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# Baseline Household Survey

# Upper Dir District

May 2010





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

## **Upper Dir**

**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 Contraceptive Pill
EmOC	Emergency Obstetric Care
FALAH	Family Advancement for Life and Health
FP	Family Planning
HANDS	Health and Nutrition Development Society
IUD	Intra Uterine Device
LAM	Lactational Amenorrhea Method
LHW	Lady Health Worker
MCH	Maternal and Child Health
MNH	Maternal and Neonatal Health
MoH	Ministry of Health
MoPW	Ministry of Population Welfare
MSU	Mobile Service Unit
MWRA	Married Women of Reproductive Age
NGO	Non Governmental Organization
NIPS	National Institute of Population Studies
PAIMAN	Pakistan Initiative for Mothers and Newborns
PC	Population Council

PDHS	Pakistan Demographic and Health Survey
PNC	Postnatal Care
PSLMS	Pakistan Social and Living Standard Measurement Survey
PSU	Primary Sampling Unit
Pvt.	Private
RH	Reproductive Health
RHC	Rural Health Center
RHSC-A	Reproductive Health Services Center- A
RSPN	Rural Support Programmes Network
SMAM	Singulate Mean Age at Marriage
TBA/ <i>Dai</i>	Traditional Birth Attendant
TFR	Total Fertility Rates
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 Upper Dir.

The survey was conducted between May and July of 2008 in a probability sample of 520 households in 40 clusters in Upper Dir. It included interviews with 548 currently married women aged 15-49 (“married women of reproductive age”, or MWRA), along with 200 married men, of whom 162 were married to the women included in the sample. As a separate activity, a mapping study<sup>1</sup> was also carried out between May and June, 2008 in Upper Dir. The FALAH project is primarily focused on birth spacing and family planning.

## *Household and Respondent Characteristics*

Upper Dir is a primarily rural district of Khyber Pakhtunkhwa. The characteristics of our sample are generally similar to those found in other surveys; some key indicators are presented in Table A.

**Table A: Selected key district characteristics from Upper Dir household survey**

Indicator	Value
Percentage of household population in rural areas	95.1
Percentage of households with electricity	89.4
Percentage of households with indoor water supply	32.3
Percentage of households with flush toilet	57.1
Percentage of households with a television	16.3
Percentage of literate female respondents	6.8
Percentage of respondents with literate husbands	53.4
Total fertility rate	5.7

Electricity was available in 89 percent of the sampled households. Thirty-two percent of the households had some indoor water supply and 57 percent had a flush toilet, while 12 percent had some type of latrine. According to the Planning Commission’s Pakistan

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

Millennium Development Goals Report 2006, Upper Dir stood 88<sup>th</sup> nationally in sanitation rankings. On the other hand, literacy was relatively low as only 7 percent of the female respondents were literate while 53 percent of their husbands were literate. Sixteen percent of the households in Upper Dir reported owning a television and 52 percent reported owning a radio/tape recorder. About 8 percent of the respondents said they listened to radio, 5 percent watched TV, and only 0.3 percent read newspapers or magazines.

### ***Fertility***

In Upper Dir, the crude birth rate was 31 births per thousand population, and the total fertility rate was 5.7 children per woman. Fertility was higher for illiterate women and wives of illiterate husbands. However, there was no urban-rural difference in fertility. Many births were spaced too closely; for example, almost 71 percent of the closed birth intervals were less than 36 months. About 14 percent of all current pregnancies in the sample were among women who already had at least two children less than five years of age.

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

The household survey obtained data on selected key indicators of maternal and neonatal health from 413 sampled women who had delivered a child during the previous four years. Of these women, only 44 percent had visited a health provider at least once for antenatal care; 39 percent had at least two tetanus toxoid immunizations; 29 percent were delivered by a skilled birth attendant; and 24 percent were delivered in a health facility, public or private. On the other hand, only 25 percent had at least one postnatal check-up. Exclusive breastfeeding was reportedly widespread and the median length of breastfeeding for the last child was 6 months.

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

<b>Indicator</b>	<b>Value</b>
Percentage of mothers with at least one antenatal care visit	44.1
Percentage of mothers who received at least two tetanus shots	39.0
Percentage of most recent deliveries conducted by a skilled birth attendant	29.3
Percentage of most recent deliveries carried out in a facility	23.7
Percentage of MWRA not wanting more children	51.3
Percentage of MWRA wanting to delay next birth for at least two years	22.8
Percentage of MWRA with knowledge of at least one contraceptive method	98.7
Contraceptive prevalence rate	11.0
Percentage of MWRA who were past users of contraception	16.0
Percentage of MWRA with unmet need for family planning	48.7
Percentage of MWRA with unmet need for spacing	12.6
Percentage of MWRA with unmet need for limiting	36.1
Total demand for family planning (CPR + unmet need)	59.3

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

The median “ideal” family size, according to the women respondents, was 5 children. Regarding desire for more children in the future, 25 percent said they wanted another child soon (within two years), 23 percent said they wanted another child, but only after two years, and 51 percent 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 2 children. Twenty percent of the women respondents thought that their husband wanted the same number of children that they did, while 63 percent were of the view that their husband wanted more children than they did.

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

Almost all currently married women knew at least one contraceptive method. The contraceptive prevalence rate (the percentage of MWRA currently using some method of contraception) was 11 percent. The most common currently used methods were injectables

(5 percent) and pills (2 percent). Condom use was relatively low (1.6 percent). Past users comprised 16 percent of MWRA; injectables and pills were common past methods. Seventy-nine percent of current users did not want more children, while 21 percent wanted more, but at a later time. Most users reported obtaining their supplies and services from BHUs/RHCs/MCH Centres and DHQ/THQ hospitals or their husband brought the supplies.

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

Overall, the reasons for current and past users were similar, so the data has been combined. Among the most common reasons for choosing a method were convenience of use, easily available, suitability for respondent and husband, low cost, effectiveness for longer period and no or few side effects. Costs were generally low (34 percent paid more than Rs.50 the last time they obtained their method). Regarding the time required to reach the supply point, 12 percent reported requiring more than 60 minutes. Forty-three percent of the respondents did not know about the time it took as their husbands brought the supplies for them. The least information provided at acceptance of some method was regarding what to do if experienced side effects. Eighty-nine percent of clients reported being examined properly; however, 14 percent of the respondents often felt that the staff was not capable of dealing with side effects.

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

Asked hypothetically about hindrances a couple might face if they wanted to avoid or delay pregnancy, ninety-eight percent of non-users mentioned husband's disapproval and FP against religion followed by possibility of getting pregnant while using any method (65 percent), problem of managing side effects (65 percent) and fear of side effects (64 percent). Religious opposition carries much weight; following side effects as a big hindrance. Past users were most likely to discontinue use because of side effects experienced (40 percent) followed by desire for another child (38 percent), husband's advice (34 percent), infrequent sex/husband away (26 percent) and rest from method (24 percent). Other reasons carried less weight. Past users' most common reasons for current non-use were: Breast feeding/lactational amenorrhea and infrequent sex/husband away (32 percent for each) and fear of side effects (26 percent). Never users were most likely to say they were not using the contraceptives because of desire for more children (91 percent) followed by husband's opposition (50 percent) and infrequent sex/husband away (37 percent). However, significant number also cited opposition of in-laws, breastfeeding and lack of

access/unavailability. Almost all never users (98 percent) knew at least one FP method but knowledge of contraceptive sources was noticeably lower; only 47 percent of never users knew one place to obtain contraceptive supply/method. About 26 percent of never users expressed their intent to use contraception in the future. This indicates that a substantial number of women in Upper Dir were ready to practice birth spacing or use family planning methods.

### ***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, 49 percent of the women in this sample were in unmet need, 13 percent for spacing and 36 percent for limiting. Unmet need for spacing was higher in rural areas and among literate women. However, unmet need for limiting was also higher in rural areas but on the other hand among illiterate women.

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

The findings reveal that all men knew at least one modern contraceptive method. Male sterilization was the least known contraceptive method after Norplant among men in Upper Dir. Only 23 percent of the men did not want more children in the future. Seventeen percent of the male respondents reported that they or their wives were currently using any family planning methods. Among the current users, all were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, a majority (60 percent) reported that they were uncertain if they would use any FP method in future. Desire for more children was the main reason for not using any FP method. Of those who did intend to use contraceptives in the future, intention to use male methods was very low. 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***

Upper Dir district was characterized by relatively low standard of living. Though knowledge of family planning methods was very high in Upper Dir but intent to use FP methods in the future (26 percent) and contraceptive prevalence rate (11 percent) as reported by women is very low. There is much room for improvement: unmet need for family planning remains high at 49 percent. Among the important issues that should be addressed in an improved program are the attitude of husbands and in-laws, inter-spousal communication, fear of side effects and knowledge of various contraceptives and their sources. Also, the concept of birth spacing needs to be stressed to lengthen birth intervals, which are often too short.

# Chapter 1

## Introduction

### Background

#### The FALAH Project

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

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

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

The aims of the FALAH project are:

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

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

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

### Upper Dir District

Upper Dir is primarily a rural district of Khyber Pakhtunkhwa province. Geographically the district is bounded on the north and northwest by Chitral district, on the east by Swat district, on the south by Lower Dir district and on the west by Chitral district and Afghanistan.

In 1998 the district had 1 Civil Hospital, 1 Zanana Hospital, 2 RHCs, 35 BHUs, 11 civil dispensaries, 2 sub-health centers and 3 MCHs. The district also provided education facilities, although the ratio for female education centers was low (Population Census Organization, 2000).

In the Planning Commission’s Millennium Development Goals Report of 2006 (United Nations, 2006), Upper Dir stood 88<sup>th</sup> on literacy, 30<sup>th</sup> on immunization, and 89<sup>th</sup> on water supply and 88<sup>th</sup> on sanitation nationally (Planning Commission of Pakistan, 2006).

## The Upper Dir Baseline Household Survey

In Upper Dir, Population Council conducted a baseline sample household survey to learn about knowledge, attitude, and practice regarding fertility, reproductive health, and child spacing/family planning.

### Objectives

The objectives of the Upper Dir Baseline Household Survey were:

- To obtain baseline measurements for those FALAH indicators that can best be measured through such surveys;
- To obtain detailed information on the knowledge, attitude and practice of married couples of Upper Dir 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**

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 knowledge, attitude and practice of these married couples regarding family planning.

### **Sample Design and Size**

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

### **Urban Sample**

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

## Rural Sample

The 1998 Population Census list of villages was used as the sampling frame for the selection of a rural sample. Villages in rural areas have been treated as primary sampling units (PSU). Sample PSUs were selected with probability proportional to size (number of households). Households within the sample PSUs were considered secondary sampling units. The household listing of each village was then prepared by the enumeration teams before selecting the sampled households. A fixed number of 13 households was selected from each sample enumeration village by the systematic random technique.

## Selection of Respondents

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

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

**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	38	2	40
Households contacted	668	33	701
Households replaced	174	7	181
Households refused	32	0	32
Households interviewed	494	26	520
Eligible women identified	674	32	706
Eligible women not interviewed	151	5	156
Eligible women refused	0	0	0
<b>Total completed women's interviews</b>	<b>521</b>	<b>27</b>	<b>548</b>

## **Questionnaire Design**

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

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

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

## **Hiring of Interviewers and Supervisors**

Since the respondents in the baseline survey were currently married women and their husbands, female interviewers were hired to interview female respondents and male interviewers to interview 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, two-week training was conducted by the Population Council in Islamabad. During the training, interviewers conducted 2-3 field interviews in order to prepare for the actual interview process.

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

## **Quality Assurance**

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

## **Data Entry and Edit Procedures**

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

## **Fieldwork**

Fieldwork for Upper Dir district was carried out between May 8 and July 13, 2008.

# Chapter 2

## Household Characteristics

### Geographic Distribution

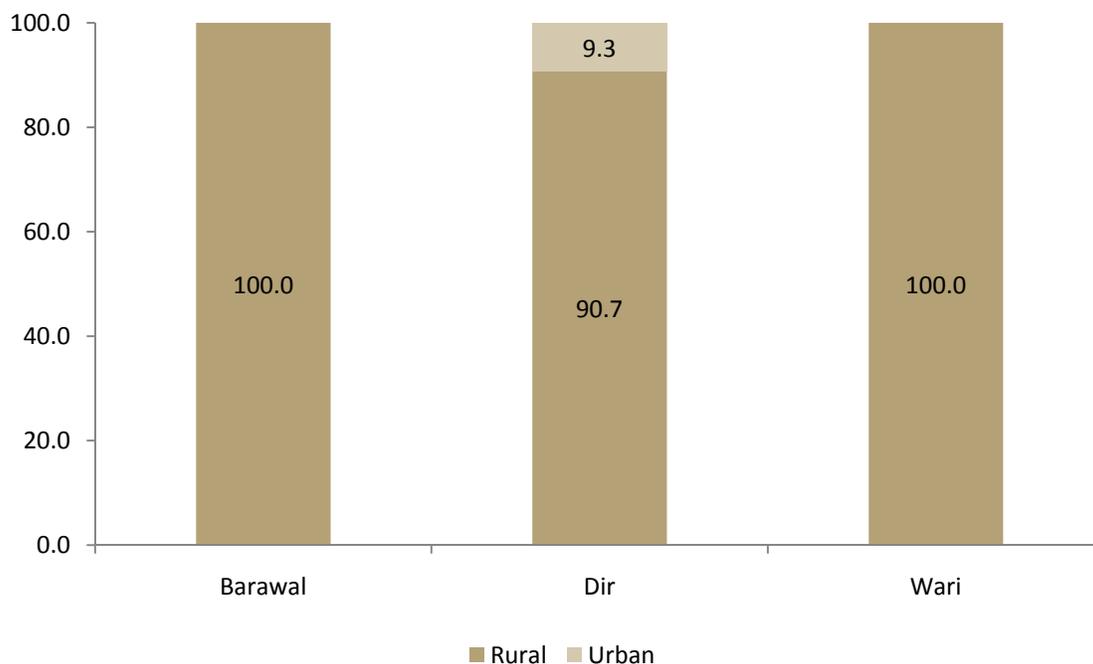
The district of Upper Dir is primarily a rural district. Table 2.1 shows the distribution of the population of sample households according to residence (urban and rural).

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

Tehsil	Rural			Urban			Total	
	N	%	1998 Census %	N	%	1998 Census %	N	%
Barawal	492	100.0	100.0	0	0.0	0	492	100.0
Dir	2304	90.7	90.4	237	9.3	9.6	2541	100.0
Wari	1807	100.0	100.0	0	0.0	0	1807	100.0
<b>Total</b>	<b>4603</b>	<b>95.1</b>	<b>94.9</b>	<b>237</b>	<b>4.9</b>	<b>5.1</b>	<b>4840</b>	<b>100.0</b>

As Table 2.1 shows, the distribution of the population of the sampled households by urban-rural residence. The table and Figure 2.1 show that Barawal and Wari are totally rural while Dir tehsil is also dominantly rural (91 percent). However, the household survey could not be conducted in tehsil Kal Kot due to poor law and order situation.

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



## Age-Sex Distribution

Table 2.2 shows the population distribution of the sampled households by age and sex. The population distribution was typical of a society with high fertility, with 50 percent of the population being under 15 years of age. Data show that there were 0.6 percent more children in age group 5-9 years as compared to the age group 0-4 years. This suggests some decline in fertility levels.

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

Age group	Sex of household member		Total
	Male	Female	
00 - 04	19.1	16.2	17.7
05 - 09	18.3	18.4	18.3
10 - 14	14.0	13.3	13.7
15 - 19	11.2	12.0	11.6
20 - 24	6.9	9.9	8.4
25 - 29	6.8	7.2	7.0
30 - 34	4.8	5.1	5.0
35 - 39	2.7	3.2	3.0
40 - 44	3.0	2.8	2.9
45 - 49	2.0	1.7	1.8
50 - 54	2.2	3.5	2.9
55 - 59	2.3	2.4	2.4
60 - 64	2.7	1.5	2.1
65 +	4.1	2.7	3.4
<b>N</b>	<b>2387</b>	<b>2408</b>	<b>4795</b>

Of the total population of the sampled households, 21 percent (1013 women of the total population of 4795) consisted of females 15-49 years of age, and 18 percent consisted of children less than 5 years of age. These groups of population are of primary interest to the FALAH project, and most of the analysis in this report will focus on them.

## Marital Status

In Upper Dir (as in Pakistan generally), two trends can be identified: first, in general women get married at an early age, and, second, that women marry men who are much older than they are. Table 2.3 shows that a higher proportion of women at younger ages were married than men of the same age. On the other hand, few men were married in the age group of 15-19, which shows that the marital age for men was higher than that of women. This difference may be a result of economic pressures among others. The singulate mean age at marriage was 25 years for men and 21 years for women.

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

Age group	Married		Widow/Divorced/ Separated		Never married	
	Female	Male	Female	Male	Female	Male
15 - 19	22.1	2.7	0.0	0.0	77.9	97.3
20 - 24	73.5	32.1	0.4	0.0	26.1	67.9
25 - 29	93.0	77.6	0.6	0.0	6.4	22.4
30 - 34	92.6	96.4	1.7	1.8	5.8	1.8
35 - 39	97.4	100.0	1.3	0.0	1.3	0.0
40 - 44	94.1	95.8	2.9	1.4	2.9	2.8
45 - 49	95.1	91.5	4.9	8.5	0.0	0.0
50 - 54	94.0	96.2	4.8	3.8	1.2	0.0
55 - 59	91.4	89.3	8.6	10.7	0.0	0.0
60 - 64	80.0	89.1	20.0	9.4	0.0	1.6
65 - 69	58.3	87.2	41.7	10.6	0.0	2.1
70+	45.9	85.1	54.1	14.9	0.0	0.0
<b>All ages 15+</b>	<b>70.7</b>	<b>61.5</b>	<b>4.7</b>	<b>3.0</b>	<b>24.6</b>	<b>35.5</b>

## Household Characteristics and Wealth Indicators

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

### Physical Characteristics of Households

Table 2.4 shows selected physical characteristics of the sample households. Nearly one-third of households (32 percent) had an indoor water supply with majority of these households in urban areas (54 percent) as compared to rural area (31 percent). The majority of population depends on rivers/canals /streams for drinking water (63 percent).

