

A Comparative Phenomenological Study of Family Planning and the Reproductive Choices among three rural Communities located in South, Central, and North Punjab



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Executive Summary

In Pakistan, Family Planning (FP) policies illustrate a recurring pattern of top-down policy design that is undermined by implementation deficits at the community level. This has led to persistently high fertility rates, especially in rural areas across the four provinces. In the Punjab, the Total Fertility Rate (TFR) is 3.5 (PBS, 2020), with rural areas reporting a higher rate of 4.1 compared to an urban TFR of 3.1. This disparity highlights a disconnect between policies and on the ground situation, especially among underserved rural communities. Contraceptive use represents an agentic choice made at the individual or household level, and FP policies have clearly overlooked the contextual realities that shape individuals' lived experiences regarding FP and its understanding.

This study examines the influence of social, cultural, and structural factors on individuals' understanding of FP and its uptake across three rural communities in the Punjab. The study applies a comparative phenomenological approach to see how individuals' sense-making of FP is shaped by the contexts in which they are embedded. Cross-cultural differences and similarities were thoroughly evaluated. Three rural communities located in or near three urban districts in the Punjab were chosen, and a judgment sample of married men and women (aged 25-50 years) from each community was selected to conduct 41 in-depth interviews (IDIs) and six Focus Group Discussions (FGDs). Data were thematically analyzed, and findings were synthesized into a theoretical model grounded in Bourdieu's theory of practice (Bourdieu, 1977) and Giddens' theory of structuration (Giddens, 1984).

Findings revealed that individuals' understanding of family planning and contraceptive methods (pills, injections, IUDs, condoms, etc.) is shaped by multiple intersecting factors, including (a) beliefs about religion, patriarchy and traditional gender roles, (b) structural conditions that influence access to social and cultural capital, (c) familial hierarchies, (d) embodied knowledge derived from lived experiences; and (e) perceptions of personal agency. Individual interpretations of FP were deeply gendered, as women typically viewed family planning through the lens of patriarchal structures that constrained their agency and embodied knowledge acquired from bearing the physical and social burdens of reproduction and contraceptive use. Overall, participants demonstrated a simplistic and one-dimensional understanding of FP, which did not align with the multilayered WHO definition that the state has formally endorsed.

The study stresses the urgent need for reviving family planning programmes and the placement of information dissemination networks at grass roots level that may target low-income rural communities.

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1. INTRODUCTION

With an annual population growth rate of 2.55%, Pakistan holds the highest position in South Asia and is projected to be among the eight most populous countries (UNFPA, 2023). Despite decades of policy interventions, the country continues to keep a high Total Fertility Rate (TFR) of 3.7 children per woman, a low Contraception Prevalence Rate (CPR) of 34%, and a persistently pervasive unmet need for family planning of 17% (NIPS, 2019). Concealed within these figures is a pronounced urban-rural disparity that disproportionately affects the financially and socially vulnerable groups. The Punjab, the most populous province of Pakistan, is grappling with a population growth crisis that is exacerbated by consistently high fertility rate and the limited uptake of contraceptives where the overall TFR of 3.5 rises to 4.1 in rural areas compared to 3.1 in urban areas.

The government has been trying to control the rapid population growth since the 60s by introducing a series of family planning policies and practices at national level, but these efforts could hardly create a wider impact. Beginning with the establishment of 'Family Planning Council in 1965,' the 'two-child policy' was introduced. Later, the council was renamed as Population Planning Council. From the 1980s to 2000s, a range of delivery system modifications were launched; the most significant of them is the 'Lady Health Worker Program'. Yet, these initiatives have consistently been marred by challenges both at the level of service provision and community uptake. In the Punjab, the CPR has been virtually unchanged since 2007, and the abortion rate has risen by 25% between 2012 and 2023 (Sathar et al. 2025). As these factors shaped the quality of life and its potential for development (Sheykhi, 2021), their impact is evident in Pakistan's present poor socio-economic outlook.

On the contrary, many lower- and middle-income countries that launched family planning initiatives during the same period have seen significant improvements. Bangladesh reduced its TFR from approximately 6.8 children per woman in the early 1970s to over 2.0 by 2020 (Federal Reserve Bank of St. Louis, 2025). In 1989, Iran saw a reduction in TFR from around 5.5 in 1988 to below 2.8 by 1996, which subsequently dropped to below-replacement levels in 2000 (Hosseini et al. 2021). Similarly, many other Middle Eastern countries like Egypt, Jordan, Tunisia, and Morocco were able to boost contraception use and control fertility rates rapidly and effectively. These improvements brought about a range of context-specific reforms like integration of reproductive health with primary healthcare, religious and cultural endorsement, and investment in women's education and empowerment (Winckler, 2023).

Evidence from lower- and middle-income countries raises serious concerns regarding the strength and adequacy of family planning policies and reforms in Pakistan. In the words of Dr Luay Shabaneh, a prominent UNFPA representative, "*Why are things not working?*" Upon preliminary examination, it was learnt that policies in Pakistan follow a top-down approach, which has not translated into the desired outcomes at the community level. Since long, there has been a continued disconnect between policies and ground realities, especially in the underserved rural communities, that has consistently undermined the effectiveness of family planning interventions. This calls for a bottom-up approach that focuses on the worldviews, experiences, and needs of individuals and communities, leading to the formulation of contextually relevant family planning policies and interventions that can improve both demand for and access to reproductive health services. This study aims to address this gap by examining the influence of social, cultural, and structural factors on individuals' understanding of family planning and its uptake across three rural regions of the Punjab. It is anchored in theory of practice by Bourdieu (1977) and theory of structuration by Giddens (1984), which provided theoretical underpinnings for the research. It has adopted a comparative phenomenological approach to develop a contextualized understanding of FP as a social phenomenon in the rural Punjab. It further explores how individuals perceive

family planning through the lens of their lived experiences, worldview, and the structural contexts that ultimately shape their reproductive choices. Cross-cultural differences and similarities related to beliefs about family planning has been thoroughly evaluated in the study.

A judgment-based sample was used to select three rural communities located in or near three urban districts across three regions, namely Lahore in Central Punjab, Multan in South Punjab, and Rawalpindi in North Punjab. The selected villages were either located on the periphery or just outside a 25-kilometer radius of the district. A purposive sampling of residents was done and a total of 41 in-depth interviews (IDIs) and 6 Focus Group Discussions (FGDs), including both married male and married female (aged 25-50 years) respondents, were conducted.

The findings of the study were synthesized into a theoretical model which shows that individuals navigate to make sense of family planning a social phenomenon. Analysis revealed that macro-level frameworks of resource distribution and competing interpretive frameworks like patriarchy and modernity mediate through community and household-level factors to shape individuals' perceptions about family planning. Individuals internalized the interpretive schemes that were filtered through the community and household, which internally constrained or enabled their agency. Belief in patriarchy, intertwined with conservative religious values, constrained women's perceived agency in making reproductive choices. This was found to be especially true in the case of older and less educated women, who were interviewed in Central Punjab. Women in South and North Punjab were younger and more educated and were found to be less likely to hold traditionalist views, enabling their perceived agency over reproductive behaviour. Material resources and internalized interpretive schemes also determine individuals' access to symbolic, social, and cultural capital needed to understand and utilize family planning. Women, especially less educated women, often lacked the cultural capital needed to gain insightful knowledge about family planning. Furthermore, the symbolic disadvantage of being a female deprived them of the autonomy to proactively seek information about family planning or its utility. A majority women depended on familial, kinship or community networks to get information about or access to family planning services. Community outreach of local female health workers was instrumental in facilitating women. By embedding themselves in the local social networks, these health workers were able to both sensitize and facilitate women in their communities. Conversely, men enjoyed the autonomy that the male symbolic capital afforded them and were able to independently seek FP-related information and help from local health facilities. Findings also revealed that, unlike the two-child policy, most respondents were unaware of the *Tawazun* policy. Overall, participants demonstrated a simplistic and one-dimensional understanding of FP, which did not align with the multilayered WHO definition that the state has formally endorsed.

Lived and vicarious experiences with contraceptive use also emerged as a gendered source of knowledge for respondents. Men only used condoms, a short-term contraceptive method with no side effects. Based on their experiences with condoms, men understood FP as a risk-free voluntary choice. In comparison, women's contraceptive use was often driven by necessity arising from the trauma of repeated births or birthing complications. They reported using a range of short- and long-term contraceptive methods, all of which carried the risk of side effects. These negative experiences frequently resulted in contraceptive discontinuation. Thus, women's bodies were the primary sites of reproductive and contraceptive burden. The embodied knowledge they gained from personal and vicarious experience engendered an overall sense of skepticism, which guided their future reproductive decision-making. Lastly, in some cases, women's choice to use contraceptives was constrained by men's prerogative over reproductive decision-making within the household. Overall, the exercise of agency is heavily dependent upon access to social and cultural capital, which is often channeled through household, communal, or macro-level distributive and interpretive frameworks. However, women actively engaged in expanding their agency in FP-related choices through negotiating with and resisting patriarchal structures. Their

FP-related sense-making and agentic choices both reinforced and challenged traditional religious and patriarchal birth-encouraging interpretive structures, often invoking more modern birth-restrictive values, revealing the duality and multiplicity of structures.

These structures have limitations that need to be addressed through policy changes. The study suggests macro-meso level reforms focusing on new and improved dissemination platforms for FP, such as media, billboards, and street theatres, along with government-led initiatives like encouraging smaller families and improving CSR strategies through public-private partnerships. The study also encourages involving community leaders in spreading FP knowledge. Therefore, the government of Punjab could influence the symbolic capital of community (religious) leaders by incentivizing their participation in FP awareness training and dissemination programmes. Important issues like promoting FP in the education sector should be tackled by the government as well. To increase FP use and access at the household and individual level, the government of Punjab could start pre-marital counseling programs involving union councils and implement M&E systems for health workers to improve service delivery. Additionally, initiatives such as (i) pre-use counseling for contraceptives to prevent potential issues, and (ii) women's forums for FP knowledge sharing could help empower women and foster agency.

2. LITERATURE REVIEW

2.1. Background and policy review of FP

In South Asia, Pakistan pioneered the national family planning programme in 1965. The aim was to control rapid population growth. Backed primarily by the USAID (Sathar & Casterline, 1998), the federal government established a Family Planning Council whose approach was shaped by Western Cold War-era population control paradigms (Cleland & Mauldin, 1991). Further, it was rooted in modernization theory, which posits that declining fertility is linked to increased urbanization, literacy, and economic stability (Cleland & Wilson, 1987). However, this early initiative faced setbacks due to socio-cultural resistance, lack of support at grass roots level, weak public health infrastructure, and reliance on external funding. Pakistan's total fertility rate remained at 6.5 children per woman in the 1980s, which was higher than that of its neighbouring countries (PRB, 2008).

Building on these early efforts, the decades from 1960s to 1980s were characterized by vertical, top-down, donor-driven interventions. These were defined by centralized planning and an emphasis on technical delivery systems (Sathar & Zaidi, 2010). Though such efforts institutionalized family planning within government structures, they failed to translate it into behavioural change among the population. Meanwhile, the international discourse began to shift from population control to reproductive rights¹. However, Pakistan was slow to adopt this rights-based approach, reflecting ongoing challenges in aligning with global trends.

In the 2000s, policy directions evolved further with the introduction of Lady Health Worker (LHW) Program, which provided a level of community-based service delivery (Oxford Policy Management, 2009). Nevertheless, the programme continued to struggle with gendered labour inequalities, inadequate training, and compensation delays (Mumtaz et al. 2013). Many LHWs felt overburdened and were ill-equipped to address sensitive family planning needs.

These earlier reforms led to the Pakistan Population Policy 2010, which sought widespread family planning access by integrating reproductive health with primary healthcare to lower TFR. However, inadequate planning and fiscal autonomy stalled CPR, resulting in unmet needs. The 18th Constitutional Amendment allowed provinces to adjust FP policies to local demographics, cultures, and administrative capabilities by devolving authority from federal to provincial levels (Zaidi et al., 2012), thereby exposing disparities in resource availability, bureaucratic capacity, and political commitment (Nishtar, 2010). Moreover, no clear roadmap was set for monitoring national targets, such as Vision 2025 or Sustainable Development Goals (SDGs) (UNFPA, 2018). Cultural, religious, and gendered structures were again ignored, and the focus remained solely on service delivery, under the assumption that it alone would increase CPR.

As policies continued to evolve at the provincial level, the Punjab Population Policy 2017 framed family planning as a well-being scheme, emphasizing public health and healthcare measures while setting measurable targets that supported SDGs. Access to information was expanded through mobile outreach services, digital health tools, and public-private partnerships. Cultural sensitivities were also recognized, for which religious leaders and civil society actors were engaged to shift public attitudes. However, due to insufficient budget allocations, weak monitoring systems, and ongoing workforce shortages, momentum was not sustained.

¹ The 1994 International Conference on Population and Development held in Cairo shifted focus from just controlling population and emphasized on reproductive rights, women's empowerment, and their education as key to sustainable development.

Building on these provincial efforts, 'Tawazun' (Balance) framework was later applied during all family planning measures to increase acceptability, aligning birth spacing with Islamic teachings (Government of Punjab, 2017) and shifting language from limiting children to general health benefits (Shaikh et al. 2013). Its goals align with those of FP2020, i.e. to raise CPR to 55%, lower TFR to 2.1 by 2045, and increase male involvement.

2.2. Factors affecting FP

Despite these policy innovations and frameworks, recent demographic data reflect continuing challenges. The Pakistan Demographic and Health Survey 2017-18 revealed a significant gap: while 99% of married women knew of at least one contraceptive method, only 34% actively used one (NIPS, 2019). This disparity between high awareness and low usage underscores the presence of unresolved barriers beyond what quantitative data alone can explain.

Considering these persistent challenges, discussions surrounding a potential 27th amendment, aimed at redefining the federal role in service delivery, accountability, and financing have been underway (PILDAT, 2023). If passed, the amendment could revive federal involvement in FP programmes, which is necessary for statewide interventions, but it could also lead to the recurrence of past bureaucratic inefficiencies.

The UNFPA (2019) emphasized that approaches tailored to the cultural context and local barriers are crucial for improving family planning (FP) outcomes in Pakistan. Such barriers include demographics, poverty, interfamily dynamics, religion, and failures in the healthcare system. Nadeem et al. (2021) specifically identified strong correlations between contraceptive use and women's age, residence, education, household wealth, number of children, and awareness of FP services. Multiple studies support the influence of these factors on family planning uptake (Khan & Mumtaz, 2025; Meherali et al. 2021; Nisar et al. 2022; Khan et al. 2024; Asif et al. 2024).

Sultan (2018) described poverty as a multidimensional issue that intersects with limited education, rural residence, low status, large families, and early marriages (NIPS, 2019; Aslam et al., 2016). People belonging to lower socioeconomic classes often report cost as a key barrier to contraceptive use (Cheema & Nadeem, 2020; Mustafa et al. 2015), and the effectiveness of initiatives offering free FP services supports this (Azmat et al. 2023). Urban physical access issues also persist, especially for women relying on uncooperative spouses (Memon et al. 2023). Additionally, economic motivations fuel a preference for larger families and sons in lower-income groups (NIPS, 2019; Channon, 2017).

Research consistently shows that interfamilial power dynamics, specifically the authority of husbands and mothers-in-law, are the most prominent barriers to FP use in Pakistan (Yaseen et al., 2023). Obtaining the husband's permission is often a deciding factor when it comes to the use of FP services (Sarfranz et al. 2023; NSRP, 2024), with husbands controlling FP decisions in 86% of cases (Asif et al., 2021). The desire to have children is higher in men than women (NIPS, 2019), but FP is often not brought up until after the closely spaced birth of children or an unplanned pregnancy due to the shyness women feel regarding the matter (Sarfranz et al., 2023). Furthermore, mothers-in-law are the primary reproductive and FP information source in Toba Tek Singh (78.70%), Shikarpur (73.10%), and Bahawalpur (95.50%) (NRSP, 2024). Women report pressure from in-laws to have more children, especially sons, interfering with FP decisions (Shah et al., 2020).

Religious beliefs are also a significant reason for the non-use of FP (NRSP, 2024). Ideas highlighted often support a perceived misalignment between Islam and FP and include the beliefs that every child brings his/her own sustenance., Besides, having many children is encouraged to strengthen the Muslim *Ummah*, and contraceptive is sinful (Ahmed et al. 2024). While some

couples view contraception as religiously impermissible, others draw on Islamic principles of responsibility and family welfare to justify family planning, often choosing traditional methods they perceive as religiously acceptable (Ghani et al. 2024; Sarfraz et al. 2023). Moreover, community religious leaders also actively discourage the use of FP at times (Omer & Jabeen, 2022).

Apart from all these socio-cultural barriers, poor service delivery, inconsistent quality of counselling, and overburdened health workers are the main reasons for the failure of FP. Service delivery is hindered by poor coverage, inadequate data management, and frequent stock-outs. Health workers' high caseloads often compromise quality of care; only 19% of women are informed about contraceptive side effects, how to respond to them, or alternatives. Being well-informed about contraception is strongly linked to continued contraceptive use, while health concerns are the second most common reason for discontinuation in Pakistan (NIPS, 2019). Consequently, many women revert to traditional, but seemingly safer methods (Lateef et al. 2022).

2.3. International best practices of FP

The history of family planning at the international level illustrates a continuous evolution, driven by intertwined concerns over population growth, women's health, and sustainable development. From early cultural practices to the birth control movement and the opening of the first birth control clinic in the 1920s, pivotal changes emerged in response to rising population pressures, particularly from the 1960s onward, affecting both developed and developing nations. In the 1800s, only two early contraceptive methods -- withdrawal and abstinence -- were available. In 1844, vulcanized rubber was invented, which was later used to make condoms, but whose initial price was quite high (Guinnane, 2011).

The Title X program, introduced in the United States in 1970, provided grants for family planning services, training, research, and educational materials. Two years later in 1972, Medicaid was amended to cover family planning (AGI, 2000). By 2002, 98% of sexually active women had tried at least one contraception method. By 2004, 1.4 million unwanted pregnancies had been averted. During this period, Medicaid became the most prominent family planning funder in the US. Over the course of the 20th century, both mortality and fertility rates declined sharply, coming to an all-time low of 1.6 children per woman in 2024 (PBS, 2024). Meanwhile, attitudes toward family planning shifted because of women's changing roles, population concerns, and new contraceptive options (PBS, 2003).

Similarly, India's National Family Welfare Program, implemented since 1952, aims to control population growth by providing condoms, pills, emergency pills, and both surgical and non-surgical contraceptive procedures. District-level monthly sterilization camps are held at centers and rural hospitals. Turning to Bangladesh, a remarkable decline in fertility can be observed, largely due to its commitment to achieving family planning goals over the past half-century. This has resulted in significant reductions in fertility rates, with a steep decline in TFR from 5.5 in 1985 to 3.7 in 1995, to 2.1 in 2017 (Bora et al., 2023). The country's community-based programmes and national family planning efforts, which directly target women with services, have both been successful in reducing fertility rates (Bhatia et al., 2024). These included menstrual regulation, maternal and child health services integration locally, outreach programmes' expansion, and the provision of a wide variety of contraceptive methods. Moreover, since its implementation in 1977, Matlab Family Planning and Health Services Project has achieved significant success, marked by rapid increases in contraceptive use and reductions in fertility and maternal mortality rates.

Muslim countries like Iran and Indonesia have advanced family planning through state-led initiatives. Iran launched its programme in 1989 with goals such as delaying first pregnancies, spacing births, discouraging pregnancy under 18 or over 35, and limiting each family to three

children. The country showed commitment through its second social, cultural, and economic plan, which aimed to boost the family planning budget and reach more people. Religious leaders publicly supported the programme, minimizing clerical opposition. To incentivize smaller families, a 1992 law ended maternity leave and social subsidies after a third child. By 1997, many provinces adopted permanent methods like tubal ligations and vasectomies. A 1992 survey found public hospitals, pharmacies, and health centres distributed 57 per cent of contraceptives. When the Ministry of Health and Education saw rural women taking pills while pregnant, efforts shifted: focus turned to female education, increasing contraceptive use, and improving quality of life for women and children (Fahimi, 2002). Meanwhile, Indonesia's National Population Family Planning Board (BKKBN) joined the government apparatus in the 1970s, whose strong reporting led to program success. Later, another programme, 'My Choice,' was launched to boost modern contraceptive use and promote family planning methods (Putjuk, 2014).

2.4. Methods used for FP services

Like the countries as mentioned above, Pakistan has made significant contributions to the evolution of family planning over time. Community-based approaches, such as the Lady Health Workers (LHWs) programme, have played a key role, helping the country advance in service delivery, community engagement, and donor coordination. Interventions such as The Challenge Initiative (TCI) and PSI-supported programmes are significant developments. These initiatives improve access to modern contraceptives by supporting local governments in poor urban communities at the provincial level. The government has also conducted multiple rounds of the Pakistan Demographic Health Surveys (PDHS) to collect high-quality data on socio-demographic, health, and economic indicators. Through the DHS programme, over 90 countries have collected health, nutrition, and population data. Researchers worldwide have explored trends in fertility and family planning access using DHS and other survey datasets.

Asif & Pervaiz (2019b) used the PDHS 2012-13 to discover the factors for UNMFP and found that UNMFP decreased with an increase in a woman's age, educational status, wealth status, number of living children, and husband's education. Unemployed women, lack media exposure, and fear side effects of contraceptives are also more likely to have UNMFP. Aslam et al. (2016) used both the PDHS 2006-7 and 2012-13 to explore and compare socioeconomic disparities in the use of FPM. They found that while the usage of FPM increased from 28% to 54%, there was no difference in socioeconomic inequalities, and that women with no education were the biggest contributors to FPM non-use. Nadeem et al. (2023) used data from the PDHS 2017-18 and corroborated previous findings: women with higher autonomy, wealth, and educational levels lead to more family planning among husbands and wives.

However, the issue of family planning is not just about numbers; it is a deep-rooted human-centered issue. Rather than focusing only on how many women use contraceptives and what types are being used, the focus should be on individuals' experiences, interpretations, and meanings in decision-making about family planning. To thoroughly understand what informs these decisions, it is essential to uncover the deeper layers of context. These layers range from women's perceptions about family planning to the way spousal dynamics and religious beliefs influence contraceptive use, and to past traumas that shape their choices. Because such complex perceptions are inaccessible through quantitative surveys alone, this highlights the importance of phenomenology in comprehensively understanding family planning decisions.

The phenomenological approach is widely used to investigate women's contraception use and reproductive health in the Global South. Studies such as Utaile et al. (2020), Lemu et al. (2023), and Alano and Hanson (2018) employed this approach in Ethiopia to examine reasons for early Implanon removal, experiences with injectable contraceptives, and perceptions about contraceptive benefits. Similarly, Asiimwe et al. (2022) applied it in Uganda to explore experiences

of involuntary childlessness, Leekuan et al. (2022) used it in Northern Thailand to understand adolescent perspectives on sexual and reproductive health, and Kolivand et al. (2025) examined lived experiences of pregnancy and childbirth among female faculty in Iran.

However, the only study conducted by Sultana et al. (2022), employing a phenomenological approach, was conducted in Pakistan to investigate childbirth preferences. Hence, the objectives of this study differed from those of the current research. Therefore, this research employs a comparative phenomenological approach. A phenomenological approach posits that individual decision-making is situated within the context-specific interplay of structure and agency, as understood through lived experiences. These lived experiences occur within the context of social structure in which an individual resides. Social structures are multi-dimensional entities. They may include layers that operate at the individual, dyadic (married couple), familial, kinship, communal, or cultural level.

3. METHODOLOGY

3.1. Theoretical background and comparative phenomenological approach

As discussed earlier, the theoretical foundation of current research is based on Giddens' theory of structuration and Bourdieu's theory of practice. Giddens' theory of Structuration responds to the debate between structural determinism and human agency by proposing their duality: the interdependence of structure and agency. Structures shape and constrain individual actions, but individuals also shape structures through their actions. This symbiotic relationship means social change occurs when individuals challenge existing structures. Agency not only shapes structure but is also shaped by structure. Giddens also argued that unconscious factors, such as religion, tradition, and family pressure, shape agency. Similarly, Bourdieu's theory of practice asserts the mutual association between individual actions and social structures. This interplay is dynamic and based on habitus (the internalization of the structure of social space), capital (resources that enable an individual to maintain or improve their social position), and field (a structured social space in which inequality and a struggle for transformation and preservation persist). In Bourdieu's theory, different forms of capital, economic, cultural (education and knowledge), and social (family and community support) are passed down from generation to generation through habitus. Hence, both theories address the interplay of structure and agency in shaping choices and behaviour.

Therefore, in current research, dialects of structure and agency across various dimensions of participants' social existence are evaluated, using a comparative phenomenological approach. This study is the first to apply a comparative phenomenological approach to explore the reproductive choices of married individuals in rural Punjab. The main objective of this research is to understand the essence of 'family planning' as a phenomenon experienced and interpreted by the participants. This approach will enable the researchers to identify cross-cultural differences and similarities related to a) beliefs about FP and b) reproductive choices among rural communities in South, North, and Central Punjab. It addresses the following research questions:

How do married men and women in rural South, North, and Central Punjab understand and experience FP within their local social, cultural, and economic context?

What similarities and differences emerge within rural communities in South, Central, and North Punjab regarding: a) beliefs about FP, and b) reproductive decisions and choices?

What is the role of family planning policies, programmes, and campaigns in shaping their beliefs and influencing their reproductive health-related choices?

Figure 1: Research questions of the study

3.2. Pre-study and Instrument Construction

A rural community named 'Mull' was selected for pre-study near Lahore. The pre study was conducted in August 2023. The research team held a meeting with the community elders, during which they were told about the study's objectives and proposed methodology. After their consent, the research team selected two key informants, one male and one female, from the community. The key informant was asked to help the team select four married women, who may fall between the ages of 25 to 50 years.

