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HNP DISCUSSION PAPER

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Health, Nutrition and Population (HNP) Discussion Paper

Involving Men in Reproductive and Fertility Issues: *Insights from Punjab*

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The study and discussion paper were prepared with funds from the Bank-Netherlands Partnership Program.

Abstract: Drawing on three sources—a 2013 qualitative study in four districts of Punjab province; a targeted analysis of the baseline and endline surveys of the Family Advancement for Life and Health (FALAH 2007–2012) project; and the Pakistan Demographic Health Survey (PDHS) of 1990–1991 and of 2006–2007—this study explores Pakistani (especially Punjabi) couples' dynamics during their decision processes on fertility intentions and practices, along with community perceptions of male-focused interventions as well as men's suggestions for future intervention strategies.

It finds that men in Punjab seem now more concerned about their fertility intentions and practices due to the financial challenges of raising large families. This concern has not only increased spousal communication about family size and contraceptive use but has also encouraged Punjabi men to practice family planning. Most men now realize that either they or their wives should use family planning. It is the next step, however, of translating intention into practice, which is a challenge. Supply-side issues, including absence or paucity of family planning services as well as poor quality of services (including service providers' lack of capability to manage side effects) are the main factors hindering couples' adoption of family planning. Perceived or experienced side effects of contraceptive methods are other factors.

Men's positive attitudes and their readiness to be involved in family planning programs suggest that the efforts of convincing men to use contraceptives have been effective and this it is now time for direct reproductive health interventions for men in Punjab. Yet heavy spending on media campaigns may not be as effective as interpersonal interventions. A focused effort to mobilize men through male-specific interventions is likely to increase the demand for contraceptives. These interventions have to be backed up by improved supply of contraceptives and availability of family planning services in accessible facilities.

Keywords: Reproduction, fertility, men, Punjab, Pakistan

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LIST OF ACRONYMS AND ABBREVIATIONS

BS	Birth Spacing
DHS	Demographic Health Survey
DHQ	District Headquarters
FALAH	Family Advancement for Life and Health
FP	Family Planning
FGD	Focus Group Discussion
IDI	In-depth Interview
IUCD	Intrauterine Contraceptive Device
LHW	Lady Health Worker
MGM	Male Group Meeting
NIPS	National Institute of Population Studies (Pakistan)
PDHS	Pakistan Demographic Health Survey
RHC	Rural Health Center
RL	Religious Leader
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

This study aims at exploring couples' dynamics during their decision processes on their fertility intentions and practices, along with community perceptions of male-focused interventions as well as men's suggestions for future intervention strategies.

The findings are based on three data sources. The primary data source is a 2013 qualitative study in four districts of Punjab province. The second is a targeted analysis of the baseline and endline surveys of the Family Advancement for Life and Health (FALAH 2007–2012) project.[1] The third is the Pakistan Demographic Health Survey (PDHS) of 1990–1991[2] and of 2006–2007, which were used to assess trends over two decades.

The four districts of the 2013 qualitative study were Bahawalpur, Jhelum, D.G.[3] Khan, and Okara. (The first three were FALAH districts in which interventions were tested, the fourth the control district.) Twelve focus group discussions were conducted with men only, and in-depth interviews were conducted with 26 couples, in these four districts in 2013.

Data from 2,649 men and 638 couples from the FALAH baseline and endline surveys in 14 selected districts of the FALAH project were reanalyzed to assess the impact of FALAH male-directed interventions on fertility intentions and behavior.

*Changes in men's attitudes towards family planning:*The study points to a real change in men's attitudes toward family planning in the Punjab and their readiness to be involved in family planning programs, through increased access to information and services. Punjabi men appeared to be more concerned about their fertility intentions and behavior than they were in the early 1990s. Since men are considered the primary earners and decision-makers in households in Pakistan, their primary motivating force is the growing economic challenge leading to an inability to meet household costs. Both qualitative and quantitative data confirm this change.

Increasing spousal communication aids decisions on fertility issues: Economic concerns also provide leverage in improving communication between husbands and wives on family size and contraceptive use. This pattern suggests it is no longer wives' exclusive responsibility to initiate discussions on their fertility intentions. Although there may be a divergence in opinion on ideal family size and contraceptive use or choice of method, increasing spousal communication makes it easier for women to convince their husbands of the need for family planning. Follow-up discussions may be necessary, however, for women to convince their husbands before they both reach full agreement.

Supply-side issues impede men from using contraceptives: The study emphasizes that supply-side issues, including lack of availability of family planning services and contraceptive methods, method failure, and contraceptive costs impede men from using

[1] The FALAH project was led by the Population Council with USAID funding. It aimed to increase adoption of birth spacing (BS) behavior and practices, with a new focus on men. FALAH's 15 districts were distributed around the country.

[2] The only PDHS where men were also interviewed. (PDHS data are national, not Punjab specific.)

[3] Short for Dera Ghazi.

contraceptives, despite men's increasing acceptance of family planning and spousal communication. In addition, limited knowledge of specific family planning methods, perceived or experienced side effects of modern methods, and lack of provider skills for managing side effects, also act as barriers to family planning method use.

Definite receptiveness toward male group meetings: The study shows strong interest among men for involvement in male-focused interventions in family planning programs. It is evident from the FALAH endline survey that male group meetings have the greatest role among FALAH interventions in changing couples' fertility intentions and practices. Male group meetings are suggested (by men and women) as the most appropriate intervention for providing men with method-specific knowledge and for underlining the importance of family planning use. Men see male group meetings as having potentially more impact than women's meetings, since educating and convincing the primary decision-makers (husbands) results in concrete steps to be taken by men themselves for practicing family planning. A suggested male group meeting strategy includes involving local persons to organize meetings and an educated and skillful outsider (preferably a doctor) to conduct them. The strategy also includes immediate provision of contraceptives after the meeting so that men who want to start using contraception can do so.

Women favor involving religious leaders as an intervention more than men: Similar to FALAH endline results, the 2013 qualitative study shows mixed opinions on involving religious leaders in family planning programs, with women more in favor than men. Those favoring this approach further suggest that religious leaders should be trained and should discuss family planning with reference to the Quran and Hadith. Generally, this suggests that religious leaders can and should play a supportive role by communicating and endorsing the message that family planning is permitted in Islam.

The role of the media is limited: Men rarely appreciated the role of broadcast media in communicating family planning messages, mainly due to the impression that neither television nor radio can fulfill men's need for details on contraceptive methods, which are not deemed appropriate for these media. Women showed greater interest in interventions through broadcast media and proposed that drama series on the topic should be broadcast in local regional languages.

Demand for male health workers: Appreciating the role and effectiveness of the government's Lady Health Worker program, men suggested recruiting male health workers in communities, with roles similar to lady health workers, providing services to men at community level.

CONCLUSION

Men in Punjab seem now more concerned about their fertility intentions and practices due to the financial challenges of raising large families. This concern has not only increased spousal communication about family size and contraceptive use but has also encouraged Punjabi men to practice family planning. Most men now realize that either they or their wives should use family planning. It is the next step, however, of translating intention into practice, which is a challenge. Supply-side issues, including absence or paucity of family planning services as well as poor quality of services (including service providers' lack of

capability to manage side effects) are the main factors hindering couples' adoption of family planning. Perceived or experienced side effects of contraceptive methods are other factors.

Men's positive attitudes and their readiness to be involved in family planning programs suggest that the efforts of convincing men to use contraceptives have been effective and this it is now time for direct reproductive health interventions for men in Punjab.

Yet heavy spending on media campaigns may not be as effective as interpersonal interventions. A focused effort to mobilize men through male-specific interventions is likely to increase the demand for contraceptives. These interventions have to be backed up by improved supply of contraceptives and availability of family planning services in accessible facilities.

RECOMMENDATIONS

- In Punjab, men need to become the primary focus of family planning programs. Male-specific interventions are urgently required, and should be introduced, in order to augment men's lack of knowledge of family planning methods, to encourage timely decisions on fertility issues, and to increase contraceptive use.
- Men express the need for frequent male group meetings with full geographic coverage, facilitated by a local or community resident. They should be conducted by an "outside" health professional (preferably a doctor). Also, to minimize delay in contraceptive uptake, contraceptives should be made available at the end of these meetings.
- Interventions involving religious leaders should play a supporting role in increasing acceptability of family planning among men. Such leaders should be trained to deliver messages that birth spacing and family planning are allowed in Islam.
- Given the supply-side barriers to family planning use, regular supplies to clients should be assured.
- Service providers should be knowledgeable and skillful, and should receive training on managing side effects.

CHAPTER 1 — INTRODUCTION TO THE STUDY

BACKGROUND

Fertility in Pakistan has been above replacement level for most of its history, with levels approaching seven births per woman in the 1960s, declining to around six in the 1980s and then to its current level of 3.7 (Sathar, Royan and Bongaarts 2013). The declining trend has been leveling off over the last five years, however, and Pakistan's slackening in its fertility transition is a cause of concern internationally, as well as within the country. High levels of unmet need for family planning (FP) at 37 percent, coupled with a low contraceptive prevalence rate of only 30 percent, are believed to be closely linked to both demand and supply factors (Sathar, Royan and Bongaarts 2013). Concerns related to supply-side issues range from the unavailability and inaccessibility of FP information and services to the quality of the services themselves, including provider-client interactions (Sathar and Zaidi 2012). Decision-making within households—particularly the low levels of female autonomy that hamper women in making decisions, and poor communication between spouses, who may not necessarily agree on fertility intentions—may be an important constraint for couples seeking FP services (Bongaarts et al. 2012).

Pakistan has a society that generally subordinates women to men. Studies repeatedly identify the husband's agreement as one of the most influential contributors to acceptance of an FP method in rural and urban areas (Mahmood and Ringheim 1996; Tuloro et al. 2006). In male-dominated societies such as Pakistan, the decision-making power of the husband—or his mother—may be critical for FP outcomes (Agha 2010). Whether actual or perceived, men's views and decision-making powers are important in seeking reproductive health care ranging from delivery, antenatal care, immunizations, and especially FP (Bongaarts et al. 2012; Khan et al. 2012; Agha 2010).

Assessing men's views is difficult due to the dearth of data and infrequent use of men as informants in health surveys and consultations. Although demographic health surveys (DHS) have provided the worldwide public health community with comprehensive data on knowledge, attitudes, and practices for reproductive health, only women of reproductive age are usually interviewed for these surveys, except for the Pakistan DHS (PDHS) 1990–1991, which had a special module for men (NIPS–Macro 1992). Men were not interviewed in PDHS 2006–2007.

There are a few notable studies on the topic of men's and couple's decision-making in Pakistan, largely based on PDHS 1990–1991 (Mahmood and Ringheim 1997; Kiani 2003) and male data from two studies in Punjab in the 1990s (Casterline et al. 2001; Ali 1999). All these studies emphasize the significance of involving men in FP programs and enhancing spousal communication to increase contraceptive uptake. Furthermore, studies on couples' behaviors are especially illuminating, as differences between husbands and wives may often be reasons for either inaction or inability to use contraception effectively over time (Kazi and Sathar 1997; Population Council 1997; Mason and Smith 2000).

Considering the fact that "men's participation and sharing of responsibility in the practice of FP" was a recommendation of the 1994 International Conference on Population and Development, the lack of practical and programmatic implementation of this

recommendation within Pakistan needs to be addressed (Lasee and Becker 1997). A study in southern Ethiopia creates a backdrop to our research interest when it states that "Family planning programs should not only focus on women, but they should also address men… Until recently, family planning programs have mainly focused on women's attitudes and behaviors" (Tuloro et al. 2006, p. 152).

The reason that researchers argue for this behavioral paradigm is the perception of women as child bearers, and consequently, the primary recipients of information and education on contraceptive knowledge and use. The attention given to them is not only considered their prerogative, but also seen as more relevant than men's contraceptive practices. Thus men's roles (who strongly influence the family's decision-making in patriarchal societies) end up ignored (Tuloro et al. 2006). Therein lies the weakness of most FP programs: an essential center of agency in the dialectical process of decision-making is ignored because little or no attention is paid to understanding men's roles in the "effective utilization of contraceptives." The authors' conclude, "Men also play a considerable role in the decision-making process, which is a good argument for involving them in family planning activities… Family planning programs should not focus only on women, but also address men as principal stakeholders" (Tuloro et al. 2006, p. 158).

