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# Baseline Household Survey

# Mansehra District

May 2010





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

## **Mansehra**

**Baseline Household Survey  
May 2010**

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## Glossary of Terms

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

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

## Executive Summary

The Family Advancement for Life and Health (FALAH) project conducted a baseline household survey for Mansehra, one of the project districts. The survey was conducted between, April to June 2009 in a probability sample of 520 households in 40 clusters in Mansehra. It included interviews with 518 currently married women 15-49 years (“married women of reproductive age” or MWRA), along with 200 married men, of whom 178 were married to women included in the sample. As a separate activity, a mapping study was also carried out in Mansehra during the period between August and November, 2009. The FALAH project is primarily focused on birth spacing and family planning.

### *Household and Respondent Characteristics*

Mansehra, a district in Khyber Pakhtunkhwa, is primarily a rural district. According to the Pakistan National Human Development Report 2003, Mansehra stood at the rank of 58<sup>th</sup> among 91 districts of Pakistan on the Human Development Index (UNDP 2003).

The characteristics of our sample are generally similar to those found in other surveys; some key indicators are given in Table A.

**Table A: Selected key district characteristics from Mansehra household survey**

Variable	Value
Percentage of households in rural areas	96.0
Percentage of households with electricity	86.5
Percentage of households with indoor water supply	50.8
Percentage of households with flush toilet	67.8
Percentage of households with television	45.2
Percentage of literate female respondents	40.7
Percentage of respondents with literate husbands	79.4
Total fertility rate	3.9

Electrification is complete in about 87 percent of the sample households, and ownership of appliances that require electricity was as: televisions (45 percent), refrigerators (33 percent) and washing machines (47 percent). A considerable percentage of the households

(51 percent) had some indoor water supply, and about 68 percent of the households had a flush toilet. However, 31 percent of the households use fields as they do not have any toilet facility. Only 8 percent of the women were working for wages. Female literacy was relatively low: 41 percent of the females were literate. However, 79 percent of their husbands were literate. Thirty-nine percent of the respondents said they watched TV, 16 percent listened to the radio and 12 percent read newspapers or magazines. Most women who heard of any FP message heard it on the television.

### ***Fertility***

The crude birth rate was 30 per thousand population, and the total fertility rate was 3.9 children per woman. Fertility was higher for illiterate women and wives of illiterate men. However, there was little urban-rural difference in fertility. Many births were spaced too closely. For example, 64 percent of birth intervals were less than 36 months. Among those who already had two living children under 5 years of age, 17 percent were currently pregnant.

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

The household survey obtained data on selected key indicators of maternal and neonatal health from 290 sampled women who had delivered a child during the previous four years. Of these women, 65 percent had visited a health provider at least once for antenatal care; 56 percent had at least two tetanus toxoid immunizations; 33 percent were delivered by a skilled birth attendant; and 31 percent were delivered in a public or private health facility. On the other hand, 35 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; 38 percent of mothers reported breastfeeding their last child for at least 6 months without supplementation.

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

<b>Indicator</b>	<b>Value</b>
Percentage of mothers with at least one antenatal care visit	65.5
Percentage of mothers with at least two tetanus shots	55.5
Percentage of most recent deliveries conducted by a skilled birth attendant	33.1
Percentage of most recent deliveries in a facility	31.0
Percentage of MWRA not wanting more children	55.6
Percentage of MWRA wanting to delay next birth for at least two years	25.5
Percentage of MWRA knowing at least one contraceptive method	100.0
Contraceptive prevalence rate	28.4
Percentage of MWRA who are past users of contraception	22.2
Percentage of MWRA with unmet need for family planning	37.3
Percentage of MWRA with unmet need for spacing	14.5
Percentage of MWRA with unmet need for limiting	22.8
Total demand for family planning (CPR + unmet need)	65.6

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

The median “ideal” family size according to the women respondents was 4 children. Regarding desire for more children in the future, 19 percent said they wanted another child soon (within two years), 26 percent said they wanted another child, but only after two years, and 56 percent said they did not want more children. The proportion wanting more children soon decreased rapidly with the number of living children, while the proportion not wanting more increased. The proportion wanting more children later was highest for women with one or two children. About 51 percent of the women respondents said their husband wanted the same number of children that they did, while 31 percent said their husband wanted more children than they did.

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

All currently married women knew of at least one contraceptive method. The contraceptive prevalence rate (the percentage of MWRA currently using some method of contraception) was 28 percent. The most commonly methods in use were: condom (6.4 percent), injectables (5.6 percent) and female sterilization (4.6 percent). Past users comprised 22.2 percent of MWRA; injectables, pills, withdrawal, and condoms were all common past methods. Seventy-three percent of the current users did not want more children, while 27

percent wanted more, but at a later time. Most users reported obtaining their supplies and services from Govt. hospitals /Centers, LHWs or their husbands obtained the supplies.

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

Stated reasons for a respondent's choice of her current or past method varied by method but commonly cited reasons included: suitability for respondent and husband, convenience of use and easy availability. Costs were generally low (only 23 percent paid more than Rs.50 the last time they obtained their method) and did not appear to be a major obstacle to contraceptive use. Similarly, travel time was usually not excessive; however 38 percent reported requiring more than 30 minutes to reach their service. Information provided at the time of acceptance of a method included less information on side effects. Clients generally reported being reasonably treated by providers, but 49 percent respondents viewed that providers were unable to deal with side effects. A variety of side effects was reported by users and past users; 59 percent were treated with medicine.

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

Nearly all users mentioned husband's possible disapproval and religious concerns while a great number of all users cited fear of side effects, and the problems of managing side effects. Past users were most likely to discontinue use because they experienced side effects and wanted more children; their reasons for current non-use were most often infrequent sex/husband away, breast feeding/lactational amenorrhea, fear of side effects, currently pregnant and rest from method. Never users were most likely to say they were not using contraceptives for the desire of more children but husband's and in-laws opposition, infrequent sex/husband away and breast feeding were other significant reasons. Knowledge of at least one service provider was good enough (74 percent) among never users. A large majority of female current and past users said they could discuss family planning easily with their husbands, but 72 percent of the never users said they could do so. Twenty two percent of the never users expressed their intent not to use contraceptives in the future, while 41 percent said they would do so. However, 27 percent were unsure who might be future prospectus users.

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

A woman is said to be in "unmet need" for family planning if she says she does not want more children, or wants them later, and is at risk of conceiving but is not using any method

of contraception. By this definition, 37.3 percent of the women in this sample were in unmet need, 22.8 percent for limiting and 14.5 percent for spacing. Unmet need for limiting was higher in rural areas, among illiterate women, and among women with lower standards of living. However, unmet need for spacing was higher among literate women and those with medium low standard of living.

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

The findings reveal that 91 percent of the men knew at least one modern contraceptive method. Least known contraceptive methods among men were norplant and male sterilization (0.5 percent for each). More than 38 percent of the men did not want more children in the future and 19 percent wanted to delay the next pregnancy. Twenty-nine percent of the male respondents reported that they or their wives were currently using any family planning methods, and 21 percent were using modern contraceptive methods. Among the current users, 69 percent were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, 33 percent reported that they were not intending to use any FP method in the future. The main reason for not intending to use any method was shyness to go to FP clinic followed by fear of side effects as one of the main reasons. Of those who did intend to use contraceptives in the future, pill was the most preferred method. It would be important to include specific interventions aimed at influencing men's attitude towards their role and responsibility in the overall health of the family and in birth spacing and limiting needs.

### ***Conclusion***

In Mansehra district knowledge and approval of family planning were high, and contraceptive prevalence, at 28 percent, was less than that of Pakistan as a whole. Nevertheless, there is much need for improvement; unmet need for family planning remains high at 37.3 percent. Among the important reasons that should be addressed in an improved program are husbands' attitude, inter-spousal communication, fear of side effects, and knowledge of various contraceptive methods and their sources. Also, the concept of birth spacing needs to be stressed to lengthen birth intervals, which are often too short.



# Chapter 1

## Introduction

### Background

#### The FALAH Project

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

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

- **Balochistan:** Gwadar, Jaffarabad, Khuzdar, Lasbela, Quetta, Kech and Zhob;
- **Khyber Pakhtunkhwa:** Charsadda, Mansehra, Mardan and Swabi;
- **Punjab:** Bahawalpur, Dera Ghazi Khan, Jhelum, Khanewal, Multan and Rajanpur;
- **Sindh:** Dadu, Ghotki, Jacobabad, Karachi (townships of 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;

- a) 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 the 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 Mansehra, 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.

### Mansehra District

Mansehra is bounded on the north by Kohistan and Batagram districts, on the south by Abbottabad and Haripur districts, on the east by Muzaffarabad district and on the west by Shangla and Buner districts.

According to the 1998 census, 0.9 percent of the district population consisted of lifetime in-migrants. Immigrants from within the province ( Khyber Pakhtunkhwa including FATA) accounted for 77 percent of the in-migrants, while 11 percent were from Sindh, Punjab, and Balochistan, 6.5 percent were from Azad Kashmir and Northern areas. Those repatriated from other countries accounted for 5.5 percent.

According to the UNDP Pakistan National Human Development Report 2003,<sup>1</sup> Mansehra stood 58<sup>th</sup> among 91 districts in Pakistan; within Khyber Pakhtunkhwa it stood 13<sup>th</sup> of 24 districts (UNDP, 2003). In the Millennium Development Goals report (Planning Commission of Pakistan, 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, district

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<sup>1</sup> The districts of Pakistan were ranked according to a Human Development Index in 2003. Districts were ranked based on literacy rates, enrolment ratios, immunization ratios, infant survival ratios, real GDP per capita, educational attainment index, health index, and income index.

Mansehra ranked above average on most measures of literacy, water supply. The district falls below average in Sanitation ranking within province. The district Mansehra stood 13<sup>th</sup> in Province on immunization rankings (Planning Commission of Pakistan, 2006; Government of Pakistan, 2006).

## **The Mansehra Baseline Household Survey**

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

### **Objectives**

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

### **Rural Sample**

The 1998 Population Census list of villages was used as the sampling frame for the selection of the rural sample. Villages in rural areas have been treated as primary sampling units (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 enumerated number of households and eligible women of reproductive age in Mansehra.

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

<b>Results</b>	<b>Urban</b>	<b>Rural</b>	<b>Total</b>
Sample blocks/villages	2	38	40
Households refused	0	0	0
Households interviewed	26	494	520
Eligible women identified	20	544	564
Eligible women not interviewed	0	45	45
Eligible women interviewed	20	499	519
Incomplete interviews	0	1	1
<b>Total completed women's interviews</b>	<b>20</b>	<b>498</b>	<b>518</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 observations with regard to each question. After making all of the revisions on the basis of the pre-test, the questionnaires were finalized and translated into Urdu.

### Hiring of Interviewers and Supervisors

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

## **Training of Interviewers and Supervisors**

In order to ensure that the training provided for interviewers was of high quality, and that interviewers understood the definitions and concepts underlying the language of the questions, a two-week training of the Mansehra team was conducted by the Population Council in Islamabad. During the training, interviewers conducted 2-3 field interviews as a mock exercise to know about the field issues if there were any and in order to prepare for the actual interview process.

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

## **Quality Assurance**

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

## **Data Entry and Edit Procedures**

Data processing was initiated in the field with the checking of the questionnaires. Each team leader completed on-the-spot checks and preliminary editing of questionnaires during the enumeration period. Team supervisors were provided with editing instructions emphasizing the importance of completing each questionnaire, correctly identifying each eligible respondent, and the completeness of household composition. Each team leader 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 Mansehra district was carried out between April and June 2009.

# Chapter 2

## Household Characteristics

### Geographic Distribution

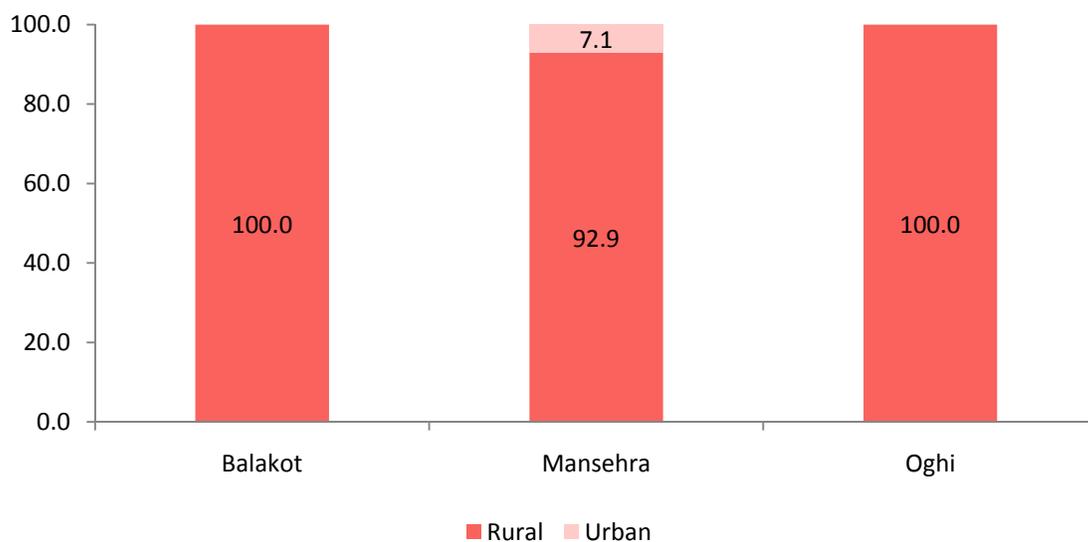
Mansehra district is divided into three tehsils: Balakot, Mansehra, and Oghi. Balakot and Oghi are completely rural, tehsils. Table 2.1 and Figure 2.1 show the distribution of the population of sample households according to residence (urban and rural) and by tehsils with comparisons to the distribution of the 1998 National Population and Housing Census.

**Table 2.1: Percentage distribution of population in sample households by residence and tehsil, and comparison with 1998 census data**

Tehsil	Rural			Urban			Total	
	N	%	1998 Census %	N	%	1998 Census %	N	%
Balakot	792	100.0	100.0	0	0.0	0.0	792	100.0
Mansehra	1906	92.9	89.3	145	7.1	10.7	2051	100.0
Oghi	767	100.0	100.0	0	0.0	0.0	767	100.0
<b>Total</b>	<b>3465</b>	<b>96.0</b>	<b>94.7</b>	<b>145</b>	<b>4.0</b>	<b>5.3</b>	<b>3610</b>	<b>100.0</b>

Table 2.1 shows the distribution of the population of the 520 households in the sample by urban-rural residence and tehsils. Ninety-six percent of the sample population of Mansehra district lived in rural areas. Fifty-seven percent of the sample population resided in Mansehra tehsil, followed by 22 percent in Balakot and 21 percent in Oghi.

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



## Age-Sex Distribution

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

**Table 2.2: Distribution of sampled population by age and sex**

Age group	Male		Female		Total	
	N	%	N	%	N	%
0 - 4	256	14.5	241	13.0	497	13.8
5 - 9	255	14.5	214	11.6	469	13.0
10 - 14	223	12.7	211	11.4	434	12.0
15 - 19	197	11.2	247	13.4	444	12.3
20 - 24	156	8.9	195	10.5	351	9.7
25 - 29	119	6.8	158	8.5	277	7.7
30 - 34	98	5.6	96	5.2	194	5.4
35 - 39	69	3.9	107	5.8	176	4.9
40 - 44	67	3.8	79	4.3	146	4.0
45 - 49	60	3.4	75	4.1	135	3.7
50 - 54	45	2.6	52	2.8	97	2.7
55 - 59	42	2.4	51	2.8	93	2.6
60 - 64	73	4.1	52	2.8	125	3.5
65 +	101	5.7	71	3.8	172	4.8
<b>Total</b>	<b>1761</b>	<b>100.0</b>	<b>1849</b>	<b>100.0</b>	<b>3610</b>	<b>100.0</b>

The population is typical of a society with past high fertility, with sharply declining percentages by age; the median age was 17 years old.

Of the total population of the sampled households, 26.5 percent consisted of females 15-49 years of age, and 13.8 percent consisted of children under 5 years old. These women and children comprise the population of primary interest to the FALAH project, and most of the analysis in this report will focus on them.

## Marital Status

Table 2.3 shows that higher proportions of females at younger ages were married than males. The singulate mean age at marriage for females was 18 years. From the table, it may be observed that only a few males were married in the age group of 15-19 as compared to females. This indicates a later age-at-marriage for men and, at the same, time it also shows that an early age-at-marriage for women was common.

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

Age group	Married		Widow/Divorced/Separated		Never married	
	Men	Women	Men	Women	Men	Women
15 - 19	3.0	13.8	0.0	0.4	97.0	85.8
20 - 24	17.3	53.8	0.0	1.5	82.7	44.6
25 - 29	43.7	77.8	0.8	0.0	55.5	22.2
30 - 34	76.5	82.3	2.0	5.2	21.4	12.5
35 - 39	89.9	83.2	0.0	8.4	10.1	8.4
40 - 44	98.5	89.9	1.5	5.1	0.0	5.1
45 - 49	95.0	80.0	0.0	17.3	5.0	2.7
50 - 54	91.1	71.2	6.7	25.0	2.2	3.8
55 - 59	85.7	88.2	7.1	11.8	7.1	0.0
60 - 64	83.6	61.5	11.0	38.5	5.5	0.0
65 - 69	75.9	48.5	24.1	51.5	0.0	0.0
70 - 74	69.0	29.4	26.2	70.6	4.8	0.0
75 - 79	84.6	27.3	15.4	72.7	0.0	0.0
80 +	82.4	20.0	17.6	70.0	0.0	10.0
<b>All ages 15+</b>	<b>54.4</b>	<b>59.3</b>	<b>4.0</b>	<b>10.0</b>	<b>41.6</b>	<b>30.8</b>

## Household Characteristics and Wealth Indicators

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

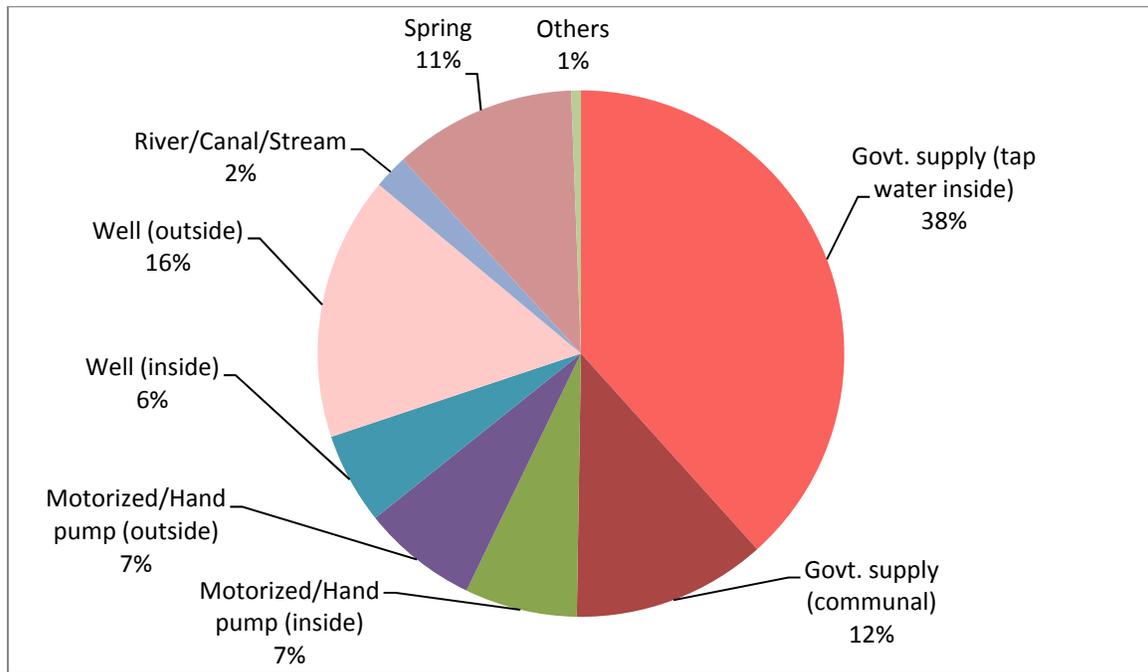
### Physical Characteristics of Households

Table 2.4 shows selected physical characteristics of the sample households. More than half of households (51 percent) had an indoor water supply, although in 38 percent of the households this consisted of an inside Govt. supply. Sixty-eight percent of the households had flush toilets. However, the number was very low for raised or pit latrines. A considerable number of households (31 percent) were using fields as latrine. As a whole, a large majority of households used firewood for cooking (87 percent) but these were all rural households (91 percent) while all urban households were using natural gas. All households in urban areas enjoyed electricity while electricity was available to 86 percent rural households. Most houses were roofed with iron sheets (40 percent) while 62 percent of the walls were made of burnt bricks or cement blocks.