First, a Focus Group Discussion (FGD) was conducted with the selected participants after obtaining their consent. During the FGD, the research teams briefed the participants about the proposed study. The team asked the FGD members if they believed: a) the subject-matter of the study was appropriate, and b) the study could be conducted in the community without exposing participants to any risk of physical harm or social censure. The participants replied: "the topic is appropriate and the risk of physical harm or social censure is minimal." Owing to a language barrier, the key informant assisted in building rapport and, when necessary, explained questions to participants in the local Punjabi dialect. After recording their suggestions, the participants were asked to share their understanding and practice of 'family planning.'

Second, the data collected from the FGD were analyzed and used to prepare the first draft of the interview instrument for the proposed study. The instrument consisted of demographic, family, children, work, and family planning information. After preparing the interview instrument and considering the participants' suggestions, a female key informant was recruited from the community. She helped the research team find four women residents between the ages of 25 and 50 for piloting the interview instrument. After selection and consent, four in-depth interviews were conducted. A female research team member conducted the interviews in the presence of the female key informant. One respondent suggested the minor changes in two questions, which were later incorporated in the revised version of the interview instrument. The interview data were analyzed, and the findings were leveraged to refine the interview instrument and design for the proposed study.

Third, the instrument was then revised after consulting the research team and partners. After finalizing and conducting the in-depth interview instrument for both female and male samples, the focus group discussion instrument (for both male and female participants) was developed, revised, and finalized. Data collection was then carried out in Central, South, and North Punjab. Detailed questionnaires are attached in Annexure A.

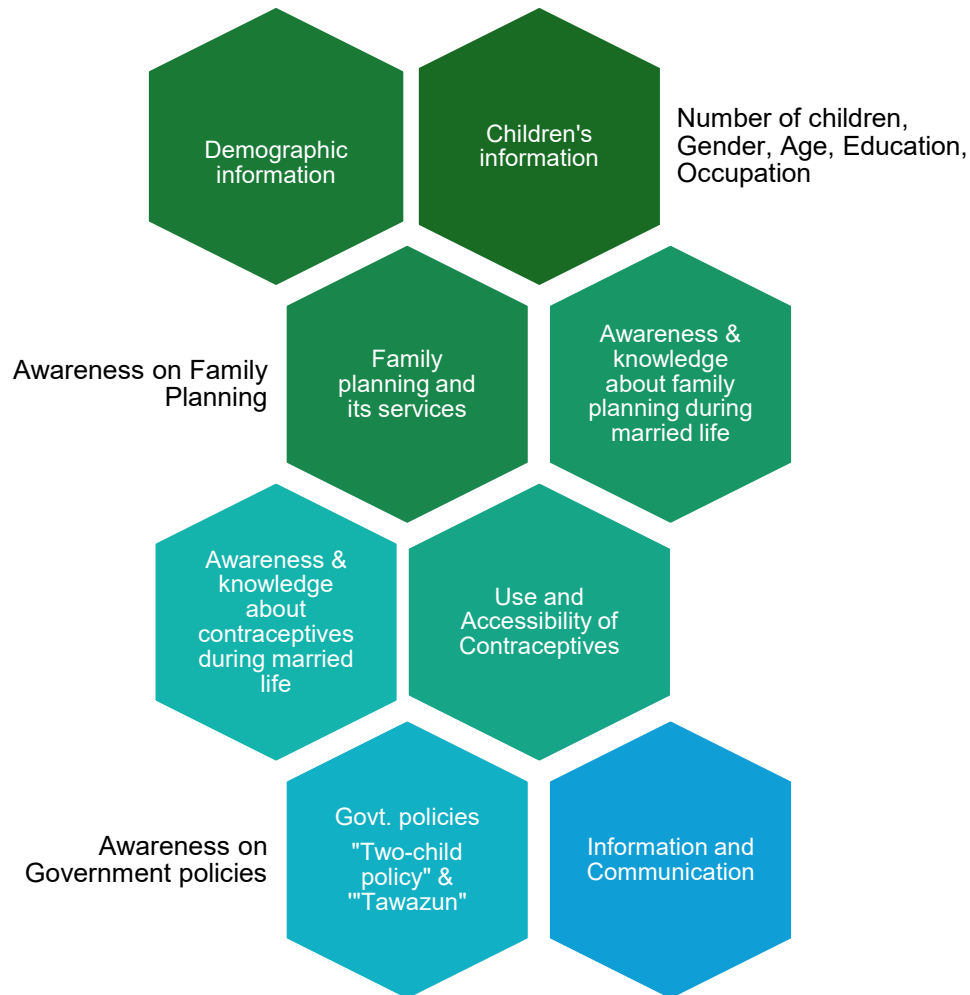


Figure 2: Interview Instrument Themes

3.3. Study sites

A sample was taken from three rural communities across three districts of the Punjab. These villages are located on the periphery of or just outside a 25-kilometer radius of their respective districts. The villages were chosen because they are in urbanized and developed settings. Residents tend to have appropriate information on FP, availability of FP services, and use of contraception. Therefore, to conduct a context-sensitive examination of the factors that shape respondents' reproductive health choices throughout their married life, and to identify cross-contextual similarities and differences between South, Central, and North Punjab communities, the following three districts were selected.

Table 1: Study sites

Sr. No.	Region	Village/Community
1.	Central Punjab	A rural community called 'Mull' is located on the periphery of Lahore district
2.	South Punjab	Shor Kot II Village, Bahawalpur Road, near Multan district
3.	North Punjab	Kauntrila Village, near Rawalpindi district

3.4. Sampling strategy & data collection

The research team consisted of both male and female members from participating departments, including the Population Research Center (PRC), FCCU, and the Directorate of Training, Research & Production, Health and Population Department, Punjab. For data collection, the female team members interviewed female respondents, and the male team members interviewed male respondents.

Purposive sampling method was used to select the sample. This followed a thorough analysis of literature review. The sample included married women and men of reproductive age (25-50 years). Once sites were identified, permission was obtained from community gatekeepers. Two key informants, one male and one female, were then recruited to help the research team select married respondents.

From Multan and Rawalpindi districts, a total of 12 In-Depth Interviews (IDIs) and two Focus Group Discussions (FGDs) were conducted. A sample of eight married women and four married men was selected for IDIs. Furthermore, a judgment-based sample of eight married females and eight married males was selected for FGDs, from each district individually.

From Lahore, a total of 15 female IDIs and five male IDIs were conducted. Two FGDs, one female and one male, were also conducted. each comprising five members. The sample selection from Lahore differed due to the larger data collection from this district. A pre-study was also conducted in Lahore to test the instrument, as described in the next section.

Table 2: Number of participants, district, and gender-wise

Subgroups	IDIs			FGDs			Total sample
	Central Punjab (LHR)	South Punjab (MLT)	North Punjab (RWP)	Central Punjab (LHR)	South Punjab (MLT)	North Punjab (RWP)	
Female	15	8	8	5	8	8	52
Male	2	4	4	5	8	8	31
	17	12	12	10	16	16	83

During the data collection phase, the interviews were recorded on electronic devices. Initially, the interviewer read a consent form in which the team explained the purpose and objectives of the study. The team introduced the respondents to the study objectives, using an informed consent form. Participants then learned about confidentiality, data use, and future implications of the study. Permission from each IDI participant was taken at the start of the interview. During FGDs, two team members, the interviewer, and the facilitator were present. At the start of each FGD, the interview began with an informed consent form. Participants were informed about the process of FGD and their participation in answering the questions.

3.5. Data analysis

After collecting data from all three districts, the research teams from both departments transcribed the data. Data was recorded in electronic devices in the Urdu/Punjabi languages (as per the language of the participant).

A coding framework was designed in accordance with one main research question of the study. To answer the question, a two-part coding scheme was created: “sense-making framework” and “understanding FP as a phenomenon”. The sense-making category included codes related to the respondent’s worldview, communicative influences on FP use, and the experiences related to FP

in terms of need, facilitation by social networks, support from healthcare workers, consequences, and the role of agency and structure. Similarly, the second component related to FP as a phenomenon included the categories of definition of FP, knowledge about two main FP policies (“Two-child policy” and “Tawazun” policy), conciliation of FP knowledge with one’s worldview, and the behavioural implications of the held knowledge. To analyze the collected data, it was sorted into the created coding categories and examined for themes. Similar ideas were grouped and analyzed thematically. The table below summarizes a coding scheme of the study’s research question as follows:

Table 3: Research question coding scheme

Research Question		Coding scheme
Family Planning (FP)	Sense-making framework	<ul style="list-style-type: none"> • Respondent’s worldview • Communicative influences on FP use • Lived experiences
	Understanding FP as a phenomenon	<ul style="list-style-type: none"> • Categories of definition of FP • Knowledge about the two main FP policies • Conciliation of FP knowledge with one’s worldview • Behavioral implications of the held knowledge

4. RESULTS AND DISCUSSION

This section is categorized into two sub-sections: (i) demographic information and analysis results of each sub-theme: worldview, communicative influences, lived experiences, definitions, and family planning policies, and (ii) discussion.

Table 4: Demographic Information of IDI respondents

ATTRIBUTES	TOTAL	CENTRAL PUNJAB	NORTH PUNJAB	SOUTH PUNJAB
Gender				
Male	10(24%)	2(12%)	4(33%)	4(33%)
Female	31(76%)	15(88%)	8(67%)	8(67%)
Age				
22-35	18(45%)	6(37.5%)	4(36%)	8(67%)
36-45	15(37.5%)	7(44%)	4(36%)	4(33%)
45+	7(17.5%)	3(19%)	3(27%)	0(0%)
Household Type				
Nuclear	25(64%)	13(76%)	8(73%)	4(36%)
Joint	14(36%)	4(23.5%)	3(27%)	7(64%)
Total Married Years				
1-15	25(66%)	7(44%)	8(73%)	10(91%)
16-30	11(29%)	8(50%)	2(18%)	1(9%)
30+	2(5%)	1(6%)	1(9%)	0
No. of Children				
0-3	28(72%)	10(62.5%)	8(73%)	10(83%)
4-7	10(26%)	5(31%)	3(27%)	2(17%)
7+	1(3%)	1(6%)	0(0%)	0(0%)
Total Sons				
0-2	34(87%)	14(82%)	9(90%)	11(92%)
3-4	5(13%)	3(18%)	1(10%)	1(8%)
Respondent's Education				
<10 Years	11(30%)	5(100%)	1(20%)	5(42%)
10 Years	13(35%)	0(0%)	3(60%)	4(33%)
12 Years	13(35%)	0(0%)	1(20%)	3(25%)
Children's Education				
Yes- School	25(83%)	10(67%)	8(100%)	7(100%)
No -School	3(10%)	3(20%)	0(0%)	0(0%)

Works -Adult	1(3%)	1(7%)	0(0%)	0(0%)
WORKS-NO SCHOOL	1(3%)	1(7%)	0(0%)	0(0%)
Note: This table excludes 5 FGDs, including males and females, as the attributes were unassigned. The table excludes a few of the attributes that were unassigned or not applicable in IDIs				

The demographic profile of the 41 respondents interviewed across Central, North and South Punjab indicates a varied but predominantly female sample, 76 per cent (31 of 41), are female, which is 88 per cent (15 of 17) in Central Punjab, 67 per cent (8 of 12) in North Punjab, and 67 per cent (8 of 12) in South Punjab. In Central Punjab, 12 (2 out of 17) per cent of respondents are male compared to 88 per cent of females. In North and South Punjab, the percentage of male respondents is the same: 33 per cent (4 out of 12).

The age range of respondents is from 22 years to 60 years. The age range of 22-35 years represents the majority (45%: 18 out of 40). This age group is especially dominant in South Punjab (67%: 8 out of 12). Next is the age group 36-45 years, comprising 38% of respondents, which was evenly represented across regions. Finally, there is the age group 45 and above (18%, 7 out of 40). There are no respondents from this age group in the South Punjab, but a significant percentage of 27% (3 out of 11) in the North Punjab. We can see from the data that most families are nuclear household oriented. 64% of respondents in total live in nuclear families (25 out of 39), and the remaining 36% (14 out of 39) live in joint families. The highest percentage, i.e. 76% (13 out of 17), of respondents, who live in nuclear families, is from Central Punjab followed by North Punjab with 73% (8 out of 11) of respondents living in nuclear families. Most respondents living in joint families are from South Punjab, with a striking percentage of 64 (7 out of 11). The data shows that in all regions of the Punjab, respondents were married from 01 to 15 years.

Most respondents, who were married from 01 to 15 years ago were from South Punjab, with 91 per cent (10 out of 11) respondents, while only one respondent was married more than 15 years ago and between 16-30 years. In North Punjab, 73 per cent (8 out of 11) respondents were married from 1-15 years ago, 18 per cent (2 out of 11) from 16-30 years, and only 9 per cent (1 out of 11) more than 30 years ago. It is worth noting that only 5 per cent of respondents from all regions of the Punjab were married during a time period of more than 30 year. In Central Punjab, 50 per cent (8 out of 16) respondents were married from 16 to 30 years ago, 44 per cent (7 out of 16) from 1-15 years ago, and only 6 per cent (1 out of 16) were married more than 30 years ago.

When it comes to the respondents' children, overall, 72 per cent (28 out of 39) respondents have 0-3 children, 26 per cent (10 out of 39) have 4-7 children, and only 3 per cent (1 out of 39) have 7+ children. In South Punjab, 83 per cent (10 out of 12) of respondents have 0-3 children. This is because most of the cohort from South Punjab are young. 17 per cent (2 out of 12) of respondents have children between 4-7, and no one has more than 7+ children. The region with the lowest percentage (62.5%) of 0-3 children is Central Punjab (10 out of 16), and the only region with 6 per cent (1 out of 16) of respondents with 7+ children. In North Punjab, 73 per cent (8 out of 11) respondents have 0-3 children, and 27 per cent (3 out of 11) have 4-7 children.

The data shows that most of the respondents have 0-2 sons. Across the select districts, 87 per cent (34 out of 39) of respondents have 0-2 sons, while only 13 per cent (5 out of 39) have 3-4 sons. South Punjab is the region has the highest percentage (92%) of 0-2 sons, In Central Punjab, 82 per cent (14 out of 17) of respondents have 0-2 sons, while only 18 per cent (3 out of 17) of respondents have 3-4 sons. In North Punjab, 90 per cent respondents (9 out of 10) have 0-2 sons, while only 10 per cent (1 out of 10) have 3-4 sons. The education level of respondents is evenly distributed between 10 and 12 years of education. Across the select districts, 35 per cent of respondents (13 out of 37) have 10 to 12 years of education, and 30 per cent of respondents

(11 out of 37) have less than 10 years of education. In Central Punjab, 100 per cent of respondents (5 out of 5) have less than 10 years of education. It is to be noted that the data for respondents' education is missing; hence, we have data for 5 respondents only in Central Punjab. In South Punjab, 42 per cent of respondents have less than 10 years of education, 33 per cent (4 out of 12) respondents have 10 years of education, and only 25 per cent (3 out of 12) respondents have 12 years of education. In North Punjab, 20 per cent (1 out of 5) respondents have less than 10 years of education, and the same is the percentage of respondents with 12 years of education, while 60 per cent (3 out of 5) of respondents have 10 years of education. As for as the education of respondents' children is concerned in all regions, 83 per cent (25 out of 30) of respondents said that their children go to school, 10 per cent (3 out of 30) of children do not attend school, 3 per cent (1 out of 30) of children are working adults, and 3 per cent (1 out of 30) of children do not attend school because they work. In Central Punjab, 67 per cent (10 out of 15) of children attend school, 20 per cent (3 out of 15) do not attend school, 7 per cent (1 out of 15) are working adults, and 7 per cent (1 out of 15) do not attend school because they work. In North and South Punjab, 100 per cent (8 out of 8 and 7 out of 7, respectively) of children attend school. These trends, excluding 2 Central (1 male and 1 female), 2 North (1 male and 1 female), and 1 South Punjab's (male) FGDs and unassigned attributes of a few other respondents of IDIs, indicate that different regions have different directions in family dynamics, education priorities, and socio-economic factors among interviewees.

Demographics of FGD Respondents

The demographics of five FGD respondents are not included as the information on the attributes is not available. Out of 5, as many as 2 respondents were from Central Punjab (1 male and 1 female), 2 from North (1 male and 1 female), and 1 from South Punjab. (male).

4.1. Worldview

The following section explores the set of beliefs and values that shape respondents' understanding of the world and how these intersect with family planning. It examines the overarching social, cultural, and religious frameworks in which reproductive health decisions are made. The goal is to understand how participants make sense of their world and gauge the context in which both their personal experiences with FP and their broader understanding of FP as a phenomenon are rooted. Some of these foundational beliefs emerged spontaneously throughout the interviews, while others were expressed in direct response to questions about the role of religion, economy, traditions, and community expectations in the perception of FP. The findings were structured to highlight the basic assumptions respondents held about the world, how they relate to FP, and any negotiation efforts employed to reconcile different foundational beliefs. Finally, the findings of the analysis were connected to the theoretical frameworks guiding this study.

Analysis:

Foundational beliefs were reflected in the comments of 44 respondents, including 26 IDIs and 18 FGD participants. Based on region, this included 16 respondents from Central Punjab (11 females, 5 males), 16 respondents from North Punjab (11 females, 5 males), and 12 respondents from South Punjab (3 females, 9 males). The analysis revealed several commonalities in their worldview, both overall and in terms of region, gender, age, and number of children, especially sons. Most prominently, there appeared to be a gendered view of the world characterized by traditional gender roles and differing levels of authority between men and women. This binary perception was evident amongst almost 76% of the respondents (n= 34) and included a wide variety of subthemes like the idea of financial responsibility lying primarily with men, marriage and childcare being more central to women's self-image, men enjoying a greater level of authority in

society, women being more susceptible to public scrutiny, and women opposing other women. In addition to this, economy-centred fears were prevalent amongst 46.7% of the respondents (n= 21), and religious ideas related to God's will and God's role as the ultimate provider were found in 37.8% of the respondents (n=17). Some other themes include the importance of education, desire for good health, and a sense that social norms were changing rapidly. All these beliefs occurred over a continuum, with some respondents passively accepting them, some negotiating with them in subtle ways, and others challenging them directly to build a nuanced worldview.

4.1.1. Gender Roles

The respondents operated on a basic assumption that men and women occupy different social roles. Men were seen as the primary breadwinners in the capacity of both husbands and sons. This was evident in male respondents' overwhelming emphasis on the changing economy and its ramifications for supporting one's family; a theme not found solely among women. This underlying belief was also made explicit by three female respondents who did not have their husbands as financial contributors due to divorce or widowhood; they described their employment as an assumed responsibility that was originally supposed to belong to someone else. A 33-year-old widow from Central Punjab said:

"As my father didn't earn, and my brother was too young to work, so I only spent 40 days in iddat² and then started working." (

Similarly, women were viewed primarily in terms of their domestic roles by both men and women. A 44-year-old male respondent from North Punjab said:

"The women in our family don't work. They stay at home, and that is what is right."

Marriage and motherhood also appeared to be more central to women's self-image, with female respondents sharing anecdotes related to them more frequently and phrasing their ideas from the perspective of being a mother.

This *doxa* came with another core belief that men enjoy greater power in society than women, especially in decision-making. This was most evident in areas of life that are directly linked to women, like childbirth. When asked who should have the authority to make decisions regarding childbirth, a 48-year-old female respondent from North Punjab, said:

"It should be with the mother, according to her health, but it isn't. It has always been like this."

Two female respondents from Central Punjab further qualified this issue by emphasizing the precedence that men's pleasure takes over women's health; a 46-year-old respondent said,

"I understand how husbands think, but a woman can't keep having a child every other year; it's just not sustainable."

Three female respondents, two of whom were from Central Punjab, also emphasized how women were generally observed more than men and were more susceptible to public scrutiny. Interestingly, one male respondent from North Punjab also ended up explicitly stating that men hold greater authority when asked if he had ever been pressurized by his wife to have more children, he replied:

"No sir. The man has all the authority".

² In Islam, *iddat* is a mandatory waiting period a woman has to observe after divorce or her husband's death. During this period, which is of 3 to 4 months long, she stays at home and cannot remarry.

The effects of this power were felt most strongly by women with histories of domestic violence, where the abstract social power held by men took a literal form in the shape of abuse.

A related theme was the view of some women that the women, especially in roles of mothers and sisters-in-law, were complicit in maintaining this power dynamic by either not supporting women when they should or by being active enforcers of patriarchal norms. This belief of women being each other's opponents was expressed mostly by female respondents of Central Punjab (n=4), followed by female respondents of North Punjab (n=2). A 40-year-old respondent from Central Punjab, said: ,

"My in-laws are always getting me into trouble, and my sister-in-law has made my life hell too... Sometimes, I think a woman is supposed to support another woman, - but in my case, women have been my worst enemies."

Most of these respondents viewed women's rivalry with each other as a natural state of affairs. A 46-year-old female respondent from Central Punjab remarked:

"Have you ever heard of a mother-in-law choosing to live with her daughter-in-law? It's rare. If the mother-in-law is kind, the daughter-in-law might not be, and vice versa."

Moreover, the female FGD respondents from North Punjab highlighted how this sense of competition directly influences family planning decisions by prompting some women to have more children simply because their close female relatives did. Many of the female respondents thus lacked social capital in the form of support from other women, which could have helped them navigate household and reproductive decisions with greater authority.

Analysis also revealed that people give different values to sons and daughters. Most of the respondents believed that families with more sons enjoyed greater respect in their communities (n= 20). A 44-year-old male respondent from North Punjab remarked:

"Yes sir, Larki ka choka hai, larkay ka chakka hai." (I have four daughters and six sons.)

A female FGD respondent from Central Punjab also highlighted the respect she herself received on account of having more sons:

"My sister-in-law has three daughters and no son. Her husband is out of the country for work, and she lives in a double-story house. But still, people do not respect her. On the contrary, they respect us more since we have two sons."

This greater value appears to be rooted in the view of sons as sources of financial support in the future (n=7), mostly by female respondents of Central Punjab (n=4). The female FGD respondents of this region crudely stated that sons were preferred because "boys earn more money" (n=2). A 36-year-old female respondent having six children from Central Punjab abandoned family planning specifically to have sons who could care for their parents and siblings in the future. These statements reflect an underlying assumption about sons, as they are to assume the family's financial responsibility in the future. In contrast, daughters were valued for their more "caring" nature (n= 7). A 35-year-old male respondent from Central Punjab, said:

"Girls don't go out; they are the shade for their parents, and they stay at home and take care of them; boys go out usually and do all the work."

However, half of the respondents, who stated that families with sons were given more respect in the community. made it a point to emphasize that either they themselves (n=6), or their families (n=4) did not share this communal mindset. A 42-year-old female respondent from Central Punjab said:

“Yes, this often happens; we often hear in the village that when someone has a daughter, the mother-in-law or husband isn’t happy. But, in our home, this has never happened. We say that a home without a daughter doesn’t receive rehmat (divine blessing).”

Moreover, when asked specifically about preference for sons within their family, more respondents stated that it was absent (n= 10), than those who said that it was present (n=3). Emphasized appreciation for daughters, especially in contrast to sons, by five respondents was also a positive indicator. In the words of a 46-year-old female respondent from Central Punjab,

“Even Pharaoh had a son, so what does that prove? A son may carry the family name. But have you noticed that most of old mothers spend their old age with their daughters, and not with their sons.”

Such beliefs, however, were expressed mostly by individuals who either did not have sons or had three or more daughters, suggesting an effort at their end to cope with their inherited patriarchal ideas.

Finally, it is important to note that an awareness of patriarchal norms did not always lead to their passive acceptance. Analysis revealed that 56% of the female respondents, who expressed their worldview in any way, subtly or directly challenged patriarchal ideas (n= 14). This mostly included women from Central Punjab (n=8), followed by North Punjab (n=5), and South Punjab (n=1). At the most conforming level was a demand for men to be more empathic towards women (n=2) and being more cooperative in matters related to women’s health, like childbirth (n=2). Besides, subtle negotiation was also evident in the emphasized value of daughters in one’s life in contrast to sons (n=5). The most direct challenge appeared in the recognition of women’s need for autonomy, especially through employment (n=6). A 46-year-old female respondent from Central Punjab, said:

“I believe every woman should be strong enough , otherwise she will be suppressed by men in the society.”

Another respondent said:

“Women should be independent... I know the parents who treat the newly married wives of their sons badly, saying you’re not worthy of our son because he is educated. Every woman should be able to earn to make herself independent.”

This is aligned with Giddens’ structuration theory; women are operating within patriarchal structures that constrain them, but at the same time, their small acts of negotiation can serve as ways for transforming these structures in the future.

4.1.2. Economy

Economic realities strongly and tangibly shaped the respondent’s worldview. The strain of household expenses and the rising cost of education were seen as important factors one had to keep in mind while making decisions in the present day. This economy-centered lens was most prevalent in North Punjab (n= 8), followed by South Punjab (n= 7), and Central Punjab (n=6). It was emphasized by the male respondents of South Punjab, who also described these concerns in the most descriptive terms. A 27-year-old respondent said:

“It is no hidden fact that today, if we own 10 marlas of property in the city, even if it is worth 20 million, you divide that by 4 and get five million each. And when you divide it by 8 that’s 2.5 million per person. Inflation is so high that only two children are good enough.”

Another respondent said:

“We should have fewer children because nowadays, inflation increases overnight. We go to bed at night, and the prices are up when we wake up.”

Female respondents of North Punjab also highlighted the economic woes that inflation posed to achieve the good quality of life for their children. Interestingly, this was the only group that emphasized the phenomenon of children becoming more demanding now and prone to feelings of inferiority in comparison to their peers.

Moreover, the present economic situation strongly pushes people to opt for smaller family sizes by using FP services. When asked specifically if having more children was advisable in the present situation, 33 out of 37 respondents stated that it was not. Frequent referrals were made to the rising cost of living and the difficulties in providing a good quality of life to a larger family. A male FGD respondent from South Punjab said:

“We used to say that there should be more children. Now inflation has broken the back of common man, so there should be three children, and we too have three. With the blessing of God, they would have good education and training.”