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

<b>Characteristic</b>	<b>Rural</b>	<b>Urban</b>	<b>Total</b>
<b>Main source of drinking water</b>			
Govt. supply (tap water inside)	31.2	53.8	32.3
Govt. supply (communal)	3.4	0.0	3.3
River/Canal/Stream	64.4	46.2	63.4
Others	1.0	0.0	1.0
<b>Sanitation facility</b>			
Flush to sewerage	0.4	3.8	0.6
Flush connected to septic tank	41.3	57.7	42.1
Flush connected to open drain	13.8	26.9	14.4
Raised latrine	10.1	7.7	10.0
Pit latrine	2.2	0.0	2.1
In fields	32.2	3.8	30.8
<b>Main type of fuel used for cooking</b>			
Fire wood	97.2	69.2	95.8
Kerosene oil	0.2	0.0	0.2
Gas cylinder	2.6	26.9	3.9
Natural gas (Sui gas)	0.0	3.8	0.2
<b>Electrical connection</b>			
Yes	89.1	96.2	89.4
No	10.9	3.8	10.6
<b>Main material of roof</b>			
Concrete	6.9	15.4	7.3
Iron sheet	2.2	7.7	2.5
Guarder and T-iron	0.8	0.0	0.8
Wood/Bamboo and mud	90.1	76.9	89.4
<b>Main material of floor</b>			
Earth/Sand/Mud	86.4	57.7	85.0
Chips	0.0	3.8	0.2
Ceramic tiles	0.4	0.0	0.4
Marble	0.6	0.0	0.6
Cement	12.4	38.5	13.7
Others	0.2	0.0	0.2
<b>Main material of walls</b>			
Burnt bricks/Blocks	27.3	50.0	28.5
Mud bricks/Mud	70.0	50.0	69.0
Wood/Bamboo	2.0	0.0	1.9
Stones	0.6	0.0	0.6
<b>N</b>	<b>494</b>	<b>26</b>	<b>520</b>

**Figure 2.2: Distribution of water supply for Upper Dir households**

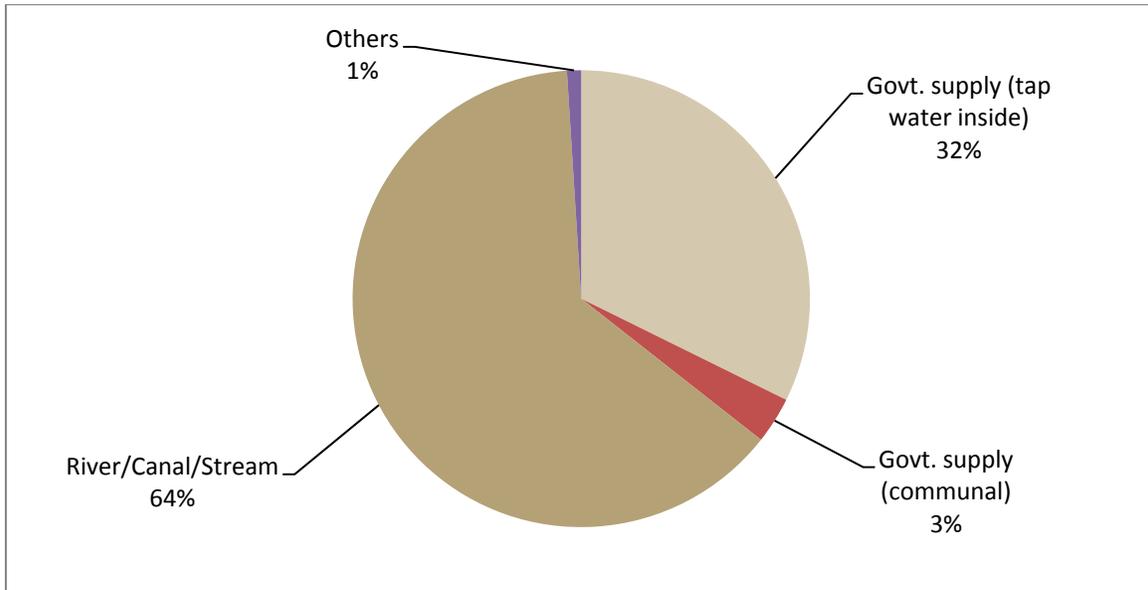
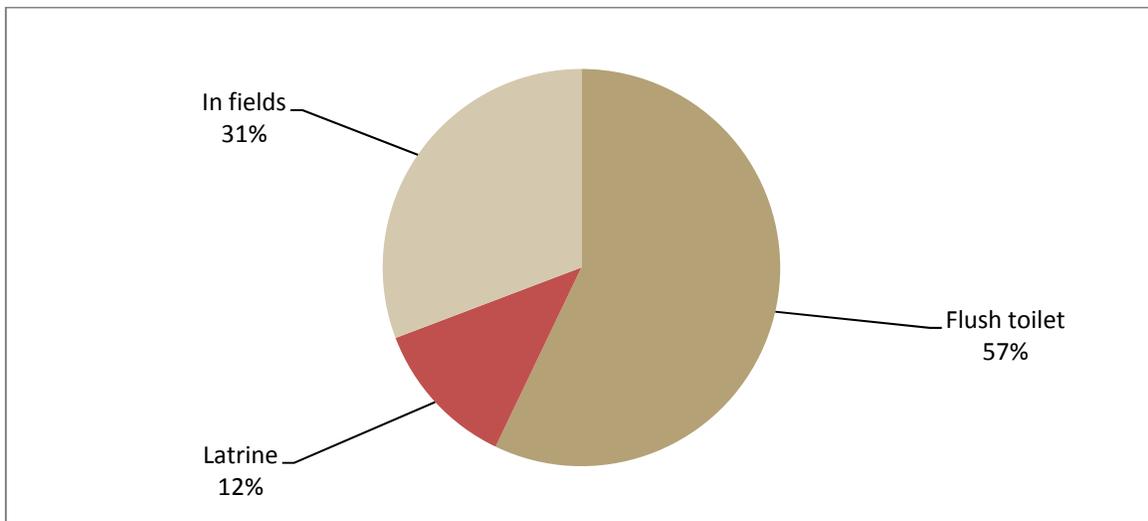


Table 2.4 and Figure 2.4 show that a good number of households (57 percent) had some type of flush toilet. The situation was better in urban areas (88 percent) as compared with rural areas where 56 percent had some kind of flush toilet. About 12 percent of households had a raised or pit latrine, while 31 percent had no toilet at all.

**Figure 2.3: Toilet facilities for Upper Dir households**



Ninety-six percent of the households used firewood for cooking, 4 percent used gas, (urban - 31 percent; rural - 3 percent). Eighty-nine percent of the households had electricity. In urban areas, almost all (96 percent) of the households had an electric connection, while in rural areas the figure was 89 percent. More than 89 percent of the houses were roofed with wood/bamboo and mud while only 29 percent of the walls were made of burnt bricks or cement blocks.

### **Ownership of Household Assets**

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

Television was available to only 16 percent of the households, while radio/tape recorder was available to 52 percent of the households. This could be of particular interest to communication specialists in developing communication strategies for the district. The recent expansion of information technology in Pakistan was visible in Upper Dir district where 49 percent of households had mobile phones, however, residence made a big difference: in urban areas 81 percent of the households had a mobile phone compared to 48 percent in rural areas. Only 4 percent of the sampled households had a computer. Motorized transport was 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	78.9	96.2	79.8
Chairs	56.5	92.3	58.3
Bed	37.4	76.9	39.4
Sofa	11.2	28.0	12.0
Sewing machine	56.9	69.2	57.5
Camera	5.1	11.5	5.4
Radio/Tape recorder	50.6	80.8	52.1
Television	14.2	57.7	16.3
Refrigerator	14.6	38.5	15.8
Land line telephone	40.3	69.2	41.7
Mobile phone	47.6	80.8	49.2
Room cooler/ Air conditioner	2.2	0.0	2.1
Washing machine	22.7	50.0	24.0
Bicycle	0.0	3.8	0.2
Motor cycle	0.2	3.8	0.4
Jeep/Car	6.5	7.7	6.5
Tractor	0.0	0.0	0.0
Computer	3.4	19.2	4.2
<b>N</b>	<b>494</b>	<b>26</b>	<b>520</b>

### Standard of Living Index

It is worthwhile to use the above data to get an overall index of the economic well-being of a household, both for making a general estimate of economic development for an area, and for use in investigating the relationship between household wealth and reproductive health behavior. One such index is the standard of living index (SLI) developed for international comparisons with data from the Demographic and Health Surveys (Rutstein, S.O., and K.

Johnson, 2004). This index gives each household a score of 0-1 or 0-2 on each of the following: source of drinking water; toilet facilities; material of floor; availability of electricity; ownership of a radio; ownership of a TV; ownership of a refrigerator; and means of transportation. For the whole household, the value of the index can range from 0 to 12. Table 2.6 gives the distribution of the SLI for the sample households according to urban and rural residence. The median index for all households was 4; the median index was also 4 for rural households and 7 for urban households. Sixty-eight percent of all households fell in the range from 3 to 8. This index will be used later in this report to examine differences in reproductive health knowledge and behavior.

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

Standard of living index	Rural		Urban		Total	
	N	%	N	%	N	%
0	26	5.3	0	0.0	26	5.0
1	58	11.7	0	0.0	58	11.2
2	54	10.9	1	3.8	55	10.6
3	100	20.2	1	3.8	101	19.4
4	72	14.6	5	19.2	77	14.8
5	63	12.8	4	15.4	67	12.9
6	61	12.3	1	3.8	62	11.9
7	28	5.7	6	23.1	34	6.5
8	11	2.2	2	7.7	13	2.5
9	10	2.0	5	19.2	15	2.9
10	5	1.0	1	3.8	6	1.2
11	5	1.0	0	0.0	5	1.0
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>4</b>	<b>na</b>	<b>7</b>	<b>na</b>	<b>4</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 548 currently married women of reproductive age. The background characteristics of these respondents are described in this chapter.

### Age

Table 3.1 shows the age distributions of the female respondents for rural and urban areas. At older ages, the numbers declined. More than half of the sample respondents were under age 30.

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

Age group	Rural		Urban		Total	
	N	%	N	%	N	%
15 - 19	49	9.4	1	3.7	50	9.1
20 - 24	129	24.8	9	33.3	138	25.2
25 - 29	119	22.8	6	22.2	125	22.8
30 - 34	88	16.9	3	11.1	91	16.6
35 - 39	62	11.9	4	14.8	66	12.0
40 - 44	48	9.2	2	7.4	50	9.1
45 - 49	26	5.0	2	7.4	28	5.1
<b>Total</b>	<b>521</b>	<b>100.0</b>	<b>27</b>	<b>100.0</b>	<b>548</b>	<b>100.0</b>

## Education and Literacy

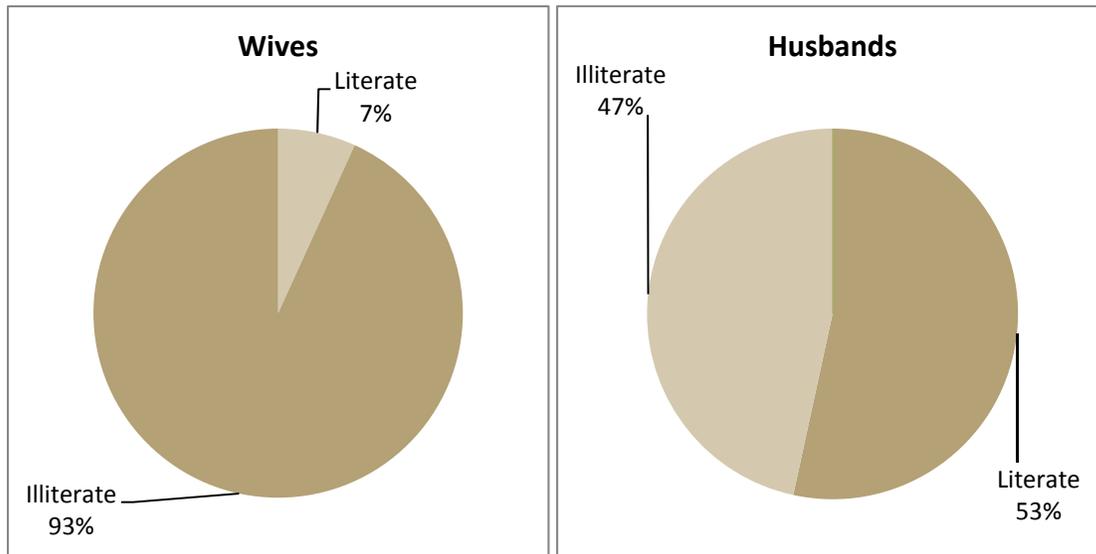
Levels of schooling completed and literacy rates for the respondents and their husbands are given in Table 3.2. Literacy rates are also shown in Figure 3.1. The 7 percent literacy rate for women was very low compared to the 53 percent for husbands. The literacy of females (aged 15+ years) recorded in PSLMS 2004-05 was 36 percent for Pakistan and 22 percent for Khyber Pakhtunkhwa. For Upper Dir, it was 6 percent. Similarly, only 3 percent of the female respondents reported having ever attended school up to secondary level. Table 3.2 also shows that younger women (aged 15-24 years and 25-34 years) were more literate than older women (35-49 years).

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

Variable	Age group			Residence		Total
	15 - 24	25 - 34	35 - 49	Rural	Urban	
<b>Respondent (women)</b>						
Proportion literate	10.4	6.5	2.8	6.4	15.4	6.8
<b>Education level</b>						
No education	86.7	91.6	97.2	91.9	81.5	91.4
Up to primary	5.9	4.2	2.1	3.8	11.1	4.2
Up to secondary	4.8	3.3	0.7	2.9	7.4	3.1
Above secondary	2.7	0.9	0.0	1.3	0.0	1.3
<b>N</b>	<b>188</b>	<b>215</b>	<b>144</b>	<b>520</b>	<b>27</b>	<b>547</b>
<b>Respondent's husband</b>						
Proportion literate	58.4	52.3	48.5	52.2	78.3	53.4
<b>Education level</b>						
No education	38.4	45.0	50.7	45.0	28.0	44.2
Up to primary	13.0	12.3	10.0	12.1	8.0	11.9
Up to secondary	35.7	33.6	29.3	32.7	44.0	33.2
Above secondary	13.0	9.0	10.0	10.2	20.0	10.6
<b>N</b>	<b>185</b>	<b>211</b>	<b>140</b>	<b>511</b>	<b>25</b>	<b>536</b>

For both women and their husbands, the literacy was higher in urban areas. Literacy for women was substantially lower than that of men. It is interesting to note that no woman is found above secondary in urban areas.

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

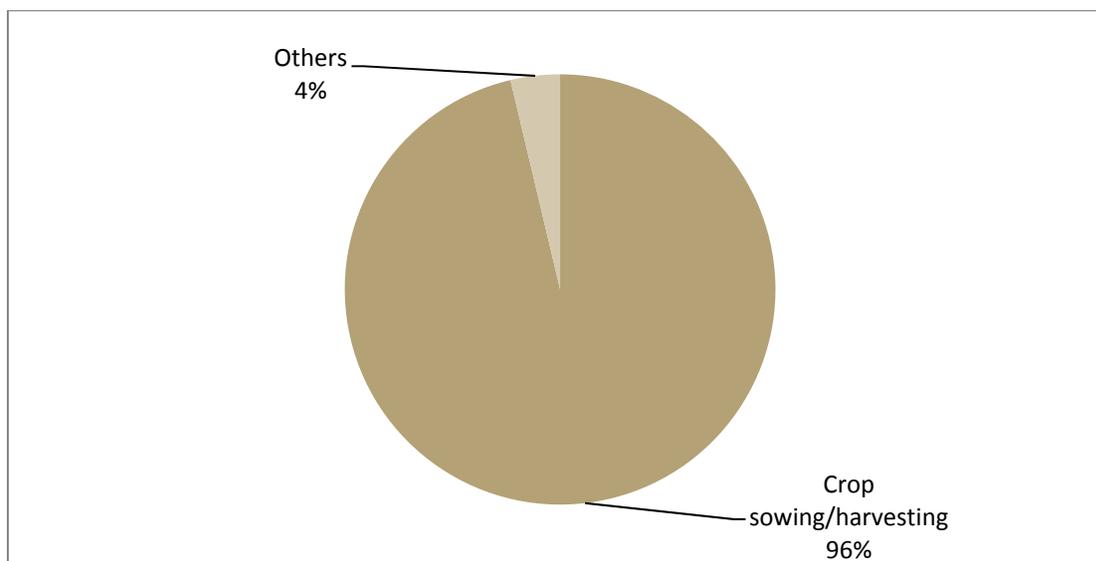


## Occupation and Work Status

For men, occupation is both an economic and social classification; some occupations usually indicate higher income levels than others, while at the same time may represent social status and life-style. Men in general are expected to work for pay; the question is, doing what? In Upper Dir district 187 women out of the 548 total women (34 percent) were working for wages. Their occupations are shown in Figure 3.2. This shows higher female participation for economic survivability, women mostly did crop sowing/harvesting (96 percent).

In this situation, women’s time spent working for wages 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.

**Figure 3.2: Type of work of women working for pay (N=187)**



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

Economic activity/occupation	Rural	Urban	Total
Agriculture/Livestock/Poultry	9.2	0.0	8.8
Petty trader	11.5	33.3	12.6
Labor (Daily wages)	34.4	22.2	33.8
Government service	8.1	18.5	8.6
Private service	3.3	3.7	3.3
Own business	1.0	11.1	1.5
Abroad	23.4	7.4	22.6
Unemployed	9.0	3.7	8.8
Others	0.2	0.0	0.2
<b>N</b>	<b>521</b>	<b>27</b>	<b>548</b>

A substantial proportion, the majority, was working as daily-wage laborers (34 percent) followed by a great number working abroad (23 percent). About 13 percent of the men were in petty trade. About 9 percent of the husbands of respondents were unemployed.

## Female Mobility

Women respondents were asked about their ability to go to places outside their homes, and what degree of permission was required. Only a few women reported being able to go to any of the places named without permission. A few women reported not being able to go to the health centre or relatives/friends, while the vast majority (95 percent) could not go to the market. Ninety - one percent of the women reported that they could go to the health center with someone, and 7 percent could do so with permission.

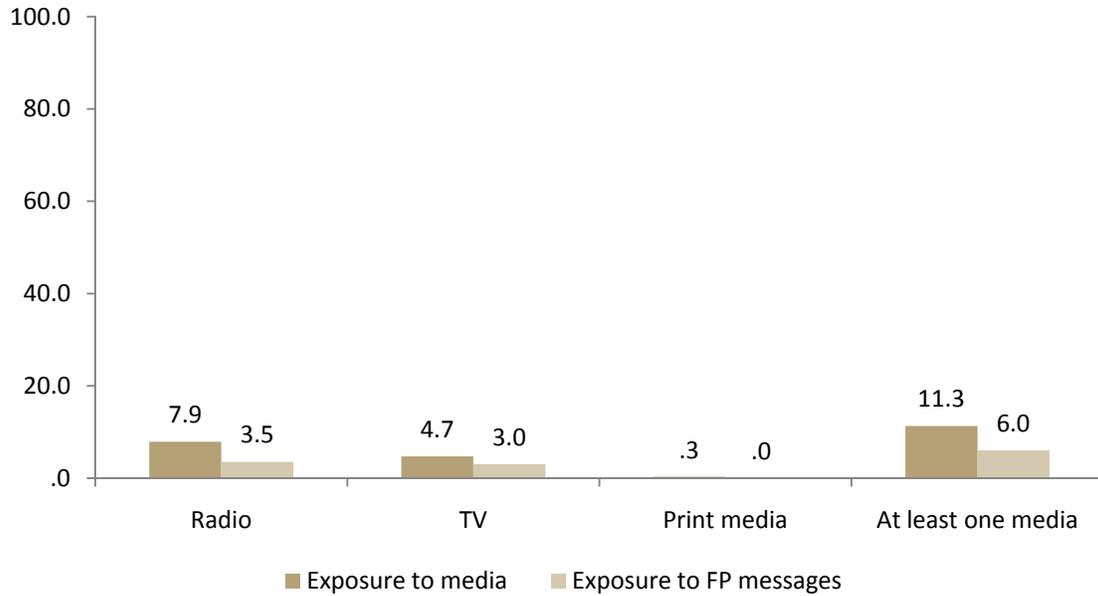
**Table 3.4: Women’s reports regarding mobility outside the home by degree of permission and destination**

Destination	Degree of permission				Total	
	Without permission	With permission	With someone	Can't go/ Doesn't go	%	N
Market	0.2	0.2	4.9	94.7	100.0	548
Health center	1.3	7.3	90.9	0.5	100.0	548
Relatives/friends	1.3	4.2	93.4	1.1	100.0	548
Out of village/ town	0.5	0.4	96.7	2.4	100.0	548

## 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. Table 2.5 shows that 16 percent of households owned a television and 52 percent owned a radio/tape recorder. Figure 3.3 shows the proportion of women who reported that they watched TV, listened to the radio, or read newspapers or magazines. Radio was relatively more commonly accessed medium, followed by T.V and print media.

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



Women who reported access to any sort of media were asked if they had ever seen, heard or read any message about the methods of family planning through these mediums. Again, more women said that they had heard family planning messages on radio (4 percent) followed by T.V (3 percent). Overall 11 percent of the women reported access to at least one of these mass media forms, and 6 percent had exposure to FP messages through them.

