Factors Associated with Failure of Family Planning Methods in Pakistan: Burhan Village Case Study

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Abstract

In Pakistan, the highest unmet need for knowledge and use of contraceptives is among the rural women and is not only associated with level of education of women, but also with the socio-cultural restraints, that deprive a women over the control of her body. Poverty, lack of opportunities and poor management of the available facilities, further burden the society, which seeks refuge by having a large family. The aim of this study is to validate the hypothesis, that cultural and psychological factors, particularly the spousal communication, behavior and attitude influence the women's decision on issues regarding fertility regulation. To identify these factors, previous empirical was researched and exploratory qualitative interviews were conducted during a six-month field visit of Burhan, district Attock, tehsil Hassan Abdal, with a population of about 8,000. A socio-economic survey was conducted from 80 households only and the total population of the selected households was 616 persons comprising 56 per cent males and 64 per cent females. The survey yielded a sample population of 43 married females in their reproductive age for detailed interviews.

The findings show that 77 per cent of the women interviewed were below 20 years of age when they got married and 17 per cent were below 15 years at the time of their marriage. The spousal age gap was found to be high as 42 per cent women were 7-9 years younger than their husbands, while 21 per cent were 10-12 years younger. The literacy level among the women was poor as well, as 28 per cent of these women had no schooling, while 33 per cent had five years of schooling and 26 per cent had 8 years of schooling. This study, did however, also reveal that even an educated women had no say in the decision making process with regards to the family size and fertility rate, because of the social constraints and culturally, traditionally defined norms. Decision making was solely the responsibility of the husband in 88 per cent cases, while only 5 per cent of the families involved both the wife and husband and in a further 5 per cent, the husband and mother-in-law were involved in the decision making process. There was only one case, where the wife alone was involved in the decision-making process for fertility regulation. With regards to the spousal communication, this study revealed that in 28 per cent spacing between children was discussed between the husband and wife, whereas only 19 per cent actually discussed the number of children that they would have and 16 per cent discussed maternal health. The most intriguing aspect of this study was revealed when women were asked about the degree of freedom granted to them by their husbands. Of these 43 women, 14 per cent said that their husbands gave them permission to leave their homes alone, 9 per cent could go the hospital alone, 58 per cent were allowed to talk to other women about matter related to family affairs and 49 per cent were allowed to talk to family health workers (LHVs, LHWs etc). The interesting part of this finding was the fact that not a single woman said that she would argue with her husband.

The culture of a given community determines the reproductive behavior of a person including family planning, family size, desire for a male child etc. This study re-enforces this hypothesis, with the added fact that the role of males is essential to curtail the menace of increasing population. At the same time, female education and empowerment of women go hand in hand with social justice and development. There is no doubt that in our society, be it rural or urban, education and empowerment of women is not

considered a high priority. Women marry at a young age to men who are often 7- 12 years older then them. As a result, they are dominated by their spouses and the prevailing conservative traditions; hence have little to say with regards to their own reproductive health. Therefore, in order to effectively promote the use of contraceptives and make family planning a success, new indicators need to be identified and captured. The role of men must be addressed adamantly and couple's joint decision-making should be promoted as a strategy for increasing family planning use.

Introduction

The sustained high fertility and rapid growth of population has made Pakistan the 7th populous country in the world with a current population exceeding 146 million and, at the present growth rate will double by 2050, making it the 3rd most populous country, after India and China (Pakistan Population Assessment Report, 2003). Despite the fact that Pakistan was a pioneer, among developing countries, in supporting family planning activities, as early as in the 1950s, family planning programs have shown very little success. All the 5-year development plans from the First plan (1955 to 1960) to the current Ninth plan (1998-2003) have articulated and suggested specific strategies and measures to reduce the high population growth rate. As a result, the awareness knowledge is high (over 95 per cent), yet the contraceptives prevalence rate (CPR) remains low at less than 30 per cent and the population growth rate, although arguably dropping (government & UNFPA figures suggest a 2.16 per cent population growth rate) the total fertility rate (rural & urban) still persists round 4.77, which means on average women are still giving birth to 4 to 5 children (Pakistan Population Assessment Report, 2003).

Family planning contributes to reproductive health in two main ways, by allowing women and men to exercise the freedom to decide it, when and how often to have children and by reducing the number of times that a woman is exposed to the risk of unsafe pregnancy and delivery (Ministry of Population Welfare Report, 1999). Although the contraceptive prevalence rate has increased but the problem of discontinuation is persists. Different socio-cultural factors are responsible for the failure of contraceptive use and by exploring these factors a more effective policy can be made to reduce fertility rates and slow population growth around the world.

The culture of a given community determines the reproductive behavior of a person including family planning, family size, desire for a male child etc. It is not the person rather the culture that determines how much autonomy one individual has in making family planning decisions. A study of secondary data of Bangladesh Demographic and Health survey 1993-94 pointed out factors such as, geographic area, socio-economic and cultural characteristics relating to women, as potential factors affecting her decision to switch method or to discontinue use. The strongest impact of family composition was proved on transition rates to non-use, the likelihood of women to discontinue contraception was determined to have a negative relationship with the family size (Fiona and Lan, 1999). In the rural areas women reject contraceptives because it is considered respectful and it raises their status in the family. The women who live in urban areas, educated women and women with higher economic status have higher continuation rates than rural women of lower socio-economic status.

Age of women has been proved to be a significant predictor of contraceptive use. Women in their teens who practice contraception are more likely to experience an undesirable outcome in the form of unplanned pregnancy, or abandonment of use, compared with older women (Mahdy and El-Zeiny, 1999).

In Pakistan, women hold considerably less power than men in most matters including issues related to reproductive health. Husbands and their families, play an important role in deciding the reproductive health choices and behaviors of their wives, both directly, by opposing use of family planning, and indirectly, by restricting their wives from visiting a health center alone, or by reinforcing social attitudes that favor sons or encourage a fatalistic response to pregnancy. Studies have reported that a husband's disapproval has led to a reduction in contraceptive use by 66 percent (Bongaarts and Bruce, 1995).

These findings are contradictory to the National Fertility and Housing Survey of Bangladesh, which shows that discontinuation of contraceptive, does not appear to be directly influenced by husband's disapproval. The report mentioned the parents desire for a child, or the misinformation on the adverse side effects of contraceptive use as the major reasons for discontinuing contraceptive use (Nancy *et al.*, 2000).

Judging from prior research conducted in Pakistan, it is evident that the health concerns constitutes a powerful obstacle in using family planning methods (El-Zanaty *et al.*, 1999; Yinger 1998; Casterline *et al*., 1997 Bongaarts and Bruce, 1995).

In 1989 and 1990, studies were conducted in Niger and Gambia to study the extent of & reasons for contraceptive discontinuation within the first eight months of acceptance. Approximately 30% of new family planning clients discontinued contraceptive use within that time. The principal reasons given for stopping use were side effects, travel by either partner, spousal disapproval, and desire for pregnancy. Discontinuation was reported to be higher among clients who felt that they did not receive adequate counseling than those who felt that they had.

Discontinuation of using contraceptives methods has been reported to be highest for oral pills, condoms, and injectables in Pakistan (Ministry of population Welfare and Population Council, 1995). Reasons for discontinuation of female methods- pills, injections and IUDs – are dominated by side effects and method switching, which itself is often because of side effects (Population Council, 1997).