Several of these respondents also believed FP to be good, specifically from an economic standpoint (n=8). Interestingly, some participants explicitly stated that having more children was fine if one's economic circumstances allowed for it (n= 9). A 27-year-old male respondent from South Punjab, while discussing whether having more children was advisable in this economy, said:

“If you can provide them comfort, good food, then you should go ahead.”

This suggests that for some respondents, having fewer children was not viewed as an inherent good (for their overall wellbeing or for tackling the country's population crisis), but rather as a necessity imposed by financial constraints.

There were only a few exceptions to this overall perspective. Two female respondents from Central Punjab believed that the present economic situation required one to have more children for the sake of greater household income; a 42-year-old female respondent, who had 8 children, said:

“If you look at it, the more children you have, the more earning hands there will be, and if you have fewer, then there'll be less income.”

In addition, two female respondents from North Punjab brought up the need for children to have siblings, especially of the same gender, when reflecting on the fact that one should have fewer children in light of the present economic pressures. A female FDG respondent, having two daughters and one son, said:

“There might be difficulty in fulfilling household needs with limited resources. However, if we look at traditions, my son often complains that he does not have a brother and there is no one to support him, and he cannot share his feelings with anyone.”

Besides, no specific region, gender, or age-based differences were observed for the role of economy in the respondents' worldview.

4.1.3. Religion

There was also a consistent undercurrent of religious ideas related to fate and divine will. The most prominent amongst these was belief in God's role as the provider of sustenance (n=7) and life, especially whether one has a son or daughter (n=5), and as the protector of one's family (n=2). In the words of a male FGD respondent from North Punjab,

“At the time of marriage, I didn’t have any specific desire for a number of children. I simply accepted whatever Allah blessed me with.”

However, this kind of religious fatalism rarely translates into passivity. Several male respondents emphasized the need to take charge of one’s life, given the present state of the economy. A male respondent of an FGD from North Punjab said:

“Of course, Allah says that how many children there are, He will provide food for them. But given the current economic situation, three children are enough or at most four.”

Similarly, a female respondent from Central Punjab, highlighting the importance of using one’s reason as provided by God, said:

“Some women think Islam doesn’t allow for family planning, but Allah has given us both a mind and a heart, and with that, He has also given us the common sense to take precautions.”

Interestingly, religious ideas were also invoked by three women to challenge their inherited patriarchal beliefs, like sons being more valuable than daughters (n=2), and women having an obligation to take care of their in-laws (n=1).

The participants appeared to be less unified in their stance on the relationship between religion and FP. While the majority did believe that family planning was allowed in Islam, concerted efforts for negotiation and reconciliation were evident. Overall, 61.4% of the respondents believed that Islam permitted the use of FP services (n= 35), 15.8% believed that it did not (n= 9), with the remaining 22.8% stating that they were not aware of Islam’s ruling on family planning (n= 13). These findings are based on the input from 39 IDI respondents and 18 FGD participants who addressed religion and FP together in some way. Based on region, this included 21 respondents from Central Punjab, 23 respondents from North Punjab, and 13 respondents from South Punjab.

The greatest clarity and consensus were found amongst the female respondents of North Punjab. Except one, all the respondents believed that family planning was not only allowed but also encouraged in Islam, especially for the sake of the mother and child’s good health. The gap brought on by nursing was frequently cited as evidence for this permission. A 49-year-old female respondent from North Punjab said:

“Islam also encourages breastfeeding till the child is 2-year old. This brings a natural gap between kids and boosts the mother’s love for kids.”

Similar beliefs were found amongst the female respondents of South Punjab. It is important to note, however, that the sample acquired from these regions included a higher number of contraceptive users. Female respondents from Central Punjab were significantly more unsure and employed a greater level of negotiation. A 40-year-old female respondent from Central Punjab said:

“Religion says a lot, if people follow it. Women just say it’s a big sin. But, there are many other sins too. It’s also a sin when you don’t raise your children properly and they go astray. So, it’s better to act according to your situation.”

Amongst the female FGD respondents, FP was believed to be impermissible because of its supposed interference with the natural process of childbirth.

Negotiation was also significantly more pronounced amongst the male respondents. Many of them believed that family planning was not exactly allowed or encouraged in Islam, but should

still be used in light of the present economic conditions. A male FGD respondent from South Punjab said:

“The Quran says not to kill your child over the fear of famine. Islam advises having as many children as possible. The Prophet Muhammad (may peace be upon him) also said to increase the “Ummah” as much as possible. However, the crux of the matter is still that we need to get by according to our resources.”

Interestingly, this reference to the expansion of the Muslim Ummah was made exclusively by male respondents (n=4). Moreover, male respondents from North Punjab emphasized the importance of one’s intention. FP was allowed if it was done for the right reasons, such as for the sake of women and children’s health and the provision of a good quality of life to them. One of the respondents said:

“You can consider family planning like medicine and religion allows medicine. But, people have made it out to be something foreign, as if it belongs only to Western systems. In fact, it is good for health and for the overall system. Wherever people oppose it, the system does not run well, situation worsens, and people suffer losses.”

Men from Central Punjab were the only ones who appeared to accept FP as permissible in Islam without engaging in any excessive deliberations or justifications.

4.1.4. Other Themes

Some other themes were also surfaced in the respondent’s worldview. Education was believed to be important for progress at both personal and national levels (n=7). Parents viewed the provision of good education to children as a primary responsibility and as an important means for better future opportunities. This was especially true for respondents of South Punjab, where the average years of education completed were higher than the average. One of the FGD respondent said:

“Development is not possible without education. It is very important and a basic thing, so it is mandatory; without it, no nation can progress.”

Besides, the importance of maternal and child health was emphasized by female respondents of North Punjab (n=3), as one of them said:

“Having more resources doesn’t mean you absolutely have to have more children. What if the woman’s health does not allow for it?”

Finally, some age-based differences were also witnessed. Several middle-aged respondents expressed the desire to provide better social and financial support to their children (n=7) than they already had. Three respondents, one from each region of the Punjab, held the belief that the younger generation is or will be more advanced and knowledgeable due to the advent of technology (n= 3). Finally, the oldest respondent in the sample, a 60-year-old female respondent from Central Punjab, viewed discussions about FP with children and grandchildren as “shameful”.

4.1.5. Theoretical note on worldview analysis

The identified themes paint a broad picture of the social space in which the respondents exist. In Bourdieu’s language, their “field” was made up of many similar assumptions about the world, which both aligned with and shaped the perceived value of different kinds of capital. Both men and women shared a basic belief that they occupy different social roles in the world, which then translates into their “habitus”. The casting of men as breadwinners and women as homemakers appeared to be automatic and came with a range of other beliefs, such as those regarding reproduction, about how one is supposed to act in society.

This central *doxa* carries immense weight in light of the feminist interpretation of Bourdieu's theory. Female respondents centered their self-image around domestic roles, especially motherhood, and operated from a basic assumption that any authority they had was secondary to men. Passive acceptance aside, this also meant that challenges to patriarchal norms were phrased as negotiations; the right to make decisions was not something women inherently possessed or deserved but rather something that had to be taken or demanded from men. This highlights how the domestic field of the respondents, the primary field under investigation, was structured in terms of a gendered binary that came with unequal distribution of power between men and women.

The worldview of the respondents also placed significant value on economic capital, both in its own right and in relation to other types of capital. Sons were directly seen as sources of financial support by some respondents. Women from Central Punjab attached significant value to employment as a means for women's empowerment, and several respondents appeared to cast aside their inherited religious beliefs in light of pressing economic demands. Male respondents of South Punjab, who possessed greater cultural capital themselves in the form of higher education levels, saw it as a valuable tool that could be transformed into economic capital. There was also a perception that economic capital gave people symbolic power by granting them higher social standing and respect in society. It is important to note, however, that this does not take away from the value placed on other kinds of capital. Many women felt disadvantaged due to the lack of social capital in the form of positive bonds with their husbands and other women, and children were valued in far greater numbers for the emotional and social support they can provide to each other and their parents in the future than for financial support. Moreover, education was seen as important in its own right for greater awareness. Overall, the findings point to a complex interplay between different forms of capital, with each being shaped by and reinforcing the respondents' worldview in unique ways.

The findings of this section also align with Giddens' structuration theory. The respondents viewed themselves in the context of the overarching structures that surround them. This primarily included gendered expectations, economic pressures, and the fatalistic demands of religion. Several respondents, however, tried to negotiate with them; for example, more than half of the female respondents challenged patriarchal beliefs in some way. Whether it was as covert as placing greater value on daughters, or more overt, such as viewing employment as a pathway to agency (Central Punjab women) or prioritizing women's health (North Punjab women), it represented efforts to make space for and the possibility of change within the present structure. The will and ability to negotiate with these structures, even on a small scale, is a positive indicator for the future, as small acts of resistance can build up to alter disadvantageous norms.

Table 5: Key Results for Worldview Analysis

Key Results – Worldview Analysis			
Sub-themes	Central Punjab (Lahore)	North Punjab (Rawalpindi)	South Punjab (Multan)

Traditional Gender Roles	17 respondents (11 females, 5 males) made comments that reflected a binary, gendered view of the world characterized by different social roles for men and women (breadwinner-homemaker) and/or differing levels of authority between them.	11 respondents (7 females, 4 males), made comments that reflected a binary, gendered view of the world characterized by different social roles for men and women (breadwinner-homemaker) and/or differing levels of authority between them.	6 respondents (3 females, 3 males), made comments that reflected a binary, gendered view of the world characterized by different social roles for men and women (breadwinner-homemaker) and/or differing levels of authority between them.
	8 female respondents emphasized the need for women's greater autonomy, especially through employment	5 female respondents emphasized the need for women's greater autonomy, especially in terms of health-related decisions.	1 female respondent emphasized the need for women's greater autonomy, especially through education
Sons and Respect in Community	8 out of 10 respondents believed that families with sons are given more respect in the community	8 out of 12 respondents believed that families with sons are given more respect in the community	4 out of 6 respondents believed that families with sons are given more respect in the community
Women as Opponents	4 female respondents believed that women were inherently each other's opponents or "enemies", especially as mothers or sisters-in-law.	2 female respondents believed that women were inherently each other's opponents or "enemies", especially as mothers or sisters-in-law.	None of the female respondents believed that women were each other's opponents or "enemies".
Economic Pressures	6 respondents viewed inflation as an important backdrop for all decisions in the present day.	8 respondents viewed inflation as an important backdrop for all decisions in the present day.	7 respondents viewed inflation as an important backdrop for all decisions in the present day.
	33 out of 37 respondents believed that it was not advisable to have more children in the present economy.		
God's Will/ God-Provider	7 respondents expressed religious ideas related to God's will and God's role as the provider of life and sustenance.	5 respondents expressed religious ideas related to God's will and God's role as the provider of life and sustenance.	5 respondents expressed religious ideas related to God's will and God's role as the provider of life and sustenance.
	12 respondents believed that FP was permitted in Islam, 3 did not, and 6 were unsure.	16 respondents believed that FP was permitted in Islam, 3 did not, and 4 were unsure.	7 believed that FP was permitted in Islam, 3 did not, and 3 were unsure.
	14 respondents believed that the permissibility of FP depended on the individual's intention and circumstances		
Education	1 respondent believed education to be important for personal and/or national progress.	2 respondents believed education to be important for personal and/or national progress.	4 respondents believed education to be important for personal and/or national progress.
Generational Change	11 respondents believed that social norms and/or expectations had changed over time		

4.2. Communicative influences

The results from this analysis include information received about family planning through direct or indirect communication. It includes all information about communication, including the source, the circumstances in which communication took place, the reason for having the communication, the communication itself, and the respondent's reaction to the communication (or discourse).

4.2.1. Community leaders (Religious Scholars)

Participation and consultation of religious leaders in relation to matters of public health is significant in societies where they are highly regarded and trusted. These leaders can help impact how people think and socially behave in their daily lives, which the government initiatives would not be able to. From a total of 33 respondents, 84.8% reported never receiving a visit from a religious leader in their community regarding FP (n=28). Amongst the respondents who did visit or were visited by a religious leader, 2 were from Central Punjab and 2 were from South Punjab. One male respondent from North Punjab also reported generally being aware of religious leaders' perspectives on FP. Most of the reported experiences were positive, highlighting the supportive role religious leaders can play in relation to FP (n= 4). A 45-year-old female respondent from Central Punjab said:

"In our village mosque, Qari Sahib (The Quran teacher) talks about children's education. His wife says that one should have as fewer children as possible. Those who already have sons and daughters, they should not have more children... They should educate their children and take proper care of them."

Moreover, a female respondent from Central Punjab, who had studied at a religious institute, reported receiving guidance about the need for fewer children for the sake of their good upbringing. Only one respondent, a 44-year-old man from North Punjab, said:

"I have heard them everywhere. On the TV and in public sermons, they say family planning is not a good thing. They say you should accept whatever God gives you."

This highlights an important gap that can be targeted by future FP programmes. The rural communities of the Punjab can benefit from the greater involvement of religious leaders, in light of both the shared positive experiences and the general ambiguity that surrounds FP from a religious angle, as evident from the worldview of the respondents. Engagement of religious leaders could help legitimize family planning and reduce resistance at the community level.

4.2.2. Community (Friends, Neighbours)

In the South Punjab, all the respondents, including one female (aged 26) and 3 males (aged 37-40), claimed to talk to a friend about family planning. In North Punjab, one female (aged 38) and four males (37-44) who were interviewed individually talked to a friend or a neighbour about family planning. Although one of the male interviewees (aged 37) emphasized that whatever he talked to a friend was nothing serious. In contrast, the male FGD did discuss family planning with their friends whereas the female FGD had mixed responses.

In Central Punjab, two out of three female respondents, i.e. almost 67 per cent (42 and 46), talked to their friends and neighbours about family planning whereas one did not (aged 33). Participants of the male focus group discussed family planning issues with their friends, but in a light and witty tone. Overall, the majority of people in all regions discussed family planning with friends. Women displayed selective openness: primarily younger women (South: 26; North: 38) discussed it, whereas younger, Central female (33) did not talk about family planning. The South displayed the most uniform openness across gender; the North had varying levels of seriousness; the Central region had partially engaged females and joking discourse among male participants. This laid-

back and nonserious approach in FP discussion among men highlights an important social issue: it prevents the conversation from being taken as seriously as it should be. When family planning is just another topic for lighthearted banter, it diminishes its role as a crucial part of both personal and public health. This casual approach can create a gap between what men know and what they actually do. In the end, the tendency to treat family planning lightly hampers meaningful progress in reproductive health outcomes.

4.2.3. Family (Paternal/Maternal)

The data indicate that social and cultural influences significantly affect how family planning information is disseminated, clearly illustrating a division in the communication methods used. In Central Punjab, participants were more inclined towards discussing family planning with paternal and maternal family rather than their in-laws. For instance, in Central Punjab, three out of four respondents, 75 per cent of respondents (all female, aged between 33-42), talked to their mothers about family planning. One woman did not talk about this with her paternal or maternal family. In the South, one of two women (both aged between 25-26) talked to her mother while the other did not; meanwhile, the men, including focus group discussions, talked to their brothers (and then relatives) about family planning. It can be observed that men and women typically talk about family planning in same-gender groupings and rarely cross-communicate, perhaps due to cultural and social barriers.

4.2.4. Family (In-laws)

Several female respondents reported that their mothers- and sisters-in-law have communicative influence over them for FP use (n= 10). This mostly included respondents from South Punjab (n= 4) and North Punjab (n=4), followed by respondents from Central Punjab (n=2). None of the male respondents shared receiving advice, guidance or support from their in-laws regarding family planning. This suggests that support from in-laws can serve as important form of social capital for women whereas men are less reliant on such networks.

The role of sisters-in-law was a positive one in this regard. Most respondents reported discussing family planning issues with their sisters-in-law. The discussion revolved around the importance of birth spacing and advice about the specific methods that should be used (n=7). Two female respondents, one from South Punjab and one from North Punjab, also received practical help from their sisters-in-law, who took them to a hospital or FP center to access contraceptives. The advice and help were provided based on the sisters-in-law's own positive experiences with FP. Mothers-in-law also provided support, although to a lesser extent than sisters-in-law. Only two female respondents, both of whom were from North Punjab, reported receiving advice from their mothers-in-law. Moreover, the mother-in-law of one of these respondents was a birth attendant, which caused her to be more acquainted with FP as a medical health professional.

This difference in frequency of support from mothers- and sisters-in-law is likely to be related to age. Sisters-in-law, being closer in age to the respondents and being users themselves, were able to provide greater assistance than the mothers-in-law. A 26-year-old female respondent from South Punjab said:

“As for as my mother-in-law is concerned, she is an aged person and doesn't know anything about this. However, my sisters-in-law told me about different methods of FP to practice.”

When compared with findings from the paternal/maternal family section, this section indicates how women's family planning matters align more with the husband's family hierarchy rather than her own family.

4.2.5. Health Workers

Across all regions of the Punjab, respondents acquired some sort of family planning advice or support from lady health workers, family welfare centre employees, and doctors or nurses. A total of 41 respondents, including 9 FGD respondents, identified health workers as communicative influencers. This primarily included respondents from South Punjab (n= 20), followed by North Punjab (n= 12) and Central Punjab (n=9). It is evident from the findings that this represents an important and widespread source of social capital that can encourage FP uptake.

The healthcare workers mainly spread general awareness about FP (n= 34). This included highlighting the importance of birth spacing and limiting family size besides providing general information about family planning. Secondly, some respondents were influenced by health workers to *use specific methods* like condoms or getting an “operation” done (n=5). For some of the respondents, this advice came at a point in time when they were directly able to benefit from it, for example, in terms of birth spacing (n= 4). A 46-year-old female respondent from Central Punjab said:

“A health worker, who was specifically working on polio campaigns, was my friend. I used to accompany her during the campaign, and it was through her that I learned a lot. Thanks to her, I had a six-year gap between my children. Before that, I had no awareness.”

Clear gender-based differences were observed. Most of the male respondents talked about health workers from the perspective of their wives, stating that health workers came to visit families. Male FGD respondents from Central Punjab stated that no information was provided directly to them by healthcare workers. This pattern was much less pronounced in South Punjab where several male respondents reported directly receiving information from a family planning center (n=8); two of these respondents reported attending an informational seminar. A 27-year-old male respondent from South Punjab admitted to the general reluctance of men to talk about FP with healthcare workers, and said:

“We never talked to anyone regarding this, so how would they advise us. We have talked to the only worker at this department, Mr. Janjua. If someone talks about this, we ask him to meet our chachu (uncle), to tell him the way or whatever they need to know.”

Two male respondents from North Punjab also reported having attended an informational session on family planning at a centre near their house. These instances highlight the importance of specifically targeting men during FP programmes, especially through male health care workers.

Besides, several other interesting observations were made. Female FGD respondents of Central Punjab agreed upon the fact that they hadn't been visited by a lady health worker since a long time. In contrast, comments of respondents from North and South Punjab reflected both more recent and frequent contact with healthcare workers. Respondents of South Punjab (n= 5) and North Punjab (n= 4) were also more likely to reach out to healthcare workers for guidance or to support themselves. This was likely due to the presence of a family welfare center in their locality that allowed easier access and greater outreach.

4.2.6. Kinship

In this section, we discovered how much kinship networks other than men's and women's immediate family impact the family planning decisions. In South Punjab, women, irrespective of their age group, were seen relying on spousal consent rather than communal. Both the women of South (aged 26 and 40) did not seek any advice from any kinship network. One of them said:

“No, I have never talked to any relative, as they say different things. The main person is your husband to whom you should discuss such things”.

This indicates traditional gender roles where husband is seen as the supreme power and the decision maker, so nothing can be done against his will. In North Punjab, two women of the female FGD and one individual from the male group agreed to talk to their cousins about family planning. In Central Punjab, an individual from a male focus group talked to his uncle, who advised him to have fewer kids. Overall, there is no crucial trend of people discussing family planning with their relatives.

4.2.7. Media (Govt/NGO)

This section explores the impact of different media platforms on family planning decision-making. Results show that a total of 26 respondents identified media sources, primarily television and social media, as communicative influences. Television was cited as a source mostly by the respondents of North Punjab (n= 6) and Central Punjab (n= 5) whereas respondents of South Punjab (n= 8), followed by North Punjab (n=2) termed social media as a source.

Most of these respondents (n= 13) reported watching advertisements about family planning on television specifically about the two-child policy (n= 6). They were recalled primarily through catchy phrases like

“bachay do hi achay” and “chota ghar khushaal gharana.”

A 52-year-old woman from North Punjab also reported learning about FP from a drama series called ‘*Janjaalpura*’. Social media emerged as the second most important source (n= 11). Three respondents identified *TikTok* as the platform on which they saw videos about FP. In addition to this, three male respondents recalled watching ads (specifically “Greenstar ads” as stated by one respondent) on *Facebook*. This process was mostly passive, with such clips showing up on the respondents’ feeds without them actively searching for them. A 23-year-old female respondent from South Punjab said:

“I see it on my phone when it appears during scrolling; otherwise I don’t know about it.”

Finally, only two respondents, a 40-year-old woman from South Punjab and a 49-year-old woman from North Punjab, recalled hearing something about family planning on the radio.

Significant age-based differences were observed. All respondents, who cited social media as a source, were between the ages of 22 and 38 years. In contrast, most of those who remembered watching ads on television were over 40 years old (n=8). They were also described in the past tense, recalling ads that aired on TV several years ago. These findings show the importance of creating FP videos for social media platforms like *TikTok* and *Facebook*, especially as ads that appear spontaneously on users’ feeds.

4.2.8. Never Heard of Family Planning

The noticeable gap in understanding family planning among many respondents highlights a deeper issue of social neglect where essential reproductive health information has not been given enough attention or shared effectively. As many as 12 female FGD participants (aged 33-60) across all three regions of Punjab had never heard about family planning, compared to only three male FGD participants in Central Punjab. Nobody talked to them about family planning at the time of marriage or during their marriage. It is also noteworthy that most individuals who have never heard of family planning are from Central Punjab. In a patriarchal system, women often find that their reproductive choices aren't really their own; instead, they are dictated by male family members, especially their husbands. A clear example of this is the data showing that more than 12 women did not know about family planning, which underscores the problem at hand. A 45-year-old woman from Central Punjab said:

“The only thing my aunt (maami) said on my wedding day was: ‘Do whatever your husband tells you to do’. That’s all. No one else said anything. I didn’t even know what it meant.”

This paints a clear picture of a marriage where obedience takes precedence over partnership, and this is how women’s rights to knowledge, which further amplifies their rights to make decisions, are taken away.

4.2.9. Husband and Wife

Almost 56 per cent women (13 out of 23) talked to their husbands about family planning, and most of them said that their husbands were on the same page about family planning. In South Punjab, all eight females (aged 22 and one 40) talked to their husbands about family planning. All these women stated that their husbands agreed to family planning: most of them had gap between children. Only one man (a 37 years old) out of three said that he never discussed family planning with his wife. In North Punjab, three out of four females (aged 38-49) agreed to have discussed family planning with their husbands. This makes 75 per cent of the females interviewed in the South. Although one woman (aged 23) said that her husband did not want to discuss family planning, as he related it to fate. This is what she said:

“ My husband says: we will have children since we are fated to have them.”

It’s not just a simple dismissal of advice, but it shows a deeply rooted perspective where human choices take a backseat to divine guidance. A woman participant of an FGD from in Lahore said:

“With my husband, I discussed family planning and not having more children. He said if God blessed us with a child, then it will be okay.”

All four male respondents from North Punjab claimed that they discussed family planning with their wives. In Central Punjab, seven (six of them were above 30) out of 13 women never talked about family planning with their husbands. The lack of these conversations suggests that a woman’s choices regarding her reproductive health might not be seen as a collective decision. Instead, it could imply that these issues are decided without her input, highlighting a larger problem of restricted female autonomy over her own body and life. Central Punjab also faces problems of communication. A woman from an FGD said:

“My husband says if you have any issues, you can discuss them with my mother. But, I refused to do so by responding that I would only discuss it with you, and not your mother.”

This shows that women in Central Punjab are willing to have a conversation with their husbands, but do not get the same response in return. A 60-year-old woman while supplementing this evidence said:

“My husband was a strict man and at that time, such matters didn’t even arise.”

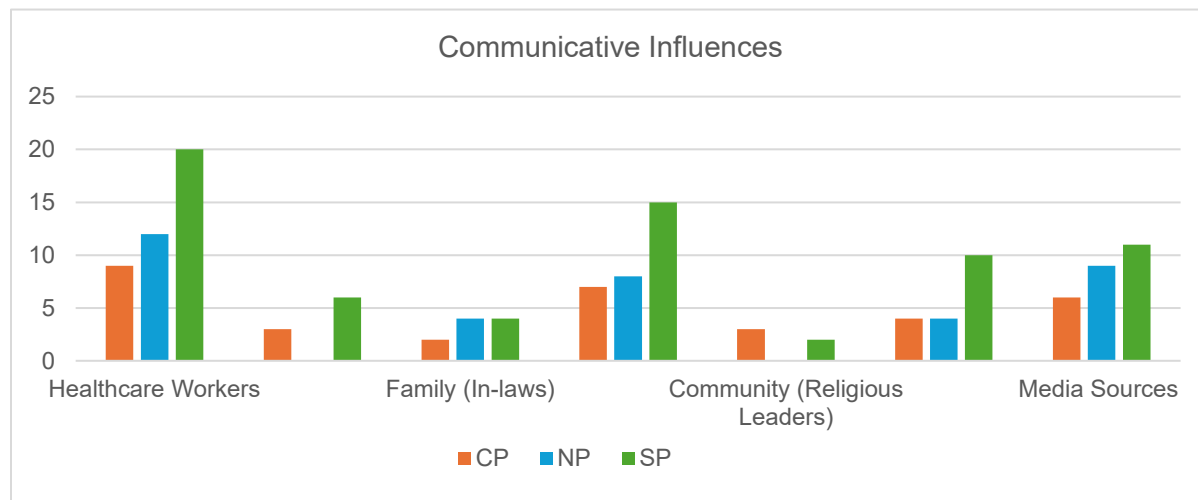
Another pattern that evolved is husbands refusing to use family planning services. A woman said:

“My husband told me not to go for any precautionary measures or contraceptives, as it usually leads to complications, and taking medicines will make me a patient. But yes, when we had four children, he said these four are enough. But we did not go for any contraceptives.”