Studies have shown that one reason women give for nonuse (of FP methods) is the husband's disapproval. This sentiment is echoed in other developing societies where it has been shown that the husband's desires have an important effect on a couple's fertility (e.g., Lasee and Becker 1997). A study on Pakistan published in 2006 sought to determine the number of children considered "ideal" by husbands and the factors associated with that view (Avan and Akhund 2006). The study was an attempt to specifically study male perspectives on intended fertility. Furthermore, it urged that "Family planning programs should focus on families as a whole unit of intervention rather than just focusing on wives" (Avan and Akhund 2006). The authors cited an excessive focus on women as one of the reasons for Pakistan's slow progress in FP and an only slowly declining population growth rate. Their study was cross-sectional and hence the respondents' husbands could not be followed up to see whether their view on the ideal number of children had translated into reproductive behavior. Moreover, while the study focused on rural villages within Khairpur district in Sindh, the authors indicated a need for a separate study that could present an urban perspective as well.

Similarly, Agha (2010) highlighted the need to have complementary "target audiences," such as mothers-in-law and husbands in FP behavior change campaigns. He further emphasized that programmatic investments in the future would prove futile without steps to assess the "successes and failures of specific interventions".

On male involvement, a qualitative study conducted by the Population Council, Islamabad in 1997 gauged the perceptions, concerns, and needs of men in their involvement in reproductive health in five districts of Punjab. The study highlighted that men were not opposed to FP. However, their actual resistance seemed to exist mainly due to ignorance (Ali 1999). The study also suggested a split between men's awareness and knowledge of FP: men had some awareness of FP topics but did not actually know about the variety of methods available, or their use. Therefore, the need to provide information on side effects and modes of action, and correct male misconceptions, was felt strongly (Ali 1999).

Mahmood and Ringheim (1997) used data from PDHS 1990–1991 to identify factors associated with desired fertility in Pakistan. Their findings led them to conclude that well-planned efforts to educate men in reproductive and child health and to expedite inter-spousal communication would help couples achieve their reproductive goals. Whereas the attainment of a sustainable level of fertility presupposes an improvement in the status of women—through education or otherwise—the authors felt that male involvement cannot be ignored, and that "a lack of attention to men's role in fertility is a shortcoming of [PDHS]." They highlighted and reiterated the vantage point that needs to be adopted by local organizations working in FP: "in the cultural context of Pakistan…all efforts in promoting family planning require involving men" (Mahmood and Ringheim 1997).

The same authors in another study asserted that communication between a husband and wife "has been found to be associated with favoring a fewer number of children and with enhancing the practice of contraception" (Mahmood and Ringheim 1996). The authors also discussed changes within the "family norm" that may be induced by an open discussion of personal aspirations for children by couples. The importance of focusing on male agency is clear since: "…many forms of contraception require partners' participation or concurrence… Past research also shows that the role of husbands in household and reproductive decision-making is significant" (Mahmood and Ringheim 1996).

After establishing that greater husband–wife communication on FP among a range of topics with gender dimensions can be conducive to advancing couples' contraceptive use, the authors highlighted certain areas that need to be examined in future demographic studies. One of these was the "empirical examination" of the question as to whether communication between husbands and wives promotes mutual agreement in family size desires or not. The same authors pointed out a gap in the academic literature (pertaining to FP) that needed to be addressed: "While it is true that interpersonal and community-based communication approaches have not been widely tested in the field of FP in Pakistan, small-scale studies have shown the potential for success and invite further exploration" (Mahmood and Ringheim 1996).

In a qualitative study, exploring the choices of contraception and abortion among couples living in a rural Punjabi village of Pakistan, Kamran et al. (2011) found a virtual absence or very infrequent communication between husbands and wives on their fertility intentions, particularly early in their reproductive lives. They emphasized that the lack of spousal communication results in one spouse's inability to understand fertility intentions and desires of the other. This late initiation of discussion leads to later uptake of contraception and unwanted pregnancies because of the delay in getting the husband's approval. Spousal communication appeared to have a close relationship with decision-making on contraceptive use or with seeking abortions. The authors recommended promoting spousal communication on family planning to encourage couples to discuss fertility intentions in their early reproductive lives (Kamran et al. 2011).

Over a decade earlier, Lasee and Becker (1997) felt that previous studies had defined communication in different ways while very few had used all three dimensions properly. They problematized the notion of inter-spousal communication by introducing three subvariables touching on different dimensions of effective communication leading to agreement: approval; discussion between partners; and spousal perception of the partner's

approval of FP. They assumed that communication between spouses on FP discouraged couples from having unwanted children and encouraged contraceptive use. Their study results showed that both approval of FP and knowledge of sources of contraception had the expected significant positive association with contraceptive use in bivariate analysis. However, when the variables were analyzed in conjunction with the communication variables in a multiple logistic regression, they found that the wife's perception of her spouse's approval of FP was statistically significant, and emerged as the most powerful variable in explaining contraceptive use—thus emphasizing the need for spousal communication. These authors, too, argued that all FP communication efforts should target men.

OBJECTIVES

Most research on couples' dynamics and reproductive intentions and behavior for Pakistan dates from the 1990s—as just seen—underlining the need for a clearer grasp of current realities. In particular, the views of men are required to assess whether men are a hindrance for women wanting to use FP services and whether their assumed resistance is still real. Fresh evidence is required on the differences between intentions and the future desire for children, and views of contraception, between men and women and husbands and wives. Also, as Pakistan sorely needs to reduce unmet need by improving contraceptive prevalence, there is a need to assess whether men themselves require certain interventions to improve their approval and uptake of family planning.

The four main objectives of this study were therefore to explore and analyze:

- Differences between men and women regarding fertility intentions and practices;
- Decision-making processes among couples regarding fertility intentions and practices;
- Local community perceptions about male-focused interventions;
- Local community suggestions and critiques for intervention strategies in the future.

This study seeks to explore the decision-making process of couples in the move from fertility intentions to behavior. It also examines the readiness of men to be involved in FP programs through different male-centered interventions. In-depth interviews (IDIs) with couples are especially direct in gauging spousal perception of the partner's FP approval or disapproval. The study focuses on urban and semi-urban areas of Punjab and can be used, at least indicatively, for interregional and temporal analyses within the Pakistani context.

METHODOLOGY

Study Tools

The analysis uses data derived from the Population Council–led and USAID-funded Family Advancement for Life and Health (FALAH 2007–2012) project, and data generated through primary qualitative research for this study. The fieldwork was carried out in 2013.

FALAH was a national initiative to increase adoption of birth spacing (BS) behavior and practices—with a new focus on men among other socially influential people. It ran in 15 districts in total. FALAH focused on communications interventions which included male

group meetings, religious leaders' (RLs') involvement, and the media. Baseline and endline surveys were carried out to assess the effect of the interventions.

In Punjab, FALAH implemented interventions in the districts of Bahawalpur, Rajanpur, and D.G. Khan from southern Punjab and Jhelum from northern Punjab. Three of these districts (Bahawalpur, D.G. Khan, and Jhelum) were selected for this study and a fourth, non-FALAH district, Okara from central Punjab, was randomly chosen as a comparison. Two rural communities and one urban community were chosen from every district.

Results of male interventions of FALAH provided the background for conducting this qualitative study. These include insights and evidence of the impact of interventions addressed to women (which enable them to communicate better with husbands), interventions directed through the mass media at both men and women, and above all, interventions addressed at men alone. Further analysis from the FALAH baseline and endline data is also included in this report.

At the study design stage two themes were identified: one on inter-spousal communication (ideal family size; decision-making on family size; and decision-making on contraceptive use); and one on the role of interventions (whether respondents report knowing about any prior interventions in FALAH districts; perceptions of male group meetings; involvement of RLs/*Ulema;* media campaigns; and the role of lady health workers (LHWs) and male mobilizers).

The following data collection tools were used to glean information and insights mainly from men (and a few women) using largely qualitative techniques given the sensitivity deemed to surround FP issues:

Focus group discussions (FGDs): Twelve FGDs were conducted with husbands across the four selected districts in Punjab, in 2013. Of these, eight were conducted in rural settings, and four in urban or semi-urban areas. The men were selected on the basis of their marital status (married) and age (below 45 years). The discussions were centered on the need to assess the nature and strength of their fertility intentions; whether they wanted to seek more information on contraception and FP; whether they were influenced by religious or community endorsement to uphold certain values; and whether the mass media influenced their personal beliefs and values. Their views about potential interventions directed at men were also noted.

The moderators were given guidelines (see Appendix D and E) for the FGDs and IDIs. Although this gives the semblance of these instruments being formally structured, they were implemented merely for interpretative purposes. The moderators exercised their judgment to mold the discussion according to the context. FGDs were given precedence as they helped to synthesize local community-based suggestions and critiques for intervention strategies in the future. IDIs were conducted as complementary exercises and helped in an understanding of inter-spousal decision-making processes on the desired or planned number of children, contraceptive use, and FP at an experiential level.

IDIs: The research team conducted 26 IDIs with 26 couples (women and their husbands separately) across the four districts in 2013. The criteria for selection were as follows:

respondents had to be married, under 45 years of age, and have had at least one child alive. Interviews with spouses were conducted simultaneously in different rooms to prevent interactions that could skew how information was provided.

Key informants: The respondents for IDIs and FGDs were identified by key informants in their respective communities. These informants belonged to district health and population departments and nongovernmental organizations working at grassroots level. Their involvement helped eliminate or diminish any barriers to trust among respondents, given the sensitive nature of the topics.

Profiling: At the time of the interviews community profiles were created through semi-structured questionnaires to gauge essential development indicators of the communities. This profile assessed markers such as population, number of households, health facilities, general economic situation, and women's economic activities (Appendix A).

Respondent Recruitment

IDI respondents, as said, had to meet the minimum selection criteria of being married, aged under 45, and have had at least one child.[4] The need for at least one living child was essential as the study examined inter-spousal communication regarding the desired/actual number of children and contraception usage status. Gauging these factors is relatively challenging with couples who are childless or just married.

FGD participants were identified and assembled by local key informants in their communities. It would in fact have been impossible to conduct FGDs without them. The discussions themselves were held at neutral locations in the community where everyone would be able to assemble without facing external disturbances. On average, 10 respondents took part in discussions. The minimum criterion of at least one child was eliminated for the FGDs as a generalized community-based response was sought.

Ethical Considerations

Ethical considerations were taken into account while conducting field research to ensure that respondents would not be at risk at any stage. The protocol was approved by the Population Council's Internal Review Board in New York. All participation by respondents at all stages was voluntary and based on informed consent (Appendix B and C).

All participants were briefed on the identity of moderators and transcribers, the Population Council's background, the purpose and benefits of the study, and the interview process. They were told that their names would not be used anywhere and that the Council was merely interested in recording their ideas and suggestions so as to incorporate them in a potential intervention strategy in the future.

Apart from confidentiality, interviews were conducted after gaining permission from respondents at a time and place convenient for them. Moreover, keeping in view the local mores and patterns of interaction between members of the opposite sex, moderators and

[4] Despite the "under-45" criterion, the sample still included some slightly older respondents.

participants always belonged to the same gender. Interviews were held in the local language.

Data Recording and Processing for Analysis

Raw audio data were recorded with participant consent using digital recorders that allowed playback for transcription. All transcribers had social science backgrounds and were present throughout the interactions. They supplemented the audio data with written notes.

Recorded files were transferred to computers daily and managed in a systematic manner by assigning a unique identification number to each field interview. The research team transcribed the recordings from Punjabi/Urdu to English immediately after returning from the field, to ensure that data were preserved and documented while still fresh in the researchers' minds. A matrix of responses on the main themes of the interviews and discussion was constructed in MS Excel after the transcriptions were complete, and was filled in by members of the qualitative research team for analysis.

Study Limitations

Only two or three couples could be interviewed per community due to funding and time limitations. Increasing the numbers of interviews would have enhanced the reliability of the field of responses. Another challenge—inherent to the topic—was participants' hesitation to talk about certain aspects of fertility behavior: although most showed no hesitation in discussing the number of children they had or possible intervention strategies, often a degree of resistance was felt whenever the couple's decision-making processes were discussed, or whenever the interviewers probed whether it was the wife or the husband who initiated the discussion. There was also some general information, especially on the number of children and their exact ages, which proved challenging to recall—a problem more pronounced among male respondents during IDIs.

CHAPTER 2 — FERTILITY INTENTIONS, COMMUNICATION, AND DECISION-MAKING ABOUT FP

This chapter focuses on the fertility intentions and the decision-making process leading to contraceptive use with a special emphasis on inter-spousal communication. It begins with fertility intentions and behaviors from PDHS 1990–1991 (for men and women in Punjab), PDHS 2006–2007 (for women in Punjab), and the 2012 FALAH national endline survey. The main findings, however, come from this 2013 qualitative study in four districts of Punjab. While FALAH data were used to establish overall reproductive patterns, the qualitative analysis explains the consistencies and differences observed in the quantitative analysis among men and women, in reporting their fertility intentions and behavior. The qualitative data were collected via 26 IDIs and 12 FGDs.

