b>	<b>1011</b>	<b>456</b>	<b>na</b>
<b>TFR: 4.7</b>			
<b>CBR: 34.3</b>			

na=not applicable.

## Mothers with Children Under Five Years

If mothers have their next child while they are breast-feeding their earlier child, they are often less able to produce breast milk for the previous child. When children are weaned too soon, their growth suffers; they are more likely to suffer from diarrheal diseases. Milk diminution is more likely to occur as women have more children and are undernourished. In addition, when children are close in age, they compete for resources as well as for maternal care. Moreover, mother may not be able to breastfeed the older sibling properly, either because her milk flow slows or because her time is taken up by the newborn as well

as other household chores. Mothers also may not be able to breastfeed the newborn properly placing the newborn at higher risk for nutritional deficiency and infectious diseases contracted from older siblings.

Table 5.7 shows a significant number of women with the burden of caring for other young children. Among those who already have two living children under 5 years of age, 14 percent are currently pregnant. For such mothers, it is particularly important for their health and that of their children to ensure that birth spacing is part of their married life at that point.

**Table 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	21	9.0	213	91.0	234	100.0
1	28	14.7	162	85.3	190	100.0
2	25	14.1	152	85.9	177	100.0
3	6	9.1	60	90.9	66	100.0
4	0	0.0	2	100.0	2	100.0
<b>Total</b>	<b>80</b>	<b>12.0</b>	<b>589</b>	<b>88.0</b>	<b>669</b>	<b>100.0</b>

### Preceding Birth Interval

Women with short birth intervals are at higher risk for delivering premature, low-birth-weight or small-for-gestational age infants. So the length of the preceding birth interval is very important for the health of both: mothers and the 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 & above months	Total	N
<b>Age group</b>							
15 - 19	54.5	36.4	9.1	0.0	0.0	100.0	11
20 - 24	29.6	35.7	19.4	12.2	3.1	100.0	98
25 - 29	19.7	23.5	32.6	15.2	9.1	100.0	132
30 - 34	11.8	14.7	40.2	17.6	15.7	100.0	102
35 - 39	6.8	21.6	29.7	27.0	14.9	100.0	74
40 - 44	0.0	0.0	45.5	9.1	45.5	100.0	11
45 - 49	0.0	0.0	0.0	0.0	0.0	0.0	0
<b>Birth order</b>							
2	29.1	27.3	23.6	14.5	5.5	100.0	55
3	24.0	22.7	22.7	18.7	12.0	100.0	75
4	18.6	32.9	21.4	12.9	14.3	100.0	70
5	8.8	22.8	31.6	22.8	14.0	100.0	57
6+	15.2	19.3	39.8	15.8	9.9	100.0	171
<b>Education level</b>							
No education	16.3	24.6	32.0	17.8	9.2	100.0	325
Up to primary	19.6	21.7	26.1	15.2	17.4	100.0	46
Up to secondary	33.3	19.0	26.2	7.1	14.3	100.0	42
Above secondary	7.7	23.1	23.1	23.1	23.1	100.0	13
<b>Standard of living index</b>							
Low	16.3	23.8	32.5	19.4	8.1	100.0	160
Medium low	16.8	27.1	28.0	19.6	8.4	100.0	107
Medium high	24.2	29.7	29.7	7.7	8.8	100.0	91
High	17.1	10.0	31.4	17.1	24.3	100.0	70
<b>Total</b>	<b>18.2</b>	<b>23.6</b>	<b>30.6</b>	<b>16.6</b>	<b>11.0</b>	<b>100.0</b>	<b>428</b>

A short interval has traditionally been viewed as a risk factor for poor pregnancy outcomes, particularly infant mortality in developing countries. It has been observed that the death risks of an index child whose birth closes a short birth interval are higher than those experienced by an index child whose birth closes a longer birth interval (Mahmood, 2002).

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

Table 5.8 shows that 18 percent of children were born with less than 18 months of birth interval. Almost 72 percent were born with a birth interval of less than 36 months, while 28 percent were born after three years or more. The differentials by mother's age, educational level and standard of living index are also shown. Younger and lower-parity women – particularly women 15-19 and of parity 2 – are substantially more likely to have short birth intervals.



# 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 406 women out of the 669 total women interviewed had borne a child during the past four years, and so were asked these questions.

### Antenatal Care

Antenatal check-ups allow for skilled health personnel to advise expecting mothers as to how to best take care of themselves and their unborn baby during pregnancy, to prepare them for childbirth and care of the newborn, and to identify possible problems during pregnancy and delivery. The Ministry of Health recommends at least three antenatal visits during pregnancy, preferably four. Traditionally many women, understanding childbirth as a natural experience and perhaps not finding nearby health providers, have not gone to skilled providers for antenatal care, but in recent years those proportions have been increasing in Pakistan. Table 6.1 and figure 6.1 show the numbers of ANC visits for the last birth of women who had delivered during the previous four years. About 75 percent of the 406 sample respondents who delivered a child during the previous 4 years had obtained at least one antenatal care visit during the last pregnancy. Interestingly, all the women in urban areas had at least one antenatal visit during the last pregnancy. This is significantly higher than the level obtained for D.G. Khan in the 2004-05 PSLM Survey (58 percent), the level for Punjab in the PDHS (61 percent) or the level obtained nationally in the PDHS (61 percent) (Government of Pakistan, 2006; NIPS/PDHS, 2008). Forty-three percent had at least three such visits.

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

Number of visits	Rural		Urban		Total	
	N	%	N	%	N	%
No visit	100	26.7	0	0.0	100	24.6
1-2 visits	124	33.2	5	15.6	129	31.8
3 visits	63	16.8	5	15.6	68	16.7
4+ visits	87	23.2	22	68.8	109	26.9
<b>Total</b>	<b>374</b>	<b>100.0</b>	<b>32</b>	<b>100.0</b>	<b>406</b>	<b>100.0</b>

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

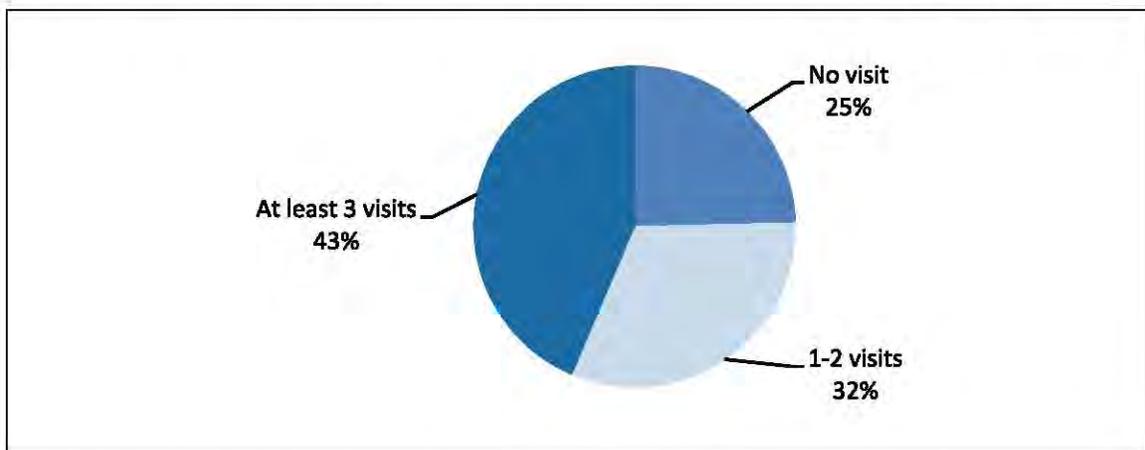
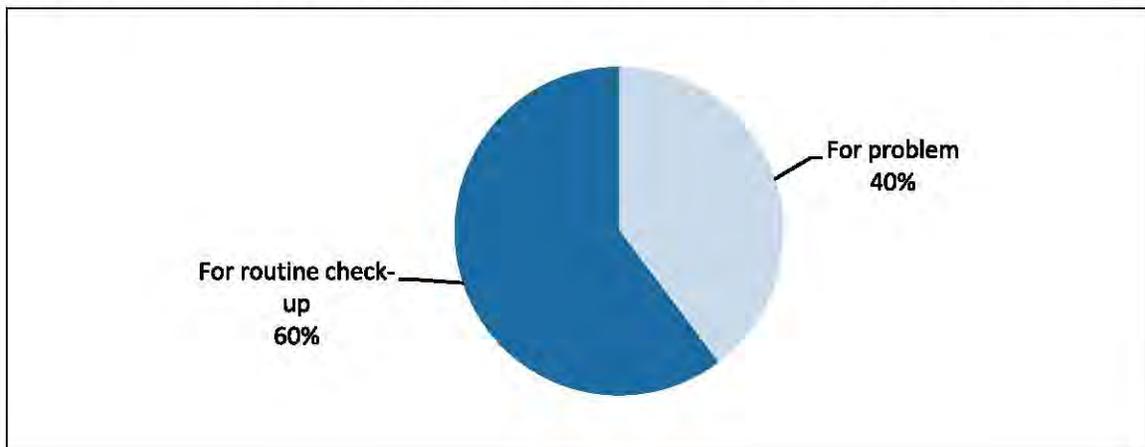


Figure 6.2 shows that in many of these visits were for a routine check-up rather than in response to some problem. Forty percent of the first antenatal visits were for curative purpose.

**Figure 6.2: Percentage of MWRA by reason for first antenatal visit during last pregnancy**



Data also show that 28 percent women made first visit within the first three months of gestation, and 20 percent of first visits occurred during the third trimester (Figure 6.3).

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

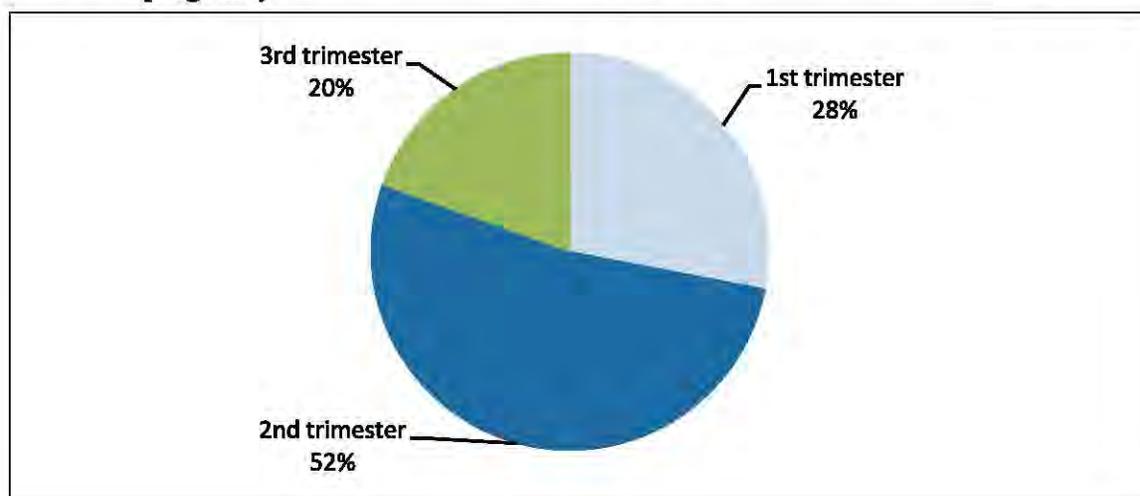
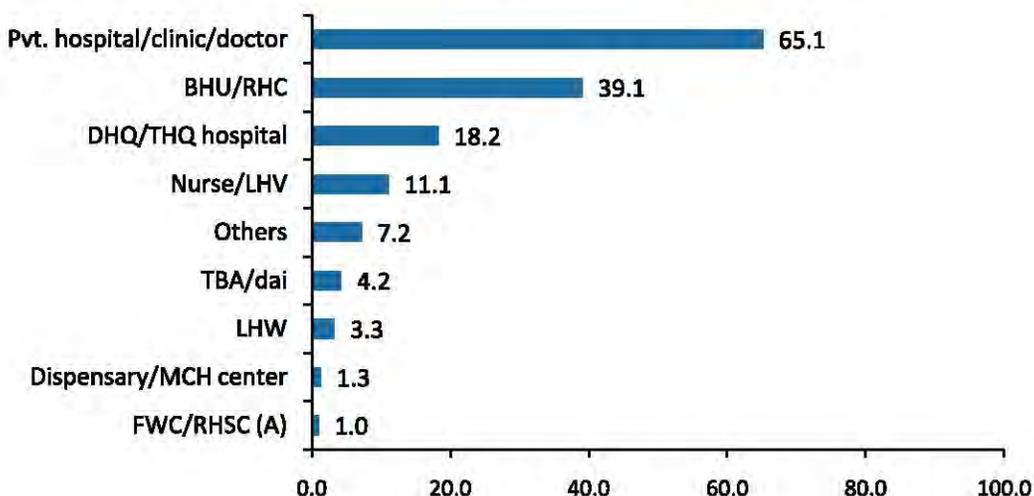


Table 6.2 shows the locations where respondents made one or more antenatal visits. Most antenatal visits took place in private sector facilities. The most common providers of antenatal care were private hospitals and clinics followed by BHUs/RHCs, DHQ/THQ hospitals; other providers were less common.

