ASSESSING THE ROLE OF PUBLIC AND PRIVATE SECTOR ORGANIZATIONS TOWARDS POPULATION CONTROL IN THE RURAL AREAS OF N.W.F.P



A thesis presented

By

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In the Name of

ALLAH,

The Most Merciful and Compassionate
The Most Gracious and Beneficent

APPROVAL SHEET

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To My Beloved Mother

ABSTRACT

The study was undertaken on the topic, "Assessing the role of public and private sector organizations towards population control in the rural areas of N.W.F.P.". The main objective of the study was to ascertain the contribution of these organizations in population control, to Asses the constraints to family planning and strategies to overcome them. For this purpose the researcher had selected three types of respondents i.e. Family planning government staff, Non-Governmental Organizations (NGOs) staff and beneficiaries of both the organizations at selected family planning centers of District Peshawar.

Proportion allocation method of sampling was used for the selection of respondents. Out of total 109 government staff 70 were selected, from total 73 NGO's staff 60 were selected and among total 11885 beneficiaries of both government and NGO's 300 were selected.

After mapping the area and selecting the respondents, the researcher had pre-tested the Interview Schedule and Questionnaire, before data collected from the sampled respondents. The data of the study was organized, analyzed and interpreted accordingly.

The study has highlighted that the major sources of awareness about family planning were TV, radio, relatives, friends and family planning staff & literature. To improve the awareness among masses suggestions have been given for involvement of media, staff training and Internet utilization for this purpose.

The study farther indicates constraints to family planning such as economic, religious, socio-cultural, medical and quality of service. In this regard strategies for the provision of free contraceptives, involvement of religious leader, proper awareness, eradication of contraceptives' side effects and improvement in the quality of service are required.

Large family size yet existed in the area, due to early marriages and desire for maximum male children. It was suggested that strategies should be made for introducing small family norms and focus should be on mother child health care, because it is the issue of mother-child health for which family planning is essential.

Both the public and private sector organizations are working for population control through family planning methods. However, there is need to change the strategies and policies in order to achieve positive results.

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CHAPTER-1

INTRODUCTION

1.1 Background of the Study:

One of the biggest challenges in the world we are living today is the rapid growth in population. The world population took 130 years to increase from one billion to two billions. The third, fourth and fifth billion took 30, 15 and 13 years respectively. The growth rate, if continues with the same pace, the developing countries population will be double in the next quarter of a century. World population is now 6.3 billion, compared with 2.5 billion in 1950 and only 1 billion in 1830. By 2050 it seems likely to reach 9 billion. Over 90 percent of this growth will take place in developing countries, many of which have serious social, economic and environmental problems. Over population is not only a problem for Pakistan, but a universal concern, especially for developing and under developed countries. The world population data sheet 2003 indicates that china is the top populated country with population 1289 million, followed by India with 1069 million, USA with 292 million, Indonesia with 220 million, Brazil with 176 million and Pakistan with 149 million. Pakistan, one of the developing country in South Asia, has a population growth rate 2.7 percent among the 6th highest populous countries of the world and 4th over populated country in Asia. The population growth rate of the developing countries is 2.1 percent lower than that of Pakistan. Pakistan will have 249.7 million population in 2025 and 348.6 million in 2050. (World Population Data Sheet 2003 of Population reference Bureau USA, p-5)

To control this higher growth rate in population, Pakistan started family planning program in 1953. In five years plan, this program was further improved and passed through various vicissitudes[1]. The growth rate in North West Frontier Province (N.W.F.P) is higher than the other provinces of the country due to a number of reasons. Why could Pakistan not succeed in achieving the desired target to control the rapid growth of population? To answer this question, the researcher intends to assess the role of public and private sector organizations in the rural areas of district Peshawar N.W.F.P.

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[1] It means an upward change in steps or alternation and mutation.

a. Reproductive Health:

The international Conference on Population Development (1994) defined Reproductive Health as: "A state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes"[International Conference on Population And Development (ICPD): 1994; p-5].

b. Family Planning:

According to World Health Organization (WHO) "Family Planning is the way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitude and responsible decision by individuals and couples in order to promote health and welfare of family group and thus contribute effectively to the social development of a country"(WHO: 1994; p-11).

c. Family Planning in Pakistan:

The importance of family planning was realized in Pakistan when family planning association of Pakistan (FPAP) was established in 1953. In the early fifties, Pakistan was the first among the developing countries to recognize the problem of rapid population growth, and its family planning/population welfare program then passed through various phases of development. In this process, each phase has subsumed earlier phase rather than replaced it. The achievements during each phase have broadened the base and scope of the next phase. The shortcomings and weaknesses have served as a lesson for the construction and promotion of the program over these years.

First Phase (1955-1960): Acknowledging the interest of citizens in the field of Planned Parenthood, the government in the first five year plan made an allocation of Rs.10 million to support voluntary family planning activities. Family planning association of Pakistan established a few clinics in selected cities of the country and the concept of small family was promoted through voluntary organizations.

Second Phase (1960-1965): Family planning activities in the public sector were initiated in the second five-year plan (1960-1965) with an allocation of Rs. 15.5 million for providing family welfare services. The program was administered as normal function of the existing health services and entirely clinic based with no motivation or follow up service activity. Research was initiated in reproductive behavior on factors, which motivate parents, to have large or small families, and on the acceptability and effectiveness of different methods of birth limitation.

Third Phase (1965-1970): A comprehensive national population program was designed to operate as an integral part of the over all development strategy within the framework of a 20-year perspective plan (1965-85). An allocation of Rs. 148.2 million was made to implement the program spelt out a clear population policy. Its main objective was to bring down the crude birth rate from an estimated level of 50 per thousand to 40 per thousand populations. The main features of the program were recruitment and training of Para-medical and field staff, establishment of family planning clinics and creation of various research and evaluation units. The clients were approached through midwives for motivation and distribution of contraceptives at doorsteps of eligible couples. The program emphasized the insertion of IUDs (Intra Uterine Device) and was successful in creating awareness among the masses.

Fourth Phase (1970-75): The fourth five-year plan allocated a sum of Rs. 314.9 million. Under this program, full time workers replaced part-time midwives and field motivators. A continuous motivation system (CMS) was introduced in 1972. Under this program, a worker's team had been assigned with the responsibilities for covering 1200-1500 eligible couples in a specified geographic area of duty. The workers were to maintain basic information of each couple, which included demographic particulars, longitudinal life history, record of response and motivational contact by the workers, contraceptive and related services provided and follow up results.

Fifth Phase (1975-80): During the fifth five-year plan (1975-80), the program operated year to year. The allocation made in the Annual development program (ADP) amounted to Rs. 1008.7 million. The family planning program was federalized in 1977 to make it more effective. But, then field activities were suspended due to unfriendly political situation prevalent in the country. Activities, however, resumed from July 1978, but the program remained in transition during (1978-80).

Sixth Phase (1980-83): During the sixth phase (1980-83) the population welfare program covered the last three years of the Fifth Five-year plan. During (1978-83) the population welfare program was transferred from Ministry of Health to Ministry of Planning and Development. A new population program was formulated to enhance the welfare of the people through social mobilization and developmental process, which encouraged the concept of small family. It was structured on the recommendation of the World Population Plan of Action (WPPA), 1974. The traditional narrow concept of family planning was replaced by a comprehensive limitation of family size as well as improvement in the

availability of social services, such as family health, education, better nutrition and employment of women. The program was designed to place single-purpose vertical family planning program to a multi-sectoral and multidimensional broad-based approach. The plan contained a variety of projects, which as a whole formed the population welfare program. These were classified into three groups. These groups included FW projects for all the provinces. Traditional Birth Attendants (TBAs), Non-Governmental Organizations (NGOs), Hakim, Target group Institution, communication strategy, population education, family health care and Azad Jammu & Kashmir and Northern Area projects).

Seventh Phase (1988-93): The over-all population policy of the 7th Five-year plan (1988-93) was an attempt to bring a behavioral change in favor of small family norm throughout voluntary birth control. Fertility management was the main objective. The multi-sectoral approach, as adopted in 6th five-year plan, was followed and efforts were made to integrate the population welfare program with the health Department at gross root level. The commitments of other Ministries like education, information, Hajj (Annual Religious and Spiritual Practice Of Muslims/ Pilgrimage), Auqaf (department that deals in giving free land for religious purposes like mosques, madrassas etc), Labour and Manpower as well as overseas Pakistani was sought for in-corporation of population component in their respective programs. For better acceptance of family planning participation of all the relevant departments, NGOs (Non Governmental Organizations), the private sector and local leadership was to be ensured. Greater emphasis was placed on motivation, training, media and program personnel.

Eighth Phase (1993-98): During the 8th five-year plan, family planning coverage was to expand to cover over 80 percent of the rural and 100 percent of the urban population. For the rural areas, a new infrastructure, comprising a network of village family planning workers to be engaged on contract basis, would be created to take family planning services to the doorstep of the people. The over all objectives of the 8th five-year plan were to raise the level of contraceptive use rate from an estimated 15 percent (1992-93) to 24 percent by the end of 1997-98. To reduce the Total Fertility Rate (TFR) from 5.9 percent in (1992-93) to 5.4 percent by the end of June, 1998, to reduce the crude birth rate (CBR) from 39 (1992-93) to 35 by the end of 8th five year plan period and to prevent 4.661 million births by serving 20.904 million acceptors and to reduce the rate of population growth from 3 percent to (1992-93) to 2.9 percent by 1997-98.