FINDINGS FROM PDHS AND FALAH

The findings of the FALAH endline survey suggest that the majority of men and women of Punjab desired no more children; this figure had risen in two decades from 34 percent to 61 percent for men, and from 41 percent to 53 percent for women, marking a much more prominent change in men's desires (Table 1). In 2012 men in FALAH districts of Punjab actually had a stronger preference than women to avoid additional children, while women's desires for controlling fertility were stronger in 1990–91. Surprisingly, PDHS 1990–91 data show higher FP approval among men than women.

Conversely, according to the FALAH endline survey, although men were slightly less likely to approve of FP than women, more than 82 percent approved when the question was framed as birth spacing rather than limiting. It was also observed that men, in the smaller sample interviewed, were more likely to report contraceptive use (43 percent) than women (37 percent), echoing the 1990–91 pattern. A systematic increase in contraceptive use is observed among women, from 13 percent in PDHS 1990–91, 33.2 percent in PDHS 2006–07, and 36.7 percent in FALAH 2012.

Table 1: Men's and women's fertility attitudes and behavior, PDHS 1990–91, 2006–07, and FALAH endline 2012, Punjab

	Women (PDHS 1990–91) %	Women (PDHS 2006–07) %	Women (FALAH 2012) %	Men (PDHS 1990–91) %	Men (FALAH 2012) %
Desire for no more children	40.5	45.2	52.8	34.0	61.2
Approve of FP	57.5	-	88.3	72.3	82.7
Current use of contraception	13.0	33.2	36.7	18.2	42.9
n	**3,948**	**4,973**	**3,717**	**801**	**751**

Source: PDHS 1990–91 and 2006–07 and FALAH endline survey 2012.
Note: Only the Punjab subset of data of PDHS are used.

Although individuals' fertility desires and intentions may vary among men and women, convergence between husbands and wives is a prerequisite for converting intentions into behavior, as it increases the chances of translating desires into reality. Table 2 suggests that

the number of couples for which husbands and wives want the same number of children has increased.

Another encouraging change is husbands wanting fewer children than their wives: it has increased from 5 percent to 8 percent. In addition, according to the FALAH endline survey, about 18 percent of wives did not have a specific number in mind and/or were unaware of their husbands' desired number. This proportion was almost half that in 1991, so this change also suggests a gradual trend of increasing spousal communication. Overall, 52 percent of wives from the FALAH endline survey reported that their desired number of children was the same as their husbands' (a small shift up from 47 percent in the PDHS 1991, but down from PDHS 2006–07). Of these couples, two-thirds desired four children or fewer (data not shown).

Table 2: Levels of convergence between husbands and wives on the desired number of children, PDHS 1990–91, 2006–07, and FALAH endline 2012, Punjab

	Couples (PDHS 1990–91) %	Women (PDHS 2006–07) %	Couples (FALAH endline 2012) %
Both husband and wife want the same number of children	47	60	52
Husband wants more children	14	14	22
Husband wants fewer children	5	4	8
Don't know what husband wants	34	22	18
n	**786**	**4,973**	**134**

Source: PDHS 1990–91 and 2006–07 and FALAH endline survey 2012.
Note: Only the Punjab subset of data of PDHS are used.

FINDINGS FROM THE FGDS AND IDIS

The 2013 qualitative study showed a wide divergence in reported ideal family size across districts. In Jhelum and Okara, the desired family size was about two to four children, compared with four to seven in Bahawalpur and D.G. Khan. Men and women generally considered four or five children as a "small family size" in the latter districts. Four children was the ideal for the majority of the men and women interviewed. Furthermore, there was no difference in the ideal family size across urban and rural settings of northern and southern Punjab.

> I think two children are enough; inflation is too high and expenses are not bearable. **FGD, Rural Okara**

Interestingly, desired family size for women was higher than for men in all the Punjab districts—a result similar to the FALAH endline findings. The main reason driving a higher desired number of children was the desire to have a son, or to have a pair of sons or daughters.

> My husband wants four children. He says that if God gives him one son, even that will be enough. I have three daughters, and I wanted two more sons. **IDI, woman with 3 children, Rural Bahawalpur**

Respondents also shared their reasons for their ideal family size(s) during FGDs and IDIs. Both male and female respondents desiring (perceived) smaller family size were driven by economic concerns.

> Islam generally advises you to spread your seed and have children. However, if we look at the conditions of a poor man, I would say that two to three children are okay. **FGD, Rural Jhelum**

The desire to provide good health, education, and other basic necessities to their children was a strong force leading to the desire for small families.

> Financial problems are a strong reason in the minds of people that convince them to try out family planning. Let us suppose that there is a small family comprising two children. They will only be able to survive if they earn 500 to 700 rupees daily. The other reason is education. **IDI, man with 4 children, Rural Jhelum**

While these views were generally shared by respondents from Bahawalpur and D.G. Khan, a few FGD respondents also justified their desire for more children on religious grounds. The concept of having a pair of boys or girls and having more children due to a fear of loss of any existing children was also reported by some respondents.

> I think children are blessings from God. I am in favor of having four to five children. **FGD, Rural Bahawalpur**

> Parents think their children would be a support in their [the parents'] old age. God forbid, if a person has only one child who becomes ill or has some problem/abnormality or dies, it would be very difficult for him to propagate his lineage. **IDI, man with 2 children, Rural Okara**

There was a divergence between husbands and wives over the desired number of children. In many cases, wives or husbands compromised their reproductive desires and accepted the desire of their spouses. Men seemed to accept their wives' wishes quite often, as women desired more children than their husbands.

> Initially, it was two children [initial planned number of children]. But then the third one came along. It was my wife's wish; she used to say that he did not have a brother [referring to the older son]. **IDI, man with 3 children, Urban Jhelum**

> I think three children are enough. My wife wants to have one more child. She wants to have a couple of sons and daughters. **IDI, man with 3 children, Rural Bahawalpur**

The desire to complete a pair of boys or girls and family pressure from mothers-in-law and relatives were also mentioned as reasons for the differences between actual and ideal family size.

> When alone, even a tree does not look good. One should have at least a couple of brothers who can share happiness and sorrows [*dukh such*]. And one should also have at least a couple of sisters who can share happiness, sorrows, and others' problems. **FGD, Rural Bahawalpur**

> We wanted only two children but ended up with four because of my mother-in-law. After having three children my seven-year old daughter used to weep about not having a sister. Even though we were using condoms at that time, one got ruptured, and I became pregnant. **IDI, woman with 4 children, Rural Okara**

> I have two daughters and a son, so I would wish for another son so that I have a pair of each. **IDI, man with 3 children, Rural Okara**

Gender Differences in Views on FP

Supporting the findings of the FALAH endline survey, a majority of male FGD respondents across the four districts (three FALAH and one non-FALAH district) were in favor of FP. They commonly claimed that all men talk openly about issues pertaining to FP. This was especially evident when men spoke without hesitation irrespective of their rural or urban backgrounds. The FGD and IDI findings presented overwhelming evidence that adverse economic circumstances and reduced purchasing power were the main reasons compelling men to think about and accept FP.

> Yes, the men are in favor of family planning. Since the condition of our country is very bad, men are compelled to think that there should be fewer children. **IDI, woman with 4 children, Rural Okara**

During an IDI, a respondent shared his own views about other men in the community.

> I have not seen anyone against it so far. In these circumstances, men are mostly in favor of birth spacing. My friends also have the same opinion and they say that it is better to have a gap between births. And since girls nowadays are also well aware and educated, they know the benefits of birth spacing. Not only is it beneficial for me, but also for my other half. **IDI, man with 1 child, Rural Okara**

Different Motivating Factors for Men and Women

Given that both men and women appeared to be concerned about fertility issues (as the previous discussion suggests), it becomes important to examine the difference in factors that motivate them to consider and initiate these discussions with their spouses. Concerns about poverty were mentioned as major motivating factors in almost all districts by both men and women for at least temporarily limiting family size and adopting contraception.

> Poverty is the major motivating reason. You must have seen that it is difficult to afford more than two kilograms of flour. I am just a laborer, so my income is quite low. Income levels are not proportionate to the level of inflation. How are we going to feed ourselves if we have a large number of children? **IDI, man with 3 children, Rural Bahawalpur**

Reduced purchasing power and rising expenses of rearing children and their schooling also emerged as important motivating factors for both men and women across the districts.

> One needs to take care of the children as well, and that is obvious. It is no use giving birth to children if you cannot bring them up properly. **FGD, Urban Jhelum**

> People think if they have a larger number of children, they will not be able to provide them with good educational opportunities and also, they will not have a chance to raise them with a good living standard. **FGD, Urban Bahawalpur**

> The children I already have are enough (five). They will get a good education that way. There are problems associated with education. After all, children incur expenses. They will have a good education, and if you have a moderate number of children, it becomes easier to handle them - it is easier to bring them up. Everything becomes easier. The more children you have, the greater the extent of division in your property. These problems carry themselves with you for the rest of your life. **IDI, man with 5 children, Rural Okara**

Maternal and child health were mentioned more by women but also by men as a motivation for FP.

> In poor households, women do not have much food to eat to ensure their own health. When a woman produces two or three children, she becomes weak and fragile. In the end, she thinks about sterilization; that it is the solution not only for her health, but also for her children's health and their upbringing. **FGD, Rural D.G. Khan**

Child rearing and women's health concerns were mentioned more by men during the IDIs stating their own realities. For example, a male respondent mentioned how his wife had convinced him to use FP by expressing her concerns:

> She used to talk about routine matters; the children's cleanliness, bathing them, putting them to sleep. She said she was sleep deprived because of the children. When my wife got fed up of looking after the children, dressing them properly, ironing their clothes, maintaining the house, and keeping them (the children) clean and neat, she used to tell me that we should stop having children. **IDI, man with 6 children, Urban D.G. Khan**

The role of relatives (other than the husband) such as the mother-in-law and other kin was also mentioned.

> Social pressure comes mainly from relatives. They will consider themselves socially stronger if they have more children, and will have an upper hand and look down upon you. **FGD, Urban Okara**

Continuation of the lineage through sons was another driving force for having more children.

> I wanted about two or three children. We have tried a lot, but these things are not in our control. Now we have five daughters. Yes, there is a specific pressure within the household. My brother recently had a son and now my parents have started discriminating against me and taunting me (that my brother has a son and I do not). **FGD, Rural Jhelum**

> There is another pressure, that if a couple has a first child and it is a daughter, then they will continue to produce (four to five) children until they have a son. … In my neighborhood, a couple has six daughters and all of them were conceived with the hope of a son. They say they will stop having children as soon as they have a son. **FGD, Urban Okara**

Initiation of Discussion about FP Use

The above motivating factors compel men and women to think about their fertility intentions. Their intentions cannot be converted into behavior unless they talk about it with their spouse. The FGDs and IDIs suggest that communication exists between spouses on family size and contraceptive use in all districts, although there was a mixed response about who initiated the communication. The nature of this response varied through districts as well as urban and rural settlements. Most FGD respondents and a few IDI respondents mentioned that women usually initiate discussions on determining FP or using contraceptives. Men and women alike said that women are more concerned with family size and the use of contraceptives because the burden of child rearing falls mainly on women. They also have the responsibility of managing the household with limited economic resources, and possess a greater realization about the significance of these issues as a result of female-focused interventions.

> My wife started this discussion about family planning because she no longer had the will to bear more children at this point and said I should use the withdrawal method. **IDI, man with 1 child, Rural Bahawalpur**

> I initiated the discussion. I think women initiate the discussion because they know that they have to run the house and manage food and clothes for their children. The woman takes care of these things; men just earn. **IDI, woman with 3 children, Rural Jhelum**

> My wife initiated the conversation and I agreed with her as we have limited resources. **FGD, Urban Jhelum**

A majority of men and women from IDIs stated that men initiated discussion on family size and contraceptive use because the responsibility of earning falls on men, and that only men make decisions on household matters in male-dominated societies.

> I started the discussion with my wife about the number of children because I have to bear all the expenses. **IDI, man with 3 children, Rural D.G. Khan**
>
> It is a male-dominated society. Women do not have any say in decision-making. **FGD, Rural D.G. Khan**
>
> The man guides the woman in this situation. He takes her into confidence by discussing the issue with her. **FGD, Urban Bahawalpur**

A third opinion emerged from the FGDs, that: either the husband or the wife can initiate the discussion; the person who suffers or experiences more problems takes the lead; and that starting it also depends on awareness and exposure. According to several respondents, it does not matter who initiates the discussion. Men generally take the initiative if economic concerns are strong, and women if there is a serious health concern or an issue with taking care of the children or household responsibilities.