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

Characteristic	Rural	Urban	Total
<b>Main source of drinking water</b>			
Govt. supply (tap water inside)	38.7	30.8	38.3
Govt. supply (communal)	12.6	0.0	11.9
Motorized/Hand pump (inside)	6.3	19.2	6.9
Motorized/Hand pump (outside)	7.1	7.7	7.1
Well (inside)	4.9	19.2	5.6
Well (outside)	16.2	15.4	16.2
River/Canal/Stream	2.2	0.0	2.1
Pooled/Pond water	0.2	0.0	0.2
Spring	11.5	3.8	11.2
Others	0.4	3.8	0.6
<b>Sanitation facility</b>			
Flush to sewerage	1.2	26.9	2.5
Flush connected to septic tank	62.1	65.4	62.2
Flush connected to open drain	2.8	7.7	3.1
Raised latrine	0.2	0.0	0.2
Pit latrine	1.0	0.0	1.0
In fields	32.7	0.0	31.0
<b>Main type of fuel used for cooking</b>			
Fire wood	91.1	0.0	86.5
Gas cylinder	3.8	0.0	3.7
Natural gas (Sui gas)	4.9	100.0	9.6
Dry dung	0.2	0.0	0.2
<b>Electrical connection</b>			
Yes	85.8	100.0	86.5
No	14.2	0.0	13.5
<b>Main material of roof</b>			
Concrete	30.2	88.5	33.1
Iron sheet	41.2	7.7	39.5
Guarder and T-iron	1.0	0.0	1.0
Wood/Bamboo and mud	27.6	3.8	26.4
<b>Main material of floor</b>			
Earth/Sand/Mud	43.1	0.0	41.0
Chips	2.4	15.4	3.1
Marble	1.8	0.0	1.7
Cement	52.4	84.6	54.0
Bricks	0.2	0.0	0.2
<b>Main material of walls</b>			
Burnt bricks/Blocks	59.5	100.0	61.5
Mud bricks/Mud	32.6	0.0	31.0
Wood/Bamboo	1.0	0.0	1.0
Stones	3.8	0.0	3.7
Others	3.0	0.0	2.9
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
N	494	26	520

**Figure 2.2: Distribution of water supply for Mansehra households**



## Ownership of Household Assets

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

Several items requiring electricity were available in a substantial proportion of households, even in rural areas. Forty-five percent of all households had television sets and 36 percent had a radio/tape recorder, a figure of particular interest to communications specialists. The recent expansion of information technology in Pakistan is reflected by the ownership of mobile phones by 77 percent of all households. Motorized transport (four wheels), however, remained fairly uncommon suggesting difficulties in arranging for transport in health emergencies.

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

Household Item	Rural	Urban	Total
Wall clock	87.7	96.2	88.1
Chairs	71.4	96.2	72.6
Bed	67.3	100.0	69.0
Sofa	36.3	76.9	38.4
Sewing machine	50.0	80.8	51.5
Camera	5.3	30.8	6.6
Radio/Tape recorder	34.5	53.8	35.5
Television	42.5	96.2	45.2
Refrigerator	30.2	80.8	32.7
Land line telephone	10.1	38.5	11.6
Mobile phone	75.9	88.5	76.5
Room cooler/ Air conditioner	3.0	15.4	3.7
Washing machine	44.1	92.3	46.5
Bicycle	1.0	3.8	1.2
Motor cycle	2.4	11.5	2.9
Jeep/Car	5.7	11.5	6.0
Tractor	1.0	0.0	1.0
Computer	6.3	26.9	7.3
<b>N</b>	<b>494</b>	<b>26</b>	<b>520</b>

### Standard of Living Index

It is useful to use the above data to get an overall index of the economic well-being of a household, both for a general estimate of economic development for an area, and for use in investigating the relationship between household wealth and reproductive health behavior. One such index is the standard of living index (SLI), which was developed for international comparisons with data from the Demographic and Health Surveys. This index gives each household a score of 0-1 or 0-2 on each of the following: source of drinking water; toilet

facilities; material of floor; availability of electricity; ownership of a radio; ownership of a TV; ownership of a refrigerator; and means of transportation. For the whole household, the value of the index can range from 0 to 12. Table 2.6 gives the distribution of the SLI for the sample households according to urban and rural residence. The median index for all households was 6 while for rural and urban households it was 6 and 8 respectively. About 74 percent of all households fell in the range of 3 to 8. This index will be used later in this report to examine differences in knowledge and behavior regarding reproductive health.

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

Standard of living index	Rural		Urban		Total	
	N	%	N	%	N	%
0	12	2.4	0	0.0	12	2.3
1	13	2.6	0	0.0	13	2.5
2	57	11.5	0	0.0	57	11.0
3	45	9.1	0	0.0	45	8.7
4	56	11.3	0	0.0	56	10.8
5	59	11.9	0	0.0	59	11.3
6	69	14.0	4	15.4	73	14.0
7	76	15.4	6	23.1	82	15.8
8	62	12.6	7	26.9	69	13.3
9	23	4.7	5	19.2	28	5.4
10	10	2.0	4	15.4	14	2.7
11	11	2.2	0	0.0	11	2.1
12	1	0.2	0	0.0	1	0.2
<b>Total</b>	<b>494</b>	<b>100.0</b>	<b>26</b>	<b>100.0</b>	<b>520</b>	<b>100.0</b>
<b>Median</b>	<b>6</b>	<b>na</b>	<b>8</b>	<b>na</b>	<b>6</b>	<b>na</b>

na= not applicable

# Chapter 3

## Respondent Characteristics

The primary source of data from the Household Survey is the interviews conducted with 518 currently married women of reproductive age. The background characteristics of these respondents are described in this chapter.

### Age

Table 3.1 shows the age distribution of the female respondents for rural and urban areas. Since many of the younger women were not married as yet, the numbers at age 15-19 were relatively small. More women were married up to the age group of 25-29, which may be attributed to early marriages in rural areas.

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

Age group	Rural		Urban		Total	
	N	%	N	%	N	%
15 - 19	32	6.4	0	0.0	32	6.2
20 - 24	94	18.9	3	15.0	97	18.7
25 - 29	112	22.5	5	25.0	117	22.6
30 - 34	70	14.1	3	15.0	73	14.1
35 - 39	78	15.7	3	15.0	81	15.6
40 - 44	55	11.0	5	25.0	60	11.6
45 - 49	57	11.4	1	5.0	58	11.2
<b>Total</b>	<b>498</b>	<b>100.0</b>	<b>20</b>	<b>100.0</b>	<b>518</b>	<b>100.0</b>

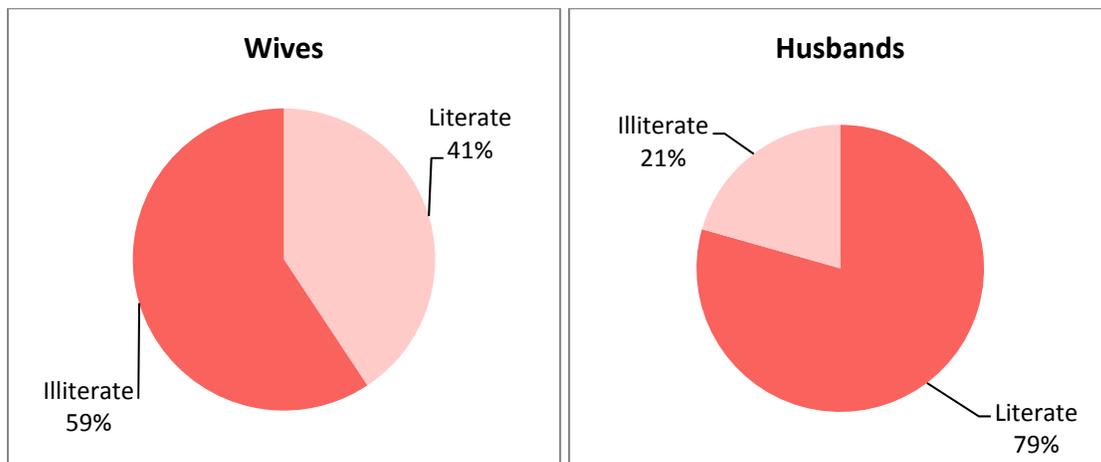
## Education and Literacy

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 female literacy stands at 41 percent while husbands' literacy is marked as 79 percent. Similarly, about 38 percent of female respondents report having ever attended school while this percentage for husbands was 75. A higher proportion of urban women were literate when compared to rural women. For women respondents, literacy and education levels were higher in urban areas. Literacy for women was low in rural areas.

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

	Age of respondent			Residence		Total
	15 - 24	25 - 34	35 - 49	Rural	Urban	
<b>Respondent (women)</b>						
Proportion literate	51.9	44.2	30.2	39.4	75.0	40.7
<b>Education level</b>						
No education	50.4	58.4	72.4	63.3	25.0	61.8
Up to primary	24.0	15.8	16.6	18.1	20.0	18.1
Up to Secondary	17.8	15.3	9.5	12.9	35.0	13.7
Above secondary	7.8	10.5	1.5	5.8	20.0	6.4
<b>N</b>	<b>129</b>	<b>190</b>	<b>199</b>	<b>498</b>	<b>20</b>	<b>518</b>
<b>Respondent's husband</b>						
Proportion literate	87.4	79.4	74.2	78.9	90.0	79.4
<b>Education level</b>						
No education	17.1	23.2	33.2	26.1	10.0	25.5
Up to primary	17.1	11.6	15.1	14.3	15.0	14.3
Up to Secondary	53.5	48.9	37.7	46.2	35.0	45.8
Above secondary	11.6	15.8	14.1	13.1	40.0	14.1
Don't know	0.8	0.5	0.0	0.4	0.0	0.4
<b>N</b>	<b>129</b>	<b>190</b>	<b>199</b>	<b>498</b>	<b>20</b>	<b>518</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 and women’s work separately. Only 41 of the 518 (8 percent) female respondents reported working for cash; their occupations are shown in Figure 3.2.

Figure 3.2: Type of work of female respondents working for pay (N=41)

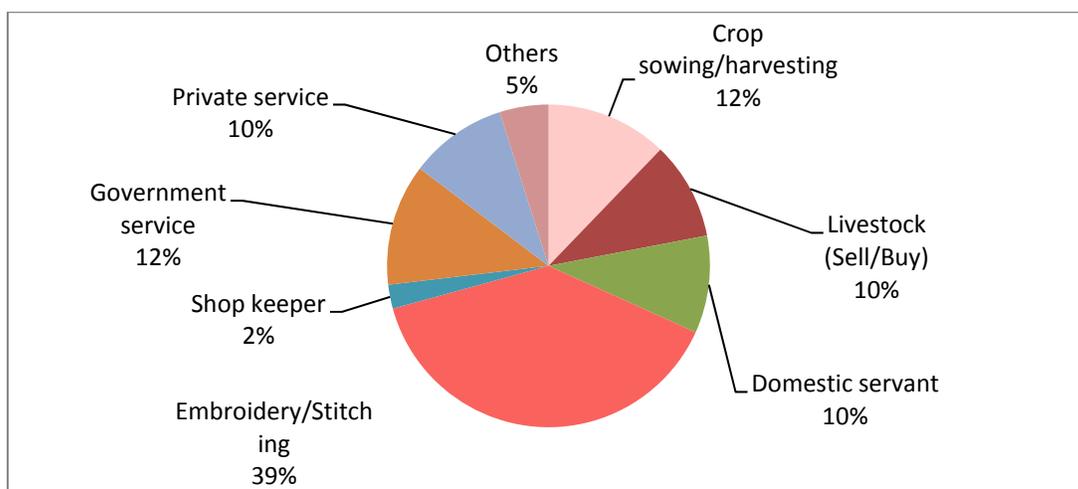


Table 3.3 shows that very low percentage of the husbands of the women (6 percent) worked in agriculture/livestock/poultry either on their own land or they were regularly employed on someone else's land. The largest occupation was labor (daily wages) which had engaged 35 percent of the husbands. About 16 percent were in government service, the second largest employer in the district. About 8 percent of the husbands of the respondents were unemployed.

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

	Rural	Urban	Total
Agriculture /Livestock/Poultry	6.2	0.0	6.0
Petty trader	11.8	20.0	12.2
Labor (Daily wages)	35.5	10.0	34.6
Government service	15.9	20.0	16.0
Private service	10.2	20.0	10.6
Own business	5.6	15.0	6.0
Abroad	5.4	5.0	5.4
Unemployed	7.4	10.0	7.5
Others	1.8	0.0	1.7
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
<b>N</b>	<b>498</b>	<b>20</b>	<b>518</b>

## Female Mobility

Women respondents were asked about their ability to go to places outside their homes and what degree of permission was required (Table 3.4). Only a few women reported being able to go to any of the places named without permission. On the other hand, 23 percent of the women reported not being able to go at all to the market. However, this number is very low for health center, and more than two-third could go there with someone. For each of the named destinations, a good number said they could go with someone.

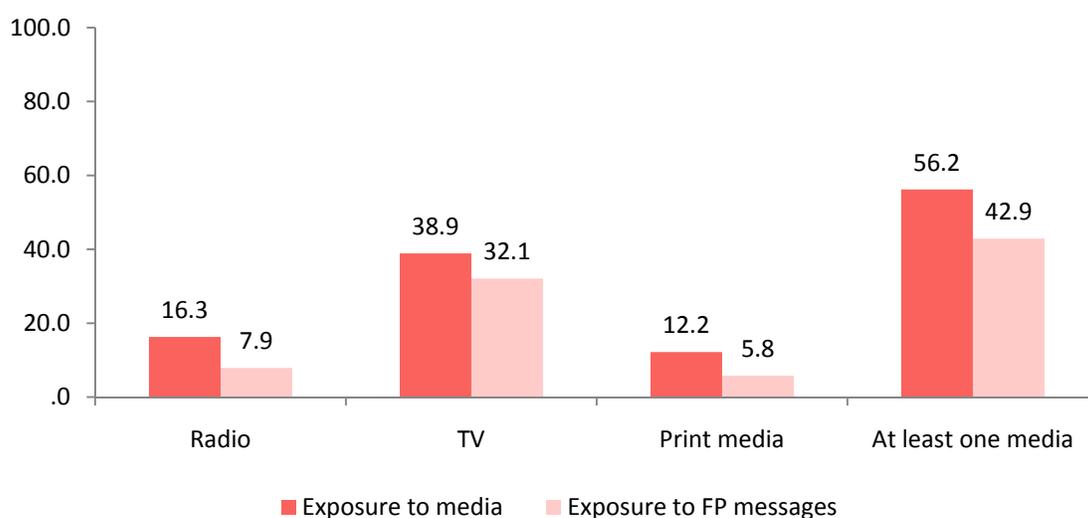
**Table 3.4: Wives' reports regarding mobility outside the home, according to degree of permission and destination**

Destination	Degree of permission				Total	
	Without permission	With permission	With someone	Can't go/ Doesn't go	%	N
Market	6.8	18.3	52.3	22.6	100.0	518
Health center	8.1	22.0	66.4	3.5	100.0	518
Relatives/friends	19.1	38.8	40.0	2.1	100.0	518
Out of village/ town	2.7	23.4	68.5	5.4	100.0	518

## Mass Media Access and Exposure to Family Planning Messages

For the development of communication activities, it is important to know which forms of mass media are available, and to what extent they are used by various segments of the population. Table 2.5 shows that 45 percent of households owned a television, while 36 percent owned a radio. Figure 3.3 shows the proportion of women who reported that they watched TV, listened to the radio, or read newspapers or magazines. Television was the most commonly used medium (39 percent), while radio and print media were less common (16 percent and 12 percent respectively).

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



Furthermore, women who reported access to any sort of media were asked if they had ever seen heard or read any message about methods of family planning through these mediums. Most women said that they had watched family planning messages on the television (32 percent), 8 percent had heard them on radio and only 6 percent of the women reported reading messages from print materials.

# Chapter 4

## Fertility

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

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

## Cumulative Fertility

### Children Ever Born and Living

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

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

Age group	Children ever born					Mean CEB	N
	0	1-2	3-4	5 or more	%		
15-19	65.6	34.4	0.0	0.0	100	0.4	32
20-24	27.8	57.7	13.4	1.0	100	1.3	97
25-29	8.5	37.6	39.3	14.5	100	2.8	117
30-34	9.6	11.0	38.4	41.1	100	4.1	73
35-39	3.7	8.6	24.7	63.0	100	5	81
40-44	3.3	1.7	16.7	78.3	100	6.3	60
45-49	3.4	3.4	15.5	77.6	100	6.4	58
<b>Total</b>	<b>13.9</b>	<b>24.9</b>	<b>24.3</b>	<b>36.9</b>	<b>100</b>	<b>3.7</b>	<b>518</b>

**Table 4.2: 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	65.6	34.4	0.0	0.0	100	0.4	32
20-24	28.9	59.8	10.3	1.0	100	1.2	97
25-29	12.0	41.9	37.6	8.5	100	2.4	117
30-34	11.0	11.0	41.1	37.0	100	3.8	73
35-39	3.7	8.6	33.3	54.3	100	4.5	81
40-44	3.3	1.7	31.7	63.3	100	5.4	60
45-49	3.4	5.2	20.7	70.7	100	5.5	58
<b>Total</b>	<b>15.1</b>	<b>26.4</b>	<b>27.4</b>	<b>31.1</b>	<b>100</b>	<b>3.3</b>	<b>518</b>

na= not applicable

Early childbearing was fairly common in Mansehra. As expected, the table shows that the mean number of children ever born (Table 4.1) and living children (Table 4.2) increased with the age of the mother, as would be expected in data of good quality. Table 4.3 shows the mean number of sons and daughters. Among currently married women aged 15-49 the mean number of children ever born was 3.7. The mean number of children ever born increased steadily with age, from 0.4 in the age group 15-19 years to 6.4 in the age group 45-49. On average, women aged 45-49 years had 5.5 living children; each woman in this age group had lost 0.9 children on average during her reproductive life.

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

Age group	Ever born			Surviving			N
	Boys	Girls	Total	Boys	Girls	Total	
	%	%	%	%	%	%	
15 - 19	0.2	0.2	0.4	0.2	0.2	0.4	32
20 - 24	0.6	0.7	1.3	0.5	0.6	1.2	97
25 - 29	1.5	1.3	2.8	1.3	1.1	2.4	117
30 - 34	2.0	2.0	4.0	1.9	1.8	3.7	73
35 - 39	2.5	2.5	5.0	2.2	2.2	4.5	81
40 - 44	3.1	3.1	6.3	2.7	2.7	5.4	60
45 - 49	3.6	2.8	6.4	3.0	2.5	5.5	58
<b>Total</b>	<b>1.9</b>	<b>1.8</b>	<b>3.7</b>	<b>1.7</b>	<b>1.6</b>	<b>3.3</b>	<b>518</b>

Table 4.1 also shows that 34 percent of married women 15-19 years of age had already had a child. Among currently married women in the 45-49 age groups, 19 percent had reached the end of childbearing with fewer than five children ever born while 3 percent showing none. Seventy-eight percent had five or more children ever born. The sex ratio at birth was 103 males per 100 females, which is consistent with international data. The sex ratio of living children was 106 males per 100 females.

### Differentials in Children Ever Born and Surviving

Table 4.4 shows that differences in mean numbers of children by literacy and educational level of currently married women were pronounced. On average, literate women bore 1.6 fewer children than illiterate women. Also, fertility declined with the level of education. Those who had “up to primary” education had, on average, 3.1 children ever born as compared to 4.3 born to women who had no schooling. Those who had “up to secondary” education had 2.6 children ever born, and those educated in college had 1.7.