# Chapter 4

## Fertility

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

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

## Cumulative Fertility

### Children Ever Born and Living

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

**Table 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	52.0	46.0	2.0	0.0	100	0.6	50
20-24	18.1	52.9	28.3	0.7	100	1.8	138
25-29	3.2	26.4	39.2	31.2	100	3.5	125
30-34	3.3	4.4	16.5	75.8	100	5.7	91
35-39	0.0	1.5	10.6	87.9	100	7.7	66
40-44	4.0	2.0	4.0	90.0	100	7.8	50
45-49	7.1	0.0	0.0	92.9	100	8.4	28
<b>Total</b>	<b>11.3</b>	<b>24.6</b>	<b>20.6</b>	<b>43.4</b>	<b>100</b>	<b>4.3</b>	<b>548</b>

Table 4.1 shows that early childbearing was common in Upper Dir and 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 women aged 15-49 in Upper Dir, the mean number of children ever born was 4.3 for currently married women. The mean number of children ever born increased steadily with age, reaching a high of 8.4 children among women aged 45-49. On average, these women also had 7.7 living children. Each woman of age group 45-49 had lost 0.7 children on average during her reproductive life.

Table 4.1 also shows that more than 48 percent of the married women who were 15-19 years of age had already given birth to at least one child. Women aged 45-49 had virtually completed childbearing. Among them, 93 percent had five or more children ever born suggesting 7 percent of primary infertility (i.e., the proportion of couples who are unable to have any children) in this sample in Upper Dir. The sex ratio at birth was 105 males per 100 females. The sex ratio of living children was about 110.

**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	52.0	46.0	2.0	0.0	100	0.6	50
20-24	18.8	55.1	26.1	0.0	100	1.7	138
25-29	3.2	28.8	43.2	24.8	100	3.2	125
30-34	3.3	5.5	22.0	69.2	100	5.4	91
35-39	0.0	3.0	12.1	84.8	100	6.9	66
40-44	4.0	2.0	6.0	88.0	100	7.3	50
45-49	7.1	0.0	0.0	92.9	100	7.7	28
<b>Total</b>	<b>11.5</b>	<b>26.1</b>	<b>22.3</b>	<b>40.1</b>	<b>100</b>	<b>4.0</b>	<b>548</b>

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

Age group	Mean number of children						N
	Ever born			Surviving			
	Boys	Girls	Total	Boys	Girls	Total	
15-19	0.4	0.3	0.6	0.4	0.3	0.6	50
20-24	0.9	0.9	1.8	0.8	0.8	1.7	138
25-29	1.8	1.7	3.5	1.6	1.6	3.2	125
30-34	3.0	2.7	5.7	2.7	2.6	5.4	91
35-39	3.9	3.8	7.7	3.5	3.5	6.9	66
40-44	4.1	3.7	7.8	3.9	3.3	7.3	50
45-49	4.3	4.0	8.4	4.0	3.7	7.7	28
<b>Total</b>	<b>2.2</b>	<b>2.1</b>	<b>4.3</b>	<b>2.1</b>	<b>1.9</b>	<b>4.0</b>	<b>548</b>

## Differentials in Children Ever Born and Surviving

Table 4.4 shows that the differences in mean numbers of children by literacy, age and educational level of currently married women were pronounced. On average, literate women bore 1.9 fewer children than illiterate women. Those who had “up to primary” education had 2.6 children on average ever born as compared to 4.5 born to those who had no schooling. Those who had “above secondary” education had 1.1 children ever born. This might be surprising but may be attributed to a very small sampling number.

Differentials were also observed on the basis of literacy and economic activity of husbands. Those who had literate husbands had 3.9 children compared to 4.7 children ever born to those who had illiterate husbands. Those who were in Government service had the highest number of children ever born (5.7).

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

<b>Characteristic</b>	<b>Mean number of CEB</b>	<b>Mean number of LC</b>	<b>Proportion dead</b>	<b>N</b>
<b>Literacy of respondent</b>				
Literate	2.6	2.6	0.02	37
Illiterate	4.5	4.1	0.08	504
<b>Schooling of respondent</b>				
No education	4.5	4.1	0.08	500
Up to primary	2.6	2.4	0.05	23
Up to secondary	2.9	2.9	0.00	17
Above secondary	1.1	1.1	0.00	7
<b>Residence</b>				
Rural	4.3	4.0	0.08	521
Urban	4.3	4.0	0.06	27
<b>Literacy of respondent's husband</b>				
Literate	3.9	3.7	0.07	269
Illiterate	4.7	4.3	0.08	235
<b>Schooling of husband</b>				
No education	4.7	4.4	0.07	237
Up to primary	4.0	3.6	0.08	64
Up to secondary	3.9	3.5	0.09	178
Above secondary	4.3	4.2	0.03	57
<b>Standard of living index</b>				
Low	4.5	4.1	0.10	234
Medium low	4.3	4.0	0.06	154
Medium high	4.2	3.9	0.06	113
High	4.1	3.9	0.05	47
<b>Economic activity/ occupation of husband</b>				
Agriculture/livestock/poultry	4.6	4.3	0.06	48
Petty trader	4.9	4.4	0.10	69
Labor (daily wages)	4.0	3.5	0.11	185
Government service	5.7	5.4	0.06	47
Private service	3.3	3.1	0.07	18
Own business	5.3	5.1	0.02	8
Working abroad	4.1	3.9	0.05	124
Unemployed	4.3	4.2	0.02	48
Others	2.0	2.0	0.00	1
<b>Total</b>	<b>4.3</b>	<b>4.0</b>	<b>0.08</b>	<b>548</b>

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 (2.6) compared to those mothers who were illiterate (4.5). Similarly, the survival of children with literate mothers was far better than those born to illiterate mothers. Literate mothers were younger than illiterate mothers. In the below-30 age group, 76 percent of the mothers were literate, as compared to 55 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 CEB	Mean LC	N	%	Mean CEB	Mean LC	N	%
15 - 19	1.0	1.0	5	13.5	0.5	0.5	44	8.7
20 - 24	1.8	1.7	14	37.8	1.8	1.7	120	23.8
25 - 29	3.3	3.3	9	24.3	3.5	3.2	115	22.8
30 - 34	3.8	3.6	5	13.5	5.8	5.4	85	16.9
35 - 39	4.8	4.8	4	10.8	7.9	7.0	62	12.3
40 - 44	0.0	0.0	0	0.0	7.8	7.3	50	9.9
45 - 49	0.0	0.0	0	0.0	8.4	7.7	28	5.6
<b>Total</b>	<b>2.6</b>	<b>2.6</b>	<b>37</b>	<b>100.0</b>	<b>4.5</b>	<b>4.1</b>	<b>504</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 31.3 births per thousand population.

## Age-specific Fertility Rates and Total Fertility Rate

Total fertility rate (TFR) is a more refined fertility measure than CBR. Age-specific fertility rates (ASFRs) and TFR have been 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. Rates rose rapidly till age 30-34 and then declined with increasing age. A TFR of 5.7 for the period 2004-2007 was obtained from the set of ASFRs calculated from the data presented in Table 4.6, compared with 4.3 for Khyber Pakhtunkhwa and 4.1 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	290	21	24.1
20 - 24	239	130	181.3
25 - 29	174	115	220.3
30 - 34	123	95	257.5
35 - 39	78	53	226.5
40 - 44	68	25	122.5
45 - 49	41	14	113.8
<b>Total</b>	<b>1013</b>	<b>453</b>	<b>na</b>

**CBR: 31.3**

**TFR: 5.7**

na=not applicable

## Mothers with Children Under Five Years

If mothers have a child while breastfeeding an older child, they are often less able to produce breast milk for the older child (Adair et al., 1994). When children are weaned too soon, their growth suffers; they are more likely to suffer from diarrheal diseases (Bohiler et al., 1995). Milk diminution is more likely to occur as women have more children and are

undernourished (Garner et al., 1994). In addition, when children are close in age, they compete for resources as well as for maternal care. The mother may also not be able to breastfeed the newborn properly, placing the newborn at higher risk for nutritional deficiency and infectious diseases contracted from older siblings.

Table 4.7 shows a significant number of women with the burden of caring for several young children. Among those who already had two living children under 5 years of age, 14 percent were currently pregnant. For such mothers, it is particularly important for their health and that of their children to ensure that birth spacing is part of their married life at this point.

**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	23	21.3	85	78.7	108
1	39	21.1	146	78.9	185
2	28	14.3	168	85.7	196
3	1	1.7	58	98.3	59
<b>Total</b>	<b>91</b>	<b>16.6</b>	<b>457</b>	<b>83.4</b>	<b>548</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 Hessel, 2000; Miller et al., 1995; Zhu et al., 1999). The length of the preceding birth interval is very important for the health of both mothers and their babies. Table 4.8 shows the length of last closed birth interval for women with two or more births by background characteristics of mothers at the time of the survey.

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

Characteristic	Less than 18 months	18 - 23 months	24 - 35 months	36 - 47 months	48 and above months	Total	N
<b>Age</b>							
15 - 19	0.0	37.5	62.5	0.0	0.0	100.0	8
20 - 24	17.0	24.5	34.0	18.1	6.4	100.0	94
25 - 29	11.4	19.5	40.7	22.8	5.7	100.0	123
30 - 34	9.4	9.4	44.8	21.9	14.6	100.0	96
35 - 39	7.7	23.1	44.6	6.2	18.5	100.0	65
40 - 44	10.0	6.7	53.3	0.0	30.0	100.0	30
45 - 49	5.3	10.5	52.6	10.5	21.1	100.0	19
<b>Number of live births</b>							
2	15.8	22.8	36.8	12.3	12.3	100.0	57
3	12.5	18.8	42.5	20.0	6.3	100.0	80
4	10.5	19.3	40.4	19.3	10.5	100.0	57
5	9.1	21.8	32.7	23.6	12.7	100.0	55
6+	9.7	14.5	47.8	13.4	14.5	100.0	186
<b>Education level</b>							
No education	11.4	17.7	42.5	16.4	11.9	100.0	402
Up to primary	6.3	31.3	43.8	12.5	6.3	100.0	16
Up to Secondary	8.3	8.3	33.3	33.3	16.7	100.0	12
Above secondary	0.0	33.3	33.3	0.0	33.3	100.0	3
<b>Standard of living index</b>							
Low	11.8	20.3	40.1	16.0	11.8	100.0	187
Medium low	11.4	14.6	46.3	19.5	8.1	100.0	123
Medium high	12.1	16.5	40.7	14.3	16.5	100.0	91
High	2.9	20.6	47.1	14.7	14.7	100.0	34
<b>Total</b>	<b>11.0</b>	<b>17.9</b>	<b>42.5</b>	<b>16.6</b>	<b>12.0</b>	<b>100.0</b>	<b>435</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 has a short birth interval are higher than those experienced by an index child whose birth has 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 11 percent of children were born with a birth interval of less than 18 months. Almost 71 percent were born with a birth interval of less than 36 months, while 29 percent were born after three years or more. The differentials by mother's age, educational level and standard of living index are also shown.

# Chapter 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 413 women (75 percent), out of the 548 total women interviewed, had borne a child during the past four years, and these women were asked 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 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. Table 5.1 and Figure 5.1 show the numbers of ANC visits for the last birth of women who had delivered during the previous four years. Forty-four percent of the sample respondents had received at least one antenatal care visit during their last pregnancy. Thirty percent of the women had at least three such visits and 15 percent had four or more visits.

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

Number of visits	Rural		Urban		Total	
	N	%	N	%	N	%
No visit	226	57.5	5	25.0	231	55.9
1-2 visits	55	14.0	2	10.0	57	13.8
3 visits	56	14.2	8	40.0	64	15.5
4+ visits	56	14.2	5	25.0	61	14.8
<b>Total</b>	<b>393</b>	<b>100.0</b>	<b>20</b>	<b>100.0</b>	<b>413</b>	<b>100.0</b>

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

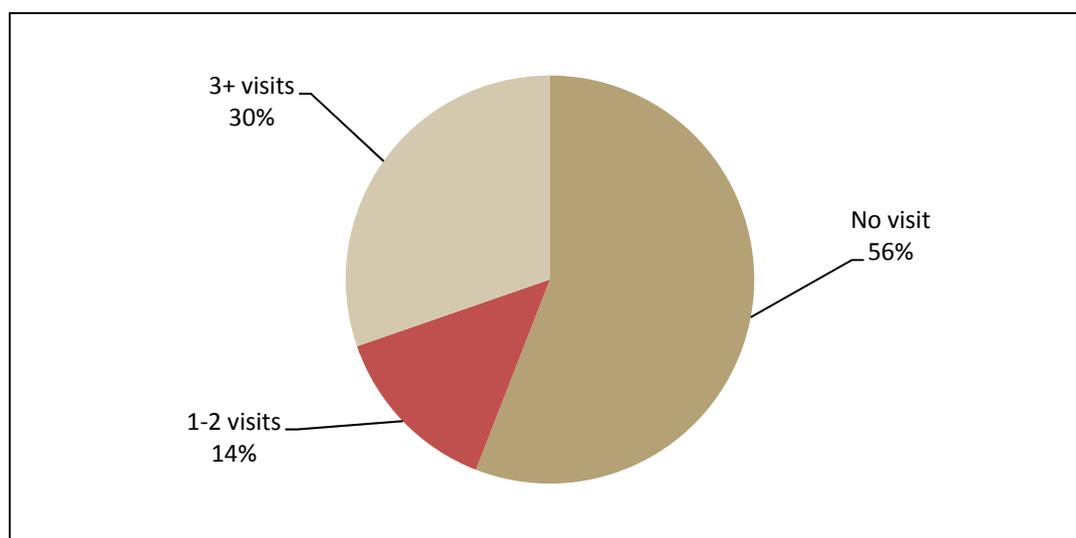


Figure 5.2 shows that many of these visits were in response to routine check up, rather than for some problem. Thirty three percent of the first antenatal visits were for curative purpose.

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

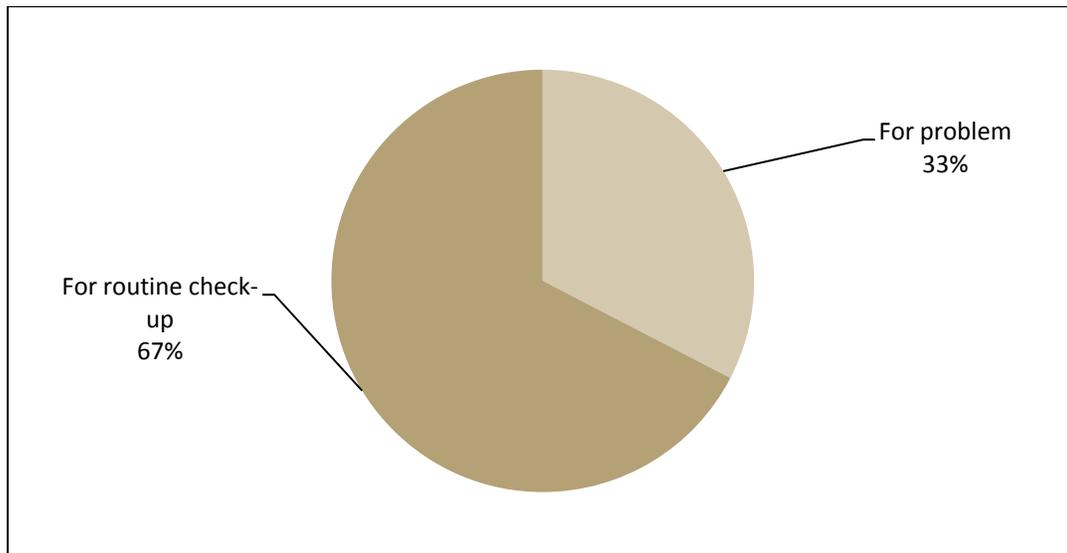


Figure 5.3 shows that for 30 percent of the women, the first visit took place within the first three months of gestation, and 15 percent of the women went for their first check-up during the third trimester of their pregnancy.

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

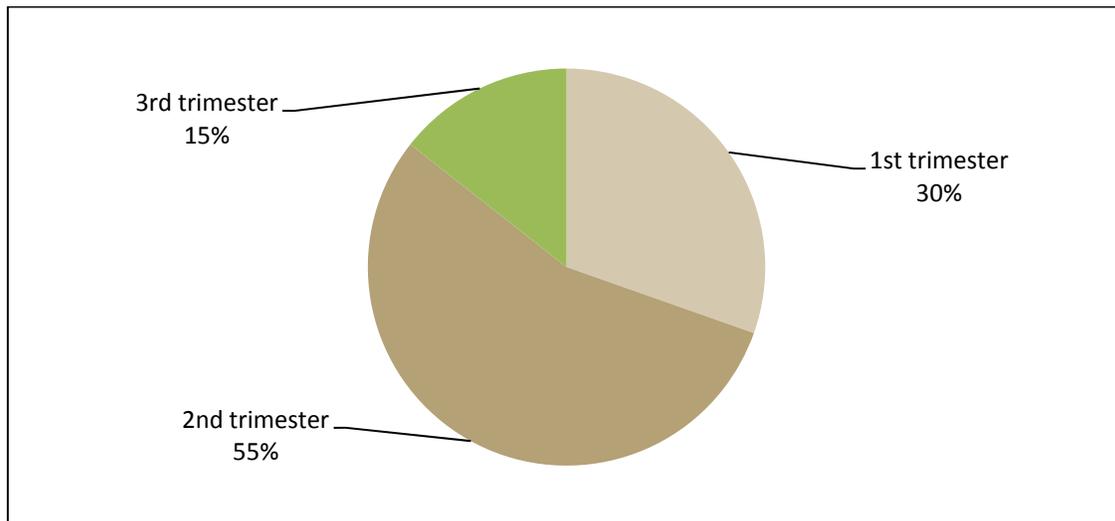
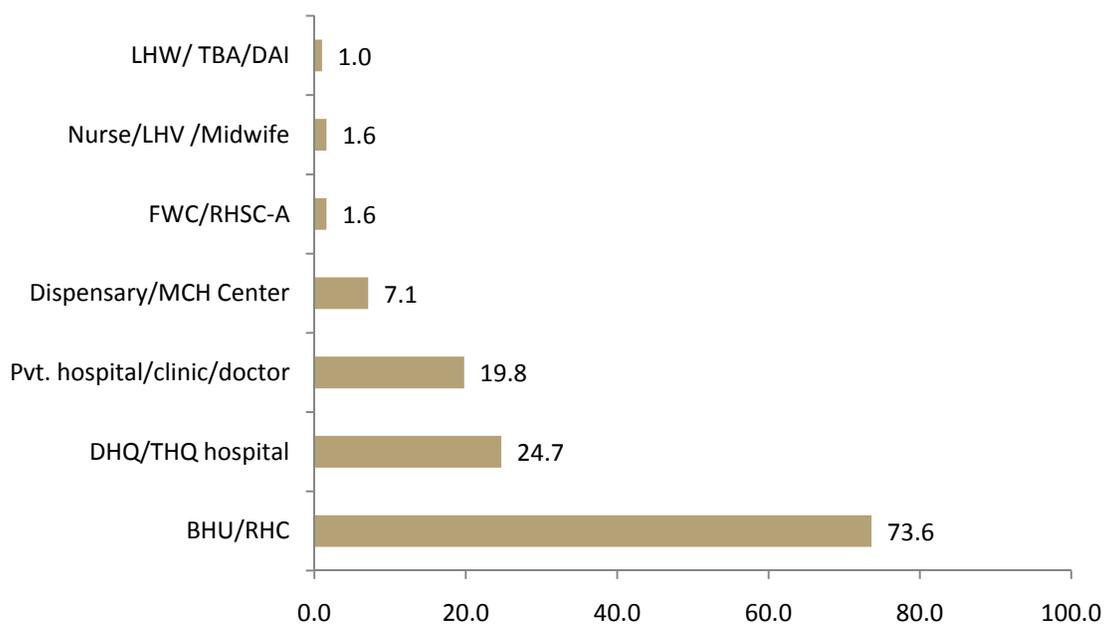


Table 5.2 shows the locations where respondents made one or more antenatal visits. . The most common providers of antenatal care were BHU/RHC followed by DHQ/THQ hospitals and private hospitals/clinics. Other providers were less common.