Another woman said:

“I talked to him about FP, but he said: ‘no’.”

In patriarchal societies, like in Pakistan, the preference for sons plays a significant role in shaping family planning choices and reproductive behaviours. This cultural trend often stems from the belief that having male children is crucial for continuing the family lineage, inheriting property, and



ensuring that parents have social and economic support in their later years. A woman said:

“Yes, I discussed family planning issue with my husband, and he said if we are blessed with a son, then we’ll stop... after three daughters, we had a son... two years have passed... Alhamdulillah.”

This shows that women have no autonomy even in the grave decisions, such as the number of births they want to have.

Others

In the South, a total of six interviewees (three females and three males), had never discussed family planning with anybody, nor did they get any advice. In North Punjab, a single woman knew about family planning before marriage during her job training. One of the men said he knew about it after his wife joined the family planning department, while another man never discussed it with anybody. In Central Punjab, a woman was advised not to have children due to some circumstances. Another woman said that she never discussed it with anybody.

Figure 3 highlights the main sources of family planning information for the respondents of Central Punja , North Punjab, and South Punjab respectively.

4.2.10. Theoretical note on communicative analysis

With the analysis of communicative influences on reproductive decisions, an additional analysis needs to be made with our underlying theoretical frameworks. While communication in some categories, such as kinship, was high, the overall effect of said communication was subpar at best, arguably due to many ingrained structures.

The first visible structure relates to the general avoidance of discussions surrounding family planning, which is likely due to shame or shyness. For a country that claims to possess deeply rooted religious values, the word of religion is important. It is seen, however, that around 70-80% of respondents in all three districts said that no religious leader had ever visited them to talk about family planning. One woman even went so far as to say that her husband would know about it,

Figure 3: Communicative influences comparison across regions

thus suggesting that interaction outside of the house was the man’s business, a sign of restricted agency for the woman. This specific structure is also evident in the fact that younger women in South and North Punjab were the ones displaying more openness towards discussions of family planning. Moreover, men and women have been found to typically discuss family planning in same-sex groups and rarely engage in cross-communication with members of the other sex. This supports Giddens’ duality of structure, which posits that while structure is the medium of action, it also becomes the outcome: the lack of cross-communication is because of restricted agency and a sense of felt shame for the topic, thus it causes restricted agency and a sense of felt shame for the topic.

Patriarchal structures within society highlight the importance of the husband and his family, leading to a disproportionate amount of power in their hands. This is seen in the data when no males discussed family planning with their in-laws, but sisters-in-law were found to be the most influential when it comes to decision-making related to family planning for women.

Patriarchy, however, relies on alienating women from other women. This is not supported by the conversation found between women and their sisters-in-law. The introduction to new interpretative frameworks relating to family planning information is done via these social networks women have with other women, such as in their in-laws or lady health workers. Thus, either women are gaining agency through social capital received by these networks, or patriarchy has evolved enough to integrate these frameworks into it such that the involvement of in-laws into family planning is nothing but powerplay.

In South Punjab, women, irrespective of age, were seen relying on spousal authority. While they were ready to have conversations about family planning with their husbands, they often did not get the same response in return. Some husbands can be seen refusing to use family planning services, and since they are viewed as the ultimate decision-makers, their decision is final. It is thus concluded that because of patrilocal and patriarchal structures, the woman’s right to her own body is placed below the family hierarchy.

The data also shows small signs of reflexive agency. For example, one woman chose to talk about family planning with her husband rather than with her mother-in-law (even when her husband told her to talk to her mother-in-law), indicating a conscious effort to transgress old norms. According to Giddens and the feminist thinkers, these seemingly insignificant actions have the power to transform structure even if the process might be tedious, thus acting as a source for future hope.

Furthermore, in the data, one man learned about family planning after his wife started working for the family planning department. From Bourdieu’s perspective, the wife’s job provides her with both cultural and social capital. This capital is then transferred to her husband: an action that occurs in the private domestic sphere, as the husband receives information through her. Bourdieu’s symbolic capital also plays a role when husbands’ commands are followed without question, demonstrating the husband’s social status that is otherwise not reflected in any other form of capital.

Table 6: Key Results for Communicative Influences

Key Results - Communicative influences			
Sub-themes	Central Punjab (Lahore)	North Punjab (Rawalpindi)	South Punjab (Multan)

Health workers	9 respondents, including 1 male respondent, visited or were visited by a health worker regarding FP.	12 respondents, including 4 male respondents, visited or were visited by a health worker regarding FP.	20 respondents, including 11 male respondents, visited or were visited by a health worker regarding FP.
	Male respondents mostly talked about health workers from the perspective of their wives.		
Community leaders (Religious scholars)	3 out of 17 respondents visited or were visited by a religious leader regarding FP	None of the respondents, out of 7, visited or were visited by a religious leader regarding FP	2 out of 9 respondents visited or were visited by a religious leader regarding FP
Community (Friends/Neighbors)	2 respondents were advised by their friends or neighbors to engage in FP.	1 respondent was advised by their friends or neighbors to engage in FP.	4 respondents were advised by their friends or neighbors to engage in FP.
Family (Maternal/Paternal)	3 female respondents discussed FP with their mothers.	None of the respondents discussed family planning with their paternal/maternal relatives.	1 female respondent discussed FP with her mother, and 3 male respondents discussed FP with their brother.
Family (In-laws)	2 female respondents received FP-related advice or support from their sisters and mother-in-law	4 female respondents received FP-related advice or support from their sisters and mother-in-law	4 female respondents received FP-related advice or support from their sisters and mother-in-law
Husband/wife	6 out of 13 respondents discussed FP with their husband/wife	8 out of 9 respondents discussed FP with their husband/wife	10 out of 11 respondents discussed FP with their husband/wife
Media source	5 respondents came across content related to FP on television, and 1 on social media.	6 respondents came across content related to FP on television, 2 on social media, and 1 on the radio.	2 respondents came across content related to FP on television, 8 on social media, and 1 on the radio.
	Social media was shared as a source exclusively by younger individuals, all under the age of 40.		

4.3. Lived experiences

In this section, the lived experiences of respondents with FP devices have been analyzed across regions, in relation to their gender and age (current age and age at the time of marriage). This section has been divided into four subsections. First, the frequency and type of usage will be described. Second, the reasons and need for using FP devices will be explored by delving into the process through which respondents sought and received help by focusing on a) the individuals in their community, family, or kinship network who prompted or facilitated them to seek help, and b) the health care providers who provided help. This section will explore the social and structural nodes through which respondents gained information and access to family planning methods. Third, the physical and emotional consequences of FP uptake and their influence on future usage

will be analyzed. In the final section, we will inquire into the interplay of structure and agency in respondents' choices to initiate, sustain or abandon the use of FP devices.

4.3.1. Frequency and type of usage

Out of 41 individuals interviewed in the three regions, a total of 20 individuals had or were currently practicing one or more contraception methods. The percentage of usage was 40% for males (4 out of 10 male respondents) and almost 52% for females (16 out of 31 female respondents). Among the women who had or were currently using contraception, 4 women (25%) had used more than one birth control method during their married life.

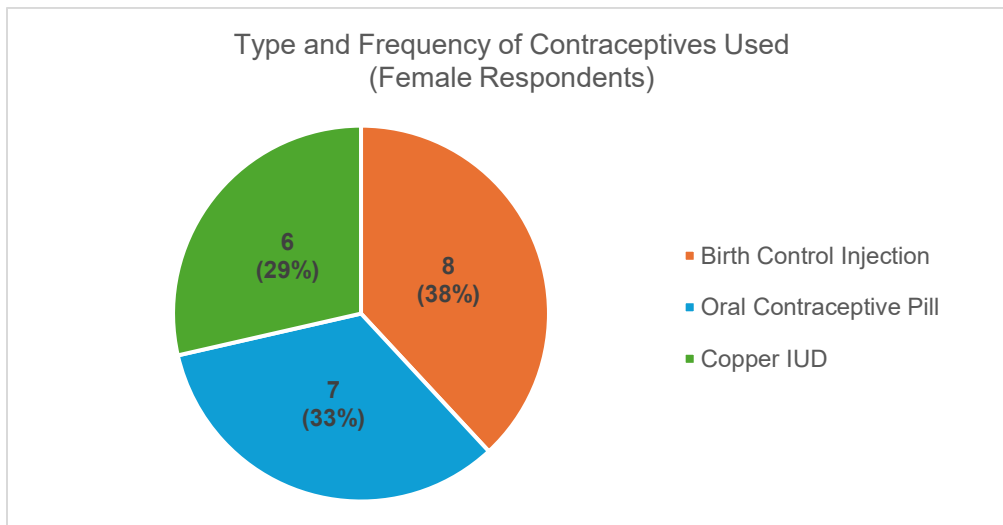


Figure 4: Frequency and type of usage of contraceptives among female respondents

Contraceptive practices were most common among women between the ages of 25 and 45 (12 out of 20 respondents). As many as three women (over 45) out of 7 and one respondent (under 25) out of 2 had used one or more family planning methods. A total of 21 respondents had never practiced family planning, out of which 5 female and 4 male respondents reported personally knowing someone who had used one or more contraception methods.

Among 20 users, birth control injections were the most common contraception method among women (8 respondents) as mentioned in Figure 4, followed by oral contraception pills (7 respondents) and Copper IUD (6 respondents). Only one respondent claimed that her relative had undergone a sterilization operation. The spouses of 6 women were using condoms. Condoms were the most commonly used contraception method among male respondents (6 respondents) whereas only two male respondents shared that their wives used some contraception device.

All 8 female respondents in South Punjab used one or more contraception methods whereas 3 out of 7 female respondents in North Punjab and 10 out of 15 female respondents in Central Punjab reported either using or personally knowing someone who had used one or more contraception methods. In Central Punjab, oral contraceptive pills were the most commonly used birth control method (4 participants), and injections (3 respondents) were the most commonly used contraception methods in North Punjab. Similarly condoms were the most commonly used contraception method in South Punjab (4 participants) followed by injections and IUD (3 participants each). In Central Punjab, contraception use (or knowing someone who used birth control methods) was most common among older women, between the ages of 35 and 45 years (8 respondents) whereas in South Punjab, contraception use was more frequent among younger women, between the ages of 25 and 35 years (7 respondents). Lastly, condoms were mostly used

in North and South Punjab. None of the male participants, who were interviewed, had opted for a permanent male sterilization procedure (such as vasectomy/ no-scalpel vasectomy).

4.3.2. Need

To gain a contextualized insight into the circumstances and structural influences that led them to opt into family planning, respondents who had or were using some method of birth control were asked to share anecdotes about the first time they felt the need for family planning. A total of twelve 12 respondents shared their stories, including eight female and four male respondents. Descriptive analysis of these narratives highlights an important gender specific difference. A majority of female respondents first felt the need to use family planning as a reaction to their circumstances whereas all the male respondents shared that they opted it proactively.

The most common reason for adopting family planning among female respondents was the trauma associated with giving birth multiple times. Five women (three in central Punjab and one each in North and South Punjab) said that after repeated births or complications during their most recent pregnancy, they chose to use birth control to avoid the ordeal of another delivery. One 46-year-old woman with six children from Central Punjab shared that she started using birth control methods after giving birth to two daughters within a couple of years of her marriage at 16 years of age.

"I needed to take a break" as "having children is easier said than done... It's like a woman loses her life in the process."

However, her respite from childbearing lasted only a couple of years as she ended up giving birth to four more children, including two sons. Similarly, another 35-year-old mother of four from North Punjab reported that after enduring through four cesarean deliveries, her "doctor performed a procedure" that resulted in permanent sterilization.

Only three female respondents (one each from North, Central, and South Punjab) voluntarily chose FP uptake because they wanted to space births or cease further childbearing. Conversely, out of all the male respondents, only three respondents from South Punjab shared the reason for using contraception, and in all three cases, it was a proactive and independent choice to either space births or limit family size. Male respondents' overall sense of agency is demonstrated in the following quote: "No, there weren't any specific circumstances; I just used condoms for family planning purposes. It is my life and I have to live it my way."

Overall, data indicate that male respondents framed family planning as a voluntary choice, while female participants usually opted for family planning a necessity to avoid negative health consequences.

4.3.3. Facilitation and Help

This subsection will focus on the social and structural nodes through which respondents gained information and access to family planning methods. The section will first look at the individuals in the participants' family, kinship or communal network who advised or helped them in any way to access family planning services at a public or private facility. We will then briefly look at the type and quality of help that the participants received from health providers at health facilities.

As many as 12 women across the three districts and three men (all from South Punjab) either independently sought family planning services or were advised and facilitated by spouses, family members (including in-laws and parents), kinship networks or community members. In comparison, two men initiated the pathway to family planning on their own, while the third learned about it from a friend and later went independently to the local health centre for further information and access.

All 12 women recounted receiving advice or help from someone in their social network to gain access to family planning services. Facilitation to access family planning services came from various sources, including sisters in-law (n=3), mothers-in-law (n=3), neighbours and friends (n=3), mother of respondents (n=2), cousin-in-law (n=1), and husband (n=1).

In two cases, the respondents were not only advised but were also taken by a facilitator (mother-in-law and neighbour, respectively) to a health centre for an access to services. In the Central Punjab sample, neighbours and friends (n=3) most frequently facilitated respondents, while in the South Punjab sample, sisters in law (n=2) and mothers (n=2) most often provided help.

Three out of 12 women (two in Central Punjab and one in South Punjab) were facilitated by someone in their social network who was engaged in healthcare-related work, including *Dai* (an informal midwife), a lady health worker, and a member of the local polio vaccination team.

Interestingly, only one woman across all three districts mentioned the husband as the facilitator. Overall, the role of a facilitator within their family, kinship or communal network emerged as an important factor in women's decision to access family planning services, which will be discussed at the conclusion of this section. The importance of communal networks in informing and facilitating women's decision to access seemed instrumental.

The community level facilitation often extended to the healthcare system itself, specifically when healthcare workers integrated themselves within these networks to proactively give advice to respondents. Regardless of whether they ultimately availed themselves of family planning services, six women (two in Central Punjab three in North Punjab and one in South Punjab) and two men (one in North and South Punjab, each) proactively received advice about family planning from health care workers.

Access to family planning information for women in Central Punjab was facilitated by a Lady Health Worker (LHW) in one case, and a neighbor who worked part-time with the local polio vaccination team in another case. Similarly, family planning information was proactively conveyed to two women in South Punjab and one in North Punjab through LHWs, while another woman in North Punjab received information at a health camp that was organized in her community. Proactive advice for male respondents was correspondingly provided to two male respondents, one each in North and South Punjab, by a local health worker and social workers, respectively.

Reactive advice was another significant source of facilitation to respondents. Reactive advice for women constituted cases where the respondents visited a health facility, often for a reproductive health-related issue, and were subsequently guided by health professionals to opt for contraception. A clear pattern emerged, as women who visited a doctor for complications related to post-abortion care, childbirth, or post-cesarean recovery were guided toward contraception use. In some of these cases, contraception was not presented as a choice but as a necessary course of action to avoid impending negative consequences, including death. In one case in Central Punjab, the husband continued to have unprotected intercourse with his wife and got the child aborted whenever she got pregnant. While advising her husband to opt for contraception, the doctor said,

"You leave her in near-death condition (every time)". Similarly, in North Punjab, a woman's doctor performed an IUD insertion immediately following her fourth cesarean operation. A total of eight women reported receiving reactive advice from a doctor or paramedical worker. This group included three women from Central Punjab, one from North Punjab, and four from South Punjab. Two male respondents in South Punjab also received proactive advice at the local health and welfare center, respectively.

In the case of female respondents, access to contraception was enabled through a healthcare worker. Access was provided both proactively and reactively. One woman in each district reported having received contraceptive devices at their home or community through an LHW. Understandably, the contraception provided proactively was typically short-term methods like pills and condoms. Long-term methods like IUD or injections were accessed reactively by the respondents visiting their local health centers. Five women fell into the category of reactive access: one each in Central and North Punjab and two in South Punjab.

Male respondents exclusively reported gaining proactive or reactive access to condoms. The pathway to access was evenly divided: two men from South Punjab proactively received condoms from health workers in their community, and one respondent each from South and North Punjab obtained them by visiting their local health center. Overall, there is a gender disparity in the use of contraception, as male respondents only reported using condoms while female respondents used a variety of short-term and long-term contraception methods.

After having examined respondents' pathways to accessing contraception, the analysis will move to the positive and negative health consequences of using contraception, leading to the decision to continue or discontinue the use of contraception.

4.3.4. Consequences

The cognitive and physical journey of utilizing or not using contraception methods inevitably led to consequences that further shaped respondents' understanding of the family planning phenomenon. Manifesting themselves beyond physical outcomes, these consequences also actuated profound psychological, social, and relational experiences. A few female respondents recounted significant health complications and method efficacy issues based on their lived experiences with contraception use. Women also faced psychological trauma, familial conflict, and struggles against restrictive social and religious norms in deciding to take up, continue, or forego contraception use. Their recollections reflected the power dynamics of reproductive decision-making that were deeply rooted in patriarchy. The influence of patriarchy was reiterated in the male narratives, revealing an absence of negative health-related outcomes, whereas the women consistently reported facing multi-faceted problems.

This section will analyze from a gendered lens the physical, psychological, and social ramifications of contraception use and their influence on the decision of continuing or discontinuing its practice.

Physical effects:

Many women reported experiencing severe health problems after using contraception. These cases were especially concentrated in Central Punjab. Two women discontinued the use of birth control pills in Central Punjab because they caused "*heavy bleeding*" in one case and "*stomach problems*" in another. The ordeal of a 46-year-old mother of six children with contraception and reproduction throughout her 30 years of married life presents a cautionary tale. Her arduous journey included removal of a Copper T after one year, because it caused her to have heavy periods to the point that she would "*unable to walk*". Later she also discontinued taking birth control pills because they caused jaundice and "*heat in the body*".

Each negative experience was followed by pregnancy, reinforcing the concentric cycle of trial and error. The respondents' summation of the entire experience was that "It was *Allah's (God's) Will*."

Another woman in Central Punjab recalled a similar experience of having a defective IUD removed that resulted in the birth of her fourth child. These analogous narratives from the rural community in Central Punjab demonstrate an alarming trend of severe side effects and inefficacious interventions, pointing to shortcomings in healthcare service quality, leaving women vulnerable to health challenges and unintended pregnancies. In contrast, the prevalence of severe side effects was observed to be less frequent in other parts of Punjab, as only one woman in South Punjab reported having an Intrauterine Device (IUD) removed because it caused "persistent discharge."

Despite the prevalence of negative outcomes, some respondents also shared their positive experiences with contraception. Two men from South Punjab expressed satisfaction with their long-term use of condoms without any health complications. Similarly, a 26-year-old woman in South Punjab reported using an IUD for four years to space births and was subsequently able to achieve a planned pregnancy. Another woman from the same region used an IUD for five years without experiencing any side effects and later switched to another method. Overall, men did not face any negative health-related, social or normative challenges associated with the use of condoms, which was their preferred method of contraception, demonstrating a gender-based or patriarchal advantage over women who endured multi-faceted issues with both short and long-term contraception methods.

Learning vicariously from the experiences of others is another important mode for acquiring knowledge about a phenomenon. One female respondent from each community in Central and South Punjab shared accounts of relatives' and friends' experiences with contraception. Both stories presented worst-case scenarios to emphasize the possible adverse effects of contraception. In both cases, someone close to the respondent used an IUD, which led to physically debilitating side effects and consequent removal. The women saw these as exemplars for not using family planning methods. As the woman from Central Punjab put it, "I am grateful that I have never had the need for something like this (IUD)."

Beyond the personal and observed experiences of adverse side effects, women identified psychological distress and social pressures as an additional dimension of negative consequences associated with contraception use.

Psychological and social structural pressures:

Parallel to physical side effects, women reported encountering psychological and social structural pressures related to contraception use, whereas men did not recount any comparable experiences. Again, except one woman from South Punjab, all such accounts originated from Central Punjab. A 36-year-old mother of six children from Central Punjab, who got married at the age of 12, linked contraception use to the symbolic capital of bearing a son, while narrating the poignant story of her aunt in the following words:

"My aunt opted for family planning after she gave birth to four daughters and a son. Her life was fine. She had a grown-up son who used to earn good money. Unfortunately, he died in an accident. After this, I discontinued using injectable contraception. I had four daughters at the time. We do not know what the future holds; only Allah knows. I gave birth to two sons after that. If I didn't have my sons, who would take care of my daughters? Even if they are younger brothers, they take care of their sisters... that is why I stopped using birth control methods."

In her admonitory account, the respondent implicitly represents contraception use as a deliberate expression of agency in a world governed by Divine Will. Her decision to abjure contraception conveys a fatalistic difference to that of Will, thereby exercising her agency to prepare for

unforeseen tests or calamities. Religious fatalism has become a channel for adherence to patriarchal values, constraining women's reproductive agency. This pattern of rationalizing is repeated in another case, presented previously, where a female respondent attributed a contraceptive failure leading to an unplanned pregnancy to "Allah's Will". This complex interplay between constrained agency and fatalistic deference to divine and patriarchal structures requires deeper analysis, which will be presented later in this report.

Patriarchal hegemony and constraining gender roles were particularly prominent in the narratives of two women in South Punjab. One woman, who had two children from a previous marriage, shared that after remarrying, she gave birth to two more children even though she had been using contraceptives during her first marriage. She explained that after remarrying, she wanted to "put Islam first," showing how pro-natalist patriarchal expectations are embedded in conservative religious ideology. The respondent's understanding of gender roles echoes the convergence of religion and patriarchy observed in the previous paragraph. In another instance, a 40-year-old woman with three children described how her husband exercised the male prerogative by unilaterally deciding to stop using condoms. Her account of the interaction clearly demonstrates the power dynamics of their relationship:

"I asked him about it, and he said that he just cannot use them anymore. It is just my husband's decision to stop using them now."

The restricted agency and negotiating power afforded to women in patriarchal contexts often translate into sets of inflexible behavioral and normative expectations that shape gender roles. Challenging and deviating from these roles often result in social reprisals, including stigmatization, marginalization, or worse.

These social reprisals manifested themselves as concrete realities in the lives of two female respondents from Central Punjab. In these cases, control over women's fertility emerged both as a reason for and a mode of chastisement for women who challenged the patriarchal order. In the first case, a 46-year-old mother of seven children advised and helped her married daughter to get an unspecified birth control procedure done, possibly without the knowledge of her husband. At the time, her daughter was nursing a three-month-old son. This act of creating space to exercise agency over her reproductive choices by withholding information from her husband resulted in a divorce, which the respondents euphemistically described as her son-in-law's "emotional decision." In the second case, a 40-year-old woman who got married at the age of 17 was impregnated many times in the initial years of her marriage, only to be sent back to her parents' house to get an abortion because her "in-laws did not value" her. This account illustrates how reproductive coercion operates as a mechanism of symbolic power, maintaining patriarchal dominance, and compelling women to perform socially expected gender roles.

For the most part, cases in which respondents experienced psychological and social structural pressures related to contraception use were concentrated in Central Punjab. Furthermore, women who recounted such challenges were all above 35 years of age.

4.3.5. A note on Agency

After analyzing the multidimensional physical, social, and psychological problems that respondents encountered in relation to the use of contraceptives, we will now explore respondents' overall expression of agency, or the freedom to use contraception. Although a majority of respondents expressed some control over their reproductive choices, an examination revealed a nuanced interplay between the expression of agency and the ability to negotiate and resist power within patriarchal contexts.

Firstly, reproductive agency was dichotomized by gender. A total of four males (three in South Punjab and one in North Punjab) expressed a sense of assertive agency, signified by an independent and unqualified control over the choice to use contraception. Only one male respondent in South Punjab felt that the wife should also be part of the decision-making process. Interestingly, a sizable majority of female respondents also believed that they had an independent and assertive control over their choice to opt for contraception. Out of 19 women, who commented on agency, 10 believed that they could independently decide to use contraception. Six of these women were from the community in Central Punjab, and two each from North and South Punjab. Four women (one from North and three from South Punjab) stated that they had negotiated agency, as their decision was contingent upon the agreement of their spouses.

Four women (three in Central Punjab and one in North Punjab) had restricted agency and expressed having no control over their reproductive choices. Lastly, one woman in Central Punjab exercised resistive agency, whereby knowing that her husband would not acquiesce, she clandestinely continued to use contraception for over five years. With no reported cases of restricted agency, South Punjab emerged as the most enabling community for women. As mentioned earlier, the women's sample in the South Punjab community was constituted by younger and more educated women, so this difference may be reflective of age and educational background. The community in Central Punjab presented a complex milieu in which both women with assertive and restricted agency coexisted. The struggle of women, who exercised resistive agency, presents an illustration of this complexity. Although no clear correlation between age and agency emerged, the fact that many older women had more children (more than three), specifically in Central Punjab, indicates the presence of a cumulative effect of reproductive pressure on constraining agency, incrementally depleting their ability to resist over time.

Findings align with the structuration theory as social structures within the three rural communities were not observed to be monolithic and unilaterally patriarchal. The social structure in the Central Punjab community seemed more deeply embedded in patriarchy and pronatalism, with many women volitionally or non-volitionally conforming to conventional gender roles. However, women in the Central Punjab community were not passive victims but active agents. They constantly engaged in empowering discourses and leveraging their agency to negotiate, resist, and challenge patriarchal control. This presents evidence of the duality of structures and coexistence of multiple interpretive schemes, as women derive meaning from modern interpretive schemes and exercise their agency to challenge dominant patriarchal frames in making reproductive choices. These findings also align with the feminist perspective's emphasis on the significance of mundane everyday acts of resistance as necessary for gradually transforming patriarchal structures. The surreptitious use of contraception by a woman in Central Punjab presents a clear example of such acts of subversion. Conversely, the community in South Punjab was more enabling, granting women the agency to make independent or negotiated choices, further supporting the argument against monolithic structures.