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

Facility/service provider	Rural	Urban	Total
Dispensary/MCH center	1.1	3.1	1.3
BHU/RHC	43.6	0.0	39.1
DHQ/THQ hospital	13.8	56.3	18.2
Pvt. hospital/clinic/doctor	63.3	81.3	65.1
FWC/RHSC (A)	0.7	3.1	1.0
LHW	3.6	0.0	3.3
TBA/dai	4.7	0.0	4.2
Nurse/LHV	11.6	6.3	11.1
Others	7.6	3.1	7.2
<b>N</b>	<b>275</b>	<b>32</b>	<b>307</b>

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

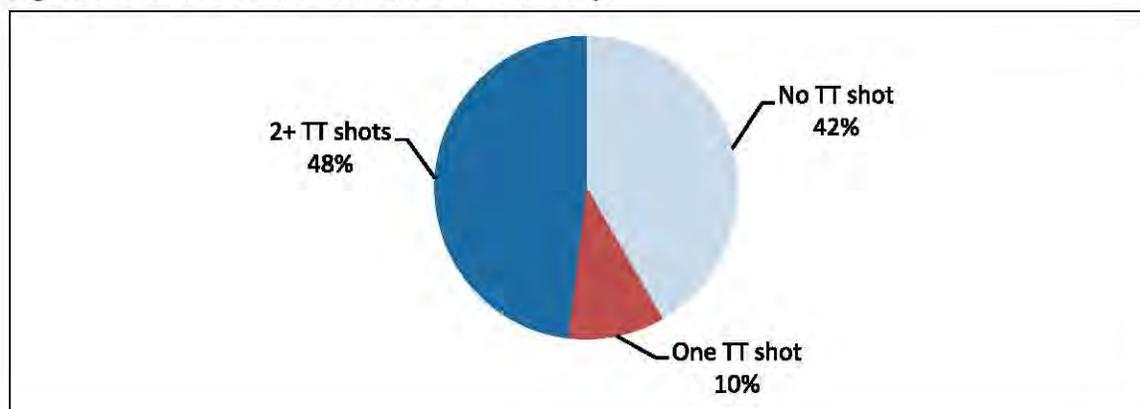


## Tetanus Immunization

Tetanus toxoid immunization is important to avoid tetanus in the newborn and mother. Two doses in a pregnancy are sufficient to prevent tetanus; however, if the woman was immunized during her previous pregnancy only one dose may be needed, and five doses are sufficient for lifetime protection. According to PSLMS 2004-05, 65 percent of mothers in D.G. Khan had received at least one shot; according to the PDHS 2006-07, 59 percent in Punjab and 53 percent nationally were appropriately protected from tetanus, according to guidelines (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 6.3 and Figure 6.5 show that 58 percent of mothers had received at least one shot during their last pregnancy, and 48 percent had received two or more shots. The immunization rate was higher in urban areas. A substantial proportion of mothers remain unprotected.

**Table 6.3: Tetanus immunization at last delivery**

Number of injections	Rural		Urban		Total	
	N	%	N	%	N	%
No TT shot	162	43.3	7	21.9	169	41.6
One TT shot	39	10.4	3	9.4	42	10.3
2+ TT shots	173	46.3	22	68.8	195	48.0
<b>Total</b>	<b>374</b>	<b>100.0</b>	<b>32</b>	<b>100.0</b>	<b>406</b>	<b>100.0</b>

**Figure 6.5: Tetanus immunization at last delivery**

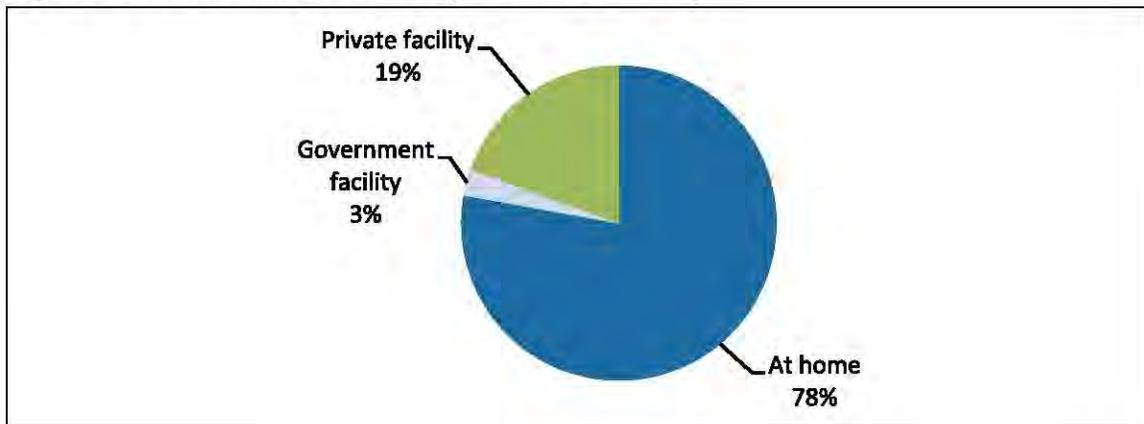
## Location and Attendance at Delivery

One of the most important ways to reduce maternal mortality is to increase the proportion of mothers delivering in a health facility with the support of a trained birth attendant. These proportions have been historically low in Pakistan, contributing substantially to high maternal mortality, but have been rising in recent years. In D.G. Khan according to the 2004-05 PSLMS, 13 percent of 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, 22 percent of the most recent deliveries were in some health facility. (Table 6.4 and Figure 6.6). Very high proportion of deliveries took place in private hospitals /clinics (19 percent); others have less role even the public facilities. This shows more confidence of the people in private sector as well as importance accorded to mothers for their special care in the event like delivery.

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

Place of delivery	Rural		Urban		Total	
	N	%	N	%	N	%
At home	308	82.4	8	25.0	316	77.8
Dispensary/MCH center	0	0.0	2	6.3	2	0.5
BHU/RHC	2	0.5	0	0.0	2	0.5
DHQ/THQ hospital	4	1.1	2	6.3	6	1.5
Pvt. hospital/clinic	58	15.5	19	59.4	77	19.0
FWC/RHSC(A)	1	0.3	0	0.0	1	0.2
Others	1	0.3	1	3.1	2	0.5
<b>Total</b>	<b>374</b>	<b>100.0</b>	<b>32</b>	<b>100.0</b>	<b>406</b>	<b>100.0</b>

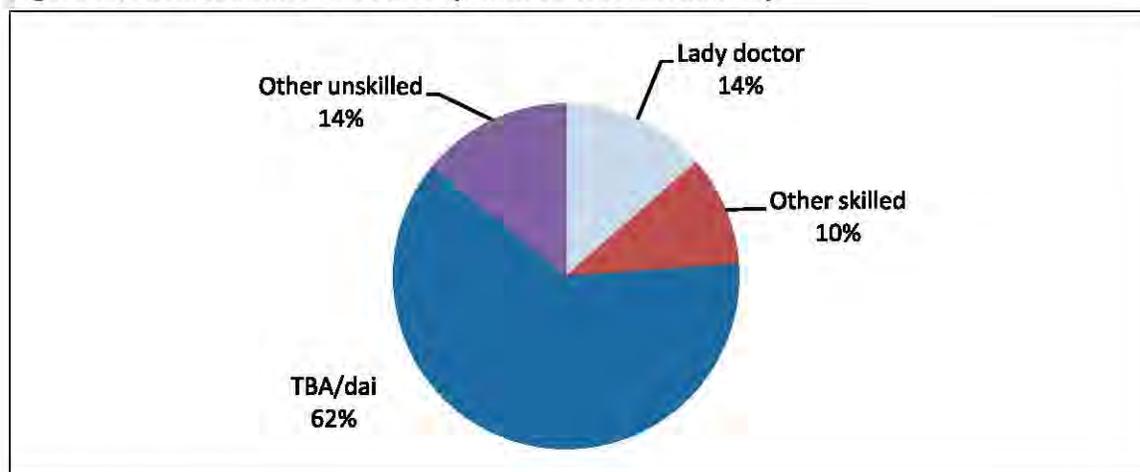
**Figure 6.6: Distribution of mothers by location of delivery**



In this survey, 24 percent of reported deliveries in the previous 4 years were delivered by a skilled birth attendant. (Table 6.5 and Figure 6.7). This shows that the proportion of deliveries by unskilled attendant is very high (76 percent) posing the lives of mothers at high risk. Though the situation is far better in urban areas where 78 percent deliveries were performed by skilled attendant. In the PSLMS 2004-05 for D.G. Khan, only 16 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). About 62 percent of births were delivered by *dais* (traditional birth attendants), while another 14 percent, all in rural areas, were delivered by a relative or neighbor who was not a dai.

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

Type of birth attendant	Rural		Urban		Total	
	N	%	N	%	N	%
No one	2	0.5	0	0.0	2	.5
TBA/dai	245	65.5	7	21.9	252	62.1
Nurse/LHV	36	9.6	6	18.8	42	10.3
Lady doctor	36	9.6	19	59.4	55	13.5
Female relative /friend /neighbor (not dai)	55	14.7	0	0.0	55	13.5
<b>Total</b>	<b>374</b>	<b>100.0</b>	<b>32</b>	<b>100.0</b>	<b>406</b>	<b>100.0</b>
Skilled birth attendant	72	19.3	25	78.1	97	23.9
Unskilled birth attendant	302	80.7	7	21.9	309	76.1

**Figure 6.7: Distribution of mothers by attendant at last delivery**

## Postnatal Care

For both the health of the mother and the health of the newborn, a newly delivered mother and baby should be followed up for at least about 6 weeks after delivery; MOH guidelines recommend at least one postnatal visit after discharge during the first 42 days after delivery. This, however, is a major weakness of MNH care in Pakistan; women who deliver at home rarely go for any postnatal check-up, and women who deliver in facilities will usually be seen while they are in the facility, but not after. D.G. Khan is no exception. Almost 27 percent of respondents reported having postnatal care within 40 days after delivery (Table 6.6), compared with 43 percent nationally and 40 percent in Punjab (NIPS/PDHS, 2008). Twenty-four percent postnatal check-up occurred during 24 hours. Unsurprisingly, only 7 percent of women delivered at home reported one or more postnatal visits. This bears investigation: at face value, this represents very poor care at the facilities, although possibly some respondents don't know what a postnatal check-up is, and may have actually received such care without knowing it.

In any case, with regard to family planning, the absence of postpartum visits represents a missed opportunity to talk to the mother about birth spacing. Much international evidence supports the value of the postpartum period as a critical time for the mother to focus on family planning and how it might assist in postponing the next pregnancy or in ending childbearing.

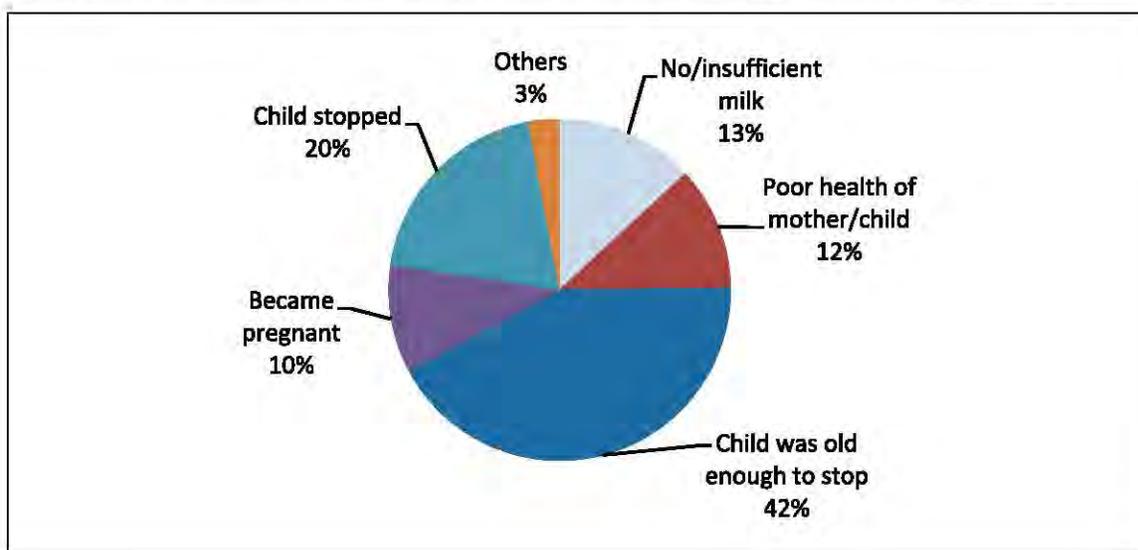
**Table 6.6: Distribution of mothers by status of postnatal check-up and place of delivery**

Place of delivery	Within 24 hours		After 24 hours		Didn't have postnatal check-up		Total	
	N	%	N	%	N	%	N	%
Institution	88	100.0	0	0.0	0	0.0	88	100.0
Non-institution	9	2.8	14	4.4	295	92.8	318	100.0
<b>Total</b>	<b>97</b>	<b>23.9</b>	<b>14</b>	<b>3.4</b>	<b>295</b>	<b>72.7</b>	<b>406</b>	<b>100.0</b>

## Breastfeeding

Breastfeeding is a critical component of newborn and infant health. In addition, it is a primary determinant of the length of postpartum amenorrhea. In this aspect, breastfeeding can be consciously 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 13 of 406 respondents reported not having breastfed their last child at all. Breastfeeding is normally done for a substantial time; the median length of breastfeeding for the last baby (not currently being breastfed) was 18 months, and the most common length was 24 months. Five main reasons were given for discontinuation of breastfeeding: child was old enough (42 percent); child stopped (20 percent), no or insufficient milk (13 percent); poor health of mother or child (12 percent) and mother became pregnant (10 percent).

**Figure 6.8: Distribution of mothers by reasons for discontinuing breastfeeding (n=137)**





# Chapter 7

## Preference for Children

To understand how to meet peoples' family planning needs, it is essential to understand how they feel about the number and timing of the children they want. Couples' views on this typically evolve over the course of their reproductive years: in the beginning, they want their first children quickly; toward the end of their reproductive lives, they are quite sure they want to stop. At some point in the middle, they may go through a period of ambivalence, where their views are uncertain and conflicted. Husbands and wives may or may not agree on these matters, and may or may not communicate well. Often it is difficult to get at the full truth of couples' feelings on these issues, because they themselves do not fully know. We can, however, ask questions and record responses, and investigate in as much depth as possible.

## Ideal Number of Children

One way of investigating fertility preference is to ask respondents, regardless of current fertility status, what they would ideally want. The exact wording, asked from female respondents, was (English translation): "If you could choose exactly the number of children to have in your whole life, how many would that be?" Table 7.1 shows the responses.

**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	0.2	0	0.0	1	0.1
2	34	5.7	17	22.7	51	7.6
3	44	7.4	13	17.3	57	8.5
4	247	41.6	32	42.7	279	41.7
5	82	13.8	5	6.7	87	13.0
6	88	14.8	6	8.0	94	14.1
7+	91	15.3	2	2.7	93	13.9
Up to God	7	1.2	0	0.0	7	1.0
<b>Total</b>	<b>594</b>	<b>100.0</b>	<b>75</b>	<b>100.0</b>	<b>669</b>	<b>100.0</b>

The median “ideal” number, in the sense indicated above, is four children; 58 percent of respondents wanted four or fewer but most preferred four. However, only 8 percent viewed their desire for two or fewer children. These proportions vary according to residence but urban –rural women both are also on the same wave for the best number as four. Urban women did not give non-numeric response while only 1.2 percent rural women left it up to the will of God.