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

Characteristic	Children ever born	Total living children	Proportion dead	N
<b>Literacy of respondent</b>				
Literate	2.7	2.5	0.902	211
Illiterate	4.3	3.8	0.879	307
<b>Schooling of respondent</b>				
No education	4.3	3.8	0.877	320
Up to primary	3.1	2.8	0.890	94
Up to Secondary	2.6	2.4	0.918	71
Above secondary	1.7	1.7	0.982	33
<b>Residence</b>				
Rural	3.7	3.3	0.886	498
Urban	3.9	3.4	0.883	20
<b>Literacy of respondent's husband</b>				
Literate	3.4	3	0.894	408
Illiterate	4.8	4.2	0.865	106
<b>Schooling of husband</b>				
No education	4.7	4.1	0.861	132
Up to primary	3.9	3.4	0.885	74
Up to Secondary	3.3	3	0.896	237
Above secondary	2.9	2.7	0.928	73
Don't know	2	1.5	0.750	2
<b>Standard of living index</b>				
Low	3.7	3.2	0.860	117
Medium low	3.9	3.5	0.877	115
Medium high	3.7	3.3	0.901	152
High	3.5	3.1	0.901	134
<b>Husband's occupation</b>				
Agriculture/Livestock/ Poultry	4.5	4	0.899	31
Petty trader	3.7	3.2	0.883	63
Labor (Daily wages)	3.4	3	0.877	179
Government service	3.6	3.3	0.907	83
Private service	3.3	2.9	0.868	55
Own business	3.2	3	0.929	31
Abroad	3.7	3.3	0.883	28
Unemployed	4.8	4.3	0.878	39
Others	6	5.3	0.875	9
<b>Total</b>	<b>3.7</b>	<b>3.3</b>	<b>0.886</b>	<b>518</b>

Differentials were also observed on the basis of literacy and economic activity of husbands. Those who had literate husbands had 3.4 children ever born as compared to 4.8 for those who had illiterate husbands. Women with illiterate husbands had the highest number of children ever born (4.8 children) compared to the women who themselves were illiterate (4.3 children). Similarly, women with unemployed husbands had the highest number of children ever born (4.8 children). Women with husbands who had their own business had the lowest number of children ever born (3.2 children).

Table 4.5 further explains the relationship of age of mothers and literacy with mean number of children ever born and their survival. It is evident that the mean number of children ever born to literate mothers was lower (2.7 children) compared to those mothers who were illiterate (4.3 children). Similarly, the survival of children with literate mothers was better than those born to illiterate mothers. In the below 30 age group, 60 percent were literate, as compared to 39 percent who were illiterate.

**Table 4.5: 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	0.6	0.6	16	7.6	0.3	0.3	16	5.2
20 - 24	1.0	0.9	51	24.2	1.7	1.5	46	15.0
25 - 29	2.4	2.1	60	28.4	3.2	2.7	57	18.6
30 - 34	3.4	3.2	24	11.4	4.3	4.0	49	16.0
35 - 39	4.5	4.1	30	14.2	5.3	4.7	51	16.6
40 - 44	5.2	4.5	17	8.1	6.7	5.8	43	14.0
45 - 49	5.0	4.4	13	6.2	6.8	5.8	45	14.7
<b>Total</b>	<b>2.7</b>	<b>2.5</b>	<b>211</b>	<b>100.0</b>	<b>4.3</b>	<b>3.8</b>	<b>307</b>	<b>100.0</b>

## Current Fertility

### Crude Birth Rate

The crude birth rate (CBR), though a crude measure of fertility, is the most widely understood and used fertility measure. In this survey, it is calculated from the number of births that occurred during the last three years before the survey and the mid-period total population in the sample households. The baseline survey provides an estimate of 29.5 births per thousand population (Table 4.6).

### Age-specific Fertility Rates and Total Fertility Rate

The total fertility rate (TFR) is a more refined measure of fertility than CBR. Age-specific fertility rates (ASFRs) and TFR are based on births to currently married women and the number of women living in the sample households. One of the limitations of measuring ASFRs is the low number of births in the sample during the last three years. The findings show a pattern of ASFRs common in developing countries: rates rose rapidly till age 25-29 then declined with increasing age. A TFR of 3.9 for the period 2004-2007, obtained from the set of ASFRs calculated from the data presented in Table 4.6, can be compared with 4.3 for Khyber Pakhtunkhwa and 4.1 for Pakistan as a whole reported in the PDHS (NIPS/PDHS, 2008).

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

Age group	women	Births	Age specific fertility rate (ASFR)
15 - 19	247	16	21.6
20 - 24	195	77	131.6
25 - 29	158	120	253.2
30 - 34	96	47	163.2
35 - 39	107	40	124.6
40 - 44	79	14	59.1
45 - 49	75	5	22.2
<b>Total</b>	<b>957</b>	<b>319</b>	<b>na</b>
<b>TFR: 3.9</b>			
<b>CBR: 29.5</b>			

na= not applicable

## Mothers with Children Under Five Years

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

Table 4.7 shows a significant number of women with the burden of caring for several young children. Further, among those who already had two living children less than 5 years of age, 17 percent were currently pregnant. For such mothers, it is particularly important for their health and that of their children to ensure that birth spacing is a part of their married life at this point.

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

Number of children <5 years	Currently pregnant		Currently not pregnant		Total	
	%	N	%	N	%	N
0	13.1	28	86.9	186	100.0	214
1	10.1	15	89.9	134	100.0	149
2	16.8	22	83.2	109	100.0	131
3	0.0	0	100.0	25	100.0	25
<b>Total</b>	<b>12.5</b>	<b>65</b>	<b>87.5</b>	<b>454</b>	<b>100.0</b>	<b>519</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 (Fuentes-Affelick and Hessol, 2000; Miller et al., 1995; Zhu et al., 1999). The length of the preceding birth interval is very important for the health of both mothers and their babies. Table 4.8 shows the length of the last closed birth interval for women with two or more births by background characteristics of mothers at the time of the survey.

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

characteristic	Less than 18 months	18 - 23 months	24 - 35 months	36 - 47 months	48 or more months	Total	N
<b>Age</b>							
15 - 19	66.7	33.3	0.0	0.0	0.0	100.0	3
20 - 24	20.0	10.0	47.5	20.0	2.5	100.0	40
25 - 29	20.8	17.8	36.6	15.8	8.9	100.0	101
30 - 34	6.9	24.1	27.6	27.6	13.8	100.0	58
35 - 39	13.9	8.3	22.2	30.6	25.0	100.0	36
40 - 44	10.5	5.3	21.1	21.1	42.1	100.0	19
45 - 49	25.0	0.0	0.0	25.0	50.0	100.0	4
<b>Number of lives</b>							
2	29.4	17.6	31.4	13.7	3.9	100.0	51
3	16.7	13.3	40.0	18.3	11.7	100.0	60
4	5.9	13.7	31.4	33.3	15.7	100.0	51
5	7.4	22.2	44.4	7.4	18.5	100.0	27
6+	18.1	15.3	20.8	26.4	19.4	100.0	72
<b>Education level</b>							
No education	14.7	14.1	32.9	22.9	15.3	100.0	170
Up to primary	24.3	16.2	24.3	21.6	13.5	100.0	37
Up to Secondary	14.3	14.3	37.1	17.1	17.1	100.0	35
Above secondary	21.1	31.6	31.6	15.8	0.0	100.0	19
<b>Standard of Living Index</b>							
Low	14.8	16.7	38.9	16.7	13.0	100.0	54
Medium low	13.8	20.0	38.5	18.5	9.2	100.0	65
Medium high	17.5	11.3	23.8	28.8	18.8	100.0	80
High	19.4	16.1	30.6	19.4	14.5	100.0	62
<b>Total</b>	<b>16.5</b>	<b>15.7</b>	<b>32.2</b>	<b>21.5</b>	<b>14.2</b>	<b>100.0</b>	<b>261</b>

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

Table 4.8 shows that almost 17 percent of children were born with a birth interval of less than 18 months. About 64 percent were born with a birth interval of less than 36 months, while 36 percent were born after three years or more. The differentials by mother's age, educational level and standard of living index are also shown.



# Chapter 5

## Maternal and Neonatal Care

Birth spacing is an integral part of maternal and neonatal care. Adequate spacing of births improves the health of mothers and babies; at the same time, the survival of mothers and babies allows for longer birth intervals. In this survey, a small battery of questions was asked regarding the most recent child born during the past four years, reflecting some of the essential indicators of maternal and neonatal care. A total of 290 women out of 518 women interviewed had borne a child during the past four years, and these women were asked additional questions about maternal and neonatal care.

### Antenatal Care

Antenatal check-ups allow for skilled health personnel to advise expecting mothers as to how to best take care of themselves and their unborn baby during pregnancy, to prepare them for childbirth and care of the newborn, and to identify possible problems during both pregnancy and delivery. The Ministry of Health recommends at least three antenatal visits during pregnancy, preferably four. Traditionally, many women, understanding childbirth as a natural experience and perhaps not finding health providers nearby, have not gone to skilled providers for antenatal care, but in recent years those proportions have been increasing in Pakistan. Table 5.1 and Figure 5.1 show the number of ANC visits for the last birth of women who had delivered during the previous four years. About 65 percent of the sample respondents had received at least one antenatal care visit during the last pregnancy. Forty-nine percent had at least three such visits and 37 percent had four or more ANC visits.

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

Number of visits	Rural		Urban		Total	
	N	%	N	%	N	%
No visit	100	35.5	0	0.0	100	34.5
1-2 visits	47	16.7	0	0.0	47	16.2
3 visits	35	12.4	0	0.0	35	12.1
4+ visits	100	35.5	8	100.0	108	37.2
<b>Total</b>	<b>282</b>	<b>100.0</b>	<b>8</b>	<b>100.0</b>	<b>290</b>	<b>100.0</b>

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

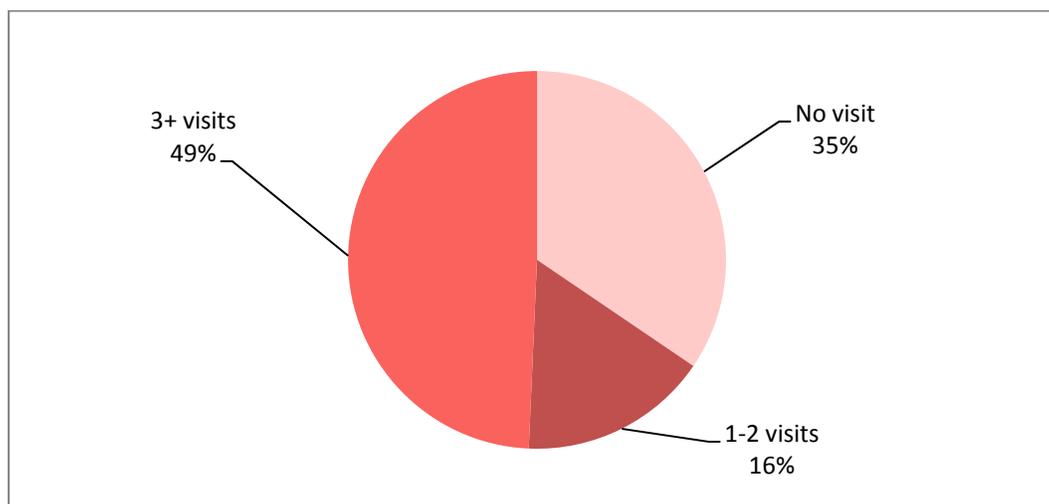


Figure 5.2 shows that many of these visits were in response to routine check up, rather than for some. Forty-one percent of the first antenatal visits were for curative purpose.

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

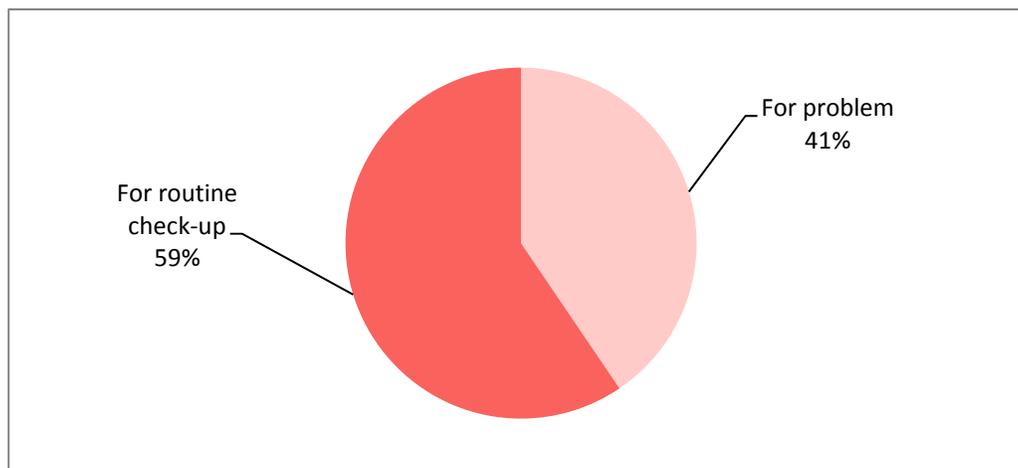


Figure 5.3 shows that 48 percent of the first visits took place within the first three months of gestation, and 13 percent of the first visits occurred during the third trimester.

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

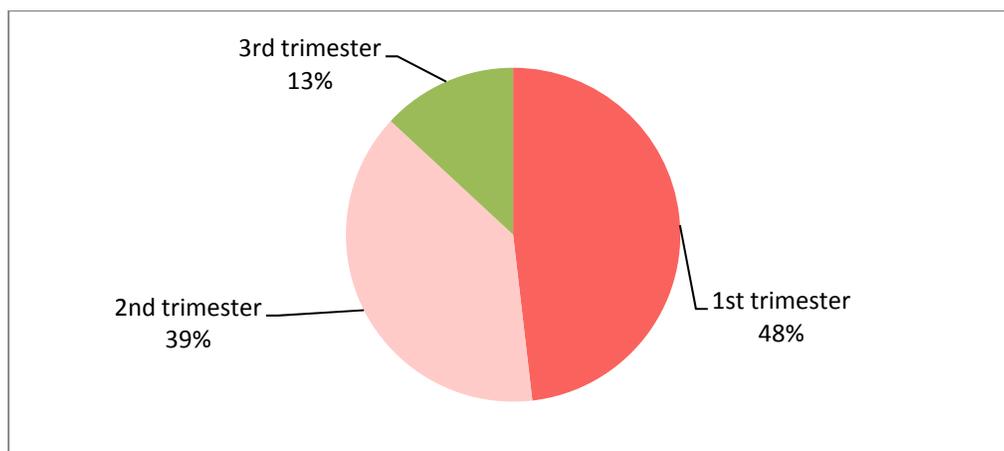
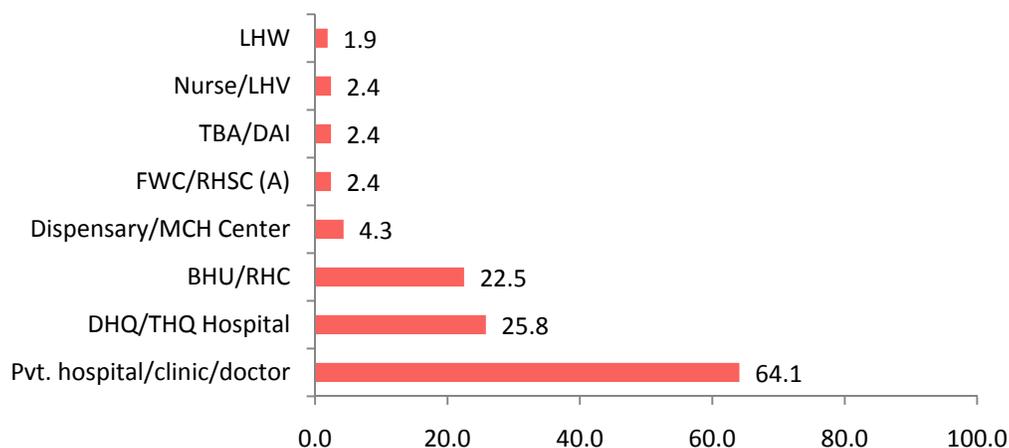


Table 5.2 shows the locations where respondents made one or more antenatal visits. Most antenatal visits took place in private-sector facilities followed by DHQ/THQ hospitals and BHUs /RHCs; other providers were less common.

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

Facilities/service providers	Rural	Urban	Total
Dispensary/MCH Center	4.0	12.5	4.3
BHU/RHC	23.4	0.0	22.5
DHQ/THQ Hospital	26.4	12.5	25.8
Pvt. hospital/clinic/doctor	63.2	87.5	64.1
FWC/RHSC (A)	2.5	0.0	2.4
LHW	1.5	12.5	1.9
TBA/DAI	2.5	0.0	2.4
Nurse/LHV	2.5	0.0	2.4
<b>N</b>	<b>201</b>	<b>8</b>	<b>209</b>

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

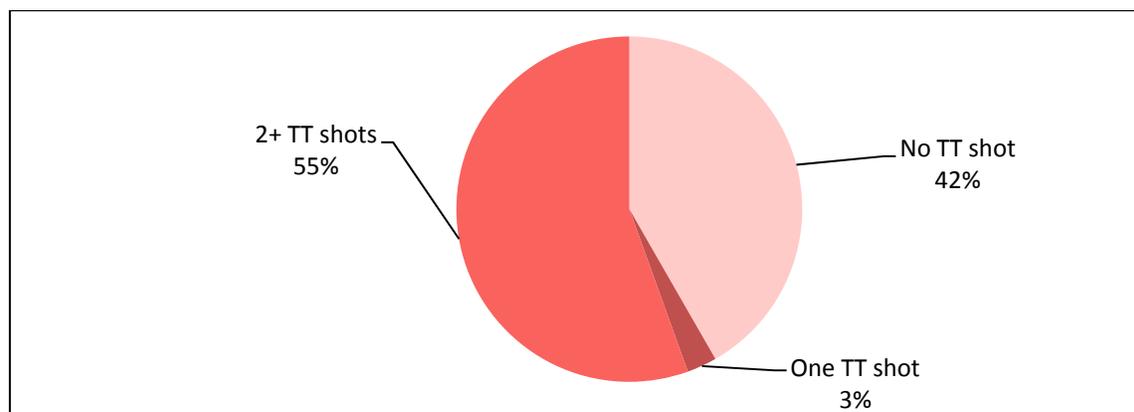


## Tetanus Immunization

Tetanus toxoid immunization is important to avoid tetanus in the newborn and mother. Two doses in a pregnancy are sufficient to prevent tetanus; however, if the woman was immunized during her previous pregnancy only one dose may be needed. Five doses are sufficient for lifetime protection. According to PSLMS 2004-05, 50 percent of mothers in Mansehra had received at least one shot; according to the PDHS 2006-07, 43.2 percent in Khyber Pakhtunkhwa and 53 percent nationally were appropriately protected from tetanus, according to guidelines (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 5.3 and Figure 5.5 show that 58 percent of the mothers had received at least one shot during their last pregnancy, and 56 percent had received two or more shots. Interestingly tetanus toxoid immunization for 2+ shots was 100 percent in urban areas.

**Table 5.3: Tetanus immunization at last delivery**

Number of injections	Rural		Urban		Total	
	N	%	N	%	N	%
No TT shot	121	42.9	0	0.0	121	41.7
One TT shot	8	2.8	0	0.0	8	2.8
2+ TT shots	153	54.3	8	100.0	161	55.5
<b>Total</b>	<b>282</b>	<b>100.0</b>	<b>8</b>	<b>100.0</b>	<b>290</b>	<b>100.0</b>

**Figure 5.5: Tetanus immunization at last delivery**

## Location and Attendance at Delivery

One of the most important ways to reduce maternal mortality is to increase the proportion of mothers delivering in a health facility with the support of a trained birth attendant. Although these proportions have been rising in recent years, they have been historically low in Pakistan and have contributed substantially to high maternal mortality. According to the 2004-05 PSLMS, in Mansehra 14 percent of deliveries took place in institutions, compared with PDHS 2006-07 figures of 29.7 percent for Khyber Pakhtunkhwa and 34 percent nationally (Government of Pakistan, 2006; NIPS/PDHS, 2008). In the present survey, 31percent of the most recent deliveries were in a health facility (Table 5.4 and Figure 5.6). Of these, most of the deliveries took place in private hospitals. The table indicates that a large number of deliveries are still taking place in homes, particularly in rural areas, which increases the risk of maternal mortality.