> Couples automatically start thinking about family planning after the first child if they are sensible and educated. People should have a planned number of children even if they possess (ample) resources. If a man wants to "tease" his family, he will have many children. Otherwise, he will think about family planning (The respondent used the word "tease" to imply someone causing discomfort). **FGD, Urban Okara**
>
> A husband initiates the topic if he gets tired and thinks he is unable to meet the expenses of the household. A wife initiates the conversation if she gets tired and cannot take care of the children. These are the two common situations (which motivate people to initiate such discussions). **FGD, Urban Bahawalpur**

Although few, some respondents from D.G. Khan (three FGDs) and only one female (IDI) in Jhelum mentioned that educated couples and those with greater awareness are more concerned about family size or birth spacing and are more likely to discuss these issues with each other.

> Those who are aware of family planning do discuss it. Some literate people think we need to give a "perfect product" [educated children] to society; such people think about and discuss family planning. **FGD, Rural D.G. Khan**
>
> Both men and women have the faculty of thought and consider the fact that they want a good education and living standard for their children. Whoever [husband or wife] has greater awareness initiates the discussion. **FGD, Rural Jhelum**

A considerable part of the men and women in almost all places stated during the IDIs (males 9 of 26 and females 13 of 26 IDI respondents) and FGDs (8 of 12 FGD) that they initiated the discussion about the issue of FP after having their first or second child. A few IDI respondents (6 of 52, men and women) from Bahawalpur, Okara, and Jhelum said that they started discussing these plans just after getting married and even before the wife's first pregnancy. One man from Bahawalpur said that his wife started using pills just after getting married in order to delay her first pregnancy and that it was done with mutual consent.

> Two days after we got married, we had a discussion about having children. We decided not to rush into it and wait a year. Then, we got pills from a local doctor. She [my wife] took three strips of pills for a gap of nine months. She started taking pills three days after our marriage. **IDI, man with 3 children, Rural Bahawalpur**

Still fewer men and women (4 of 52 IDI respondents) reported that they began the discussion on the issue of FP or desired family size after having three or four children.

> We thought we should practice birth spacing [due to inflation] after the birth of our youngest child [the fourth child]. That is why we are now using condoms. **IDI, man with 4 children, Rural D.G. Khan**

The combined responses suggest a pattern: women and even men are now concerned and plan their fertility even at the beginning of their marital life. Though the gap between fertility intention and behavior is wide due to many factors, they have started being more concerned and discussing these issues.

> My wife mentioned that our child was only two and a half years old, and still young. I told her that it was up to her [to use FP methods]. I stayed for two to three months, and then returned after another one and a half to two years [abroad]. This is how a gap of four years was maintained. It was my wife's desire to increase the gap a bit. **IDI, man with 3 children, Urban Jhelum**

The Road to Contraceptive Use

Further exploration was required to assess whose thoughts dominated the final decision, and how long it took to actually start using contraceptives. Men in FGDs (6 of 12) and IDIs (4 of 26) admitted that despite living in a male-dominated society, women often persuaded them of the woman's desired number of children and contraceptive methods when the couple's thoughts differed. Men further explained that it was not easy for them to agree, but that women eventually managed to make their husbands agree with them. The discussions also suggested that if women keep on repeating their point of view, men eventually agree.

> For two months, she kept on disturbing me by being angry, beating the children, bad cooking, and irregularity in performing household chores. Finally, she made me agree and I permitted her to get sterilization. **FGD, Rural Bahawalpur**

Men also reported that the number of living children (particularly sons) empowered women because children are considered a guarantee against being thrown out of husbands' houses.

> I told my wife she must not get sterilized. She said she would go to the hospital for the procedure anyway. Then I threatened to marry another woman. She said it would not matter to her as she already had children which are blessings from God. She gave me permission for a second marriage because she knew she had children for support. **FGD, Rural Bahawalpur**

The majority of the IDIs showed that wives convinced their husbands to use contraceptives. In two cases in D.G. Khan, men reported that their wives did not even inform them before using contraception: one respondent's wife consulted her cousin and started using injectable contraceptives; the other's informed him after having herself sterilized. These examples suggest that women can make independent decisions to use contraception, even if the husband may not fully approve of the decision.

> She did not discuss anything with me before sterilization. She got herself sterilized when she was at her parents' home. After having the operation done, she called and told me that she had had herself sterilized. I said to her, "You should have gotten my permission and had a discussion with me." **IDI, man with 6 children, Rural D.G. Khan**

> She consulted her cousin who is living here. He recommended the injection for my wife. **IDI, man with 3 children, Rural D.G. Khan**

The majority of women, however, require their husband's consent to use contraception. In fact, without a husband's agreement, access to contraceptives is harder. Women usually initiate discussions, they try to convince their husbands, and most of them succeed—or contraceptive use is a mutual decision. Either way, the positive and supportive role of the husband is prominent.

> Without the consent of the wife, a man cannot do anything. If both agree, then they will use any method they want. **FGD, Rural Bahawalpur**

> I think women start it [discussion] first. So, you have to accept your wife's demands. Women convince their husbands. **FGD, Rural Okara**

Factors Impeding Men: Unmet Need for FP

Still, what about those cases when husbands are not convinced? A common situation reported in FGDs and IDIs was husbands' disagreement or non-consensus on a particular contraceptive method. Moreover, religious concerns, particularly on methods used for limiting family size, were also mentioned as barriers to FP.

Approving FP does not necessarily mean that all husbands will allow their wives to use contraceptives. In one of the FGDs in rural Bahawalpur, the husband's disapproval was mentioned as an obstacle to using contraceptives as a birth-limiting method. One FGD respondent elaborated:

> I have told you that the woman [neighbor] did not want to bear more children and wanted to get sterilized, but her husband warned her not to go to the hospital for sterilization. She discussed the issue with me and forced me [to take her]. Then, I took her to the hospital [on a motorbike] for sterilization. **FGD, Rural Bahawalpur**

> My husband is not against family planning, but he does not like family planning methods [due to a fear of side effects]. **IDI, woman with 3 children, Rural Okara**

Religion

Religion was not a strong constraint to men using FP—only a small minority of men (2 of 26 IDIs and 3 of 12 FGDs) reported that it was. One IDI view was against modern contraceptive methods, while the other IDI view considered FP to be against nature but a part of social practice and constituting a need—but both respondents were using FP. (One was practicing the withdrawal method and the other's wife was using injectable contraceptives.)

From the point of view of women, two respondents from D.G. Khan and Okara reported that their husbands were not against FP, but were against modern methods, particularly sterilization, which they regarded as against their religion.

> I think that FP is against the laws of nature. However, you can say that using contraception has more to do with social norms [*dunyadari*]. **IDI, man with 6 children, Rural D.G. Khan**

> My husband says that you can use any method but sterilization as it is a sinful act. **IDI, woman with 6 children, Rural D.G. Khan**

Similarly in rural D.G. Khan, respondents said that that most men are against FP on religious grounds. However, it was stated in later discussions with men in this community

that a considerable number of men and women were practicing FP. During these group discussions, respondents sometimes shared the views of others who were not in favor of FP.

> People think that newborns bring bread and butter with them. You were not able to earn when you were a child but even then, you have grown up. Similarly, these children will also grow. Why should we stop child bearing—it is a sin. People argue that children should be produced. It is interference with nature to prevent fertility. **FGD, Rural D.G. Khan**

FP Services

Other reasons were cited for not using contraceptive methods, including non-availability, experienced and perceived side effects, contraceptive failure, and cost. Men said that apart from LHWs, there was no information source for them at community level. According to a few FGDs as well as IDIs, in recent years the involvement of LHWs in the labor-intensive polio eradication campaigns has diverted their time and attention and rendered them unable to fully perform their primary duties as LHWs.

In two FGDs (urban D.G. Khan and rural Bahawalpur), the discussions centered on the point that most contraceptive methods are for women and thus the burden of use is on women. Those FGDs also heard that it was stated that all interventions for FP are aimed at women, as a result of which husbands remain largely unaware and cannot take initiatives themselves. In addition, they do not value the information their wives give them. The respondents further explained that due to men's limited knowledge of methods, arguments arise between husbands and wives about contraceptive use.

> There should be a man who takes the initiative to start discussions and give information about family planning. In our houses, there is usually a clash of opinions (between a husband and a wife on contraceptive use) because the wife has a better understanding of family planning thanks to the LHWs; men have no such knowledge. **FGD, Rural Bahawalpur**

Issues of uneven contraceptive supply at community level also came up in two communities of Bahawalpur, one urban community of D.G. Khan, and one rural community of Okara. According to community members, the diversion of LHWs' scope of work from FP services to the polio campaign presented non-availability generally of contraceptives as a barrier, as was their lack at nearby static health facilities.

> After the birth of my third child, I asked my husband to use something (family planning method). He refused (he did not want to use condoms or withdrawal and was also against female sterilization) and asked me to use a method instead. Then I asked an LHW to provide injectables but she said she received just one injectable every month and had already given it to someone else. I tried the hospital (BHU) three times but they said they were short of injectables and/or syringes. I could not go there again as it is hard to leave house and there is no one to accompany me. [As a result] I am pregnant again. Methods should always be available at hospitals so that women never find themselves in these situations. **IDI, woman with 3 children, Rural Okara**

Side Effects

Experienced or perceived side effects were highlighted in all FGDs and most of the IDIs, both in urban and rural areas as barriers to using contraceptives. Male respondents stated that methods such as pills, injectables, intrauterine contraceptive devices (IUCDs), and

female sterilization all have severe side effects for women. Irregularity in the menstrual cycle, obesity, and anemia were commonly mentioned.

> Women face bleeding problems due to the injection. After a month, the menses cycle is natural, but the injectable disturbs the menstrual cycle. It is very threatening for a woman. **FGD, Rural D.G. Khan**

> She (my wife) faced severe prolonged menstrual problems and it affected her health. She was not in good health very often then. IDI, man with 6 children, Urban D.G. Khan

> My friend's wife used an injectable to avoid unwanted pregnancies, but was surprised to find her pregnant some days later. He now believes all such things [contraceptives] are ineffective. **FGD, Rural D.G. Khan**

A few respondents also mentioned the cost of managing the side effects of contraceptive methods. Participants said the whole experience is useless if they used FP for economic concerns but then had to bear a heavy cost for treating side effects.

> People faced side effects after using various family planning methods and cannot afford the cost for side effect management. People believe that family planning can lead to many diseases. **FGD, Rural Bahawalpur**

CHAPTER 3 — READINESS AND RECEPTIVENESS OF MEN TOWARD MALE-FOCUSED INTERVENTIONS

BACKGROUND

The FALAH project was designed to tackle the major obstacles leading to high levels of unmet need and low FP use in primarily rural areas across the four districts. Among FALAH's major initiatives in its communication and mobilization strategy was a focus on addressing men and husbands as primary audiences, given that they are major influencers at community and household levels. The strategy used mass media and interpersonal communication to provide information to men and to prompt them to use FP services. The indirect influence of RLs on men was used through the training of local *pesh Imams*[5] to include messages in Friday sermons.

Analysis of findings from the quantitative evidence in the FALAH baseline and endline evaluation and from 2013's qualitative study—for the impact on attitudes, approval, and behavior of individual male interventions—suggests that interventions in general and male-focused interventions in particular played an important role in shaping the fertility behavior of couples.

The FALAH survey findings related to comparisons of the impacts of, above all, interventions addressed to men alone; targeted at women (enabling them to communicate better with their husbands); and directed through the mass media at men and women. Some relevant results of these surveys of 638 couples are presented in Tables 3, 4, and 5 comparing data of couples who were exposed to the interventions with those not exposed to them.

EFFECT OF MALE-CENTERED INTERVENTIONS ON FERTILITY INTENTIONS AND BEHAVIOR—EVIDENCE FROM FALAH

The approval of FP increased over four years (Table 3). Male group meetings (MGMs) seem to be highly effective in increasing approval of FP by men. Unfortunately there were only 16 men in MGMs. Group meetings for women and visits by LHWs also proved to be agents for changing couples' approval of FP. Interventions through the media or RLs' sermons had less impact on changing couples' perspectives. (These findings concur with the findings of the FGDs and IDIs, which strongly endorsed group meetings and person to person interactions to gain FP approval and to spread information.)

[5] A religious leader who leads the Friday prayer.