## Desire for More Children

### Levels of desire for more children

A more immediate measure of fertility preference is whether a couple wants to have more children; if so, do they want the next child now or later, and how many more do they want. The desire for future children is closely linked with the number of children a couple already has. Table 7.2 shows, whether respondents want more children soon, later (after 2 years or more) or not at all, by the number of living children they already have. More than half of the respondents (55 percent) do not want more children whereas, near to a quarter (24 percent) want to delay their next child while 21 percent want soon. The proportion wanting more children sooner rather than later, declines sharply after the first birth. Among those who have one living child, most of the respondents who want an additional child want to have it later, rather than right away. On the other hand, most women with three or more living children do not want to have more children; for those with five or more, the

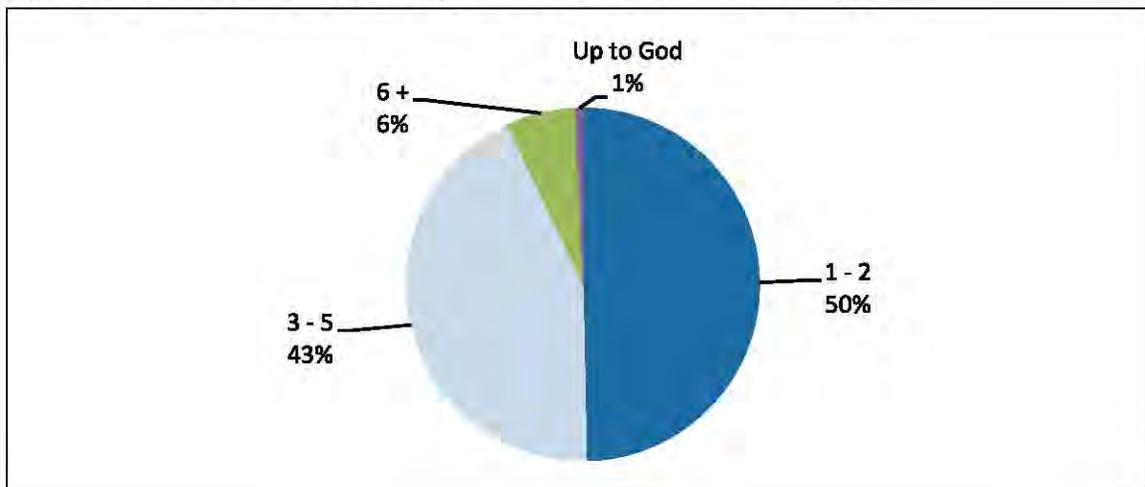
proportion wanting to stop is over 80 percent. This table clearly indicates the level of interest vested in both spacing and limiting births.

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

Number of living children	Desire for more children				Total	
	Soon	Later	Never	Don't know/ unsure	N	%
0	68.5	31.5	0.0	0.0	73	100.0
1	39.0	57.1	2.6	1.3	77	100.0
2	28.9	44.6	26.5	0.0	83	100.0
3	21.8	27.6	50.6	0.0	87	100.0
4	5.5	20.5	74.0	0.0	73	100.0
5	9.5	10.5	80.0	0.0	95	100.0
6 +	2.8	4.4	92.3	0.6	181	100.0
<b>Total</b>	<b>21.1</b>	<b>24.1</b>	<b>54.6</b>	<b>0.3</b>	<b>669</b>	<b>100.0</b>
N	141	161	365	2	669	100.0

For those women who wanted more children, we also asked how many more. About half of the women who wanted more, and who had an opinion, wanted one or two more children. Almost one percent of the respondents opined that having more children is up to God. This proportion tends to be higher for those with fewer children. It would be useful to explore what such respondents mean; i.e., whether this is a religious statement, an indication that she has not thought about it, or a polite way of telling the interviewer that she does not want to talk about it.

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



## Socioeconomic Correlates of Desire for Children

The woman's stated desire was analyzed in relation to three possible socioeconomic determinants: standard of living index (SLI), respondent's literacy, and residence (Table 7.3). The relationship between SLI and desire for more children was weak and inconsistent. Ownership of television was moderately associated with desire not to have more children. Literate women were more likely to have children later but less likely to have no more children. Interestingly, rural women if compared with urban women were more likely to have children later.

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

Characteristic	Desire for more children				Total	
	Soon	Later	Never	Don't know/unsure	%	N
<b>Standard of living index</b>						
Low	22.6	25.0	51.9	0.5	100.0	212
Medium low	22.8	27.6	49.7	0.0	100.0	145
Medium high	19.3	23.4	56.6	0.7	100.0	145
High	19.2	20.4	60.5	0.0	100.0	167
<b>Ownership of TV</b>						
Yes	19.7	22.1	57.9	0.3	100.0	340
No	22.5	26.1	51.1	0.3	100.0	329
<b>Literacy</b>						
Literate	20.4	33.1	45.9	0.6	100.0	181
Illiterate	21.4	20.6	57.8	0.2	100.0	486
<b>Residence</b>						
Rural	21.5	25.1	53.0	0.3	100.0	594
Urban	17.3	16.0	66.7	0.0	100.0	75
<b>Total</b>	<b>21.1</b>	<b>24.1</b>	<b>54.6</b>	<b>0.3</b>	<b>100.0</b>	<b>669</b>
N	141	161	365	2	100.0	669

## Son Preference

In Pakistan, substantial preference exists for sons over daughters; in particular, the belief that a family is incomplete without sons is stronger than the corresponding belief for daughters. In the questionnaire, respondents were asked, if they did not have a son, how many daughters they would have before stopping; and correspondingly how many sons if

they did not have a daughter. For respondents, son preference comes out most strongly in the proportions stating that there would be no limit: 51 percent said there would be no limit in the number of daughters before bearing a son, while 31 percent said there would be no limit in sons before bearing a daughter. For those respondents who gave a number, in both cases the median were four children.

**Table 7.4: Son and daughter preferences by the respondents**

Response	Number of daughters for desire of son		Number of sons for desire of daughters	
	N	%	N	%
Up to God	0	0.0	8	1.2
No limit	341	51.0	206	30.8
Other non-numeric responses	5	0.7	6	0.9
Numeric responses	323	48.3	449	67.1
<b>Total</b>	<b>669</b>	<b>100.0</b>	<b>669</b>	<b>100.0</b>
Median*	na	4	na	4

\*Of the numeric responses. na=not applicable.

## Strength of Preference

The strength of preferences asked in such surveys can be questioned. The need for birth spacing can be presumed to be greater if a couple is strongly motivated not to have more children, or to delay the next pregnancy, than if this does not matter much to them. We asked respondents whether, if she became pregnant soon, she would be pleased, worried, accept it, or it does not matter. Results are shown in Table 7.5 and Table 7.6. (This question excludes those 253 of the total 669 women who wanted next child soon, were currently pregnant, sterilized, menopausal or had hysterectomy.)

Among those who wanted no more children at all, more than half (51 percent) said that they would be “worried” if they became pregnant. Forty-three percent reported that they would accept the new pregnancy, while only 2 percent, among those who wanted no more children, said they would be pleased. Among those women who wanted to delay their next pregnancy for more than 2 years, almost one-third (32 percent) would be “worried” while 34 percent would accept it and 25 percent would be pleased. Acceptance or pleasure may mean helplessness under the will of God. However, the high proportion of those saying they would be worried if they became pregnant supports clearly to their earlier statement that they wanted to delay or stop childbearing.

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

Reaction if pregnant	Desire for next child		Total	
	Later	Never	%	N
Pleased	24.8	2.0	9.1	34
Worried	31.6	51.4	45.2	168
Accept it	34.2	42.7	40.1	149
Doesn't matter	9.4	3.9	5.6	21
<b>N</b>	<b>117</b>	<b>255</b>	<b>372</b>	<b>372</b>

Further, women who expressed a desire for no 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 caring of children as a whole followed by the respondents' own health. It is pertinent to note that the least importance was given to the health of youngest child.

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

Problem faced if pregnant	Desire for next child		Total	
	Later	Never	%	N
Own health	63.9	82.0	76.2	285
Health of youngest child	72.3	60.8	64.4	241
Caring of children	73.9	78.8	77.3	289
Schooling of children	57.1	78.0	71.4	267
Family economic situation	65.5	79.2	74.9	280
<b>Others</b>	<b>0.8</b>	<b>0.4</b>	<b>0.5</b>	<b>2</b>

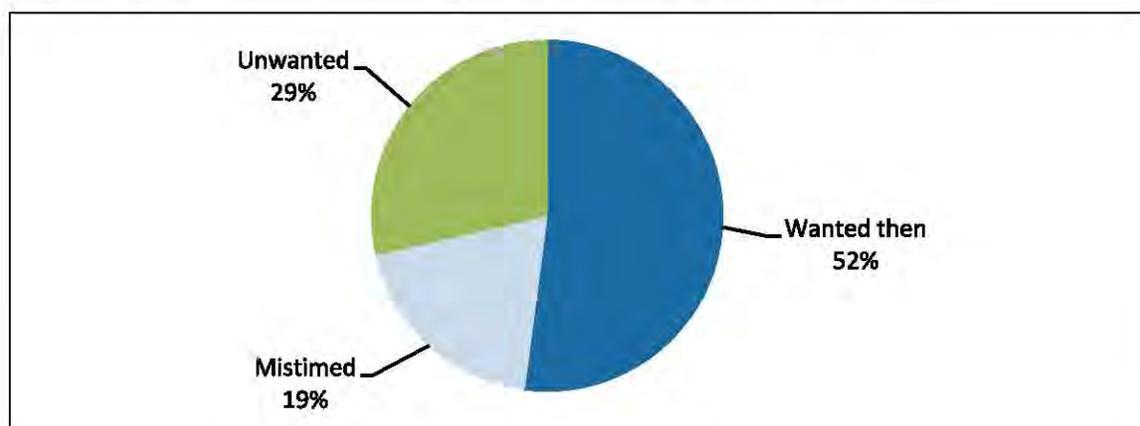
Respondents could give more than one response.

## Attitude towards Last Pregnancy

Another important dimension of fertility preference relates to whether the last pregnancy was wanted at the time, was mistimed (i.e., wanted later), or was not wanted at all. Pregnancies that are unwanted cause hardship in many ways, and represent a failure to realize a couple's right to have the number of children they want, at the time they want them. This can be somewhat difficult to determine precisely in surveys. Sometimes parents report that an unwanted pregnancy was actually wanted, but it is less common to report that a child was wanted when in fact it was not. In this survey as shown in figure 7.2, many

women reported that their last pregnancy was unwanted (29 percent) or mistimed (19 percent).

**Figure 7.2: Distribution of MWRA by attitude towards their last pregnancy**



## Women's Perception of Husband's Fertility Preference

Women were asked whether they think their husbands want the same number of children as they do, more, or fewer. In Table 7.7, their responses are tabulated according to their ideal family size. About 11 percent did not know their husband's preference while 65 thought their husbands want the same number of children as they do. However, 16 percent of the women thought their husbands want more than they do, while only 8 percent think their husbands want fewer.

**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	Perception of husband's desire for more children				Total	
	Same number	More children	Fewer children	Don't know	%	N
1-2 children	63.5	26.9	1.9	7.7	100.0	52
3-4 children	61.9	17.3	8.3	12.5	100.0	336
5+ children	70.1	12.8	8.4	8.8	100.0	274
Up to God	14.3	28.6	14.3	42.9	100.0	7
<b>Total</b>	<b>64.9</b>	<b>16.3</b>	<b>7.9</b>	<b>10.9</b>	<b>100.0</b>	<b>669</b>
N	434	109	53	73	100.0	669



# Chapter 8

## Contraceptive Knowledge and Use

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

### Knowledge

At least 95 percent of married women of reproductive age in Pakistan have known at least one method of contraception for many years. Table 8.1 shows that this holds true for D.G. Khan as well; virtually all women (99.7 percent) know at least one method. A majority of the female respondents know the most commonly used program methods – pills, IUD, female sterilization, Injectables and condoms. These methods and withdrawal are known to higher proportions in D.G. Khan than in the national PDHS 2006-07. Conversely, more women in the PDHS knew of the less common methods, i.e., rhythm (“safe period”), and emergency contraceptive pills (NIPS/PDHS, 2008). There was a slight difference in knowledge between rural and urban women.

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

<b>Method</b>	<b>Rural</b>	<b>Urban</b>	<b>Total</b>
Female sterilization	98.8	96.0	98.5
Male sterilization	88.4	88.0	88.3
Pill	99.8	94.7	99.3
IUD	99.2	96.0	98.8
Injectables	98.5	94.7	98.1
Norplant	50.8	53.3	51.1
Condom	85.4	90.7	85.9
Rhythm	10.3	16.0	10.9
Withdrawal	82.0	88.0	82.7
Emergency pills	15.3	18.7	15.7
Others FP method	6.9	5.3	6.7
At least one FP method	100.0	97.3	99.7
At least one modern FP method	100.0	97.3	99.7
At least one traditional FP method	83.2	90.7	84.0
<b>N</b>	<b>594</b>	<b>75</b>	<b>669</b>

## Use of Contraceptive Methods

### Levels of Ever Use and Current Use

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

Of all the married women interviewed in our sample, 44 percent report having used some method of contraception during their married lives (Table 8.2). It is lower than the proportion obtained in the PDHS 2006-07 for Pakistan as a whole (48.7 percent)

(NIPS/PDHS, 2008). However, this percentage is much higher in urban women (68 percent) as compared to rural women (41 percent).

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

Method	Ever users				Current users				Past users			
	Rural	Urban	Total	N	Rural	Urban	Total	N	Rural	Urban	Total	N
Pill	11.4	22.7	12.7	85	1.9	2.7	1.9	13	9.6	20.0	10.8	72
IUD	11.4	21.3	12.6	84	2.5	4.0	2.7	18	8.8	17.3	9.7	65
Injectables	13.5	16.0	13.8	92	2.7	2.7	2.7	18	10.6	13.3	10.9	73
Norplant	0.2	1.3	0.3	2	0.0	0.0	0.0	0	0.2	1.3	0.3	2
Condom	8.8	41.3	12.4	83	2.7	18.7	4.5	30	5.9	22.7	7.8	52
Rhythm method	1.2	2.7	1.3	9	0.3	0.0	0.3	2	0.8	2.7	1.0	7
Withdrawal	13.3	29.3	15.1	101	6.1	4.0	5.8	39	7.1	25.3	9.1	61
Female sterilization	8.2	6.7	8.1	54	8.2	6.7	8.1	54	0.0	0.0	0.0	0
Male sterilization	0.5	0.0	0.4	3	0.5	0.0	0.4	3	0.0	0.0	0.0	0
Other FP method	1.9	2.7	1.9	13	0.2	0.0	0.1	1	1.7	2.7	1.8	12
Any FP method	41.1	68.0	44.1	295	25.1	38.7	26.6	178	16.0	29.3	17.5	117
Any modern FP method	33.8	61.3	36.9	247	18.5	34.7	20.3	136	15.3	26.7	16.6	111
Any traditional FP method	15.5	32.0	17.3	116	6.6	4.0	6.3	42	8.8	28.0	10.9	73
Emergency pills	0.5	2.7	0.7	5	na	na	na	na	na	na	na	na
<b>N</b>	<b>594</b>	<b>75</b>	<b>669</b>	<b>669</b>	<b>594</b>	<b>75</b>	<b>669</b>	<b>669</b>	<b>594</b>	<b>75</b>	<b>669</b>	<b>669</b>

na=not applicable.