Along with these reasons the poor access to high quality family planning services is also a problem. Numerous studies, have revealed that large segments of the population, concentrated in rural areas, face considerably difficulty in obtaining low-cost, high quality family planning services. Contraceptive use world wide is three times greater among women than men and cause more potential health hazards. Accessibility to information and services is vital to enable women to continue use of contraceptives. Client's access to services includes clinic hours, clinic location, fees and waiting time. Client satisfaction is key to clients' decision to use and to continue using services, and is essential for long-term use of contraceptives (Timothy *et al*., 2000).

Contraceptive use is nearly twice as high in urban areas as in rural areas and the unmet need is highest in rural areas and among women with little or no education. The aim of the study is to determine which factors stymie the translation of women's desires to avoid pregnancy into contraceptive practice in the rural areas of Pakistan. To identify these factors, we drew both on previous empirical research and on exploratory qualitative interviews that were conducted during fieldwork. A series of studies carried out during the past three decades have sought to explain the discrepancy between fertility preferences and contraceptive practice in Pakistan. We summarize the main findings from the existing research literature and discuss conclusion from analysis of the qualitative interviews.

In short, modern methods of contraception are very effective but still many women are not using modern contraceptives or stop using after some time due to various factors. In this study an attempt has been

made to identify these factors, which could be helpful in introducing new changes and development in the modern medical system according to the requirements of the people.

The main objectives of the study were:

1. To examine the cultural and psychological factors particularly husband's behavior and attitude that influence a woman's decision regarding fertility regulation.
2. To know the reasons for the use and non-use of contraceptives.
3. To know the local perception and level of satisfaction concerning the various family planning methods.

The data analyzed in this paper was collected from village "Burhan" in district Attock, Tehsil Hassanabdal and province of Punjab. The total population of the village according to the census in 1998 is about 8004 persons. Due to the limitations of time the socio-economic survey was conducted from 80 households only and the total population of the selected households was 616 persons comprising 56% males and 64% females. The survey used a stratified sample of the entire village, and yielded a sample of 43 married females of reproductive age for detailed interviews.

Methodology

The principal objective of the study was to estimate the causes of unmet need for family planning and to identify the obstacles that effect their decision to practice contraception. To obtain such information, structured and unstructured interviews; i.e. through a designed questionnaire (Annexure I) and focus-group discussions with the identified women, were conducted under the supervision of the local LHVs to cross check the data.

Specific questions were asked, in accordance to the format used by the National Institute of Population Studies (1998) for their surveys. These structured questions addressed the respondent's knowledge and views about modern contraceptives, as well as traditional methods of family planning, husband's approval, health concerns, perception of access to services interalia.

Additional information was collected on demographic and socio-economic characteristics of the respondents, including measures of economic status, family composition, years of schooling, number of living children and women's degree of autonomy and the extent of her decision-making power in various domains of everyday and family life. It was assumed that all these variables accurately reflect the stage of the respondent's ability to express and formulate reproductive intentions and their authority to make reproductive decisions.

On the basis of this exploratory qualitative research, the answers obtained were tabulated and analyzed in order to identify the factors that may contribute the to the failure of family planning practices in rural Pakistan. The identification and explicit ranking of these obstacles may be helpful for the setting of policy and program priorities.

Results

The results are a compilation of data obtained through the in-depth interviews, and qualitative information, from 43 married women between 15 – 49 years, residing in the Burhan village.

The economic conditions of these 43 married women was determined by ascertaining their earning capacity, which revealed that 70 per cent of these women belonged to households that earned Rs. 6,000 or less per month. This translates to approximately US$ 3.50 per day. Half of these households earned less that Rs. 3,000 per month, which placed them below the poverty line (Table 1). The results also revealed that the contraceptive acceptance rate was directly proportional to the economic status. Acceptance rate was higher in the higher income group. Improved economic status of the families leads to a greater acceptance of family planning. The family structure and its influence on reproductive rights of women, i.e. joint family is a significant variable, especially in the traditional households of rural Pakistan, however, in this study, no such impact was found.

Age, at the time of marriage, though, is a known and well documented, determining factor for the number of children borne by a woman (Mahdy and El-Zeiny, 1999). This study, too, endorses the hypothesis that those who marry at a young age tend to produce more children and are less aware of their reproductive rights and health related issues. At the time of marriage, most of the women, in this study, were below the age of 20 years (77 per cent) and 16 per cent were even younger than 15 years of age. A significant number of women were aged between 21 and 25 years (19 per cent), while only 4 per cent were over the age of 26 years (Table 2). The results indicated that a higher proportion of those of who married late, readily accepted family planning methods and used contraceptives. Therefore, it is more likely that women marrying late, in all likelihood have greater degree of education and knowledge of contraceptives, and hence have a better understanding of the her rights and health benefits, so may be inclined to use them, in order to ensure better childcare and health.

The fact that most women marry at a very young was further exacerbated by the fact that the spousal age gap, too, was very large in most cases, reflecting the societal trends of marrying off girls at a very young age to older men. A majority of the women in this study were 7 – 9 years younger than their spouse (42 per cent), followed by those 10 – 12 years younger (21 per cent). Only 12 per cent of the women were less than 6 years younger than their respective husbands (Table 3).

Education, in more cases than not, facilitates rational thinking of individuals in terms of a planned family. In our findings women's education was found to have a strong association with the initiation of contraception. The higher the level of education, the earlier was the adoption of contraception. Among these women questioned in the study, the level of education was very low as well, reflective once again of our societal practices of not educating girl children added to the fact that the social development, in terms of health and education, is very poor, especially in the rural sectors of Pakistan. Twenty-eight per cent of these women had no schooling, 59 per cent had less than 8 years of schooling and only one woman had an intermediate diploma and none had an undergraduate degree (Table 4).

What makes the results, of this study under discussion, more interesting is the fact that even after a few years of education these women could have brought down their fertility through greater knowledge and use of methods. Although women's education has been one of the most thoroughly studied determinants of fertility, the research in this are is still far from being exhausted. Researchers recently have found overwhelming evidence that education of women increases their knowledge of the outside world, provides them with certain practical and theoretical skills that enhance their productivity. In addition, a woman's position relative to their spouse, in terms of economic and physical independence as well as decision-0making autonomy, which may vary by individual factors, yet in most cases, are largely determined by the community norms and institutional structures prevailing in the society (Jeheehboy, 1995). However, in a study conducted in Zimbabwe, education was found to be a key factor enabling women to seek employment outside their own homes, if allowed to do so, thereby possibly reducing her

fertility desire (Kravdal, 2000). This of course may be true for the urban centers, however, in the rural setup the dominance of cultural and community norms far outweigh the educational level of women.

Without a doubt education does enhance a woman's confidence, giving her the knowledge and awareness of her reproductive and basic human rights. If their qualifications reach the required levels, women have a good chance of being gainfully employed, thereby contribute to their economic well-being of their family and may receive the recognition leading to their economic empowerment. Such women are able to think for themselves and adopt any family planning method, which best suits them and do not necessarily require the co-operation of their husbands. However, in most cases these women are able to convince their spouses to the betterment of their health and that of the child.