Table 3: Change in couples' approval of FP before and after FALAH interventions (Punjab)

	Baseline %	Endline %	Change %	n
FALAH Interventions				
TV				
Watched	**87.7**	**87.2**	**-0.5**	**36**
Didn't watch	69.6	77.4	7.7	602
Radio				
Heard	**76.4**	**84.1**	**7.7**	**240**
Did not hear	67.1	74.2	7.0	398
Women group meeting				
Attended WGM	**75.9**	**87.0**	**11.0**	**54**
Didn't attend WGM	70.1	77.1	6.9	584
Men group meeting				
Attended MGM	**62.6**	**83.3**	**20.7**	**16**
Didn't attend MGM	70.8	77.8	6.9	622
Friday sermon				
Attended	**71.8**	**78.4**	**6.6**	**45**
Not attended	70.5	77.9	7.3	593
Attended MGM[6] or Friday sermon				
Attended MGM or Friday sermon	**72.6**	**79.2**	**6.6**	**57**
None	70.4	77.8	7.4	581
LHW visit				
Visited	**72.1**	**81.9**	**9.8**	**291**
Not visited	69.4	74.5	5.1	347
Total (overall)	**70.6**	**77.9**	**7.3**	**638**

Source: FALAH baseline survey 2007 and endline survey 2012.

A decline in the desire to have more children was noted in all groups (Table 4). MGMs seemed to be effective in changing the behavior of men and ultimately helped couples limit their family size compared with those who did not attend them. The MGMs and attendance at Friday religious sermons also played an important role in lowering the desire to have more children among couples. Media interventions, particularly television, did not. (This again largely ties in with the qualitative findings.)

[6] In this case an MGM with an RL.

Table 4: Change in couples' desire for more children before and after FALAH interventions (Punjab)

	Baseline %	Endline %	Change %	n
FALAH Interventions				
TV				
Watched	**31.0**	**30.2**	**-0.7**	**36**
Did not watch	28.8	22.3	-6.5	602
Radio				
Heard	**31.5**	**26.3**	**-5.2**	**240**
Did not hear	27.3	20.6	-6.7	398
Women group meeting				
Attended WGM	**29.9**	**19.5**	**-10.4**	54
Did not attend WGM	28.8	23.1	-5.8	584
Men group meeting				
Attended MGM	**27.9**	**8.0**	**-20.0**	16
Did not attend MGM	28.9	23.1	-5.8	622
Friday sermon				
Attended	**24.5**	**16.2**	**-8.2**	45
Did not attend	29.2	23.2	-6.0	593
Attended MGM or Friday sermon				
Attended MGM or Friday sermon	**27.7**	**15.3**	**-12.4**	57
Neither	29.0	23.5	-5.5	581
LHW visit				
Visited	**32.7**	**24.8**	**-7.9**	291
Not visited	25.7	21.1	-4.6	347
Total (overall)	**28.9**	**22.8**	**-6.1**	**638**

Source: FALAH baseline survey 2007 and endline survey 2012.

The role of interventions such as MGMs in increasing contraceptive use was very strong (Table 5). This paralleled the need expressed in the FGDs and IDIs for men to get direct information in group settings.

Table 5: Change in couples' contraceptive use status before and after FALAH interventions (Punjab)

	Baseline %	Endline %	Change %	n
FALAH Interventions				
Television				
Watched	**27.8**	**41.0**	**13.2**	**36**
Did not watch	29.3	37.8	8.5	602
Radio				
Heard	**39.8**	**50.7**	**10.8**	240
Did not hear	22.8	30.4	7.6	398
Women group meeting				
Attended WGM	**39.4**	**55.3**	**15.9**	54
Did not attend WGM	28.3	36.4	8.2	584
Men group meeting				
Attended MGM	**37.7**	**62.6**	**24.9**	**16**
Didn't attend MGM	29.0	37.4	8.4	622
Friday sermon				
Attended	**39.5**	**51.0**	**11.5**	45
Not attended	28.4	37.0	8.6	593
Attended MGM or Friday sermon				
Attended MGM or Friday sermon	**37.8**	**51.4**	**13.6**	57
None	28.4	36.7	8.3	581
LHW visit				
Visited	**27.2**	**38.4**	**11.2**	291
Not visited	30.9	37.7	6.8	347
Total (overall)	**29.2**	**38.0**	**8.8**	**638**

Source: FALAH baseline survey 2007 and endline survey 2012.

MEN'S READINESS TO BE INVOLVED IN FP PROGRAMS—EVIDENCE FROM FGDS AND IDIS

This qualitative study of 2013 was designed to examine some of the responses to these interventions in three FALAH districts of Punjab and to explore what men require in the way of interventions directed at them. Similar questions were asked in Okara, which had no such interventions.

Further exploration of the role of interventions, particularly those that were male focused (notably MGMs, those involving RLs, and media campaigns) was a main objective of the qualitative study. Therefore the FGDs and IDIs sought local perceptions and suggestions on different types of interventions, from men and women, and explored other suggestions from men and women.

Most men (in 4 of 12 FGDs and 22 of 26 IDI respondents) from all four districts expressed strong FP desire. Further, they stated the need to be involved in FP programs through interventions. They believed that women have been the focus of all interventions to date, which has no doubt raised their awareness of FP but has also shifted the entire burden of FP adoption and use to them. However, according to women it is essential to involve men and to ensure that these programs are successful because men are the real decision-makers in this male-dominated society.

> Motivating men is like word-of-mouth marketing. If I have some information about family planning, I can transfer it to other people more easily than women can as they have limited mobility. **FGD, Rural D.G. Khan**

> No matter how much a woman is motivated, there is no way she would willingly adopt family planning methods unless her husband agrees to it. A method can only be adopted when both concerned parties talk to each other about it. **FGD, Urban Bahawalpur**

Women also emphasized that such interventions require that a major knowledge gap on contraceptive methods be filled.

> A program initiated through men will be more effective. Seventy percent of Pakistan's population lives in the rural areas. The remaining thirty percent resides in urban centers. Such programs can be initiated through men and women with the same kind of impact. But the same success in rural areas can only be achieved if men in those areas are properly motivated. **FGD, Urban Bahawalpur**

Interventions through MGMs

The majority of respondents in FGDs (12 of 12) and IDIs (36 of 52) displayed a strong interest in intervention through MGMs. Variation across districts and rural–urban areas was negligible. However, perspectives and concerns varied across communities.

Even in Okara (a non-FALAH district) men, unprompted, mentioned the need for such meetings. Almost all of them felt that MGMs were the best way to convey FP information to men. Most of the men stated that MGMs could be very helpful in passing on specific FP messages.

> I think there should be a gathering of a large number of people and that they should be told of the threats of not planning their families. Many people feel shy attending small gatherings (or one-to-one meetings). You should arrange the meeting and brief them about the possibilities of threats and the cons of not practicing or listening to these instructions which are for their own benefit. **FGD, Rural Jhelum**

> There should be separate meetings for men and women. They should be told everything about childbirth and spacing. They should be told about the different facilities and methods available for birth spacing. **FGD, Rural Okara**

In most communities, men highlighted the importance of MGMs by comparing them with women's meetings. Men believed that MGMs could be more effective and beneficial than women's group meetings because women cannot do anything nor decide on anything if the men are not persuaded.

> There should be more meetings for men. A woman cannot do anything and is helpless. If there will be more meetings with men, this will be useful for their women as well. If you conduct a meeting once a month consistently, the message will gradually be conveyed effectively. Even if someone does not have any medicine, he can be prescribed that medicine which can be obtained from the market. **FGD, Rural Okara**

Similar to the responses from FGDs with men, the majority of men and women interviewed in the IDIs from all four districts were in favor of MGMs.

> Yes, we have a male-dominated society. The family planning program will yield excellent results and success via a men-to-men policy (men motivating men). **FGD, Rural D.G. Khan**

> The door-to-door approach is not possible in the case of men. There should be a separate place where meetings can be held to educate men. One man should deliver a lecture on the topic to a local gathering of men. People should be educated on this matter in the form of a group. It would be more effective. **IDI, man with 3 children, Rural Bahawalpur**

They felt that such meetings should be held to educate and motivate men as men generally lack knowledge on FP methods and do not know how or where to procure contraceptives. Moreover, they are the main decision-makers at the household level for many issues, including fertility.

> It is the male who has the decision-making power in our area. Women are not heard from until their husbands are convinced. **IDI, man with 6 children, Urban D.G. Khan**

Men from Bahawalpur and D.G. Khan also said that public gatherings/MGMs would be effective for people who did not have access to FP information, and that they would propagate awareness among the male population. These views came across repeatedly from male respondents in each district during the IDIs. This general perception about the success of MGMs was also endorsed by male respondents who had already attended such meetings under the FALAH interventions.

> These meetings proved to be very helpful. My husband's views were different after attending the meeting. It was very helpful for us, and we learnt which methods were easy to use. Therefore, we discussed it with one another. **IDI, woman with 3 children, Rural Jhelum**

> These meetings are very helpful for men. They (the hosts) put forward suggestions in the meetings. They also told us about different methods and how to use IUCDs and condoms. Some people learnt the entire procedure from them. My husband's views were different after attending the meeting. We knew which method was easy to use. **IDI, woman with 3 children, Rural Jhelum**

Proposed Strategy for Male Group Meetings

Respondents were asked about the ideal strategy for holding these meetings, including how they should be organized, who should conduct them, and potential outcomes. The most prominent suggestion during the FGDs with men was to hold these meetings regularly. In the IDIs, men (20 of 26) suggested that meetings be organized near their localities or within their villages so that everybody could participate easily. Men were quite specific and suggested men gather at a prearranged spot to discuss FP and BS.

> There should be a work plan according to which it must be announced that a meeting will be held at a specific time and place, where a man would deliver a lecture on family planning and the various issues pertaining to it. **IDI, man with 3 children, Rural Bahawalpur**

> The whole point is managing the population. Instead of conducting the meetings in their offices twice a week [referring to the Family Welfare Center in the area], they should do the same in some village. There should be a list telling them that the meeting next week will be in the village so and so. They should proceed by putting a "*manji*" at the center of the "*chowk*." [7] **IDI, man with 7 children, Rural Okara)**

In comparison, men and women alike from the urban areas of Jhelum district emphasized the need for having female group meetings parallel to the men's to promote couples' communication. Several respondents argued that, even though male meetings are very

[7] Translation: They should proceed by creating a meeting place (lit. putting a bed) in the middle of the central crossing.

important, there should be group meetings for women as well. This would simultaneously bridge the gap of communication and decision-making among couples.

> It would be easier for women who cannot convince their husbands if there is a meeting for men on one side and a meeting for women on the other. **IDI, woman with 3 children, Urban Jhelum**

> There should be a program which can be introduced for (both) men and women as this problem is faced by both sexes. There would have been no need to ask anyone had it been only one gender's problem. **IDI, man with 2 children, Urban Jhelum**

In response to the question "Who should conduct these meetings?" the majority of FGD and IDI respondents from all districts suggested community-level meetings be organized and facilitated through local people as they know their communities better, and people trust them.

> A local person needs to be hired to cater to the men's needs. There should be a meeting once a month or once every two months. **FGD with rural men, Jhelum**

> The team should comprise outsiders, but there must be one representative from our village because people trust local persons. **IDI, woman with 4 children, Rural Okara**

Respondents did, however, feel the need for an educated outsider to conduct the meetings.

> Ideas of people, who belong to same community, are similar. That is why a person who comes from the outside will be able to educate the people in a better manner. It would have an effect. **IDI, woman with 3 children, Urban Jhelum**

Generally, male doctors were considered ideal for conducting such meetings as community men would trust such a knowledgeable person. In addition, men can also share their FP and general health-related issues with doctors.

> Your strategy of coming here and briefing me on family planning should be done everywhere. By this, I mean that I will go to my friends/peer group and gather them in the town to convey your message. I will also refer to you for proper guidance. This will prove to be beneficial for you as well as the government. This is how campaigners can garner a good response. **IDI, man with 6 children, Urban D.G. Khan**

> A more effective thing will be making the people understand/telling them. Since most people listen to doctors, it would be more effective (to involve doctors). **IDI, woman with 1 child, Rural Bahawalpur**

> Education is obtained by almost everyone, but a proper training and education on this matter (family planning) can only be provided by the department or doctors. **FGD, Urban Okara**

Another suggestion from half the FGDs (6 of 12) was that merely raising awareness and providing knowledge on FP would be insufficient; these doctors should provide contraceptives on the spot as well. These respondents believed not supplying contraceptives would allow the chances of laziness to take over, preventing men from buying or accessing contraceptives themselves later.