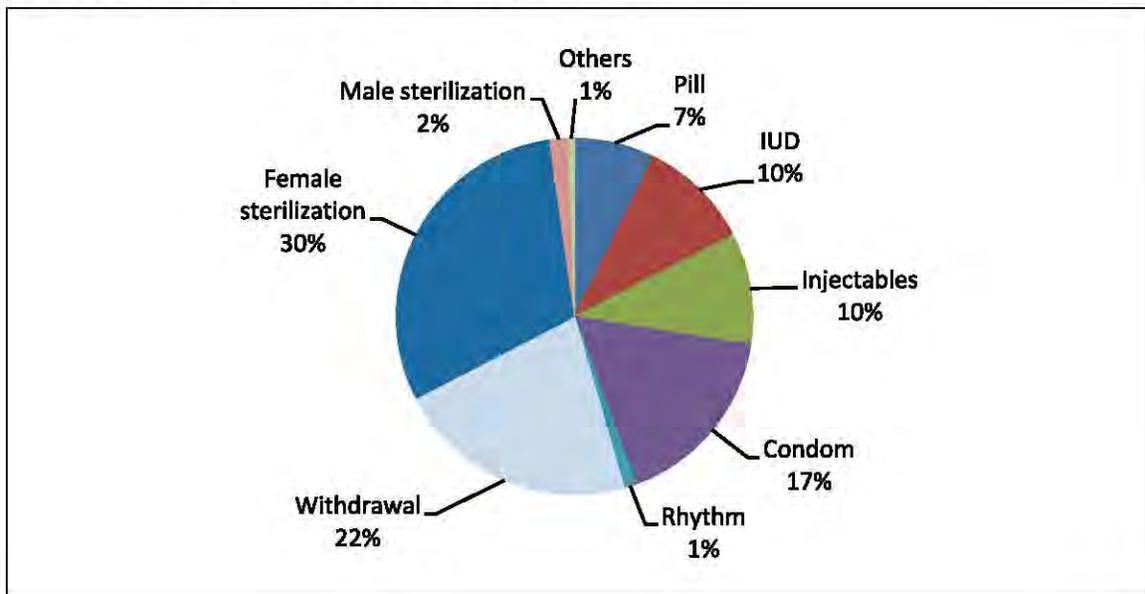
The proportion of currently married women of reproductive age who are currently using some form of contraception, commonly known as the “contraceptive prevalence rate” (CPR) is one of the central indicators of the status of family planning programs. It shows the degree to which couples are actively involved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

As regards current use of family planning methods if compared with Pakistan in general, D.G. Khan lags behind (see Table 8.2). A total of 26.6 percent of all married women in the sample were found to be “currently users of some method of contraception”, (the “contraceptive prevalence rate”, or 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 this baseline survey, in urban areas, the CPR was found as 38.7 percent compared with 25.1 percent in rural areas.

Table 8.2 shows that the methods most commonly in current use are female sterilization, withdrawal and condoms. Overall, 20.3 percent of married women are using modern methods, 6.3 percent are using traditional methods (withdrawal and rhythm), and 0.1 percent are using “other” methods. Distribution of current users by method mix may be seen at figure 8.1.

If we compare ever use and the current use of individual methods, Table 8.2 shows that overall 85 women started using oral pills as their FP method but 72 discontinued it, it means that more than 85 percent of oral pill users dropped out from oral pill. Similarly, 77 percent and 79 percent dropped out from using IUD and injectables methods respectively. The reasons for drop out of these methods are given in chapter 10.

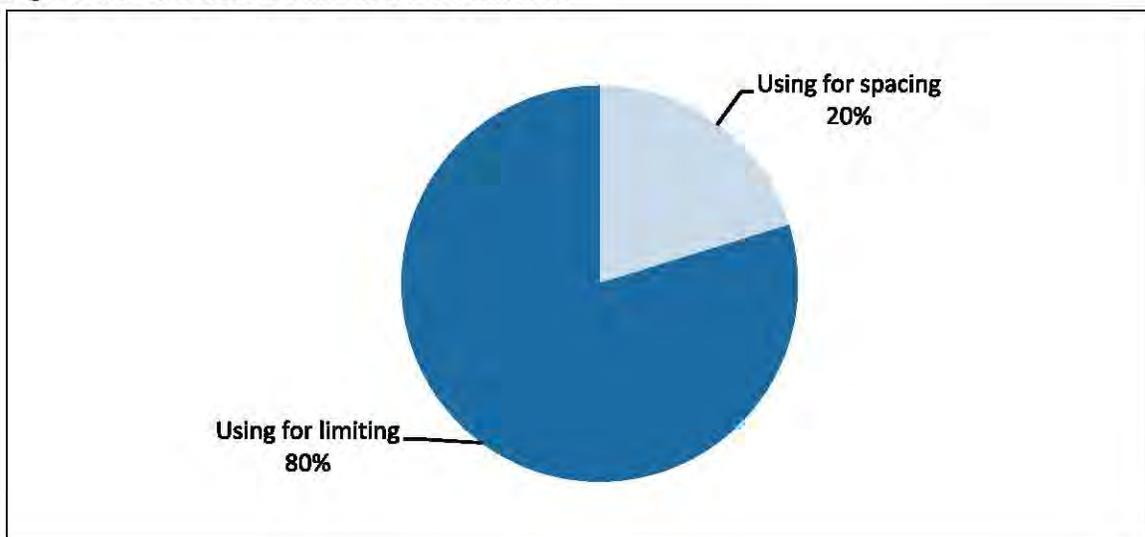
**Figure 8.1: Distribution of current users by method mix**



### Current use and desire for children

For current users of contraception, it is important to determine how many are using for spacing purpose, and how many are using to stop having children altogether. Overall, 80 percent of current use is for limiting purpose compared with 20 percent for spacing (Figure 8.2).

**Figure 8.2: Current use and desire for children**

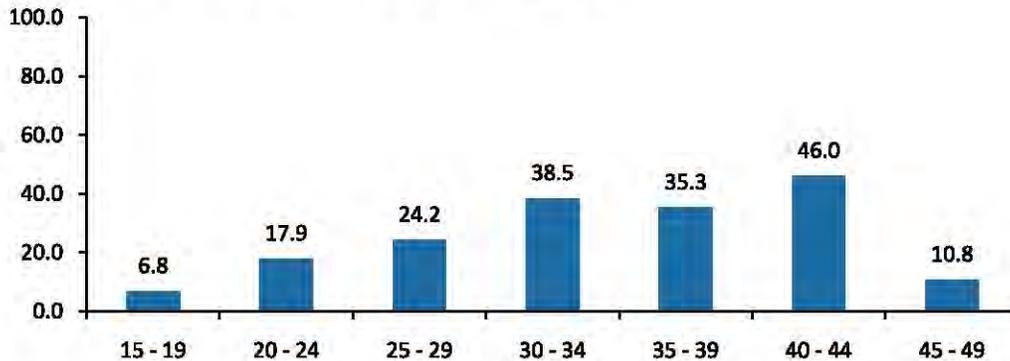


## Correlates of Contraceptive Use

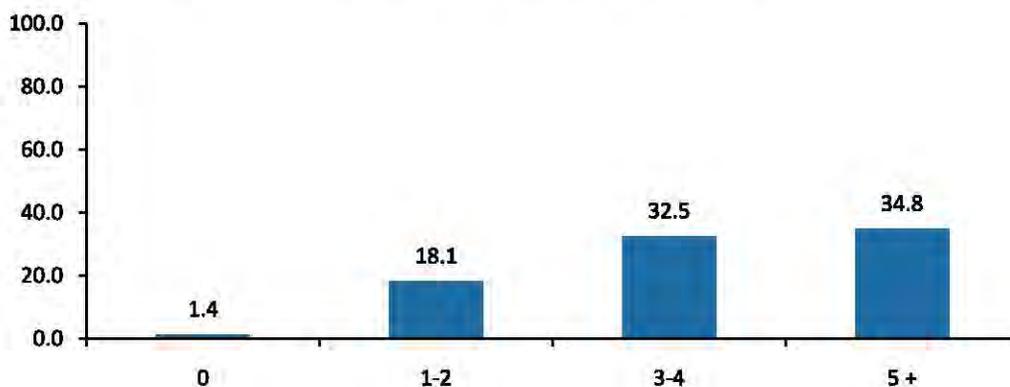
Figures 8.3 and 8.4 reflect the relationship between contraceptive prevalence and the woman's age and number of living children. The shape of the graph for age is similar to that seen in other Pakistani and international studies, with low prevalence among both younger and older women, and higher prevalence in between.

Contraceptive use increased rapidly with the increase in the number of living children. This is consistent with low age-specific fertility rates among women at older ages (from chapter 5). Figure 8.4 shows a rapid increase in contraceptive prevalence rate among the women who had 1-2 children compared to those women who had 3-4 children. The CPR was the highest at 35 percent among women who had 5 or more children.

**Figure 8.3: Contraceptive prevalence by woman's age**



**Figure 8.4: Current contraceptive use by number of living children**



**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	%
<b>Standard of living index</b>					
Low	18.9	10.4	70.8	212	100.0
Medium low	20.7	21.4	57.9	145	100.0
Medium high	26.9	24.1	49.0	145	100.0
High	41.3	17.4	41.3	167	100.0
<b>Ownership of TV</b>					
Yes	33.8	20.0	46.2	340	100.0
No	19.1	14.9	66.0	329	100.0
<b>Literacy of respondent</b>					
Literate	35.9	18.2	45.9	181	100.0
Illiterate	23.0	17.1	59.9	486	100.0
<b>Residence</b>					
Rural	25.1	16.0	58.9	594	100.0
Urban	38.7	29.3	32.0	75	100.0
<b>Total</b>	<b>26.6</b>	<b>17.5</b>	<b>55.9</b>	<b>669</b>	<b>100.0</b>

Contraceptive use is associated with higher socioeconomic status and urban residence, as shown in Table 8.3. Respondents in households with the highest SLI had substantially higher contraceptive prevalence (41 percent) than those with the low SLI (19 percent); conversely, women from households with low SLI were substantially more likely to be never users. Similarly, respondents' literacy was associated with higher current use and lower never use. Past use was demonstrating the same pattern for SLI and literacy. Ownership of television was compatible to all users. Current use and past use was also higher in urban localities and never users were staying more in rural community as per expectation.

## Source of Method

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

From this table, it is clear that the source depends on the method. Pills are mostly obtained from the Lady Health Worker; IUDs in most cases are inserted at private facilities and injectables are also obtained from private hospitals and clinics in general. Female sterilization is preferred to obtain from the DHQ/THQ hospital. The major source of condoms is husband.

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

Source	Family planning method					Total	
	Pill	IUD	Injectables	Condom	Female sterilization	%	N
Govt. hospital (DHQ/THQ)	3.1	13.2	8.2	0.0	63.0	20.0	44
BHU/RHC/MCH	9.4	21.1	14.3	2.1	1.9	9.1	20
FWC	3.1	0.0	6.1	0.0	0.0	1.8	4
MSU	0.0	2.6	0.0	0.0	0.0	0.5	1
LHW	40.6	0.0	0.0	17.0	0.0	9.5	21
Other public facility	0.0	2.6	0.0	0.0	0.0	0.5	1
Pvt. Doctor	3.1	5.3	10.2	0.0	0.0	3.6	8
Pvt. hospital/clinic	6.3	44.7	28.6	0.0	24.1	20.9	46
Dispenser/Componder/referral	0.0	2.6	18.4	0.0	0.0	4.5	10
NGO hospital	0.0	7.9	0.0	0.0	11.1	4.1	9
Pharmacy, chemists	15.6	0.0	0.0	0.0	0.0	2.3	5
Homeopath/Hakeem	3.1	0.0	0.0	0.0	0.0	0.5	1
TBA/Dai/referral	3.1	0.0	0.0	0.0	0.0	0.5	1
Husband brings method/Don't know	6.3	0.0	10.2	80.9	0.0	20.5	45
Others	6.3	0.0	4.1	0.0	0.0	1.8	4
<b>N</b>	<b>32</b>	<b>38</b>	<b>49</b>	<b>47</b>	<b>54</b>	<b>220</b>	<b>220</b>

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

### Reasons for Method Choice

Current and past users were asked if the reasons they chose a particular method included those from a list read out to them; i.e., several reasons might be expected from a respondent. The results are shown in Table 9.1. Overall, the reasons for current and past users were similar, so the data are combined. Among the most common reasons for choosing a method were convenience of use, suitability for respondent and husband, easily available, and no or few side effects. For female sterilization, suitability of use for a long period was often cited. Least cited was “no other method available”. Clients tend to make decisions appropriately according to the known attributes of the various methods, but not always. For example, about 81 percent of pill users cited lack of side effects, 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					Female sterilization	Male sterilization	Total
	Pill	IUD	Injectables	Condom				
Easily available	93.8	65.8	79.6	89.6		50.0	33.3	73.7
Low cost	87.5	36.8	57.1	81.3		57.4	100.0	63.8
Convenient to use	93.8	76.3	87.8	93.8		72.2	100.0	84.4
Suitable for respondent and husband	75.0	76.3	79.6	87.5		81.5	100.0	80.8
No/fewer side effects	81.3	81.6	61.2	85.4		70.4	100.0	75.4
Can be used for long period	40.6	84.2	44.9	18.8		96.3	100.0	58.5
No other method available	18.8	2.6	14.3	4.2		1.9	0.0	7.6
Method always available	59.4	13.2	36.7	62.5		22.2	33.3	37.9
Provider advised	62.5	50.0	51.0	29.2		55.6	100.0	49.6
Others	0.0	5.3	0.0	0.0		18.5	0.0	5.4
<b>N</b>	<b>32</b>	<b>38</b>	<b>49</b>	<b>48</b>		<b>54</b>	<b>3</b>	<b>224</b>

Respondents could give more than one reason

To look more specifically at why some users prefer traditional methods to modern ones, 42 current traditional method users were asked why they were not using modern methods. Fear or experience of side effects was the main issue: 93 percent cited fear of side effects, and 33 percent reported their own experience of side effects. Husband's disapproval (of the modern methods) was cited by 21 percent users, with other reasons (method not available, cost, lack of knowledge about method and source of method) cited by few.