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

Facilities/service providers	Rural	Urban	Total
Dispensary/MCH Center	6.6	13.3	7.1
BHU/RHC	80.2	0.0	73.6
DHQ/THQ hospital	20.4	73.3	24.7
Pvt. hospital/clinic/doctor	18.0	40.0	19.8
FWC/RHSC-A	0.6	13.3	1.6
LHW/ TBA/DAI	1.2	0.0	1.0
Nurse/LHV /Midwife	1.8	0.0	1.6
<b>N</b>	<b>167</b>	<b>15</b>	<b>182</b>

**Figure 5.4: Locations where respondents made one or more antenatal visits**



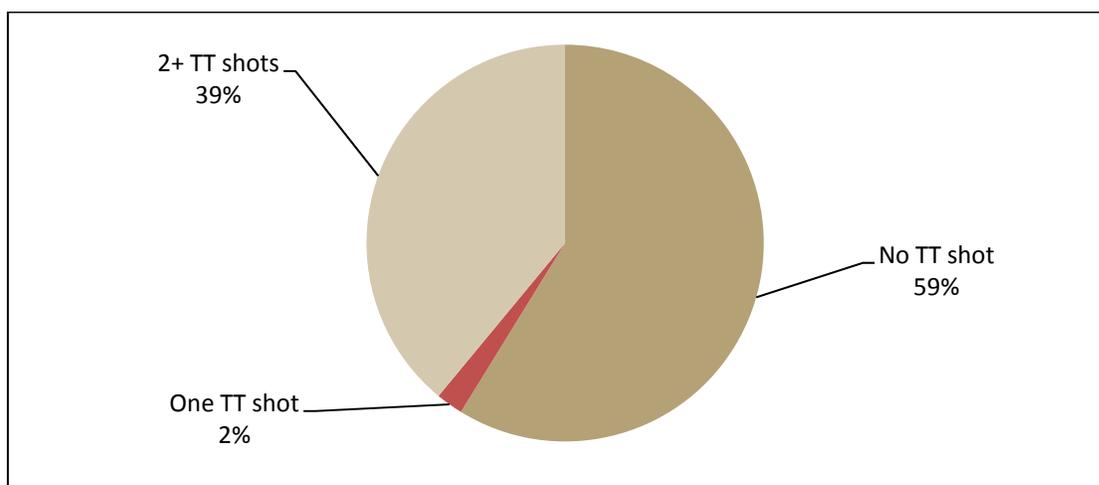
## Tetanus Immunization

Tetanus toxoid immunization is important to avoid tetanus in the newborn or mother. Two doses in a pregnancy are sufficient to prevent tetanus; however, if the woman was immunized during her previous pregnancy only one dose may be needed, and five doses are sufficient for lifetime protection. According to PSLMS 2004-05, 44 percent of mothers in Upper Dir had received at least one shot; according to the PDHS 2006-07, 43 percent in Khyber Pakhtunkhwa and 53 percent nationally were appropriately protected from tetanus, according to guidelines (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 5.3 shows that 41 percent of mothers had received at least one TT shot, while 39 percent received two or more TT shots during their last pregnancy. The immunization rate was higher in urban areas, while it was poor in rural areas. A number of mothers remained unprotected.

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

Number of injections	Rural		Urban		Total	
	N	%	N	%	N	%
No TT shot	239	60.8	4	20.0	243	58.8
One TT shot	7	1.8	2	10.0	9	2.2
2+ TT shots	147	37.4	14	70.0	161	39.0
<b>Total</b>	<b>393</b>	<b>100.0</b>	<b>20</b>	<b>100.0</b>	<b>413</b>	<b>100.0</b>

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



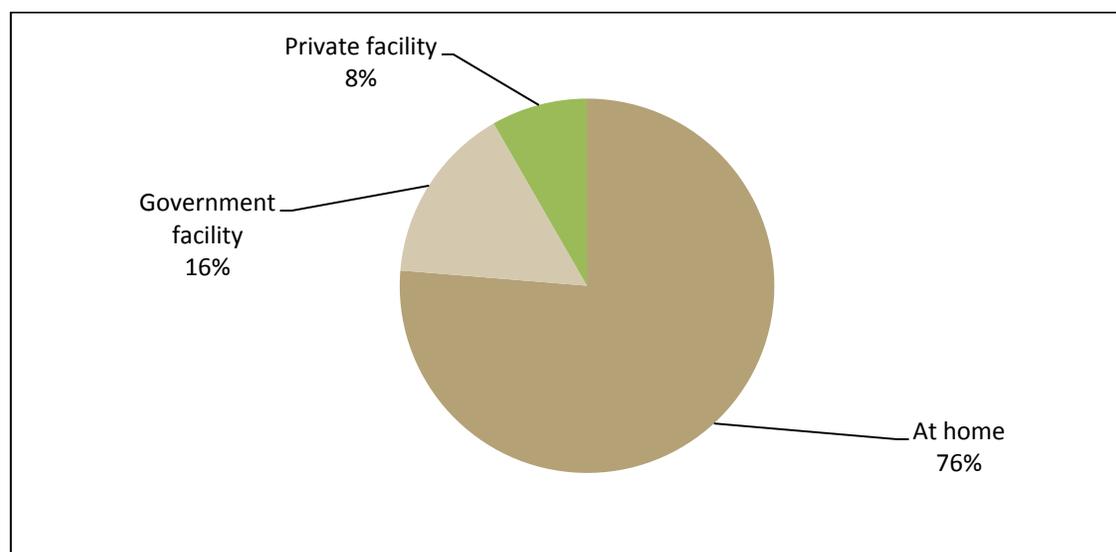
## Location and Attendance at Delivery

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. These proportions have been historically low in Pakistan, contributing substantially to high maternal mortality. In Upper Dir, according to the 2004-05 PSLMS, 17 percent of the deliveries took place in institutions, compared with PDHS 2006-07 figures of 30 percent for Khyber Pakhtunkhwa and 34 percent nationally (Government of Pakistan, 2006; NIPS/PDHS, 2008). In the present survey, 24 percent of the most recent deliveries were in a health facility (Table 5.4 and Figure 5.6).

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

Place of delivery	Rural		Urban		Total	
	N	%	N	%	N	%
At home	303	77.1	12	60.0	315	76.3
BHU/RHC	41	10.4	0	0.0	41	9.9
DHQ/THQ hospital	18	4.6	3	15.0	21	5.1
Pvt. hospital/clinic	29	7.4	5	25.0	34	8.2
Others	2	0.6	0	0.0	2	0.4
<b>Total</b>	<b>393</b>	<b>100.0</b>	<b>20</b>	<b>100.0</b>	<b>413</b>	<b>100.0</b>

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

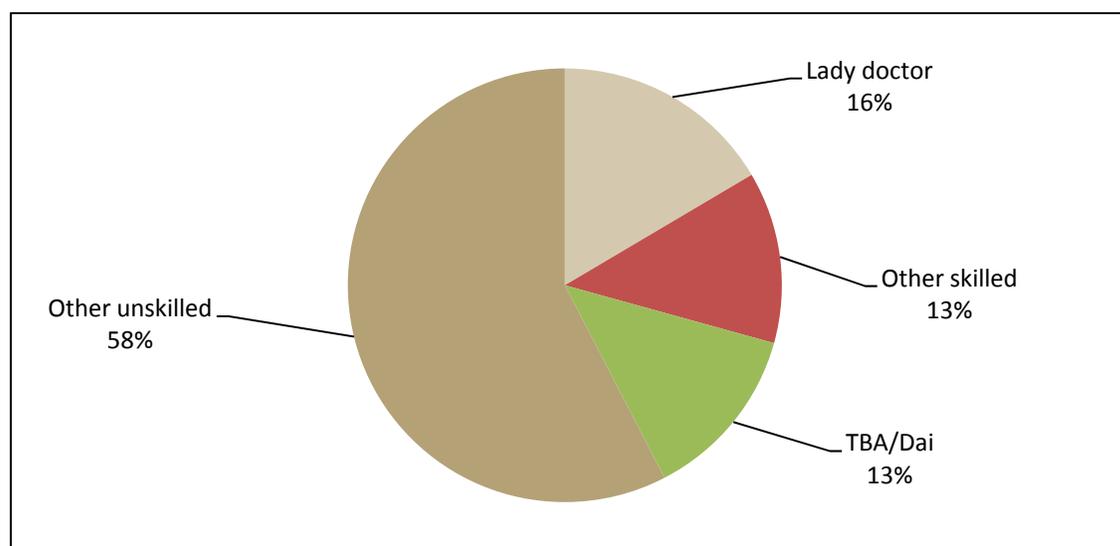


The proportion of births delivered by skilled attendants was 29 percent (Table 5.5 and Figure 5.7). In the PSLMS 2004-05 for Upper Dir, only 15 percent of births were delivered by a skilled attendant; in the PDHS 2006-07, the corresponding figures were 38 percent for Khyber Pakhtunkhwa and 39 percent for Pakistan as a whole (Government of Pakistan, 2006; NIPS/PDHS, 2008). Most of the births attended by a skilled attendant in this household survey were reportedly attended by a lady doctor. The term “doctor,” however may mean a paramedic, such as a Lady Health Visitor, in such interviews. About 57percent of the births were delivered by Female relative /Friend /Neighbor (Not 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/LHW	49	12.5	6	30.0	55	13.3
Nurse/LHV/midwife	51	13.0	2	10.0	53	12.8
Lady doctor	61	15.5	7	35.0	68	16.5
Relative/friend/neighbor (not a dai)	232	59.1	5	25.0	237	57.4
<b>Total</b>	<b>393</b>	<b>100</b>	<b>20</b>	<b>100</b>	<b>413</b>	<b>100</b>
Skilled birth attendant	112	28.5	9	45.0	121	29.3
Unskilled birth attendant	281	71.5	11	55.0	292	70.7

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



## Postpartum Care

For both the health of the mother and the health of the newborn, a newly delivered mother and baby should be followed up for at least 6 weeks after delivery; MoH guidelines recommend at least one postpartum visit after discharge during the first 42 days after delivery. However, this is a major weakness of maternal and newborn health care in Pakistan. Women who deliver at home rarely go for any postnatal check-up, and women who deliver in facilities will usually be seen while they are in the facility, but not after that. Upper Dir is no exception: 25 percent of respondents reported having received postnatal care within 40 days after delivery (Table 5.6). In 24 percent of these cases, the first visit took place within 24 hours, and 0.5 percent had a check-up after 24 hours of the delivery. Only 1 percent of the women who delivered at home reported one or more postnatal visits, whereas all of the women delivering in facilities reported having a postnatal check-up within 24 hours.

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

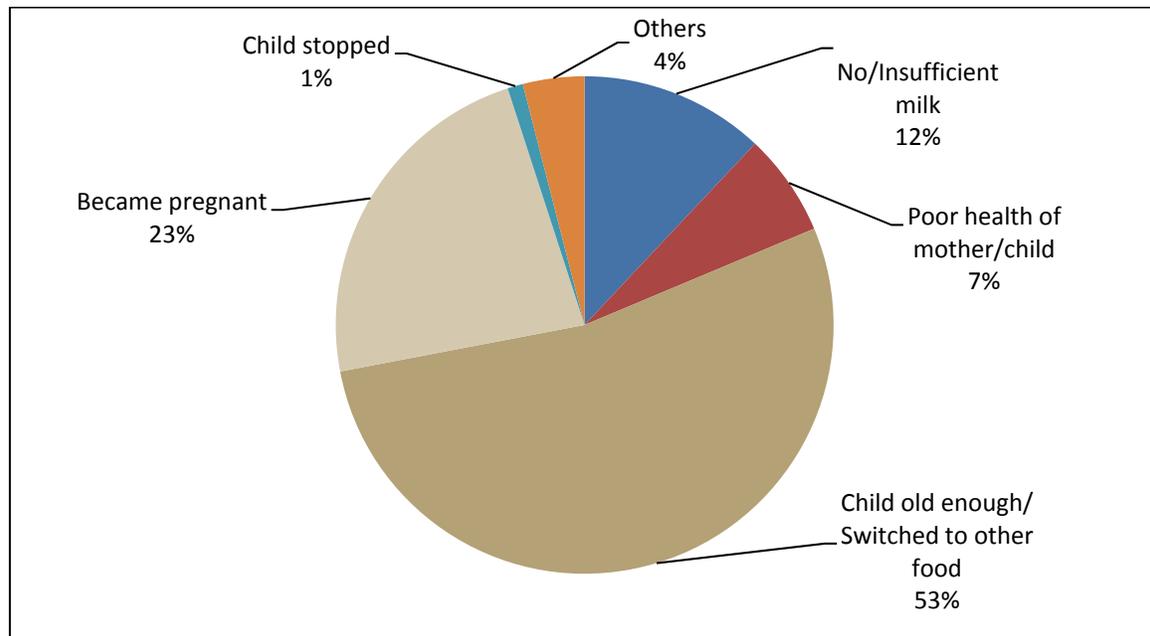
**Table 5.6 Distribution of mothers by status of postnatal check-up and place of delivery**

Place of delivery	Postnatal check-up within 24 hours		Postnatal check-up After 24 hours		Did not have postnatal check-up		Total	
	N	%	N	%	N	%	N	%
Institution	97	100.0	0	0.0	0	0.0	97	100
Non institution	2	0.6	2	0.6	312	98.7	316	100
<b>Total</b>	<b>99</b>	<b>24.0</b>	<b>2</b>	<b>0.5</b>	<b>312</b>	<b>75.5</b>	<b>413</b>	<b>100</b>

## Breastfeeding

Breastfeeding is a critical component of newborn and infant health. In addition, it is a primary determinant of the length of postpartum amenorrhea. In this aspect, breastfeeding can be deliberately used to delay pregnancy, either through a formal procedure such as “lactational amenorrhea method” (LAM), or more informally through the assumption that breastfeeding protects against pregnancy. Virtually all Pakistani women breastfeed their children to some extent. In our sample, only 6 of 404 respondents reported not having breastfed their last child at all. Breastfeeding is normally done for a substantial period of time. The median length of breastfeeding for the last baby (not currently being breastfed) was 24 months. Three main reasons were given for discontinuing breastfeeding: child was old enough to stop (53 percent), mother became pregnant (23 percent) and no/ insufficient milk (12 percent).

**Figure 5.8: Distribution of mothers by reasons for discontinuing breastfeeding (N=150)**





# 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 on this typically evolve over the course of their reproductive years; in the beginning, they want their first children quickly, while toward the end of their reproductive lives, they are quite sure they want to stop. At some point, they may go through a period of ambivalence where their views are uncertain and conflicted. Husbands and wives may or may not agree on these matters, and may or may not communicate well. Often it is difficult to learn what couples truly feel on these issues because they themselves may not be certain. 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 5 children; 39 percent of the respondents wanted four or fewer children. However, substantial numbers cited six or more as the ideal number. Urban and rural women wanted the same number of children as median ideal number (5 children). Overall in Upper Dir, 7 percent of the women also gave a non-numeric response to this question such as up to God.

**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	2	0.4	0	0	2	0.4
2	24	4.6	1	3.7	25	4.6
3	44	8.4	3	11.1	47	8.6
4	133	25.5	6	22.2	139	25.4
5	107	20.5	6	22.2	113	20.6
6 +	173	33.2	7	25.9	180	32.8
Up to God	38	7.3	4	14.8	42	7.6
<b>Total</b>	<b>521</b>	<b>100</b>	<b>27</b>	<b>100</b>	<b>548</b>	<b>100</b>

## Desire for More Children

### Levels of Desire for More Children

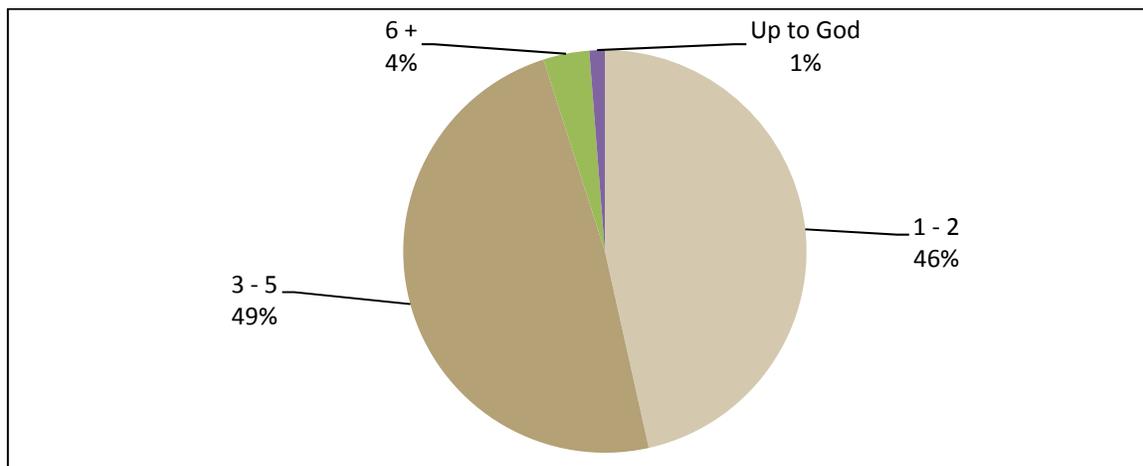
A more immediate measure of fertility preference is whether a couple wants more children; if so, do they want the next one now or later, and how many more do they want. The desire for future children is closely linked with the number of children a couple already has. Table 6.2 shows that whether respondents 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. More than half of the respondents ( 51 percent ) did not want more children than they already had and about a quarter (23 percent) wanted to delay their next child. This trend changes for those who already had two children. The proportion of women wanting more children soon declined sharply after the second birth. On the other hand, most women with five or more living children did not want to have more. For those with five children, the proportion wanting to stop was 78 percent. A majority of women having 6 or more children wanted to stop. This table indicates clearly the level of interest in both spacing and limiting births.

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

Number of living children	Desire for next child				Total	
	Soon	Later	Never	Don't know	N	%
0	61.9	33.3	4.8	0.0	63	100
1	46.6	45.2	6.8	1.4	73	100
2	34.3	45.7	20.0	0.0	70	100
3	34.8	25.8	36.4	3.0	66	100
4	7.1	19.6	73.2	0.0	56	100
5	18.0	4.0	78.0	0.0	50	100
6+	3.5	5.3	91.2	0.0	170	100
<b>Total</b>	<b>25.4</b>	<b>22.8</b>	<b>51.3</b>	<b>0.5</b>	<b>548</b>	<b>100</b>
N	139	125	281	3	548	548

For those women who wanted more children, we also asked how many more they wanted to have. As shown in Figure 6.1, 46 percent of the women who wanted more children wanted one or two more children. Another 49 percent wanted three to five children. Only one percent respondents were of the view that it was up to God. It would be useful to explore what such respondents mean, i.e., whether this is a religious statement, an indication that she has not thought about it, or a polite way of telling the interviewer that she did not want to give a specific answer .

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



## Socioeconomic Correlates of Desire for Children

A woman's stated desire for children was analyzed in relation to four possible socioeconomic determinants: standard of living index (SLI), respondent's literacy, age and residence (Table 6.3). The relationship between SLI and desire for more children was found to be moderate. The age of a respondent was strongly associated with a desire not to have more children. Literate women were more likely to want the next child at a later time (32 percent) compared to illiterate women (22 percent). On the other hand, illiterate women were more likely to not have more children (52 percent) compared to literate women (43 percent).

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

Characteristic	Desire for next child				Total	
	Soon	Later	Never	Don't know	N	%
<b>Standard of living index</b>						
Low	31.2	17.9	50.0	0.9	234	100
Medium low	20.1	27.3	51.9	0.6	154	100
Medium high	22.1	26.5	51.3	0.0	113	100
High	21.3	23.4	55.3	0.0	47	100
<b>Age group</b>						
<25	42.0	41.5	16.0	0.5	188	100
25 or more	16.7	13.1	69.7	0.6	360	100
<b>Literacy of respondent</b>						
Literate	24.3	32.4	43.2	0.0	37	100
Illiterate	25.6	21.8	52.0	0.6	504	100
<b>Residence</b>						
Rural	25.3	22.5	51.6	0.6	521	100
Urban	25.9	29.6	44.4	0.0	27	100
<b>Total</b>	<b>25.4</b>	<b>22.8</b>	<b>51.3</b>	<b>0.5</b>	<b>548</b>	<b>100</b>
N	139	125	281	3	548	548

## Son Preference

In Pakistan, there is usually a substantial preference for sons over daughters. The belief that a family is incomplete without sons is stronger than the corresponding belief for daughters. In this questionnaire, respondents were asked how many daughters they would have before stopping if they did not have a son, and correspondingly for sons if they did not have a daughter. The son preference came out most strongly in the proportions saying that there would be no limit: 91 percent of women said there would be no limit to the number of daughters before having a son, while 54 percent said there would be no limit to sons before having a daughter. For those respondents who gave a number in both cases the median was three children.