While talking about possible incentives for men to attract them to the meetings, male respondents generally stated that medicines and some kind of refreshment should be provided. Overall, they suggested that the meetings should be informative and interesting to attract men. Most of the women considered knowledge and information related to FP techniques to be sufficient incentives in themselves for male participants.

> These meetings are very important. If they [men] do not gain any knowledge about family planning, how can they practice it? My husband, for example, does not know anything about IUCDs and admits it. If men are told about contraceptive use and the various methods, then

> their minds can be changed. They will think about it. **IDI, woman with 2 children, Urban Jhelum**

> Medicines should be given and the procedures should be accounted for (details about the procedures should be given). Providing food, however, is a separate issue. **IDI, man with 7 children, Rural Okara**

Some male respondents agreed and said the main incentive of going to MGMs for males was information and awareness.

> Without the motivation and awareness of the man, a woman cannot pursue the family planning program successfully. For example, LHWs can tell only women about birth spacing. She [the woman] can use family planning secretly without her husband's permission. That is why the need of the hour is that men should also be motivated and convinced about family planning. It will be more effective then. So, a man can convince another man properly about using family planning methods. **IDI, man with 6 children, Urban D.G. Khan**

Potential Benefits of Male Group Meetings: Women's Perspectives

Most women voiced strong opinions about the potential benefits of MGMs. They felt that male-directed meetings would be very effective and would lead to a positive change in the mindsets of men on FP. For them, the main benefit was that wives would eventually find it easy to discuss FP with their husbands and convince them of their merits. Women in Bahawalpur considered these meetings a source of knowledge sharing.

> Meetings should be arranged for both men and women. But meetings for men are necessary. For example, if my husband listens to someone talk about these things, he will go and discuss it with another man. It will have an effect. It might not come to his mind directly, but at least he will know that the meeting was held and will go and tell a third person. I think that it is better this way and that these [meetings] should be organized. **IDI, woman with 3 children, Rural Bahawalpur**

Women from Jhelum stated that MGMs would also help men who consider FP to be against religion.

> These meetings should be effective for men who consider family planning to be a sin. Their minds could change. There should be awareness for such men. If men are made aware, there would be less population, and they will think over it. **IDI, woman with 3 children, Urban Jhelum**

If men are persuaded and educated in FP, it would sort out half the problems that women face, many women argued. Their husbands would realize the effectiveness and benefits of FP and allow the women to visit facilities

> There is a general hold of men in our society. Women cannot do things without the permission of men. Since men play an important role, everything will be fine if men are convinced. **IDI, woman with 1 child, Rural Okara**

Potential Benefits of Male Group Meetings: Men's Perspectives

Men from every district during the FGDs (8 of 12) and IDIs (22 of 26) expressed their perceptions and understanding of the outcomes of MGMs. Men generally considered MGMs beneficial.

> It is our opinion that a man will convey the message to ten people and the ten people will convey the message to a hundred people. In this way an "awareness chain" will be created and it will be easier for your motivators to convey their messages. **FGD, Urban D.G. Khan**

For these men, MGMs would prove a source of knowledge and information for men and, as a result, not only would they be able to initiate discussions with their wives, but also be convinced of the merits of contraceptive use.

> Group meetings are better as they produce better results. Meetings for men will lead to fewer children being born. People will get more information about family planning and refrain accordingly. Men will also be inclined to go home and talk to their wives about it, willing to take the first step. Out of the 50 percent who go home and talk to their wives, 60 percent will actually use them. It should make a difference. **IDI, man with 4 children, Rural Okara**

This effect can help poor people have as many (or few) children as they can support according to their resources.

> The people who are overburdened would of course accept it. The poor would appreciate this sort of education because it provides a solution to their misery. There are two or three men in this locality who want to get themselves sterilized because they already have nine or ten children and cannot afford more. **IDI, man with 6 children, Rural D.G. Khan**

Some men felt there would be less conflict between husbands and wives because men who were not ready to use any method earlier will try to use FP after attending these meetings.

> In my opinion, if men discuss [or initiate discussions] about family planning, it would be easier for women to convince their husbands because both would have knowledge about family planning. In this way, they would agree with each other quicker and decision-making would be faster as the wives would get information from the LHWs and the husbands from group meetings. It will make decisions easier and prevent unnecessary quarrels. Yes, in this way there will be equality in their thinking which can lead to easy decision-making. **FGD, Urban Okara**

Interventions through Religious Leaders

RLs are respected figures, highly knowledgeable in religious matters, and considered an authority on most issues. People also seek help from RLs in many family matters, including health. RLs are also consulted during decision-making, especially if an issue is considered to be controversial religiously. If the RL of a community declares an act permissible, everyone agrees to follow it. The use of FP is also sometimes considered to be against Islam. Thus if RLs declare that contraception is allowed by Islam, people can use it more confidently.

FGDs and IDIs discussed the practicality of interventions through RLs, including perceptions of the involvement of RLs and the feasibility and benefits of involving them to increase contraceptive use. There was a mixed response across the districts.

Generally, men and women from all districts mentioned the social acceptability and respect for RLs in their communities. During FGDs in Bahawalpur, an extensive debate was held on the involvement of RLs in creating awareness and motivation about FP. Almost all respondents felt that interventions should be made through *Ulema*. However, a few stated that they should not use loudspeakers for this purpose and should instead talk about such matters in private settings.

> People should be convinced on religious grounds because a layman thinks a soul that has been destined to come into the world will come. He says that you [the person who tries to convince him about family planning], God forbid, consider yourselves gods and that you are asking me to stop a soul entering this world. Thus, there should be a counter argument against this view in light of the Sharia [Islamic code]. Religious scholars should disseminate this knowledge from a Sharia perspective. **FGD, Urban Bahawalpur**

Respondents from D.G. Khan stated that RLs can address the issue during sermons, but some also mentioned that, as very few people visit mosques or *maulvis* (religious leaders), they cannot approach every man in the community.

> *Maulvis* can only speak to people who visit mosques. They cannot communicate their message to the entire populace of the area. **FGD, Rural Jhelum**

Some respondents felt that RLs' involvement could generate awareness among men, stressing that an RL is more influential and his words carry more weight than any other person's. Women were more vociferous than men on the potential benefits.

> The *maulvi*'s word has an effect on people. In fact, it will be more effective if the (programs) are conducted through *maulvis*. **IDI, man with 4 children, Rural Okara**

> It would be useful because when religious leaders gather people, people listen to them. **IDI, woman with 3 children, Rural Bahawalpur**

> It would be beneficial when he [the religious leader] talks about the topic from an Islamic perspective. People obey them because religious leaders help distinguish between right and wrong and legal and illegal. I think that religious leaders can play a vital role in this respect. **IDI, woman with 2 children, Urban Jhelum**

However, the majority from all four districts was not in favor of interventions through RLs and had four sets of reservations. Foremost was the perception that these leaders are against FP and that their belief is to support more children. Therefore it was questionable as to how they can talk about small families. This notion was reported mainly by the men of D.G. Khan and Bahawalpur during IDIs.

> I think religious leaders will never say that there should be fewer children. They say, According to the orders of God, family planning is not the right thing to do. **IDI, woman with 2 children, Urban Bahawalpur**

> If someone goes to a religious scholar and is told not to produce children, he would obviously think that life is given by Allah. What kind of scholar would say that? **IDI, man with 4 children, Urban D.G. Khan**

> The *maulvis* say that children are a blessing from God and that contraception is equal to murder. That is their opinion. **IDI, man with 4 children, Urban Okara**

The second dimension was the perception on the possible reaction of the community on involving RLs. They thought that members of the community would not accept RLs in this role and would count it as his "bad" deed. This was reported mainly in FGDs in Okara, D.G. Khan, and Bahawalpur.

> People will have objections. They will say that the *maulvi* receives bribes [*rishwat*]. The people will not like it if a *maulvi* talks about these matters after the Friday prayers [Namaz Juma] in an open congregation. **FGD, Rural D.G. Khan**

> He cannot do so. He only gets one day in a week to preach [Friday], and if he starts talking about this topic after seven days, the people will make sure that he does not come back to the mosque again! **FGD, Rural Okara**

> They surely listen to him. But people do not like this type of talk at the mosque. Society is like this. There should be a program like group meetings. **FGD, Rural Okara**

The third reason came from respondents in Jhelum, who argued that, because contraceptive use is more of a young man's domain, and that RLs are usually older men, the generation gap can act as a barrier to communication.

> Obviously if the *maulvi* is older, people will feel ashamed talking to him and discussing such things with him. **IDI, man with 3 children, Rural Jhelum**

The fourth reservation, from urban Jhelum, was that young men do not value RLs nowadays, so RLs' involvement would not be effective.

> I think that it is difficult to accomplish it through a *maulvi*. *Maulvis* do not agree with it; it is as simple as that. As far as the briefing is concerned, they are not convinced much or in favor of family planning, in my opinion. The youngsters stay away from *maulvis*. The reason for that is that some people do not usually consult elders. **IDI, man with 3 children, Urban Jhelum**

Still, 18 men and women among 52 respondents in IDIs showed a positive response to involving RLs in FP interventions, especially in Jhelum and Okara. One female respondent said that meetings for *maulvis* would be more effective and beneficial for the community because they are respectable people and have a special place in the community.

> Religious leaders have a high social status in villages because people are uneducated. They do not have knowledge, and they consider a religious leader to be a wise man because he is associated with religion. That is why people obey religious leaders. **IDI, woman with 1 child, Rural Okara**

> The cleric's words carry more weight than the Prime Minister's. The cleric should deliver a speech at least three times a month on this topic according to the Quran and Hadith so that people can be educated and motivated. **FGD, Rural Jhelum**

Another woman explained that members of the rural community relied on *maulvis*, especially for health issues. They went to *maulvis* whenever their children had health problems:

> These people are most effective. The people of our village obey religious leaders even more than doctors. They take them to religious leaders when their children are taken ill. **IDI, woman with 2 children, Rural Okara**

Respondents in favor of involving RLs in FP interventions discussed suitable strategies to make RLs' involvement effective. Because men and women from Jhelum and Okara during IDIs were generally more in favor of the role of RLs than respondents from D.G. Khan and Bahawalpur, most of the suggestions came from them. The respondents said RLs should be counseled and trained on the issue and that they should talk about it at Friday sermons.

> It will be beneficial if the *maulvis* are trained and counseled. However, they might not agree to it. **IDI, man with 2 children, Urban Okara**

A woman from Okara suggested that RLs give a speech after every Friday prayer. One of the main suggestions was that RLs should discuss FP with the community's men with reference to the Sharia, Quran, and Hadith to make the intervention more effective.

> I think the *maulvi* of a village should deliver a speech on these issues in light of the Quran and Hadith. As he is a religious scholar, he would have a strong impact on the people of the community and they would obviously follow him. **IDI, man with 2 children, Rural Okara**

> The cleric is more influential in persuading any person; one will always prefer the words of a *maulvi* sahib to those of any other person [health worker, friend, or a neighbor]. So, a religious leader is important in convincing any person, if necessary. **IDI, man with 3 children, Rural Jhelum**

Media Interventions

The next set of interventions discussed were media FP campaigns on radio and television. Discussions about the role of the media did not reflect any significant regional variations, but did vary by gender. Women expressed their views in greater detail than men, and often

more enthusiastically, believing that the media could play a positive role in increasing awareness and knowledge among men and women alike. A few women were concerned that current advertisements cannot be viewed properly in the presence of elders or children.

> Every home has a television. Dramas should be in the Saraiki language. They will understand. They will say that they are watching the dramas, and through the dramas, they can understand. **IDI, woman with 5 children, Urban D.G. Khan**

> Men do not pay attention to the commercials on television. When I watch an advertisement, I ask my husband to look at it: "two children are enough." He just said that people have up to six children. **IDI, woman with 3 children, Rural Okara**

Men overall did not appreciate the idea of relying on the media for interventions. (This was quite different from what was reported by men in the PDHS 1990–91, where the majority of the husbands who had heard radio or TV messages about FP, perceived the media to be effective in persuading couples to use FP—NIPS–Macro 1992).

Both male and female respondents mentioned that media campaigns were not effective because such programs could not be viewed in the presence of other family members. Perhaps the key point was made during an FGD in Jhelum that, keeping in view the cultural context, programs with detailed FP messages cannot be covered on television or radio. Thus, media campaigns would have a very limited effect in giving direct information. They can create awareness about FP, which was more possibly the need in the 1990s, but as mentioned earlier, men now require more detailed information on FP methods, which the media cannot address properly.

A few men from D.G. Khan argued that poor people do not have access to a television and that is why these media campaigns cannot play a positive role (two respondents from D.G. Khan evidently did not have television or radio at home).