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

Place of delivery	Rural		Urban		Total	
	N	%	N	%	N	%
At home	199	70.6	1	12.5	200	69.0
Dispensary/MCH centre	2	0.7	0	0.0	2	0.7
BHU/RHC	6	2.1	0	0.0	6	2.1
DHQ/THQ hospital	20	7.1	0	0.0	20	6.9
Pvt. hospital/clinic	53	18.8	7	87.5	60	20.7
FWC/RHSC(A)	1	0.4	0	0.0	1	0.3
Others	1	0.4	0	0.0	1	0.3
<b>Total</b>	<b>282</b>	<b>100.0</b>	<b>8</b>	<b>100.0</b>	<b>290</b>	<b>100.0</b>

**Figure 5.6: Distribution of mothers by location of last delivery**

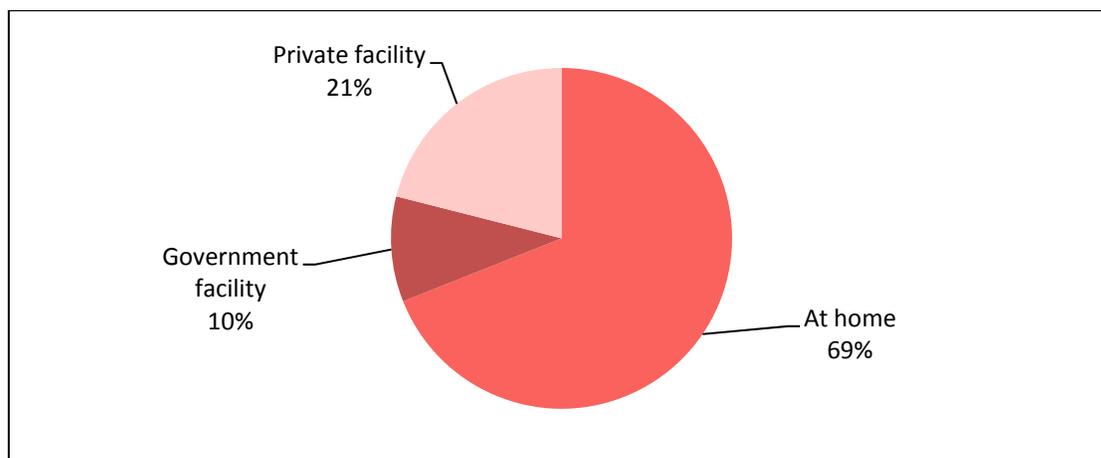
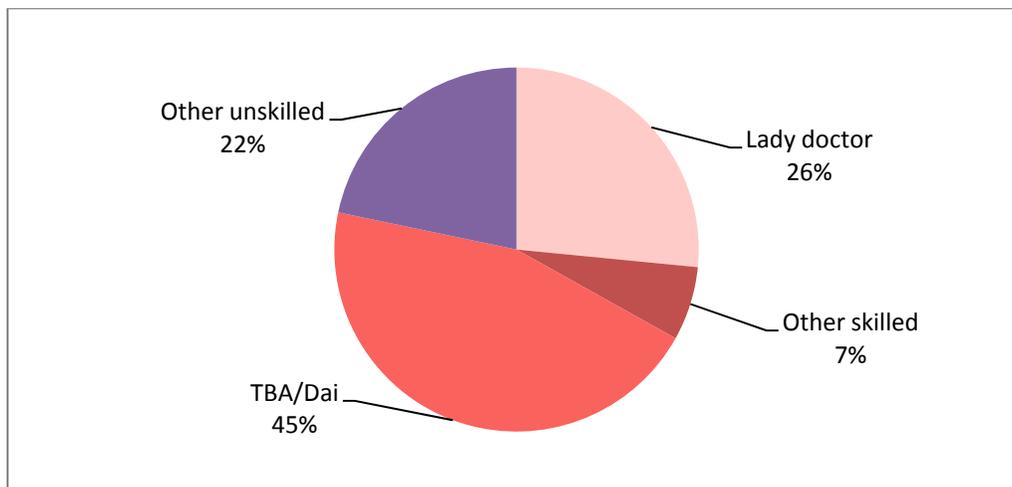


Table 5.5 and Figure 5.7 indicate that in this survey, 33 percent of the reported deliveries in the previous 4 years were assisted by a skilled birth attendant. This was significantly higher in urban areas. In the PSLMS 2004-05 for Mansehra, 66 percent of the births were delivered by a skilled attendant; in the PDHS 2006-07, the corresponding figure was 38 percent for Khyber Pakhtunkhwa and 39 percent for Pakistan as a whole (NIPS/PDHS, 2008). A number of births attended by a skilled attendant in this household survey were reportedly attended by a lady doctor. (The term “doctor” however, may, in such interviews, mean a paramedic, such as a Lady Health Visitor.) About 45 percent of births were delivered by Dai /TBA (traditional birth attendants), while another 21percent, all in rural areas, were delivered by a relative or neighbor who was not a dai.

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

Birth attendant and skill level	Rural		Urban		Total	
	N	%	N	%	N	%
TBA/Dai	130	46.1	1	12.5	131	45.2
LHW	2	0.7	0	0.0	2	0.7
Nurse/LHV	19	6.7	0	0.0	19	6.6
Lady doctor	70	24.8	7	87.5	77	26.6
Female relative/Friend/Neighbor (Not Dai)	61	21.7	0	0.0	61	21.0
<b>Total</b>	<b>282</b>	<b>100.0</b>	<b>8</b>	<b>100.0</b>	<b>290</b>	<b>100.0</b>
Skilled birth attendant	89	31.6	7	87.5	96	33.1
Unskilled birth attendant	193	68.4	1	12.5	194	66.9

**Figure 5.7: Distribution of mothers by attendant at last delivery**

## Postpartum Care

For the health of mothers and newborns, a newly delivered mother and baby should be followed up for at least about 6 weeks after delivery. MoH guidelines recommend at least one postpartum visit after discharge during the first 42 days after delivery. This, however, is a major weakness of maternal and newborn health care in Pakistan: women who deliver at home rarely go for any postnatal check-up, and women who deliver in facilities are usually seen while they are in the facility, but not after. This is also the case in Mansehra. Almost 35 percent of respondents reported receiving postnatal care within 40 days after delivery (Table 5.6) compared with 43 percent nationally and 27.4 percent in Khyber Pakhtunkhwa (NIPS/PDHS, 2008). However, 34 percent received this care within 24 hours. As expected, only 6 percent of the women who delivered at home reported that they had a postnatal check-up within or after 24 hours.

It is pertinent to mention that the absence of postpartum visits represents a missed opportunity to talk to the mother about birth spacing. Much international evidence supports the value of the postpartum period as critical for the mother to focus on family planning and the role it can play in postponing the next pregnancy or in ending childbearing.

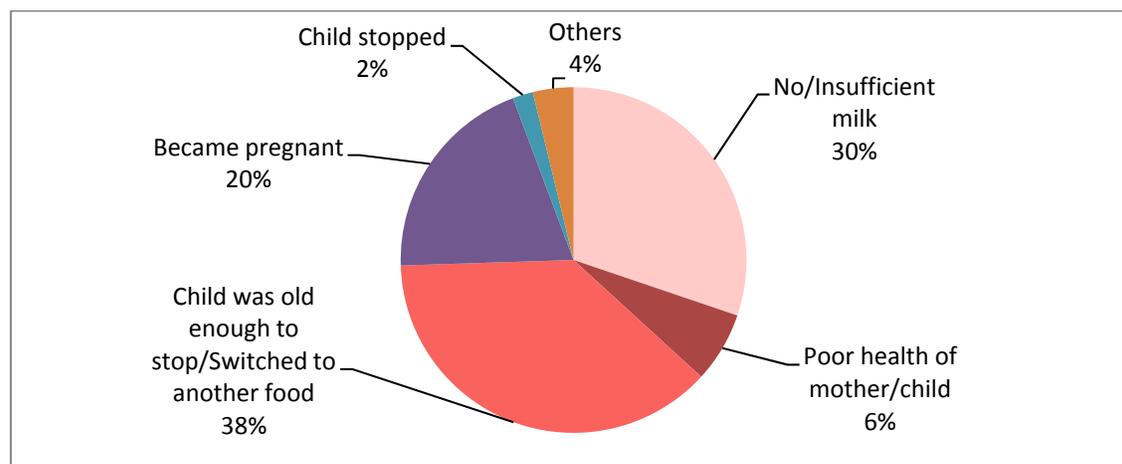
**Table 5.6: Distribution of mothers by status of postnatal check-up and place of delivery**

Place of delivery	Within 24 hours		After 24 hours		Didn't have postnatal checkup		Total	
	N	%	N	%	N	%	N	%
Institutional delivery	87	100.0	0	0.0	0	0.0	87	100.0
Non institutional delivery	11	5.4	2	1.0	190	93.6	203	100.0
<b>Total</b>	<b>98</b>	<b>33.8</b>	<b>2</b>	<b>0.7</b>	<b>190</b>	<b>65.5</b>	<b>290</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. Breastfeeding can be used to deliberately delay pregnancy, either through a formal procedure such as “lactational amenorrhea method” (LAM), or more informally through the assumption that breastfeeding protects against pregnancy. Virtually all Pakistani women breastfeed their children to some extent; in our sample, only 8 of 272 respondents reported not having breastfed their last child at all. Breastfeeding is normally done for a substantial period of time; the median length of breastfeeding for the last baby (not currently being breastfed) was 18 months. Four main reasons were given for discontinuing breastfeeding: child was old enough (38 percent); no or insufficient milk (30 percent); mother became pregnant (20 percent) and poor health of mother or child (6 percent).

**Figure 5.8: Distribution of mothers by reason for discontinuing breastfeeding (N=106)**





# Chapter 6

## Preference for Children

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

## Ideal Number of Children

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

The median "ideal" number, in the sense indicated above, was 4 children; 79 percent of the respondents wanted 4 or fewer children. However, only 14 percent said they wanted 2 or fewer children. These proportions varied according to residence.

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

Number of children	Rural		Urban		Total	
	N	%	N	%	N	%
1	3	0.6	0	0.0	3	0.6
2	65	13.1	8	40.0	73	14.1
3	126	25.3	0	0.0	126	24.3
4	195	39.2	9	45.0	204	39.4
5	70	14.1	2	10.0	72	13.9
6+	33	6.6	1	5.0	34	6.5
Others	6	1.2	0	0.0	6	1.2
<b>Total</b>	<b>498</b>	<b>100.0</b>	<b>20</b>	<b>100.0</b>	<b>518</b>	<b>100.0</b>

## Desire for More Children

### Levels of Desire for More Children

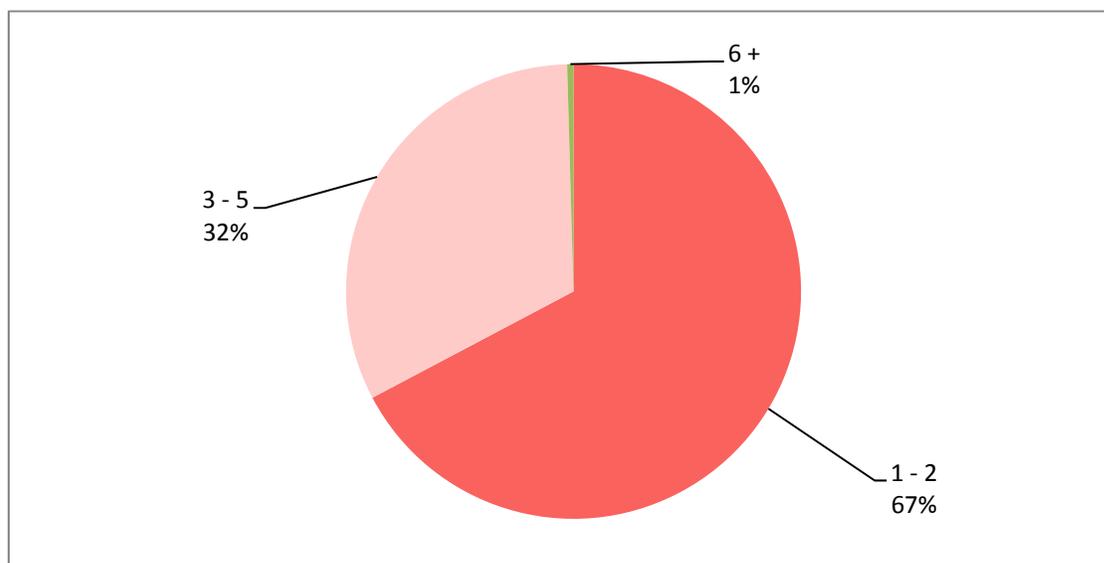
A more immediate measure of fertility preference is whether a couple wants to have more children; if so, do they want the next child now or later, and how many more do they want. The desire for future children is closely linked with the number of children a couple already has. Table 6.2 shows that whether respondents wanted more children soon, later (after 2 years or more) or not at all was based on the number of living children they already had. Fifty six percent of the respondents did not want more children. A quarter (25 percent) wanted to delay their next child. Also, the proportion wanting more children sooner rather than later declined sharply after the first birth. Those who had one living child, most of the respondents who wanted an additional child wanted to have it later, rather than right away. On the other hand, most women with three or more living children did not want to have more children; for those with six or more, the proportion wanting to stop was 98 percent. This table clearly indicates the high level of interest in spacing or limiting births.

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

Number of living children	Desire for next child			Total	
	Soon	Later	Never	N	%
0	61.5	37.2	1.3	78	100.0
1	31.5	60.3	8.2	73	100.0
2	21.9	48.4	29.7	64	100.0
3	9.0	29.9	61.2	67	100.0
4	5.3	6.7	88.0	75	100.0
5	3.1	3.1	93.8	64	100.0
6 +	1.0	1.0	97.9	97	100.0
Total	18.9	25.5	55.6	518	100.0
N	98	132	288	518	na

na= not applicable

For those women who wanted more children, we also asked how many more. Figure 6.1 indicates that more than two-third of the women who wanted more children, and who had an opinion, wanted one or two more children.

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

## Socioeconomic Correlates of Desire for Children

A woman's stated desire was analyzed in relation to four possible socioeconomic determinants: standard of living index (SLI), respondent's age, literacy and residence (Table 6.3). The relationship between SLI and desire for more children was consistent. The age of the respondent was strongly associated with the desire to not have more children. Illiterate women were more likely to have no more children (63 percent) compared to the literate women (46 percent). Rural residents were more likely to want more children soon compared to urban dwellers.

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

Characteristic	Desire for next child			Total	
	Soon	Later	Never	N	%
Low	23.1	28.2	48.7	117	100.0
Medium low	20.0	26.1	53.9	115	100.0
Medium high	15.1	23.7	61.2	152	100.0
High	17.9	24.6	57.5	134	100.0
<b>Age of woman</b>					
< 25	31.8	58.1	10.1	129	100.0
25 or more	14.4	14.7	71.0	389	100.0
<b>Literacy of respondent</b>					
Literate	22.7	31.8	45.5	211	100.0
Illiterate	16.0	21.2	62.9	307	100.0
<b>Residence</b>					
Rural	19.3	25.5	55.2	498	100.0
Urban	5.0	25.0	70.0	20	100.0
<b>Total</b>	<b>18.7</b>	<b>25.5</b>	<b>55.8</b>	<b>518</b>	<b>100.0</b>
<b>N</b>					

## Son Preference

In Pakistan, there is known to be a substantial preference for sons over daughters; in particular, the belief that a family is incomplete without sons is stronger than the corresponding belief for daughters. In this questionnaire, respondents were asked how many daughters they would have before stopping if they did not have a son, and correspondingly for sons if they did not have a daughter. In Mansehra the data show no limit: 5 percent for daughters before having a son, 5.4 percent for sons before having a daughter (Table 6.4). For those women who gave a number, the median number of daughters before having a son was 4 and the median number of sons before having a daughter was also 4.

**Table 6.4: Son and daughter preferences by the respondents**

Response	Number of daughters for desire of a son		Number of sons for desire of a daughter	
	N	%	N	%
Numeric responses	249	48.1	474	91.5
Other non-numeric responses	6	1.2	13	2.5
Up to God	4	0.8	3	0.6
No limit	259	5.0	28	5.4
<b>Total</b>	<b>518</b>	<b>100.0</b>	<b>518</b>	<b>100.0</b>
<b>Median*</b>	<b>4</b>	<b>na</b>	<b>4</b>	<b>na</b>

na = not applicable.

\* of the numeric responses

## Strength of Preference

The strength of preferences asked in such surveys can be questioned. The need for birth spacing can be presumed to be greater if a couple is strongly motivated not to have more children, or to delay the next pregnancy, than if this does not matter much to them. We asked respondents whether, if they became pregnant soon, would they be pleased, worried, accept it, or it did not matter. Results are shown in Tables 6.5 and 6.6. (This question excludes 98 of the total 518 women who wanted a next child soon, were currently pregnant, had been sterilized, had gone through menopause or had a hysterectomy).

Table 6.5 shows that among those who did not want more children at all, 60 percent said that they would be worried if they became pregnant. Thirty-six percent reported that they would accept the new pregnancy, while only 0.5 percent, among those who did not want more children, said they would be pleased. Among those women who wanted to delay their next pregnancy for more than 2 years, 45 percent would be worried while 3 percent would be pleased if they became pregnant, and 46 percent would accept the pregnancy. These responses show weak motivation for spacing. However, the high proportion of women who said they would be worried if they became pregnant supports their earlier statement that they wanted to delay or stop childbearing.

**Table 6.5: 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	3.2	0.5	1.4	4
Worried	44.7	59.5	54.8	161
Accept it	45.7	36.0	39.1	115
Doesn't matter	3.2	1.0	1.7	5
Will abort	3.2	3.0	3.1	9
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>294</b>
<b>N</b>	<b>94</b>	<b>200</b>	<b>294</b>	<b>294</b>

Further, women who expressed a desire not to have more children or to delay the next child were asked what problems they would face if they became pregnant soon. Table 6.6 shows their responses. If we observe the situation overall the problem most commonly faced was own health followed by caring for the children. This shows that health is emerging as a priority in planning a family.

**Table 6.6: Distribution of MWRA who did not want more children soon by reaction if they become pregnant in near future**

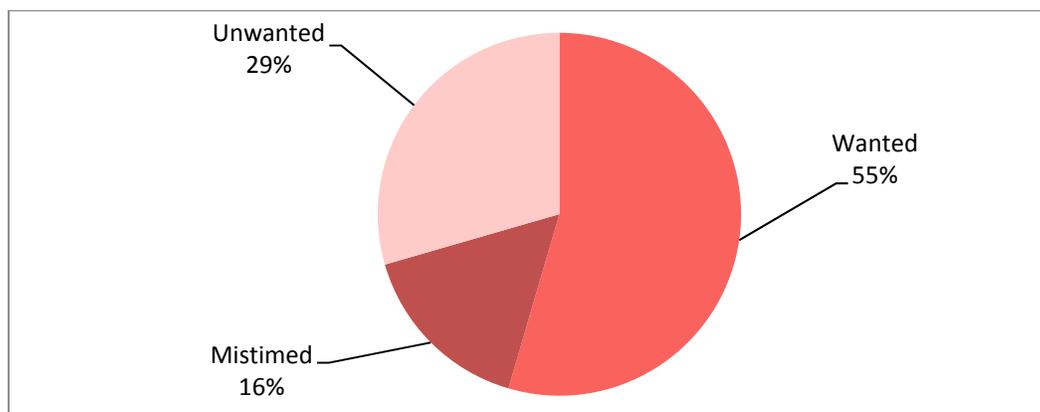
Problems faced if pregnant	Desire for next child		Total	
	Later	Never	%	N
Own health	87.2	95.5	92.9	273
Health of youngest child	86.2	56.5	66.0	194
Caring of children	74.5	70.5	71.8	211
Schooling of children	27.7	64.3	52.6	154
Family economic situation	52.1	78.0	69.7	205
Will feel shy because other kids are grown	0.0	4.0	2.7	8
Others	1.1	0.0	0.3	1
<b>N</b>	<b>94</b>	<b>200</b>	<b>294</b>	<b>294</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 6.2, many women reported that their last pregnancy was unwanted (29 percent) or mistimed (16 percent).