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

Reason	Percentage
Fear of side effects	92.9
Husband's disapproval	21.4
Experienced side effects	33.3
Method not available	2.4
Cost too much	4.8
Doesn't know about modern methods	9.5
Doesn't know about source of method	9.5
<b>N</b>	<b>42</b>

Respondents could give more than one reason

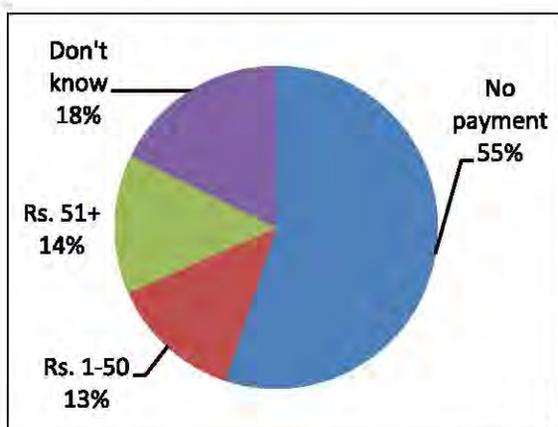
## Cost, Distance and Time to Reach the Facility

Cost to users of contraceptive methods varies widely in Pakistan according to: method, whether public or private sector as well as other factors. Table 9.3 and figure 9.1 show woman's reported costs the last time she obtained the method. Fifty-five percent of users were not charged for their contraceptives, including all female sterilization users (who are, in fact, typically reimbursed for expenses involved). Notably for condom users, as the husband brings condoms, the wife does not know the cost. Thirteen percent paid less than 50 rupees and only 14 percent paid more than 50 rupees. . IUD users often, pay more than 50 rupees for their method; but for the IUD in particular, that is a one-time cost, so the monthly cost may be quite low.

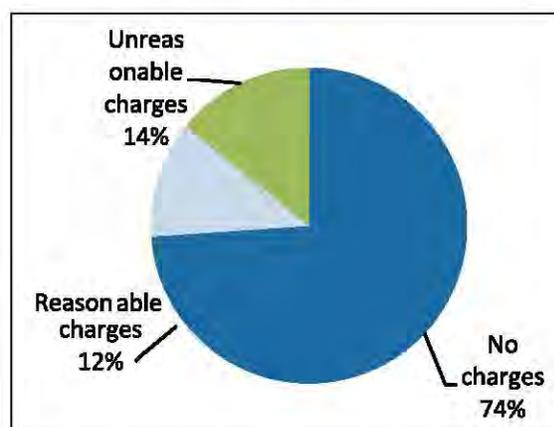
**Table 9.3: Distribution of cost of current specific contraceptive method**

Method	Cost in rupees					Total	
	No payment	1-20	21-50	51+	Don't know	%	N
Pill	69.2	23.1	0.0	0.0	7.7	100.0	13
IUD	5.6	16.7	5.6	66.7	5.6	100.0	18
Injectables	11.1	11.1	38.9	38.9	0.0	100.0	18
Condom	20.0	3.3	3.3	0.0	73.3	100.0	30
Female sterilization	100.0	0.0	0.0	0.0	0.0	100.0	54
Male sterilization	100.0	0.0	0.0	0.0	0.0	100.0	3
<b>Total</b>	<b>55.1</b>	<b>6.6</b>	<b>6.6</b>	<b>14.0</b>	<b>17.6</b>	<b>100.0</b>	<b>136</b>

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



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



Current users were also asked whether their facility charges them for service, other than the method itself. Figure 9.1B reflects that 74 percent were not charged, 12 were charged a reasonable amount, and 14 percent were demanded an unreasonable amount.

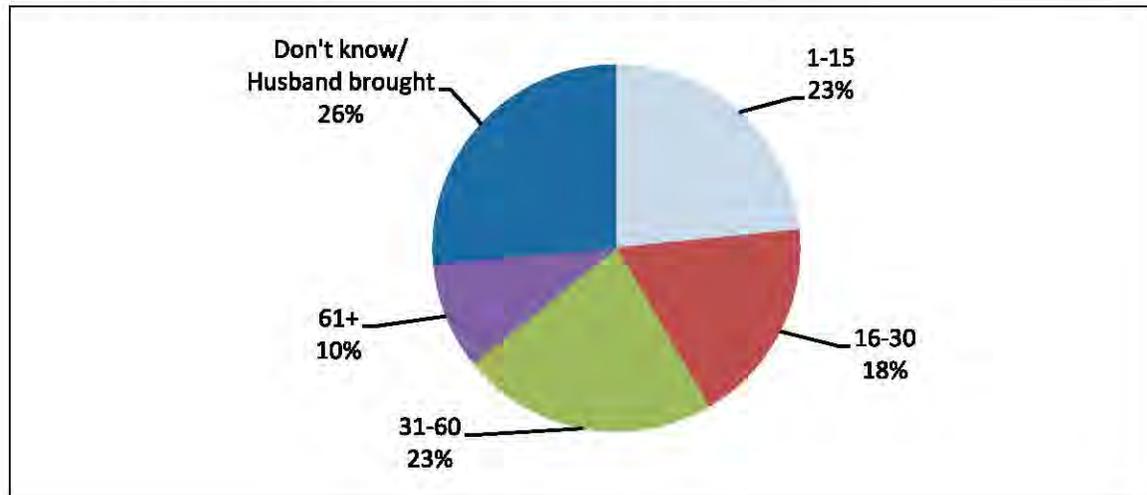
**Table 9.4: Distribution of current contraceptive users by time to reach specific contraceptive service**

Methods	Time in minutes					Total	
	1 - 15	16 - 30	31 - 60	61 +	Don't know/ Husband brought method	%	N
Pill	61.5	7.7	7.7	7.7	15.4	100.0	13
IUD	27.8	22.2	33.3	16.7	0.0	100.0	18
Injectables	55.6	11.1	0.0	5.6	27.8	100.0	18
Condom	6.7	6.7	0.0	0.0	86.7	100.0	30
Female sterilization	13.0	29.6	40.7	14.8	1.9	100.0	54
Male sterilization	0.0	0.0	33.3	0.0	66.7	100.0	3
Others	0.0	0.0	100.0	0.0	0.0	100.0	1
<b>Total</b>	<b>23.4</b>	<b>18.2</b>	<b>22.6</b>	<b>9.5</b>	<b>26.3</b>	<b>100.0</b>	<b>137</b>

The time usually needed for current users to obtain a specific method is shown in Table 9.4 while figure 9.2 reflects overall travel time in minutes to seek the contraceptive services/supplies. About 23 percent users need not more than 15 minutes to reach the service point for their specific method; this includes the LHWs, who often bring injectables, pills, and condoms to the doorstep. For 26 percent users, the husband brings the supply, so

they don't know how long it takes. For a few, particularly female sterilization and IUD users, it takes more than an hour to reach the service place; but in these cases, there is usually no need for frequent visit.

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



## Treatment by Provider

### Information Provided

Current and past users were inquired by reading out important topics from a list what information was given to them by providers at the time of acceptance of the method (Table 9.4). The accuracy of clients' responses may be questioned, due to problems of recall or understanding; still, it appears that information provided is seriously deficient. Effectiveness of the method was more much emphasized followed by the way to use the method, how the method works and the advantages more importantly. Other topics like contraindications, possible side effects, what to do if experienced side effects, possibility of switching the method, and other FP methods received less importance. Condom users were given less information in general than users of clinical methods, perhaps because they are often obtained by husbands. There is a need to emphasize providers to provide comprehensible information on the method selected by the clients especially hormonal contraceptive.

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

Information	Contraceptive method						Total
	Pill	IUD	Injectables	Condom	Female sterilization	Male sterilization	
How method works	37.5	47.4	34.7	8.3	59.3	0.0	37.1
How to use method	68.8	63.2	57.1	10.4	51.9	33.3	48.2
Contraindications	28.1	18.4	28.6	6.3	33.3	0.0	22.8
Effectiveness	68.8	86.8	81.6	8.3	79.6	33.3	63.8
Advantages	40.6	50.0	34.7	12.5	50.0	33.3	37.1
Possible side effects	31.3	63.2	36.7	6.3	37.0	33.3	33.9
What to do if experienced side effects	18.8	57.9	28.6	2.1	25.9	0.0	25.4
Possibility of switching	28.1	44.7	26.5	12.5	3.7	0.0	21.0
About other methods of FP you could use	34.4	50.0	36.7	12.5	13.0	0.0	27.2
<b>N</b>	<b>32</b>	<b>38</b>	<b>49</b>	<b>48</b>	<b>54</b>	<b>3</b>	<b>224</b>

Respondents could give more than one reason

## Treatment at Facility

Current users were asked about various aspects of their treatment when they last visited a provider for family planning. As Table 9.6 shows, responses were mainly positive but with the degree of variations. More dissatisfaction was recorded over staff attitude, an important factor in treatment.

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

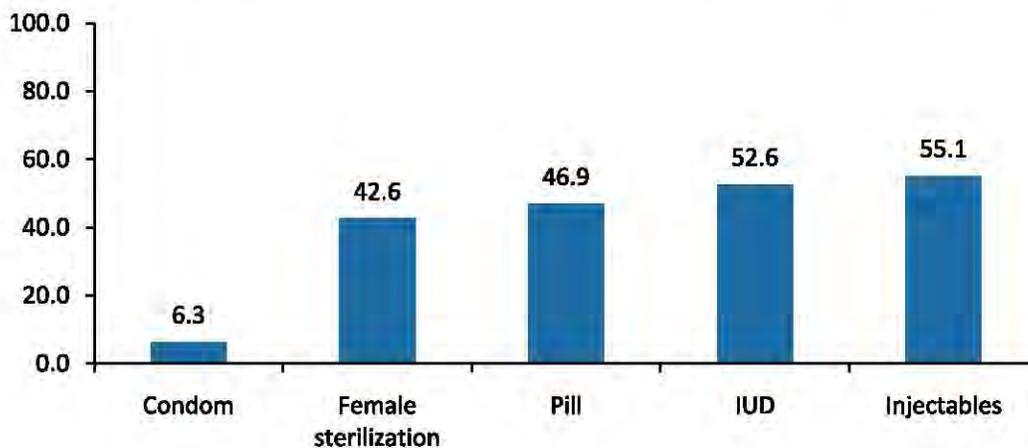
Aspect of treatment	Percentage
Staff attitude cooperative	59.6
Provider available	96.9
Attend/examine properly	75.5
Doesn't demand charges	73.9
Can deal with side effects	91.7
<b>N</b>	<b>84</b>

## Side Effects

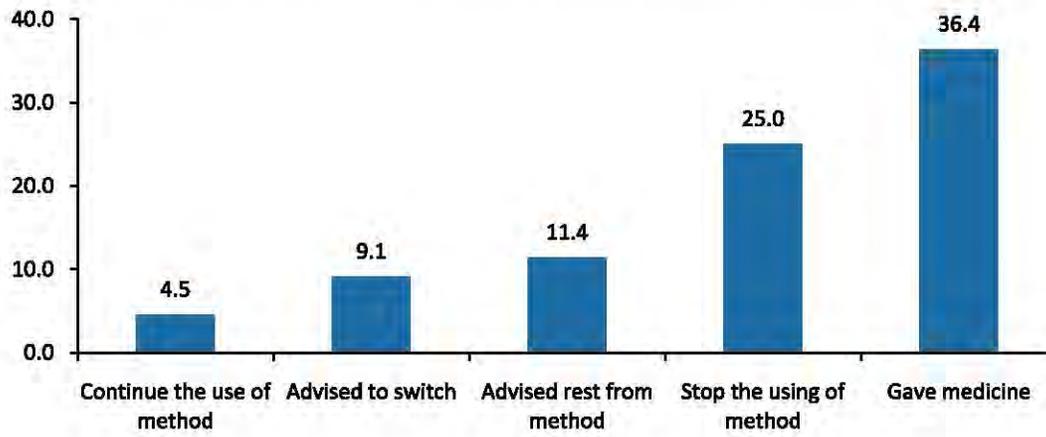
Current users were asked if they had experienced, or were experiencing, any side effects from their current method; past users were asked if side effects were among the reasons for their discontinuation. If so, a list of possible side effects was read out to them, and they were asked if they had experienced them; multiple responses were allowed. Twenty-six percent of the current users and 38 percent of the past users (31 percent of all current and past users) responded positively. As shown in figure 9.3, side effects were most commonly reported by injectables and IUD users (55 percent and 53 percent respectively) but others share is also worth attention. However, least commonly reported side effects were by condom users (6 percent).

Of the 44 past users who reported that they experienced side effects, 21 said they had consulted someone for the management of these side effects; in 15 of these 21 cases, this was said to be a doctor. These were asked if the provider had taken any step/measure out of the list of possible responses. Thirty-six percent reported to be treated with medicine, 25 percent were advised to stop the practicing of the method and 11 percent were advised rest from the method. Nine percent were advised to switch to another method while 5 percent were advised to continue the method (Figure 9.4).

**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**



# Chapter 10

## Reasons for Non-use

There are many reasons why a couple is not practicing birth spacing at any given time. The women may already be pregnant, the couple wants another child soon; the women may already have passed menopause, or they may believe themselves to be sterile. Other reasons, however, may result in a couple that wants to avoid children, not using any contraception that could help them to-do so. There are many such reasons: for example, lack of knowledge of methods or places to obtain them; fear of the side effects of the methods they know ; opposition of husband or family; 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 couples are not practicing birth spacing, in relation to the situation they are currently in.