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

Response	Number of daughters for the desire of a son		Number of sons for the desire of a daughter	
	N	%	N	%
Up to God	0	0.0	1	0.2
No limit	500	91.2	295	53.8
Other non-numeric responses	4	0.7	6	1.1
Numeric responses	44	7.4	246	44.9
<b>Total</b>	<b>541</b>	<b>100</b>	<b>542</b>	<b>100</b>
Median*	3	na	3	na

\*Of the numeric responses. na=not applicable

## Strength of Preference

The strength of preferences asked in such surveys can be questioned. The need for birth spacing can be presumed to be greater if a couple is strongly motivated not to have more children, or to delay the next pregnancy, than if it does not matter much to them. We asked respondents whether they would be pleased, worried, accepting, or indifferent if they became pregnant. Results are shown in Tables 6.5 and 6.6. (This question excludes those 240 of the total 548 women who wanted a child soon, who were currently pregnant, had been sterilized, had gone through menopause or had a hysterectomy.)

Among those who did not want more children at all, 73 percent said they would be worried if they became pregnant, while 1 percent would be pleased. Among those who wanted to delay their pregnancy for more than two years, 63 percent would be worried, while 14 percent would be pleased.

**Table 6.5: Distribution of MWRA who did not want more children soon by reaction if become pregnant in near future**

Reaction if pregnant	Desire for next child		Total	
	Later	Never	%	N
Pleased	13.9	0.8	3.9	12
Worried	62.5	73.3	70.8	218
Accept it	22.2	25.0	24.4	75
Doesn't matter	1.4	0.8	1.0	3
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>308</b>
N	72	236	308	308

Further, women who expressed a desire to not have more children or to delay the next child were asked what problems they would face if they became pregnant soon. Table 6.6 shows their responses. The problems most commonly faced by those who did not want more children at all were their own health (87percent), health of youngest (59 percent) and caring of children (66 percent). Same common problems were cited by those who wanted to delay the next child. This suggests that health was a priority for most of the women. This is a good sign for the project, which supports birth spacing with a focus on the health of the mother and child.

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

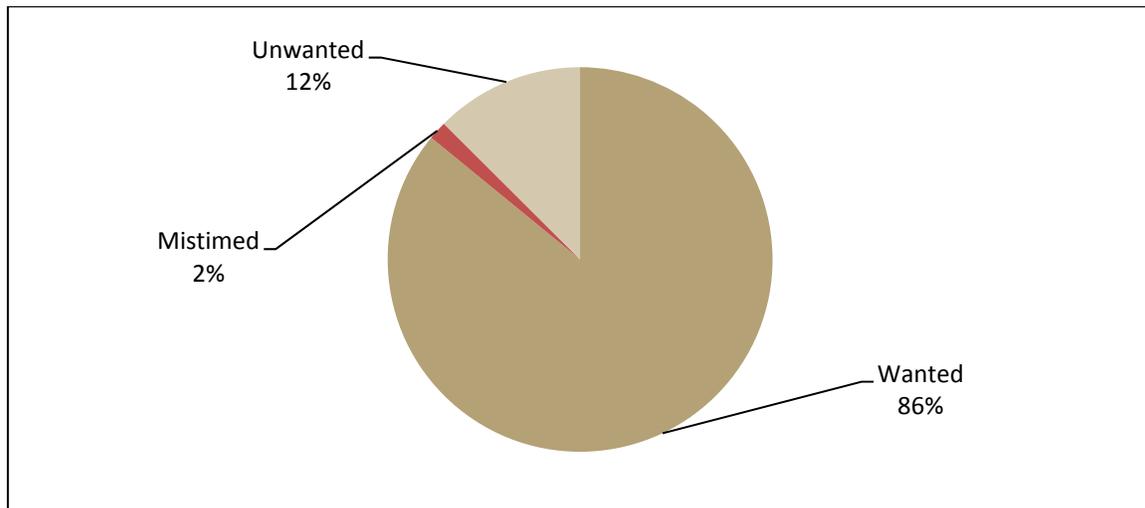
Reaction if pregnant	Desire for next child		Total	
	Later	Never	%	N
Own health	77.8	87.2	84.6	301
Health of youngest child	75.8	59.5	64.0	228
Caring of children	67.7	66.0	66.5	236
Schooling of children	32.3	61.1	53.1	189
Family economic situation	47.5	63.0	58.7	209
Will feel shy because other kids are grown	0.0	12.1	8.7	31
Other	0.0	1.2	0.8	3
<b>N</b>	<b>99</b>	<b>257</b>	<b>356</b>	<b>356</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, or was mistimed (i.e., wanted later), or was not wanted at all. Pregnancies that are unwanted cause hardship in many ways, and represent a failure to realize a couple's right to have the number of children they want, at the time they are wanted. This can be somewhat difficult to determine precisely in surveys. Sometimes parents report that an unwanted pregnancy was actually wanted, but it is less common to report that a child was wanted when in fact it was not. In this survey, 12 percent of the women reported that their last pregnancy was unwanted, while only 2 percent said that their last pregnancy was mistimed.

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



## Women's Perception of Fertility Preferences of Husbands

Women were asked whether they thought their husbands wanted the same number of children as they did, or more, or fewer. In Table 6.7, their responses are tabulated according to their ideal family size. About 16 percent of the women did not know their husband's preference; while another 20 percent thought their husbands wanted the same number of children as they did. However, about two-third (63 percent) thought their husbands wanted

more children than they did, while only 1 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	3.7	66.7	7.4	22.2	100.0	27
3 - 4 children	21.0	65.1	1.6	12.4	100.0	186
5 + children	22.9	63.1	1.0	13.0	100.0	293
Others	0.0	66.7	0.0	33.3	100.0	3
Up to God	6.3	40.6	0.0	53.1	100.0	32
Don't know	0.0	100.0	0.0	0.0	100.0	7
<b>Total</b>	<b>19.9</b>	<b>63.1</b>	<b>1.5</b>	<b>15.5</b>	<b>100.0</b>	<b>Na</b>
N	109	346	8	85	100.0	548

# Chapter 7

## Contraceptive Knowledge and Use

The FALAH baseline household surveys obtained data on contraceptive knowledge and use by first asking what methods they knew, if any (spontaneous knowledge). Then, for each method not mentioned, that method was named by the interviewer and described, and the respondent was asked if she knew that method, if she had ever used it, and if she was using it currently. This approach is standard in such surveys in Pakistan and elsewhere. In addition, respondents were asked to report their most recent source of contraceptive methods. Besides providing detailed data on use problems, this approach provides a useful check on the accuracy of the information provided in the first set of questions.

### Knowledge

For many years, at least 95 percent of the married women of reproductive age in Pakistan have known at least one method of contraception. Table 7.1 shows that this holds true for Upper Dir as well; virtually almost all women knew at least one method. A majority of the female respondents knew the most commonly used program methods – pills, injectables, IUD and female sterilization. They knew about condoms as well but to a lesser degree. Data show that the variations in knowledge of various methods between rural and urban women existed.

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

<b>Method</b>	<b>Rural</b>	<b>Urban</b>	<b>Total</b>
Female sterilization	81.3	100.0	82.2
Male sterilization	22.2	29.6	22.5
Pill	98.3	100.0	98.4
IUD	82.9	100.0	83.7
Injectables	95.4	100.0	95.6
Norplant	4.8	18.5	5.5
Condom	60.1	74.1	60.8
Rhythm	1.2	3.7	1.3
Withdrawal	24.9	48.1	26.0
Emergency pills	1.5	3.7	1.7
At least one method	98.7	100.0	98.7
At least one modern method	98.7	100.0	98.7
At least one traditional method	25.7	51.9	27.0
<b>N</b>	<b>521</b>	<b>27</b>	<b>548</b>

## Use of Contraceptive Methods

### Levels of Ever Use and Current Use

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

Of all the married women interviewed in our sample, 27 percent reported having used some method of contraception during their married lives (Table 7.2). It was substantially lower than the proportion obtained in the PDHS 2006-07 for Pakistan (48.7 percent) (NIPS/PDHS, 2008). This figure of ever use was higher for urban women (63 percent) than for rural women (25 percent).

**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	10.0	22.0	11.0	58	2.3	0.0	2.2	12	7.7	22.0	8.4	46
IUD	1.9	7.4	2.2	12	0.4	3.7	0.5	3	1.3	3.7	1.5	8
Injectables	16.0	26.0	16.0	89	4.2	11.0	4.6	25	12.0	15.0	12.0	64
Condom	2.7	26.0	3.8	21	1.2	11.0	1.6	9	1.5	15.0	2.2	12
Rhythm	0.0	0.0	0.0	0	0.0	0.0	0.0	0	0.0	0.0	0.0	0
Withdrawal	0.4	0.0	0.4	2	0.4	0.0	0.4	2	0.0	0.0	0.0	0
Female sterilization	1.0	7.4	1.3	7	1.0	7.4	1.3	7	0.0	0.0	0.0	0
Any method	25.0	63.0	27.0	148	9.4	33.0	11.0	58	16.0	30.0	16.0	90
Modern method	25.0	63.0	27.0	146	9.0	33.0	10.0	56	16.0	30.0	16.0	90
Traditional method	0.4	0.0	0.4	2	0.4	0.0	0.4	2	0.0	0.0	0.0	0
<b>N</b>	<b>521</b>	<b>27</b>	<b>548</b>	<b>na</b>	<b>521</b>	<b>27</b>	<b>548</b>	<b>na</b>	<b>521</b>	<b>27</b>	<b>548</b>	<b>na</b>
Emergency pills	0	0	0	0	na	na	na	na	na	na	na	na

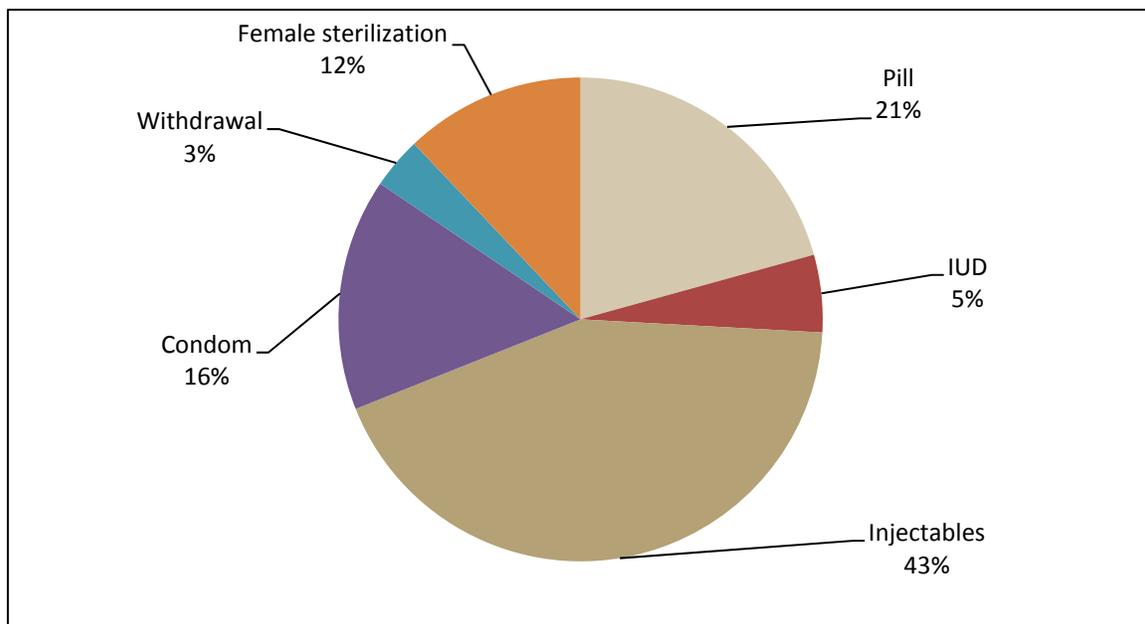
na=not applicable.

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

Current use of family planning methods in Upper Dir as compared with Pakistan in general was very low (see Table 7.2). Only 11 percent of all married women in the sample were currently using some method of contraception (CPR) compared with 24.9 percent for Khyber Pakhtunkhwa and 29.6 percent for Pakistan in the 2006-07 PDHS (NIPS/PDHS, 2008). In urban areas, the CPR was 33 percent, compared with 9 percent in rural Upper Dir.

Table 7.2 shows that the methods most commonly being used were injectables, pills and condoms. Overall, 10 percent of the married women were using modern methods and only 0.4 percent respondents were using traditional methods (withdrawal and rhythm). Distribution of current users by method mix may be seen in Figure 7.1.

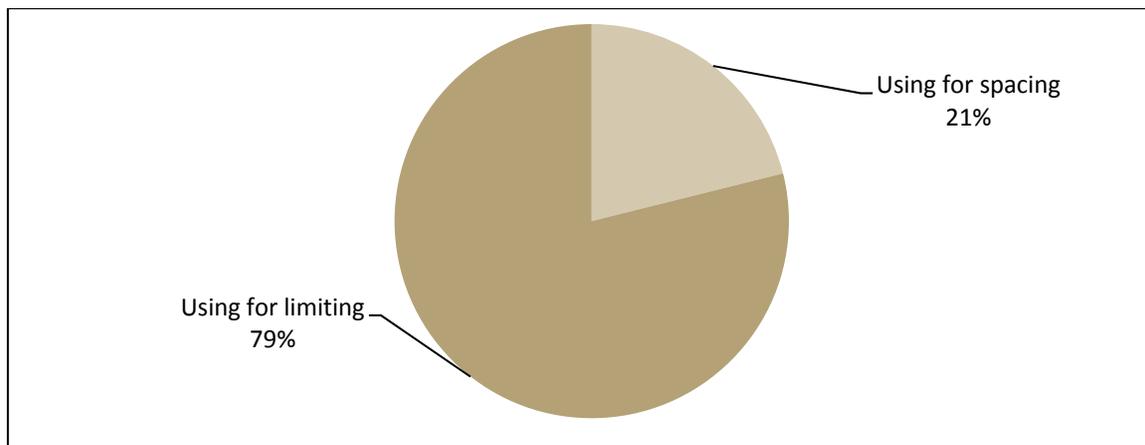
**Figure 7.1: Distribution of current users by method mix**



### Current Use and Desire for Children

For current users of contraception, it is important to determine how many are using a contraceptive method for spacing purpose, and how many are using to stop having children altogether. Figure 7.2 shows this by current method. Overall, 79 percent of current use was for limiting purpose compared with 21 percent for spacing.

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

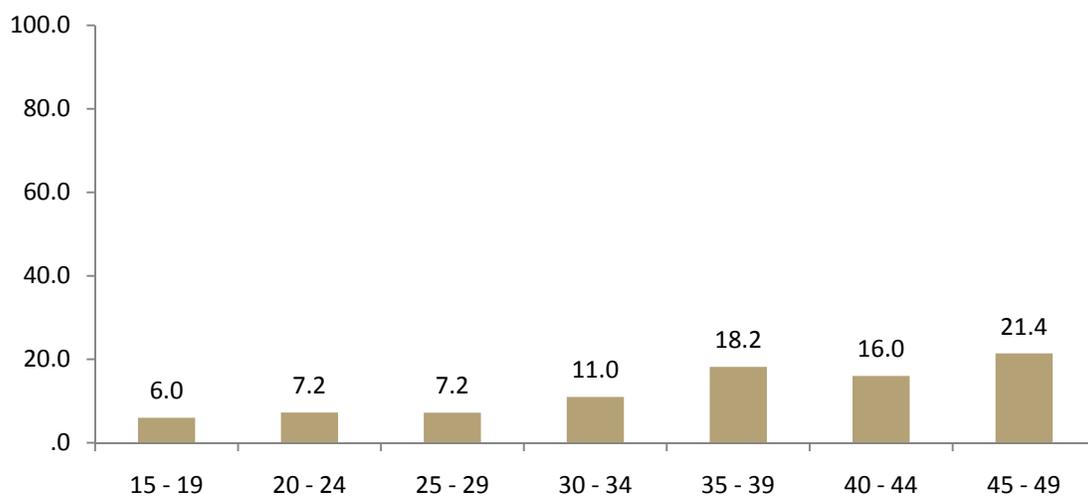


### Correlates of Contraceptive Use

Figure 7.3 shows the relationship between contraceptive prevalence and the women’s ages. The shape of the graph for age reflects the low prevalence among younger women and higher prevalence for older age women. The CPR for the age group 15-19 years was 6. The prevalence was highest among women in the age group 45 -49.

Figure 7.4 indicates the contraceptive prevalence by the number of living children. Those who had more children had a higher contraceptive prevalence rate. A maximum CPR of 18 percent was recorded for women who had 5 or more children.

**Figure 7.3: Contraceptive prevalence by age**



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

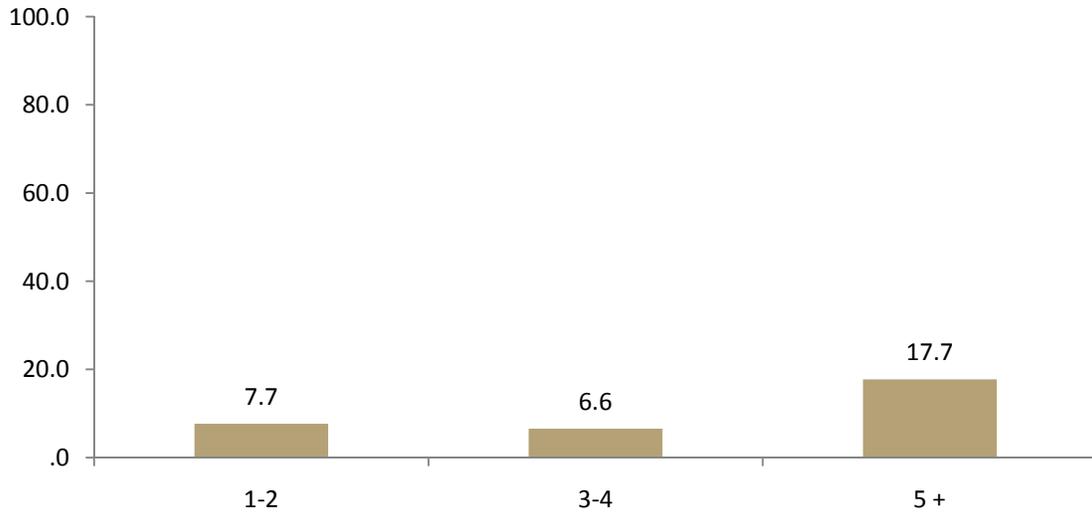


Table 7.3 shows that contraceptive use was associated with socioeconomic status and residence. Respondents in households with the highest SLI had a substantially higher contraceptive prevalence (34 percent) than those with the lowest SLI (6 percent). Conversely, women from households with a low SLI (83 percent) were more likely to be never users. Similarly, respondents' literacy was associated with higher current use and lower never use. An association of CPR was observed between SLI and literacy in the past users. Owning a television was positively associated with current or past use. Past and current users were more likely to live in urban areas, while more never users lived in rural areas.