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



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

Women were asked whether they thought their husbands wanted the same number of children as they did, more or fewer children. In Table 6.7, responses are tabulated according to the woman's ideal family size. About 15 percent did not know their husband's preference, while 51 percent thought their husbands wanted the same number of children as they did. However, 31 percent of the women thought their husbands wanted more children than they did, while only 3 percent thought their husbands wanted fewer children.

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

Ideal family size of women	Perceived husband's desire for more children				Total	
	Same number	More children	Fewer children	Don't know	%	N
1 - 2 children	42.1	39.5	0.0	18.4	100.0	76
3 - 4 children	57.0	27.3	4.5	11.2	100.0	330
5 + children	40.6	37.7	1.9	19.8	100.0	106
Up to God/Others	16.7	0.0	0.0	83.3	100.0	6
<b>Total</b>	<b>51.0</b>	<b>30.9</b>	<b>3.3</b>	<b>14.9</b>	<b>100.0</b>	<b>518</b>
<b>N</b>	<b>264</b>	<b>160</b>	<b>17</b>	<b>77</b>	<b>518</b>	<b>518</b>

# Chapter 7

## Contraceptive Knowledge and Use

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

### Knowledge

At least 95 percent of married women of reproductive age in Pakistan have known of at least one method of contraception for many years. Table 7.1 shows that this holds true for Mansehra as well where 100 percent of the respondents knew of at least one FP method. A majority of the female respondents knew of the most commonly used program methods – pills, injections, female sterilization IUD and condoms. Male sterilization, Norplant, and emergency pills were relatively less known. Natural methods were also less known. Variations in knowledge between rural and urban women are shown in Table 7.1.

**Table 7.1: 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	96.8	100.0	96.9
Male sterilization	19.3	55.0	20.7
Pill	98.6	100.0	98.6
IUD	86.5	100.0	87.1
Injectables	99.4	100.0	99.4
Norplant	16.9	40.0	17.8
Condom	85.1	100.0	85.7
Rhythm	31.3	60.0	32.4
Withdrawal	61.2	90.0	62.4
Emergency pills	13.1	40.0	14.1
Others FP method	3.8	5.0	3.9
At least one FP method	100.0	100.0	100.0
At least one modern FP method	100.0	100.0	100.0
At least one traditional FP method	68.5	100.0	69.7
<b>N</b>	<b>498</b>	<b>20</b>	<b>518</b>

## Use of Contraceptive Methods

### Levels of Ever Use and Current Use

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

Of all the married women interviewed in our sample, 51 percent reported having used some method of contraception during their married lives (Table 7.2). This percentage was higher in urban areas (75 percent) as compared to rural areas (50 percent). It was also higher than the proportion obtained in the PDHS 2006-07 for Pakistan as a whole (48.7 percent) (NIPS/PDHS, 2008).

**Table 7.2: 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	18.5	20.0	18.5	96	2.4	5.0	2.5	13	16.1	15.0	16.0	83
IUD	8.8	25.0	9.5	49	2.4	0.0	2.3	12	6.4	25.0	7.1	37
Injectables	25.3	30.0	25.5	132	5.6	5.0	5.6	29	19.7	25.0	19.9	103
Nor plant	0.4	0.0	0.4	2	0.0	0.0	0.0	0	0.4	0.0	0.4	2
Condom	20.3	45.0	21.2	110	6.0	15.0	6.4	33	14.3	30.0	14.9	77
Rhythm method	5.4	5.0	5.4	28	0.6	0.0	0.6	3	4.8	5.0	4.8	25
Withdrawal	20.3	40.0	21.0	109	6.0	15.0	6.4	33	14.3	25.0	14.7	76
Female sterilization	4.6	5.0	4.6	24	4.6	5.0	4.6	24	0.0	0.0	0.0	0
Other FP method	0.8	0.0	0.8	4	0.0	0.0	0.0	0	0.8	0.0	0.8	4
Any FP method	49.6	75.0	50.6	262	27.7	45.0	28.4	147	21.9	30.0	22.2	115
Any modern FP method	46.6	65.0	47.3	245	21.1	30.0	21.4	111	25.5	35.0	25.9	134
Any traditional FP method	22.7	40.0	23.4	121	6.6	15.0	6.9	36	16.1	25.0	16.4	85
<b>N</b>	<b>498</b>	<b>20</b>	<b>na</b>	<b>518</b>	<b>498</b>	<b>20</b>	<b>na</b>	<b>518</b>	<b>498</b>	<b>20</b>	<b>na</b>	<b>518</b>
Emergency pills	2.6	10.0	2.9	15	na	na	na	na	na	na	na	na

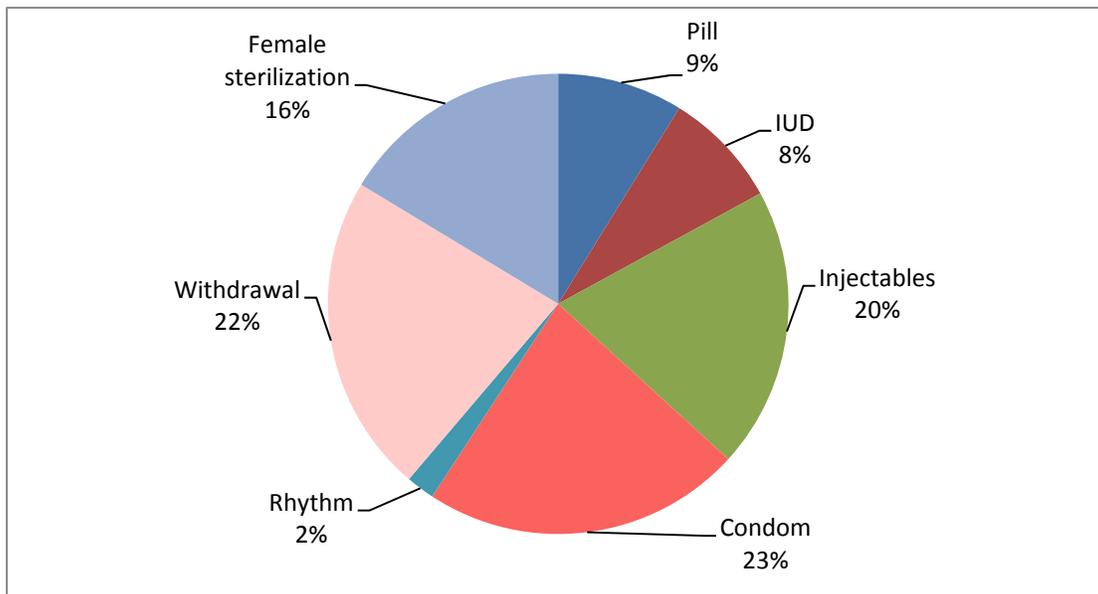
na: not applicable.

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

A total of 28 percent of all married women in the sample were currently using some method of contraception (contraceptive prevalence rate or CPR), compared with 29.6 percent for Pakistan in the 2006-07 PDHS, and 24.9 percent for Khyber Pakhtunkhwa as a whole (NIPS/PDHS, 2008). In this survey, the CPR was 45 percent in urban areas compared with 28 percent in rural areas.

The modern methods most commonly in use were condoms and injectables (Table 7.2). Female sterilization was also a popular choice for those who did not want more children. Overall, 21 percent of married women were using modern methods; 7 percent were using traditional methods. Figure 7.1 shows the proportion of current users by method mix.

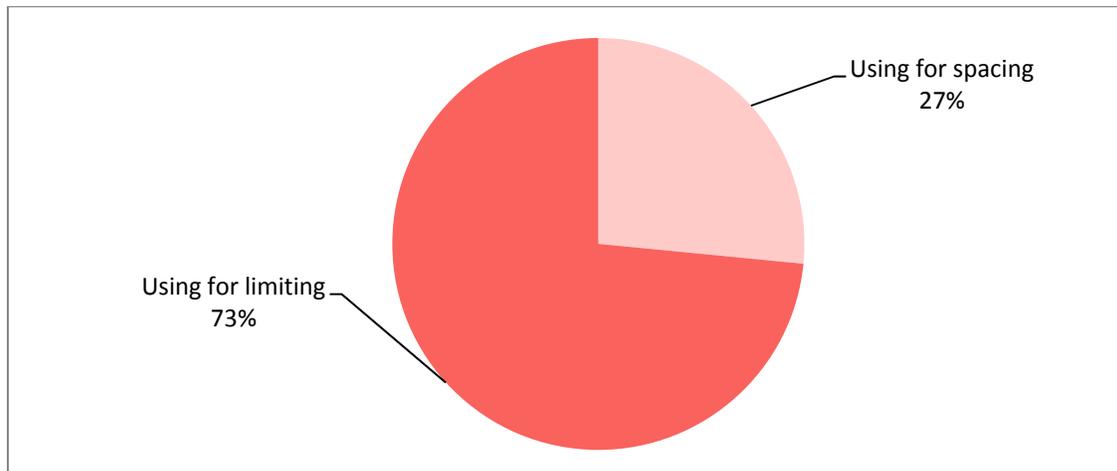
**Figure 7.1: Distribution of current users by method mix**



### Current Use and Desire for Children

It is important to determine how many current users of contraception were using contraceptives for spacing purpose, and how many were using them to stop having children altogether. Figure 7.2 shows that overall 73 percent of current use was for limiting compared with 27 percent for the purpose of spacing births.

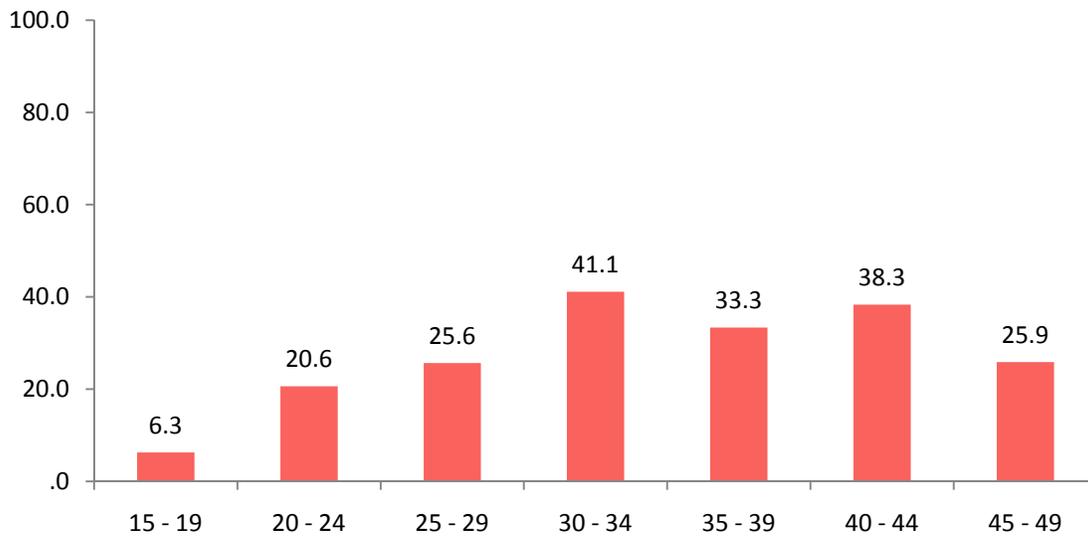
**Figure 7.2: Current use and desire for children**



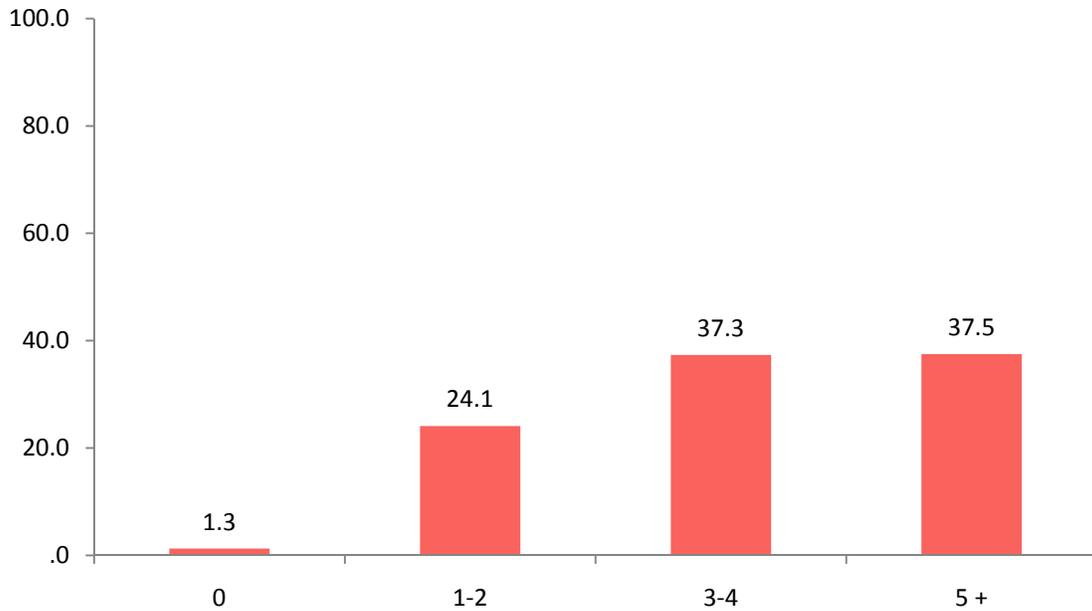
### Correlates of Contraceptive Use

Figures 7.3 and 7.4 show the relationship between contraceptive prevalence and the woman's age and number of living children. The shape of the graph for age shows increasing prevalence up to the age group of 30-34 years. The prevalence was highest in this age group. Figure 7.4 shows that prevalence for women with more than five children was higher.

**Figure 7.3: Contraceptive prevalence by woman's age**



**Figure 7.4: Current contraceptive use by number of living children**



Contraceptive use is associated with higher socioeconomic status and urban residence, as shown in Table 7.3. Respondents in households with the highest SLI had much higher contraceptive prevalence (40 percent) than those with the lowest SLI (16 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 also consistent with SLI and literacy. However, past and current users were much more likely to live in urban areas, while more never users resided in rural areas.

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

	Contraceptive use status			Total	
	Current user	Past user	Never user	N	%
<b>Standard of Living Index</b>					
Low	16.2	14.5	69.2	117	100.0
Medium low	20.9	20.9	58.3	115	100.0
Medium high	32.9	28.9	38.2	152	100.0
High	40.3	22.4	37.3	134	100.0
<b>Ownership of television</b>					
Yes	36.6	25.9	37.4	243	100.0
No	21.1	18.9	60.0	275	100.0
<b>Literacy of respondent</b>					
Literate	33.6	26.5	39.8	211	100.0
Illiterate	24.8	19.2	56.0	307	100.0
<b>Residence</b>					
Rural	27.7	21.9	50.4	498	100.0
Urban	45.0	30.0	25.0	20	100.0
<b>Total</b>	<b>28.4</b>	<b>22.2</b>	<b>49.4</b>	<b>518</b>	<b>100.0</b>

## Source of Method

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

From this table, it is evident that the source depends on the method. Pills and condoms were mostly obtained from the Lady Health Worker or by the husband; IUDs were mostly

inserted in private hospitals. Injectables were obtained mostly from BHUs /RHCs/MCH Centres. Female sterilization was generally sought from DHQ/THQ hospitals.

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

Source	FP method ever used					Total
	Pill	IUD	Injectables	Condom	Female sterilization	
Govt. hospital (DHQ/THQ)	3.1	22.7	10.1	1.9	62.5	14.4
BHU/RHC/MCH Centre	6.3	13.6	34.8	1.9	4.2	15.4
FWC	3.1	18.2	7.2	1.9	0.0	5.5
MSU	0.0	0.0	0.0	0.0	8.3	1.0
LHW	40.6	0.0	24.6	22.2	0.0	20.9
Pvt. Doctor	0.0	9.1	4.3	1.9	4.2	3.5
Pvt. hospital/clinic	0.0	31.8	5.8	0.0	16.7	7.5
NGO hospital	0.0	0.0	1.4	0.0	0.0	0.5
Pharmacy, chemists	6.3	0.0	0.0	3.7	0.0	2.0
TBA/Dai/Referral	0.0	4.5	4.3	0.0	0.0	2.0
Grocery shop/general store	9.4	0.0	0.0	5.6	0.0	3.0
Husband brings method	28.1	0.0	7.2	61.1	0.0	23.4
Others	3.1	0.0	0.0	0.0	4.2	1.0
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
<b>N</b>	<b>32</b>	<b>22</b>	<b>69</b>	<b>54</b>	<b>24</b>	<b>201</b>

# Chapter 8

## Experience with Contraceptive Methods

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

### Reasons for Method Choice

In the survey, current and past users were asked the reasons why they chose a particular method. The list of possible reasons was read out to them; the results are shown in Table 8.1. Overall, the reasons for current and past users were similar, so the data were combined. Among the most common reasons for choosing a method were: suitability for respondent and husband, convenience of use and easy availability. For female sterilization and IUD users, suitability of use for a long period of time was often cited. Cited less frequently was no other method available and least cited was provider's advice. This means that clients had access to a variety of methods. They tended to make decisions according to the known attributes of the various methods, but not always. For example, about 63 percent of pill users cited lack of side effects, even though pills are in fact associated with a number of common side effects.

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

Reason	Contraceptive method					N
	Pill	IUD	Injectables	Condom	Female sterilization	
Easily available	93.8	70.8	87.3	89.1	41.7	168
Low cost	62.5	50.0	66.2	74.5	75.0	138
Convenient to use	93.8	70.8	91.5	81.8	58.3	171
Suitable for Respondent/ husband	81.3	87.5	87.3	90.9	87.5	180
No/fewer of side effects	62.5	66.7	64.8	78.2	41.7	135
Can be used for long period	78.1	91.7	91.5	76.4	91.7	176
No other method available	12.5	0.0	12.7	7.3	4.2	18
Method always available	68.8	45.8	74.6	80.0	29.2	137
Provider advised	40.6	29.2	33.8	25.5	50.0	70
Others	6.3	4.2	7.0	3.6	12.5	13
<b>N</b>	<b>32</b>	<b>24</b>	<b>71</b>	<b>55</b>	<b>24</b>	<b>206</b>

Respondents could give more than one response

To look more specifically at why some users preferred traditional methods to modern ones, 37 current traditional method users were asked why they were not using modern methods. Side effects were by far the main issue: 84 percent cited fear of side effects, and 32 percent reported their own experience of side effects. Husband's disapproval (of modern methods) was cited by 14 percent of the users.

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

Reason	Percentage
Fear of side effects	83.8
Husband's disapproval	13.5
Experienced side effects	32.4
Method not available	2.7
Doesn't know about source of method	2.7
<b>N</b>	<b>37</b>

Respondents could give more than one response

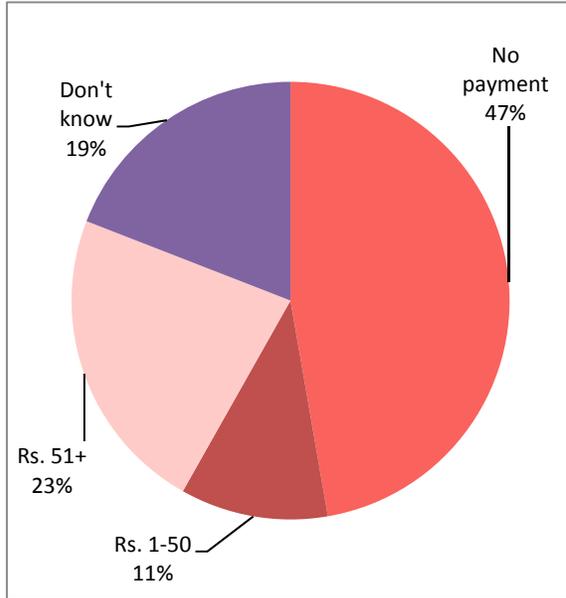
## Cost, Distance and Time to Reach a Facility

Costs of contraceptive methods for users vary widely in Pakistan according to method, whether public or private sector, and the distance from home to facility. Table 8.3 and Figure 8.1 show women's reported costs the last time they obtained a method. Forty-seven percent of users were not charged for their contraceptives, including female sterilization users (who are, in fact, typically reimbursed for expenses involved). For another one of fifth respondents (19 percent), notably condom users, as the husband obtained the method, so the wife did not know the cost. Twenty-three percent paid more than Rs 50 and 11 percent paid less than Rs 50. IUD users often and injectable users many times paid more than Rs 50 for their method. However, for IUD it is a one-time cost, so the monthly cost may be quite low.