Of course, it not to say that the less educated women of rural Pakistan do not contribute to the household finances. Rural women are the cornerstone of a family unit in Pakistan, yet because of societal and traditional practices, these women are not given the due respect, as their work is not translated to employment, hence are not considered as contributing, economically, to the household. As a consequence, their rights are curtailed and their opinion does not carry much weight in the largely patriarchal society.

These factors cumulatively have contributed to the low, or non-usage of contraceptive throughout Pakistan, as an overall rate of only 27.6 per cent, with the rural rate even lower at 21.7 per cent (Pakistan Population Assessment Report, 2003). However, in this study, the usage rate was considerably higher at 51 per cent among the married women interviewed (Table 5). This may largely be attributed to the fact that Burhan, the village under study, is located in northern Punjab, District Attock, where there 59 basic health units, 29 dispensaries, 8 hospitals, 12 mother and child health centers, 5 rural health centers, 2 sub-health centers, 2 tuberculosis clinics and 855 Lady Health Workers, catering for a female population of 638,597 (Pakistan Health and Population Welfare Facilities Atlas, 2002). This translates to a low maternal mortality rate (MMR) of less than 250 per every 100,000 live births for this area (Pakistan Population Assessment Report, 2003). Added to this fact is the Burhan village is located near the main road linking Islamabad/Rawalpindi to Peshawar, where, again, access to information and health facilities is greatly enhanced. This, one may argue, may contribute to the greater awareness ratio and knowledge base in Burhan, as compared to other rural areas of Pakistan, specifically those of Mansehra, Abbottabad and Haripur districts of N.W.F.P., where the MMR is excess of 430 and numerous districts of Balochistan, where the MMR exceeds 600 (Pakistan Population Assessment Report, 2003). In these areas primary health care facilities are few and far between and are often ill-equipped, or understaffed to cater for the large local populous (Pakistan Health and Population Welfare Facilities Atlas, 2002).

Despite the relatively high usage rate, there were quite a few interesting aspects that had lead some of these women to either dropout of the family planning practices, or not adopt them in the first place. The most common reason for abandoning the family planning methods, reported in this study, was the fear of side effects (29 per cent), followed by the need for a boy child (19 per cent); opposition from husband and the belief that these methods are un-Islamic (14 per cent). Some were not entirely convinced that the methods actually worked (10 per cent), whereas only one woman stated that she could not afford it, but another preferred using family planning methods to enhance the spacing between her children (Table 6).

The rumors and myths associated with using contraceptives have indeed dissuaded women from using then, not only because of aversion to the expected physical discomfort, but also due to the financial costs of managing the side effects (Katz *et al*., 2002). The possibility of interference with spousal sexual relations and a sense that side effects may, subconsciously, signify divine disapproval to the user. This leads to the side effects to become an insurmountable obstacle to satisfactory resolution of women's

preference-use gap. Strong association of dropouts based on rumors and myths about the method; improper counseling and inadequate provider experience, restricted access to methods, as well as health related factors has been reported by other researchers as well, from studies in El Salvador and other developing countries (Katz *et al*., 2002 Ross *et al*., 2002).

Specific questions were asked, from these women, to determine the extent of their knowledge regarding the side effects of modern contraceptive methods, their perception about the unpleasant effect such methods may have on their health and whether they had actually experienced any of the stated side effects. This study revealed that their perceptions, or in reality, misperceptions, of contraceptives was significantly associated with dropout. Negative, or incorrect perceptions of family planning methods and contraceptive usage are primarily based on the lack of proper information, or disinformation in general about these methods, coupled with the high degree of illiteracy. Specifically, methods like IUD insertion have received added "bad" publicity – some arguably rightly so – because of the insufficient attention given to such methods during counseling sessions, insufficient provider experience – malpractices by doctors (who are not trained gynecologists) and in some extreme cases no guidance and counseling what-so-ever (Katz *et al*., 2002). Such cases, prevalent in Pakistan as well, have done greater harm then the contraceptive itself. A woman who thinks the method to be painful is more likely to discontinue contraceptive use. These results are supported by number of studies that indicate side effects, health concerns and method used to be significant indicator of discontinuation (Nancy *et al*., 2000, Mahdy and El-Zeiny, 1999, Bongaarts and Bruce, 1995).

In this study, under discussion, women who were using contraceptives associated all subsequent health problems including obesity, body aches, weak eyesight, high blood pressure, nausea, irregular bleeding, infertility, anemia, weakness to the use of contraceptives. This, of course is misleading, most of these health problems may be associated with numerous other aspects, such as poor diet, overexertion, in adequate healthcare facilities, congenital illnesses and, above all, the fact that they had already given birth to numerous children in a short space of time. Such health related problems may be addressed through trained service providers, like Lady Health Visitors (LHV) and Lady Health Workers (LHW) as well as family planning health workers.

However, as a result of these misgivings, women of Burhan were reluctant to use three of the most common contraceptive methods, namely; the pill, IUD, and injections. On the contrary condom was the most popular contraceptive method for its perceived to have no side effects. It was found that the lack of proper information leads to development of negative perceptions that are harmful for the prospects of family planning program. Furthermore, the study revealed that a common reason for choosing withdrawal and other traditional methods and home remedies was the absence of side effects, compared with the hormonal and surgical methods. Most of the females preferred male methods because female methods required female mobility, physical examination; increased expenses etc. In addition, they wanted to avoid the perceived problems associated with modern methods and wanted to actively involve their husbands.

It was also observed that the women did not get the desired results from their contraceptive methods, due to the lack of proper knowledge about the function of contraceptives. This may be due to improper use which brings about an overall dissatisfaction with the method, which, of course, is spread by word of mouth and turned into exaggerated rumors leading to the decline of its usage. Sometimes when the use of contraceptives does not show any side effects, the efficacy of the method is questioned, resulting in an increase in the dropout rate.

Knowledge of family planning methods was also found to have a substantial effect on contraceptives use. While assessing the knowledge about the modern methods of family planning it became evident that women did not have sufficient information about the reliability and efficacy of a particular method. Additionally, knowledge about the use methods was also found deficient. These factors lead to their inappropriate use, method failure, and generated misconceptions. It was found that women possessing higher knowledge of family planning methods were more likely to acquire correct knowledge and use different temporary methods, while And those who had lack of information ended up with method discontinuation.

Researchers in developed countries also concur with this fact that contraceptive information and use is not up to mark, as studies, in France showed that, over a period of 5 years, two out of three pregnancies occur when couples were using contraceptives, either the pill, condoms or IUD. These researchers concluded that doctors and healthcare providers should do more to ensure that couples, who do not wish to have any more children, have adequate knowledge of the family planning methods and use the most suitable forms of contraception. The study revealed that of the 2,863 women questioned, 36 per cent of them had become pregnant unexpectedly and half of these subsequently decided to have an abortion. But of these 65 per cent had been using contraception: 21 per cent the pill, 12 per cent condoms, 9 per cent IUD and the rest some other method, such as the "natural method", *coitus interruptus* etc. The survey did find that most of these women had become pregnant because they had not use the contraceptive properly. Therefore, to avoid unplanned pregnancies, it is essential that women are made aware of all the contraceptive choices available, and that professionals are fully trained to take into account the different factors that impact on effective contraceptive use, such as socio-cultural constraints and acceptability as well as accessibility (Bajos *et al*., 2003).