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

Characteristic	Contraceptive use status			Total	
	Current user	Past user	Never user	N	%
<b>Standard of living index</b>					
Low	5.6	11.1	83.3	234	100.0
Medium low	10.4	16.2	73.4	154	100.0
Medium high	11.5	17.7	70.8	113	100.0
High	34.0	40.4	25.5	47	100.0
<b>Ownership of television</b>					
Yes	16.5	25.2	58.3	103	100.0
No	9.2	14.4	76.4	445	100.0
<b>Literacy of respondent</b>					
Literate	21.6	43.2	35.1	37	100.0
Illiterate	9.7	14.7	75.6	504	100.0
<b>Residence</b>					
Rural	9.4	15.7	74.9	521	100.0
Urban	33.3	29.6	37.0	27	100.0
<b>Total</b>	<b>10.6</b>	<b>16.4</b>	<b>73.0</b>	<b>548</b>	<b>100.0</b>

## Source of Method

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

From this table, it is clear that the source depends on the method. Condoms were obtained mostly from the husband; IUDs were mostly inserted at government facilities; injectables were mostly obtained from government facilities or through husbands. Female sterilization was mostly carried out at the DHQ hospital and to a lesser extent in private hospitals. These statements hold true for both current and past users.

**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)	0.0	16.7	9.2	0.0	85.7	9.6
BHU/RHC/MCH Centre	2.4	50.0	32.9	0.0	0.0	19.9
MSU	0.0	0.0	1.3	0.0	0.0	0.7
LHW/TBA/dai	14.3	0.0	6.5	13.3	0.0	8.9
Pvt. hospital/clinic/doctor	0.0	33.4	11.8	0.0	14.3	8.2
Dispenser/compounder	7.1	0.0	9.2	0.0	0.0	6.8
Pharmacy/chemists/ grocery shop	9.5	0.0	2.6	0.0	0.0	4.2
Husband brings method	66.7	0.0	26.3	86.7	0.0	41.8
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>
S	42	6	76	15	7	146

# Chapter 8

## Experience with Contraceptive Methods

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

### Reasons for Method Choice

In this survey, current and past users were asked the reasons they chose a particular method. A list of possible reasons was read out to them, and the results are shown in Table 8.1.

Overall, the reasons for current and past users were similar, so the data has been combined. Among the most common reasons for choosing a method were convenience of use, easily available, suitability for respondent and husband, low cost, effectiveness for longer period and no or few side effects. For IUD and female sterilization, suitability for respondent/husband was cited by all. Less frequently cited was method always available. Provider's advice and no other method available were mentioned by a few. Clients tend to make decisions according to the known attributes of the various methods, but not always. For example, about 86 percent of both current and past pill users cited. No/fewer side effects as a reason for choosing the pill, even though it is in fact associated with a number of common side effects.

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

Reason	Contraceptive method					Total
	Pill	IUD	Injectables	Condom	Female sterilization	
Easily available	97.6	83.3	97.4	100.0	85.7	96.6
Low cost	100.0	83.3	86.8	100.0	42.9	89.7
Convenient to use	100.0	83.3	98.7	93.3	85.7	97.3
Suitable for respondent/ husband	92.9	83.3	94.7	93.3	71.4	92.5
No/fewer side effects	85.7	66.7	65.8	73.3	42.9	71.2
Can be used for long period	76.2	100.0	64.5	86.7	100.0	73.3
No other method available	2.4	16.7	6.6	6.7	0.0	5.5
Method always available	76.2	0.0	53.9	66.7	0.0	56.8
Provider advised	9.5	16.7	6.6	0.0	14.3	7.5
<b>N</b>	<b>42</b>	<b>6</b>	<b>76</b>	<b>15</b>	<b>7</b>	<b>146</b>

Respondents could give more than one reason

To look more specifically at why some users prefer traditional methods to modern ones, the current traditional method users were asked why they were not using modern methods. All reasons were cited by 50 percent.

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

Reason for not using	Percentage
Method not available	50.0
Cost too much	50.0
Doesn't know about modern methods	50.0
Doesn't know about source of method	50.0

Respondents could give more than one reason

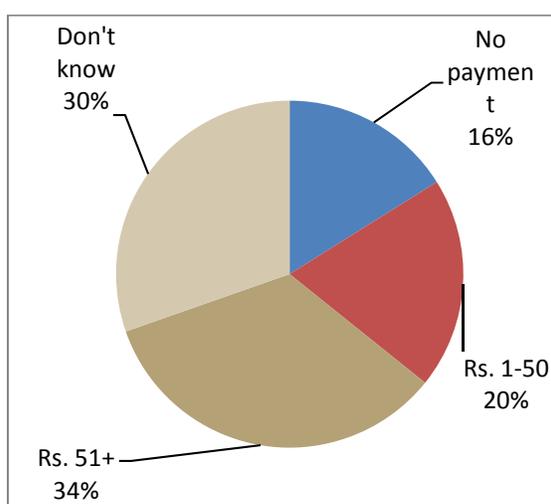
## Cost, Distance and Time to Reach a Facility

Costs to users of contraceptive methods vary widely in Pakistan according to method, whether public or private sector, and the distance from the home to the facility. Table 8.3 and Figure 8.1 show the reported costs the last time the women obtained the method. Only 16 percent of the clients reported that they were not charged for the contraceptives. A great number (30 percent) did not know about charges. Fifty-four percent paid. However, 34 percent paid more than 50 rupees.

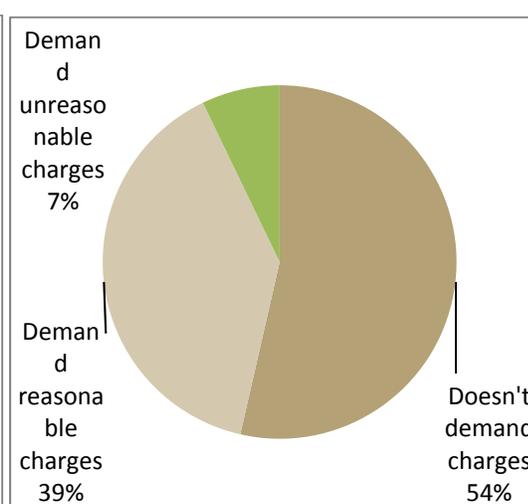
**Table 8.3: Distribution of costs of current specific contraceptive method**

Method	Cost (in rupees)					Total	
	No payment	1-20	21-50	51+	Don't know	%	N
Pills	8.3	50.0	0.0	0.0	41.7	100	12
IUD	33.3	0.0	33.3	33.3	0.0	100	3
Injectables	0.0	8.0	8.0	64.0	20.0	100	25
Condom	0.0	0.0	0.0	22.2	77.8	100	9
Female sterilization	100.0	0.0	0.0	0.0	0.0	100	7
<b>Total</b>	<b>16.1</b>	<b>14.3</b>	<b>5.4</b>	<b>33.9</b>	<b>30.4</b>	<b>100</b>	<b>56</b>

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



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



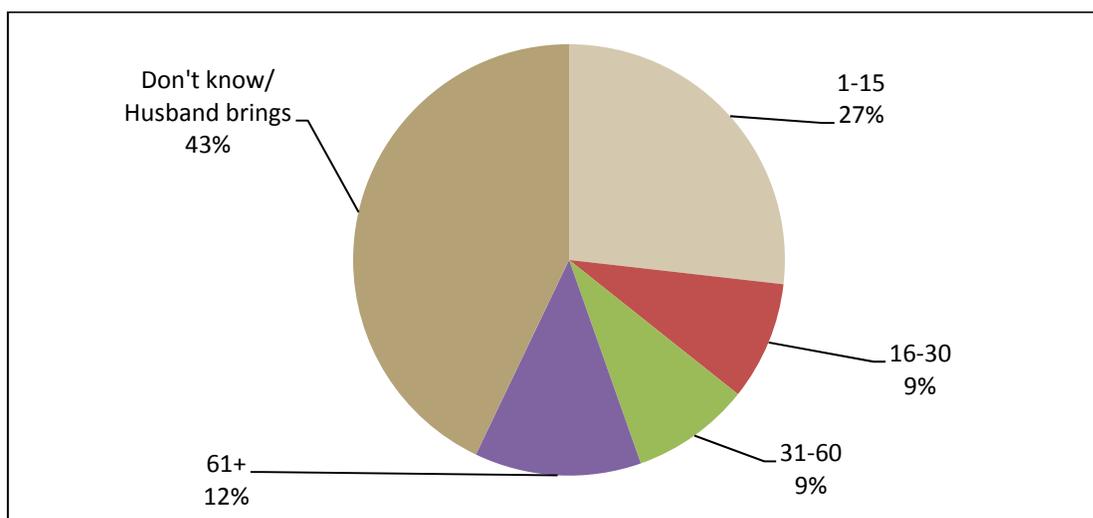
Current users were also asked whether their facility charged them for service, other than the method itself. Fifty-four percent said they were not charged, 39 percent were charged a reasonable amount, and only 7 percent said they were charged an unreasonable amount.

The time usually needed for current users to obtain a specific method is shown in Table 8.4, while Figure 8.2 shows the overall travel time in minutes to acquire the contraceptive method. A large number (43 percent) did not know the time spent to get the contraceptive as husband brought the method. However, 12 percent claimed to have spent more than 60 minutes to seek the contraceptive.

**Table 8.4: Distribution of current contraceptive users by time to reach specific contraceptive service**

Method	Time (in minutes)					Total	
	1-15	16-30	31-60	61-180	Don't know/ husband brought	%	N
Pills	25.0	0.0	0.0	0.0	75.0	100	12
IUD	0.0	33.3	0.0	66.7	0.0	100	3
Injectable	40.0	16.0	12.0	8.0	24.0	100	25
Condom	11.1	0.0	0.0	0.0	88.9	100	9
Female sterilization	14.3	0.0	28.6	42.9	14.3	100	7
<b>Total</b>	<b>26.8</b>	<b>8.9</b>	<b>8.9</b>	<b>12.5</b>	<b>42.9</b>	<b>100</b>	<b>56</b>

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



## Treatment by Provider

### Information Provided

Current and past users were asked what information the service provider might have given them. For this purpose, list of important topics was read out to them (Table 8.5). The accuracy of clients' responses may be questioned due to problems of recall or understanding it; however, it appears that information provided is seriously inadequate. The most common topics respondents said they were told about were effectiveness/duration, how to use the method and advantages. Others were rated less important. A few were told about side effects and what to do if experienced side effects particularly in case of pills users no one was told about side effects. Condom users were given less information in general than users of clinical methods.

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

Information provided at acceptance	Family planning method					Total
	Pill	IUD	Injectables	Condom	Female sterilization	
How the method works	16.7	33.3	15.8	0.0	14.3	15.1
How to use method	54.8	50.0	40.8	13.3	42.9	42.5
Contraindications	0.0	0.0	14.5	0.0	0.0	7.5
Effectiveness/duration of effectiveness	35.7	83.3	81.6	20.0	85.7	62.3
Advantages compared to other method	9.5	33.3	35.5	13.3	28.6	25.3
Possible side effects	0.0	16.7	7.9	6.7	0.0	5.5
What to do if experienced side effects	0.0	16.7	6.6	0.0	0.0	4.1
Possibility of switching	4.8	16.7	17.1	0.0	0.0	11.0
About other method that you could use	2.4	16.7	7.9	6.7	14.3	6.8
<b>N</b>	<b>42</b>	<b>6</b>	<b>76</b>	<b>15</b>	<b>7</b>	<b>146</b>

Respondents could give more than one response

## Treatment at Facility

Current users were asked about various aspects of their treatment when they last visited a provider for family planning. As Table 8.6 shows, responses were mainly positive. However, 46 percent informed that they were charged.

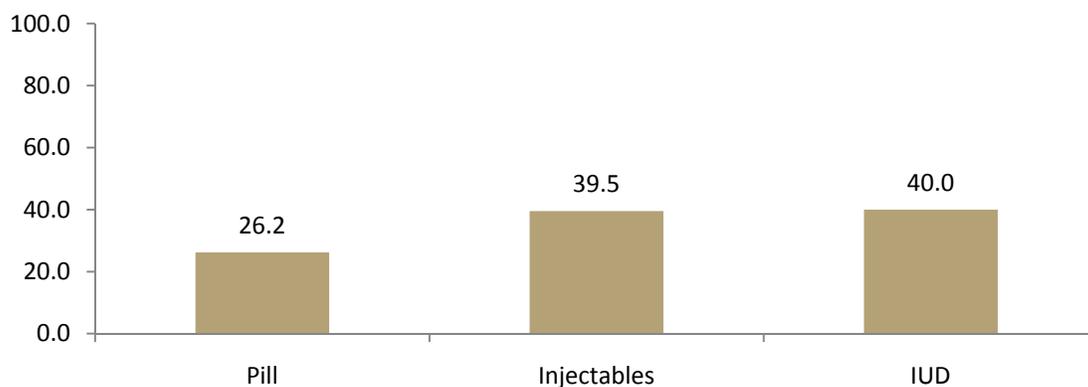
**Table 8.6: Percent current users responding positively on treatment at last visit, by aspect of treatment**

Aspect of treatment	Percentage
Staff attitude cooperative	100.0
Provider available	96.7
Attend/examine properly	88.9
Doesn't demand charges	53.6
Can deal with side effects	85.7

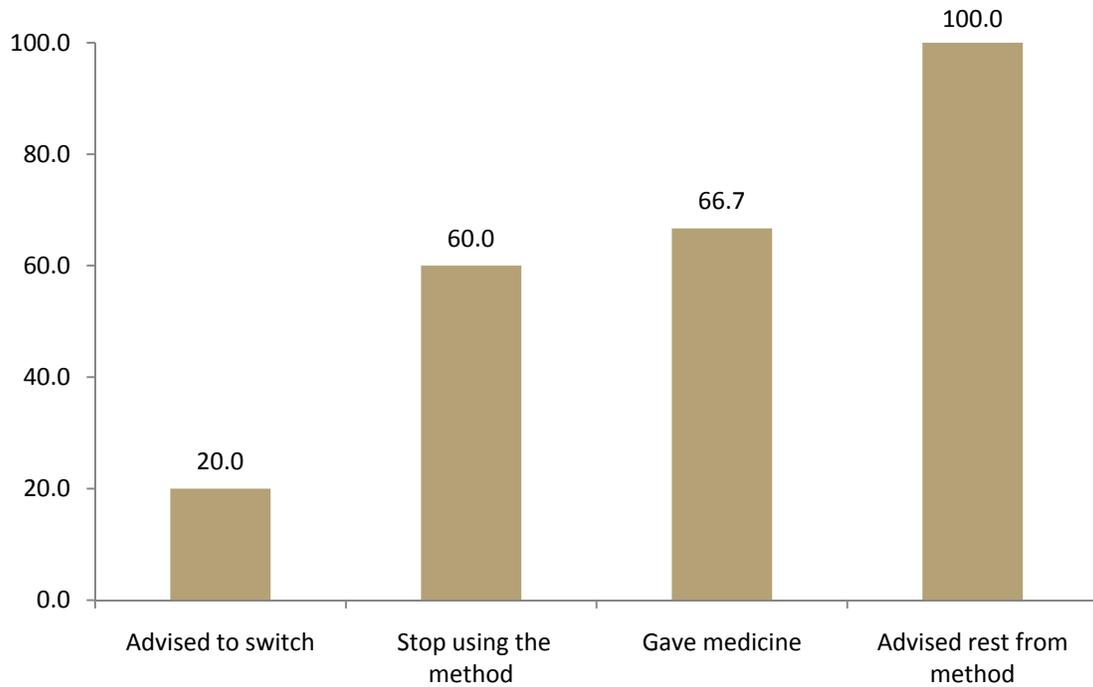
## Side Effects

Current users were asked if they had experienced, or were experiencing any side effects from their current method. Past users were asked if side effects were among the reasons for their discontinuation. If so, a list of possible side effects was read out to them, and they were asked if they had experienced them. Multiple responses were allowed. Fifty-eight current users and 148 past users (21 percent of all current and past users) responded positively. As shown in Figure 8.3, side effects were most commonly reported by IUD (40 percent), injectable (39 percent) and pill (26 percent). No side effects were reported in case of female sterilization and condoms.

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



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



The past users who reported experiencing side effects and consulted someone for the management of side effects were asked if the provider took any measures given in the list of possible responses (Figure 8.4). Sixty percent were advised to stop the method, 67 percent were given medicine, 100 percent were advised to take rest from the method and 20 percent were asked to switch the method.



# Chapter 9

## Reasons for Non-use

There are many reasons why a couple may not be using birth spacing at any given time. The women may already be pregnant, the couple may want another child soon, the women may already have passed menopause, or believe themselves to be sterile. Other reasons may prevent couples from using contraception 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 using 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. Ninety-eight percent of non-users mentioned husband's disapproval and FP against religion followed by possibility of getting pregnant while using any method (65 percent), problem of managing side effects (65 percent) and fear of side effects (64 percent). Religious opposition carries much weight; following side effects as a big hindrance. This calls for a strong IEC campaign and may be the subject of interest of communication experts for strategy formulation of IEC.

**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 users		Past users		Never users	
	N	%	N	%	N	%
Husband's disapproval	57.0	98.3	89.0	98.9	392.0	98.0
Other people may find out about contraceptive use	34.0	58.6	32.0	35.6	204.0	51.0
Distance and travel costs to FP outlet	43.0	74.1	58.0	64.4	248.0	62.0
Probability of getting pregnant while using contraceptives	47.0	81.0	74.0	82.2	260.0	65.0
Fear of side effects	46.0	79.3	75.0	83.3	254.0	63.5
Problem of managing side effects	45.0	77.6	76.0	84.4	260.0	65.0
FP is against religion	55.0	94.8	87.0	96.7	393.0	98.3
<b>N</b>	<b>58</b>	<b>na</b>	<b>90</b>	<b>na</b>	<b>400</b>	<b>na</b>

na=not applicable.

Respondents could give more than one response.

## Past Users

### Reasons for Discontinuing Contraceptive Use

Table 9.2 shows past users by reason for discontinuing their last contraceptive method (more than one reason was permitted). Several reasons were given. The most common reason given was side effects experienced (40 percent) followed by desire for another child (38 percent), husband's advice (34 percent), infrequent sex/husband away (26 percent) and rest from method (24 percent). Other reasons carried less weight.

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

Reason	Percentage
Wanted another child	37.8
Fear of side effects	1.1
Side effects experienced	40.0
Method failure	7.8
Lack of access/unavailability	3.3
Cost not affordable	3.3
Method inconvenient to use	3.3
Rest from method	24.4
Provider's advice	3.3
Infrequent sex/Husband away	25.6
Husband's advice	34.4
In laws appose	2.2
<b>N</b>	<b>90</b>

Respondents could give more than one reason.

### Reasons for Current Non-use

It is important to know the reasons why couples who had used contraception in the past but are not currently using any method. Past users were read out a list of possible reasons for their not currently using a method, with more than one reason possible (Table 9.3). The most common reason was Breastfeeding/lactational amenorrhea and Infrequent sex/husband away (32 percent for each) and fear of side effects (26 percent). Other reasons were less important.

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

Reason	Percentage
Fear of side effects	25.6
Want another child	15.6
Currently pregnant	16.7
Rest from method	7.8
Provider's advice	5.6
Infrequent sex/husband away	32.2
Breast feeding/lactational amenorrhea	32.2
Just not using/too lazy	3.3
Others	2.2
<b>N</b>	<b>90</b>

Respondents could give more than one response.

## Never Users

### Reasons for Non-use

The 400 women in the sample who reported never use were asked about various possible reasons for not using any method, with each reason read out separately. For these women, the most important reason was desire for more children (91 percent) followed by husband's opposition (50 percent) and infrequent sex/husband away (37percent). However, significant number also cited opposition of in-laws, breastfeeding and lack of access/unavailability (Table 9.4).

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

Reason	Percentage
Husband opposes	49.8
In laws oppose	27.8
Fear of side effects	10
Lack of access/Unavailability	15.8
Cost not affordable	12.3
Shy to consult about family planning	4.5
Method inconvenient to use	4.5
Infrequent sex/Husband away	36.8
Difficult/Unable to conceive	15.3
Breast feeding/lactational amenorrhea	23.8
Respondent/Husband infertile	0.3
Wanted (more) children	90.5
Against religion	2.8
Others	0.8
<b>N</b>	<b>400</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 disapproved of family planning in principle, as opposed to accepting it in principle but not using any method for some other reason. Table 9.5 shows this for never using respondents. Approval for limiting and spacing was the same (80 percent).