## Hindrances to Use

One way to understand common hindrances to contraceptive use is to ask respondents about their understanding of the concerns of people in general, with the view that people may feel less need to conceal their real concerns than when they are discussing their own situation. All respondents were asked, "If a couple wants to avoid or space a birth, which of the following hindrances might they face?" Each item on the list was read out to the respondent. Table 10.1 shows the responses of the female respondents, according to whether they are 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	Current user		Past user		Never user	
	N	%	N	%	N	%
Husband's disapproval	172	96.6	110	94.0	359	96.0
Other people may find out about contraceptive use	140	78.7	89	76.1	312	83.4
Distance and travel costs to FP outlet	130	73.0	89	76.1	315	84.2
Probability of getting pregnant while using	155	87.1	103	88.0	330	88.2
Fear of side effects	176	98.9	116	99.1	367	98.1
Problem of managing side effects	172	96.6	114	97.4	362	96.8
FP is against religion	163	91.6	101	86.3	352	94.1
<b>Total</b>	<b>178</b>	<b>na</b>	<b>117</b>	<b>na</b>	<b>374</b>	<b>na</b>

na=not applicable, Respondents could give more than one reason

Some hindrances that might be faced by some couples were almost universally acknowledged. In case of never users, fear of side effects and the problem of managing side defects were the major hindrances for not applying the FP methods. Other strong reason was husband's disapproval or opposition. Religion was also considered a big reason. Other reasons carried comparatively less weight. This may be worth mentioning that side effects are the most important problem which needs to be addressed.

## Past Users

### Reasons for Discontinuing Contraceptive Use

Past users were asked about their reasons for discontinuing their last contraceptive method. Several reasons were given frequently; the most commonly given were the experience of side effects, rest from the method, the desire of another child, infrequent sex/husband away, husband's advice and method failure (Table 10.2). These reasons are in many cases appropriate, but not always. Method failure results from using methods that have high failure rates. The clinical methods do have associated side effects; but as we have seen, providers rarely try to counsel users through the temporary experience of common, non-dangerous side effects.

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

Reason	Percentage
Wanted another child	23.1
Fear of side effects	7.7
Side effects experienced	37.6
Method failure	17.9
Lack of access/unavailability	4.3
Cost not affordable	4.3
Method inconvenient to use	2.6
Rest from method	27.4
Missed the dose	4.3
Provider's advice	10.3
Infrequent sex/Husband away	23.1
Husband's advice	19.7
In laws oppose	11.1
Menopause	3.4
<b>N</b>	<b>117</b>

Respondents could give more than one reason

### Reasons for Current Non-use

It is important to know whether couples who have used contraception in the past but are not currently using, are acting in conformance with their expressed desires, or whether there is an inconsistency. Past users were read out a list of possible reasons for their not currently using, with more than one reason possible. The most common reasons were infrequent sex/husband away, fear of side effects and breastfeeding. However, significant percentages have been cited for wanting more children and currently pregnant as reasons for non-use (Table 10.3).

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

Reason	Percentage
Fear of side effects	23.1
Want another child	15.4
Currently pregnant	18.8
Rest from method	18.8
Provider's advice	5.1
Infrequent sex/husband away	25.6
Breastfeeding/lactational amenorrhea	19.7
Menopause	6.8
Just not using/too lazy	6.0
Others	12.0
<b>N</b>	<b>117</b>

Respondents could give more than one reason

## Never Users

### Reasons for Non-use

Women (374) in the sample who reported never use were asked about various possible reasons for not using contraceptives, with each reason read out separately. As shown in Table 10.4, the most important reason is a desire for more children followed by side effects and husband's opposition as the significant reasons for not using contraceptives. A number of women feel themselves unable to conceive. Other reasons are relatively less referred to.

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

Reason	Percentage
Husband opposes	41.7
In-laws oppose	28.6
Fear of side effects	54.8
Lack of access/unavailability	10.2
Cost not affordable	10.2
Shy to consult about family planning	16.8
Method inconvenient to use	9.6
Infrequent sex/husband away	17.4
Difficult/Unable to conceive	23.0
Breastfeeding/lactational amenorrhea	30.2
Respondent/husband infertile	1.1
Wanted (more) children	59.9
Against religion	1.9
Natural spacing	0.3
Others	6.1
<b>N</b>	<b>374</b>

Respondents could give more than one reason

## Attitude towards Birth Spacing and Limiting

It is important to see the extent to which never users disapprove family planning, as opposed to accepting it in principle but not using for some other reason. Table 10.5 shows this for never using respondents. Only about 32 percent of women disapprove spacing while 26 percent disapprove limiting. Though the opposition for limiting is less but this may include the women who have completed their family up to their desire but more much important is spacing for which relatively opposition is higher which is a point of seeking attention. This needs most effective IEC campaign to lessen the opposition.

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

Attitude	Attitude towards spacing		Attitude towards limiting	
	N	%	N	%
Approve	256	68.4	274	73.3
Disapprove	118	31.6	97	25.9
Don't know	0	0.0	3	0.8
<b>Total</b>	<b>374</b>	<b>100.0</b>	<b>374</b>	<b>100.0</b>

## Knowledge of Contraceptive Users, Methods and Facilities

Of the 374 female never users in the sample, two-third reported knowing some woman who had ever applied a method to delay or avoid pregnancy. Sixty percent of the respondents had a relative who had used some method, and more than one third knew a friend or neighbor who had used some method.

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

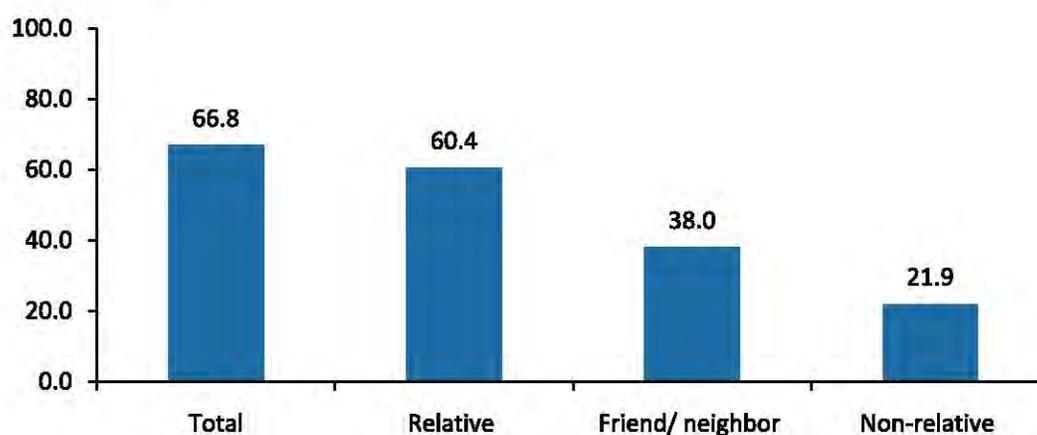


Table 10.6 indicates that almost all respondents who are never users have knowledge of at least one FP method. For each method, a somewhat smaller percent of never users knows that method than the general distribution (Table 8.1); but most never users know a variety of methods. However, these women's knowledge of where to get services and supplies is less satisfactory.

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

Method	Percentage
Female sterilization	97.9
Male sterilization	83.7
Pill	98.9
IUD	97.9
Injectables	96.8
Norplant	44.9
Condom	78.1
Rhythm	8.0
Withdrawal	73.3
Emergency pills	12.8
Others	4.3
At least one FP method	99.5
<b>N</b>	<b>374</b>

Respondents could give more than one response.

Of 374 never users, (42 percent) did not know the 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 private hospitals/clinics/doctors followed by Department of Health outlets – the District/Tehsil Headquarters hospitals, BHUs/RHCs/MCH centers, and the Lady Health Workers. Others were known less.

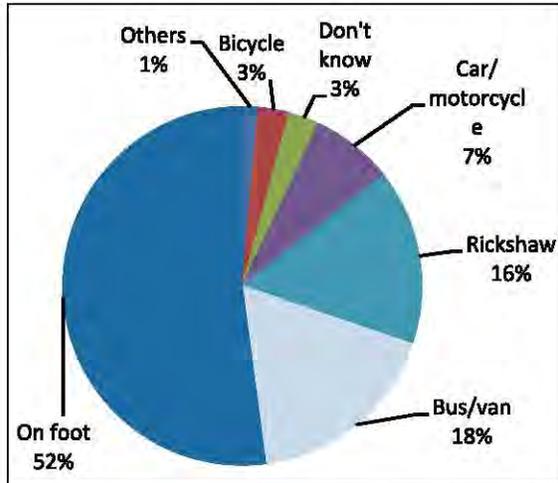
**Table 10.7: Knowledge of sources of contraception of never users by source of supply**

Facility/ service provider	Percentage
At least one service provider	57.5
DHQ/THQ hospital	42.5
BHU/RHC/MCH center	35.6
Family Welfare Center	13.4
Mobile service unit camp	11.2
Lady Health Worker	24.1
Greenstar clinic	12.3
Private hospital/clinic/doctor	44.4
Dispenser/compounder	4.8
Pharmacy/chemists	21.7
Homeopathic/hakim	3.2
TBA/dai	4.3
Grocery shop (not pharmacy/ chemist)	1.9
Others	1.3
<b>N</b>	<b>374</b>

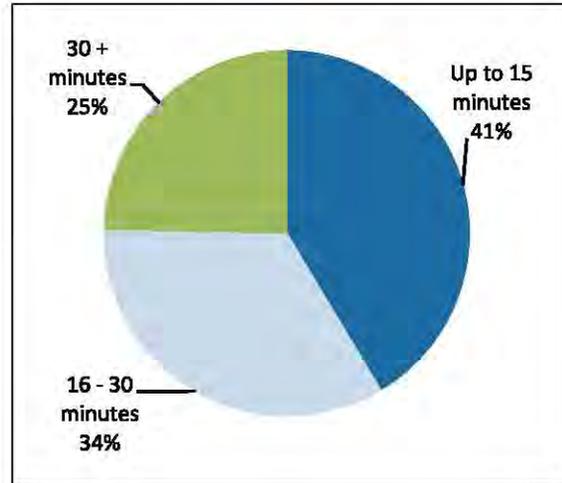
Respondents could give more than one source

When asked which of the facilities named was nearest, the respondents were again most likely to name BHU/RHC/MCH centers and private hospitals/clinics, in that order. Mostly they go there on foot, sometimes by rickshaw and bus/van (Figure 10.2). Time to reach the facility, 41 percent needed 15 minutes or less, 34 percent 16-30 minutes, and 25 percent 30+ (Figure 10.3).

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



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



## Intent to Use

When never users were asked about whether they intended to use contraceptives in the future, 40 percent respondents showed their intention to use FP method in future (Table 10.8). Thirty-three percent refused to do so while 22 percent were not sure. This group needs to bring into the flux of family planning by adopting different ways to address reasons particularly by convincing husbands whose opposition is much, while they are the real decision makers with specific scenario of Pakistani society. An effective IEC strategy is needed to encourage their acceptance and use of family planning.

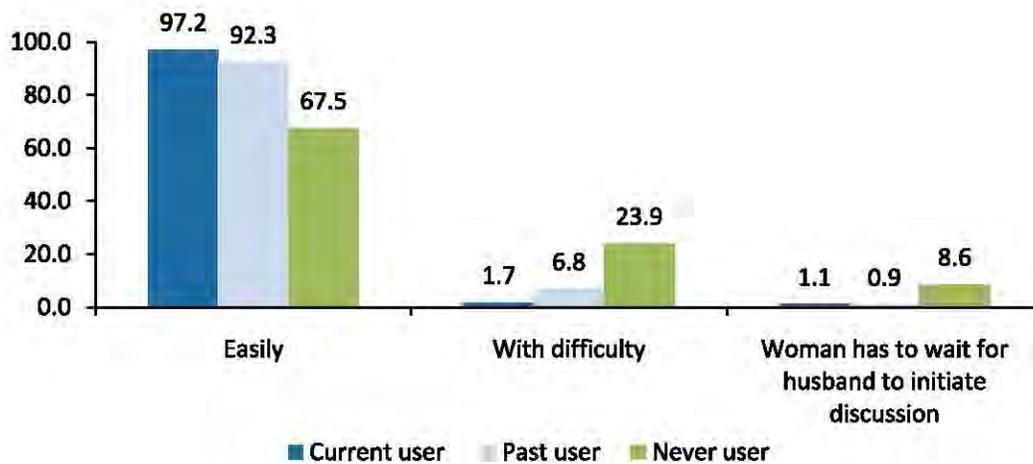
**Table 10.8: Distribution of never users by intent to use a method in future and number of living children**

Number of living children	Intention to use FP method in future				Total	
	Yes	No	Unsure/uncertain	Can't get pregnant	%	N
0	45.1	25.4	29.6	0.0	100.0	71
1-2	48.7	30.1	20.4	0.8	100.0	113
3-4	36.7	31.6	26.6	5.1	100.0	79
5 or more	31.5	40.5	14.4	13.5	100.0	111
<b>Total</b>	<b>40.4</b>	<b>32.6</b>	<b>21.7</b>	<b>5.3</b>	<b>100.0</b>	<b>374</b>

### Ease of Communications with Husband

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 she has to wait for her husband to initiate the discussion. Most of the women said they could do so easily (Figure 10.4). However, this varied by use status. Current users and past users were with more comfort than never users. Twenty-four percent never users had difficulty to initiate the discussion on FP while 9 percent had to wait for husband to initiate the discussion.

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

## Levels and Correlates

Table 11.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in D.G. Khan. Of the 669 women, 42 percent were judged to be in unmet need. This proportion is higher than is typically found using the same definition in Pakistan as a whole, where unmet need tends to be around 37 percent of MWRA (NIPS/PDHS, 2008). The higher proportion may be a reflection of the relatively lower contraceptive prevalence; lower levels of use may mean that less of the total demand for family planning is being met.

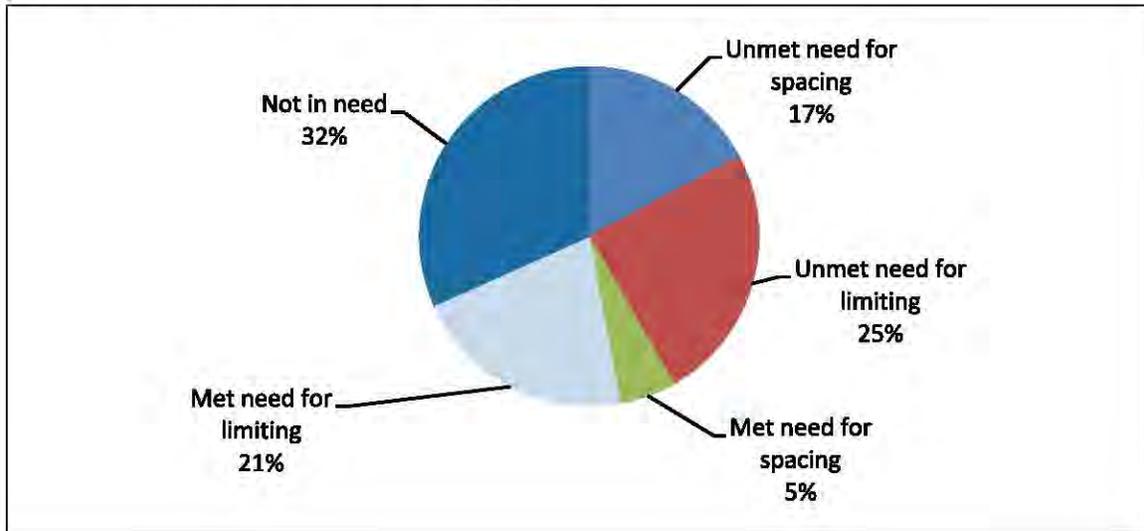
Of the 42 percent of the women who had unmet need, 17 percent was for spacing and 25 percent for limiting. Unmet need for spacing is concentrated among younger women and women with one or two children. Unmet need for limiting, unsurprisingly, is highest among women with three or more children, because at that stage couples begin to want to have no more children.