> I do not have a television or radio at home. Sometimes I go out to read a newspaper. **IDI, man with 3 children, Rural D.G. Khan**

> Television is not viewed by everyone. Many laborers who will have children, the people who process sugarcane and corn plantations, and people who farm potatoes; a lot of them probably do not have televisions. Poor people do not usually have televisions. These are the people who will bear the greatest number of children. **IDI, man with 7 children, Rural Okara**

> I have seen advertisements for your pills in the commercial breaks between the dramas that are aired on television. There are boys and girls sitting around who are befuddled because of it. In my opinion, about 50 percent of society has been rendered corrupt because of this. **FGD, Rural Okara**

> It cannot be properly portrayed by advertising on television and radio. **FGD, Rural Jhelum**

A minority of male respondents felt that the media could play a positive role; a few men from Bahawalpur and Jhelum stated they had learned at least something from television and that it could play a positive role in educating men.

> Televisions are better, because these days, everyone has a television. **FGD, Rural Jhelum**

> The media can play a better role to educate people about family planning. **FGD, Rural Bahawalpur**

Women were more explicit about the positive role of the media. A general reason for the lack of interest by men and women's keen interest (particularly in television) may be associated with their presence at home. Women spend more time at home than men, and the television is women's main source of entertainment; dramas attract them most. Women

respondents generally believed that media can create awareness of FP methods' advantages and can be a source of inspiration for their adoption by others.

Some women suggested a strategy involving media as an intervention tool:

- FP messages should be conveyed in proper drama serials;
- These drama serials should be telecast in local and regional languages, to make them more understandable;
- Recurring information on FP methods and messages should be shown on different channels.

> Dramas should be telecast on the subject of family planning. These dramas should narrate a story that will compel people with many children not to have any more. The dramas should be in the Saraiki language. **IDI, woman with 5 children, Urban Okara**

> Tell them through the television about how many children are "enough" for them. Also, show them slides related to [the different] family planning methods. If a person is uneducated, his or her educated friends can read and tell them. **IDI, woman with 3 children, Rural Okara**

Interventions for Men through Community Health Workers

LHWs

A few men and women also suggested other intervention strategies to increase FP knowledge and information in communities. First of all, most women commented on the performance of LHWs in their areas. Generally, men and women from Jhelum and D.G. Khan positively commented on LHWs. Men and women in Okara were not satisfied with their LHW services, however. A common complaint was LHWs' constant involvement in the polio eradication campaigns, which compromised their role of providing FP services.

> LHWs' scope of work has been confined to polio campaigns for many years due to which they neither visit women for FP motivation nor provide services at home. Secondly, they do not have contraceptive supplies on hand which diminishes their role anyway. **FGD, Rural D.G. Khan**

> The polio teams (including LHWs and male mobilizers) come, give the drops to the children, and go away. If we want to ask them anything specific, they will tell us. Other than that, they do not provide any information. **IDI, woman with 4 children, Urban D.G. Khan**

It was generally suggested by women that LHWs should concentrate on FP service provision and should be more knowledgeable and skillful for addressing women's needs. They also mentioned that LHWs should be more educated and informative. In Okara, the fact that there are no other health services available in their area except LHWs was particularly mentioned.

> There should be a facility for us in the village. We do not have any facility. The LHW gets us free condoms, but she sells each for five rupees. **IDI, woman with 4 children, Rural Okara**

> LHWs should be humble and polite. If they will not cooperate, people will question people's need to go there [to the health centers, in the face of their non-cooperative behavior]. They should have a better attitude [with clients]. **IDI, woman with 4 children, Rural Jhelum**

These suggestions indicate that women want greater reliance and utilization of existing sources of LHWs for bettering their communities. Some of the men also emphasized that LHWs must visit more.

> I think that LHWs must go door-to-door and brief every woman about the current situation of the population and guide them on birth spacing and the different methods for this. **IDI, man with 2 children, Rural Okara**

Male Health Workers

During many FGDs and IDIs, men spontaneously compared the greater range of facilities available to women for FP in communities with limited facilities available to men.

> Just as there are LHWs, there should be male workers as well. They should debate with the men and have small corner meetings and should have materials and different services. Men should consult these health workers to acquire these services. I want these services to be available to men. It should be advertised that these materials are available from this specific center. Our women are Eastern, and they feel shy availing these methods. So, a man should be aware and he should acquire these methods. **FGD, Rural Jhelum**

> In the same way as LHWs, there should be a male team for men that can gather them somewhere and guide them about what is better for them and how to use different [contraceptive] methods. Either that, or they can go door-to-door. **IDI, man with 2 children, Rural Okara**

The majority of male respondents strongly suggested there be male health workers who provide services at the same scale as LHWs to men at community level.

> Similar to an LHW who guides and discusses family planning with women, a man should be there to discuss, guide, and convince men about the importance of family planning. **FGD, Rural Bahawalpur**

They felt that they should provide counseling, arrange "corner meetings," and provide contraceptives.

> There are some questions that a woman [LHW] cannot ask a man but a man can ask such questions from another man. Therefore, a man's involvement in this becomes imperative. Men should join this field [as male motivators]. **IDI, man with 4 children, Urban Bahawalpur**

In this way, men could use the services of someone who would listen to them and manage their FP concerns.

> Well, it will cause greater awareness. If you have a problem, you should know that there is a person who can be contacted. **FGD, Rural Jhelum**

CHAPTER 4 — CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

There has been a real change in Punjabi men's attitude toward FP (based on the 2013 qualitative study; baseline and endline FALAH surveys; and PDHS 1990–91 and 2006–07). They appear more concerned about their fertility intentions and behavior than they were in the 1990s. Economic stringencies and inability to meet household costs, including raising children, are men's primary motivations for approving FP. Our qualitative study is fully in line with the quantitative survey findings.

Improvement in spousal communication has made it easier for wives to sway their husbands on fertility issues. Communication is widespread between husbands and wives on their family sizes and contraceptive use. While there are differences between them on the desired number of children (higher for women than men in all districts), they talk about the issue. Given their strong concerns, men sometimes initiate the discussion with their wives about their fertility intentions. This pattern suggests it is no longer the exclusive responsibility of wives to think about FP and initiate FP discussions. Due to both men's and women's emerging concerns, they often converge on ideal family size and contraceptive use. Among couples with a divergence of opinion, women try to convince their husbands after discussions, as they cannot make independent decisions and their husbands are the ultimate decision-makers in all household matters.

Regional differences persist in ideal family size, as reported by men and women. The ideal number of children in Jhelum and Okara is lower than in D.G. Khan and Bahawalpur, reflecting established northern and southern Punjab differences. Moreover, there is always a difference between ideal and actual family size, the latter generally exceeding the former, for a variety of reasons ranging from family pressure and couples' own desires for ideal numbers of children for each sex.

Supply-side issues act as a barrier to men using contraception. Despite their positive attitudes toward FP and frequent reported communication with their wives, a few factors inhibit men from using FP. Supply-side issues are the most often cited by men, including lack of FP services or contraceptive methods, along with method failure and contraceptive costs. Men recognize that their lack of knowledge about specific FP methods is an obstacle to contraceptive use. In addition, men voice fears of perceived or experienced side effects of modern methods along with lack of provider skills for managing these effects.

Men are highly enthusiastic about interventions employing male group meetings. Despite their apprehensions, it appears that men are eager for male-focused interventions that increase their involvement in FP programs. Men and women in all districts seem to be really keen on the introduction of male group meetings. Men especially see them as having potentially more impact than women's meetings because it would be more effective to educate and pass on FP messages to them rather than to their wives. One approach would be to conduct male group meetings includes involving a local to organize the meeting and an educated and skillful outsider (preferably a doctor) to conduct it. This also includes providing contraceptives after the meeting to involve men in increasing contraceptive use.

Religious leaders' involvement is a good source of support. A mixed response came through on the involvement of religious leaders in FP programs—women are more in favor than men. Regional differences are also apparent: men from Jhelum and Okara favor the idea more, men from D.G. Khan and Bahawalpur less so. Those in favor suggest that religious leaders should be trained and talk about FP with reference to the Quran and Hadith. The overall impression of the interventions through religious leaders suggests that they should play a supportive role by communicating the message that FP is allowed in Islam.

The media play a positive but limited role. Men were generally not very appreciative of the role of media such as television or radio in the effective communication of FP messages. The reasons for this cited by male respondents were: lack of time to watch television, lack of availability of television (D.G. Khan), and the inability of television and radio to provide details on methods according to men's needs. Women showed greater interest and proposed telecasting of drama series on the topic in local languages.

Male health workers need to be involved to provide services. Men suggested that a male health worker on the lines of the Lady Health Worker program would be an ideal way of providing FP services to men at community level.

RECOMMENDATIONS

This is an ideal time to carry out the following direct interventions aimed at men in Punjab because the findings suggest that husbands are ready to be involved in FP programs and are supportive of their wives using contraception. Thus:

- Interventions should be designed to provide information on the use and side effects of various contraceptive methods available to men.
- As a first step, group meetings or alternative channels of interpersonal communication should be organized for men. This type of intervention is essential to fill the gaps in men's knowledge of FP methods, and would help to remove any fear of side effects—a big hurdle in sustaining contraceptive use.
- These interventions have to be backed by an improved supply of contraceptives and FP services in facilities nearby. Even for male group meetings, a recommendation was that they be combined with provision of some supplies.
- In areas where there is a LHW, men generally appreciated her work but the point was raised that LHWs had moved away from their focus on FP, often to polio vaccine administration. LHWs should regain their focus on FP, balanced with other priorities such as polio.
- An improved FP service delivery environment is necessary—a demand voiced by men themselves.
- Additional interventions such as the training of religious leaders to encourage birth spacing and maternal and child health issues can have a positive influence. While this may not be carried out in each community, there are many settings where such an intervention helps to clarify men's views on Islam and FP.

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APPENDIXES

APPENDIX A: DISTRICT AND COMMUNITY PROFILES

District Profiles

Attributes	Districts			
	Jhelum	**Okara**	**DG Khan**	**Bahawalpur**
Geographical location	North	Center	South	South
Rank by index of multiple deprivations* (low=1 and highest=36)	8	18	31	35
Net enrollment at primary level**	77	69	51	40
Population***	936,957	2,232,992	1,643,118	2,433,091
Density***	261	510	138	98
Area***	3,587	4,377		24,830
Tehsils	4	3	2	5

Sources: * Social Policy and Development Centre, Research Report No. 82. Districts' Indices of multiple deprivations for Pakistan, 2011.
** PSLM 2010–2011. Net enrolment rate: [Number of children aged 5–9 years attending primary level (classes 1–5) divided by number of children aged 5–9 years] multiplied by 100.
** Census 1998.

Community profiles

1) Jhelum District (Northern Pakistan)

Attributes	Communities		
Community name	**Sanghoi Toor**	**Naka Kalan**	**Kala Gujran**
Type of community	Rural	Rural	Urban
Health facilities	BHU, private hospital	RHC at 1 KM distance	Government MCH center, small scale private clinics of MBBs doctors and dispensers
Family planning services	LHW, FWC, Local dispensaries	Nil	MCH center
Education opportunities	High girls school, high boys school and a private degree college	Middle girls school and a Primary boys school	Four girls schools at primary, secondary and high level, two boys high schools and eight private schools
Major occupations	Shop keeping, Farming	Army and government service employees	Business, shop keeping, Government service employees, employees of a tobacco company in the area
Major castes	Rajgan, Taili, Choudhry, Arain, Butt	Malik	Gujars, Malik, Khokhar, Kashmiri Butt and Daar
Distance to main road	20 Km	-	-
Road conditions	Semi Paved	Paved	Paved

2) Okara District (Central Pakistan)

Attributes	Communities		
Community name	**4/ 1A.L**	**14/ 1A.L**	**Renala Khurd**
Type of community	Rural	Rural	Urban
Health facilities	BHU at 2km	BHU and private clinic	RHC, maternity home, private clinics
Family planning services	Male mobilizer	LHW and Male mobilizer	FWCs
Education opportunities	Two primary schools, girls' high school and boys' high school at 3km distance	Boys' primary school and girls' high school	Four girls' primary schools, three boys' and two girls' secondary schools, and a degree college
Major occupations	Farming	Farming, shop keeping and transportations services	Shop keeping and government services
Major castes	Arain, Jutt, Kamyana, Soday	Arain, Jatt and Syed	Rajput, Sayyed, Jat, Arain, Gujjar and Gakhar
Distance to main road	8km	1km	-
Road conditions	Semi-Paved	Semi-Paved	Paved