According to the report by The Alan Guttmacher Institute, crucial contraceptive information and services is not reaching Asian adolescents. The report highlights that a various societal pressures, lack of access to appropriate information and services discourage contraceptive use among married adolescents in South and Southeast Asia. The analysis revealed that Pakistan ranked the lowest, among these countries, for use of modern methods of contraception among the married youth (2 per cent) with Indonesia the highest at 44 per cent. The report blamed societal and familial pressures to have children as the leading cause of low usage, discouraged often by provider resistant, religious beliefs or fear of side effects. Therefore, in order for any family planning program to be effective, it is vital that adolescent's sexual and reproductive health needs be assessed. Targeted and effective information dissemination may encourage contraceptive use, as well as access to appropriate supplies and services to combat societal pressures and misconceptions about contraception (Darabi, 2002).

The second most important obstacle was the overwhelming preference for a male child, as having more sons is considered a matter of pride, economic strength and the survival of the family lineage. This study revealed that women who had had 3, or more, sons were more consistent in adopting family planning methods and using contraceptives than those who did not have any sons, or had just one son. This finding is supported by studies carried out in Bangladesh and Morocco, which also reported that women with sons were more likely to use contraceptives to prevent further pregnancies (Fiona and Jan, 1999; Mahdy and El-Zeiny, 1999). Therefore, it is safe to assume that the number of sons borne by a woman is a strong indicator as to whether she will adopt family planning methods. Another factor that influenced the use, or non-use of contraception, that is prevalent in societies of Pakistan and well documented in this study as well, is the desire to have sons, which in turn influences the fertility behavior of women.

This study also found that there was a pronounced variation of use of contraceptives across the different socio-economic and demographic parameters. It was found that the proportion of contraceptive users was substantially higher among women with more living sons, women in wealthier households, women who have attended school and those who had frequent interactions with Lady Health Visitors. Furthermore, the primary reasons for using contraceptives stated among those women who had adopted family planning methods, was for the preservation of their health (41 per cent), the desire to have longer periods between successive pregnancies (27 per cent), contentment with the existing family size (18 per cent) and to ensure better child health and care (14 per cent) (Table 7).

With the extremely high maternal mortality rate (MMR) already prevalent in Pakistan, ranging from 300 to 700 deaths for every 100,000 liver births, it is essential that adequate time intervals between consecutive pregnancies, of between 2 to 4 years, be promoted and advocated among the population to ensure better mother-child healthcare and survival. Numerous researchers, while investigating the association between inter-pregnancy intervals and premature birth, neonatal death, maternal morbidity and mortality, support and such practices. Studies have reported women with very short intervals between pregnancies are at an increased risk of complications of pregnancy, such as premature birth, neonatal death and intrauterine growth restrictions. Of course other factors, such as maternal age, physical condition and health, socioeconomic deprivation and previous case history also have an effect on the outcome of pregnancies, but short spacing between consecutive births does seem to exacerbate the matter (Smith *et al*., 2003),

Other studies have revealed that both short inter-pregnancy intervals as well as long inter-pregnancy intervals have adverse effects on maternal health. The common ailment associated with short intervals is anemia, caused by depletion of maternal nutrients and bleeding disorders and eventually leading to weakness, fatigue and in some extreme cases the rupturing of membranes and the endometrium. All these conditions may contribute to the increased risk of maternal death. Again these researchers also argue that other factors such as socio-economic status, level of education, insecurity, poverty, community variables such as inadequate health care services, or inaccessibility to such facilities may cumulatively contribute to high IMR and MMR (Conde-Agudela and Belizán, 2000).

The preference of male children does not stop at just one, as families often want more. Due to the high IMR in Pakistan, 85 – 102 deaths per 1,000 live births, and the fact that genetically and biologically speaking, boys are more vulnerable to illnesses than girls, if all other parameters are equal, the question of a boy's survivorship is so vital, that families do not feel secure with just one son. Culturally and traditionally, sons are valued as assets that pay off through future dividends, such as bread earners providing security at an old age, heirs and harbingers of the family gene pool. Young men provide income and also attract dowries at the time of marriage. Girls, on the other hand, are wrongly often regarded as temporary occupants of the house, whose actual house and life lies somewhere else and hence their responsibility also lies in someone else's hands. Therefore, investment in girl children is not deemed as essential. The findings of this study reflect this hypothesis, as those women, who had sons, were more likely to adopt family planning methods as compare to those who had daughters only. Generally, the percentage of women who did not want additional children increased with the rise in the number of surviving sons.

Traditional and cultural norms have also resulted in the discriminatory behavior towards women and their reticence due to of their non-participation in decision-making processes and discussions. Women are apprehensive about speaking out and voicing their opinions, fearing that it may be perceived as being offensive by their husbands and the negative consequences that may result, such as divorce, abuse and

violent backlash if they pursue their right to discuss matters such as family size, child spacing and other reproductive health related matters, leaving aside all other matters such as finances and budgetary allocations. This study did reveal that women had no say in the decision making process with regards to the family size and fertility rate, because of the social constraints and culturally, or traditionally defined norms. Decision making, reportedly, was solely the responsibility of the husband (88 per cent), while only 5 per cent of the families involved both parents, and in a further 5 per cent, the husband and mother-in-law were involved in the decision making process. There was only one case, where the wife alone was involved in the decision-making process to determine her fertility regulation (Table 8).

Another, rather surprising, yet arguably welcome, change exposed in this study was the absence of elders and in-laws from the decision making process. Discussing family-related matters, such as number of children, use or non-use of contraception, seems now to be have become the domain of the husband exclusively. However, more in-depth studies must be carried out to ascertain if any "unseen forces" are wielding their choices on his decision.

The results of this study under discussion also indicated that spousal communication on matters related to family planning had a pronounced effect on contraceptive use. Couples who discussed family size matters were more likely to be current users of contraceptives. Such behavior must be advocated and encouraged to ensure the gradual increase in the contraceptive prevalence rate (CPR). Societies where spousal communication has been encouraged through various programs, using the media (radio and television) as a tool have shown a considerable increase in the CPR and an associated decline in their fertility rate (Sharan and Valente, 2002). Our study revealed that among the women who used contraceptives, 28 per cent discussed using contraceptives with their husbands to enhance the spacing between their children, whereas 19 per cent discussed the number of children that they would have and 16 per cent discussed matters related to maternal and child health (Table 9).

The effect of spousal communication upon family planning may also depend upon the level of education, enlightenment and knowledge of each spouse in the decision-making process. Studies from other developing countries, like Uganda suggest that explicit consideration of gender inequalities within a society, as an important component of the study of the reproductive outcomes (Sharan and Valente, 2002). Similar findings have been reported from India, where husbands were found to be the principal decision-makers and initiators of discussion on using family planning methods (Raju, 1987).

These findings are entirely consistent with the prevailing condition in Pakistani society today, especially in the rural setup, where emancipation of women is a far cry from reality. Decision-making powers, regardless of what the subject matter may be, reside primarily with the husband. Of course what makes the matter even worse is that issues like reproductive and child health, related mainly to women, must lie within their domain to freely discuss what is best for them and their off-spring (Kazi and Sathar 1997). As a consequence of these restrictions, wives often cite husband's disapproval as a reason for not implementing their reproductive rights. What needs to be addressed here are the misperceptions that husbands may have regarding family planning. LHWs have reported considerable discrepancies between the married couples perception regarding approval of family planning. Therefore one can expect wives' may misperceive their husbands' views on this matter and act accordingly, which may not reflect the truth of the matter.