Ninth Phase (1998-2003): During the 9th five-year plan, it was decided that family planning coverage would be expanded to cover over 90 percent of the rural and about 100 percent of the urban population. Moreover, it was planned that rapid contraceptive and surgery services will be provided in each district health unit level. Mobile health worker, LHWs, motivators and social organizers were appointed to accelerate the family planning service in both rural and urban areas. The goal of the plan was to raise the level of contraceptive use rate from 24 percent (1997-98) to 40 percent up to 2003. To reduce total fertility rate (TFR) from 5.4 percent (1997-98) to 4.3 percent in 2003, to reduce the crude birth rate (CBR) from 35 to 31.1 by the end of 9th five year plan period, and to reduce the rate of population growth from 2.9 percent (1997-98) to 2.2 percent (2003). [Ministry of Population Welfare (MoPW): 1994; P-5-11, Begum A.: 1997; P3-14 and Economic Survey of Pakistan: 2002; P3-13]

d. Utility of Family Planning:

i. Family planning protects women from unwanted pregnancies, different diseases and maternal deaths.

ii. Family planning saves the lives of children by helping women space births.

iii. Family planning helps men to care and to provide a better life to their families.

iv. Family planning improves family well-being. Couples with fewer children are better able to provide them with enough food, clothing, housing, and schooling.

v. Family planning helps nations in true development. (Robert, Ward, Richard, Judith, James: 2001; P1-2)

e. Principles of Counseling in Family Planning:

1. Treat each client well.
2. Proper Interact with client.
3. Tailor information to the client
4. Avoid too much information.
5. Provide the method that the client wants.
6. Help the client understand and remember.(Robert, Ward, Richard, Judith, James: 2001; P3-8)

f Various Contraceptives:

I. Female contraceptives: These include the following;

a. **Oral Contraceptives:** These are the strips, which contains 28 pills. A woman takes one pill daily containing progestin[2] to stop ovulation (release of eggs from ovaries).

b. **Inject-able contraceptives:** These are the injections, which are taken after 2 or 3 months and stop ovulation for 2 or 3 moths.

c. **Norplant Implants:** The Norplant implant system is a set of 6 small plastic capsules like small matchsticks. The capsules are placed under the skin of a woman's arm, which contain progistin, released very slowly for at least 5 years.

d. **Female Sterilization:** It is a safe and simple surgical procedure. The health care provider makes a smaller incision in the woman's abdomen and blocks off or cuts the 2 fallopian tubes[3].

e. **Female Condom:** A sheath made of thin, transparent, soft plastic, before sex a woman places the sheath in her vagina. During sex the man's penis goes inside the female condom.

f. **Multi Load/ Copper-T / IUD:** An intrauterine device usually is a small, flexible plastic frame. It often has copper wire or sleeves on it. It is inserted into a woman's uterus through her vagina. It has one or two strings, or threads, tied to them. The strings hang through the opening of the cervix into the vagina for checking. Tcu-380A IUD works up to 10 years and MLCu-375 up to 5 years.

g. **Vaginal Methods:** These are;

- **Spermicides:** Including foaming tablets, foam, melting film, jelly, and cream. These kill sperm or make sperm unable to move toward the eggs.
- **Diaphragm:** A soft rubber cup that covers the cervix. Should be used with spermicidal jelly or cream. It block sperm from entering the uterus and tubes, where sperm could meet an egg.

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[2] Any hormone concerned with changes before pregnancy.

[3] These are the tubes that connect the uterus to the region of each ovary. It carries the ovum from the ovary to the uterus and carries sperm from the uterus towards the ovary. Fertilization of the ovum by sperm usually takes place in the fallopian tube.

- **Cervical Cap:** It is like the diaphragm but smaller. Not widely available in Third world. It block sperm from entering the uterus and tubes, where sperm could meet an egg.

h. **Fertility Awareness-Based Method:** It means that a woman learns how to tell when the fertile time of her menstrual cycle starts and ends. (The fertile time is the time when she can become pregnant.) A woman can use several ways to tell when her fertile time begins and end; calendar calculation, cervical secretion, based body temperature and feel of the cervix.

i. **Lactation Amenorrhea Method (LAM):** It is the use of breastfeeding as temporary family planning method. "Lactational" means breast-feeding and "Amenorrhea" refers to menstrual bleeding. It protects from pregnancy up to 2 years as the mother breastfeeds the baby.

II. Male contraceptives: These are bellow;

a. **Traditional / Withdrawal:** It is the traditional method of contraception. It is also called withdrawal. During this method a husband discharge out side.

b. **Male condoms:** A condom is a sheath, or covering, made to fit over a man's penis.

c. **Vasectomy:** It is a safe, simple and quick surgical procedure. The health care provider makes a smaller opening in the man's scrotum (the sac of skin that holds his testicles) and close off both tubes that carry sperm from his testicles. This keeps sperm out of his semen. (Robert, Ward, Richard, Judith, James: 2001; P 14-18)

1.2 Statement of the Problem:

The problem of this study is "Assessing the role of public and private sector organizations towards population control in the rural areas of N.W.F.P." The focus of the study was on the sources of awareness, facilities, reducing side effects of contraceptives, improving mother-child health care, reasons of large family size and strategies of these organizations as well as constraints and shortcomings of family planning program in the selected family planning organizations.

1.3 Research Questions:

- What are the sources of awareness and popularization of family planning?
- What are the facilities and types of contraceptives provided to clients?

- What type of strategies are adopted for mother-child health care and reducing the side effects of contraceptives?
- What are the causes of large family size and strategies for small family norms?
- What are the various constraints and shortcomings in family planning and strategies to overcome them?

1.4 Objectives of the Study:

The following objectives have been set for the study.

- To evaluate the role of family planning organizations in bringing up the awareness (education, information, popularization & motivation) among the people about the family planning program.
- To assess the provisions of various facilities in family planning by these organizations.
- To find out the problems and Strategies of family planning organizations in reducing the side effects of contraceptives & improvement in mother-child health care.
- To perceive the causes of large family size and its solution by these organizations in the area.
- To understand various constraints and shortcomings in family planning and strategies of family planning organizations in its solution.
- To suggest a comprehensive strategy to deal effectively with the problem of population control and strengthening family planning implementation in the target area.

1.5 Assumptions in the Study:

The following assumptions are made in the study.

- It is assumed that better awareness; information and popularization program of family planning organizations will ensure success of family planning in the area.
- It is assumed that the availability of family planning facilities will lead to its acceptability.
- It is assumed that better strategies in reducing the side effects of contraceptives and improving mother-child health care will ensure success of family planning organizations.

- It is assumed that the large family size has certain problematic factors and better strategies of family planning organizations will solve this problem.
- It is assumed that higher constraints to family planning organizations are the shortcomings in its implementation and required better strategies.

1.6 Hypotheses:

- Better awareness; information and popularization program of family planning organizations better would be the chances of family planning strategies implementation in the area.
- Better the facilities and functions of family planning centers, higher would be the use of various contraceptives/ methods of family planning.
- Problems and side effects of contraceptives lead to better strategies to overcome them.
- Better the mother-child health care program better would be the result and strategies.
- Higher the existence (Causes) of large family size problem, higher would be the acceleration in the role/ strategies of family planning organizations.
- Higher the constraints and shortcomings in family planning, higher would be the struggle and strategies to overcome them.

1.7 Significance of the Study:

The study will be sociologically significant on the following grounds:

a. The significance of the study is attributed to its greater contribution both in academic and practical terms towards better understanding of the concept of family planning, removing obstacles in the way of population control and improving the life style of the people living in the target area.

b. The study is hoped to bring out in limelight the problems, issues, weaknesses and deficiencies in achieving the goals of population control among the rural community.

c. The study is hoped to influence the policy of the public and private organizations towards adopting better and workable strategies for the achievement of their objectives of improving the family planning program to ensure the population control.

d. The study would prove a useful document for faculty members, students, and research scholars who could be benefited from its results.

e. The study may have international value for all concerned with the development of awareness & implementation of family planning programs in the developing countries and may get first hand information about the efforts made by various organizations in Pakistan towards easing the problem of over population in rural society.

1.8 Delimitations of the Study:

The Problem of the study was limited to the selected popular public and private sectors organizations, involved in multifarious activities of family planning in the target area. The 'Thrust' of the activities were further looked into such crucial problems as:

a. Awareness, education, community participation and adaptation of culturally familiar and sensitive language for popularization of family planning.

b. Facilities/ Functions of family planning centers and staff as well as contraceptives provision, check-up, treatment and provision of medicines by family planning organizations.

c. Provision of mother-child health care, prevention and reducing side effects of contraceptives.

d. Causes of large family size and strategies of family planning organizations.

e. Various shortcomings and obstacles to family planning and strategies of family planning organizations.

1.9 Organization of Study:

The present thesis has been organized in five chapters. A brief encounter of each chapter is outlined below:

Chapter-I: This chapter is focusing on a broader introduction to over population, family planning program in Pakistan, utility and types of contraceptives. It also includes statement of the problem, objectives, assumptions, significance and delimitation of the study.