Table 7: Key Results for Lived Experiences

Key Results - Lived experiences			
Sub-themes	Central Punjab (Lahore)	North Punjab (Rawalpindi)	South Punjab (Multan)
Frequency and type of usage	10 out of 15 females reported either using or personally knowing someone who used one or more contraception methods	3 out of 7 females reported either using or personally knowing someone	8 females used one or more contraceptive methods

		who used one or more contraception methods	
Most commonly used methods	Oral contraceptive pills	Injections	Condoms, followed by Injections and IUD
Need (cause for adoption of the FP method)	3 female respondents shared the reason 'trauma of giving birth multiple times due to complications in their last pregnancy or negative health consequences', and 1 female respondent initiated it voluntarily	1 female respondent shared the reason 'trauma of giving birth multiple times due to complications in their last pregnancy or negative health consequences,' and 1 female respondent initiated it voluntarily	1 female respondent shared the reason 'trauma of giving birth multiple times due to complications in their last pregnancy or negative health consequences,' and 1 female respondent initiated it voluntarily While 3 male respondents started using it for 'Family planning purposes'
Facilitation and help	15 respondents, 12 females and 3 males, reported receiving advice or facilitation from their spouses, family (including in-laws and parental family), community (including friends), kin, or independently seeking family planning services.		
	2 female respondents were facilitated by someone in their social network who was engaged in healthcare-related work, including an informal 'midwife (dai)', a 'lady health worker', and a member of the local polio vaccination team' while two females proactively received advice about family planning from 'health care workers'.	3 females proactively received advice about family planning from 'health care workers'.	1 female was facilitated by someone in their social network who was engaged in healthcare related work, including an informal midwife (dai), a lady health worker and a member of the local polio vaccination team For all 3 male respondents, the pathway to FP was independent or self-initiated.
Physical consequences	Two women discontinued the use of birth control pills due to 'heavy bleeding' and 'stomach problems' Removal of 'Copper T' because it caused 'heavy periods'		1 woman reported having an IUD removed because it caused "persistent discharge." Positive outcomes: 2 men shared positive outcomes of using condoms, while 2 women used an IUD for 4-5 years without any side effects
Psychological consequences	Cases in which respondents experienced psychological and social structural pressures related to contraception use were concentrated in Central Punjab. Furthermore, women who recounted such challenges were all above 35 years of age.		
Role of agency	1 male expressed a sense of	2 women believed	3 males expressed a

	<p>assertive agency</p> <p>6 women believed that they could independently make the decision to use contraception, 3 women had a restricted agency, while 1 exercised resistive agency</p>	<p>that they could independently make the decision to use contraception</p> <p>1 stated that she had negotiated agency, while 1 had a restricted agency</p>	<p>sense of assertive agency, while 1 male believed that the wife should also be part of the decision-making process</p> <p>2 women believed that they could independently decide to use contraception, while 3 stated that they had negotiated agency</p>
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4.4. Understanding FP as a phenomenon

This section deconstructs respondents' self-articulated definitions of family planning (FP). It begins with a comparative analysis of the respondents' conceptualization of FP and the globally shared multi-dimensional understanding of family planning. The following definition of FP by the World Health Organization (WHO)'s, which is also shared by the Punjab's Population Welfare Department (PWD), will be taken as a global benchmark:

"...family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through the use of contraceptive methods and the treatment of involuntary fertility."

Individuals' definitions also signify fundamental interpretive frameworks that shape and provide cues for behaviour. We have previously argued that these interpretive frameworks are not formed in isolation, but they are the products of a complex interplay between individuals' worldview, communicative influences, and lived experiences. Following this reasoning, the section will explore the core beliefs in which the respondents embedded their definitions of FP. In the next subsection, the functional and moral import of FP from the perspective of the respondents will be discussed. In the final sub-section, respondents' level of awareness of FP-related policy initiatives will be analyzed.

4.4.1. Definitions of the Family Planning phenomenon

A total of 33 respondents (24 females and 9 males) out of 41 IDIs, along with seven male FGD participants, shared their definitions of FP. A comparison of these definitions against the global benchmark revealed considerable variance in understanding. The WHO's definition shared above has three key components: 1) achieving the desired family size, 2) spacing and timing of births, 3) using contraceptive methods and treatments. Comparing this definition with respondents' self-styled conceptualization of FP revealed that four respondents did not understand the term FP. Many respondents (22 respondents) understood FP as a one-dimensional phenomenon, including only one of the three components mentioned in the WHO definition, with 'spacing' being the most frequent (10 respondents). Only a few respondents (six respondents) understood FP as a multidimensional phenomenon. Five individuals in this group included two out of the three components in their definitions, while only one mentioned all three.

Respondents defined FP within the frameworks of their core beliefs. They were able to integrate FP into their worldview by interpreting it through the lens of their fundamental beliefs and attributing a rationale to the phenomenon. In other words, core beliefs were channels through which respondents made sense of FP. The following analysis will explore how respondents rationalized or made sense of the FP phenomenon in accordance with their worldview.

Respondents with no knowledge of FP:

Interestingly, respondents who reported no awareness or prior knowledge about FP had similar educational and regional backgrounds. All four IDI respondents (three women and one man), who belonged to Central Punjab, were unaware about FP. Likewise, all six male participants in the FGD held in the Central Punjab, stated that they knew nothing about FP. Lack of formal education was a common factor, as all the individuals with no knowledge of FP were either uneducated or had less than five years of education. This finding indicates that the cultural capital empowering individuals with knowledge of FP is not evenly distributed across regions. Structural barriers like limited access to education or a lack of proactive efforts by the local healthcare system to disseminate information about FP at the community level, potentially constrain individuals' agency by depriving them of the knowledge and resources necessary to understand and utilize FP.

Respondents with a unidimensional view of FP:

While some respondents were completely unaware of FP, the majority saw family planning as a unidimensional phenomenon. Their definitions of FP fell into three categories: having fewer children, spacing births, and utilizing FP methods and interventions. Seven women from CP defined FP as only "having fewer children." Except two respondents (aged 27 and 36 years, respectively), all the women in this group were above 40 years of age. Four women in this group had four or more children. These women embedded the concept of FP in a variety of rationales. The most common justification emphasized the changing role of parents as nurturers. Four women believed that FP was necessary because parents, as nurturers, should exercise prudence in allocating necessary resources to their children's nutrition, education, and future. Two women connected religion and economic pragmatism in strikingly opposing ways. The first, a 40-year-old mother of eight, entwined traditional religious fatalism with a sense of agrarian economic wisdom, saying:

"Our children are our true wealth. People say fewer kids are better, and I agree with that too. However, we know that if one son brings Rs.20,000 per month and another also earns the same amount, it adds up to Rs 40,000. So, we can plan our living wisely. We see children as our assets. We always think ahead about how to support our kids. We tell them to stand on their own feet. That's why, we have no complaints - every child brings his or her own fate. We are just a means. Only God provides food."

From a structuration perspective, the woman acknowledges modern rules (limiting family size) but reinforces the superiority of traditional structures by invoking religious fatalism ("Only God provides"). In doing so, she negates the modern economic rationale of having fewer children to secure access to the necessary resources needed to raise them, with the fatalistic and pronatalist argument that the Divine Being provides for the needs of all children. She further reinforces this fatalism by linking it with traditional agrarian economic wisdom, arguing that having more children guarantees more future earners for the family. By contrast, a 27-year-old mother of two with eight years of education emphasized economic prudence over fatalism in the following words:

"...have fewer children ... and have enough money to take care of them. People used to say having children was Allah's blessing.... That was the pure desi (traditional) era. Oil was Rs. 100 per kilo (very cheap), but this is not the time our children are growing up in."

These two accounts from the same community reveal the dialectic interplay between traditional and modern value systems in determining reproductive choices observed in Central Punjab. Both women adhere to conflicting interpretive schemes, and their expression of agency, molded by their differential access to cultural capital, simultaneously reproduces and challenges structures, reflecting the coexistence of traditional and modern interpretive schemes and the duality of structures. Lastly, only one woman in Central Punjab connected having fewer children to maternal well-being. The low priority given to health in Central Punjab may be the result of limited access

to cultural capital, since most of the women in this group were over 40 years old and had little or no education. Furthermore, most of the women in this group had more than four children, underscoring belief in patriarchy and compulsory motherhood.

Among the group that conceptualized FP as unidimensional, "spacing births" was the most frequently emphasized aspect. A total of 10 respondents (five females and males, each) out of 22 defined FP in terms of spacing births: six from South Punjab (three females and males each); three from North Punjab (one female and two males); and one female from Central Punjab. There was a noticeable gender-specific difference in the justifications respondents shared for spacing births. None of the five male respondents mentioning spacing births provided any rationale or justification to support their view. One male respondent in South Punjab and another in North Punjab stated that they received information about spacing births from male health workers, either in their community or at local health centers. Both respondents believed that the birth intervals should ideally range between two and three years. Another respondent from SP specified the recommended birth interval to range between one and three years. In contrast, all five female respondents who defined FP as "spacing births" justified their views with a health-based rationale. They believed that FP was a necessary precaution to safeguard the health of both mother and infant. Only one 26-year-old mother of three children, with middle-school education, grounded her definition within her lived experiences, in the following words:

"It is about timing and spacing pregnancies in a way that prioritizes health. Also, I did not get my periods after the birth of my second daughter, and during that time, I got pregnant again. So, I could not breastfeed my daughter; that is why she is weak."

The dominance of birth spacing in respondents' definitions reflects the legitimization of medical norms consonant with both birth-encouraging and birth-limiting interpretive schemes. In other words, adherence to the norm of "spacing" does not explicitly challenge either of the conflicting interpretive schemes that support limiting or encouraging births. Men's understanding of spacing illustrates a routinized doxic acceptance shaped by the symbolic capital of local healthcare providers rather than developed through a discursive process of sense-making. It further underscores a patriarchal disconnect with the experience of childbirth and postpartum care, as none of the male respondents grounded their definitions in their partners' birthing experience and caregiving responsibilities. Women's justification for spacing was rooted in embodied knowledge, or insights acquired through the experiences of childbirth and childcare. Therefore, they framed spacing as a necessary choice to safeguard maternal and infant health. Most women defining FP in terms of spacing tended to be younger and educated, illustrating the significance of cultural capital shaping understanding of FP. The account of the 26-year-old woman, who faced difficulty breastfeeding her daughter due to an unplanned pregnancy, signifies a process of reflexive monitoring. Her embodied knowledge enabled agency and transformed both her understanding of FP and her subsequent reproductive choices.

The third group that conceptualized FP as unidimensional defined it in terms of contraceptive interventions or treatments. A total of five women (two each from Central and South Punjab, and one from North Punjab), and one male respondent shared this view. The two women from CP defined FP through specific contraception methods like birth control pills, injections, or insertion of an IUD. Interestingly, both women qualified the use and effectiveness of these methods as contingent on higher forces beyond their control. One respondent believed that the success of these "precautions" was subject to "God's Will," while the other explained that, although she was aware of contraceptive methods, her ability to adopt them was restricted because her husband "did not believe" in FP. Both women expressed deference to religious fatalism or patriarchal prerogative while making sense of FP as a medical intervention or clinical treatment within the framework of their constrained agency.

In SP, two women couched their understanding of FP in embodied experience by defining it with reference to the contraception methods they were personally using, namely IUD and condoms. Similarly, another woman in North Punjab defined FP through her lived experiences with birth control injections in the following words:

"When I used to get injections... I did not get pregnant easily. When the time of the injection would run out, it was only then that I would get pregnant."

This definition underscores a practical sense of method efficacy derived from embodied experience. From Bourdieu's perspective, embodied experience reinforces interpretive schemes that legitimize contraception use and may eventually be absorbed into doxa. Doxa shapes habitus by predisposing women to use contraception methods. Habitus reinforces doxa, as repeated use of injections ingrains practical knowledge that normalizes the use of contraceptive methods as "common sense".

Respondents viewing FP as a multidimensional construct:

Lastly, six respondents (four females and two males) conceived FP as a multidimensional construct, integrating and relating two of the three factors mentioned in the WHO definition. These six respondents can be divided into three groups, each representing a different way of conceptualizing FP as a two-dimensional concept. One female IDI respondent from Central Punjab and one male respondent from North Punjab defined FP as involving both limiting and spacing births. In contrast, one female respondent from Central Punjab and one male respondent from South Punjab conceptualized FP as a medical intervention for limiting births. Finally, one female respondent in South Punjab described FP as a medical intervention for spacing births. Data shows that only a few respondents understood FP as a more complex, two-dimensional construct that integrated two of the three essential components included in the WHO definition. The incorporation of a multidimensional understanding of FP into interpretive schemes can facilitate its routinization as practice. Yet only a few respondents demonstrated this level of comprehension. Notably, only one female respondent from Central Punjab included all three components in her definition, conceptualizing FP as a medical intervention that encompassed both limiting and spacing births. These observations are consistent with Bourdieu's framework of doxa informing habitus, as discussed in the preceding paragraph.

4.4.2. FP as a functional and moral construct

In this section, we will analyze whether respondents made sense of FP as a functionally useful and morally permissible construct. In total, 19 respondents (17 females and two males) commented on the functionality of FP, with 15 respondents (13 females and two males) considering FP as a useful phenomenon and four (one male and three females) labeling FP as a harmful phenomenon. Of the 13 females who considered FP as useful, nine were from Central Punjab, three from North Punjab, and one from South Punjab. Both male respondents who characterized FP as "useful" were from North Punjab. Out of the four respondents, who labeled FP negatively, three women were from Central Punjab, and one man was from South Punjab.

Participants framed the functionality of FP within three broad dimensions, namely economic necessity, medical consequences, and family continuity and nurturing. Three women from CP and two from North Punjab emphasized the necessity of FP to limit family size and utilize available economic resources to meet household and childcare expenses. Out of these, three respondents further linked this argument to their lived experiences during the recent wave of inflation, using embodied knowledge as evidence to support their views. All five respondents in this group supported limiting family size in accordance with a family's economic standing. A 27-year-old mother of two sons said:

"Family planning means having fewer children to ensure that their needs are fulfilled and that they get proper education. (The idea is) that the money we can spend on having more children should be spent on the education of children (that we already have)".

Four female respondents (two each from Central Punjab and North Punjab) emphasized the necessity of family planning to safeguard the health of mothers and infants. Conversely, one 33-year-old woman from Central Punjab believed that using long-term contraception methods, especially injections, exposed women to the risk of suffering debilitating side effects and complications in future pregnancies. To support her claim, she shared the cautionary stories about two female relatives who had negative experiences with contraceptive injections. As discussed earlier, the perceived costs of using FP (such as side effects, method failure, or complications in future pregnancies) acquired through lived experience or vicarious observations are incorporated into lifeworld as embodied knowledge. This embodied knowledge challenges the state-promoted interpretive frameworks that legitimize FP and can lead to the construction of negotiated meanings that validate cautionary anti-FP norms. An example of such negotiated meaning can be observed in the words of a 32-year-old woman in Central Punjab:

"There are good and bad examples, sometimes taking contraceptive medicines causes a very bad reaction."

Lastly, three women (one each from Central Punjab, North Punjab, and South Punjab), along with one male respondent from North Punjab believed that FP was necessary for parents to properly nurture and care for their children. Their concern extended beyond meeting economic needs to include emotional and developmental care. The respondents argued that having fewer children allowed parents to devote more time and resources to their children's development and secure their prospects. From Bourdieu's perspective, this can be seen as the conversion of economic and social capital into cultural capital, chartering children's and families' access to pathways of social mobility. A male respondent in North Punjab said:

"There should be small families. Children should be well-fed and should be given proper education and a good upbringing. Life is spent well if you have a small family."

Alternatively, two women (from Central Punjab and South Punjab, respectively) supported the traditional interpretive framework of 'family continuity'. These women perceived large families as assets and having additional children as a form of old-age security. A woman from South Punjab said:

"Yes, but two children are not enough. One should have four children, so if something happens to one of them, you still have another with you."

These words illustrate the intertwining of the traditional interpretive framework of family continuity and patriarchal reproductive preferences, as the respondent implied that an ideal family would have at least two boys (two sons and two daughters), thereby securing the family's future prospects by providing a fallback.

Only four respondents (three women from Central Punjab and one man from South Punjab) discussed the moral implications of using FP methods. Two women from Central Punjab made sense of the moral ramifications of FP from within the interpretive framework of religion. While commenting on incidences of contraception failure, one woman remarked:

"Using contraceptive methods is good; but they often don't prevent childbirth, so it reinforces our faith."

In this comment, the respondent framed the failure of contraceptive interventions as evidence bolstering her faith in the finality of predestination. In contrast, another woman from Central Punjab aligned religion with a modern interpretive framework emphasizing agency and prudence, in the following words:

"Some women think Islam doesn't allow for family planning, but Allah gave us both a mind and a heart, and with that, He also gave us the wisdom to take precautions."

Finding reinforces the point made earlier, that the respondents in Central Punjab were actively negotiating the meaning of FP, illustrating both the coexistence of and conflict between modern and traditional interpretive structures within the community.

Patriarchal values and relations furnished another avenue for moral reasoning about FP. One woman in Central Punjab regarded FP as morally justified by reframing conventional patriarchal relationships between women and their in-laws. She believed that FP safeguarded women's health and argued that ensuring women's well-being was the moral duty of both the husband and the in-laws.

The comments of a male respondent in South Punjab reveal how moral reasoning can intersect with traditional notions of masculinity. While discussing different contraception methods in connection with male sterilization, he said: "... the operation that people go for should not be permissible."

The respondent's rejection of male sterilization can be understood in terms of the value attached to fertility in the construction of male symbolic capital and its significance in fulfilling gender expectations.

The analysis of quotes in which respondents questioned the usefulness or moral legitimacy of FP represents an exception rather than the rule. Overall, the findings suggest that an overwhelming majority of male and female respondents across all three regions perceived FP as a functional and morally justifiable phenomenon.

4.5. Understanding FP Policies

In this section, respondents' understanding of the Punjab government's FP policies will be analyzed. The policy review section in the literature review outlines the Punjab Government's shift from a two-child policy to *Tawazun* in 2017. Respondents in all three districts were asked if they were aware of both policies. Since most of the IDI and FGD participants were under 35 years of age, particularly in the South Punjab and North Punjab, and had married after 2017, their likelihood of being aware of the *Tawazun* policy was deemed higher. However, the findings proved otherwise. A majority respondents were aware of and understood the two-child policy that was in force prior to 2017. Out of the 41 IDI respondents, a total of 31 respondents said that they were aware of the two-child policy (Figure 5). A total of 10 respondents reported that they were not aware of the two-child policy. These included six female respondents from Central Punjab, two female and one male respondent from North Punjab, and one male respondent from South Punjab.

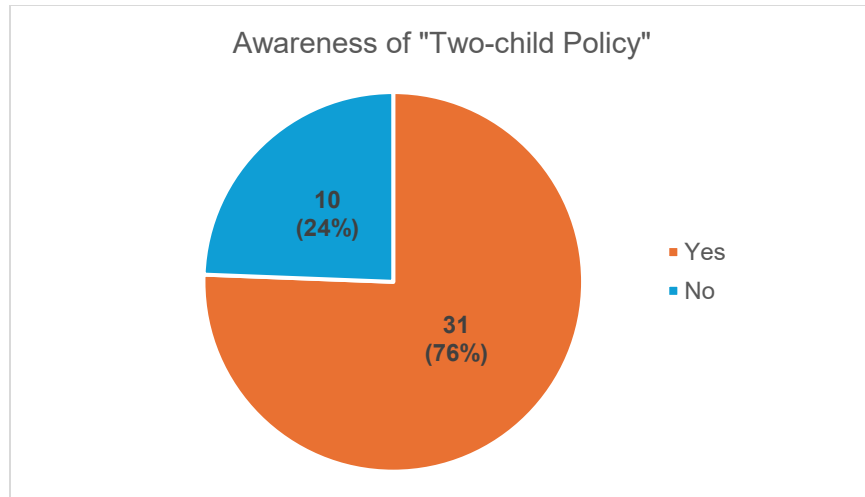


Figure 5: Awareness of the 'two-child policy' among total respondents

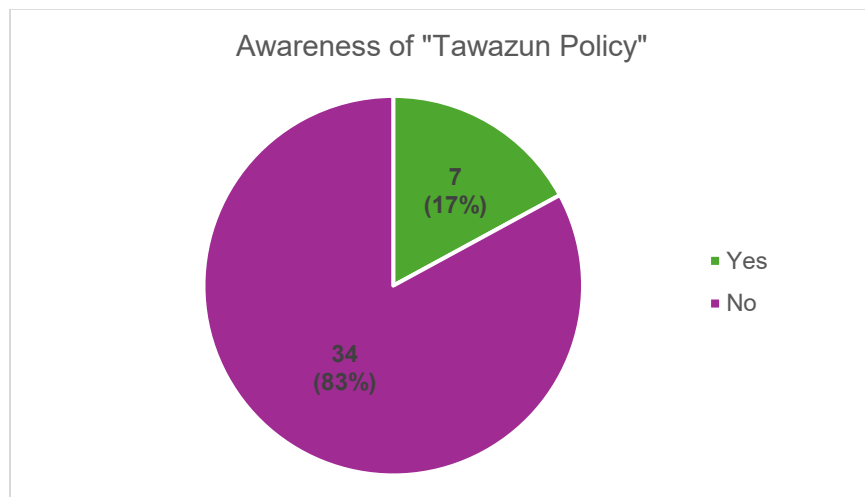


Figure 6: Awareness of 'Tawazun Policy' among total respondents

Except for two female respondents from Central Punjab and South Punjab, all those who were aware of this policy considered it a functionally useful idea, indicating the overall dominance of interpretive frameworks that legitimized FP. The two respondents who questioned the functionality of the *two-child* policy did not necessarily oppose contraception but believed that a family should ideally have four children, with two sons and two daughters. Findings indicate that contraception use has become part of the doxa that guides the reproductive choices of majority respondents.

Unlike the two-child policy, most respondents were unaware of the *Tawazun* policy (Figure 6). None of the respondents in Central Punjab had heard of it, and only one male respondent in South Punjab reported that he was familiar with the policy. Knowledge of *Tawazun* was found to be highest in North Punjab, where five female and one male respondent reported being aware of the policy. Only three female respondents in North Punjab and one male respondent in South Punjab

identified the source of their information about the policy. In all four cases, mass media, specifically television, were identified as the source.

This finding is notable because the majority respondents in North Punjab and South Punjab had been either informed about or facilitated in contraception use by community healthcare workers or at local state-run healthcare facilities. This may indicate that the Punjab government is not actively promoting this policy at grass roots level. This being the case, the Punjab government is failing to capitalize on the potential influence of the policy's message and its underlying ideology. As part of the interview and FGD protocol, when respondents reported being unaware of *Tawazun*, the interviewer was required to explain the policy and record their views on it. All respondents agreed with the overall message of the policy and believed that it could promote responsible reproductive decision-making. One respondent noted that the ethos of the policy matched with her core beliefs, stating that, "Finally someone has said what has been in my heart."

Tawazun, as an overall construct, appeared to assimilate well with dominant interpretive frames shaping respondents' reproductive choices, providing a favourable backdrop for improving future FP uptake.

Table 8: Key Results for Definition and FP Policy

Key Results - Definition and FP policy Awareness			
Sub-themes	Central Punjab (Lahore)	North Punjab (Rawalpindi)	South Punjab (Multan)
Definition of FP according to WHO	4 IDI (3 women and 1 man) and 6 FGD respondents did not know FP	A total of 3 (1 female and 2 males) defined FP as 'spacing births' while 1 woman defined FP in terms of a specific contraception method, 'injections'	A total 6 (3 male and 3 female) defined FP as 'spacing births' while 2 women defined FP with reference to the contraception method they were personally using, namely 'IUD' and 'condoms'.
(i) no knowledge	7 women defined FP as only "having fewer children," while 1 female defined FP as 'spacing births.'		
(ii) unidimensional			
(iii) multi-dimensional	The two women defined FP through specific contraception methods like 'birth control pills', 'injections' or 'IUD'		
	1 female respondent defined FP as involving both 'having fewer children' and 'spacing children', while another female respondent defined FP as 'medical intervention aimed at limiting births'	1 male respondent defined FP as involving both 'having fewer children' and 'spacing children'	1 male respondent defined FP as 'medical intervention aimed at limiting births' while 1 female defined FP as 'medical intervention for spacing births'
	Two women framed contraception methods within a qualifying framework of (a) religious fatalism and (b) patriarchal prerogative		
	Only 1 female respondent defined FP, which included all three elements in the definition		

Understanding FP as a functional (useful) and moral construct	9 females considered FP as 'useful' or 'morally acceptable' phenomenon, while 3 women labeled FP as 'negative'	3 females and 2 males considered FP as 'useful' or 'morally acceptable' phenomenon	1 female considered FP as a useful or morally acceptable phenomenon, while 1 male labeled FP as 'negative'
'Two-child' Policy	6 female respondents were not aware of this policy	2 female and 1 male respondents were not aware of this policy	1 male respondent was not aware of this policy
	Out of 41 respondents across all regions, 10 (as mentioned in the above row) were not aware of the 'two-child' policy. Although 31 respondents were aware of it.		
'Tawazun' policy	None of the respondents knew about this policy	5 female and 1 male respondents were aware of this policy	1 male was aware of this policy
	The majority respondents were unaware of <i>Tawazun</i> policy.		

4.6. Key findings

The following section provides the comprehensive key findings of all four sub-sections.