3) D.G. Khan District (Southern Pakistan)

Attributes	Communities		
Community name	**Mohallah Sadat Junobi (Kot Chutta)**	**Sero Jadeed (Basti Bashrat)**	**Ghousabad**
Type of community	Urban	Rural	Rural
Health facilities	RHC, many private clinics	BHU	BHU and private clinics
Family planning services	LHW and male mobilizer	LHW	LHW
Education opportunities	Primary and higher secondary school for boys and primary and high school for girls	Primary schools for boys and girls	Primary and high schools for boys and primary school for boys
Major occupations	Agriculture, jobs, small business and laborer	Agriculture	Agriculture
Major castes	Rajpoot, Qureshi and Mohnay	Ammadani, Sadat, Mohanay and Mochi	Jatoi Dareeja, Bodala and Malik
Distance to main road	0	20km	12km
Road conditions	Paved	Semi-Paved	Semi-Paved

4) Bahawalpur District (Southern Pakistan)

Attributes	Communities		
Community name	**Mari Qasim Shah**	**Dera Bakha, Chak 4 B.C.**	**Islamic Colony**
Type of community	Rural	Rural	Urban
Health facilities	BHU at 3km and private clinics	BHU	DHQ and private clinics
Family planning services	LHW	LHW	LHWs
Education opportunities	Primary and middle schools for boys and girls	Primary schools for boys and girls	Primary schools for boys and girls
Major occupations	Agriculture, and agriculture labor	Agriculture, and agriculture labor	Government servants and small scale business
Major castes	Bhatti and Kulare	Rajpoot, Arain, Jutt, Chugtai and Bhatti	Jutt and Arain
Distance to main road	5km	2km	1km
Road conditions	Paved	Semi-Paved	Paved

APPENDIX B: CONSENT FORM—IN-DEPTH INTERVIEWS (MEN/WOMEN)

Greetings. My name is _____. I am working with an organization called the Population Council that is helping the government of Pakistan improve health programs in the country.

You are invited to take part in a research study. Before you decide whether to participate, you need to understand why the research is being done and what it will involve. Please take the time to listen carefully as I read the following information. Please ask me if there is anything that is not clear, or if you would like more information. When all of your questions have been answered and you feel that you understand the purpose of the study, you will be asked if you wish to participate in the study.

We are interviewing men/women in your community regarding the decision-making process about reproductive health issues. We also need to know your views about involvement of men in FP programs through different interventions. I am here today to talk with you and you have been randomly selected from your community.

If you agree to take part in the study, you will be asked to give information about your own experience regarding reproductive health. Your participation will be voluntary and you will not receive any compensation/cash for participating in this study. It will take 30 to 40 minutes to complete the interview with you.

I am going to ask you some personal questions; you do not have to answer any questions that you do not want to answer, and you may end this interview at any time you wish. However, your honest answers to these questions will help us better understand the phenomena. Moreover, the information that is collected during the study will be kept confidential. Data will be stored in a locked cabinet dedicated to this study that only the study team can access.

If you permit us, we shall tape record the discussion for the convenience of retrieving the information easily in future. This tape will be confidential material and no one will ever be identified by name.

We would greatly appreciate your help in sharing your views for this study. It will take 30 to 40 minutes to complete the discussion. Are you willing to participate in the discussion?

Yes ☐

No ☐

Thank you for your cooperation.

Investigator or person who conducted informed consent discussion: I confirm that I have personally explained the nature and extent of the planned research, study procedures, potential risks and benefits, and confidentiality of personal information.

Name of person obtaining consent: _____

Signature of person obtaining consent: _____Date:_____

APPENDIX C: CONSENT FORM—FOCUS GROUP DISCUSSIONS (MEN)

Greetings. My name is _____. I am working with an organization called the Population Council that is helping the government of Pakistan improve health programs in the country. You are invited to take part in a group discussion. Before you decide whether to participate, you need to understand why the research and discussion is being done and what it will involve. Please take the time to listen carefully as I read the following information. Please ask me if there is anything that is not clear, or if you would like more information. When all of your questions have been answered and you feel that you understand the purpose of the study, you will be asked if you wish to participate in the discussion.

We will have a group discussion with men of your community regarding decision-making processes about reproductive health issues. We also need to know your views about the involvement of men in FP programs through different interventions. I am here today to talk with you and you are randomly selected from your community for this discussion.

If you agree to take part in the discussion, we will ask you to give your views during the discussion. Your participation will be voluntary and you will not receive any compensation/cash for participating in this study. It will take 40 to 60 minutes to complete the group discussion.

You do not have to share experiences or views that you do not want to share, and you may withdraw from this discussion any time you wish. However, your honest answers to these questions will help us better understand the phenomena. Moreover, the information that is collected during the study will be kept confidential. Data will be stored in a locked cabinet dedicated to this study that only the study team can access.

If you permit us, we shall tape record the discussion for the convenience of retrieving the information easily in future. This tape will be confidential material and no one will ever be identified by name.

We would greatly appreciate your help in sharing your views for this study. It will take 40 to 60 minutes to complete the discussion. Are you willing to participate in the discussion?

Yes ☐
No ☐

Thank you for your cooperation.

Investigator or person who conducted informed consent discussion: I confirm that I have personally explained the nature and extent of the planned research, study procedures, potential risks and benefits, and confidentiality of personal information.

Name of person obtaining consent: _____

Signature of person obtaining consent: _____Date:_____

APPENDIX D

In-depth interview guidelines (men/women)

1. Did you ever go to school?
2. How many years did you go to school for?
3. How many children do you have?
4. What are their ages?
5. How old is your youngest child?
6. How long did you/your wife breastfeed them?
7. When would you like to have the next child if you want to?
8. How many children do you want in all?
9. Why do you want that many children?
10. What is your ideal family size and why is it so?
11. Have you ever talked to your husband/wife about the number of children that you want to have?
12. What is your spouse's ideal family size and why does he/she think so?
13. Did he/she want to have the same number of children (as you did), fewer or more?
14. Why is there such a difference, if any?
15. Why didn't you ever talk to your husband/wife about the number of children that you wanted to have (if the respondent never talked about it with his/her spouse)?
16. If you did talk, who initiated the discussion?
17. Did you ever try not to get pregnant while your child was (still) very young?
18. What did you do to avoid the early pregnancy?
19. Have you ever talked about contraceptive use with your husband/wife (detailed history of the communication process with reference to contraceptive use)?
20. If yes, who really initiated this discussion and why?
21. If you initiated the discussion, how did your spouse react to it and why (did he/she react the way that he/she did)?
22. What sorts of topics/areas were discussed regarding contraceptive use?

- **Probes:** choice of methods, source of procurement, efficacy, cost etc.

23. When did you and your spouse start talking about contraception or desired family size with each other?
24. What were/are the different motivating factors/concerns for you/your spouse that forced you to talk about FP adoption with each other?

25. Did it ever happen that you intended to use any contraceptive but you did not discuss it with your husband, perceiving that he would disapprove of it? How did you perceive that?

26. What happened if there was a difference of opinion regarding the desired family size and contraceptive use?

27. How did you reach a decision regarding the use of contraceptives or family size: What is the role of the husband, the wife, and the mother in-law?

28. How important is the role of your husband in making decisions regarding family size and FP/BS?

29. What would you do to avoid pregnancy if you do not want more children?

30. Would you like to start using any contraceptive method?

31. What would you do if your husband does not want to use FP?

32. Do you approve or disapprove of FP/BS? Why?

33. In your view, does your spouse approve or disapprove of FP/BS? Why?

34. In you view, if a woman approves of FP/BS and her husband does not, can she convince him to (allow her to) use contraceptives?

    - If yes, how (grounds of the arguments, time in process of communication)?
    - If not, why not?

35. (For women who never communicated with their husbands) Why did you never discuss family size and contraceptive use with your husband? What are the reasons that made you feel that it was not important(Probe for any social or cultural constraints)?

Role of interventions in shaping fertility behavior of men

1. Have you ever heard about an intervention in your area for men to educate or sensitize them about contraceptive use and family size (prompt only in FALAH districts)? The intervention included media campaigns, MGMs, and meetings with RLs so that they can include this topic in their addresses.
2. Did you/your husband share any 'main' message of these interventions with each other?
3. What is your own opinion on these interventions?
4. Do you think that through interventions focused on men, you/your husband:
    - Could obtain more information on FP methods?
    - Could initiate a discussion on FP?
    - Could become more supportive in using contraception?
5. Do you think that the intervention has changed your husband's views about FP/BS, number of children, and future intention to use FP/BS? How?
6. What kind of intervention had the most positive affect?
7. Do you think that interventions for women (LHW, media) have helped you to communicate or convince your husband of FP adoption? How?
8. Do you think that interventions for men helped you to communicate or convince your husband of FP adoption? How?
9. In your view, what kind of intervention (men/women) had/can have the most positive affect in increasing FP adoption?
10. In your view, did these interventions result in a convergence between you and your spouse regarding reproductive intentions?

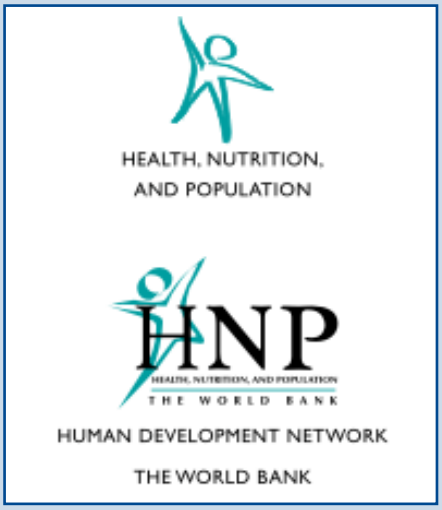
APPENDIX E: FOCUS GROUP DISCUSSION GUIDELINES (MEN)

Perceptions about FP, fertility intentions, and inter-spousal communication

1. What types of health facilities are available in your community?
2. How far are these health facilities from this location?
3. What types of health services are provided at these facilities/LHWs?
4. About how many (%) of the women and children go to avail these health services?
5. Is any LHWs posted at the facility?
6. Are FP services available at these facilities (particularly LHWs)?
7. Do you know what FP services are being provided at these facilities?
8. For what purpose do women use FP services: Limiting and/or spacing?
9. Do you/the men from your area approve of FP and BS or disapprove of it? (What are the) Reasons for the approval or disapproval?
10. In your view, what is an ideal size (in terms of the number of children) of a family? Why is this number ideal?
11. In your view, does a couple discuss contraceptive use and the number of children that they want to have, with one another? Ideally, when do they start this communication in their marital life?
12. What sorts of topics/areas are discussed regarding contraceptive usage?
    - **Probes:** choice of methods, source(s) to procure method(s), efficacy, cost etc.
13. Why is there generally a gap in communication between the husband and the wife regarding FP use in our society?
    - **Probes:** social norms, husband's dominating status, etc.
14. What are the different motivating factors/concerns for men and women that force them to talk about FP adoption with their spouses?
15. Between a husband and a wife, who generally realizes earlier that contraceptives should be used (in order) to induce a gap between births? Why?
16. Does it ever happen that a wife intends to use any contraceptive but does not discuss it with her husband perceiving that he would disapprove of it? How does she perceive it to be like this?
17. What happens if there is a difference of opinion between a couple regarding the desired family size and contraceptive use?
18. How does a couple reach a decision regarding the use of contraceptives: What is the role of the husband, the wife, and the mother in-law?
19. What are the positives if the husband and wife have an agreement on contraceptive use, and what are the negatives if they disagree with one another?

Role of interventions in shaping the fertility behavior of men

1. Have you ever heard about an intervention in your area for men to educate or sensitize them about contraceptive use and family size (prompt only in FALAH districts)? The interventions included media campaigns, MGMs, and meetings with RLs so that they can include this topic in their addresses.
2. Do you remember the basic, or the 'main' message of these interventions and what is your opinion about these interventions?
3. Do you think that through interventions focused on men, they (the men):
    - Can obtain more information on FP methods?
    - Can initiate a discussion on FP with their wives?
    - Can be more supportive of their wives in using contraception?
4. Do you think that the intervention has changed your views about FP/BS, the number of children, and future intention to use FP/BS? How?
5. What kind of intervention had the most positive effect?
6. Do you think that interventions for women can make it easier for women to communicate with or convince their husbands of FP adoption? How?
7. Do you think that interventions for men can make it easier for women to communicate with or convince their husbands of FP adoption? How?
8. In your view, what kind of intervention (men/women) had/can have the most positive affect in increasing FP adoption?
9. In your view, can such interventions result in a convergence between a husband and a wife regarding reproductive intentions?



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