Chapter-II: This chapter reviews the literature based on researches conducted on global, national and provincial level. There are six parts of this chapter. Part-A shows area and organizations profiles, Part-B indicates a brief historical background of population growth,

Part-C highlights theoretical perspectives and theories on population growth, Part-D narrates family planning definition, theories and obstacles in terms of research reviews, Part-E reveals the contribution of public and private organizations in family planning implementation in Pakistan and Part-F depicts review of Community Based Distribution (CBD) model on international and national level.

Chapter-III: This chapter shows the nature of the study, universe, study matrix, parameters of the study, sampling technique used for the selection of respondents, tools, which were used for data collection and procedure of data analysis and presentation.

Chapter-IV: This chapter deals with data analysis and presentation. Data has presented in simple tables and figures. Brief explanations of the tables have been given for the understanding of the readers.

Chapter-V: This chapter includes; research findings, verification of hypothesis, and conclusion of the study and then pertinent recommendations have been given towards the resolution of the research problem.

At the end bibliography and appendixes have been annexed consisting of the following:

1. Model questionnaire/Interview schedules.
2. Organizational structure of Public and Private Sectors.
3. Map of the targeted area.

CHAPTER-2

REVIEW OF THE RELATED LITERATURE

2.1 Organization of the Literature:

The purpose of this chapter is to furnish guidance in evolving a comprehensive lay out of the study through the help of related materials, which included conceptual framework, demographic profile of the area, and information on the structure and strategy plan of family planning organizations, related theories, contribution of public and private organizations and community based distribution model implementation across the country and abroad. All the theoretical stuff hints at pointing out the nature of the problem and associated factors, diverse modes of inquiry of the included studies, study procedure, and finding sketch in the form of abstract or executive summary. For this study, the research scholar made his utmost efforts to search out studies related to community based distribution model of family planning within Pakistan and other countries of the world. All studies were thoroughly checked, placed in chronological order and then their abstracts were developed. Besides, the chapter contains materials related to the very concept of community based distribution family planning approach that were made available after hectic efforts. It is needful to mention here that all these materials played an important role in providing a rational foundation to the designing of the research methodology and imparting of valuable guidelines on any required juncture in the existing study. This chapter has six sub parts.

Part-A: It relates to the area and organizations profile.

Part-B: It includes materials revealing the historical background of population growth.

Part-C: It gives theoretical perspectives and theories in population growth.

Part-D: It consists on definition, related theories and constraints to family planning in the light of various studies.

Part-E: It reveals the contribution of public and private organizations in population control in Pakistan.

Part-F: It indicates the case studies on community based distribution model implementation in Pakistan and other countries.

Part-A Area and Organizations' Profile

2.2 District Peshawar Profile:

Topography: Peshawar is the capital of N.W.F.P, standing right at the entrance of world famous Khyber Pass. The total area of the district Peshawar is 1257 sq.km. The temperature in Peshawar district is up to 48°C in summer and down to 0°C in winter. Peshawar valley is famous for its fertile and densely cultivated land. According to land utilizing statistics 1998 the total cultivated area in the district is 74287 hectares, while the uncultivated area is 52374 hectares. The common Rabbi crops are wheat, barley, onion, potato and garlic, while Kharif are maize, rice and sugarcane. The main sources of irrigation in the district are canals and tube-wells. Total area under canals are 53208 hectares, while under tube-wells are 353 hectares. The common livestock of the districts are buffaloes, cows, goats, horses, sheep and donkeys. There are also several poultry and birds farms in the district. Peshawar district has a good network of roads. The main road namely Shahrah-e-Pakistan "Grand Trunk Road" enters the district at Tarnab Bridge and old Bara River and leaves at Bab-e-Khyber in Khyber Agency. The road passes through the middle of the city from East to West. All other minor and major roads are linked with this road at different places. Pakistan motorway also passes through the district approaching central Asia. The Railway line enters N.W.F.P at Attock and Peshawar district at *Akbar Pura* and ends at Landi Kotal, Khyber Agency. The Peshawar International Airport falls at a distance of 3 km from the city. The country's international postal services are also available at the district. Historically Peshawar is the center of trade in the whole sub-continent.

Social Setup: The different tribes inhibited at Peshawar are *Afridi, Khattak, Mohmand, Orakzai, Wazir, Masood (Pushto speakers) and Peshawares (Hindko* speakers). The common food in the whole district is bread usually made of wheat or maize flour. The average man takes two meals a day. The bread is baked in *Tandoor* (Oven). The people of the area are fond of meat, they like *Chapli Kabab, Tikka Karhai,* and Bar-b-que. Green tea *(Qahwa)* is popular and usually taken after meal. *Shelwar Kameez, Chappal,* white cap and Chadar (Shawl) are the traditional outfits of the area. Pant, coat, suites are also used by the nominal persons. Women are observing veil (Pardah) and use Borqa (Shuttle Cock / Shawl). The dwelling pattern of the area is village pattern in rural and city pattern in urban areas. Agriculture is the major occupation in the rural area while sub-urban and urban

people are involved in services and businesses. The urban women are also doing jobs parallel with the males. Pathan customs and traditions are observable in this district. The people are very fond of sports. Cricket, squash, lawn tennis, table tennis, football Kabaddi, swimming, hockey etc. are popular in the sports of the district. The district has produced many famous champions like Hashim Khan, Jehangir Khan, Jan Sher Khan and Qamar Zaman (Squash) and Lala Ayub, Qazi Muhib (Hockey) and others. On account of conservatism and strict segregation of sexes, the parents usually arrange marriages among the pathans. The prospective bride and bridegroom have no part in the negotiations excepting upper section of society. The parents regarding Mahar and dowry etc take the decisions.

General and Reproductive Health Facilities: There are three major hospitals in the district namely Lady Reading Hospital, Khyber Teaching Hospital and Hayathabad Medical Complex providing medical, surgical and reproductive health as well as mother child healthcare services in the district. There are ten class-I and class-II hospitals providing basic health care and mother child health care services. There are 50 Basic Health Units in the district, 4 TB clinics, 19 Mother Child Health centers, 1 Lapracy clinic and 77 dispensaries as well as 17 Family Welfare Centers and 1 Mobile Service Unit on the part of government, while there are about 5 maternity homes, 5 Family Health Centers and 2 Mobile Health Unites in private sector providing family planning and reproductive health services in the district.

Education Facilities: There are 4 universities (3 for Co and 1 exclusively for women), 7 degree colleges (4 male and 3 female), 1 commerce college (male only), 2 polytechnic colleges (1 for male and 1 for female), 17 higher secondary schools (11 male and 6 female), 89 high schools (65 male and 24 female), 12 Middle schools (8 male and 4 female), 1,032 primary schools (648 male and 384 female) in the public sector, while 8 universities (for both male and female), 6 degree colleges (3 male and 3 female), 2 Management Institutes (for both boys and girls), 4 intermediate colleges (2 male and 2 female), 2 commerce colleges(for both male and female), 4 law colleges (for both male and female), 2 polytechnic institutes (1 for male and 1 for female), 60 high schools (35 for male and 25 for female), 10 middle schools (5 for male and 5 for females), 400 nursery and primary schools (for both boys and girls).

Historical Places: The important historical places of district Peshawar are Peshawar city, Qilla Bala Hissar, Masjid Mahabat Khan, Shahgee kee Dheri, Islamia College, Peshawar, Peshawar University, Peshawar Museum, Baab-e-Khyber, Shahi bagh and Chowk Yadgar.

Demographic Profile: According to District Census Report 1998, the total population of district Peshawar is 20, 19,000 persons, where rural is 10, 36,000 persons, (i.e. 51.31 percent) and urban is 983,000 persons (48.68 percent). The population growth rate is 3.6 percent. The average household size is 8.5 persons. Majority of the district population is Muslim i.e. 98.57 percent (99.50 percent in rural and 97.60 percent in urban). There are very few Christians i.e. 0.94 percent (0.13 percent in rural and 1.79 percent in urban), Hindu 0.06 percent all in urban and Quaidanies 0.36 percent all in urban. The sex ratio in the district is 110.76. The marital status of the population in the age of 15 and above shows that 34.12 percent never married, 62.37 percent married, 3.45 percent widowed and 0.06 percent is divorced. Out of the total female population 45.21 percent is in childbearing age (i.e. 15 to 49 years), which is relatively higher. Among the female in reproductive age, 31.30 percent never married, 66.65 percent currently married, 1.96 percent widowed and 0.08 percent divorced. Among the women in the childbearing age 33.97 percent have 6 and above children, 9.58 percent have 5 children, 45.75 percent have 2 to 4 children and 6.72 percent have reported 1 child. The number of early aged married women and number of children produced are higher in rural areas as compared to the urban areas of the district. The disabled persons constitute 0.75 percent (0.20 percent female and 0.55 percent male) of the total population of the district. The literacy ratio of the district among the population aged 10 years and above is 41.79 percent. The literacy ratio for male is higher i.e. 65.97 percent compared to 25.85 percent for female. The enrolment ratio in the age 5 to 24 years is 49.64 percent in the district. It is higher for male i.e. 57.61 percent as compared to 40.98 percent for female. Out of the total educated persons 24.92 percent have passed primary, 19.99 percent middle, 19.61 percent Matric, 8.88 percent intermediate, 6.94 percent graduate and 3.06 percent postgraduate. The total lifetime migrants are 301788 (55.80 percent male and 44.20 percent female). The economically active population of the district (10 years and above age) is about 393000 persons, where 92.51 percent are male and 7.94 percent are female. The remaining 80.56 percent economically inactive population consists of 32.07 percent children below 10 years 31.14 percent domestic workers (64.23 percent female, 1.26 percent male) and 1.03 percent students. The employed population is 23.52 percent. About 83.00 percent of the