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

Attitude	Attitude towards spacing		Attitude towards limiting	
	N	%	N	%
Approve	321	80.3	321	80.3
Disapprove	77	19.3	78	19.5
Don't know	2	0.4	1	0.2
<b>Total</b>	<b>400</b>	<b>100.0</b>	<b>400</b>	<b>100.0</b>

## Knowledge of Contraceptive Users, Methods and Facilities

Of the 400 female never users in the sample, 50 percent reported knowing some woman who had ever used a method to delay or avoid pregnancy, 41 percent knew a relative, and 31 percent knew friends or neighbors.

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

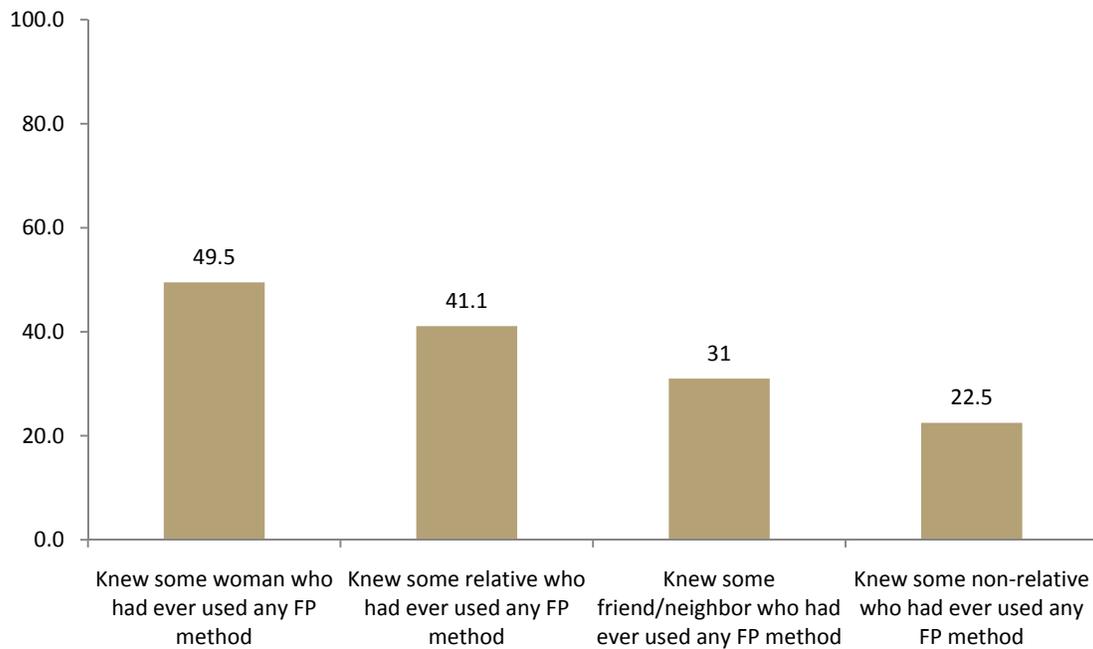


Table 9.6 shows that almost all never users (98 percent) knew of at least one method, but for each method there was a knowledge variation. Pills and injectables were the most widely known methods.

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

Method	Percentage
Female sterilization	79.4
Male sterilization	19.5
Pill	97.7
IUD	80.7
Injectables	94.0
Norplant	4.3
Condom	51.9
Rhythm	1.3
Withdrawal	22.1
Emergency Pills	1.5
At least one FP method	98.3
<b>N</b>	<b>400</b>

Respondents could give more than one response.

The knowledge of different sources of contraception was poor. Only 47 percent of the never users knew at least one place to obtain a method. For those who did know, the places they were aware of are shown in Table 9.7. The sources best known were health department outlets – BHUs/RHCs/MCH centers and District/Tehsil Headquarters hospitals. A few knew about Family Welfare Centers of the Ministry of Population Welfare.

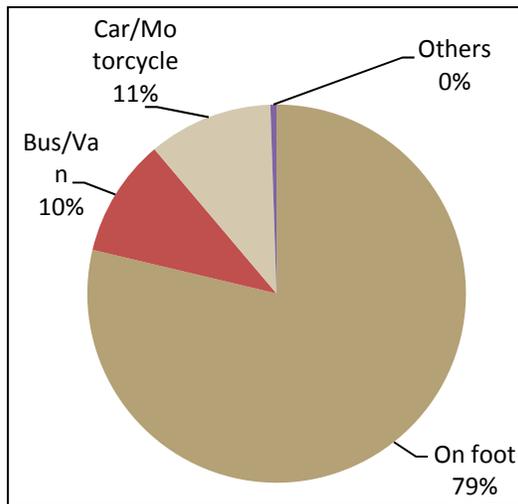
**Table 9.7: Knowledge of sources of contraception of never users by source of supply**

Source	Percentage
Knowledge of at least one service provider	46.8
DHQ/THQ hospital	21.5
BHU/RHC/MCH Centre	39.5
Family Welfare Center	0.3
Lady Health Worker	3.8
Private hospital/ Clinic/ Doctor	11.8
Dispenser/ Compounder	5.3
Pharmacy/ Chemists	14.8
Homeopathic/ Hakim	0.5
TBA/ Dai	2.8
Grocery shop (not pharmacy/ chemist)	1.0
<b>N</b>	<b>400</b>

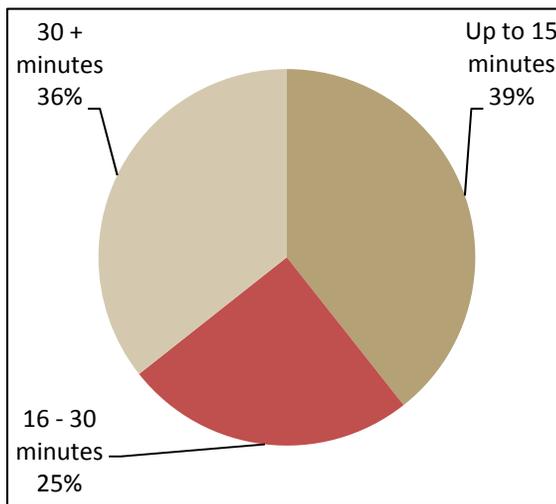
Respondents could give name more than one source.

When asked which of the facilities named was nearest, the respondents were again most likely to name BHU/RHC/MCH Centre and DHQ/THQ hospitals. Mostly they would go there on foot (Figure 9.2). Of the 59 respondents who indicated the time needed to go to the nearest facility, 39 percent gave a time up to 15 minutes, 25 percent gave a timeframe of 16 to 30 minutes, and 36 percent gave a time of more than 30 minutes (Figure 9.3).

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



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



### Intent to Use

When never users were asked about whether they intended to use contraceptives in the future, 26 percent of the female respondents did show their intention (respondents who believed they could get pregnant) (Table 9.8). It is interesting to note that lower parity women who had not yet used a method (29 percent of the women with 1-2 children) expressed their more intent to use a method in the future compared to high parity women.

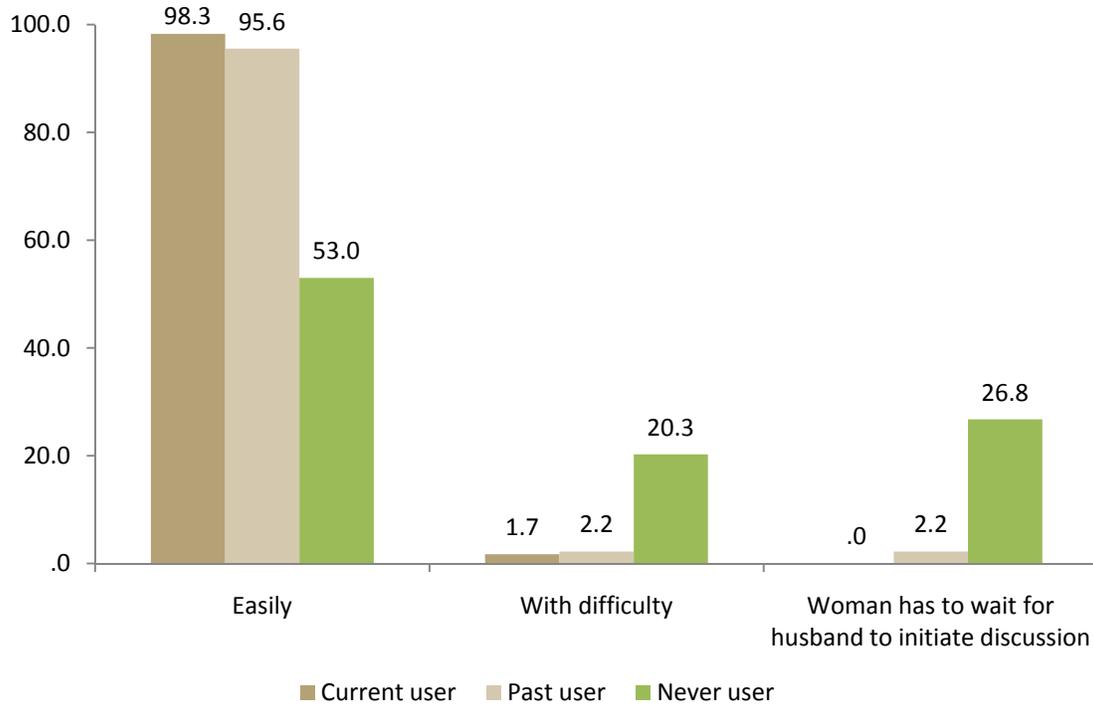
**Table 9.8: Distribution of never users by intent to use a method in future and number of living children**

Number of living children	Intention to use FP method in future				Total	
	Yes	No	Unsure/ Uncertain	Can't get pregnant	%	N
0	28.6	31.7	39.7	0.0	100.0	63
1-2	29.2	32.7	38.1	0.0	100.0	113
3-4	24.7	44.9	29.2	1.1	100.0	89
5 or more	23.7	56.3	20.0	0.0	100.0	135
<b>Total</b>	<b>26.3</b>	<b>43.3</b>	<b>30.3</b>	<b>0.3</b>	<b>100.0</b>	<b>400</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 the women said they could do so easily (Figure 9.4). However, this varied by use status. Ninety-eight percent of current users, and 96 percent of past users, said they could approach their husbands easily, and a few said they had to wait for their husband to initiate the discussion. For never users, 53 percent reported being able to approach their husbands easily, while 20 percent reported that they could only do so with difficulty, and another 27 percent saying they had to wait for their husband 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 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 contraception. Women currently pregnant or who are experiencing postpartum amenorrhea are said (in this formulation) to be in unmet need if their current or last (if amenorrheic) pregnancy was said to be unwanted or mistimed. Women who want to delay their next pregnancy are said to have an unmet need of spacing; those who do not want more children at all are said to have an unmet need for limiting. Women in unmet need in this sense are those for whom there is an inconsistency between what they say they want and what they are doing. These women would appear to be in need of some support to avoid unwanted pregnancies.

## Levels and Correlates

Table 10.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in Upper Dir. Of the total 548 women, 267 (49 percent) were judged to be in unmet need. This proportion was higher than is typically found in Pakistan, where unmet need tends to be around 37 percent of MWRA. This higher proportion may be a reflection of the relatively lower contraceptive prevalence. Lower level of use may mean that less of the total demand for family planning was being met.

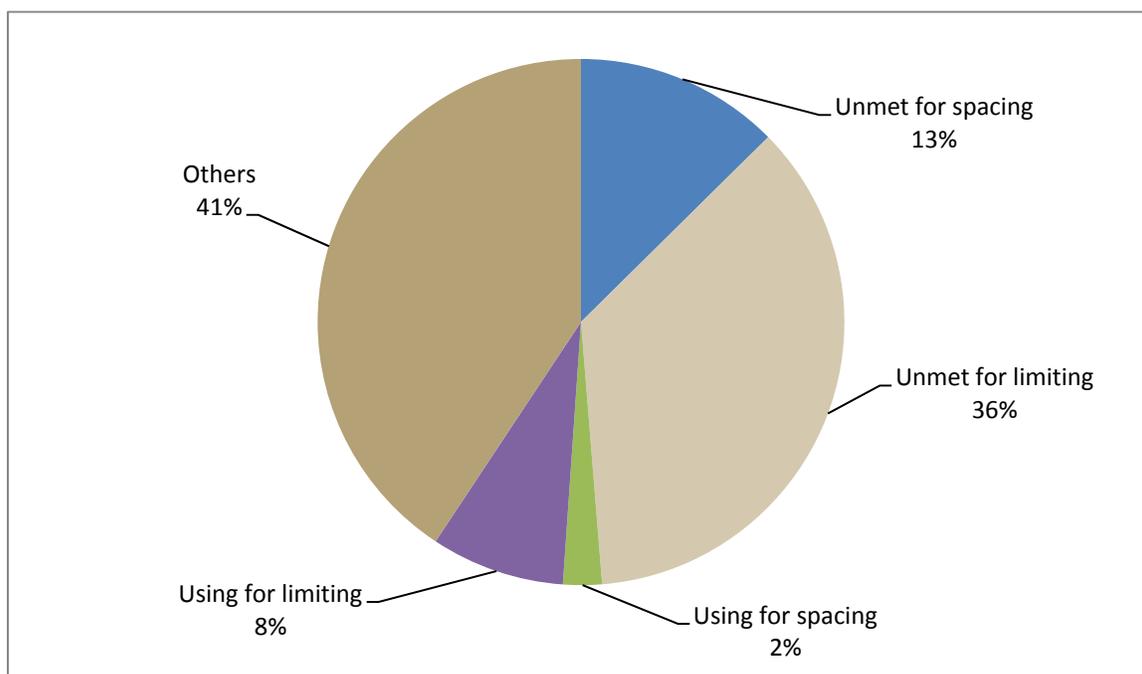
Of the 49 percent women who had unmet need, 13 percent were for spacing, while 36 percent for limiting. Unmet need for spacing was concentrated among women with 1-2 children. Unmet need for limiting in Upper Dir was high among women with five or more children.

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

Characteristic	Unmet need			Met need			Total demand	Not in need	Total	
	For spacing	For limiting	Total	For spacing	For limiting	Total			%	N
<b>Age of respondent</b>										
15 – 24	21.3	10.6	31.9	5.9	1.1	7.0	38.9	61.1	100.0	188
25 – 34	11.1	39.8	50.9	0.9	7.9	8.8	59.7	40.3	100.0	216
35 – 49	3.5	63.9	67.4	0.0	18.1	18.1	85.5	14.5	100.0	144
<b>Type of community</b>										
Rural	12.7	36.9	49.6	1.7	7.7	9.4	59.0	41.0	100.0	521
Urban	11.1	22.2	33.3	14.8	18.5	33.3	66.6	33.4	100.0	27
<b>Literacy of respondent</b>										
Literate	18.9	24.3	43.2	13.5	8.1	21.6	64.8	35.2	100.0	37
Illiterate	11.9	37.1	49.0	1.6	8.1	9.7	58.7	41.3	100.0	504
<b>Education of respondent</b>										
No education	11.8	37.2	49.0	1.4	8.4	9.8	58.8	41.2	100.0	500
Up to primary	21.7	21.7	43.4	8.7	8.7	17.4	60.8	39.2	100.0	23
Up to Secondary	11.8	35.3	47.1	17.6	5.9	23.5	70.6	29.4	100.0	17
Above secondary	42.9	0.0	42.9	14.3	0.0	14.3	57.2	42.8	100.0	7
<b>Children ever born</b>										
None	1.6	4.8	6.4	0.0	0.0	0.0	6.4	93.6	100.0	62
1 – 2	26.7	8.1	34.8	6.7	0.7	7.4	42.2	57.8	100.0	135
3 – 4	18.6	32.7	51.3	2.7	4.4	7.1	58.4	41.6	100.0	113
5 or more	4.6	61.8	66.4	0.4	16.4	16.8	83.2	16.8	100.0	238
<b>Ownership of TV</b>										
Yes	14.6	35.0	49.6	6.8	9.7	16.5	66.1	33.9	100.0	103
No	12.1	36.4	48.5	1.3	7.9	9.2	57.7	42.3	100.0	445
<b>Standard of living index</b>										
Low	11.1	38.9	50.0	0.4	5.1	5.5	55.5	44.5	100.0	234
Medium low	14.9	35.7	50.6	2.6	7.8	10.4	61.0	39.0	100.0	154
Medium high	13.3	36.3	49.6	2.7	8.8	11.5	61.1	38.9	100.0	113
High	10.6	23.4	34.0	10.6	23.4	34.0	68.0	32.0	100.0	47
<b>Total</b>	<b>12.6</b>	<b>36.1</b>	<b>48.7</b>	<b>2.4</b>	<b>8.2</b>	<b>10.6</b>	<b>59.3</b>	<b>40.7</b>	<b>100.0</b>	<b>548</b>

The correlations between unmet need and various socioeconomic indicators varied by whether the unmet need was for spacing or for limiting. Unmet need for limiting was strongly associated with illiteracy and rural residence. Unmet need for spacing was also associated with rural residence, and more literate women as compared to the illiterate women were in unmet need for spacing. However, conclusions should be tentative, given the small sample sizes involved. Figure 10.1 shows the need and demand for family planning of the sampled women.

**Figure 10.1: Need and demand for family planning**



## Total Demand

The sum of current use (“met need”) and unmet need is often called “total demand” for family planning. It would normally be expected to rise with the number of living children a couple has. Table 10.1 shows total demand by background characteristics of the women. Overall, total demand was 59 percent of all married women of reproductive age. As the table shows, total demand rose rapidly, and fairly consistently, by the 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). Fifty-nine percent of the women with unmet need for spacing said they would be worried if they became pregnant. Twenty-four percent said they would accept and 14 percent would be pleased. Of those with unmet need for limiting, 73 percent said they would be worried if they became pregnant. It is perhaps not unreasonable for women to be more concerned about the consequences of an unwanted pregnancy than about the consequences of a wanted pregnancy coming too soon.

**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	9	13.6	1	0.5
Worried	39	59.1	136	72.7
Accept it	16	24.2	49	26.2
Doesn't matter	2	3.0	1	0.5
<b>Total</b>	<b>66</b>	<b>100.0</b>	<b>187</b>	<b>100.0</b>

## Reasons of Non-use

Women with unmet need were asked (whether they were never users or past users) why they were not using some method of contraception; the results are shown in Table 10.3. Some of these reasons represent barriers as perceived by the women. The most important of these hindrances were: opposition by husbands and in-laws, fear of side effects and lack of access/unavailability. On the other hand, many women with defined unmet need gave reasons that did not reflect perceived need, at least at present. The most important reason was desire for more children.

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

<b>Reason</b>	<b>Unmet need for spacing</b>	<b>Unmet need for limiting</b>	<b>Total unmet need</b>
Fear of side effects	14.5	17.7	16.9
Husband opposes	47.8	38.9	41.2
In laws oppose	30.4	16.7	20.2
Rest from method	0.0	3.0	2.2
Shy to consult about FP	4.3	4.0	4.1
Provider's advice	0.0	2.0	1.5
Against religion	0.0	3.5	2.6
Lack of access/Unavailability	10.1	10.1	10.1
Cost not affordable	4.3	9.6	8.2
Just not using/too lazy	0.0	1.5	1.1
Method inconvenient to use	2.9	3.5	3.4
Infrequent sex/Husband away	39.1	40.4	40.1
Difficult/Unable to conceive	14.5	4.5	7.1
Want (more) children	87.0	57.1	64.8
Currently pregnant	1.4	2.0	1.9
Breast feeding/lactational amenorrhea	2.9	3.5	3.4
Others	0.0	2.5	1.9
<b>N</b>	<b>69</b>	<b>198</b>	<b>267</b>

Respondent s could give more than reason

## Unmet Need for Spacing: Profile

Women with unmet need for spacing comprise 69 (12.6 percent) of MWRA. As shown in Table 10.4, they were characterized by:

- **Living Children:** Most (55 percent) had 1 or 2 living children.
- **Family Planning Use:** More never users (87 percent) than past users (13 percent).
- **Strength of Preference:** High (59 percent “worried” if they became pregnant earlier than they wanted compared to those who were pleased (14 percent) or would accept (24 percent) the unwanted pregnancy).
- **Intent to use FP method in future:** Low (29 percent intended to use an FP method in future).
- **Approval of FP:** High (77 percent approved of using an FP method for spacing purpose).
- **FP Communication with Husband:** Low (33 percent had communicated with husbands on FP in the past one year; while 17 percent said approaching the husband was “difficult”).
- **Obstacles to FP Use:** Fear of side effects (15 percent); husband and in-laws opposition (48 percent and 30 percent respectively) (Table 10.3).