4.6.1. Worldview

- Foundational beliefs were reflected in the comments of 44 respondents (26 IDIs and 18 FGD respondents), including a roughly equal mix of individuals from Central Punjab (n=16), North Punjab (n=16), and South Punjab (n=12).
- The respondents perceived the world in terms of a gender binary in which men and women occupied different social roles that came with their own set of expectations (n= 34). This included two main doxic beliefs or assumptions: financial responsibility of the house lies primarily with men and domestic care with women, and men enjoy greater levels of decision-making authority in society.
- This trickled into differential valuation of sons and daughters (n=11), with greater respect being granted to families with sons by community members (n=20). It was also evident in the view of women as each other's opponents or competitors (n=6), especially by the female respondents of Central Punjab (n=4).
- Encouragingly, many female respondents, especially from Central Punjab, subtly or directly challenged patriarchal norms in some way, like pushing for greater autonomy for women, especially through the means of employment (n= 6) and emphasizing the value of daughters in their lives in contrast to sons (n= 5).
- Economy-focused concerns, like inflation making survival difficult, were central to the worldview of many respondents (n= 21), especially in South Punjab (n= 8) and North Punjab (n= 7). There was a strong consensus amongst the respondents that the present economy favoured smaller sizes (n= 33). Interestingly, some participants stated that having more children was fine if one's economic circumstances allowed for it (n= 9), reflecting a one-dimensional, surface-level acceptance of FP.

- There was a consistent undercurrent of religious ideas related to God's will and God's role as the provider of life and sustenance (n= 17). However, this rarely took the form of religious fatalism. Many of the respondents believed that Islam permitted the use of FP services (n=35), but this conclusion was reached through significant negotiation efforts.

4.6.2. *Communicative influences*

- Health Workers: Health workers emerged as the most common sources of communicative influence (n= 41, including 9 FGD respondents), especially in South Punjab (n= 20). Most of the respondents learned about the overall importance of family planning from health workers (n= 34), with some also being influenced to use specific FP methods (n= 5). Only a few male respondents were targeted directly by health workers (n= 10).
- Family (Maternal/Paternal): Mothers were an important source of FP advice for female respondents of Central Punjab (n=3), and South Punjab (n=1). Male FGD respondents of South Punjab also sought advice from their brothers (n=3).
- Family (In-Laws): Sisters-in-law (n=8) and mothers-in-law (n=2) provided both general advice about FP and practical help to some female respondents. This mostly included respondents from North Punjab (n=4) and South Punjab (n=4).
- Husband/Wife: In Central Punjab, seven (six of them were above 30) out of thirteen women never talked about family planning with their husbands. In South Punjab, women, irrespective of their age group, were seen relying on spousal consent rather than communal one.
- Community (Religious Leaders): From a total of 33 respondents, 84.8% never received a visit from a religious leader in their community regarding FP (n=28). Those who did reported the leaders having a positive attitude towards smaller family sizes and FP (n=5).
- Community (Friends & Neighbours): Several respondents from South Punjab (n=4), Central Punjab (n=2), and North Punjab (n=1) reported being convinced by their friends and neighbours to use FP. These were mostly young women between the ages of 26 and 38 years.
- Media Sources: Television (n= 13), social media (n= 11), and radio (n= 2) were important communicative influencers. Social media was identified by younger respondents between the ages of 22 and 38, and television by respondents over the age of 40. Social media platforms, like "Tiktok" and "Facebook", were mostly reported as sources by the respondents of South Punjab (n=8).

4.6.3. *Lived experiences*

- Married women aged 25 to 45 years shouldered the main burden of *contraception use*, frequently using short-term and often invasive long-term contraception methods that exposed them to the risk of side effects and method failure while men's use was mostly limited to condoms. Women's bodies remained primary sites of contraceptive interception, primarily to satisfy patriarchal reproductive expectations whereas men uncompromisingly preserved the symbolic capital of male fertility or virility.
- *Gendered expectations* relating to reproductive responsibility are further reflected in the finding that women tended to reactively take recourse in FP, often due to trauma of undergoing multiple pregnancies whereas men conceptualized contraception use as a free choice taken proactively and voluntarily.
- Often lacking the *cultural capital of knowledge* about FP, women relied on social capital, leveraging family, kinship, and communal networks to gain information or facilitate access. Local health workers also supported women in providing information or facilitating access to

FP services by embedding themselves within family, communal, or neighborhood-level social networks.

- Women also received help directly at local *healthcare facilities*, where health professionals recommended contraceptive methods based on their reproductive history and associated health risks. Conversely, men needing information or access to FP services sought it independently from local healthcare workers and facilities. No major problems were reported either by men or women in relation to access to FP services.
- Many women's experiences of contraception use were marred by severe side effects and method failure, particularly in Central Punjab. These embodied experiences were incorporated into habitus often leading to discontinuation and an overall skepticism towards contraception usage. Women also reported lacking prior knowledge of potential side effects, revealing a gap in information-sharing protocols that health providers are expected to follow when recommending contraceptive devices or contraceptive interventions.

4.6.4. *Definition and FP policies*

- *Definitions:* The unidimensional view of FP as "limiting births" was found exclusively in Central Punjab, particularly among older women with four or more children. "Spacing" was the dominant frame among respondents who understood FP in unidimensional terms. The third group that understood FP as unidimensional defined it as the use of specific contraceptive methods such as pills, injections, condoms, or IUDs. Only a small number of respondents conceptualized FP as a two-dimensional construct, combining two of the three factors mentioned in the WHO definition.
- *FP as a functional and moral construct:* Participants framed the functionality of FP within three broad dimensions, namely economic necessity, medical consequences, and family continuity and nurturing. Four female respondents (two each from Central Punjab and North Punjab) stressed on the need for family planning to safeguard the health of mothers and infants. One female each from Central Punjab, North Punjab, and South Punjab, along with one male from North Punjab believed that FP was necessary for family nurturing. Only four respondents (three women from Central Punjab and one man from South Punjab) discussed the moral implications of using FP methods. Two women from Central Punjab made sense of the moral ramifications of FP from within the interpretive framework of religion.
- Finding reinforces the point made earlier that the respondents in Central Punjab were actively negotiating the meaning of FP, illustrating both the coexistence of and conflict between modern and traditional interpretive structures within the community. *Patriarchal values* and relations presented another avenue for moral reasoning about FP.
- Overall, the findings suggest that an overwhelming majority of male and female respondents across all three regions perceived FP as a functional and morally justifiable phenomenon.
- *Understanding FP Policies:* Out of the 41 IDI respondents, a total of 31 respondents said that they were aware of the FP policy.
- 10 respondents, including six female respondents from Central Punjab, one male and two female respondents from North Punjab, and one male respondent from South Punjab, stated that they knew nothing about the two-child policy.
- Unlike the two-child policy, a majority of the respondents were unaware of the *Tawazun* policy. None of the respondents in CP knew about this policy, while only one male respondent in South Punjab reported being aware of it. Punjab Government (PG) is not actively promoting

this policy at the grassroots community level. If this is the case, the PG is not capitalizing on the potential influence of the policy's message or its underlying ideology.

4.6.5. *Connection to theory*

- Women have restricted agency when it comes to communication and discussions regarding family planning.
- Patriarchal structures highlight the importance of husband, his obedience, and his family. Women rely on spousal authority and cannot proceed without their permission.
- Women can be seen gaining social capital from networks such as lady health workers and their sisters-in-law, perhaps as an opposition to patriarchy.
- Some amount of reflexive agency can be seen in women through mundane actions, an important aspect for changing structure.
- Husbands have strong symbolic capital which translates into the need to obey them.
- Bourdieu's field in this context was based on similar beliefs such as men and women's occupation of different social roles, which then translates into their habitus.
- Challenging patriarchal norms came in the form of women negotiating decision-making instead of believing it to be their right.
- Worldviews placed increasing importance on economic capital. Sons were seen as a direct source of financial support, and women's employment was emphasized upon.
- Many women felt disadvantaged due to a lack of social capital in their networks with other women and their husbands.
- Structures such as religious fatalism, economic pressures, and gendered expectations affected their worldview, but several respondents tried to negotiate with these by challenging them representing the possibility of change.

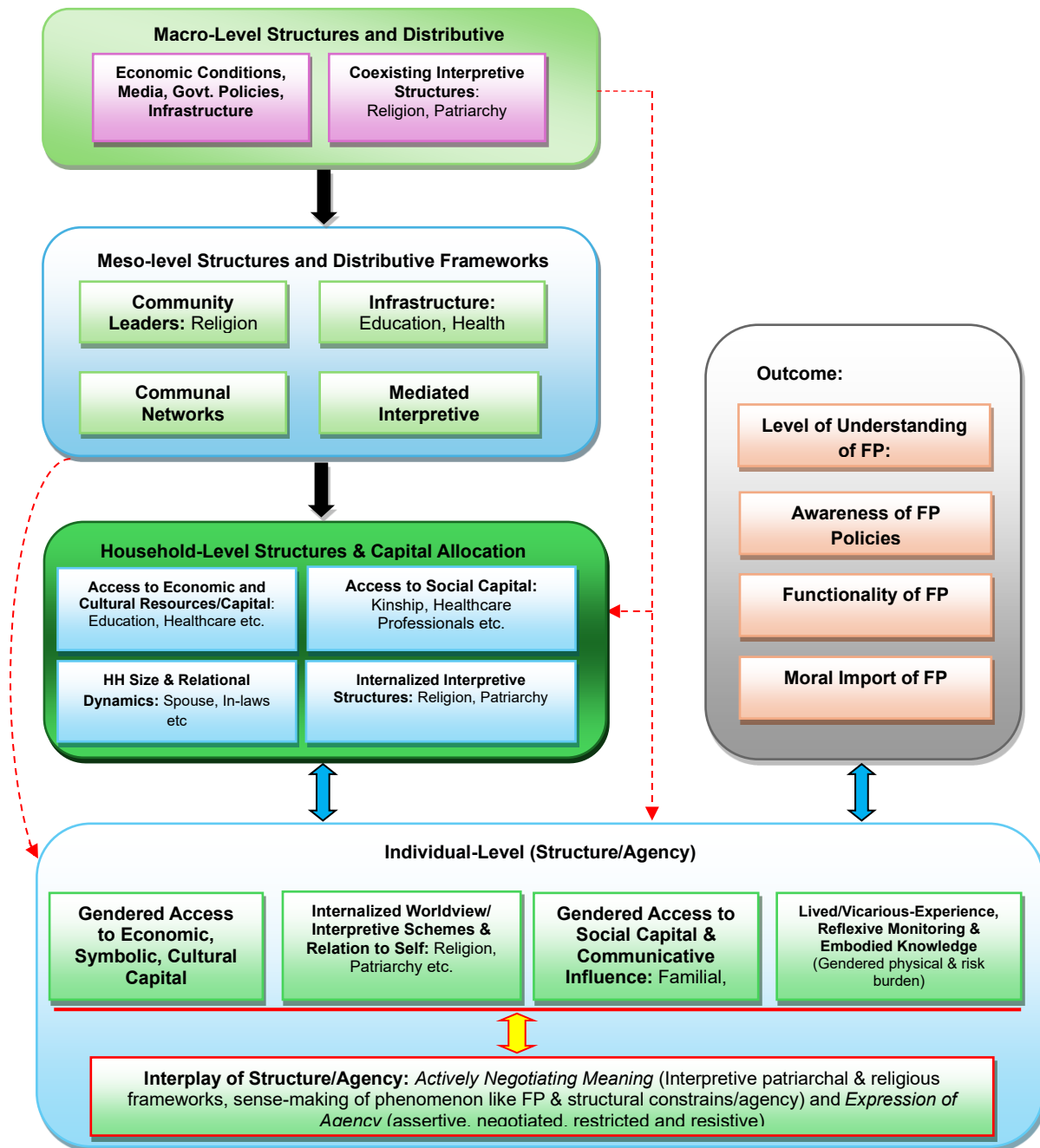
4.7. **Discussion**

The model presents a synthesized theoretical framework of the multilevel process that individuals navigate to make sense of the FP phenomenon. The model indicates how macro-level influencers mediated by meso- or community-level factors shape distributive and interpretive structures.

The model further illustrates how individuals' socio-economic context and internalized interpretive frameworks interact with micro- and meso-level structures, which is reflected in their understanding of and choices related to FP on a day-to-day basis. Thus, individuals are consistently engaged in a formative and active process of negotiating both meaning and agency. Their FP related sense making and agentic choices both reinforce and challenge traditional patriarchal birth-encouraging interpretive structures, often invoking more modern birth-restrictive values, revealing the duality and multiplicity of structures. The expression of agency is heavily dependent upon access to social and cultural capital, which is often channeled through household, communal or macro-level distributive and interpretive frameworks. Ultimately, access to capital is gendered, as women have restricted access to economic, cultural and social resources that enhance their distributive and interpretive repertoire for exercising agency. However, women actively engage in expanding their agency in FP related choices through negotiating with and

resisting patriarchal structures. In the following paragraphs, a deconstruction of this process grounded in the key findings of the study will be presented.

Model: Phenomenological Model of Gendered Lifeworlds: The Multilevel Intersubjective Process of Sense-Making of the FP Phenomenon



4.7.1. Macro-level Structures and Distributive Frameworks

The process begins with overarching macro-level forces that shape structural horizons. These forces can be classified into material and competing interpretive structures. Material structures constitute the overall economic conditions and government budgets, policies and infrastructure relating to health and education. They also include government funded media campaigns designed to promote FP awareness and policies. Media emerged as a powerful tool for the state to directly reach households and individuals. Fifteen respondents, mainly from Central Punjab and North Punjab, reported exposure to FP-related content on television or radio, while eleven

encountered similar content on social media. Younger and more educated respondents, particularly in South Punjab, were more likely to watch FP-related material on the social media.

Government policies, infrastructure and budgetary allocations indirectly influenced households and individuals by shaping the health and education landscape at the communal level. Adverse economic conditions were the most frequently mentioned macro-level influence. Thirty-three respondents across all three communities shared the belief that having more children was untenable under the prevailing economic conditions. Economic conditions provide an example of material structures superseding interpretive frameworks by narrowing the realm choices available to individuals and households.

Analysis of ideational structures revealed that traditional patriarchal and religious frameworks were dominant but not monolithic. A sizable majority of thirty-three respondents, from both genders in the three communities believed in traditional gender roles. However, this view was challenged by fourteen female respondents (mainly in Central Punjab followed by North Punjab), asserting the need for women to have autonomy in health, education and employment related decision-making. In contesting conventional attitudes about gender, women frequently drew on modern and progressive values reflecting multiplicity of structures. This trend was observed to be stronger in the analysis of religious-based explanations underlying the conceptualization of ideal family size amid current economic turmoil. Seventeen women, almost evenly spread across the three communities, shared pro-natal beliefs couched in religious determinism that the Divine Being provides life and sustenance for all. In comparison, thirty-five women (twelve in CP, sixteen in North Punjab and seven in South Punjab) subscribed to a contemporary view of religion, arguing that Islam preaches prudence and permits limiting family size if circumstances demand. Evidence shows that macro-level interpretive structures are not static but are subject to reinterpretation, highlighting the existence of competing traditional and modern frameworks that individuals must navigate in their sense making process, thus enabling agency.

4.7.2. Meso-Level Distributive and Interpretive Frameworks

Macro-level influences often do not manifest themselves directly but are refracted through community-level mechanisms. Actors and institutions at the community-level modulate the flow of resources and ideas from the macro-level to households or individuals' lifeworlds. Data show the mediating influence of community leaders, local healthcare infrastructure (and its community-outreach component), and communal networks as nodes through which social, cultural and symbolic capital flow, and interpretive structures are reinforced or challenged. Local healthcare workers were pivotal in providing information about and facilitating access to FP in all three communities. Forty-one respondents reported receiving information about FP from healthcare workers. Many of these respondents, mostly women, received this information at their homes through community health workers. Some were even facilitated by community health workers to seek help at local healthcare centers. Through community outreach, healthcare workers permeated barriers of gendered access to the cultural capital signifying knowledge about FP. Furthermore, they enabled women's agency by facilitating the adoption of rationalistic frameworks and access to FP services.

In contrast to the critical role played by health workers, the role of community leaders, such as local religious leaders, was considerably limited. Only five respondents (three in Central Punjab and two in South Punjab) reported receiving any advice on FP from local religious leaders, and in each case, the advice was supportive of FP. The absence of religious leaders as active mediators and facilitators of FP uptake in their communities reveals a gap in the community engagement frameworks. The limited role of faith leaders could also reflect the sensitivity attached to contraception-related discourses in religious domains. Religious leaders can play an important

role in facilitating FP uptake within their communities by leveraging their symbolic capital and evoking contemporary religious interpretive schemes.

In addition to the formal healthcare system and the informal authority of religious leaders, everyday communal networks were often instrumental in facilitating FP awareness and uptake. Seven women (two in Central Punjab, one in North Punjab and four in South Punjab) received information about FP, while three women (one in Central Punjab and two in South Punjab) were facilitated in accessing FP services by friends and neighbors in the community. These interactions flowing through communal networks elucidate the significance of social capital in strengthening women's agency and improving their access to cultural capital.

Overall, the mediating role of actors and institutions at the meso-level was beneficial in bolstering birth-restrictive interpretive frameworks and challenging gendered barriers to access FP uptake within communities. However, there is evidence that communities were also sites of contestation, where patriarchal and reformist interpretive frameworks collided and were negotiated. For instance, out of the twenty-eight participants who responded to the question related to communal norms of son preference, twenty (eight each in Central Punjab and North Punjab, and four in South Punjab) believed that families with sons enjoyed more respect in their communities. Higher status granted to families with male heirs represents symbolic violence or the incorporation of patriarchal norms into doxa that perpetuates the male privilege across generations.

4.7.3. Household-level Structures and Resource Allocation

Community-level resources and influences are subsequently channeled into the household, which is the primary site of reproductive decision-making. The household is both the key conduit through which (economic, social, and cultural) capital flows to individuals, and the field where individuals enact capital and internalized schemes in decision-making within structures. Micro- and meso-level influences are filtered into households. These influences shape access to economic, social and cultural capital (including family and kinship networks), the size and composition of the households, families' internalized gender norms and religious frameworks, and individuals' expression of agency within the dynamics of relationships with spouses and in-laws. Households control access to allocative resources. As discussed above, adverse economic conditions were a major driver for limiting family size among respondents. These choices were not necessarily the result of a weakening of patriarchal interpretive schemes within households but of material structures (inflation, poverty, etc.) reshaping how patriarchal values were expressed through reproductive choices. Additionally, households were key entry points for healthcare workers to permeate the gendered distribution of cultural capital by conducting community outreach to inform and facilitate women and families about FP.

Access to authoritative resources was also gendered at the household level. Authoritative resources signify power over familial and kinship relationships, which influence access to FP and women's agency over contraceptive use. Men's access to FP information and services was not mediated through communal or household relationships. All four men (one in North Punjab and three in South Punjab) who discussed their agency in contraception use described it as a free choice independent of spousal or familial influence. Only one man in South Punjab believed contraceptives should be used with a wife's consent. In contrast, familial networks were often instrumental in gaining FP knowledge and access among women. A majority women (six in Central Punjab, eight in North Punjab, and 10 in South Punjab) reported discussing FP with their spouses. However, only one woman across all three communities reported being facilitated by her husband in seeking FP services, reflecting a patriarchal deferral of the reproductive burden onto women. Some women also directly expressed that FP uptake was solely the husband's choice (discussed in the next section).

In-laws often took on a facilitative role in advising women on FP and facilitating their uptake of FP services. As many as 10 female respondents (two in Central Punjab and four each in North Punjab and South Punjab) reported receiving advice or support from their mothers-in-law or sisters-in-law to use FP. Overall, seven women across the three communities were actively facilitated by their in-laws to access FP services. This is an example of social capital flowing through and being shaped by patriarchal structure, indicating that these networks can be both a source of support and a mechanism for reinforcing traditional norms. For instance, one woman in Central Punjab faced reproductive coercion from in-laws because they wanted her to conform to the norm of compulsory motherhood. A few women also received information and help from natal networks, especially from mothers in Central Punjab (three women).

The model further explores the duality of structures at the household-level by analyzing how multiple and competing interpretive schemes from macro- and meso-levels are internalized and how these beliefs are actively negotiated within this field. A few older and uneducated women in Central Punjab manifested internalization of traditional beliefs in their deference to religious fatalism and patriarchal norms to reinforce values like compulsory motherhood and son preference. In such cases, patriarchal structures had been incorporated into doxa, constraining women's reproductive agency. In other cases, households were the site of contestation and negotiation of meaning. For instance, four men (one in North Punjab and three in South Punjab) declared having complete agency over decision-making related to contraception use, while fourteen female respondents (mainly in Central Punjab and North Punjab) stressed the need for women's autonomy in decisions related to their education, employment and health, including their reproductive health. Households emerged as fields where traditional structures were reproduced, negotiated, and contested through individuals' reproductive choices, reflecting the multiplicity of interpretive frameworks. Interpretive structures internalized at the household levels are simultaneously constrained and challenged by individuals' agentic choices, indicating the duality of structures.

4.7.4. Individual Level (Structure and Agency)

The individual represents the vessel into which multi-level material and interpretive forces flow and are enacted and reinforced through lived experiences to shape the worldview. Worldview structures agency, but agency, informed through the reflexive monitoring of lived experiences, can also restructure worldview. With specific reference to FP, individuals' expression of agency ranged between assertive, negotiated, constrained, and resistive.

Gendered access to (social, cultural, and economic) capital was a key determinant that shaped individuals' lifeworld. Men's pathway to FP information and services was independent and enabled by symbolic capital. The four men who discussed their agency gained access directly at healthcare facilities. Women often relied on familial, kinship, and community ties to obtain information and support for utilizing FP services. For example, 10 women were advised and seven were actively facilitated by their in-laws to use FP. Women's relational dependency in adopting FP structurally constrained their agency to make independent reproductive choices, whereas men exercised complete autonomy. Lack of access to cultural capital (like education) further entrenched women's dependency on social ties. While adverse economic conditions pushed women to adopt FP as a functional necessity.

Macro-level and meso-level interpretive schemes are often filtered, structurally enforced, and operationalized at the household level. These interpretive schemes are internalized via lived experience and shape the worldview through which individuals understand the lifeworld. The worldviews of some female respondents reflected doxic acceptance of patriarchal and traditional religious norms that constrained their agency. For instance, seventeen women from all three communities viewed births and family subsistence from a fatalistic lens by framing these

phenomena within the interpretive scheme of predestination. In some cases, mostly in Central Punjab, submission to religious fatalism led to acceptance of patriarchal norms like compulsory motherhood and son preference. However, the majority actively negotiated and reinterpreted religious frames to enable agency. A total of thirty-five respondents from the three communities supported a modern interpretation of Islam that emphasized prudence over fatalism and allowed for limiting births depending upon the economic circumstances of a particular family. Analysis shows that worldviews are not static or monolithic but dynamic spaces for sense-making that are constantly being shaped and reshaped by the process of reflexive evaluation of lived experience.

Apart from the mediated influence of material and interpretive distributive frameworks and individuals' access to (economic, social, cultural, and symbolic) capital, worldviews were also shaped through experiential learning. Individuals created repositories of embodied knowledge about FP gained through lived and vicarious experiences. Consistent with the overall trend observed in findings, the lived experiences and experiential learning they generated were heavily gendered. Women's bodies remained the primary site of reproduction, contraceptive use, and their consequences. Their construction of embodied knowledge was generated through reflexive monitoring of the personal or 'felt' experiences. Women reported using a variety of short-term and long-term contraception devices, often exposing their bodies to intrusive procedures and their side effects. Instances of severe side effects were found to be fairly common, especially in Central Punjab. In case of method failure, they bore the consequences of unplanned pregnancies. Their embodied knowledge about FP showed a practical and nuanced understanding of associated risks, and potential costs and benefits. Men's experience of contraception is afforded to them by male privilege. Men only reported using condoms, a short-term and non-intrusive method with no side effects. By assimilating their lived experiences with patriarchal symbolic capital and privileged access to social and cultural capital, men made sense of FP and contraceptive use as a free and optional choice. Conversely, women's sense of contraceptive use was based on embodied experience seen through the lens of patriarchal relegation and restricted access to social, symbolic, and cultural capital. Women understood contraceptive use as a risky and burdensome necessity. Five (three in Central Punjab and one each in North Punjab and South Punjab) out of eight women who shared their reasons for adopting FP took up contraception as a necessary precaution after repeated births or complications in a recent pregnancy. Often enough, women were socially dependent in accessing FP services, which further added to the perceived burden of necessity. The majority women, who had used contraceptives, reported that they initially gained access either through social or communal networks or through local health workers' community outreach activities. Alternatively, men primarily gained access by directly visiting the local healthcare facility.

Analysis showed that women's embodied knowledge of contraceptive use was frequently marred by unexpected negative experiences, revealing a critical gap in contraceptive healthcare protocols. A few female respondents, especially in Central Punjab, reported experiencing mild to severe side effects due to contraceptive use. None of them recounted being duly warned about the potential side effects of the prescribed method by healthcare professionals. These negative experiences prompted a process of reflexive monitoring that led to re-evaluation, and in most cases, discontinuation of contraceptive use. Vicarious learning also played a significant role in FP uptake. Some women in Central and North Punjab shared cautionary tales of failure of contraceptive methods and severe side effects to argue against FP uptake. Overall, embodied knowledge gained through reflexive monitoring of lived and vicarious experiences with FP was incorporated into habitus, influencing both individuals' worldview and their use of agency.

4.7.5. *The Interplay of Structure and Agency*

Within the distributive framework of material resources and access to economic, social, and cultural capital, the reciprocal relationship between individuals' worldview and lived experiences shaped the expression of agency. Findings indicated that respondents' use of agency was a dynamic process leading to four distinct types of expression.

Men typically exercised assertive agency. Their FP-related choices were autonomous and independent. All four men, who discussed their decision-making process, described contraceptive uptake as a free and volitional choice. Their male privilege distanced them from the physical burden of contraceptive use and accorded them the symbolic capital that granted them the autonomy to make decisions without needing spousal consent.

Women exercised their agency in diverse ways. As many as 10 women exercised assertive agency by independently taking contraceptive-related decisions, four women showed negotiated agency by making choices with spousal consent, while another four experienced constrained agency due to doxic acceptance of patriarchal or traditional religious norms. One woman from Central Punjab exercised resistive agency by covertly using contraception without her spouse's knowledge. Women demonstrated the capacity to challenge patriarchy through agentic choices in their daily lives, illustrating the duality of structures.