children fewer than 10 years of age have vaccinated. About 63.96 percent of the population aged 18 years and above have obtained national identity card. About 24.00 percent of the housing units in Peshawar district are single room houses and 31.80 percent housing have 2 rooms 12.29 percent houses have 4 rooms while 11.27 percent houses have 5 and more rooms. About 69 percent of the population lives in their own houses. About 84.17 percent of the housing units are having the facility of drinking water inside the houses, while 15.83 percent of the housing units use outside source as a drinking water. About 94.98 percent of the housing units are using electricity as a source of lighting (97.98 percent urban and 91.95 percent rural). In rural areas 6.23 percent housing unit use kerosene oil as a source of lighting and only 1.47 percent in urban areas. About 48 percent of the housing unit use wood for cooking i.e. 81.73 percent in rural area, while 15.45 percent in urban. The other sources are 7.27 percent use kerosene oil 39.29 percent use gas in rural areas while 11.25 percent kerosene oil and 70.10 percent gas in urban areas. About 29.71 percent of the housing unit in the district had a separate kitchen (28.55 percent rural and 30.83 percent urban), 37.23 percent shared (37.18 percent rural and 37.28 percent urban), 33.05 percent none (34.27 percent rural and 31.88 percent urban. About 30.83 percent had separate bathrooms (27.48 percent rural and 34.15 percent urban), 46.90 percent shared (40.24 percent rural and 53.31 percent urban) and 22.26 percent none (32.37 percent rural and 12.54 percent urban). About 28.06 percent had separate latrine (20.15 percent rural and 35.67 percent urban), 45.17 percent shared (34.39 percent rural and 55.54 percent urban) and 26.77 percent none (45.46 percent rural and 8.80 percent urban). About 49.15 percent of the population has access to Television (36.91 percent rural and 60.92 percent urban), 23.23 percent to radio (23.03 percent rural and 25.35 percent urban) and 24.46 percent to newspaper (12.51 percent rural and 28.12 percent urban). (District census report Peshawar 1998, pp 5-15)

Targeted Union Councils and Villages: The following union councils and villages were selected for this study, having the facilities of Family Welfare Centers and Family Health Centers in the district. Therefore, their brief population characteristics are given:

i. **Achini Bala:** It has 9930 (5144 male and 4786 female) population, 21.2% literacy ratio, 786 male and 80 female have up to Matric educational level, 306 male and 41 female have above Matric education level and 9916 persons are Muslims while 14 are others, the average house hold number is 13.2, women in child bearing age (15-49 years) are 2026 and currently married are 1555. There are both family

welfare center and family health center one each having the facility of Family Welfare Worker (FWW), Lady Health Worker (LHW), Lady Health Visitor (LHV) and Trained Birth Attendant (TBA) providing family planning and mother-child health care services in the area.

ii. **Akhonzadgan:** It has 3762 (1976 male and 1786 female) population, 36.6% literacy ratio, 335 male and 89 female have up to Matric educational level, 254 male and 23 female have above Matric education level and 3754 persons are Muslims while 8 are others, the average house hold number is 8.3, women in child bearing age (15-49 years) are 787 and currently married are 546. There is Family Welfare Center (FWC) having the facility of FWW, LHV and TBA providing family planning and mother-child health care services in the area.

iii. **Alaf Khan Kale:** It has 3838 (1994 male and 1844 female) population, 39.3% literacy ratio, 364 male and 157 female have up to Matric educational level, 299 male and 49 female have above Matric education level and 3820 persons are Muslims while 18 are others, the average house hold number is 7.9, women in child bearing age (15-49 years) are 863 and currently married are 526. There is FWC having the facility of FWW, LHV and TBA providing family planning and mother-child health care services in the area.

iv. **Garhi Sanobar:** It has 4976 (2554 male and 2422 female) population, 17.5% literacy ratio, 283 male and 10 female have up to Matric educational level, 98 male and 3 female have above Matric education level and 4959 persons are Muslims while 17 are others, the average house hold number is 9.4, women in child bearing age (15-49 years) are 1050 and currently married are 768. There is FWC having the facility of FWW, LHV and TBA providing family planning and mother-child health care services in the area.

v. **Gulbahar -I:** It has 7319 (3783 male and 3536 female) population, 28.4% literacy ratio, 424 male and 92 female have up to Matric educational level, 317 male and 44 female have above Matric education level and 7315 persons are Muslims while 4 are others, the average house hold number is 9.2, women in child bearing age (15-49 years) are 1498 and currently married are 999. There is Family Health Hospital (FHH) in Gulbahar covering the whole Gulbahar, Pandu, Chughul Pura, Sardar Gari, Gangh and Kohati etc. It has the facility of Gynecologists, LHWs,

LHVs and TBAs providing family planning and mother-child health care services in the area.(District Peshawar census report-1998:25).

vi. **Musafar Kali:** It has 6917 (3613 male and 3304 female) population, 37.6% literacy ratio, 635 male and 123 female have up to Matric educational level, 437 male and 29 female have above Matric education level and 6883 persons are Muslims while 34 are others, the average house hold number is 8.0, women in child bearing age (15-49 years) are 1356 and currently married are 948. There is FWC having the facility of FWW, LHV and TBA providing family planning and mother-child health care services in the area.

vii. **Palosi Talar Zai / Muqaddarzai:** It has 2180 (1182 male and 998 female) population, 39.4% literacy ratio, 189 male and 23 female have up to Matric educational level, 117 male and 14 female have above Matric education level and 2177 persons are Muslims while 3 are others, the average house hold number is 11.0, women in child bearing age (15-49 years) are 447 and currently married are 332. There are both family welfare center and family health center one each having the facility of FWW, LHW, LHV and TBA providing family planning and mother-child health care services in the area.

viii. **Sofaid Dheri (Spina Warai):** It has 12981 (6814 male and 6167 female) population, 49.3% literacy ratio, 1418 male and 592 female have up to Matric educational level, 1335 male and 324 female have above Matric education level and 12898 persons are Muslims while 83 are others, the average house hold number is 8.5, women in child bearing age (15-49 years) are 2892 and currently married are 1817. There are both family welfare center and family health center one each having the facility of FWW, LHW, LHV and TBA providing family planning and mother-child health care services in the area.

ix. **Sori Zai Payan:** It has 33488 (17682 male and 15806 female) population, 16.1% literacy ratio, 1617 male and 146 female have up to Matric educational level, 727 male and 50 female have above Matric education level and 33373 persons are Muslims while 115 are others, the average house hold number is 10.8, women in child bearing age (15-49 years) are 6558 and currently married are 4873. There is FWC having the facility of FWW, LHV and TBA providing family planning and mother-child health care services in the area.

x. **Tarai Payan:** It has 9935 (5290 male and 4645 female) population, 29.1% literacy ratio, 995 male and 111 female have up to Matric educational level, 640 male and 28 female have above Matric education level and 9913 persons are Muslims while 22 are others, the average house hold number is 8.4, women in child bearing age (15-49 years) are 1968 and currently married are 1268. There is FWC having the facility of FWW, LHV and TBA providing family planning and mother-child health care services in the area.

xi. **Tarnab:** It has 7575 (3963 male and 3612 female) population, 37.5% literacy ratio, 775 male and 255 female have up to Matric educational level, 643 male and 127 female have above Matric education level and 7402 persons are Muslims while 173 are others, the average house hold number is 7.5, women in child bearing age (15-49 years) are 1640 and currently married are 1058. There is FWC having the facility of FWW, LHV and TBA of public and Family Health Centers (FHC) having the facility of LHW, LHV, and TBA of private (NGO), providing family planning and mother-child health care services in the area. (District census report Peshawar 1998, pp 15-20)

2.3 Organizations' Profile

2.3.1 Public Sector Organization:

I. Federal Ministry of Population Welfare: At the federal level, population welfare division was created in March 1968. It got the status of a full fledged ministry of population welfare in 1990. The overall execution and entire funding of the program is the responsibility of the federal government. The ministry of population welfare is the main executing agency of the national program while implementation of field activities is the responsibility of the population welfare departments in each of the four provinces, headed by a secretary. (http://www.mopw.gov.pk)

II. Provincial Setup: A secretary administratively heads the population welfare department in the province. The director general is the senior most programme officer, responsible for the following operational functions.

- To maintain provincial population profile and to assist the federal Govt. in formulation of overall policy goals, targets and strategies for the program.