It is instructive to know that women might have an exaggerated impression of their husband's opposition. The results have shown that the most commonly used contraceptive was condom, which is a male method of family planning. Among the non-users withdrawal method was preferred. These findings are also

consistent at the national level. One concrete indicator is that nearly one-half of couples practicing contraceptives are using methods that requires male co-operation. Ample evidence indicates that an increasing fraction of men are strongly motivated towards contraceptive use. A discernible transformation of men's views towards fertility regulation is under way in Pakistan; the conviction is growing among men that family size must be limited above all for economic reasons but also for health concerns (Leuack and Rahim 1998; Sathar and Casterline 1998). The findings provide some basis for suggesting that, in Pakistan, the husband's opposition to use, knowledge and acceptance of contraceptives may wane in the future.

However, to date this seems unlikely, at least in the rural areas of Pakistan, as another intriguing aspect of this study revealed when women were asked about the degree of freedom granted to them by their husbands. Of the women questioned, 14 per cent said that their husbands gave them permission to leave their homes alone, 9 per cent said that they were permitted go the hospital alone, 58 per cent were allowed to talk to other women about matters related to family affairs and 49 per cent were allowed to talk to family health workers (LHVs, LHWs etc). What is pertinent from these results, however, is the fact that none of them were allowed to talk to their daughters about matters related to their sexuality, reproductive health issues, menstruation and other aspects of family planning, until the time of marriage (Table 10).

This is reflective of the behavior pattern throughout Pakistan, where the youth, especially young girls have no or little knowledge of their own physiology and changes that take place within their bodies through the years of growth. When these young adults do not get answers from their parents, they often turn to other sources, such as friends, "quacks", or older, experienced siblings. More often than not, the information they do get is, either, incorrect, grossly exaggerated or misguiding, resulting in a largely misinformed populous of adolescents (Sultana and Qazilbash, 2002; Qazilbash, 2002).

Discussion

From the study under discussion, numerous factors have been identified that have an effect on the use, or no-use of family planning methods in Pakistan and that the lack of spousal communication is one of the key factors that may contribute to the low level of contraceptive use among the women. Women are often scared to initiate a discussion on family planning and related reproductive health issues, fearing repercussions from their husband's, which may be in form of violence, social isolation and even divorce! Such actions totally alienate women within the community and the society at large. This fear factor often prevents these women from seeking their rights and voicing their opinion.

Despite the long history of Government sponsored family planning programs, the contraceptive prevalence rate (CPR) in Pakistan remained remarkably low until the 1990s, reaching only 11.8% of married women of reproductive age. During the 1990s however there has been substantial increase by 1996-97, CPR had doubled, the 23.9% and today it stands at an overall rate of 27.6 per cent, with it being 39.7 per cent in the urban centers and 21.7 per cent in the rural areas (Pakistan Population Review, 2003). Despite this increase, little has been known about the causes of failure of contraceptives in Pakistan, which seems as complex a reality as the population growth rate.

The central theme of this study was to determine why a large fraction of rural women accept family planning and desire to avoid pregnancy but do not practice contraception. This question of the unmet need of contraception presumes the existence of a motivation to avoid pregnancy that is not translated into behavior due to the numerous aspects reported in this study. Of course poverty seems to be the underlying

determinant, as research has pointed out that those who live above the poverty line are more likely to accept and adopt family planning methods than those who live below the dreaded line of poverty (UNFPA report, 2002). Since 1970 developing countries that have lowered their fertility rates and slowed population growth have registered faster economic growth. However, this is a vicious circle that links fertility with poverty, as those who are poorest among the poor tend to have more children. Therefore, by recognizing that by increasing budgetary allocations for health, education and advancement of women rights and empowerment, these countries gradually controlled their population growth rate at the same time gave rise to an educated, healthy and productive society. Fertility regulation is a fraction of two classes of factors: the motivation to avoid pregnancy and the costs of fertility regulation. Costs are broadly defined to include not simply the time and financial reasons required to acquire contraceptive supplies and services but also the social, psychic, cultural and health costs that accompany adoption and continued use of contraceptives. If the perceived costs are too high, the women will resist contraceptive practice despite a desire to avoid pregnancy (Easterlin 1975; Hermalin 1983).

From this research, clear findings emerge, as a clear distinction has identified those factors that carry substantial weight, from those factors that are relatively inconsequential in their impact in terms of the success rate of family planning practices. What is quite obvious is that women, in Bhurhan, were well aware of the concept of family planning and had a fairly good knowledge of how to control their fertility rates, yet because of other mitigating circumstances, or influences, this knowledge was not being translated into actual practice. Therefore, there is need to further determine the reasons for the low contraceptive use and prevalence rate, both at local and national levels, and to ascertain if there is a difference along the traditional rural-urban divide.

Based on the qualitative interviews carried out in this research, under discussion, different aspects emerged, with the most important obstacle to the use of contraceptives being the feeling that the extended family members, communities and society as a whole may construe such behavior as being unacceptable. Social, cultural and traditional norms outweighed any rational thinking attached to the use of contraceptives. Women often thought that such behavior would conflict with their husband's fertility preferences, or views about family planning. Such findings emphasize the need for male involvement and sensitization towards reproductive health issues and practices. Men, especially the clerics of the region, must be encouraged, educated and trained to talk about such issues first with their spouses and then with their family doctors to instill confidence among the women that their well-being is of the utmost importance. Clerics too, must be asked to talk about these issues during their daily congregations, especially on Fridays, which would give the men the courage to face up to their responsibilities and duties towards the health of their wives and daughters. In settings where family planning is a sensitive issue and overt spousal communication is uncommon, women may not be clear about their husband's views. Therefore, such innovative methods of trainings and knowledge enhancement would go a long way in remedying the problem of spousal non-communication.

Most women reported that communication about family planning is much easier, and they are more likely to express their opinion when their husbands hold that view also. This study also showed that spousal communication was limited and not very effective, with couples less likely to discuss child spacing and maternal health issues. Yet at the same time, the study did reflect that among those couples where the men communicated more with their wives, the likelihood of using contraceptives increased considerably as such families showed a more positive attitude towards family planning. This assumption is supported by similar findings of other researchers, particularly in the study carried out in Nepal, where research proved that those women who openly communicate with their spouses, in this case with the help of radio talk shows and drama, perceive their spouses to be more supportive, feel less fatalistic about childbearing, and

more in control of their reproductive decisions, and be less embarrassed about discussing these issues, than couples who do not communicate. By adopting such mechanisms here in Pakistan, couples may be encouraged to discuss family planning issues, and as such, may indirectly lead to family planning adoption (Sharan and Valente, 2002).

However, other studies have shown that in cases where women feel uncomfortable taking to their spouses about matters related to their fertility, they are more likely to use contraceptives methods covertly, rather than using no method whatsoever. Furthermore, the husband's disapproval of contraceptives appeared to work through spousal communication, rather than having a direct influence on covert use (Biddlecome and Fapohunda, 1998).

Such is the dilemma that women in Pakistan face today, as those who are aware, educated enough and know about the benefits and uses of contraceptives, family planning methods and their reproductive health rights, struggle with all important question of whether to use fertility control methods covertly, and face the wrath of an enraged spouse and his family, or not, thereby placing their own health at risk.