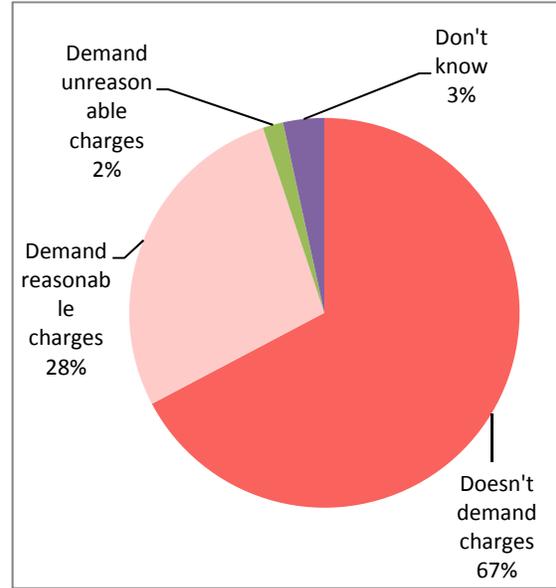
**Table 8.3: Distribution of costs of current specific contraceptive method**

Method	Cost in rupees				Total	
	No payment	21-50	51+	Don't know	%	N
Pill	76.9	7.7	0.0	15.4	100.0	13
IUD	0.0	16.7	83.3	0.0	100.0	12
Injectables	25.0	25.0	46.4	3.6	100.0	28
Condom	33.3	6.1	6.1	54.5	100.0	33
Female sterilization	100.0	0.0	0.0	0.0	100.0	24
<b>Total</b>	<b>47.3</b>	<b>10.9</b>	<b>22.7</b>	<b>19.1</b>	<b>100.0</b>	<b>110</b>

**Figure 8.1A: Cost of contraceptive supply for current users**



**Figure 8.1B: Cost of contraceptive facility charges of current users for the service**



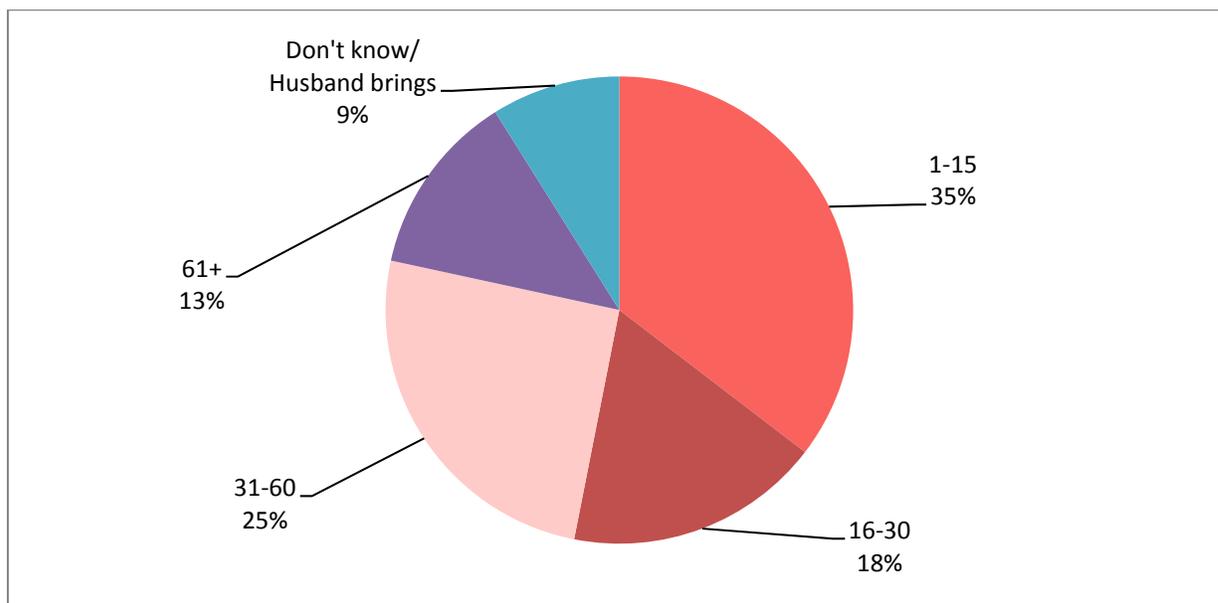
Current users were also asked whether their facility charged them for services, other than the method itself. Sixty-seven percent said they were not charged, 28 percent said that they were charged a reasonable amount and only 2 percent were of the view that they were charged an unreasonable amount.

The time usually needed for current users to obtain a specific method is shown in Table 8.4; Figure 8.2 shows the overall travel time in minutes to acquire the contraceptive methods. About 35 percent of users needed no more than 15 minutes to obtain their method; this included contraceptives from LHWs, who often brought injectables, pills and condoms to the doorstep. Thirty-eight percent needed more than 30 minutes. For a few, particularly female sterilization and IUD users, it took more than an hour to reach the service place; usually in these cases there was no need to visit frequently.

**Table 8.4: 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 brings	%	N
Pill	27.3	18.2	18.2	0.0	36.4	100.0	11
IUD	16.7	33.3	33.3	16.7	0.0	100.0	12
Injectables	66.7	19.0	0.0	14.3	0.0	100.0	21
Condom	72.7	18.2	0.0	0.0	9.1	100.0	11
Female sterilization	4.2	8.3	58.3	20.8	8.3	100.0	24
<b>Total</b>	<b>35.4</b>	<b>17.7</b>	<b>25.3</b>	<b>12.7</b>	<b>8.9</b>	<b>100.0</b>	<b>79</b>

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



## Treatment by Provider

### Information Provided

Current and past users were asked what information was provided to them by service providers. For this purpose, a list of important topics was read out to them, and the results are shown in Table 8.5. The accuracy of client responses may be questioned, due to problems of recall or understanding; still, it appears that information provided was seriously deficient. The most common topics respondents said they were told about were effectiveness and how to use the method. Few were told about possible side effects. On other topics, very less number of users were provided information. There is a need to emphasize to providers that they give comprehensible information on the method selected by the clients, especially hormonal contraceptives.

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

Information provided at acceptance	Family planning method					N
	Pill	IUD	Injectables	Condom	Female sterilization	
How the method works	3.1	8.3	7.0	3.6	4.2	11
How to use the method	56.3	45.8	42.3	18.2	41.7	79
Contraindications	0.0	0.0	2.8	1.8	4.2	4
Effectiveness	53.1	91.7	90.1	20.0	95.8	137
Advantages	6.3	12.5	9.9	10.9	8.3	20
Possible side effects	12.5	25.0	18.3	9.1	16.7	32
What to do if experienced side effects	12.5	41.7	15.5	3.6	16.7	31
Possibility of switching	6.3	20.8	4.2	1.8	0.0	11
About other methods of FP you could use	9.4	8.3	7.0	10.9	4.2	17
<b>N</b>	<b>32</b>	<b>24</b>	<b>71</b>	<b>55</b>	<b>24</b>	<b>206</b>

Respondents could give more than one response

## Treatment at Facility

Current users were asked about various aspects of their treatment on their last visit to the provider for family planning. As Table 8.6 shows, responses were mainly positive but with some exceptions. Thirty-eight percent of the respondents said that the attitude of staff was non-cooperative. However, the point to be noted is that 49 percent of the users viewed that the providers were unable to deal with side effects.

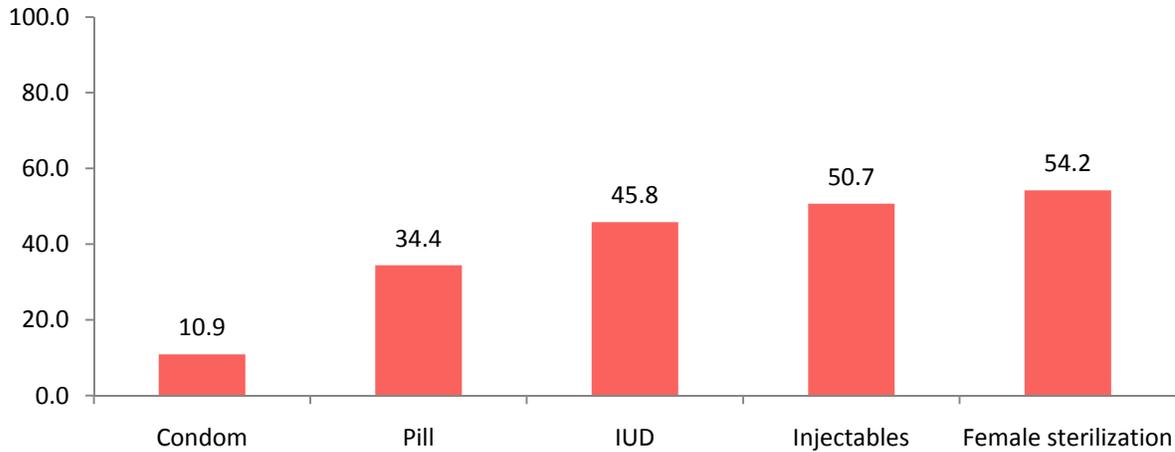
**Table 8.6: Percent of current users responding positively on treatment at last visit by aspect of treatment**

Aspect of treatment	Percent
Staff attitude cooperative	62.1
Provider available	96.5
Attend/examine properly	81.0
Doesn't demand charges	67.2
Can deal with side effects	51.2

## Side Effects

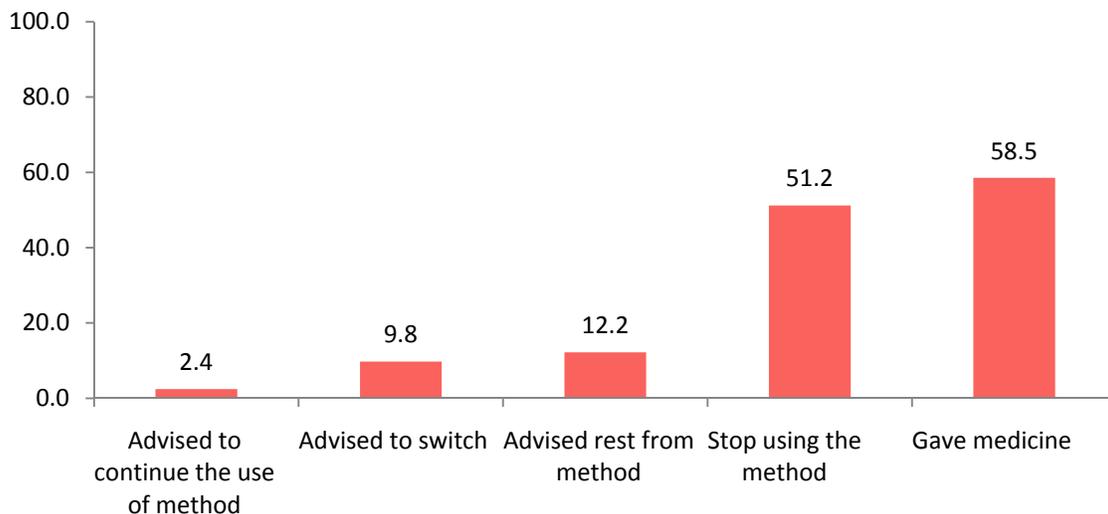
Current users were asked if they had experienced, or were experiencing, any side effects from their current method, and past users were asked if side effects were among the reasons for their discontinuation of a method. If so, a list of possible side effects was read out to them, and they were asked if they had experienced them; multiple responses were allowed. As shown in the Figure 8.3, side effects were most commonly reported by females having sterilization (54 percent) and were least commonly reported by condom users (11 percent).

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



These respondents were asked if the provider responded in a manner included in a list read out to them (Figure 8.4). Only 3 percent were advised to continue the use of the chosen method, 51 percent were advised to stop, 12 percent were advised to have rest from the method and 10 percent were asked to switch to another method. However, the treatment was provided with medicine to 59 percent of the users.

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



# Chapter 9

## Reasons for Non-use

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

## Hindrances to Use

One way to understand 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 9.1 shows the responses of the female respondents, according to whether they were current users, past users or never users.

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

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

Hindrance	Use of family planning					
	Current user		Past user		Never user	
	N	%	N	%	N	%
Husband's disapproval	141	95.9	110	95.7	251	98.0
Other people may find out about contraceptive use	120	81.6	104	90.4	243	94.9
Distance and travel costs to FP outlet	124	84.4	100	87.0	223	87.1
Probability of getting pregnant while using	126	85.7	103	89.6	214	83.6
Fear of side effects	140	95.2	107	93.0	234	91.4
Problem of managing side effects	138	93.9	107	93.0	229	89.5
FP is against religion	143	97.3	111	96.5	253	98.8
<b>N</b>	<b>147</b>	<b>na</b>	<b>115</b>	<b>na</b>	<b>256</b>	<b>na</b>

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

## Past Users

### Reasons for Discontinuing Contraceptive Use

Past users were asked about their reasons for discontinuing their last contraceptive method. The most commonly given reasons were experience of side effects, desire for another child, infrequent sex, rest from the method and method failure (Table 9.2). These reasons are appropriate in many cases, but not always. Clinical methods do have associated side effects; but as we have seen, providers rarely try to counsel users through the temporary experience of common, non-dangerous side effects.

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

Reason	Percentage
Wanted another child	24.3
Fear of side effects	9.6
Side effects experienced	33.9
Method failure	14.8
Lack of access/unavailability	3.5
Cost not affordable	1.7
Method inconvenient to use	3.5
Rest from method	16.5
Missed the dose	3.5
Provider's advice	12.2
Infrequent sex/Husband away	17.4
Husband's advice	12.2
In laws Oppose	4.3
Menopause	5.2
<b>N</b>	<b>115</b>

Respondents could give more than one response

### Reasons for Current Non-use

It is important to know the reasons for non-use of those couples who have used contraceptive methods in the past but are not currently using them. A list of possible reasons was read out to past users for their not currently using contraceptives, with more than one reason possible (Table 9.3). The most common reasons were: infrequent sex/husband away, breastfeeding/lactational amenorrhea, fear of side effects, currently pregnant and rest from method.

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

Reason	Percentage
Fear of side effects	18.3
Want another child	11.3
Currently pregnant	16.5
Rest from method	16.5
Provider's advice	8.7
Infrequent sex/husband away	23.5
Breast feeding/Lactational amenorrhea	19.1
Menopause	10.4
Just not using/too lazy	7.0
Others	14.8
<b>N</b>	<b>115</b>

Respondents could give more than one response

## Never Users

### Reasons for Non-use

The 256 women in the sample who reported never use were asked about various possible reasons for not using contraceptives, with each reason read out separately. As shown in Table 9.4, the most important reason was a desire for more children, and a concern about their ability to conceive as an additional factor. Women were more likely to cite husband and in-laws' opposition, infrequent sex/husband away and breast-feeding/lactational amenorrhea as significant reasons for not using contraceptives. Other important reasons cited were: lack of access/unavailability and fear of side effects. A small percentage reported religious objection which is often cited in other literature as a barrier to family planning use.

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

Reason	Percentage
Husband opposes	18.4
In laws oppose	10.2
Fear of side effects	10.9
Lack of access/Unavailability	14.8
Cost not affordable	4.7
Shy to consult about family planning	12.1
Method inconvenient to use	1.2
Infrequent sex/Husband away	18
Difficult/Unable to conceive	32.4
Breast feeding/Lactational amenorrhea	17.6
Respondent/Husband infertile	1.2
Wanted (more) children	67.2
Against religion	6.3
Natural spacing	3.1
Others	4.7
<b>N</b>	<b>256</b>

Respondents could give more than one response

### Attitude towards Birth Spacing and Limiting

It is important to see the extent to which never users disapprove of family planning in principle, as opposed to accepting it in principle but not using contraceptives for some other reason. Table 9.5 shows this for never using respondents. About 25 percent of the women disapproved of limiting, while only 9 percent disapproved of spacing. There seems to be more opposition to contraceptive use for limiting rather than for the purpose of spacing children.

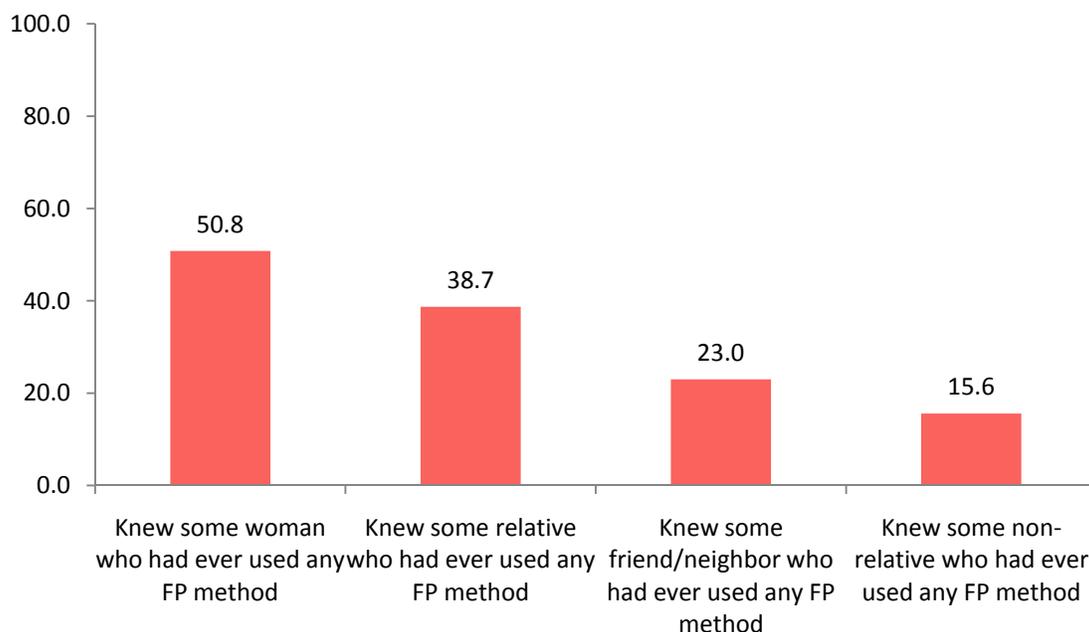
**Table 9.5: Distribution of never users by attitude towards spacing and limiting birth**

Attitude	Attitude towards spacing		Attitude towards limiting	
	N	%	N	%
Approve	234	91.4	189	73.8
Disapprove	20	7.8	65	25.4
Don't know	2	0.8	2	0.8
<b>Total</b>	<b>256</b>	<b>100.0</b>	<b>256</b>	<b>100.0</b>

### Knowledge of Contraceptive Users, Methods and Facilities

Of the 256 female never users in the sample, 51 percent reported knowing some woman who had ever used a method to delay or avoid pregnancy. Thirty-nine percent of the respondents had a relative who had used some method, and 23 percent knew of a friend or neighbor who had used contraceptives. Sixteen percent of the never users knew someone (who was not relative) who had ever used an FP method to delay or avoid pregnancy.

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



Respondents who were never users had the same level of knowledge of at least one FP method (100 percent) as of general cited in Table 7.1(100 percent). For each method, a smaller percent of never users knew that method than the general distribution but with some exceptions. Never users knew a variety of methods.