- To be responsible for operational planning, monitoring and evaluation and to ensure implementation of program within the framework of the strategies and goals assigned to the province.
- To ensure widespread availability of quality services to the clients with adequate follow-up arrangements and supply of contraceptives in the province.
- To liaise with provincial health and line departments as well as NGOs for delivery of family planning service through their outlets.
- To compile statistical reports on program performance, to under-take, periodic sample surveys of households for collecting information on fertility, knowledge, and attitude.
- To design and implement information, education and communication activities assigned to the province.
- To act as secretariat for the population welfare council, inter-departmental committee for population welfare.
- To undertake regular reviews of the program implementation.

III. District set-up: There are 24 district population welfare offices to look-after the implementation of the program for planning implementing supervision and coordinating the work of service delivery outlets. There are 8 high density and 16 low-density districts in N.W.F.P. The district population office performs the following functions:

- To prepare and maintain a district population profile.
- To plan, organize and implement family planning activities through Family Welfare Centers (FWCs), Mobile Service Unit (MSUs), and Reproductive Health Services – A [Govt./ public] (RHS-As).
- To undertake regular reviews of the program implementation and to organize the assigned communication activities.
- To identify training needs and impart local level training.
- To provide logistic support and contraceptive supply.
- Maintenance of equipments, instruments and furniture etc.
- To monitor, supervise and provide on the job guidance to the service providers through field visits.
- To disburse and maintain financial record for all expenditures.
- To provide secretariat support to the district population welfare committee.

IV. **Tehsil set-up:** In the province there are 24 districts having 55 revenue tehsils. Out of which, 24 tehsils are located in the district HQ, while 31 tehsils are out of the district HQ. The tehsil offices with 3-staff members have been retained. A motorcycle has provided to the tehsil officer for monitoring purposes. The tehsil office has made the center of activities in order to improve the service delivery. A tehsil population welfare committee supports the activities of tehsil setup. The tehsil population welfare office performs the following functions:

- To prepare tehsil population profile and to provide administrative and logistical support to FWCs, and MSUs.
- To establish linkages with health, NGOs and elected representatives.
- To undertake regular review of the program implementation.
- To supervise and monitor program activities in the tehsil on a regular basis.
- To ensure distribution of contraceptives.
- To maintain contact with the communities for awareness.

V. **Service Delivery Infrastructure:** In the population welfare program, service delivery being core component of the program plays a pivotal role to facilitate the community. The family planning and reproductive health services are being provided through a network of the facilities, in static/extension service. For population stabilization, reduction in growth rate/unmet need and to increase the contraceptive prevalence rate, there is a need that the services are improved and reach the far-flung remote population, particularly in the rural areas. The service delivery component of the program comprises of the following:

a. **Reproductive Health Services Centers (A & B):** There are three reproductive health service centers in public sector i.e. Lady Reading Hospital (LRH), Khyber Teaching Hospital (KTH) and Hayatabad Medical Complex (HMC) and one Reproductive Health Service–B (RHS-B) in private sector (NGO) Rokhana Kor Family Health Hospital Gul Bahar.

b. **Mobile Service Units (MSUs):** There is a mobile service unite possessing a vehicle (van) equipped with contraceptive devices and lady doctor, LHV, FWW and TBAs.

c. **Family Welfare Centers (FWCs):** It is a reproductive and family planning service outlet. There are 17 family welfare centers, in public sector, in the rural areas of

Peshawar. There is a family welfare worker, lady health workers; village based female and male mobalizers as well as traditional birth attendants, providing informative and curative service in family planning and reproductive as well as mother-child health care in villages. (D.G. Pc-1 for population welfare program (2003-08) DOPW, NWFP pp 1-20)

2.3.2 Private Sector Organizations:

I. Family Health Hospital Peshawar (RHS-B): Family Health Hospital (FHH) is the heart of focus area approach of Family Planning Association of Pakistan (FPAP) established in 1953 at Lahore. It is a 20 bedded hospital, providing informative, curative and surgical reproductive health services within three mile radius, located in the lower middle class of Gulbahar housing colony, Peshawar. Initially it was started as a small family planning center in 1982 and then it was upgraded as model family planning clinic in 1987. In 1999 the model clinic was upgraded to family health hospital to provide 24 hours maternity services including reproductive health services.

Family Health Hospital (FHH) Components:

A. Static:

- Reproductive health services, Deliveries Antenatal and postnatal care[4]
- Family planning services
- Ultrasound and Laboratory facilities as well as Surgery

B. Training Component:

- Lady doctors and Female paramedics
- TBAs and LHVs

C. Information and Education:

- Reproductive health promotional activities for community awareness
- Workshops for volunteers
- Islam and family planning
- Distribution of Information Education and Communication (IEC) material

D. Quality Care Component Program:

- On job staff training and Refresher training

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[4] After delivery mother-child health care

- Reproductive health and Surgical contraception
- Family planning methods and Counseling
- Quality assurance manuals, formats for LHV, LHW, FHCs and clients
- Focus group discussions

E. Up gradation of FHH:

- Provision of quality maternity services.
- Reproductive health care through information and awareness services.
- Mother-child health care services.
- Family planning counseling for small family norms. (FHH Annual Report 2003 pp 1-10)

II. Family Health Centers (FHCs): There are three family health centers in the rural area of Peshawar working for reproductive heath and family planning in the area. Such centers were established with the goals and objectives to provide reproductive heath and family planning services on the doorstep to the clients. The FHCs at Peshawar are the following:

a. Family Health Center Tarnab: It is situated near Tarnab agriculture research center on the main Islamabad Peshawar main trunk road. It was established with one LHV and Chukidar in 1990. Now this FHC has the facility of 2 LHVs and TBAs to provide reproductive and family planning informative and curative services to the target communities. LHVs are providing useful information for mother and child health care, as well as check-up, treatment and provision of contraceptives and vitamin tablets. The staff also provides; home delivery services, and also clinic facilities in their own house after the office hours.

b. Palosi Family Health Center: It is situated adjacent to University of Peshawar at a distance of about 10 km from University road. It was also established with the facilities of one LHV and chukidar in a rented house in 1990. The FHC got progress in distribution of contraceptives and its information and thus was strengthen by 2 LHVs and 2 TBAs providing reproductive and family planning services to the target community.

c. Family Health Center Achini: It is situated on ring road Peshawar leading to Hayatabad. It is the most backward area and staff is facing variety of problems. It was established in 1990. It has the facility of 2 LHVs and 2 TBAs; they are

providing reproductive, mother-child health and family planning services in the area.

III. **Mobile Health Unit (MHU):** Mobile health unit is provided in those for flung areas, where there is no family planning center and the people cannot get the family planning facilities easily. The mobile team including LHV, TBA and some time a lady doctor visit the home in different areas to provide doorstep family planning and reproductive service to those deprived areas. (FHH Annual Report 2003 pp 10-12)

Part-B Historical Background of Population Growth

2.4 History of Population Growth:

Joel Cohen, of the Laboratory of Population at Rockefeller University, has an excellent discussion of the history of population growth in his book, "How many people can the earth support?" Cohen provides a sophisticated and detailed discussion of historical estimates of world population. He estimates the following world population history (Cohen 1995):

Table-1 World Population Growth since 8000 BC to 1995 AD

Year	8000 BC	1750 AD	1950	1970	1995
Population (billions)	0.005	0.75	2.5	3.7	5.6

Table-1 indicates that the world population was 0.005 billions in 8000 BC, it was 0.75 billions in 1750 AD, it was 2.5 billions in 1950, it was 3.7 billions in 1970 and it was 5.6 billions in 1995.

There is another estimate of world population growth given by McEvedy, Colin and Richard Jones, 1978, "Atlas of World Population History and U.S. Census Bureau" as follow:

Table-2 World Population Growth since 10000 BC to 2000 AD

Year	10000 BC	1000BC	1 AD	1000	1500	1700	1800	1900	2000
Population (millions)	4	50	170	265	425	610	900	1625	6078

Table-2 shows that the world population was 4 millions in 10000 BC, it was 50 millions in 1000 BC, it was 170 millions in 1 AD, it was 265 millions in 1000 AD, it was 425 millions in 1500 AD, it was 610 millions in 1700 AD, it was 900 millions in 1800 AD, it was 1625 in 1900 AD and it was 6078 millions in 2000 AD.

Table-3 Population Growth (Millions) By Continent, 1650-2010

Continent	1650	1750	1850	1950	1970	1990	2000	2010
Africa	100	95	95	221	356	619	794	1221
Asia	330	479	749	1399	2142	3164	3672	3770
Latin America	12	11	33	167	285	440	519	521
North America	1	1	26	172	232	283	314	589
Europe	100	140	266	548	657	722	727	414
Oceania	2	2	2	13	19	26	31	37
The World	545	728	1171	2519	3691	5255	6057	6552

Source: Vaughn 1980 World Population Summary P-4

Table-3 shows the population growth in millions by continent, since 1650-2010. The highest populated continent is Asia followed by Africa, Europe, North and Latin America and Oceania.