Interestingly, the age of the women had no real bearing on the dropout ratio, but what was found in this study under discussion, was that couples with the least age difference between husband and wife, were more likely to discuss and communicate on a wide ranging topics, which included family size, child spacing and other family planning related matters, with each other which of course enhanced the use of contraceptives. The study also revealed that among those couples where the age difference was high the use of contraceptive methods declined dramatically this can easily be explained by the simple fact that a young, teenaged girl, marrying a person 12 to 15 years her senior would be awestruck by her husbands prowess and his worldly knowledge, albeit limited and to some extent incorrect, yet still influence her on decisions regarding family size, fertility rates and child spacing. Furthermore, religious belief, or more precisely the interpretation of these beliefs, also plays a key role in whether a family will adopt family planning methods.

Interestingly, though findings from the qualitative interviews indicated that deliberate fertility regulation, through modern family planning methods and other means, is becoming more acceptable on religious grounds. Old mores on this point are weakening. Cases have been reported in other findings where clerics themselves have accompanied their wives to doctors asking for advise on fertility control. Of course in nearly all such cases the underlying factor has been poverty, where couples have simply stated that they cannot afford to have another mouth to feed. Therefore, the time is ripe, both in terms of the political climate and socio-economic status of the masses in Pakistan, to involve the clergy in advocating the use of family planning methods to control both the fertility rate as well as child spacing, to ensure the health of both mother and child. Numerous religious scholars agree that family planning is not un-Islamic and advocate its use to control the population growth rate, which in turn would help to alleviate plight of the poor (Abro, 2002; Shehzad, 2002).

Another attitudinal change reported in this study was the absence of elders and in-laws from the decision-making process. It must be stated here that the joint family system was not prevalent in the village under study, as most of the couples lived independently. This, of course may be the reflection of the today's day an age, and as such lessened the chances of interference by the extended family members in matters related to family size, child spacing and related reproductive health issues. Therefore, the decisions regarding such matters were exclusively dealt with between husbands and wives. This may well be the reason why, despite all other restrictive barriers, the prevalence and contraceptive use rate in this particular village is higher than other villages of the region and throughout Pakistan.

When the women were asked about the family planning services, they rarely give much weight to poor access to services as an explanation for their unwillingness to adopt contraception, or for their discontinuation of family planning methods. The services of family planning were available at Burhan village, as trained LHVs provided contraceptives and also motivate and refer or accompany potential clients for other methods, such as IUDs and sterilization. These findings are in agreement with those reported by other researchers, investigating similar happenings in other developing countries (Bongaarts and Bruce, 1995; Westoff and Bankole, 1995; Mishra *et al*., 1999).

The women of Burhan, however, despite being told about the workings and practical applications of these methods of contraception, were not provided with sufficient knowledge regarding the contraindication, side effects and management of contraceptive methods. Similarly, those women who were experiencing side effects were not given any advise, assurance or treatment by the healthcare providers. Furthermore, among those women who had switched their current methods, or had abandoned all methods completely, these LHVs did not ask them for the reason of doing so. This kind of behavior not only makes it more difficult to convince the staunchest opponents of family planning methods, but also reflects the mindset of the LHVs, who seem more concerned about achieving their supply-goals for contraceptives, rather than educating the users of the various aspects associated with using family planning methods.

Therefore, it is paramount that the LHVs first receive proper, comprehensive training on matters related to reproductive health and family planning and have current knowledge of the latest scientific findings in this regard, so that they may better advocate the use of contraceptives and be in the better position to advise which method would be most suitable for the client. Contraceptives are such that one method may suit a specific client, whereas the same method may not be advisable for another. Hence education and knowledge of the various techniques, including their possible and probable side effects must be disseminated to the LHVs and LHWs to ensure that they too pass this information to the end user. Simultaneously, these health care providers must have access to the most recent information on the various family planning methods, so that they may, with a certain degree of confidence, convey the correct information to their clients and answer their every question with a degree of satisfaction instilling confidence and trust in their abilities.

In addition, these health care providers must be equally good listeners so as to gather the necessary information from their clients, to understand their reproductive needs, goals, health status and general condition, in order to recommend the most appropriate method. During this study, the technical competency of these health workers was assessed in terms of their ability to counsel the clients. Lady health visitors (LHVs) did perform admirably when recommending contraceptives to women who wanted enhance the time period between consecutive children, but failed to advise their clients on managing the side effects of these methods. The LHVs seemed more concerned about achieving their targets, as mentioned earlier, and quantity of contraceptives being supplied, than the needs of the women. However, these drawbacks may easily be eliminated through programs that strengthen the knowledge, skills and technical competence of the LHVs and the choice of methods offered.

Another implication of these findings is the need for quality education, access to schools and institutes of higher learning for girls, adolescents and the youth throughout Pakistan. Topics related to reproductive health, sexuality and information on the many methods of family planning must be incorporated in the syllabi of the courses starting at the matriculation level. Girls should be encouraged to attend school and continue with their education till, at least, such a level where a certain degree of independence and self-confidence is achieved. This would require a comprehensive effort, which would mean involving men, the clerics, community elders as well as the women to give them a sense of belonging, responsibility and

role in contributing towards the development of the society as a whole. These aspects, albeit, are meant to strengthen the socio-economic status of women particularly, and the community and society in general, one must not forget that there is a nexus between all these aspects, which in turn would be reflected in the fertility rates and overall health of women and children. Of course this would mean that the health workers would have to remove any anxiety, or apprehensions women may have regarding contraceptives, specifically those that are "women focused" such as hormone pills and the IUD.

While these methods are, arguably, successful in the developed world, as well as other developing countries (Ross et al., 2002; Smith et al., 2003), here in Pakistan, it is evident, from this study, that women are not given the correct information, or proper counseling specifically on these two contraceptive methods. Instead, most of the women rely on information handed down by others who may have had bad experiences with methods, or even worse, base their opinions on rumors and disinformation generated by those with little or no knowledge about the advantages and disadvantages of using family planning methods. Taking the case of the contraceptive pill, one must confess that there are opinions amongst certain circles that this form of family planning, although 99 per cent effective, provided that you take the "pill" everyday, may lead to breast cancer. This may have been true for pills manufactured in the 1970s, which contained high levels of estrogen, but the pill of today either has very low estrogen levels, or has only progesterone in it. In layperson's terms, this means that the chances of breast cancer are greatly diminished, in fact latest research has shown that progesterone provides the highest level of protection against ovarian cancer, with minimum side effects, such as water retention and weight gain, both of which can be reduced through exercise and diet control (Schildkraut *et al*., 2002). Furthermore, researchers have identified three genes that cause breast cancer, all of them present on the maternal set of chromosomes, which we inherit. These genes are passed on from mother to daughter to grand-daughter (Loman *et al*., 2001). Now in societies, such as ours, where cousin marriages is commonly practiced, the chances of expression of these genes is greatly enhanced, especially amongst marriages between maternal cousins. Therefore, in order to ascertain the true reproductive health status of women in Pakistan, comprehensive research work has to be conducted covering both the clinical and socio-economic aspects of the targeted populous. What is irrefutable though is the fact that poverty, lack of quality education, inadequate health facilities and the mere fact that the development policies in Pakistan are urban-based, has resulted in the population explosion and distrust amongst the people that family planning methods do actually work without causing harm to the end user. If the current government wants to increase the CPR to 53 per cent, from the current 33 per cent (Ministry of Population Welfare, 2003) in real earnestness, then it must address these issues with a greater degree of conviction and zeal. The approach has to have a client-oriented theme, which takes into consideration the requirements, needs, cultural norms and practices of the client.