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

Method	Percentage
Pill	98.8
IUD	79.7
Injectables	99.6
Norplant	14.5
Condom	76.6
Rhythm	21.9
Withdrawal	50.4
Female sterilization	94.9
Male sterilization	11.7
Emergency Pills	6.6
Other FP method	2.3
At least one FP method	100.0
<b>N</b>	<b>256</b>

Respondents could give more than one response

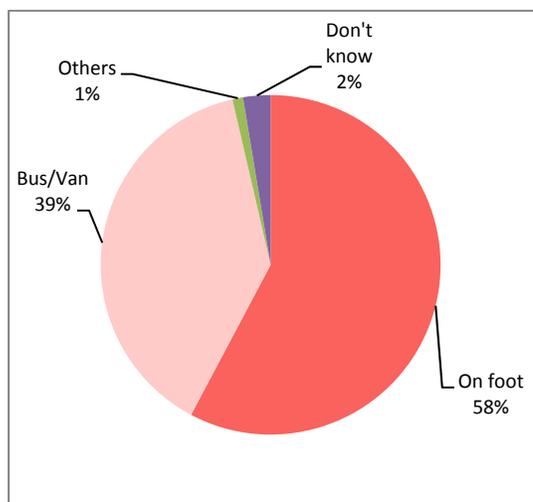
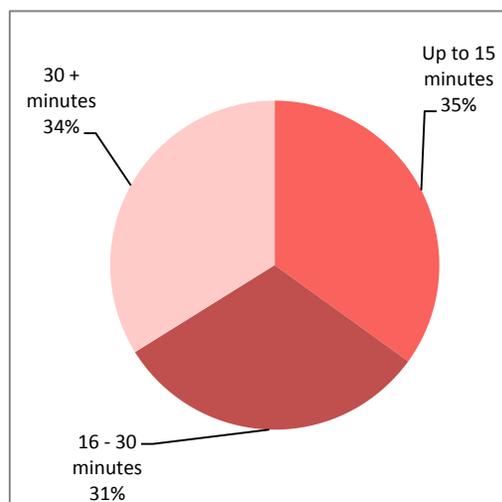
Of the 256 never users, 26 percent did not know of a place to obtain a method. For those who did know, the places they were aware of are shown in Table 9.7. The sources best known were , Department of Health outlets – the District/Tehsil Headquarters hospitals and BHUs/RHCs/MCH centers, private hospitals/clinics, Lady Health Workers -- pharmacy/chemists and, some knew of the Family Welfare Centers of the Ministry of Population Welfare. A few women were aware of other sources, including Greenstar clinics.

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

Source	Percentage
Knowledge of at least one service provider	73.8
DHQ/THQ hospital	55.5
BHU/RHC/MCH Centre	32.4
Family Welfare Center	10.9
Mobile Service Unit Camp	1.2
Lady Health Worker	24.2
Greenstar Clinic	3.9
Private hospital/ Clinic/ Doctor	34.4
Dispenser/ Compounder	9
Pharmacy/ Chemists	13.3
Homeopathic/ Hakim	3.5
TBA/ Dai	7.8
Grocery shop (not pharmacy/ chemist)	10.2
<b>N</b>	<b>256</b>

Respondents could give more than one response

When asked which of the facilities named was nearest, the respondents were most likely to name LHW and BHU/RHC/MCH. Mostly they would go there on foot, sometimes by bus/van (Figure 9.2). Of the 80 respondents who indicated the time required to go to the nearest facility, 35 percent reported 15 minutes or less, 31 percent cited 16 to 30 minutes and 34 percent replied more than 30 minutes (Figure 9.3).

**Figure 9.2: Mode transport to nearest facility/ provider****Figure 9.3: Time to reach nearest facility/ provider**

Never users were asked about whether they intended to use contraceptives in the future. Table 9.8 shows that 41 percent of female respondents (104 out of 256 who believed they could get pregnant) said that they intended to use some method. Lower parity women who had not yet used a method (women with 2 or fewer children) expressed their more intent to use contraception in the future than women with 3 or more children. Twenty-two percent of the never user women said they did not intend to use contraceptives in the future and a great number (27 percent) were unsure; this is a matter of concern. An effective IEC strategy is needed to encourage their acceptance and use of family planning methods.

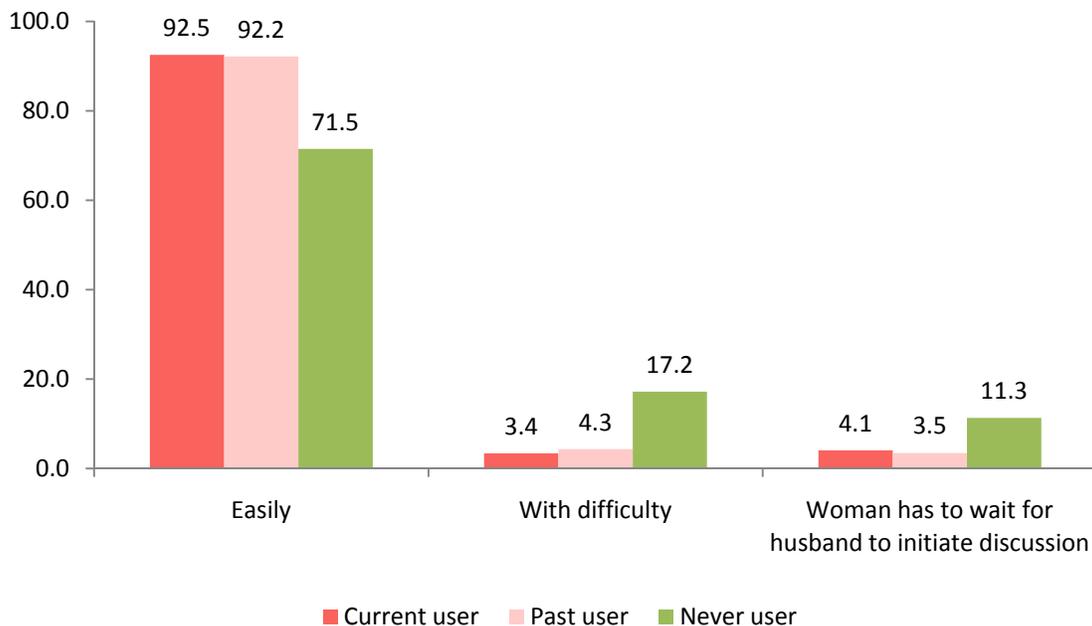
**Table 9.8: Distribution of never users by intent to use a method in future and number of living children**

Number of living children	Intention to use FP method in future				Total	
	Yes	No	Unsure/ Uncertain	Can't get pregnant	%	N
0	51.3	10.3	34.6	3.8	100.0	78
1-2	57.7	14.1	25.6	2.6	100.0	78
3-4	20.0	36.4	27.3	16.4	100.0	55
5 or more	17.8	37.8	17.8	26.7	100.0	45
<b>Total</b>	<b>40.6</b>	<b>21.9</b>	<b>27.3</b>	<b>10.2</b>	<b>100.0</b>	<b>256</b>

## Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Women were also asked whether they could approach their husbands to discuss family planning easily, with difficulty or if they had to wait for their husbands to initiate the discussion. Most of those who responded said they could do so easily (Figure 9.4). However, this varied by use status. Ninety-three percent of the current users and 92 percent of the past users said they could approach their husbands easily; very few said they had to wait for their husband to initiate the discussion. However, for never users, 72 percent reported being able to approach their husbands easily, 17 percent could only do so with difficulty and 11 percent said they had to wait for him to begin the conversation.

**Figure 9.4: Women’s report regarding ease of approach to husband to discuss family planning**





# Chapter 10

## Unmet Need

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

## Levels and Correlates

Table 10.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in Mansehra. Of the 518 women, 37 percent were judged to be in unmet need. Of the 37 percent of the women who had unmet need, 14 percent were for spacing and 23 percent for limiting. Unmet need for spacing was concentrated among younger women and women with one or two children. Unmet need for limiting, unsurprisingly, was highest among women with five or more children, because at that stage couples do not want to have more children.

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

Characteristic	Unmet need			Met need			Total demand	Not in need	Total	
	For spacing	For limiting	Total	For spacing	For limiting	Total			%	N
<b>Age of respondent</b>										
15 – 24	30.2	3.9	34.1	13.2	3.9	17.1	51.2	48.8	100.0	129
25 - 34	17.9	20.5	38.4	11.1	20.5	31.6	70.0	30.0	100.0	190
35 – 49	1.0	37.2	38.2	0.5	32.2	32.7	70.9	29.1	100.0	199
<b>Type of community</b>										
Rural	14.9	23.1	38.0	7.0	20.7	27.7	65.7	34.3	100.0	498
Urban	5.0	15.0	20.0	20.0	25.0	45.0	65.0	35.0	100.0	20
<b>Literacy of respondent</b>										
Literate	16.6	12.8	29.4	12.3	21.3	33.6	63.0	37.0	100.0	211
Illiterate	13.0	29.6	42.6	4.2	20.5	24.7	67.3	32.7	100.0	307
<b>Education of respondent</b>										
No education	12.5	28.4	40.9	5.3	20.3	25.6	66.5	33.5	100.0	320
Up to primary	14.9	17.0	31.9	8.5	24.5	33.0	64.9	35.1	100.0	94
Up to Secondary	19.7	12.7	32.4	9.9	22.5	32.4	64.8	35.2	100.0	71
Above secondary	21.2	6.1	27.3	21.2	12.1	33.3	60.6	39.4	100.0	33
<b>Children ever born</b>										
None	4.1	1.4	5.5	1.4	0.0	1.4	6.9	93.1	100.0	73
1 – 2	38.8	6.2	45.0	18.6	4.7	23.3	68.3	31.7	100.0	129
3 – 4	15.1	28.6	43.7	8.7	27.8	36.5	80.2	19.8	100.0	126
5 or more	1.6	38.4	40.0	1.6	35.3	36.9	76.9	23.1	100.0	190
<b>Ownership of TV</b>										
Yes	11.9	16.9	28.8	10.7	25.9	36.6	65.4	34.6	100.0	243
No	16.7	28.0	44.7	4.7	16.4	21.1	65.8	34.2	100.0	275
<b>Standard of Living Index</b>										
Low	16.2	26.5	42.7	4.3	12.0	16.3	59.0	41.0	100.0	117
Medium low	16.5	26.1	42.6	6.1	14.8	20.9	63.5	36.5	100.0	115
Medium high	13.2	22.4	35.6	7.2	25.7	32.9	68.5	31.5	100.0	152
High	12.7	17.2	29.9	11.9	28.4	40.3	70.2	29.8	100.0	134
<b>Total</b>	<b>14.5</b>	<b>22.8</b>	<b>37.3</b>	<b>7.5</b>	<b>20.8</b>	<b>28.3</b>	<b>65.6</b>	<b>34.4</b>	<b>100.0</b>	<b>518</b>

## Total Demand

The sum of current use (“met need”) and unmet need is often called “total demand” for family planning. It would normally be expected to rise with the number of living children a couple has. Table 10.1 also shows total demand by background characteristics of the women. Overall, total demand was 66 percent of all married women of reproductive age. As the table shows, total demand did rise rapidly, and fairly consistently, by number of children.

## Strength of Preference

It is of interest to look at the responses of women in unmet need (those not currently pregnant) according to their reaction if they became pregnant in the near future (Table 10.2). Forty-one percent of the women with unmet need for spacing said they would be worried if they became pregnant again; 45 percent said that they would accept it. Of those with unmet need for limiting, 58 percent said they would be worried if they got pregnant. Thirty-six percent would accept it.

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

Reaction if become pregnant in near future	Unmet need for spacing		Unmet need for limiting	
	N	%	N	%
Pleased	3	5.2	1	0.9
Worried	24	41.4	62	57.9
Accept it	26	44.8	39	36.4
Doesn't matter	5	8.6	5	4.7
<b>Total</b>	<b>58</b>	<b>100.0</b>	<b>107</b>	<b>100.0</b>

## Reasons for Non-use

Past and never users were asked why they were not using some method of contraception; the results are shown in Table 10.3. Some of these reasons represent barriers as perceived by the women; the most important of these were opposition by husbands or in-laws, lack of access and fear of side effects. On the other hand, many women with defined unmet need

stated reasons that did not reflect perceived need, at least at present. Such reasons included: wanted more children, infrequent sex/husband away, natural spacing, difficulty in conceiving, currently pregnant and currently breastfeeding. Some of these women may have had more need than they realized; for example, women using “natural spacing” or breastfeeding may in fact be at substantial risk of pregnancy. Women currently pregnant or amenorrheic may be in need of contraception in the near future.

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

Reason	Unmet need for spacing	Unmet need for limiting	Total unmet need
Fear of side effects	5.3	25.4	17.6
Husband opposes	24.1	33.3	28.9
In laws oppose	17.2	14.3	15.7
Rest from method	5.9	18.2	15.3
Shy to consult about FP	20.7	11.1	15.7
Provider's advice	0.0	14.5	11.3
Against religion	5.3	5.1	5.2
Lack of access/Unavailability	13.8	27.0	20.7
Cost not affordable	3.4	14.5	9.2
Don't know any FP method	1.3	0.0	0.5
Just not using/too lazy	0.0	14.5	11.1
Method inconvenient to use	3.4	0.0	1.7
Infrequent sex/Husband away	12.3	32.2	24.6
Natural spacing	2.7	5.9	4.7
Difficult/Unable to conceive	21.1	22.6	21.8
Want (more) children	50.7	16.9	30.1
Currently pregnant	58.8	9.1	20.8
Breast feeding/Lactational amenorrhea	2.7	3.4	3.1
Others	8.0	11.0	9.8
<b>N</b>	<b>75</b>	<b>118</b>	<b>193</b>

Respondents could give more than one reason

## Unmet Need for Spacing: Profile

Women with unmet need for spacing comprised 75 (14.5 percent) of the MWRA. As shown in Table 10.4, they were characterized by:

- **Living Children:** Most (69 percent) had 1 or 2 living children.
- **Family Planning Use:** More never users (77 percent) than past users (23 percent).
- **Strength of Preference:** Low (only 41 percent “worried” if they became pregnant earlier than they wanted compared to those who were pleased [5 percent] or accept [45 percent] the unwanted pregnancy).
- **Intent to use FP method in Future:** High (71 percent intended to use an FP method in future).
- **Approval of FP:** High (95 percent approved of using an FP method for spacing purpose).
- **FP Communication with Husband:** Limited (65 percent had communicated with husbands on FP in the past one year; 19 percent said approaching the husband was “difficult”).
- **Obstacles to FP Use:** opposition by husband and in-laws (24 percent and 17 percent respectively); shy to consult about FP (21 percent) and lack of access/Unavailability (14 percent) (Table10.3).

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

Characteristic	Unmet need for spacing		Unmet need for limiting	
	N	%	N	%
<b>Number of living children (Grouped)</b>				
0	3	4.0	0	0.0
1-2	52	69.3	10	8.5
3-4	18	24.0	44	37.3
5 or more	2	2.7	64	54.2
<b>Contraceptive use status</b>				
Current user	0	0.0	0	0.0
Past user	17	22.7	55	46.6
Never user	58	77.3	63	53.4
<b>Reaction if become pregnant in future</b>				
Pleased	3	5.2	1	0.9
Worried	24	41.4	62	57.9
Accept it	26	44.8	39	36.4
Doesn't matter	3	5.2	2	1.9
Menopausal/Hysterectomy/Sterilized	0	0.0	0	0.0
Will abort	2	3.4	3	2.8
Others	0	0.0	0	0.0
<b>Intention to use a method in future</b>				
Yes	53	70.7	50	42.4
No	8	10.7	36	30.5
Unsure/Uncertain	12	16.0	25	21.2
Can't get pregnant	2	2.7	7	5.9
<b>Approval of FP</b>				
Approve	71	94.7	107	90.7
Disapprove	3	4.0	10	8.5
Others	1	1.3	1	0.8
<b>FP communication with husband in past one year</b>				
Never	26	34.7	56	47.5
Once or twice	23	30.7	23	19.5
More often	26	34.7	39	33.1
<b>Approach the topic of FP with husband</b>				
Easily	55	73.3	91	77.1
With difficulty	14	18.7	19	16.1
Respondent has to wait for husband to initiate discussion	6	8.0	8	6.8
<b>Total</b>	<b>75</b>	<b>100.0</b>	<b>118</b>	<b>100.0</b>

## Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 118 (22.8 percent) of MWRA. As shown in Table 10.4, they were characterized by:

- **Living Children:** A strongly positive association with number of living children; 54 percent had 5+ living children.
- **Family Planning Use:** More never users (53 percent) than past users (47 percent).
- **Strength of Preference:** Moderate (58 percent would be “worried” if they became pregnant compared to those who would accept [36 percent] the unwanted pregnancy).
- **Intent to use FP method in Future:** Moderate (42 percent intended to use an FP method in future).
- **Approval of FP:** High (91 percent approved of FP for limiting purpose).
- **FP Communication with Husband:** Limited (52 percent had communication with husband on FP in the past year; 16 percent said approaching the husband was “difficult”).
- **Obstacles to FP Use:** Fear of side effects (25 percent), opposition of husbands and in-laws (33 percent and 14 percent respectively), cost not affordable and lack of access/unavailability (15 percent and 27 percent respectively) (Table 10.3).



# Chapter 11

## Reproductive Preferences and Behavior of Men

It is often the case that in matters relating to family planning the focus has 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 FALAH 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 Mansehra, the field team was able to interview 178 men who were husbands of the married women of reproductive age interviewed for the survey plus 22 married men living in selected areas but were not husbands of the female respondents. In this chapter, the results for the respondents' husbands and the other married men who were interviewed (N = 200) are always grouped together, whether the reference is to "men," "male respondents," "married men," or "husbands."

A husband's approval of family planning is a powerful factor in explaining contraceptive use (Tawiah, 1997). In families, fertility decisions occur within specific social contexts and according to prevailing social norms that restrict individual decisions on fertility and

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

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

## Background Characteristics

Table 11.1 shows the background characteristics of the men interviewed in the survey. It shows that 5 percent of the men were under 25 years of age and 18 percent were 50 years of age and above.

As shown in Table 11.1, the men were much better educated than the sampled currently married women of reproductive age. Twenty-nine percent of the men had not been to school, compared to 62 percent of the currently married women (Table 3.2). It also shows that 53 percent of the men had more than primary education, whereas 20 percent of the currently married women had attained that level of education (Table 3.2).

The occupations of men are also shown in Table 11.1. The highest proportion (36 percent) of men were laborers, 13 percent were serving the government while 12 percent were petty traders.

**Table 11.1: Background characteristics of male respondents**

<b>Characteristic</b>	<b>Percentage</b>
<b>Age</b>	
15-19	1.0
20-24	4.0
25-29	17.5
30-34	15.0
35-39	15.0
40-44	16.0
45-49	13.5
50-54	10.0
55+	8.0
<b>Education</b>	
Proportion literate	80.5
No education	29.0
Up to primary	18.0
Up to Secondary	41.0
Above secondary	12.0
<b>Occupation</b>	
Agriculture/Livestock/Poultry	10.0
Petty trader	12.0
Labor	35.5
Govt. service	12.5
Pvt. Service	6.0
Own business	11.0
Abroad	1.0
Unemployed	10.5
Others	2.0
<b>N</b>	<b>200</b>

## Contraceptive Knowledge and Use

Ninety-one percent of the interviewed men (Table 11.2) while 100 percent of the currently married women of reproductive age interviewed in Mansehra knew of at least one modern method of contraception.

As depicted in Table 11.2, knowledge of modern methods was highest for pills (79 percent), followed by injectables (72 percent) , condom (70 percent), female sterilization (26 percent), and IUD (14 percent). The least known methods were Norplant and male sterilization (0.5 percent for each). Knowledge of at least one traditional method was prevalent among 33 percent of the men. The pattern of ever use and current use of contraception reported by husbands is also shown in Table 11.2. Fifty-one percent of the MWRA reported having used some method of contraception during their married lives (Table 7.2); of the male respondents, 53 percent reported ever using some method of contraception in their married lives. For the men, among modern methods, condom was the most popular method ever used (29 percent), followed by injectables (23 percent), pills (18 percent), IUD (10 percent), female sterilization (4 percent). Male sterilization and norplant methods have never been used.