Overall, the use of agency did not merely signify the ability to act, but the reflexive process of navigating structural constraints in the 'field' of their reproductive lives. Choices also shaped their lived and vicarious experiences, which simultaneously shaped their worldview, understanding of structure, and eventually their future choices.

4.7.6. *Understanding of FP*

As an outcome, individuals' view of FP and awareness of policies were shaped by the mediated influence of material and structural endowments and constraints, as seen through the emergent interplay between their worldview and agentic choices. A majority respondents had a narrow unidimensional understanding of FP, conceptualizing it as signifying only birth control, birth restriction, or medical intervention. This can be interlinked to respondents' limited and gendered access to cultural capital and constrained agency. Only a few respondents understood FP as a multidimensional construct. The development of a complex understanding of FP depends on access to resources like education, kinship or communal networks, and access to healthcare workers, and assertive or negotiated agency. The significance of health system's community-level outreach cannot be overstated in this regard. Moreover, well-defined protocols, requiring healthcare workers to give complete information about FP methods and their side effects can further foster a deeper understanding of the phenomenon. Findings indicate that such initiatives by the healthcare system will be met by increased uptake of FP, as majority respondents considered FP a functional and morally justifiable choice.

Lastly, majority respondents were aware of the two-child policy, while most did not know about the *Tawazun* policy. This illustrates a failure of the state's information dissemination chain, revealing the significance of macro-level structures in policy diffusion at grass roots level.

5. POLICY RECOMMENDATIONS

The following policy recommendations are characterized by the model, which consisted of four structures and distributive frameworks. These structures are found at macro, meso, household, and individual levels, and are aligned with the findings from the sections' worldview, communicative influences, lived experiences, definitions of family planning, and policy frameworks.

1. *Macro-Level Structures and Distributive Frameworks*

- *Implementation of Family Planning & Reproductive Health Rights (FP&RH) Bill:* In light of the perennial family planning issues in the Punjab, the provincial government should implement the FP&RH bill in letter and spirit to guarantee family planning as a fundamental right. Through this bill, citizens will be able to recognize and access FP services not as a 'programme' but a 'legally protected right'. The bill should clearly define FP a positive right. "Positive rights, also called rights of the recipient or entitlement, provide something that people need to secure their well-being. The existing legislation, the Punjab Reproductive, Maternal, Neonatal and Child Health Authority Act 2014, limits the provision of FP as a legal human right. Classifying the right to family planning as a positive right will construe an obligation on the Punjab government to provide this service at the community and neighborhood level. The implementation of this new bill in accordance with the national-level frameworks 'Tawazun' and 'National Action Plan' on Family Planning would prove instrumental by creating awareness, fostering social development, and empowering individuals to make informed decisions, leading to reduced poverty.
- *Public-Private Partnership:* Public-Private Partnership initiatives, such as ongoing collaborations with the Greenstar and The Challenge Initiative (TCI), could serve as an additional and crucial resource for addressing financial and social outreach challenges in mainstreaming family planning at grass roots level. The Punjab government could offer tax incentives to companies that provide financial or logistical support to ongoing FP programmes as part of their Corporate Social Responsibility (CSR) initiatives. The National Action Plan's report highlights that federal and provincial governments could potentially face a financial deficit of Rs 80 billion. CSR strategies can facilitate resource mobilization by leveraging corporate logistics and retail networks. Several state-led companies such as the National Bank of Pakistan, Pakistan State Oil, and the Fatima Group, aim to advance social development through CSR efforts focused on health. A joint effort between Punjab's health and population departments and the private sector could play a pivotal role in streamlining family planning reforms. This initiative would boost domestic funding for family planning programmes, ultimately reducing reliance on international sources like the World Bank.
- *State-led family planning programme initiatives:* The governments of Pakistan and the Punjab can start a programme that encourages smaller families. Since family sizes are increasing among the poor and impoverished families, this programme should focus on low-income rural or peri-urban households. Initial data on these households can be collected with help from the Benazir Income Support Programme (BISP), which has already reached millions of poor households. The government can also introduce Conditional Cash Transfers (CCT) to families that meet specific criteria, such as (i) the number of children (2 or 3) and (ii) birth spacing (2-3 years). Similar programmes have been implemented in countries like Iran in the late 1980s, demonstrating the government's commitment to promoting family planning.

- *Dissemination/Information about FP and FP policies:* The Government of Pakistan and the Punjab government have failed to create public awareness about the existing FP framework and ‘*Tawazun*’ policy. Findings showed that *Tawazun* policy had great potential and most respondents, after the policy was explained, unequivocally agreed with it. *Tawazun* policy could provide a strong ideological ethos that could serve as the basis for a renewed province-wide campaign to promote family planning. While designing promotional campaigns for FP awareness, the government should ensure that all components of the WHO’s multi-dimensional definition are explained in detail. The provincial government should strengthen its information dissemination network through the following platforms:
 - The Council of Islamic Ideology (CII) can be contacted to develop a campaign aimed at framing FP within the principles of Islam. The campaign should specifically address misconceptions that portray FP as un-Islamic and emphasize the religious perspective on responsible parenthood and maternal well-being. It could enhance the moral legitimacy of FP in rural communities and help reduce resistance to its uptake. Overall, the campaign could potentially build public trust in FP programmes and encourage wider acceptance of FP among diverse social groups across the Punjab.
 - *Media*, especially (i) television ads (public service messages), using standardized terminologies, i.e. “*Sehatmand Maa, Sehatmand Bacha*”, etc., and (ii) TV dramas: conveying messages and lessons on FP, maternal and child health on popular private TV channels. In the Punjab, Population Welfare Department (PWD) is already engaged in producing TV drama to promote FP. However, these efforts are isolated and sporadic. Besides, new content needs to be consistently produced to reinforce this message.
 - *Social media*: State-led targeted campaigns on social media platforms like YouTube, TikTok, and Instagram for the youth, newly married couples, etc., through digital storytelling. Findings showed that social media was the primary source through which many educated women under the age of 35, received information about FP, especially in South Punjab and North Punjab. Social media provides a cheaper and effective channel for promoting FP among youth.
 - *Billboards*: Billboards are a great source of information dissemination, especially in populated districts like Lahore, Multan, and Rawalpindi. Information should be provided in Urdu language so that every citizen can understand the message.
 - *Street theater*: Street theater has proven to be a powerful medium for promoting Water, Sanitation, and Hygiene (WASH) and FP in India. The Punjab government could also incorporate this strategy into its campaign to promote FP. A practical approach would be to incentivize community healthcare workers to collaborate with local theater groups and design culturally relevant performances that address local myths, stereotypes, and misconceptions about FP while highlighting its benefits. These performances could be staged at village fairs and community gatherings to help normalize and encourage open social dialogue on FP within communities.

2. *Meso-level Structures and Distributive Frameworks*

Multi-sectoral approaches for FP campaigns:

Getting Local Religious Leaders Onboard: The Punjab government could leverage the symbolic capital of local clerics by incentivizing them to participate in an FP awareness training and dissemination programme. This programme should be specifically designed for community-level religious leaders and should provide training on 1) understanding FP and available FP services; 2) how FP can be justified within Islamic principles, and 3) strategies for disseminating information about FP in communities through sermons and outreach. The trained religious leaders should be further incentivized to operationalize their training by spreading awareness about FP in their communities. Additionally, the health department could strengthen this initiative by hiring their wives as community health workers or as part-time members of immunization teams. As community health workers and the wives of local religious leaders would be in a better position to connect with women in their communities and effectively disseminate awareness about FP.

Education: *First*, FP awareness sessions should be mandatory in academic institutions, specifically in colleges and universities with no Population Research Centers (PRCs). Children living in rural or peri-urban areas travel to colleges and universities, as also revealed in the results of existing research. Thus, these awareness sessions will be a value addition.

Second, FP education from an early age will yield long-term benefits. However, in Pakistan, cultural beliefs play a vital role in adapting any new practice. Providing mandatory FP education in schools or colleges will not be an acceptable approach to parents, due to cultural and religious beliefs. The state should address this issue and provide solutions as *how to incorporate FP knowledge in education*.

3. Household-Level Structures & Capital Allocation

- *Strengthening women's empowerment and awareness of the role of agency:* The current research indicates that majority women in Central, South, and North Punjab were either unaware of or had a unidimensional understanding of FP. This has emerged as a major impediment in women's non-utilization or delayed uptake of FP services. Pre-marital counseling initiatives, such as *Aghaaz*, could provide a viable solution to address this knowledge gap. Pre-marital counseling could significantly contribute to empowering families and couples to make informed reproductive choices. Pre-marital counseling should be instituted as a mandatory component of the Nikah process. Prior to the registration of a Nikah, it should be incumbent upon prospective spouses to undergo pre-marital training that provides comprehensive information about *nikah nama* (marriage contract) and FP services. Local Union Councils should offer this training free of charge to all residents. Iran has implemented a similar pre-marital training programme that emphasizes health and well-being, marital skills, and reproductive health.
- *Considering social norms:* The Punjab government has considerably failed to consider social norms while implementing family planning policies and programmes. Social Norms and cultural beliefs shared by residents of rural or peri-urban areas shape their families. 'Son preference' is considered to be the prevalent norm in Pakistani rural culture because of gender inequity and often leads to other problems like health complications for the mother due to giving multiple births. First, the government of Punjab can leverage electronic and print media to carry out targeted awareness and educational campaigns that promote gender equality, especially among the younger population. Furthermore, these campaigns should specifically target in-laws.

- *Strengthening service delivery:* The Punjab government should strengthen service delivery by providing targeted subsidies for LHWs and Community Health Workers (CHWs).
 - LHWs and CHWs communicate and provide service to residents of low-income areas. Inclusion of modules that train health workers to communicate about FP in a culturally and contextually relevant manner will likely improve FP uptake in low-income rural areas. Furthermore, proactively reaching out to low income and illiterate women in their communities should be made part of their regular performance evaluation. Findings revealed that women in Central Punjab were rarely visited by health workers, and those who had received visits from LHWs expressed dissatisfaction with the information provided. This highlights the lack of Monitoring and Evaluation (M&E) of community health workers in Central Punjab. Community health workers should be given manuals that clearly lay down protocols for providing information or facilitation to women during community outreach.
 - The Punjab government can implement an experimental programme in one of its rural district to test the effectiveness of service delivery and expand community outreach. A notable example can be taken from Bangladesh's MATLAB programme, which aimed to strengthen service delivery through the involvement of community workers.

4. *Individual-Level (Structure/Agency)*

- *Addressing consequences of contraceptives:* Research has shown that female respondents are burdened with contraception methods like pills, injections, IUDs, etc. Utilizing these methods exposes them to the risk of suffering side effects and method failure. Their bodies remain primary sites of intrusive contraceptive interventions, while male respondents' contraception use is limited to condoms. It leads to multiple physical and psychological consequences for women. To address this persisting issue, the Punjab government needs to i): provide pre-use counseling to women at the community and household level where local health centers should maintain an updated medical history of women opting for FP methods, making monthly checkups mandatory, and ii) create awareness on male contraceptives other than condoms, like vasectomy.
- *Enhancing access to cultural capital:* Women often lack access to information about FP, limiting their ability to autonomously engage in informed reproductive health decision-making. Reliance on social capital, like kinship, familial, and communal networks, for information could sometimes lead to misinformation and potentially expose them to the risk of social exploitation. Considering FP as a positive right, the state should take on the responsibility of proactively providing FP and contraceptive-related information to women within their communities. To tackle this, the Punjab government, in collaboration with the provincial health and population department, Pakistan Medical Association, should design awareness campaigns involving doctors, community leaders, and health workers.
- *Incorporating agency in family planning programmes:* In the present study, agency (assertive, restrictive, and resistive) emerged as an important contributing factor in FP-related decision-making. Women who exercised assertive agency demonstrated higher and continued FP uptake, suggesting that individual autonomy can counter cultural and normative barriers. The Punjab government should leverage the individual-level lived experiences of women who have exercised assertive agency at grass roots level by organizing women's community forums (LHWs and NGOs). These forums could provide

platforms where women could share stories of gaining autonomy over their reproductive health and mentor other women in the community. Under these forums, confidentiality should be maintained by forum members for women who are sharing their stories about using contraceptives.

6. CONCLUSION

The results of this comparative phenomenological approach, which addressed family planning and its services in three districts of the Punjab, highlight the viewpoints of both men and women. These viewpoints have been analyzed from four different dimensions, i.e. worldview, communicative influences, lived experiences, understanding of family planning, and awareness of family planning policies. The interplay of these dimensions is further accumulatively distributed at macro, meso, household, and individual levels.

Factors such as traditional gender roles, government policies, cultural factors like religion, community, and community leaders, health workers, family, and media sources significantly contribute to decision-making about family planning and the adaptation of its services by male and female respondents, leading to their lived experiences. These lived experiences are derived from multiple factors, such as facilitation and help, consequences of contraception (physical/physiological), and agency. It was also analyzed that the adaptation of family planning services depends upon the above-mentioned factors, including the understanding of family planning through its definition. Some respondents did not know about the term 'family planning', while some of them understood it as unidimensional and some as multidimensional. Only one female respondent from Central Punjab defined family planning, which synchronizes with all the three WHO components that is: (i) achieving desired family size, (ii) spacing and timing of births, (iii) using contraceptive methods and treatments. This highlights the lack of knowledge among individuals residing in the sample districts of the Punjab. These districts are not purely rural. It further shows that the lack of family planning understanding is not only limited to rural areas but also to urban vicinities. The structural gaps need to be addressed at grass roots levels for better communities.

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Annexure A: Female Questionnaire Instruments

Female IDI - Urdu (PRC-Family Planning Questionnaire)

آبادیاتی معلومات:

1. نام
2. جنس
3. ذات
4. مذہب
5. شادی کے وقت عمر
6. پہلے بچے کے وقت عمر
7. آخری بچے کے وقت عمر
8. آپ کی شادی کو کتنا وقت گزر چکا ہے؟
9. خاندان کی قسم؟ (1) جوہری (2) مشترکہ

10. بچوں سے متعلق سوالات
(a) آپ کے کتنے بچے ہیں؟
(b) بچوں کی جنس؟
(c) بچوں کی عمر؟
(d) تعلیم؟ کیا وہ اسکول جاتے ہیں؟
(e) کیا وہ بھی کام کرتے ہیں؟ اگر 'ہاں'، تو، کام کی نوعیت؟
(f) اگر وہ اسکول نہیں جا رہے ہیں تو پھر اسکول نہ جانے کی وجہ؟

11. آپ کے مطابق، ایک کامل خاندان میں کتنے بچے ہونے چاہئیں؟
جواب جو بھی ہو، ان سے پوچھیں کہ یہ ان کے مطابق بہترین تعداد کیوں ہے۔

12. 'خاندانی منصوبہ بندی' کے بارے میں
(a) کیا آپ خاندانی منصوبہ بندی سے واقف ہیں؟ اگر ہاں، تو اپنے الفاظ میں 'خاندانی منصوبہ بندی کیا ہے' کی وضاحت کریں۔
(b) کیا آپ خاندانی منصوبہ بندی کی خدمات سے واقف ہیں؟ اگر ہاں، تو اپنے الفاظ میں 'خاندانی منصوبہ بندی کی خدمات کیا ہیں' کی وضاحت کریں۔
(c) کیا آپ کو لگتا ہے کہ آپ اس خیال کو مکمل طور پر سمجھتے ہیں یا آپ محسوس کرتے ہیں کہ ایسی چیزیں ہیں جو آپ ابھی تک اس کے بارے میں نہیں جانتے یا سمجھتے نہیں ہیں؟
(d) آپ کو پہلی بار خاندانی منصوبہ بندی کے بارے میں کب پتہ چلا؟ اور کیسے؟
(e) کیا آپ کی زندگی میں کبھی ایسا وقت آیا ہے جب آپ نے خاندانی منصوبہ بندی کے بارے میں مزید جاننے کی ضرورت محسوس کی؟
(f) حالات کیا تھے؟
(g) آپ کو خاندانی منصوبہ بندی کے بارے میں مزید کیسے پتہ چلا (آپ نے کس سے پوچھا)؟

13. 'حکومت کی پالیسی' سے اوپر

- (a) کیا آپ فیملی پلاننگ کے بارے میں حکومت کی دو بچوں کی پالیسی سے واقف ہیں، جو ۲۰۱۷ تک نافذ تھی؟ اگر ہاں، تو آپ اس کے بارے میں کیا جانتے ہیں؟
- (b) کیا آپ حکومت کی نئی پالیسی 'توازن' سے واقف ہیں جو اب نافذ العمل ہے؟ اگر ہاں، تو آپ اس کے بارے میں کیا جانتے ہیں؟

14. 'مانع حمل کے طریقوں' کے بارے میں
- (a) کیا آپ نے کبھی مانع حمل کے طریقوں کا استعمال کیا ہے؟
- (b) کس نے مشورہ دیا کہ آپ انہیں استعمال کریں؟
- (c) کن حالات نے آپ کو ان کا استعمال شروع کرنے پر مجبور کیا؟
- (d) اگر ہاں، تو آپ نے انہیں کتنے عرصے تک استعمال کیا؟
- (e) آپ کس قسم کی مانع حمل ادویات استعمال کر رہے ہیں؟ (جیسا کہ اس کی متعدد اقسام ہیں: روایتی، جدید "کنڈوم، گولیاں، ہنگامی مانع حمل، انجکشن، امپلانٹس، انٹرا یوٹیرین مانع حمل ڈیوائس (آئی یو سی ڈی))
- (f) آپ نے مانع حمل ادویات تک رسائی کیسے حاصل کی؟ کیا وہ آپ کے لئے آسانی سے قابل رسائی تھے؟
- (g) آپ نے مانع حمل ادویات کا استعمال کب بند کیا؟
- (h) آپ نے مانع حمل ادویات کا استعمال کیوں بند کر دیا؟
- (i) کیا کسی نے آپ پر دباؤ ڈالا، یا ان کا استعمال شروع کرنے یا بند کرنے کا آپ کا اپنا فیصلہ تھا؟

15. 'خاندانی منصوبہ بندی پر تبادلہ خیال' کے بارے میں
- (a) آپ کی شادی کے دوران، کیا کسی نے آپ کو خاندانی منصوبہ بندی کے بارے میں مشورہ دیا تھا؟ اگر ہاں، تو آپ کو کس نے مشورہ دیا اور انہوں نے آپ کو کیا مشورہ دیا؟
- (b) اپنی شادی کے دوران، کیا آپ نے کبھی اپنے شوہر کے ساتھ خاندانی منصوبہ بندی پر تبادلہ خیال کیا ہے؟ اگر ہاں، تو بحث کی نوعیت کو اپنے الفاظ میں بیان کریں۔
- (c) کیا آپ نے کبھی کسی دوسرے شخص کے ساتھ خاندانی منصوبہ بندی پر تبادلہ خیال کیا ہے (بشمول کمیونٹی کی ایک خاتون رکن، پڑوسی، دوست، یا رشتہ دار - ساس / بہابھی وغیرہ)؟ اگر ہاں، تو بحث کی نوعیت کو اپنے الفاظ میں بیان کریں۔
- (d) کیا آپ کسی ایسے شخص کو جانتے ہیں جو مانع حمل ادویات کا استعمال کرتا ہے؟
- (e) کیا آپ نے کبھی ان کے ساتھ 'خاندانی منصوبہ بندی' کے بارے میں بات کی ہے؟

16. آپ کے مطابق بچے کی پیدائش سے متعلق فیصلے کرنے کا حق کسے حاصل ہے؟
- (1) شوہر (2) بیوی (3) شوہر اور بیوی دونوں (4) سسرال (5) دیگر۔

17. دین کی روشنی میں
- (a) کیا مذہب زیادہ یا کم بچے پیدا کرنے کے بارے میں کوئی رہنمائی یا اصول فراہم کرتا ہے؟
- (b) کیا مذہب خاندانی منصوبہ بندی کی خدمات کے استعمال کی اجازت دیتا ہے؟

18. آپ کی خاندانی روایات اور آبائی طرز زندگی کی روشنی میں،
- (a) کیا وہ زیادہ یا کم بچے پیدا کرنے کی اجازت دیتے ہیں؟
- (b) کیا وہ خاندانی منصوبہ بندی کی خدمات کے استعمال کی اجازت دیتے ہیں؟

19. معاشی اور مالی حالات کی روشنی میں
- (a) کیا زیادہ بچے پیدا کرنا مناسب ہے؟
- (b) خاندانی منصوبہ بندی کی خدمات اچھی ہیں یا بری؟

20. کیا آپ کے خاندان / گاؤں میں زیادہ بچے پیدا کرنا اچھا سمجھا جاتا ہے؟

21. کیا کسی این جی او، کسی سرکاری محکمے کے کسی افسر نے فیملی پلاننگ کے بارے میں بیداری فراہم کرنے کے لیے کبھی آپ کے گاؤں کا دورہ کیا ہے؟ اگر ہاں، تو انہوں نے کیا کہا؟
22. کیا کسی سرکاری یا نجی اسپتال سے کسی صحت کی دیکھ بھال فراہم کرنے والے، لیڈی ہیلتھ ورکر، یا کسی ڈاکٹر نے آپ کے گاؤں کا دورہ کیا ہے یا آپ کو خاندانی منصوبہ بندی کے بارے میں کوئی آگاہی / معلومات فراہم کی ہیں؟ اگر ہاں، تو انہوں نے کیا کہا؟
23. کیا کسی مذہبی اسکالر (مولوی، پادری، پادری، بہن) نے کبھی خاندانی منصوبہ بندی کے بارے میں بیداری فراہم کرنے کے لئے آپ کے گاؤں کا دورہ کیا ہے؟ اگر ہاں، تو انہوں نے کیا کہا؟
24. کیا آپ نے کبھی سوشل میڈیا، ریڈیو، اخبار یا ٹیلی ویژن کے ذریعے خاندانی منصوبہ بندی کے بارے میں کوئی معلومات حاصل کی ہیں؟
25. اگر آپ خاندانی منصوبہ بندی کے بارے میں پہلے سے جانتے، تو آپ کی ذاتی زندگی میں کیا تبدیلی ہو سکتا تھا؟
26. آپ کی رائے میں حکومت کو خاندانی منصوبہ بندی کے بارے میں بیداری کیسے پیدا کرنی چاہیے؟ کس قسم کی مہمات لوگوں کے لئے فائدہ مند ہوں گی؟
27. میرے پاس مزید کوئی سوال نہیں ہے۔ اگر آپ کے پاس میرے لئے کوئی سوال ہے تو، براہ مہربانی آگے بڑھیں اور پوچھیں۔

Female – FGD - Urdu (PRC-Family Planning)

Section A: آبادیاتی معلومات					
					نام
					عمر
					ذات
					مذہب
					شادی کے وقت عمر
					پہلے بچے کے وقت عمر
					آخری بچے کے وقت عمر
					آپ کی شادی کو کتننا وقت گزر چکا ہے؟
					آپ کی شادی کو کتننا وقت گزر چکا ہے؟

سوال نمبر	پیشن گوئی کرنے والا عنصر	ایف جی ڈی کا سوال
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<p>آپ کے کتنے بچے ہیں؟ ان کی جنس، عمر اور تعلیم کیا ہے؟ کیا ان میں سے کوئی کام کر رہا ہے؟ اگر ہاں، تو کام کی نوعیت؟</p> <p>کیا وہ اسکول جا رہے ہیں، اگر نہیں، تو اسکول نہ جانے کی کیا وجہ ہے؟</p> <p>آپ کے مطابق، ایک کامل خاندان میں کتنے بچے ہونے چاہئیں اور کیوں؟</p>	<p>بچوں کی معلومات</p>	<p>1.</p>
<p>○ کیا آپ خاندانی منصوبہ بندی سے واقف ہیں؟ اگر ہاں، تو اپنے الفاظ میں 'خاندانی منصوبہ بندی کیا ہے' کی وضاحت کریں.</p> <p>○ کیا آپ خاندانی منصوبہ بندی کی خدمات سے واقف ہیں؟ اگر ہاں، تو اپنے الفاظ میں 'خاندانی منصوبہ بندی کی خدمات کیا ہیں' کی وضاحت کریں.</p> <p>○ کیا آپ کو لگتا ہے کہ آپ اس خیال کو مکمل طور پر سمجھتے ہیں یا آپ محسوس کرتے ہیں کہ ایسی چیزیں ہیں جو آپ ابھی تک اس کے بارے میں نہیں جانتے یا سمجھتے نہیں ہیں؟</p> <p>○ آپ کو پہلی بار خاندانی منصوبہ بندی کے بارے میں پتہ چلا اور کیسے؟</p> <p>○ کیا آپ کی زندگی میں کبھی ایسا وقت آیا ہے جب آپ نے خاندانی منصوبہ بندی کے بارے میں مزید جاننے کی ضرورت محسوس کی؟</p> <p>○ حالات کیا تھے؟</p> <p>○ آپ کو خاندانی منصوبہ بندی کے بارے میں مزید کیسے پتہ چلا (آپ نے کس سے پوچھا)؟</p>	<p>خاندانی منصوبہ بندی کے بارے میں معلومات</p>	<p>2.</p>
<p>○ کیا آپ فیملی پلاننگ کے بارے میں حکومت کی دو بچوں کی پالیسی سے واقف ہیں، جو ۲۰۱۷ تک نافذ تھی؟ اگر ہاں، تو آپ اس کے بارے میں کیا جانتے ہیں؟</p> <p>○ کیا آپ حکومت کی نئی پالیسی 'توازن' سے واقف ہیں جو اب نافذ العمل ہے؟ اگر ہاں، تو آپ اس کے بارے میں کیا جانتے ہیں؟</p>	<p>'حکومت کی پالیسی' کے بارے میں تشکیل</p>	<p>3.</p>
<p>○ کیا آپ نے کبھی مانع حمل کے طریقوں کا استعمال کیا ہے؟</p> <p>○ کس نے مشورہ دیا کہ آپ انہیں استعمال کریں؟</p> <p>○ کن حالات نے آپ کو ان کا استعمال شروع کرنے پر مجبور کیا؟</p> <p>○ اگر ہاں، تو آپ نے انہیں کتنے عرصے تک استعمال کیا؟</p> <p>○ آپ کس قسم کی مانع حمل ادویات استعمال کر رہے ہیں؟ (جیسا کہ اس کی متعدد اقسام ہیں: روایتی، جدید "کنڈوم، گولیاں، ہنگامی مانع حمل، انجکشن، امپلانٹس، انٹرا یوٹیرین مانع حمل ڈیوائس (آئی یو سی ڈی))</p> <p>○ آپ نے مانع حمل ادویات تک رسائی کیسے حاصل کی؟ کیا وہ آپ کے لئے آسانی سے قابل رسائی تھے؟</p> <p>○ آپ نے مانع حمل ادویات کا استعمال کب بند کیا؟</p> <p>○ آپ نے مانع حمل ادویات کا استعمال کیوں بند کر دیا؟</p> <p>○ کیا کسی نے آپ پر دباؤ ڈالا، یا ان کا استعمال شروع کرنے یا بند کرنے کا آپ کا اپنا فیصلہ تھا؟</p>	<p>مانع حمل ادویات کا استعمال اور ان تک رسائی</p>	<p>4.</p>
<p>○ آپ کی شادی کے دوران، کیا کسی نے آپ کو خاندانی منصوبہ بندی کے بارے میں مشورہ دیا تھا؟ اگر ہاں، تو آپ کو کس نے مشورہ دیا اور انہوں نے آپ کو کیا مشورہ دیا؟</p> <p>○ اپنی شادی کے دوران، کیا آپ نے کبھی اپنے شوہر کے ساتھ خاندانی منصوبہ بندی پر تبادلہ خیال کیا ہے؟ اگر ہاں، تو اپنے الفاظ میں بحث کی نوعیت کی وضاحت کریں.</p> <p>○ کیا آپ نے کبھی کسی دوسرے شخص کے ساتھ خاندانی منصوبہ بندی کے بارے میں تبادلہ خیال کیا ہے (بشمول کمیونٹی کی خاتون رکن، پڑوسی،</p>	<p>شادی شدہ زندگی کے دوران 'خاندانی منصوبہ بندی' اور مانع حمل ادویات کے بارے میں آگاہی اور علم</p>	<p>5.</p>