Such is the dismal state of the reproductive health status of women in Pakistan, that according to the UNFPA report, 1 in 188 live births results in the death of the mother and that only 19 per cent of deliveries are attended by a skilled health care professional. Two-thirds of pregnant women receive no prenatal care and the same number of pregnant women are anemic (Pakistan Population Assessment Report, 2003). As a result, 30 women die every minute due to birth complications, aside from the 48.9 per cent neo-natal mortality rate (Dawn, 2003).

Solutions to these problems cannot be easily found, or formulated in the background of growing poverty, rising inflation and unemployment. Government budgetary allocations for the health and education sector pale in comparison to the defense and debt reserving costs. The fact the devolution plan has also failed to deliver the people from the deluge of illiteracy, poor health care and overall environmental degradation, as locally elected leaders claim that their hands are tied and that they have not been given the promised

monies to improve the socio-economic conditions of their constituencies. Family planning programs face several constraints, exacerbated by lack of quality education for girls, their diminished socio-economic status and resultant disempowerment, which because of the social constraints, attached to the cultural and traditional norms, confines women to the compounds of their homes.

The results of this study provide an assessment that anxieties about detrimental health consequences are a serious impediment to the contraception. Women have by-in-large been misinformed about contraceptives and because of the rumors and myths about these methods, coupled with insufficient information and poor counseling services, choose to abandon these practices fearing for their health and safety. Power imbalances in marital relationship, husband's opposition and lack of communication further block contraceptive use in many cases.

Therefore, in order to effectively promote the use of contraceptives and make family planning a success, new indicators need to be identified and captured. The role of men must be addressed adamantly and couples joint decision-making should be promoted as a strategy for increasing family planning use. Interventions are needed to improve women's autonomy, education to strengthen their negotiating capacity for family planning use.

Recommendations/Future strategies

- All health care workers, who provide family planning advise, should receive comprehensive training regarding the subject matter, interpersonal communication skills and evaluated from time to time, to ensure that their clientele has received the necessary information, is aware of her rights and choices and her fears and apprehensions about contraceptive methods and reproductive health issues have been adequately addressed to her satisfaction.
- The health care workers should be more sensitive to the implications of gender stratification as an obstacle to women's reproductive health and address issues that encompass their clients' family and social situation.
- Overcoming women's entrenched misgivings about the social and cultural acceptability of contraceptives requires a different set of initiatives. All relevant and standard IEC materials should be provided to lady health workers. Focused IEC campaign, through the mass media and local efforts, can emphasize that family planning can be in the best interest of women, men and their children, and that it is ethically sound behavior.
- Women participation in household decisions and their mobility is another area, which needs more attention. Their autonomy may be increased through education and communication.
- The population program needs to put extra effort to increase male motivation and involvement in RH & FP issues. This means involving the clergy where possible to help in advocating the necessity of FP and explaining to their congregations that Islam promotes FP. Rural men are neglected and family planning services need to expand among rural men. In this regard male family planning workers and the clerics can help to educate men about the risks associated with having large families compares with the risks of contraceptive use.
- LHVs & LHWs need refresher training on technical knowledge of contraceptives methods, sharing of information for better counseling, motivating hard-core couples, management of side effects and effective use of the IEC material. Health concerns might be reduced by means of effective counseling and follow-up of contraceptive users.
- Education must be made compulsory for all, interesting and need-based, starting at an early age to ensure sustained enrollment and to decrease the dropout rates.

- If necessary, co-education should also be promoted to lessen the burden on the national exchequer to construct, additional, separate schools for boys and girls. At the same time, the youth will be and should be taught on how to respect the opposite sex and how to best interact with them through mutual respect.
- Male opposition to women's empowerment should be addressed at the community–level through awareness campaigns and by advocating that educating and empowering women and giving them equal responsibility, can and, will lead the community towards better opportunities for poverty alleviation, sustainable livelihoods and economic uplift.

In short, the prospects for a decline in the fertility rate will primarily depend on more effective population policy, which focuses on the youth, RH issues and education. The role of the clerics has to be redefined along the same lines, as the "maddrasas", which are being re-oriented to teach science and the arts as well as religion. The line departments, such as the ministries of health, environment and finance must work had-in-hand with the ministry of Population Welfare to build public-private partnership with civil society groups, NGOs and INGOs to ensure equity and equality for all. Only then can the socio-economic problems be addressed with true earnestness and remove the apprehension, misgivings of family planning methods and deliver the people of Pakistan from poverty and over-population.

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Table 1: Economic distribution pattern of households in study

Class Differentiation	Percentage of Households (n = 43)
Upper class > Rs. 6,000	30%
Middle class Rs. 3,000 - 6,000	35%
Lower class < Rs. 3,000	35%

Table 2: Age of women at time of marriage

Age Group	Percentage of Respondents (n = 43)
10-15	16%
16-20	61%
21-25	19%
26-30	2%
31-35	2%

Table 3: Spousal age gap among the women of Burhan

Age gap (years)	Percentage of Respondents (n = 43)
No gap	5%
1-3	5%
4-6	2%
7-9	42%
10-12	21%
13-15	2%
16-18	2%

Table 4: Education among the married women

Education Level (years at School)	Percentage of Respondents (n = 43)
No Schooling	28%
Primary (1-5)	33%
Middle (6-8)	26%
Matriculation (9-10)	12%
Intermediate (11-12)	2%
Graduation (13 +)	0

Table 5: Use of contraceptives among the women of Burhan Village

Category	Percentage of Respondents (n = 43)
Users of contraceptives	51%
Non-users of contraceptives	49%

Table 6: Reasons associated with non-use/discontinued use of contraceptives

Reasons	Percentage of Respondents (n = 21)
Cannot afford method	5%
Not fully convinced of methods	10%
Afraid of side effects	29%
Spouse objects	14%
Fear family objections	5%
Need for sons	19%
Against religion	14%
Natural spacing	5%

Table 7: Reasons associated with contraceptive use

Reasons	Percentage of Respondents (n = 22)
Preservation of women's health	41%
Exceeded the desired family size	18%
Spacing between child birth	27%
Better life for children	14%

Table 8: Decision making on FP/RH issues among the populous of Burhan

Decisions made by	Percentage of Respondents (n = 43)
Husband	88%
Wife	2%
Joint decision by husband and wife	5%
Mother in-law	0
Joint decision by husband and mother-in-law	5%
Father-in-law	0
Entire family	0

Table 9: Topics related to FP/RH for Spousal communications among women using contraceptives

Topic	Percentage of Respondents (n = 29)
Spacing between children	28%
Number of children to have	19%
Maternal health	16%
Infant loss	5%

Table 10: Acceptable activities of women

Activities	Percentage of Respondents (n = 43)
Go out alone	14%
Argue with husband	0
Talk with other women related to family affairs	58%
Talk to family health worker's	49%
Going alone to hospital	9%
Informing your daughter about reproductive health	0

Annexure I

Questionnaire

Marriage

1. Which is the most suitable age for the marriage of a girl?
2. What was your age at marriage?
3. What was your husband's age at marriage?
4. Did your parents ask your opinion about the selection of spouse?
   (a) Yes (b) No
5. If no, why not?
6. Are you married within Biradari or out of Biradari?