Table-4 World Top Six Populated Countries in 2003 and 2050

Rank (2003)	Country	Population (millions)	Rank (2050)	Country	Population (millions)
1	China	1289	1	India	1628
2	India	1069	2	China	1394
3	USA	292	3	USA	422
4	Indonesia	220	4	Pakistan	349
5	Brazil	176	5	Indonesia	316
6	Pakistan	149	6	Nigeria	307

Sources: World population data sheet-2003s; Population Reference Bureau. USA, P-5

Table-4 highlights the world top six populated countries. During 2003 the top populated country was China followed by India, USA, Indonesia, Brazil and Pakistan, while during 2050, the top populated country of the world will be India followed by China, USA, Pakistan, Indonesia and Nigeria. Thus Pakistan was 6th during 2003 and will be 4th during 2050 populated country of the world.

Table-5 World Population Trends (billions), Population Growth Rate (PGR) & Contraceptive Prevalence Rate (CPR) 2004

Regions	Population (in billions)	PGR	CPR
World	6.396	1.3	59
Less Developed	5.190	1.6	57
More Developed	1.206	0.1	69

Source: National Institute of Population Studies (NIPS), 2004, Population growth and its implications p-7.

Table-5 shows the world population trends in billions, population growth rate and contraceptive prevailing rate. The total population of the world was 6.396 billions, population growth rate was 1.3 percent and contraceptives prevailing rate was 59 percent during 2004. The less developed countries total population was 5.190 billions, population growth rate was 1.6 percent and contraceptives prevailing rate was 57 percent during 2004. The total population of more developed countries was 1.206 billions, population growth rate was 0.1 percent and contraceptives prevailing rate was 69 percent during 2004.

Table-6 TFR, PGR and CPR, in Top Five populated Muslim Countries, 2004

Muslim Countries	TFR	PGR	CPR
Pakistan	4.1	1.9	34
Malaysia	3.3	2.1	55
Bangladesh	3.3	1.7	54
Egypt	3.2	2.0	56
Indonesia	2.6	1.6	57

Source: NIPS, 2004, Population growth and its implications p-41

Table-6 depicts the total fertility rate, population growth rate and contraceptives prevailing rate in top five populated Muslim Countries (Pakistan, Malaysia, Bangladesh, Egypt and Indonesia) during 2004.

Table-7 Population Size of Pakistan

Years	1947	1951	1961	1972	1981	2004	2025
Population (Millions)	32.5	33.7	42.9	65.3	84.3	151.1	208.8

Source: NIPS, 2004, Population growth and its implications p-13.

Table-7 indicates the population size of Pakistan in millions since 1947 to 2025.

Table-8 Pakistan Provinces Population 1998 (Thousands)

Pakistan/ Provinces	Pakistan	N.W.F.P	Punjab	Sindh	Balochistan	FATA	FCT Islamabad
Population	130580	17555	72585	29991	6511	3138	799

Source: Bureau of Statistics, N.W.F.P, Development Statistics, 1999, P-4

Table-8 shows the Pakistan provinces population in thousands during 1998.

Table-9 Top Five Populated Districts in N.W.F.P census 1998

District	Peshawar	Mardan	Swat	Mansehra	Swabi
Population	2038629	1450469	1249572	1141573	1010691
Position	1st	2nd	3rd	4th	5th

Source: Bureau of Statistics, N.W.F.P, Development Statistics, 1999, P-8

Table-5 shows the world population trends in billions, population growth rate and contraceptive prevailing rate. The total population of the world was 6.396 billions, population growth rate was 1.3 percent and contraceptives prevailing rate was 59 percent during 2004. The less developed countries total population was 5.190 billions, population growth rate was 1.6 percent and contraceptives prevailing rate was 57 percent during 2004. The total population of more developed countries was 1.206 billions, population growth rate was 0.1 percent and contraceptives prevailing rate was 69 percent during 2004.

Table-6 TFR, PGR and CPR, in Top Five populated Muslim Countries, 2004

Muslim Countries	TFR	PGR	CPR
Pakistan	4.1	1.9	34
Malaysia	3.3	2.1	55
Bangladesh	3.3	1.7	54
Egypt	3.2	2.0	56
Indonesia	2.6	1.6	57

Source: NIPS, 2004, Population growth and its implications p-41

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Table-9 indicates the top five districts in N.W.F.P during 1998. The top populated district in N.W.F.P is Peshawar with the population of 2038629, followed by Mardan with 1450469, Swat with 1249572, Mansehra with 1141573 and Swabi with 1010691.

Part-C Theoretical Perspectives on Population Growth

2.5 Responses to Population Growth:

Anxiety about the negative effects of rapid population growth and excessive population numbers has a long history. Long before Malthus, ancient Greeks and Egyptians voiced concern about "overpopulation". In the 1930's and 1940's, scientists and intellectuals in some less developed countries such as Egypt, India, and Mexico began to express concern that rapid population growth would hinder development in their countries. Widely publicized food shortages and famines in certain less developed areas in the 1960's were also linked to rapid population growth.

These concerns sparked a number of actions around the world directed at lowering fertility and slowing population growth. India and Pakistan initiated a national policy to control population growth in 1952. The International Planned Parenthood Federation, the largest private sector organization devoted to family planning, was founded in the same year. United Nation (UN) involvement in population issues also expanded. The first UN meeting on global population was convened in 1954, in collaboration with the International Union for the Scientific Study of Population. UN agencies, including United Nations International Children's Emergency Fund (UNICEF) and the World Health Organization (WHO), incorporated reproductive health services into their missions. In 1969, the United Nations Fund for Population Activities (UNFPA) became a separate entity.

Beginning in the 1960s, governments of some wealthier countries, most notably the United States, supported efforts to strengthen family planning programs in less developed countries. (Alene.G., Carl. H., Mary M. K., 1991, P-4).

2.6 Perspectives to Explain Population Growth:

a. Functionalist Perspective: Functionalist are interested in the social effects of rapid population growth. They have found that population expansion may perform several important functions. When the world's population was low and there was no shortage of

natural resources, there was no dysfunction of population[5]. Now the social forces, which promote desirable population growth[6], produce hunger, poverty, and social instability. For this reason, functionalist say, the population problem will be solved only when dysfunctional attitudes[7], values, and institutions that promote excessive birth rates should be changed. In a given time, the social system will reach a new balance. This balance should not come about as a result of famine, wars, or other disasters. It should come, instead, from well-organized programs to change traditional attitudes toward childbearing. (James M. Henslin: 1997; p. 550)

b. The Conflict Perspective: The conflict perspective sees the population problems of the Third World to be a direct result of European colonialism and technological development in Europe. The obvious solution to this problem is to redistribute the world's food so that everyone is adequately fed. There are enormous political and economic barriers to such a program for the international redistribution of food supplies. These barriers seem insurmountable[8] at present. Some nations, however, have dealt effectively with their domestic inequality. Sweden and Norway, for example, have guaranteed a good diet to the poor by means of welfare programs, and China has relied on stationing and careful government controls to ensure that its limited food supplies are distributed fairly. (James M. Henslin: 1997; p. 551)

c. The Socio-Psychological Perspective: Biosocial theorists see human evolution[9] as the root of the population problem. Because the most fertile individuals pass more genes on to the next generation, humans developed a high level of fertility. Throughout most of human history this process promoted the survival of the species. But now overpopulation is a serious threat to human survival, but the evolutionary process continues to promote high fertility. Many biosocial theorists see that development of more effective artificial means of birth control as the best solution to the population problem.

Social psychologists point out that learned attitude and beliefs must change before birth control measures can be effective, mere propaganda and personal appeals are not enough; they must be accompanied by concrete economic and social changes. For example, a

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[5] Negative function or effects of population on society
[6] The growth rate of population which is desired in a specific period of time in a specific area.
[7] Negative attitude regarding any thing or object
[8] Which cannot be overcome.
[9] To unfold, to develop and bringing change in any system with differentiation and integration.

sound social security plan can do much to convince people that a large family is not necessary to support them in their old age. (James M. Henslin: 1997; p. 552)

2.7 Theories of Population Growth:

Over the past two centuries many theorists have tried to explain why do populations change? Which patterns do they follow? And what can be expected in the future? Some of the prominent theories are examined here, i.e. Thomas Malthus, New Malthusian (William Faunce) and Demographic Transition.

a. Thomas Malthus Theory of Population Growth: In 1798 an English economist, Thomas Robert Malthus (1766-1834), wrote a book entitled "An Essay on the Principles of Population". Malthus stated if birth rates are left unchecked, the population goes on doubling, or increases geometrically (e.g., 1,2,4,8...), while subsistence (food) only increases arithmetically (e.g., 1,2,3,4...). Malthus examines "the general checks to population", "Moral restraint" (delay of marriage) and "vice" (measures of birth control) (James M. Henslin: 1997; p. 555).

b. The New Malthusians Theory of Population Growth: The New Malthusians "William Faunce (1981)'' is convinced that today's situation is at least as grim, if not grimmer, than Malthus ever imagined. In each second 2.8 accumulating increase, each minute 168, each hour 10100, each day 242000, each week 1700000, each month 7360000 and each year 88500000. By this time tomorrow, the earth will have an additional quarter of a million people to support. This increase goes on hour after hour, day after day, without letup. The result of a single day: Births (382000)-Deaths (140000) =Population Increase (242000). The New Malthusians believe that the only solution is birth control through family planning. (James M. Henslin: 1997; p. 556)

c. Demographic Transition Theory / Model: The demographic transition is a model of population history based on the experiences of Western Europe. As, countries in Western Europe developed; they went through a series of defined stages in terms of birth rates and death rates. The demographic transition model describes these changes in human fertility and mortality related to shifts in economic development through the industrial revolution and urbanization, which took place throughout Western Europe.