<p>دوست، یا رشتہ دار – ساس / بہابھی وغیرہ)؟ اگر ہاں، تو بحث کی نوعیت کو اپنے الفاظ میں بیان کریں۔</p> <p>○ کیا آپ کسی ایسے شخص کو جانتے ہیں جو مانع حمل ادویات کا استعمال کرتا ہے؟</p> <p>○ کیا آپ نے کبھی ان کے ساتھ 'خاندانی منصوبہ بندی' کے بارے میں بات کی ہے؟</p> <p>○ کیا آپ اپنے بچے (لڑکے / لڑکی) کو ان کی شادی کے وقت خاندانی منصوبہ بندی کے بارے میں مشورہ دیں گے؟ اگر ہاں، تو یہ کیا مشورہ ہوگا؟</p> <p>○ آپ کے مطابق بچے کی پیدائش سے متعلق فیصلے کرنے کا حق کسے حاصل ہے؟</p> <p>○ شوہر (2) بیوی (3) شوہر اور بیوی دونوں (4) سسرال (5) دیگر۔</p>		
<p>○ کیا مذہب زیادہ یا کم بچے پیدا کرنے کے بارے میں کوئی رہنمائی یا اصول فراہم کرتا ہے؟ کیا یہ خاندانی منصوبہ بندی کی خدمات کے استعمال کی اجازت دیتا ہے؟</p> <p>○ کیا آپ کی خاندانی روایات اور آبائی طرز زندگی آپ کو زیادہ یا کم بچے پیدا کرنے کی اجازت دیتے ہیں؟ کیا وہ خاندانی منصوبہ بندی کی خدمات کے استعمال کی اجازت دیتے ہیں؟</p> <p>○ معاشی اور مالی حالات کی روشنی میں، کیا زیادہ بچے پیدا کرنا مناسب ہے؟</p> <p>○ کیا آپ کے خاندان / گاؤں میں زیادہ بچے پیدا کرنا اچھا سمجھا جاتا ہے؟</p> <p>○ کیا لڑکوں کو جنم دینے والی خواتین کو لڑکیوں کو جنم دینے والی خواتین کے مقابلے میں خاندان / گاؤں میں زیادہ احترام کیا جاتا ہے یا زیادہ اہمیت دی جاتی ہے؟ اگر ہاں، تو وضاحت کریں کہ کس طرح؟</p>	<p>6. 'خاندانی منصوبہ بندی' کے بارے میں رویے اور عقائد (مذہب / روایات اور معاشی)</p>	
<p>○ کیا کسی این جی او، کسی سرکاری محکمے کے کسی افسر نے فیملی پلاننگ کے بارے میں بیداری فراہم کرنے کے لیے کبھی آپ کے گاؤں کا دورہ کیا ہے؟ اگر ہاں، تو انہوں نے کیا کہا؟</p> <p>○ کیا کسی سرکاری یا نجی اسپتال سے کسی صحت کی دیکھ بھال فراہم کرنے والے، لیڈی ہیلتھ ورکر، یا کسی ڈاکٹر نے آپ کے گاؤں کا دورہ کیا ہے یا آپ کو خاندانی منصوبہ بندی کے بارے میں کوئی آگاہی / معلومات فراہم کی ہیں؟ اگر ہاں، تو انہوں نے کیا کہا؟</p> <p>○ کیا کسی مذہبی اسکالر (مولوی، پادری، پادری، بہن) نے کبھی خاندانی منصوبہ بندی کے بارے میں بیداری فراہم کی ہے؟ اگر ہاں، تو انہوں نے کیا کہا؟</p> <p>○ کیا آپ نے کبھی سوشل میڈیا، ریڈیو، اخبار یا ٹیلی ویژن کے ذریعے خاندانی منصوبہ بندی کے بارے میں کوئی معلومات حاصل کی ہیں؟</p>	<p>7. معلومات اور مواصلات</p>	
<p>○ اگر آپ خاندانی منصوبہ بندی کے بارے میں پہلے سے جانتے تھے، تو آپ کی ذاتی زندگی میں کیا تبدیل ہوسکتا تھا؟</p> <p>○ آپ کی رائے میں حکومت کو خاندانی منصوبہ بندی کے بارے میں بیداری کیسے پیدا کرنی چاہیے؟</p> <p>○ کس قسم کی مہمات لوگوں کے لئے فائدہ مند ہوں گی؟</p>	<p>8. سفارشات اور تجاویز</p>	
<p>میرے پاس مزید کوئی سوال نہیں ہے۔ اگر آپ کے پاس میرے لئے کوئی سوال ہے تو، براہ مہربانی آگے بڑھیں اور پوچھیں۔</p>		

Annexure B: Male Questionnaire Instruments

Male IDI - Urdu Questionnaire (PRC-Family Planning)

آبادیاتی معلومات:

1. نام
2. جنس
3. ذات
4. مذہب
5. شادی کے وقت عمر
6. پہلے بچے کے وقت عمر
7. آخری بچے کے وقت عمر
8. آپ کی شادی کو کتنا وقت گزر چکا ہے؟
9. خاندان کی قسم؟ (1) جوہری (2) مشترکہ
10. بچوں سے متعلق سوالات
(a) آپ کے کتنے بچے ہیں؟
(b) بچوں کی جنس؟
(c) بچوں کی عمر؟
(d) تعلیم؟ کیا وہ اسکول جاتے ہیں؟
(e) کیا وہ کام کرتے ہیں؟ اگر 'ہاں'، تو، کام کی نوعیت؟
(f) اگر وہ اسکول نہیں جا رہے ہیں تو پھر اسکول نہ جانے کی وجہ؟
11. آپ کے مطابق، ایک کامل خاندان میں کتنے بچے ہونے چاہئیں؟
جواب جو بھی ہو، ان سے پوچھیں کہ یہ ان کے مطابق بہترین تعداد کیوں ہے۔
12. 'خاندانی منصوبہ بندی' کے بارے میں
(a) کیا آپ خاندانی منصوبہ بندی سے واقف ہیں؟ اگر ہاں، تو اپنے الفاظ میں 'خاندانی منصوبہ بندی کیا ہے' کی وضاحت کریں۔
(b) کیا آپ خاندانی منصوبہ بندی کی خدمات سے واقف ہیں؟ اگر ہاں، تو اپنے الفاظ میں 'خاندانی منصوبہ بندی کی خدمات کیا ہیں' کی وضاحت کریں۔
(c) کیا آپ کو لگتا ہے کہ آپ اس خیال کو مکمل طور پر سمجھتے ہیں، یا کیا آپ محسوس کرتے ہیں کہ ایسی چیزیں ہیں جو آپ اب بھی اس کے بارے میں نہیں جانتے یا سمجھتے نہیں ہیں؟
(d) آپ کو پہلی بار خاندانی منصوبہ بندی کے بارے میں پتہ چلا اور کیسے؟
(e) کیا آپ کی زندگی میں کبھی ایسا وقت آیا ہے جب آپ نے خاندانی منصوبہ بندی کے بارے میں مزید جاننے کی ضرورت محسوس کی؟
(f) حالات کیا تھے؟
(g) آپ کو خاندانی منصوبہ بندی کے بارے میں مزید کیسے پتہ چلا (آپ نے کس سے پوچھا)؟
13. 'حکومت کی پالیسی' کے بارے میں

- (a) کیا آپ فیملی پلاننگ کے بارے میں حکومت کی دو بچوں کی پالیسی سے واقف ہیں، جو ۲۰۱۷ تک نافذ تھی؟ اگر ہاں، تو آپ اس کے بارے میں کیا جانتے ہیں؟
- (b) کیا آپ حکومت کی نئی پالیسی 'توازن' سے واقف ہیں جو اب نافذ العمل ہے؟ اگر ہاں، تو آپ اس کے بارے میں کیا جانتے ہیں؟

14. 'مانع حمل کے طریقوں' کے بارے میں
- (a) کیا آپ نے کبھی مانع حمل کے طریقوں کا استعمال کیا ہے؟
- (b) کس نے مشورہ دیا کہ آپ انہیں استعمال کریں؟
- (c) کن حالات نے آپ کو ان کا استعمال شروع کرنے پر مجبور کیا؟
- (d) اگر ہاں، تو آپ نے انہیں کتنے عرصے تک استعمال کیا؟
- (e) آپ کس قسم کی مانع حمل ادویات استعمال کر رہے ہیں؟ (جیسا کہ اس کی متعدد اقسام ہیں: روایتی، جدید، کنڈوم، گولیاں، ہنگامی مانع حمل، انجکشن، امپلانٹس، انٹرا یوٹیرین مانع حمل ڈیوائس (آئی یو سی ڈی))
- (f) آپ نے مانع حمل ادویات تک رسائی کیسے حاصل کی؟ کیا وہ آپ کے لئے آسانی سے قابل رسائی تھے؟
- (g) آپ نے مانع حمل ادویات کا استعمال کب بند کیا؟
- (h) آپ نے مانع حمل ادویات کا استعمال کیوں بند کر دیا؟
- (i) کیا کسی نے آپ پر دباؤ ڈالا تھا، یا ان کا استعمال شروع کرنے یا بند کرنے کا آپ کا اپنا فیصلہ تھا؟

15. 'خاندانی منصوبہ بندی پر تبادلہ خیال' کے بارے میں
- (a) آپ کی شادی کے دوران، کیا کسی نے آپ کو خاندانی منصوبہ بندی کے بارے میں مشورہ دیا تھا؟ اگر ہاں، تو آپ کو کس نے مشورہ دیا اور انہوں نے آپ کو کیا مشورہ دیا؟
- (b) اپنی شادی کے دوران، کیا آپ نے کبھی اپنی بیوی کے ساتھ خاندانی منصوبہ بندی پر تبادلہ خیال کیا ہے؟ اگر ہاں، تو بحث کی نوعیت کو اپنے الفاظ میں بیان کریں۔
- (c) کیا آپ نے کبھی کسی دوسرے شخص کے ساتھ خاندانی منصوبہ بندی کے بارے میں تبادلہ خیال کیا ہے (بشمول مرد کمیونٹی ممبر، پڑوسی، دوست، یا رشتہ دار - بھائی / بہنوئی وغیرہ)؟ اگر ہاں، تو بحث کی نوعیت کو اپنے الفاظ میں بیان کریں۔
- (d) کیا آپ کسی ایسے شخص کو جانتے ہیں جو مانع حمل ادویات کا استعمال کرتا ہے؟
- (e) کیا آپ نے کبھی ان کے ساتھ 'خاندانی منصوبہ بندی' کے بارے میں بات کی ہے؟

16. آپ کے مطابق بچے کی پیدائش سے متعلق فیصلے کرنے کا حق کسے حاصل ہے؟
1. شوہر (2) بیوی (3) شوہر اور بیوی دونوں (4) سسرال (5) دیگر۔

17. دین کی روشنی میں
- (a) کیا مذہب زیادہ یا کم بچے پیدا کرنے کے بارے میں کوئی رہنمائی یا اصول فراہم کرتا ہے؟
- (b) کیا مذہب خاندانی منصوبہ بندی کی خدمات کے استعمال کی اجازت دیتا ہے؟

18. آپ کی خاندانی روایات اور آبائی طرز زندگی کی روشنی میں،
- (a) کیا وہ زیادہ یا کم بچے پیدا کرنے کی اجازت دیتے ہیں؟
- (b) کیا وہ خاندانی منصوبہ بندی کی خدمات کے استعمال کی اجازت دیتے ہیں؟

19. معاشی اور مالی حالات کی روشنی میں
- (a) کیا زیادہ بچے پیدا کرنا مناسب ہے؟
- (b) خاندانی منصوبہ بندی کی خدمات اچھی ہیں یا بری؟

20. کیا آپ کے خاندان / گاؤں میں زیادہ بچے پیدا کرنا اچھا سمجھا جاتا ہے؟
21. کیا کسی این جی او، کسی سرکاری محکمے کے کسی افسر نے فیملی پلاننگ کے بارے میں بیداری فراہم کرنے کے لیے کبھی آپ کے گاؤں کا دورہ کیا ہے؟ اگر ہاں، تو انہوں نے کیا کہا؟

22. کیا کسی سرکاری یا نجی اسپتال سے کسی صحت کی دیکھ بھال فراہم کرنے والے، لیڈی ہیلتھ ورکر، یا کسی ڈاکٹر نے آپ کے گاؤں کا دورہ کیا ہے یا آپ کو خاندانی منصوبہ بندی کے بارے میں کوئی آگاہی / معلومات فراہم کی ہیں؟ اگر ہاں، تو انہوں نے کیا کہا؟

23. کیا کبھی کسی مذہبی اسکالر (مولوی، پادری، پادری) نے خاندانی منصوبہ بندی کے بارے میں بیداری فراہم کرنے کے لئے آپ کے گاؤں کا دورہ کیا ہے؟ اگر ہاں، تو انہوں نے کیا کہا؟

24. کیا آپ نے کبھی سوشل میڈیا، ریڈیو، اخبار یا ٹیلی ویژن کے ذریعے خاندانی منصوبہ بندی کے بارے میں کوئی معلومات حاصل کی ہیں؟

25. اگر آپ خاندانی منصوبہ بندی کے بارے میں پہلے سے جانتے تھے، تو آپ کی ذاتی زندگی میں کیا تبدیل ہو سکتا تھا؟

26. آپ کی رائے میں حکومت کو خاندانی منصوبہ بندی کے بارے میں بیداری کیسے پیدا کرنی چاہیے؟ کس قسم کی مہمات لوگوں کے لئے فائدہ مند ہوں گی؟

میرے پاس مزید کوئی سوال نہیں ہے۔ اگر آپ کے پاس میرے لئے کوئی سوال ہے تو، براہ مہربانی آگے بڑھیں اور پوچھیں۔

Male – FGD - Urdu (PRC-Family Planning)

Section A: آبادیاتی معلومات					
					نام
					عمر
					ذات
					مذہب
					شادی کے وقت عمر
					پہلے بچے کے وقت عمر
					آخری بچے کے وقت عمر
					آپ کی شادی کو کتنی وقت گزر چکا ہے؟
					آپ کی شادی کو کتنی وقت گزر چکا ہے؟

سوال نمبر	پیشین گوئی کرنے والا عنصر	ایف جی ڈی کا سوال
9.	بچوں کی معلومات	آپ کے کتنے بچے ہیں؟ ان کی جنس، عمر اور تعلیم کیا ہے؟ کیا ان میں سے کوئی کام کر رہا ہے؟ اگر ہاں، تو کام کی نوعیت؟ کیا وہ اسکول جا رہے ہیں، اگر نہیں، تو اسکول نہ جانے کی کیا وجہ ہے؟ آپ کے مطابق، ایک کامل خاندان میں کتنے بچے ہونے چاہئیں اور کیوں؟
10.	خاندانی منصوبہ بندی کے بارے میں معلومات	<ul style="list-style-type: none"> ○ کیا آپ خاندانی منصوبہ بندی سے واقف ہیں؟ اگر ہاں، تو اپنے الفاظ میں 'خاندانی منصوبہ بندی کیا ہے' کی وضاحت کریں۔ ○ کیا آپ خاندانی منصوبہ بندی کی خدمات سے واقف ہیں؟ اگر ہاں، تو اپنے الفاظ میں 'خاندانی منصوبہ بندی کی خدمات کیا ہیں' کی وضاحت کریں۔ ○ کیا آپ کو لگتا ہے کہ آپ اس خیال کو مکمل طور پر سمجھتے ہیں یا آپ محسوس کرتے ہیں کہ ایسی چیزیں ہیں جو آپ ابھی تک اس کے بارے میں نہیں جانتے یا سمجھتے نہیں ہیں؟ ○ آپ کو پہلی بار خاندانی منصوبہ بندی کے بارے میں پتہ چلا اور کیسے؟ ○ کیا آپ کی زندگی میں کبھی ایسا وقت آیا ہے جب آپ نے خاندانی منصوبہ بندی کے بارے میں مزید جاننے کی ضرورت محسوس کی؟ ○ حالات کیا تھے؟ ○ آپ کو خاندانی منصوبہ بندی کے بارے میں مزید کیسے پتہ چلا (آپ نے کس سے پوچھا)؟
11.	'حکومت کی پالیسی' کے بارے میں تشکیل	<ul style="list-style-type: none"> ○ کیا آپ فیملی پلاننگ کے بارے میں حکومت کی دو بچوں کی پالیسی سے واقف ہیں، جو ۲۰۱۷ تک نافذ تھی؟ اگر ہاں، تو آپ اس کے بارے میں کیا جانتے ہیں؟ ○ کیا آپ حکومت کی نئی پالیسی 'توازن' سے واقف ہیں جو اب نافذ العمل ہے؟ اگر ہاں، تو آپ اس کے بارے میں کیا جانتے ہیں؟
12.	مانع حمل ادویات کا استعمال اور ان تک رسائی	<ul style="list-style-type: none"> ○ کیا آپ نے کبھی مانع حمل کے طریقوں کا استعمال کیا ہے؟ ○ کس نے مشورہ دیا کہ آپ انہیں استعمال کریں؟ ○ کن حالات نے آپ کو ان کا استعمال شروع کرنے پر مجبور کیا؟ ○ اگر ہاں، تو آپ نے انہیں کتنے عرصے تک استعمال کیا؟ ○ آپ کس قسم کی مانع حمل ادویات استعمال کر رہے ہیں؟ (جیسا کہ اس کی متعدد اقسام ہیں: روایتی، جدید "کنڈوم، گولیاں، ہنگامی مانع حمل، انجکشن، امپلانٹس، انٹرا یوٹیرین مانع حمل ڈیوائس (آئی یو سی ڈی)) ○ آپ نے مانع حمل ادویات تک رسائی کیسے حاصل کی؟ کیا وہ آپ کے لئے آسانی سے قابل رسائی تھے؟ ○ آپ نے مانع حمل ادویات کا استعمال کب بند کیا؟ ○ آپ نے مانع حمل ادویات کا استعمال کیوں بند کر دیا؟ ○ کیا کسی نے آپ پر دباؤ ڈالا، یا ان کا استعمال شروع کرنے یا بند کرنے کا آپ کا اپنا فیصلہ تھا؟
13.	شادی شدہ زندگی کے دوران 'خاندانی منصوبہ بندی' اور مانع حمل ادویات کے	<ul style="list-style-type: none"> ○ آپ کی شادی کے دوران، کیا کسی نے آپ کو خاندانی منصوبہ بندی کے بارے میں مشورہ دیا تھا؟ اگر ہاں، تو آپ کو کس نے مشورہ دیا، اور انہوں نے آپ کو کیا مشورہ دیا؟ ○ اپنی شادی کے دوران، کیا آپ نے کبھی اپنی بیوی کے ساتھ خاندانی منصوبہ بندی پر تبادلہ خیال کیا ہے؟ اگر ہاں، تو بحث کی نوعیت کو اپنے الفاظ میں بیان کریں۔

<p>○ کیا آپ نے کبھی کسی دوسرے شخص کے ساتھ خاندانی منصوبہ بندی کے بارے میں تبادلہ خیال کیا ہے (بشمول مرد کمیونٹی ممبر، پڑوسی، دوست، یا رشتہ دار – بھائی / بہنوئی وغیرہ)؟ اگر ہاں، تو بحث کی نوعیت کو اپنے الفاظ میں بیان کریں۔ کیا آپ کسی ایسے شخص کو جانتے ہیں جو مانع حمل ادویات کا استعمال کرتا ہے؟</p> <p>○ کیا آپ نے کبھی ان کے ساتھ 'خاندانی منصوبہ بندی' کے بارے میں بات کی ہے؟</p> <p>○ کیا آپ اپنے بچے (لڑکے / لڑکی) کو ان کی شادی کے وقت خاندانی منصوبہ بندی کے بارے میں مشورہ دیں گے؟ اگر ہاں، تو یہ کیا مشورہ ہوگا؟</p> <p>○ آپ کے مطابق بچے کی پیدائش سے متعلق فیصلے کرنے کا حق کسے حاصل ہے؟</p> <p>○ آپ کے مطابق بچے کی پیدائش سے متعلق فیصلے کرنے کا حق کسے حاصل ہے؟</p> <p>○ شوہر (2) بیوی (3) شوہر اور بیوی دونوں (4) سسرال (5) دیگر۔</p>	<p>بارے میں آگاہی اور علم</p>	
<p>○ کیا مذہب زیادہ یا کم بچے پیدا کرنے کے بارے میں کوئی رہنمائی یا اصول فراہم کرتا ہے؟ کیا یہ خاندانی منصوبہ بندی کی خدمات کے استعمال کی اجازت دیتا ہے؟</p> <p>○ کیا آپ کی خاندانی روایات اور آبائی طرز زندگی آپ کو زیادہ یا کم بچے پیدا کرنے کی اجازت دیتے ہیں؟ کیا وہ خاندانی منصوبہ بندی کی خدمات کے استعمال کی اجازت دیتے ہیں؟</p> <p>○ معاشی اور مالی حالات کی روشنی میں، کیا زیادہ بچے پیدا کرنا مناسب ہے؟ کیا آپ کے خاندان / گاؤں میں زیادہ بچے پیدا کرنا اچھا سمجھا جاتا ہے؟</p> <p>○ کیا وہ مرد جن کے بچپن میں لڑکے ہیں، آپ کے خاندان / گاؤں میں ان مردوں کے مقابلے میں زیادہ عزت اور اہمیت دی جاتی ہے جن کے بچے لڑکیاں ہیں؟ اگر ہاں، تو وضاحت کریں کہ کس طرح؟</p>	<p>14. 'خاندانی' منصوبہ بندی کے بارے میں رویے اور عقائد (مذہب / روایات اور معاشی)</p>	
<p>○ کیا کسی این جی او، کسی سرکاری محکمے کے کسی افسر نے فیملی پلاننگ کے بارے میں بیداری فراہم کرنے کے لیے کبھی آپ کے گاؤں کا دورہ کیا ہے؟ اگر ہاں، تو انہوں نے کیا کہا؟</p> <p>○ کیا کسی سرکاری یا نجی اسپتال سے کسی صحت کی دیکھ بھال فراہم کرنے والے، لیڈی ہیلتھ ورکر، یا کسی ڈاکٹر نے آپ کے گاؤں کا دورہ کیا ہے یا آپ کو خاندانی منصوبہ بندی کے بارے میں کوئی آگاہی / معلومات فراہم کی ہیں؟ اگر ہاں، تو انہوں نے کیا کہا؟</p> <p>○ کیا کسی مذہبی اسکالر (مولوی، پادری، پادری، بہن) نے کبھی خاندانی منصوبہ بندی کے بارے میں بیداری فراہم کی ہے؟ اگر ہاں، تو انہوں نے کیا کہا؟</p> <p>○ کیا آپ نے کبھی سوشل میڈیا، ریڈیو، اخبار یا ٹیلی ویژن کے ذریعے خاندانی منصوبہ بندی کے بارے میں کوئی معلومات حاصل کی ہیں؟</p>	<p>15. معلومات اور مواصلات</p>	
<p>○ اگر آپ خاندانی منصوبہ بندی کے بارے میں پہلے سے جانتے تھے، تو آپ کی ذاتی زندگی میں کیا تبدیل ہو سکتا تھا؟</p> <p>○ آپ کی رائے میں حکومت کو خاندانی منصوبہ بندی کے بارے میں بیداری کیسے پیدا کرنی چاہیے؟</p> <p>○ کس قسم کی مہمات لوگوں کے لئے فائدہ مند ہوں گی؟</p>	<p>16. سفارشات اور تجاویز</p>	
<p>میرے پاس مزید کوئی سوال نہیں ہے۔ اگر آپ کے پاس میرے لئے کوئی سوال ہے تو، براہ مہربانی آگے بڑھیں اور پوچھیں۔</p>		