Conception

7. After marriage how soon should the first conception take place?
   (a) As soon as possible.
   (b) After some time.
   (c) At God's will.
   (d) Don't know.
   (e) Other.
8. Did you conceive within a year or later?
   (a) Yes (b) No
9. If later, then what was the reaction of the family?
10. How did you know you had conceived?
11. Was the conception according to your own will or not?
12. What made you agree on this?
   (a) Pressure from the husband.
   (b) Pressure from in-laws.
   (c) Sexual obligation of a woman.
   (d) Economic reasons.
   (e) Other.
13. Which is the more fertile period in your opinion?

Female role in decision making

14. Who takes the decisions how many children to have?
   (a) Husband.
   (b) Wife.
   (c) Joint decision by husband and wife.
   (d) Mother in law.
   (e) Father in law
   (f) Joint decision by entire family.
   (g) Any other.
15. After your first child did you and your husband discuss when to have your next child?
   (a) Yes (b) No
16. Which of the following did you and your husband discuss?
   (a) Spacing between children.

(b) Number of children planning to have.
(c) Maternal health.
(d) Infant loss.
(e) Abnormal pregnancy.

17. Which of the following things your husband allows you to do and those, which he does not allow you to do?

	Always allow	Sometimes allow	Do not allow	Not certain
Go out alone.				
Argue with him.				
Talking with other women related to family affairs.				
Talking to family health workers.				
Going alone to hospital.				
Informing your daughter about reproductive health.				

Family Planning

18. Have you and your husband ever used any method of family planning?
(a) Yes (b) No
19. If no, why not?
(a) Don't know any method.
(b) Can't afford any method.
(c) Method's / services are not available.
(d) Not fully convinced of methods.
(e) Afraid of side effects.
(f) Spouse objects.
(g) Fear family objections.
(h) Need for male child.
(i) Need for daughter's.
(j) Against religion.
(k) Any other.
20. If yes, which contraceptive did you use?
21. Why this particular method?
22. On whose advice did you use this method?
(a) Spouse.
(b) Relatives.
(c) Neighbors and friends.
(d) Doctor.
(e) Health and family planning workers.
(f) Mass media sources.
23. Any pressure from the husband or in-laws about using contraceptive?
24. Your views about,
(a) Condoms
(b) Pills
(c) IUD
(d) Injection

(e) Male sterilization
(f) Female sterilization
(g) Abstinence
(h) *Coitus interruptus*
(i) Breast feeding

25. What are the natural or traditional methods of family planning?

Pregnancy

26. What foods are not eaten during pregnancy?
27. Which foods do you eat and why?
28. What were the complications faced during pregnancy and why?

(a) Weakness	(b) Headache	(c) Vomiting
(d) Backache	(e) Dizziness	(f) Cramps
(g) Abdominal pain	(h) Fever	(i) Blood Pressure
(j) Nausea	(k) Loss of Appetite	(l) Jaundice
(m) Constipation	(n) Anemia	(o) Heartburn

(p) Others

29. From where you seek treatment?
    (a) Doctor / Nurse.
    (b) TBA / LHW.
    (c) Hakim.
    (d) Spiritual healer.
    (e) Female non-technical person or home remedies.
    (f) No help.
30. Did you go for antenatal checkup?
    (a) Yes (b) No
    31. What were the reasons for having the checkups?
        (a) Health problem.
        (b) Better for the health of the baby and mother.
        (c) Recommended by Doctor.
32. What were the reasons for not having the checkups?
    (a) No health facility nearby.
    (b) No female staff.
    (c) Not allowed.
    (d) Not necessary.
    (e) Financial reasons.
    (f) Too far / no transportation.
    (g) Traditionally never went.
33. Were you satisfied with the antenatal care during the last pregnancy?

Reasons for satisfaction

(a) Attention and facility was provided.
(b) Center was nearby.
(c) Resolved the problems.
(d) Was given medicines.
(e) Checkup by Doctor / Dai.

Reasons for dissatisfaction

(a) Domestic problems.

(b) No female Doctor available.
(c) Too far.
(d) Too expensive.
(e) Services were not good.
(f) Other.

34. How frequently you visit Doctor or Dai?
35. Did you take any iron tablet during pregnancy?
    (a) Yes (b) No
36. If no, why not?
37. Did you go for injections during pregnancy?
    (a) Yes (b) No
38. Did you reduce work load during pregnancy?
    (a) Yes (b) No
39. Did others help you in your routine work or not?
    (a) Yes (b) No
40. Did others psychologically take care of mother or not?
    (a) Yes (b) No
41. Are their special rituals performed during pregnancy?

Delivery

42. Where was your delivery conducted?
43. Who assisted you during delivery and why?
44. Were you satisfied by the assistant? If not, why?
45. What are the practices conducting delivery at home?
46. What were the problems you faced during delivery?
    (a) Prolonged delivery
    (b) Excessive bleeding.
    (c) Caesarian / operation.
    (d) Torn code.
    (e) Epiziotomy (small operation).
    (f) Pain.
    (g) Stillbirth.
    (h) Vaginal wounds.
    (i) Twin pregnancy.
    (j) Pre-mature delivery.
    (k) Breached birth
    (l) Others.
47. What were the causes?
48. From whom did you seek treatment?
49. Who decides the place of delivery?
50. Average amount paid for delivery?

Survival and disability of neonates

51. What is the total number of births?
    (a) Normal live birth.
    (b) Stillbirth.
    (c) Lived for a short time.
    (d) New born with disability.
52. What was the size of the baby?
    (a) Very small.
    (b) Small.
    (c) Normal
    (d) Big.
53. Were you physically abused or emotionally disturbed by the family members?

54. What type of harm you got from the abuse?
    (a) Body ache.
    (b) Wounds / bleeding.
    (c) Bone injury.
    (d) Stressed / frightened.
    (e) Anger.
    (f) Fever.
    (g) Developed chronic disease.
    (h) Headache.
    (i) Others.

55. What thing is first fed to the child after birth?
    (a) Water
    (b) Ghutti / Herbal drops.
    (c) Honey.
    (d) Breast milk.
    (e) Other milk.
    (f) Butter.
    (g) Gur.
    (h) Other.
56. Did you feed your child with colostrum after birth?
    (a) Yes (b) No
57. After how much time the baby is put to the breast of the mother?
58. What is the average time for the period of lactation for girls and boys?
59. If you cannot breast feed the child then what will you do?
60. What type of diet is taken during breast feeding to increase the quantity of milk?
61. What are the common practices and complications during breast feeding?
62. Do you go to the Hospital for the vaccination of your child?
    (a) Yes (b) No
63. How the birth of a male and female child is celebrated?
64. What is the status of the mother of a girl?

Confinement

65. Do you practice confinement? If yes, for how many days?
66. What kinds of food eaten during confinement? Why?
67. Were you and the baby left alone? If not, then why?
68. What are the other practices followed during confinement?
69. What are the complications during confinement?
70. What are the causes?
71. What was the treatment?

Abortions

72. How did you know about abortion?
73. Where do you go for treatment?
74. What you do to get rid of unwanted pregnancy at home?
75. What are the after effects of abortions?