The model is comprised of four stages:

Stage 1: High birth rates and a high but fluctuating death rate.

Stage 2: Declining death rates and high birth rates.

Stage 3: Declining birth rates and death rates.

Stage 4: Low death rates with low but fluctuating birth rates (often countries in this stage experience negative growth) (James M. Henslin: 1997; p. 561).

Synthesizing and Correlating Theories: Malthus argues that population is growing rapidly and resources slowly, population needs to be control. The New Malthusians believe that the rapid growth of population can be controlled only through successive family planning program. The demographic transition theory/ model indicates that due to technological advancement both the fertility and mortality rates are getting decline/ stabilization and will bring a better position to the world.

Part-D: Definition, Theories, History and Constraints to Family Planning (FP):

2.8 Definition of Family Planning:

1. "Family planning is a low rate of child bearing and nothing unnatural and inhuman" (Chaudhry: 1980: P-326)
2. "The Conscious action of couples to regulate the number and spacing of their children in accordance with personal preference is called family planning" (Allman: 1978: P-35)
3. "Family planning is the knowledge and information about reproductive physiology and contraceptive techniques and supports the small family ideal and the acceptability of contraception" (Ritzier and Yetman: 1987; p-44)
4. "Knowledge about methods to prevent or delay pregnancy is essential for a woman to limit the number of children she is likely to have" (Shah: 1986: P-302).
5. "Individual and couples adopt patterns of birth control in accordance with their cultural values, reinforced by formal or informal social pressures" (Christopher Tietze: 1968: p-22)

On the basis of the above definitions of family planning it is concluded that family planning is an arrangement of better mother-child health care and small family size through birth spacing by using various contraceptives.

2.9 Related Theories and Research in Family Planning:

Family Planning has been one of the most important field of research in U.S.A., Europe and then in India, Bangladesh, Pakistan, Sri Lanka and several other Far East countries. A

large number of various studies on family planning relating to sociological and psychological variables have been reported in the last three decades. It is difficult to enumerate all but a few studies are mentioned here.

The Indianapolis Study (Whelp ton & Kiser, 1946-58), which includes both sociological and psychological variables on fertility. The Princeton study (Westoff, Potter and Sagi, 1961), like the Indianapolis was to identify the sociological and psychological variables, which determine human fertility. Fishbein (1972) proposed a theory of social behaviors, which was considered much useful for the analysis of family planning behavior. Jaccord (1973) has supported the application of this theory (Sarwar G.K. 1985, pp 212-228).

There is another study of similar nature, which shows the contraceptive behavior by Virupaksha Kothadapani in 1971.

"Validation of feeling, belief, and intention to act as components of attitude and their contribution to prediction of contraceptive behavior" (Kothadapani. V.1971, P. 321).

In a study by Crawford (1968), which is based on proposition of Roseburg's affective cognitive consistency theory of attitudes to family planning (1956).

"Adoption of new idea is cognitive and psychological in nature" (Crawford and Rosumburg 1971 P-155).

Jolly has given his view in 1986 for implementing a new program according to the local requirements. He says;

New approach in designing and implementing a new program cannot be effective unless and until local needs and conditions are taken care of the strategy for executing the program (Jolly: 1986: p-44).

Brown and Roger are Describing the diffusion of innovation process as one by which an innovation is communicated through certain channel period among the members of a social system. They concluded that;

Adoption of innovation is the outcome of the learning or communication process. The fundamental step in exploring the diffusion process is identification of factors related to effective information and the characteristics of information flow, information reception, and resistance to adoption. Resistance in the adoption of innovation is due to the degree of innovativeness". Roger also assumes that all people have equal opportunity to adopt and focuses therefore on individual characteristics to explain actual time of adoption. (Roger:1983:33).

Brown in his 'Market and Infrastructure' approach suggests that unlike Roger's view, adoption opportunity in many cases is purposely unequal. This may be due to the potential adopter's lack of knowledge about an innovation, access to innovation, price of innovation, ability to obtain and financial resource etc. Brown emphasized the supply aspect of diffusion and stated that diffusion as a process involves three activities. The initial activity is the establishment of a diffusion agency (or outlets) through which innovation will be distributed to the population at large. To illustrate the important activity on diffusion of innovation, he argues that unless some government, entrepreneurial or non governmental organization makes the innovation available at or near the location of a potential adopter, that person or house will not have chance to adopt in the first place. The activity is the formation of a strategy implemented by each agency to induce adoption in the population in the service area. The third activity is the adoption of the innovation. (Brown. L.A. 1981, P-212).

2.10 Historical Background of Birth Control:

A variety of birth control methods have been used throughout history and across cultures. In ancient Egypt women used dried crocodile dung and honey as vaginal suppositories to prevent pregnancy. One of the earliest mentions of contraceptive vaginal suppositories appears in the Ebers Medical Papyrus, a medical guide written between 1550 and 1500 BC. The guide suggests that a fiber tampon moistened with an herbal mixture of acacia, dates, colocynth, and honey would prevent pregnancy. This mixture can result in the production of lactic acid, which today is recognized as a spermicidal.

Before the introduction of the modern birth control pill, women ate or drank various substances to prevent pregnancy or induce miscarriage. The seeds of Queen Anne's lace, pennyroyal, giant fennel, and many other concoctions of plants and herbs were used as oral contraceptives.

Ancient Turks and Arabs who inserted smooth pebbles into the uterus of a camel to prevent from getting pregnant developed the concept of the IUD. In the 16th century the Italian Anatomist Fallopian (for whom the tubes that carry the eggs from the ovary to the uterus were named) described linen sheaths to be used to protect against syphilis. Condoms made of sheep intestines were created by a physician in the court of King Charles II of England. Casanova is said to have referred to the device as an "English riding coat". It was not until after the vulcanization of rubber in 1844 that the condom was widely used as a birth control device.

The availability of vulcanized rubber was also important to the promotion of the diaphragm as a contraceptive method. A German physician invented the modern diaphragm in 1838. The cervical cap was invented in 1860, but it did not receive the approval of the Food and Drug Administration for use in the United States until the late 1980s, despite its widespread use in Europe.

Margaret Sanger, an American nurse, pioneered the modern birth control movement in the United States. In 1912 she began publishing information about women's reproductive concerns through magazine articles, pamphlets, and several books. In 1914 Sanger was charged with violation of the Comstock Law, federal legislation passed in 1873 prohibiting the mailing of obscene material including information about birth control and contraceptive devices. In defiance of the Comstock Law and despite being jailed for these activities, Sanger continued to publish and disseminate information about birth control. She and her sister Ethel Byrne opened the first of several birth control clinics in America on October 16, 1916, in Brooklyn, New York. Congress revised the Comstock Law in 1936 to exclude birth control information and devices. In 1965, the Supreme Court of United States ruled that married people have the right to practice birth control without government intervention. In 1972, the court held that unmarried people have the same right. (Barnes. A.C. 1997, P. 35).

a. **20th century advancement in birth control:** Great advances were made in birth control with the improvement of intrauterine devices in the 1950s and oral pills in 1960 by the American biologist Gregory Pincus. By the 1990s long lasting hormonal implants and contraceptive injections were developed. Voluntary sterilization, involving vasectomies in men and sterilization / tub-legation in women, emerged as a popular way of permanent birth control. Unwanted pregnancies, however, remained a serious problem in the late 1990s. Researchers still sought more convenient and safer methods of birth control, including a male birth control pill.(Bounds and Newman: 1997; p. 123)

b. **Birth Control in China:** The decrease in fertility recorded between the 1950s and 1990s was largely affected by government efforts to promote late marriages and, more recently, to induce the Chinese family to have only one child. It was officially estimated in 1984 that 70 percent of all married couples of childbearing age were using contraception, and that 24 million couples had formally pledged to have not more than one child.

With the population of more than 1 billion already pressing the limits of its resources, China began to confront the need to control population growth. The state set targets for the

total number of births in each place and then assigned to smaller units, down to individual factories and other workplaces. Young people had to get permission from their work units to get married and then to have a child. Women who became pregnant outside the system face strong pressure from birth-control workers and local party officials to have an abortion. The government promoted one-child families through financial incentives and bureaucratic regulations. In the cities, one-child families became commonplace. In the countryside, families with two or even three children remained common, because families who first gave birth to a girl are usually allowed for a boy. Because of a preference for boys, families that could only have one or two children often would take extreme measures to get a boy, such as aborting female fetuses. This created an unbalanced sex ratio. (World Encyclopedia: 2000; p. 13).

c. **Birth Control in USA:** In the United States women attempted to control child bearing in various ways, including prolonged breast feeding, abstaining from sex, taking herbal remedies, jumping rope, horseback riding, and having abortions. By the early 19th century, condoms, originally intended to prevent the spread of sexually transmitted diseases, were being used to prevent pregnancy. The vulcanization of rubber after 1839 and the invention of latex[10] in world war-I (1914-1918) made condoms, cervical caps, and diaphragms, more widely available. From 19th century newspaper's advertisements, it seems that abortion was a common method of controlling family size.