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

Characteristic	Unmet need			Met need			Total demand	Not in Need	Total	N
	For spacing	For limiting	Total	For spacing	For limiting	Total				
<b>Age group</b>										
15 - 24	33.2	9.3	42.4	9.3	3.9	13.2	55.6	44.4	100.0	205
25 - 34	16.7	28.2	44.9	6.5	24.5	31.0	75.9	24.1	100.0	245
35 - 49	2.7	34.7	37.4	0.5	33.8	34.2	71.7	28.3	100.0	219
<b>Residence</b>										
Rural	18.7	25.1	43.8	5.1	20.0	25.1	68.9	31.1	100.0	594
Urban	5.3	20.0	25.3	8.0	30.7	38.7	64.0	36.0	100.0	75
<b>Literacy of respondent</b>										
Literate	19.3	14.9	34.3	9.9	26.0	35.9	70.2	29.8	100.0	181
Illiterate	16.5	28.2	44.7	3.7	19.3	23.0	67.7	32.3	100.0	486
<b>Education of respondent</b>										
No education	16.3	28.5	44.8	3.8	19.0	22.8	67.6	32.4	100.0	478
Up to primary	21.2	22.4	43.5	4.7	24.7	29.4	72.9	27.1	100.0	85
Up to secondary	20.0	11.4	31.4	14.3	25.7	40.0	71.4	28.6	100.0	70
Above secondary	14.7	2.9	17.6	11.8	32.4	44.1	61.8	38.2	100.0	34
<b>Children ever born</b>										
0	9.0	0.0	9.0	1.5	0.0	1.5	10.4	89.6	100.0	67
1-2	36.8	5.9	42.8	11.2	5.3	16.4	59.2	40.8	100.0	152
3-4	24.8	22.7	47.5	7.8	23.4	31.2	78.7	21.3	100.0	141
5+	5.8	39.8	45.6	2.3	32.7	35.0	80.6	19.4	100.0	309
<b>Ownership of TV</b>										
Yes	13.5	22.1	35.6	6.8	27.1	33.8	69.4	30.6	100.0	340
No	21.0	27.1	48.0	4.0	15.2	19.1	67.2	32.8	100.0	329
<b>Standard of living index</b>										
Low	19.8	29.7	49.5	3.8	15.1	18.9	68.4	31.6	100.0	212
Medium low	17.9	22.8	40.7	4.8	15.9	20.7	61.4	38.6	100.0	145
Medium high	20.7	24.1	44.8	4.1	22.8	26.9	71.7	28.3	100.0	145
High	10.2	19.8	29.9	9.0	32.3	41.3	71.3	28.7	100.0	167
<b>Total</b>	<b>17.2</b>	<b>24.5</b>	<b>41.7</b>	<b>5.4</b>	<b>21.2</b>	<b>26.6</b>	<b>68.3</b>	<b>31.7</b>	<b>100.0</b>	<b>669</b>

The correlations between unmet need and various socioeconomic indicators vary by whether the unmet need is for spacing or for limiting. Unmet need for limiting is strongly associated with low SLI, no education, and rural residence. The unmet need for spacing is associated with rural residence and low SLI. 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 called “total demand” for family planning. It would normally be expected to rise with the number of living children a couple has. Table 11.1 also shows total demand by background characteristics of the women. Overall, total demand is 68 percent of all married women of reproductive age. As the table shows, total demand does rise rapidly, and fairly consistently, by number of living children.

## Strength of Preference

It is of interest to look at the responses of women in unmet need (those not currently pregnant) according to their response if they became pregnant in the near future (Table 11.2). Twenty eight percent of the women with unmet need for spacing said they would be worried if they became pregnant again; while 37 percent would accept it, and 27 percent would be pleased. Of those with unmet need for limiting, 50 percent said they would be

worried if they became pregnant. It is perhaps not unreasonable for women to be more concerned about the consequences of an unwanted pregnancy than about the consequences of a wanted pregnancy coming too soon.

**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	25	26.9	2	1.3
Worried	26	28.0	75	50.0
Accept it	34	36.6	65	43.3
Doesn't matter	8	8.6	8	5.3
<b>Total</b>	<b>93</b>	<b>100.0</b>	<b>150</b>	<b>100.0</b>

## 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 are fear of side effects and opposition by husbands or in-laws. On the other hand, many women with defined unmet need gave reasons that did not reflect perceived need, at least at present. Such reasons included wanted more children, infrequent sex/husband away, natural spacing, difficulty in conceiving, currently pregnant, and currently breastfeeding. Some such 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	
	N	%	N	%	N	%
Fear of side effects	57	49.6	94	57.3	151	54.1
Husband opposes	40	34.8	39	23.8	79	28.3
In-laws oppose	23	20.0	26	15.9	49	17.6
Rest from method	4	3.5	7	4.3	11	3.9
Shy to consult about FP	20	17.4	19	11.6	39	14.0
Provider's advice	1	0.9	3	1.8	4	1.4
Against religion	2	1.7	2	1.2	4	1.4
Lack of access/unavailability	6	5.2	20	12.2	26	9.3
Cost not affordable	9	7.8	18	11.0	27	9.7
Just not using/too lazy	1	0.9	5	3.0	6	2.2
Method inconvenient to use	9	7.8	15	9.1	24	8.6
Infrequent sex/husband away	19	16.5	39	23.8	58	20.8
Natural spacing	0	0.0	1	0.6	1	0.4
Difficult/unable to conceive	14	12.2	7	4.3	21	7.5
Want (more) children	89	77.4	4	2.4	93	33.3
Currently pregnant	8	7.0	7	4.3	15	5.4
Breastfeeding/lactational amenorrhea	9	7.8	15	9.1	24	8.6
Others	6	5.2	19	11.6	25	9.0
<b>Total</b>	<b>115</b>	<b>na</b>	<b>164</b>	<b>na</b>	<b>279</b>	<b>na</b>

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

## Unmet Need for Spacing: Profile

Women with unmet need for spacing comprise 114 (17 percent) of MWRA. As shown in Table 11.4, they were characterized by:

**Living Children:** Most (51 percent) had 1 or 2 living children.

**Family Planning Use:** More never users (85 percent) than past users (15 percent).

**Strength of Preference:** Low (only 28 percent “worried” if they became pregnant earlier than they wanted compared to those who were pleased (27 percent) or accept (37 percent) the unwanted pregnancy).

**Intent to Use FP in Future:** Moderate (about 62 percent intended to use a FP method in future).

**Approval of FP:** High (79 percent approved of using a FP method for spacing purpose).

**FP Communication with Husband:** Limited (only 37 percent had communicated with husbands on FP in the past one year; while 23 percent said approaching the husband was “not easy”).

**Obstacles to FP Use:** Fear of side effects (50 percent); opposition by husband and in-laws (35 percent and 20 percent respectively) (Table 11.3).

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

Characteristic	Unmet need for spacing		Unmet need for limiting	
	N	%	N	%
<b>Number of living children</b>				
0	6	5.2	0	0.0
1-2	59	51.3	10	6.1
3-4	37	32.2	39	23.8
5 or more	13	11.3	115	70.1
<b>Contraceptive use status</b>				
Current user	0	0.0	0	0.0
Past user	17	14.8	60	36.6
Never user	98	85.2	104	63.4
<b>Reaction if become pregnant in near future</b>				
Pleased	25	26.9	2	1.3
Worried	26	28.0	75	50.0
Accept it	34	36.6	65	43.3
Doesn't matter	8	8.6	8	5.3
<b>Intention to use a method in future</b>				
Yes	70	61.9	84	51.9
No	20	17.7	42	25.9
Unsure/uncertain	23	20.4	26	16.0
Can't get pregnant	0	0.0	10	6.2
<b>Approval of FP</b>				
Approve	91	79.1	138	84.1
Disapprove	24	20.9	26	15.9
<b>FP communication with husband in past one year</b>				
Never	72	62.6	79	48.2
Once or twice	24	20.9	28	17.1
More often	19	16.5	57	34.8
<b>Approach the topic of FP with husband</b>				
Easily	88	77.2	134	81.7
Not easily	26	22.8	30	18.3
<b>Total</b>	<b>114</b>	<b>na</b>	<b>164</b>	<b>na</b>

na=not applicable.

## Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 164 (25 percent) of MWRA. As shown in Table 11.4, they were characterized by:

**Living Children:** A strongly positive association with number of living children; 70 percent had 5+ living children.

**Family Planning Use:** More never users than past users (63 percent and 37 percent respectively).

**Strength of Preference:** Moderate (50 percent would be “worried” if they became pregnant compared to those who were pleased (1 percent) or accept (43 percent) the unwanted pregnancy).

**Intent to Use FP in Future:** Moderate (about 52 percent intended to use a FP method in future.)

**Approval of FP:** High (84 percent approved of FP for limiting purpose).

**FP Communication with Husband:** Moderate (52 percent had communication with husband on FP in the past year; while 18 percent said approaching the husband was “not easy”).

**Obstacles to FP Use:** Fear of side effects (57 percent); opposition by husbands and in-laws (24 percent and 16 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 contraception (NIPS/PDHS, 2008; Population Council, 1995). The objectives of interviewing husbands/men in the FALAH baseline survey were to explore their perspectives on birth spacing/family planning and to use the information obtained to design the communication strategy for the FALAH project. Overall, the planned sample size was 200 husbands in each district. The intention was to interview as many husbands as possible who were available when the household interviews were undertaken. Knowing that some husbands might be at their places of work during the timing of the interviews, the plan was to then make up for any of the husbands who were unavailable by interviewing other married men available in the selected communities in order to come as close as possible to meeting the objective of interviewing 200 husbands/men in each FALAH district. In D.G. Khan, the field team was able to interview 167 men who were husbands of the married women of reproductive age who had been interviewed for the survey plus 33 married men living in selected areas who were not husbands of the female respondents. In this chapter, the results for the respondents' husbands and the other married men who were interviewed (N = 200) are always grouped together, whether the reference is to "men," "male respondents," "married men," or "husbands."

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

are important predictors of a woman's contraceptive use and fertility desire (Bongaarts and Bruce, 1995; Mahmood and Ringheim, 1997).

This baseline survey investigates social and demographic differentials, and knowledge, ever use and current use of family planning methods. It also explores how approval and discussion of birth spacing/family planning influence the use of contraceptive methods. Traditionally, the measurement of contraceptive use has been based on women's self-reports of current use. The rationale for interviewing men was to investigate their perspective on the issues of fertility and family planning.

## Background Characteristics

Table 12.1 shows the background characteristics of the men interviewed in the survey. It shows that 2 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, the men were much better educated than the sampled currently married women of reproductive age. Thirty-eight percent of the men had not been to school, compared to 72 percent of the currently married women (Table 3.2). It also shows that 46 percent of the men had more than primary education, whereas 16 percent of the currently married women had attained that level of education (Table 3.2). Ninety-seven percent of the urban men had received some schooling compared to 56 percent of the rural men.

The occupations of men are also presented in Table 12.1. The highest proportion (29 percent) of men was working in agriculture-related activities. Twenty-two percent were working as daily wage laborers while another 22 percent were running their own business.

**Table 12.1: Background characteristics of male respondents by residence**

Characteristic	Rural	Urban	Total
<b>Age group</b>			
20-24	1.8	0.0	1.5
25-29	7.1	0.0	6.0
30-34	18.8	6.7	17.0
35-39	12.4	13.3	12.5
40-44	18.2	23.3	19.0
45-49	15.9	13.3	15.5
50-54	11.2	20.0	12.5
55+	8.8	10.0	9.0
<b>Education</b>			
Proportion literate	51.2	93.3	57.5
No education	44.1	3.3	38.0
Up to primary	18.2	6.7	16.5
Up to secondary	24.1	33.3	25.5
Above secondary	13.5	56.7	20.0
<b>Occupation</b>			
Agriculture/livestock/poultry	32.9	3.3	28.5
Petty trader	2.4	0.0	2.0
Labor	22.9	16.7	22.0
Govt. service	11.8	23.3	13.5
Pvt. service	2.4	16.7	4.5
Own business	20.0	33.3	22.0
Abroad	1.8	3.3	2.0
Unemployed	2.4	3.3	2.5
Others	3.5	0.0	3.0
<b>N</b>	<b>170</b>	<b>30</b>	<b>200</b>

## Contraceptive Knowledge and Use

Almost all (99.5 percent) of the interviewed men in D.G. Khan knew of at least one modern method of contraception. As presented in Table 12.2, knowledge of modern methods was highest for pills and condoms (98 percent each), followed by injectables (96 percent) and female sterilization (95 percent). The least known method was Norplant (15 percent).. Nearly all currently married women of reproductive age interviewed in D.G. Khan (99.7 percent) also knew at least one contraceptive method (Table 8.1).

The pattern of ever use and current use of contraception reported by husbands is also shown in Table 12.2. Forty-four percent of the MWRA reported having used some method of

contraception during their married lives (Table 8.2); of the male respondents, 36 percent reported ever using some method of contraception in their married lives. For the men, among modern methods, condom and pill were the most popular method ever used (14 percent each), followed by female injectables (8 percent). None of the men reported ever use of emergency pills or Norplant by their wives.