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

Characteristics	Unmet need for spacing		Unmet need for limiting	
	N	%	N	%
<b>Number of living children</b>				
0	1	1.4	3	1.5
1-2	38	55.1	12	6.1
3-4	21	30.4	43	21.7
5 or more	9	13.0	140	70.7
<b>Contraceptive use status</b>				
Current user	0	0.0	0	0.0
Past user	9	13.0	52	26.3
Never user	60	87.0	146	73.7
<b>Reaction if become pregnant in near future</b>				
Pleased	9	13.6	1	0.5
Worried	39	59.1	136	72.7
Accept it	16	24.2	49	26.2
Doesn't matter	2	3.0	1	0.5
<b>Intention to use a method in future</b>				
Yes	20	29.0	66	33.3
No	26	37.7	73	36.9
Unsure/Uncertain	23	33.3	59	29.8
<b>Approval of FP</b>				
Approve	53	76.8	168	84.8
Disapprove	16	23.2	29	14.6
Others	0	0.0	1	0.5
<b>FP communication with husband in past one year</b>				
Never	46	66.7	113	57.1
Once or twice	13	18.8	49	24.7
More often	10	14.5	36	18.2
<b>Approach the topic of FP with husband</b>				
Easily	38	55.1	128	64.6
With difficulty	12	17.4	37	18.7
Respondent has to wait for husband to initiate discussion	19	27.5	33	16.7
<b>Total</b>	<b>69</b>	<b>100.0</b>	<b>198</b>	<b>100.0</b>

## Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 198 (36.1 percent) of MWRA. As shown in Table 10.4, they were characterized by:

- **Living Children:** A strongly positive association with number of living children; 71 percent had 5+ living children.
- **Family Planning Use:** More never users (74 percent) than past users (26 percent).
- **Strength of Preference:** High (73 percent would be “worried” if they became pregnant compared to those who would accept (26 percent) the unwanted pregnancy).
- **Intent to use FP method in future:** Low (33 percent intended to use an FP method in future).
- **Approval of FP:** High (85 percent approved of FP for limiting purpose).
- **FP Communication with Husband:** Low (43 percent had communication with husband on FP in the past year; while 19 percent said approaching the husband was “difficult”).
- **Obstacles to FP Use:** Fear of side effects (18 percent); husbands and in-laws opposition (39 percent and 17 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 district. The intention was to interview as many husbands as possible who were available when the household interviews were undertaken. Knowing that some number of husbands might be at their places of work during the timing of the interviews, the plan was to then make up for any of the husbands who were unavailable, by interviewing other married men available in the selected communities in order to come as close as possible to meeting the objective of interviewing 200 husbands/men in each FALAH district. In Upper Dir, the field team was able to interview 162 men who were husbands of the married women of reproductive age interviewed for the survey, plus 38 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 only 0.5 percent of the men were under 25 years of age and 17 percent were 50 years of age and above.

As shown in Table 11.1, the men were substantially better educated than the sampled currently married women of reproductive age. Thirty-nine percent of the men had not been to school, compared to 91 percent of the currently married women (Table 3.2). It also shows that 45 percent of the men had more than primary education, whereas only 4 percent of the currently married women had attained that level of education (Table 3.2).

The occupations of men are also presented in Table 11.1. The highest proportion (33 percent) of men was working as daily wage laborers. After agriculture activities (27 percent), 19 percent men were engaged in their own business. Eight percent were unemployed.

Table 11.1: Background characteristics of male respondents

Characteristics	Percentage
<b>Age</b>	
20-24	0.5
25-29	7.5
30-34	25.5
35-39	18.0
40-44	17.0
45-49	14.0
50-54	11.0
55+	6.0
<b>Education</b>	
Proportion literate	59.0
No education	38.5
Up to primary	17.0
Up to Secondary	31.0
Above secondary	13.5
<b>Occupation</b>	
Agriculture/Livestock/Poultry	27.0
Petty trader	0.5
Labor	32.5
Govt. service	11.5
Pvt. Service	3.5
Own business	19.0
Abroad	3.5
Unemployed	8.0
Others	1.5
<b>N</b>	<b>200</b>

## Contraceptive Knowledge and Use

All of the interviewed men in Upper Dir knew of at least one modern method of contraception. As shown in Table 11.2, knowledge of modern methods was highest for pills (99 percent) followed by injectables (98 percent) and female sterilization (77 percent). The least known methods were Norplant (1 percent) and male sterilization (2 percent). Almost all currently married women of reproductive age interviewed in Upper Dir also knew at least one contraceptive method (Table 7.1).

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

Methods	Knowledge	Ever use	Current use
Female sterilization	77.0	1.0	1.0
Male sterilization	1.5	0.0	0.0
Pill	99.0	8.0	2.5
IUD	25.5	2.0	1.0
Injectables	98.0	15.5	7.0
Norplant	1.0	0.0	0.0
Condom	71.5	5.0	3.5
Rhythm	15.0	0.5	0.0
Withdrawal	38.0	4.5	2.5
Others	0.0	0.0	0.0
At least one FP method	100.0	28.0	16.5
At least one modern FP method	100.0	23.5	14.0
At least one traditional FP method	46.5	5.0	2.5
Emergency Pills	4.0	0.0	na
<b>N</b>	<b>200</b>	<b>200</b>	<b>200</b>

na=not applicable.

The pattern of ever use and current use of contraception reported by husbands is also shown in Table 11.2. About one quarter (27 percent) of the MWRA reported having used some method of contraception during their married lives (Table 7.2); of the male respondents, 28 percent reported ever using some method of contraception in their married lives. For the men, among modern methods, injectables was the most popular method ever used (16 percent), followed by pill (8 percent).

As mentioned in Table 7.2, 11 percent of all MWRA in the sample were currently using some method of contraception, while for the male respondents this figure was slightly higher at 17 percent. The most common current modern methods reported by male respondents were injectables (7 percent) and condoms (4 percent). Although, almost half of the men knew about traditional methods, the use of these methods was in a lesser degree (2.5 percent). Emergency pills have never been in use.

Table 11.3 shows ever use and current use of modern contraception among respondents by background characteristics. More than 46 percent of the respondents who had secondary and above education reported ever use of any contraceptive method, compared to 22 percent of men with no education. The current use of family planning 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**

Characteristics	Ever used at least one FP method	Currently using any FP method	N
<b>Residence</b>			
Rural	27.9	16.8	190
Urban	30.0	10.0	10
<b>Education level</b>			
No education	22.1	13.0	77
Below secondary	17.5	9.5	63
Secondary and above	46.7	28.3	60
<b>Number of living children</b>			
None	0.0	0.0	17
1-2	19.6	12.5	56
3-4	28.3	10.9	46
5+	39.5	25.9	81
<b>Future desire for children</b>			
Soon	13.9	5.0	101
Later	32.1	17.0	53
Never	54.3	41.3	46
<b>Total</b>	<b>28.0</b>	<b>16.5</b>	<b>200</b>

Table 11.3 also shows a positive relationship between the number of living children and ever use as well as current use. Of those who had 5 or more children, 40 percent reported ever use of family planning methods compared to 28 percent who had 3-4 children and 20 percent who had 1-2 children. For current use, it is 26 percent who had 5+ children, 11 percent for those who had 3-4 children and 13 percent who had 1-2 children.

Table 11.3 also shows contraceptive current use by the future desire for children. Highest current use was found among the male respondents who said they did not want any more children: 41 percent of those respondents who did not want more children were currently using a contraceptive method, and 54 percent had used some form of contraception in their reproductive life.

## Source of Contraceptive Methods

As shown in Table 11.4, among those who reported the last source for obtaining contraceptive methods, 51 percent reported that they obtained it from pharmacy /chemists, 17 percent obtained it from the “grocery shop/general store” 13 percent from BHU/RHC/MCH Centre and 11 percent from the “Government hospital (DHQ/THQ)”. LHWs were reported by only 2 percent.

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

Source	Percentage
Govt. hospital (DHQ/THQ)	10.6
BHU/RHC/MCH Centre	12.8
LHW	2.1
Dispenser/Compounder	4.3
Pharmacy, chemist	51.1
Grocery shop/general store	17.0
Wife brings method	2.1
<b>Total</b>	<b>100.0</b>
N	47

## Approval of Family Planning

Respondents were asked about their approval of birth spacing and use of any form of contraception for spacing purpose. A husband's opposition may prevent his wife from using contraception, even when she wants to delay or stop childbearing (Casterline, Perez, and Biddlecom, 1997). It is very interesting to know that in Upper Dir, almost all men approved spacing between children and 86 percent also approved of the use of any form of contraception for this purpose (Table 11.5).

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

Variable	Percentage
<b>Spacing between children</b>	
Approve	99.5
Disapprove	0.5
Total	100.0
N	200
<b>Using family planning methods for spacing</b>	
Approve	86.0
Disapprove	13.5
Others	0.5
<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 they continue with the method. Male contraceptive users were asked to report how satisfied they were with their present contraceptive method. Table 11.6 shows all men were very satisfied with their current method.

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

Level of satisfaction	Percentage
Very satisfied	100.0
<b>Total</b>	<b>100.0</b>
N	28

The reasons why male respondents stopped using their last method are presented in Table 11.7. The table shows that wanting another child was the main reason for stopping the use of a family planning method. However, 26 percent stopped due to health concerns while 17 percent of past male users stopped using their method because of side effects the couple experienced with their method. Thirteen percent reported the reason of stopping the method due to fear of side effects. Twenty-two percent male respondents reported the opposition of wife.

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

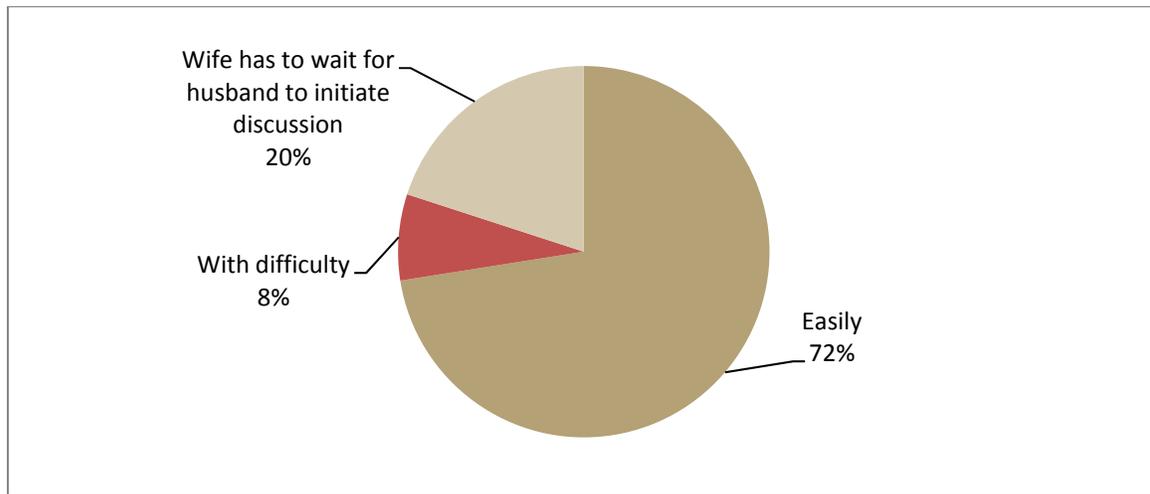
Reason	Percentage
Experienced side effects	17.4
Fear of side effects	13.0
Want another child	82.6
Method failure	4.3
Method inconvenient to use	4.3
Rest from method	30.4
Health concern	26.1
Infrequent sex/respondent away	4.3
Wife opposes	21.7
<b>N</b>	<b>23</b>

Respondents could give more than one reason

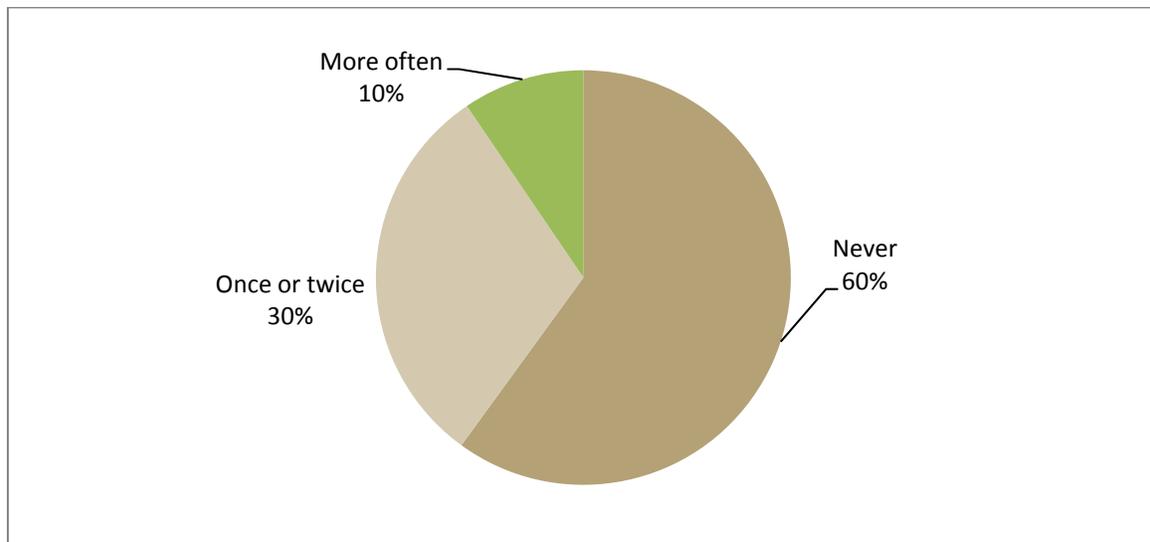
## Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Husbands were asked if during the last year their wives could approach them to discuss family planning easily, with difficulty, or if they had to wait for their husbands to initiate the discussion; the responses are shown in Figure 11.1. Seventy two percent of the men reported that their wives could talk to them easily about family planning and fertility-related issues easily. However, 60 percent of the men reported that their wives had never approached them during the last year on this issue. Ten percent of the men reported that their wives had talked more often about this subject during the last year, while 30 percent reported they had talked about it once or twice.

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



**Figure 11.2: Frequency of discussion on FP with wife in last year**



## Potential Users

Men who were non-users of contraception were asked about their intended future use of contraception and their method preferences. Table 11.8 shows that only 22 percent intended to use contraception in the future, while 18 percent did not intend to do so. A large majority (60 percent) of the male 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	21.5
Will not use	18.1
Unsure/Uncertain	60.4
Total	100.0
<b>N</b>	<b>144</b>

As shown in Table 11.9, the major reason husbands said they did not intend to use contraception was the desire of more children(69 percent ).The major hindrance faced by them was fear of side effects (54 percent) followed by opposition of wives and shyness to go to FP clinic(46 percent for each) and too much cost (27 percent).

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

Reason	Percentage
Wife opposes	46.2
In laws/parents oppose	15.4
Fear of side effects	53.8
Cost too much	26.9
Shy to go to FP clinic	46.2
Infrequent sex/respondent away	3.8
Difficult/unable to conceive	11.5
Breastfeeding/ Lactational amenorrhea	69.2
Want more children	69.2
<b>N</b>	<b>26</b>

Respondents could give more than one reason

Table 11.10 shows the distribution of the male respondents who intended to use a specific contraceptive method in the future. It is observed that the intention to use male methods was low. Injectables and pills were the main contraceptive methods proposed to be used in future.

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

Method	Percentage
Female sterilization	12.9
Pills	22.6
Injectable	54.8
Condom	3.2
Withdrawal	3.2
Others	3.2
Total	100.0
<b>N</b>	<b>31</b>

## Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 11.11 shows that 51 percent of the respondents wanted another child soon (within two years). Twenty-six percent of the respondents wanted to delay their next child for more than two years while 23 percent did not want any more children at all.

The desire to stop having children was positively associated with the number of living children. Ten percent of the respondents who had 4 children did not want more children, while 54 percent of those who had 5 or more children did not want more children.

If those who wanted to postpone having another child are combined with those who did not want any more children, the sum would constitute more than 49 percent of all the men. This percentage is much higher than the 17 percent for husbands who reported current use of contraception. This suggests that there is a substantial need for family planning, but motivational programs and service delivery are not keeping pace with this need.

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

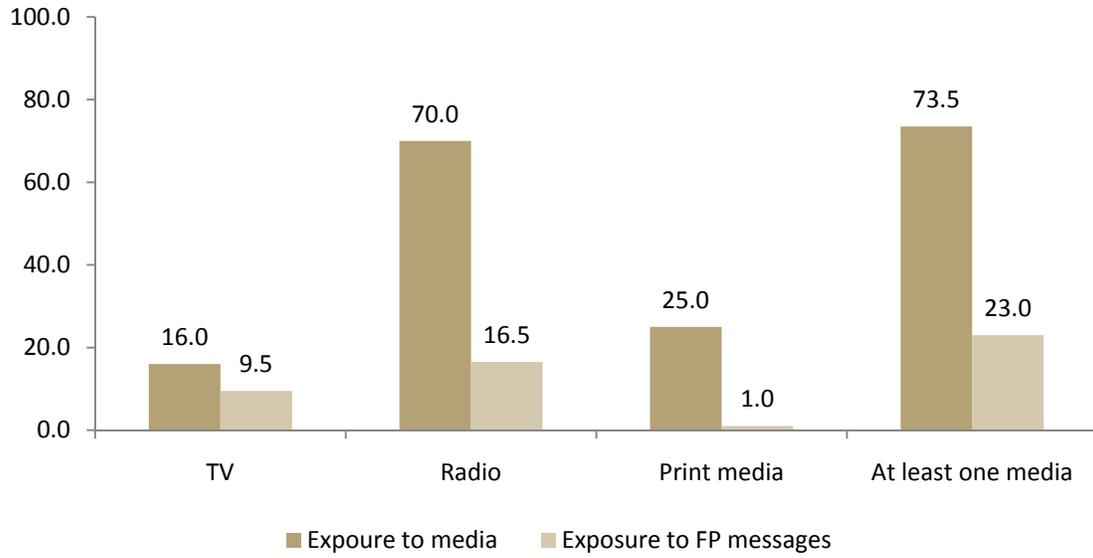
Number of living children	Desire for next child			Total	
	Soon	Later	Never	%	N
0	82.4	17.6	0.0	100.0	17
1	59.4	40.6	0.0	100.0	32
2	70.8	29.2	0.0	100.0	24
3	69.2	30.8	0.0	100.0	26
4	60.0	30.0	10.0	100.0	20
5	27.3	18.2	54.5	100.0	11
6+	25.7	20.0	54.3	100.0	70
<b>Total</b>	<b>50.5</b>	<b>26.5</b>	<b>23.0</b>	<b>100.0</b>	<b>200</b>

## 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. Radio and print media were the most commonly accessed mediums as 70 percent of the male respondents in Upper Dir listened to the radio and 25 percent reported access to print media.

Furthermore, respondents who reported access to any sort of media were asked if they had ever seen, heard, or read any message pertaining to methods of family planning through these mediums. Seventeen percent of the men had heard FP messages on radio. Overall, 23 percent of the male respondents and 6 percent of the MWRA had seen a family planning message on at least one medium.

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





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