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

Method	Knowledge	Ever use	Current use
Female sterilization	25.5	3.5	3.5
Male sterilization	0.5	0.0	0.0
Pill	78.5	18.5	2.0
IUD	13.5	9.5	3.0
Injectables	71.5	23.0	6.5
Norplant	0.5	0.0	0.0
Condom	69.5	29.0	6.0
Rhythm	9.0	6.0	1.5
Withdrawal	26.0	17.0	6.5
Others	0.0	0.0	0.0
At least one FP method	92.5	53.0	29.0
At least one modern FP method	91.0	45.5	21.0
At least one traditional FP method	32.5	21.5	8.0
Emergency Pills	0.5	1.0	na
<b>N</b>	<b>200</b>	<b>200</b>	<b>200</b>

na= not applicable

As mentioned in Table 7.2, a total of 28 percent of all MWRA in the sample were currently using some contraceptive method, while for the male respondents this figure was 29 percent. The most common current modern method reported by male respondents was the injectables (6.5 percent), followed by condom (6.0 percent). The use of traditional methods was also reported by 8 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 11.3 shows ever use and current use of modern contraception among respondents by background characteristics. More than 56 percent of the respondents who had secondary and above education reported ever use of any contraceptive method, compared to 48 percent with no education. The current use of family planning method also showed the same pattern by education of men.

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

Characteristic	Ever used at least one FP method	Currently using any FP method	N
<b>Education level</b>			
No education	48.3	31.0	58
Below secondary	53.1	21.9	64
Secondary and above	56.4	33.3	78
<b>Number of living children</b>			
None	3.6	3.6	28
1-2	52.4	21.4	42
3-4	66.1	39.3	56
5+	62.2	35.1	74
<b>Future desire for children</b>			
Soon	44.3	22.8	79
Later	44.7	23.7	38
Never	67.5	40.3	77
Don't know/unsure	33.3	0.0	6
<b>Total</b>	<b>53.0</b>	<b>29.0</b>	<b>200</b>

Table 11.3 also shows contraceptive use by the number of living children and ever use as well as current use. Of those who had one or two children, 52 percent reported ever use of family planning methods, compared to 66 percent ever use by men who had 3-4 children.

Table 11.3 also shows contraceptive ever use and current use by the future desire for children. Highest ever use was found among the male respondents who said they did not want any more children: 68 percent of those respondents who did not want more children had ever used any contraceptive method, and 40 percent were currently using a form of contraception. Among those men who wanted to delay their next child for at least two years, 24 percent reported current use of any contraceptive method.

## Source of Contraceptive Methods

As shown in Table 11.4, among those who reported the last source for obtaining contraceptive methods, 21 percent obtained it from “grocery shop/general store” and 16 percent obtained their last method from BHU/RHC/MCH Centre and LHWs were also reported as source by 16 percent of the ever users. About 15 percent of the male respondents said that Government hospitals were the source of the contraceptive method.

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

Source	Percentage
Govt. hospital (DHQ/THQ)	14.6
BHU/RHC/MCH Centre	15.9
FWC	8.5
LHW	15.9
Pvt. Doctor	1.2
Pvt. hospital/clinic	8.5
Pharmacy, chemist	13.4
Grocery shop/general store	20.7
Wife brings method	1.2
<b>Total</b>	<b>100.0</b>
N	82

## 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 Mansehra, 97 percent of men approved of spacing between children, and 83 percent also approved the use of any form of contraception for this purpose (Table 11.5). Seventeen percent of the men disapproved of using any form of contraception to space between children.

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

Variable	Percentage
<b>Spacing between children</b>	
Approve	97.0
Disapprove	3.0
<b>Total</b>	<b>100.0</b>
N	200
<b>Using FP methods for spacing</b>	
Approve	82.5
Disapprove	17.5
<b>Total</b>	<b>100.0</b>
N	200

## Satisfaction Level of Current Users

Satisfaction of the user with his/her contraceptive method is an important factor in whether or not he/she continues with the method. Male contraceptive users were asked to report how satisfied they were with their present contraceptive method. Table 11.6 shows 69 percent of the current users were very satisfied with their current method. Thirty-one percent of the current users reported being somewhat satisfied with their current method. These users would seem to be in need of more information on their current method, as well as on other available methods, so that they continue using a family planning method.

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

Level of Satisfaction	Percentage
Very satisfied	69.0
Somewhat satisfied	31.0
<b>Total</b>	<b>100.0</b>
N	42

The reasons the male respondents stopped using their last method are presented in Table 11.7. The table shows that the most important reason was “shy to go to FP” clinic followed by fear of side effects and wanting another child as main reasons for stopping the use of a family planning method. There were also a few cases where the wife opposed the use of a contraceptive method.

**Table 11.7: Percentage distribution of male past contraceptive users by reason for discontinuing last method**

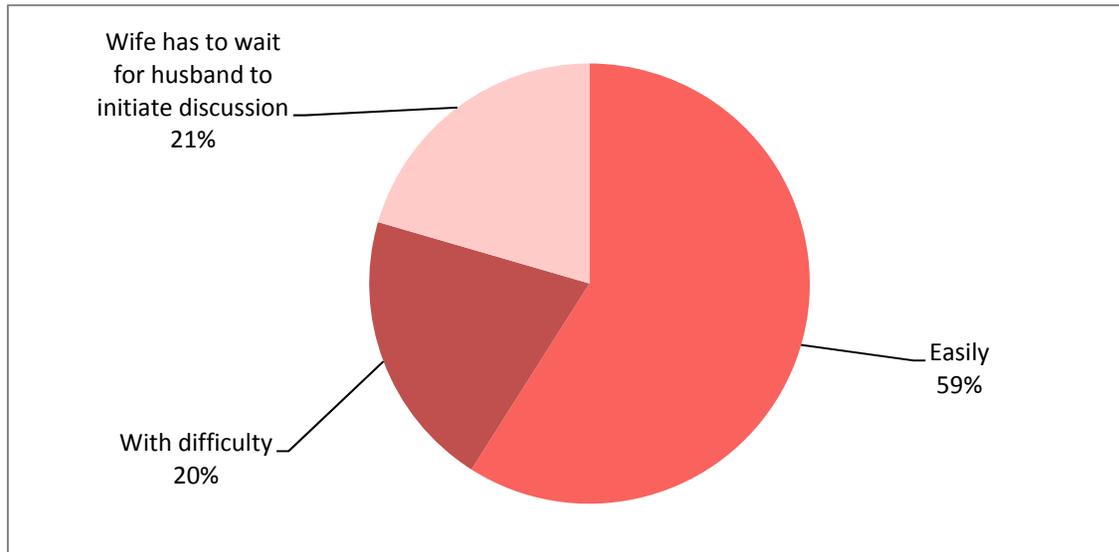
Reason	Percentage
Wife opposes	19.4
In laws/parents oppose	12.9
Fear of side effects	64.5
Lack of access/unavailability	16.1
Cost too much	45.2
Shy to go to FP clinic	77.4
Inconvenient to use	25.8
Infrequent sex/respondent away	9.7
Difficult/unable to conceive	45.2
Breast feeding/ Lactational amenorrhea	29.0
Respondent/wife infertile	3.2
Want more children	61.3
<b>N</b>	<b>31</b>

Respondents could give more than one response.

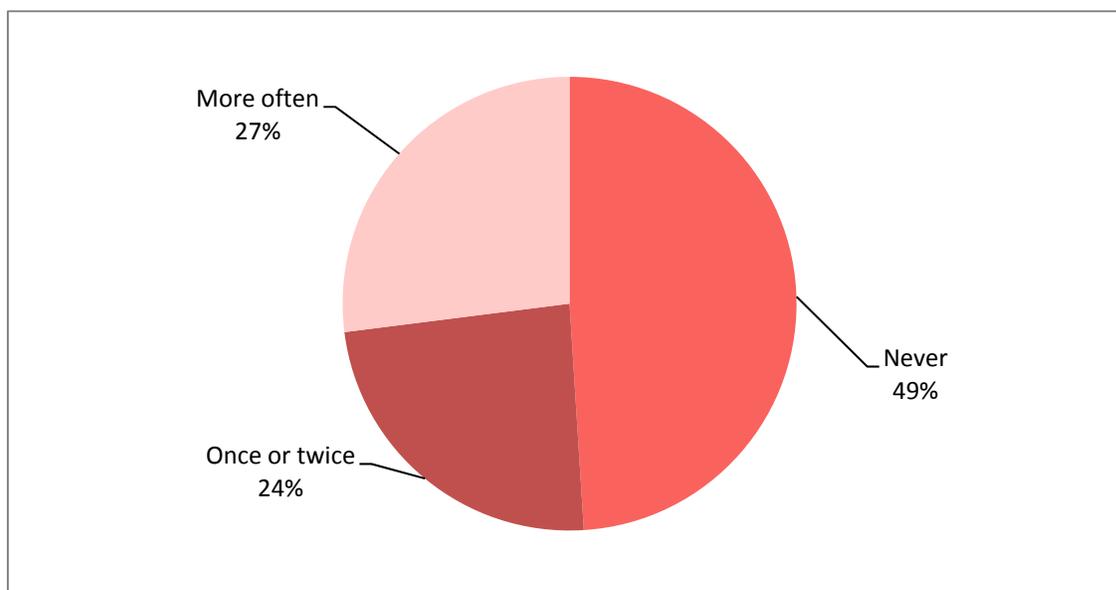
## Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Husbands were asked if during the last year their wives could approach them to discuss family planning easily, with difficulty or if they had to wait for their husbands to initiate the discussion. The responses are shown in Figure 11.1. Fifty-nine percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, 49 percent of the men reported that their wives had never approached them during the last year on this issue. Twenty-seven percent of the men reported that their wives had talked more often about this subject during the last year, while 24 percent reported they had talked once or twice.

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



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



## Potential Users

Men who were non-users of contraception were asked about their intended future use of contraception and their method preferences. Table 11.8 shows that 23 percent intended to use a contraceptive method in the future, while 33 percent did not intend to do so. Forty four percent of the respondents were uncertain about their future use of contraception.

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

Intent	Percentage
Will use	23.4
Will not use	33.0
Unsure/Uncertain	43.6
<b>Total</b>	<b>100.0</b>
N	94

As shown in Table 11.9, the major reason husbands said they did not intend to use was shyness to go to FP clinic (77 percent). For 65 percent, fear of side effects was the reason for not using a contraceptive method while their desire for more children was cited by 61 percent of the husbands.

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

Reason	Percentage
Wife opposes	19.4
In laws/parents oppose	12.9
Fear of side effects	64.5
Lack of access/unavailability	16.1
Cost too much	45.2
Shy to go to FP clinic	77.4
Inconvenient to use	25.8
Infrequent sex/respondent away	9.7
Difficult/unable to conceive	45.2
Breastfeeding/ Lactational amenorrhea	29.0
Respondent/wife infertile	3.2
Want more children	61.3
<b>N</b>	<b>31</b>

Respondents could give more than one response.

Table 11.10 shows the distribution of the male respondents who intended to use a specific contraceptive method in the future. Pills was the most preferred method for future use followed by the injectables and female sterilization.

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

Method	Percentage
Female sterilization	9.1
Pills	72.7
Injectable	13.6
Not decided	4.5
<b>Total</b>	<b>100.0</b>
<b>N</b>	<b>22</b>

## Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 11.11 shows that 40 percent of the male respondents wanted another child soon (within two years). Another 19 percent wanted to delay their next child for more than two years. The reasonable proportion of male respondents (39 percent) did not want any more children at all.

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

Number of living children	Desire for next child				Total	
	Soon	Later	Never	Don't know/ unsure	%	N
0	60.7	39.3	0.0	0.0	100.0	28
1	70.0	30.0	0.0	0.0	100.0	20
2	68.2	27.3	4.5	0.0	100.0	22
3	48.1	29.6	22.2	0.0	100.0	27
4	34.5	20.7	41.4	3.4	100.0	29
5	23.3	0.0	66.7	10.0	100.0	30
6+	6.8	2.3	86.4	4.5	100.0	44
<b>Total</b>	<b>39.5</b>	<b>19.0</b>	<b>38.5</b>	<b>3.0</b>	<b>100.0</b>	<b>200</b>

The desire to stop having children was positively associated with the number of living children. Twenty-two percent of the respondents who had 3 children did not want more children, whereas more than 86 percent who had 6 or more children did not want more children.

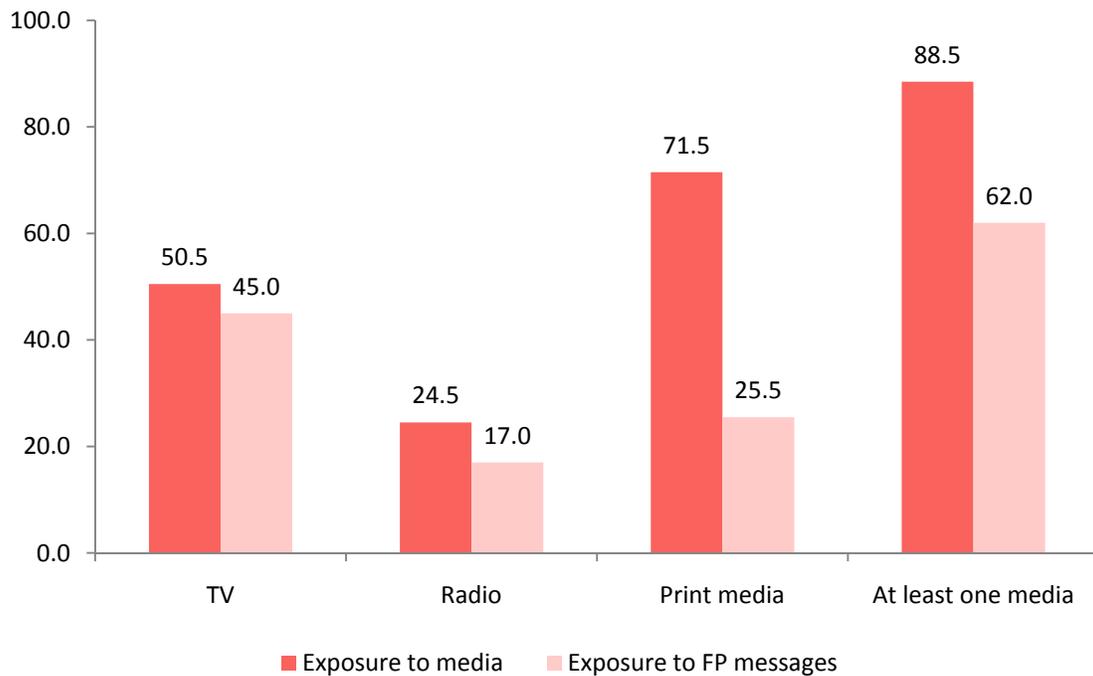
## Mass Media Access and Exposure to FP Messages

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 11.3 shows the proportion of men who reported that they watched TV, listened to the radio or read newspapers or magazines. Print media and TV were the most

commonly used mediums: 72 percent reported the use of print media while 51 percent of the male respondents in Mansehra watched TV.

Furthermore, respondents who reported access to any sort of media were asked if they had ever seen, heard or read any message pertaining to methods of family planning through these mediums. Forty-five percent of the men had seen FP messages on television while 26 percent on print media. Seventeen percent of the men reported that they had ever listened to a family planning message on the radio. Overall, 62 percent of the male respondents and 43 percent of the MWRA had seen or heard a family planning message on at least one medium.

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





# References

- Adair, L., B. Popkin and D. Guilkey. 1994. *The duration of breastfeeding: How is it affected by biological, socioeconomic, health sector, and food industry factors?* Demography 30(1): 63.
- Bohiler, E. and S. Bergstrom. 1995. *Subsequent pregnancy affects morbidity of previous child.* Journal of Biosocial Science 27(4): 431-442. Oct. 1995.
- Bongaarts, J. and J. Bruce. 1995. *The Causes of Unmet Need for Contraception and the Social Content of Services.* Studies in Family Planning 26(2): 57-75.
- Caldwell, J.C. 1976. *Toward a Restatement of Demographic Transition Theory.* Population and Development Review 2(3-4): 321-366.
- Casterline, J.B., A.E. Perez and A.E. Biddlecom. 1997. *Factors Underlying Unmet Need in the Philippines.* Studies in Family Planning 28(3): 173-191.
- Casterline, J.B., Z. Sathar and M. ul Haque. 2001. *Obstacles to Contraceptive Use in Pakistan: A Study in Punjab.* Studies in Family Planning 32(2): 95-110.
- Cleland, J. and Z. Sathar. 1984. *The Effect of Birth Spacing on Childhood Mortality in Pakistan.* Population Studies, Vol. 38, No. 3 (Nov., 1984), pp. 401-418.
- Fuentes-Affelick, E. and N.A. Hessel. 2000. *Interpregnancy interval and the risk of premature infants.* Obstetrics and Gynecology 95(3): 383-390. Mar. 2000.
- Garner, P., T. Smith, M. Baea, D. Lai and P. Heywood. 1994. *Maternal nutritional depletion in a rural area of Papua New Guinea.* Tropical and Geographical Medicine 46(3): 169-171. 1994.
- Government of Pakistan. 2005. *Pakistan Social and Living Standards Measurement Survey 2004-05: National/Provincial.* Islamabad: Federal Bureau of Statistics.
- Government of Pakistan. 2006. *Pakistan Social and Living Standards Measurement Survey 2004-05: Provincial/District.* Islamabad: Federal Bureau of Statistics.

- Mahmood, Arshad. 2002. *Determinants of Neonatal and Post-Neonatal Mortality in Pakistan*. The Pakistan Development Review, Vol. 41, No. 4, Part (Winter 2002), pp.723-744.
- Mahmood, N. and K. Ringheim. 1997. *Knowledge, Approval and Communication about Family Planning as Correlates of Desired Fertility among Spouses in Pakistan*. International Family Planning Perspectives 23(3): 122-129, 145.
- Miller, J.E. 1994. *Birth Order, Interpregnancy Interval and Birth Outcomes among Filipino Infants*. Journal of Biosocial Science 26(2): 243-259. Apr. 1994.
- NIPS (National Institute of Population Studies). 2001. *Pakistan Reproductive Health and Family Planning Survey 2000-01*. Islamabad.
- NIPS (National Institute of Population Studies). 2007. *Status of Women, Reproductive Health and Family Planning Survey: Main Report*. Islamabad.
- NIPS/DHS (National Institute of Population Studies and MEASURE DHS, Macro International). 2007. *Pakistan Demographic and Health Survey 2006-07: Preliminary Report*. Calverton, Maryland: Macro International Inc.
- Planning Commission of Pakistan. 2006. *Pakistan Millennium Development Goals Report 2006*. Islamabad: Center for Research on Poverty and Income Distribution.
- Population Census Organization. 2000. *District Census Report of Mansehra*, Islamabad: Statistics Division Government of Pakistan.
- Population Council. 1997. *The Gap between Reproductive Intentions and Behavior: A Study of Punjab Men and Women*. Islamabad: Population Council.
- Population Council. 2006. *Women's Health in Pakistan 2005*. Islamabad: Population Council. Unpublished.
- Population Council. 2007. *Diversification of Family Planning Activities in Pakistan (DFPAP): Performance Monitoring Plan*. Islamabad: Population Council. Unpublished.
- Population Council. 2008. *Communication, Advocacy and Mobilization (CAM) Strategy for the FALAH Project: A Draft Strategy*. Islamabad: Population Council. Unpublished.
- Rutstein, S.O. and K. Johnson. 2004. *The DHS Wealth Index*. DHS Comparative Report No. 6. Calverton, Maryland, USA: ORC Macro.

- Tawiah, E.O. 1997. *Factors Affecting Contraceptive Use in Ghana*. Journal of Biosocial Science 29(2): 141-149.
- UNDP (United Nations Development Program). 2003. *Pakistan National Human Development Report 2003*. Karachi.
- UNFPA/PC (United Nations Population Fund and Population Council). 2007. *Report of the Seminar on Unpacking Unmet Need for Family Planning in Pakistan*. Islamabad: The Population Council.
- United Nations. 2006. *Millennium Development Goals Report 2006*. New York: United Nations Department of Economic and Social Affairs.
- Westoff C. F. and A. Bankole A. 1999. *Mass Media and Reproductive Behavior in Pakistan, India, and Bangladesh*. Demographic and Health Surveys Analytic Reports No.10. Calverton, Maryland: Macro International Inc.
- WHO (World Health Organization). 2006. *Policy Brief on Birth Spacing - Report from a World Health Organization Technical Consultation*. WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safe.
- Zhu, B.P., R.T. Rolfs, B.E. Nangle and J.M. Horan. 1999. *Effect of the Interval between Pregnancies on Perinatal Outcomes*. New England Journal of Medicine 340(8): 589-594. Feb 25, 1999.