**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	94.1	96.7	94.5	7.1	3.3	6.5	7.1	3.3	6.5
Male sterilization	88.8	93.3	89.5	2.4	0.0	2.0	2.4	0.0	2.0
Pill	97.6	100.0	98.0	14.7	6.7	13.5	5.9	3.3	5.5
IUD	69.4	83.3	71.5	5.3	3.3	5.0	1.2	3.3	1.5
Injectables	94.7	100.0	95.5	7.6	10.0	8.0	3.5	3.3	3.5
Norplant	15.3	13.3	15.0	0.0	0.0	0.0	0.0	0.0	0.0
Condom	97.0	100.0	97.5	10.6	33.3	14.0	3.5	23.3	6.5
Rhythm	52.9	63.3	54.5	5.9	0.0	5.0	2.9	0.0	2.5
Withdrawal	80.0	90.0	81.5	5.3	16.7	7.0	2.9	10.0	4.0
At least one FP method	99.4	100.0	99.5	33.5	50.0	36.0	27.6	46.7	30.5
At least one modern FP method	99.4	100.0	99.5	29.4	43.3	31.5	22.4	36.7	24.5
At least one traditional FP method	84.1	90.0	85.0	10.6	16.7	11.5	5.9	10.0	6.5
Emergency pills	20.0	40.0	23.0	0.0	0.0	0.0	na	na	na
<b>N</b>	<b>170</b>	<b>30</b>	<b>200</b>	<b>170</b>	<b>30</b>	<b>200</b>	<b>170</b>	<b>30</b>	<b>200</b>

na=not applicable.

As mentioned in table 8.2, a total of 27 percent of all MWRA in the sample were currently using some contraceptive method, while for the male respondents this figure was higher at 31 percent. The most common current modern methods reported by male respondents were the condoms and female sterilization (7 percent each). The use of traditional methods was also reported by 7 percent of the current users. Since traditional methods are far less reliable than modern methods, an important goal of the FALAH project may be to shift users of traditional methods to more effective modern methods.

Table 12.3 shows ever use and current use of modern contraception among respondents by background characteristics. A higher proportion of urban men were currently using a family planning method compared to rural men. Nearly 44 percent of the respondents who had secondary and above education reported ever use of any contraceptive method, compared

to 30 percent with no education. The current use of family planning also showed the same pattern by education of men.

**Table 12.3: Percentage of male respondents reporting ever use or current use of a contraceptive method, by selected background characteristics**

Characteristic	Ever used at least one FP method	Currently using any FP method	N
<b>Residence</b>			
Rural	33.5	27.6	170
Urban	50.0	46.7	30
<b>Education level</b>			
No education	30.3	25.0	76
Below secondary	34.5	31.0	58
Secondary and above	43.9	36.4	66
<b>Number of living children</b>			
None	0.0	0.0	21
1-2	25.6	16.3	43
3-4	41.3	34.8	46
5+	46.7	42.2	90
<b>Future desire for children</b>			
Soon	15.8	10.5	38
Later	14.0	9.3	43
Never	56.7	49.5	97
Don't know/unsure	22.7	22.7	22
<b>Total</b>	<b>36.0</b>	<b>30.5</b>	<b>200</b>

Table 12.3 also shows the positive relationship between family planning use and number of living children. Of those who had five or more children, 47 percent reported ever use of family planning methods, compared to no ever use by men who had no children.

Table 12.3 also shows contraceptive ever use and current use by the future desire for children. Highest ever use was found among the male respondents who said they did not want any more children: 57 percent of those respondents who did not want more children had ever used any contraceptive method, and 50 percent were currently using a form of contraception. Among those men who wanted to delay their next child for at least two years, only 9 percent reported current use of any contraceptive method.

## Source of Contraceptive Methods

As shown in Table 12.4, among those who reported the last source for obtaining contraceptive methods, 30 percent obtained it from grocery shop/general store and 18 percent obtained their last method from Government hospital (DHQ/THQ). Another 18 percent reported that their wife brought the method. Seven percent of the male respondents said that LHWs were the source of the contraceptive method.

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

Source	Percentage
Govt. hospital (DHQ/THQ)	17.5
BHU/RHC/MCH	7.0
FWC	3.5
MSU	1.8
LHW	7.0
Pvt. doctor	1.8
NGO hospital	3.5
Pharmacy, chemist	8.8
Grocery shop/general store	29.8
Wife brings method	17.5
Other	1.8
<b>Total</b>	<b>100.0</b>
N	57

Respondents could name more than one source.

## Approval of Family Planning

Respondents were asked about their approval of birth spacing and use of any form of contraception for spacing purpose. A husband's opposition may prevent his wife from using contraception, even when she wants to delay or stop childbearing (Casterline et al., 1997). In D.G. Khan, 90 percent of men approved of spacing between children, and 90 percent also approved the use of any form of contraception for this purpose (Table 12.5). Ten percent of the men disapproved of using any form of contraception to space between children.

**Table 12.5: Distribution of male respondents' attitude towards spacing and use of contraceptives for spacing by residence**

Variable	Rural	Urban	Total
<b>Spacing between children</b>			
Approve	88.2	100.0	90.0
Disapprove	11.8	0.0	10.0
<b>N</b>	<b>170</b>	<b>30</b>	<b>200</b>
<b>Using family planning methods for spacing</b>			
Approve	87.6	100.0	89.5
Disapprove	12.4	0.0	10.5
<b>N</b>	<b>170</b>	<b>30</b>	<b>200</b>

## Satisfaction Level of Current Users

Satisfaction of the user with his/her contraceptive method is an important factor in whether or not he/she continues with the method. Male contraceptive users were asked to report how satisfied they were with their present contraceptive method. Table 12.6 shows 83 percent of the current users were very satisfied with their current method. Seventeen percent of the current users reported being somewhat satisfied with their current method. These users would seem to be in need of more information on their current method, as well as on other available methods, so that they continue using a family planning method.

**Table 12.6: Level of male respondents' satisfaction with their current method**

Satisfaction	Percentage
Very satisfied	83.3
Somewhat satisfied	16.7
<b>N</b>	<b>48</b>

The reasons the male respondents stopped using their last method 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, 46 percent of male past users stopped using their method because they wanted to have rest from the method. More than 9 percent of the past users stopped using a contraceptive due to method failure. This contraceptive failure may be a reason for those who were relying on natural methods. There were also a few cases where the couple stopped using contraceptive method because of the possible side effects.

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

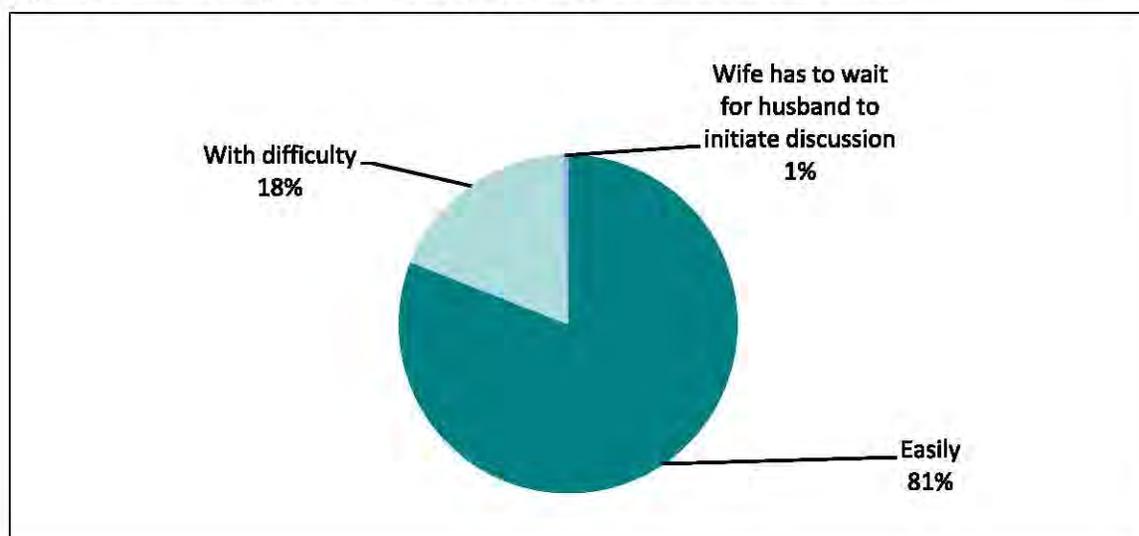
Reason	Percentage
Fear of side effects	9.1
Want another child	72.7
Method failure	9.1
Rest from method	45.5
Health concern	18.2
<b>N</b>	<b>11</b>

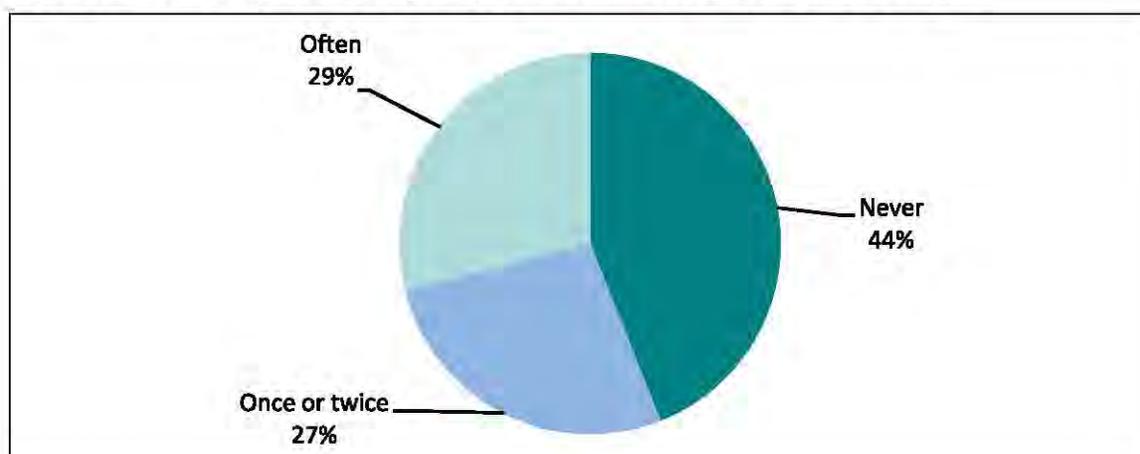
Respondents could give more than one reason.

## Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Husbands were asked if during the last year their wives could approach them to discuss family planning easily, with difficulty or if they had to wait for their husbands to initiate the discussion. The responses are shown in Figure 12.1. Eighty-one percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, 44 percent of the men reported that their wives had never approached them during the last year on this issue. Twenty-nine percent of the men reported that their wives had talked often about this subject during the last year, while 27 percent reported they had talked once or twice.

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



**Figure 12.2: Men's reports of frequency of discussion on FP with wife in last year**

## Potential Users

Men who were non-users of contraception were asked about their intended future use of contraception and their method preferences. Table 12.8 shows that 16 percent intended to use a contraceptive method in the future, while 31 percent did not intend to do so. Fifty-three percent of the respondents were uncertain about their future use of contraception.

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

Intent	Rural	Urban	Total
Will use	17.7	0.0	15.6
Will not use	30.1	40.0	31.3
Unsure/uncertain	52.2	60.0	53.1
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
N	113	15	128

As shown in Table 12.9, the major reason husbands said they did not intend to use was that they wanted more children (30 percent).

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

Reason	Percentage
Infrequent sex/respondent away	7.5
Difficult/unable to conceive	15.0
Breastfeeding/lactational amenorrhea	0.0
Respondent/wife infertile	2.5
Want more children	30.0
<b>N</b>	<b>40</b>

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. Female sterilization was the most preferred method for future use followed by the pill, and condom.

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

Method	Percentage
Female sterilization	25.0
Male sterilization	5.0
Pills	20.0
Injectable	5.0
Condom	10.0
Withdrawal	5.0
Not decided	10.0
Others	20.0
<b>Total</b>	<b>100.0</b>
<b>N</b>	<b>20</b>

## Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 12.11 shows that more than 19 percent of the male respondents wanted another child soon (within two years). Another 22 percent wanted to delay their next child for more than two years. The largest proportion of male respondents (49 percent) did not want any more children at all.

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

Number of living children	Desire for next child				Total	
	Soon	Later	Never	Don't know /unsure	%	N
0	52.4	42.9	4.8	0.0	100.0	21
1	36.4	45.5	9.1	9.1	100.0	22
2	23.8	47.6	19.0	9.5	100.0	21
3	38.1	33.3	19.0	9.5	100.0	21
4	8.0	24.0	60.0	8.0	100.0	25
5	8.6	0.0	68.6	22.9	100.0	35
6+	1.8	1.8	85.5	10.9	100.0	55
<b>Total</b>	<b>19.0</b>	<b>21.5</b>	<b>48.5</b>	<b>11.0</b>	<b>100.0</b>	<b>200</b>

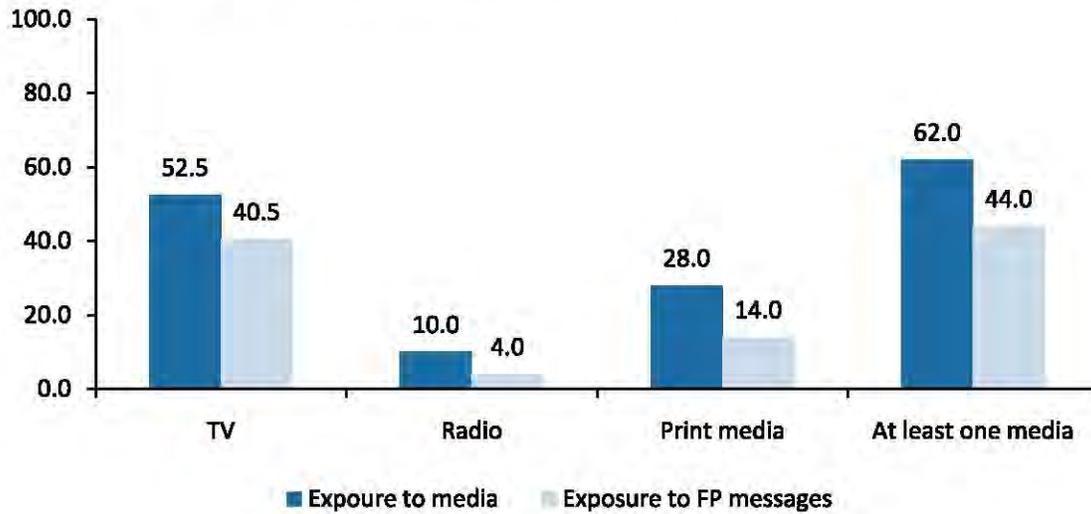
The desire to stop having children was positively associated with the number of living children. Nineteen percent of the respondents who had 2 children did not want more children, whereas 86 percent who had 6 or more children did not want more children.

## 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: 53 percent of the male respondents in D.G. Khan watched TV, and 28 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. Forty-one percent of the men had seen FP messages on television. Overall, 44 percent of the male respondents and 36 percent of the MWRA had seen or heard a family planning message on at least one medium. Only 4 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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