By the 1870s religious reformers who were worried about prostitution and foresee the spread of vice and sin began to connect contraception and abortion with immorality. The Comstock Law of 1873 declared birth control and abortion information obscene[11] and banned it from the U.S. mail. Many states passed laws against contraception. A small number of reformers spoke out in favor of birth control. The most famous of these advocates was Margaret Sanger, who in 1921 founded the organization that would become Planned Parenthood. Sanger worked to help poor women obtain what was still illegal information on birth control. Planned Parenthood led the fight to have the Comstock Law overturned. The Comstock Law was declared unconstitutional in 1938, although state laws against birth control remained active. In 1965 the Supreme Court of the United States struck down the last of state laws against contraception, asserting that married men and

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[10] The milky juice of some plants e.g. rubber trees
[11] Offending against an accepted standard of morals.

women have a right to privacy. That right was extended to unmarried persons in 1971. In 1973 abortion was legalized in the United States (Donaldson: 1990; p. 55).

d. Birth Control in India: The family planning program was initiated in India in the early 1949 when the family planning association of India was formed. In 1952, a family planning cell was formed in the directorate general of health services. A family planning program research and planning committee was formed in 1953. The central family planning board in September 1956 and the central family planning council in 1965 replaced this. The Indian nursing council in a meeting in November 1957 gave approval of a training program in family planning for nurses and midwives. By the mid 1990, the spread of family planning facilities and the increase in confidence that children would survive to adulthood helped to reduce the preferred family size to just three children: two sons and a daughter. In 2000 the government decided for two children as the limit. (World Encyclopedia: 2000; p-90).

e. Fertility Policy and Family Planning in the Arab Countries: In 11 Arab countries, increased contraceptive use is the outcome of improved socioeconomic conditions as well as stronger program effort. The government policies that promote socioeconomic development, along with the efforts of voluntary family planning programs in twelve countries and national programs in six countries, are likely to help. The effect of various components of socioeconomic development on reproductive behavior can be enormous, irrespective of the fertility policies of governments.

Urbanization, higher education, better health, and longer life are conducive to changes in the family and in aspirations for self and children. As the Arab countries are being rapidly integrated into the international economic and communication systems, people's beliefs, attitudes, and aspirations are undergoing considerable change. Throughout the oil-exporting states, the acquisition of Western consumer goods such as blue jeans, soda pop, radios, televisions, and video recorders is pervasive. They reflect an obvious rise in consumer aspirations, which is likely to be accompanied by a desire for improved socioeconomic status and recognition of the value of modern contraceptive behavior (Muhammad Faour: Sep. -Oct., 1989; pp. 254-263).

f. The Indonesian Family Planning Program-Government Influence and Client Choice: The Indonesian family planning program has brought about massive changes of human behavior. At present local Islamic leaders seem, in most quite favorably disposed

to the family planning program, and many are direct involved in carrying it out. Even with the religious support that it now enjoy family planning would be the most vulnerable of the major national progress because it is the program most closely enmeshed with moral question concern to Muslims. The Indonesian family planning program remained broadly constant since 1972, when the program adopted its present model of implementation, but its details have changed in response to politics, field situations, and criticisms. From the standpoint of program implementation, the most critical lesson is the power created by combining program operations with all levels of government and also with the efforts of private organizations. The program is not so weak that it will not crumble under the impact of slight changes in political support and religious tolerance nor so strong that it is assured of surviving major assaults should they come. As it has been all along, the program is equilibrium of forces dependent on and expressive of its national setting. (Donald P. Warwick: Sep. , 1986; pp. 453-490).

g. State Policies And The Birth Rate In Egypt-From Socialism To Liberalism: Throughout the past half-century, the Egyptian fertility transition has been characterized by discontinuity, with ups and downs corresponding roughly to the successive changes in political regimes since the establishment of the republic. The birth rate began to decline, well before the rates of other Arab countries, in the mid-1950s under a highly centralized political regime. After erratic variation, the birth rate rose sharply under the following regime, which introduced a moderate liberalism while largely retaining state control over redistribution of economic resources through various subsidies. From the mid-1980s, a steep fertility decline began under a third regime, which preserved and further extended the economic liberalism of its predecessor and, in addition, cut back on subsidies to health and other social services. The successive regimes all promulgated a policy to limit births. However, the fact that this policy was accompanied at times by a rising birth rate and at other times by the intended decline demonstrates the limitations of the state's direct efforts to reduce the birth rate.

Another instance of continuity is to be found in the Egyptian state's development of schools and the extension of schooling to girls. The most recent fertility decline parallels the accelerated rise in the level of education of women of reproductive age, which itself is the result of their schooling under the previous regime, some 15 years earlier. All the same, the steady advance in female education contrasts with the irregularity of trends in the birth rate. This indicates that, during the period when progress in female education

remained slow and entailed no noticeable change in women's status within the family or society. Trends in the birth rate can be linked remarkably closely to trends in indicators of average household standard of living. Any notable rise in the latter is accompanied by a rise in the former, while during periods of economic recession birth rates also decline.

Egypt's demographic policy is not new in its current form. It dates back to the socialist regime of the 1950s, which was itself influenced by ideas in fashion among the intellectuals of the first liberal era in the 1930s. What is perhaps novel is the function that policy performs within the context of neo-liberalism. For the socialist regime that formulated demographic policy for the first time, the planning of fertility was just one application among others seeking the centralized direction of the economy and society. For the neo-liberal regime that praises the free interplay of economic and social forces, it is, in contrast, an exception—one of the few areas of social service provision on which the state has not cut back. By catering to the practices of the population, contraceptive service delivery has, in effect, created a relationship of reciprocal dependence between the family and the state. In the meantime, demographics have a role in Egypt's external political relations. The discontinuation of the Ministry of State for Population and Family Welfare by the government formed in January 1996, less than one and a half years after the Cairo conference, and its inclusion in the newly created Ministry of Health and Population, seems to indicate that this short-lived ministry was a creature of international rather than domestic politics, and that Egypt is willing to conform to the "new" policy line and terminology adopted at the conference. (Philippe Fargues: Mar., 1997; pp. 1 15-138).

h. Birth Control through Village Midwives in Malaysia: Most Malaysian officials in health and family planning agree that kampong bidans (village midwives) should be used to promote maternal-child health and family planning in rural communities. Although these women have no formal training, they are active and influential in their communities and their participation in these programs would lessen the burden on the rural health staff that will arise from the integration of family planning services into rural health activities.

There are an estimated 3,000 traditional village midwives or kampong bidans in rural Malaysia. According to a report by the Maternal and Child Health Committee of the National Health Council about 174,000 births or 57 percent of all deliveries in 1964 were under medical supervision, e.g., through government hospitals, health center, nongovernmental nursing homes, and clinics. The remaining 43 percent of all deliveries

were attended by private midwives almost all of whom were kampong bidans. (Peng, Laily, Bakar and Ariffin: 1972; p. 25).

i. **Family Planning and Contraceptive use in Iran, 1967 –1992:** When Iran started an official family planning program in April 1967, the ultimate goal was to reduce annual population growth to 1% within 20 years. Although the program was successful to some extent, that goal was not reached and was clearly unrealistic. By 1977, when the program was at its peak, only 11% of women of reproductive age were being served by it. With the Islamic revolution in 1979, however, the program slowed down and came to a complete halt for about eight years. But in 1989, the alarming results of the 1986 census, which were well publicized in 1988, galvanized[12] the government into creating another family planning program. The program has been growing in political, ideological and economic support ever since.

A number of factors account for the relative success of the new family planning program in the Islamic Republic of Iran, which is demonstrated by increases in contraceptive knowledge and use revealed in surveys conducted since the program began. These factors, related to the family, society and religious ideology, have implications for other Islamic countries. While government contraceptive supplies and services were stalled for several years, demand for family planning undoubtedly rose among individual families during this period, mainly because of the continuous increase in child survival rates during the 1980s. The rate of infant mortality continues to decline and had dropped to 34 infant deaths per 1,000 live births in 1993, according to government reports.(Iranian Ministry of Health and Medical Education: 1993; 29) At the same time, families have been faced with increasing economic pressures caused by Iran's high rates of inflation and unemployment.

At the societal level, the government not only resumed delivery of contraceptive supplies and services, but also intensified its political and financial commitment to the program and its goals.

One of the most important aspects of the program's success is the interest, support and guidance from religious leaders. This support grows from Islam's flexibility in dealing with social issues. Once the issue of population growth was identified as a threat to the

[12] To stimulate and act as the electric current

welfare of the family, the Minister of Health reiterated[13] in 1988, the fatwa issued by the Aya-tollah Khomeini in 1980 to support and revitalize the national family planning program. The reiteration of the fatwa at various times and by various members of government since 1988 has provided a boost for family planning in Iran. The fatwa made population and family planning a concern of all social classes, not just an issue for a select group of urban educated women, as was the case in the past.

The power of Iranian religious leaders to legitimize family planning has significant implications for other Muslim countries dealing with similar population issues. In countries where *Shi'ite* Islam predominates, Ayatollah Khomeini's fatwa can be easily adopted and supported by the religious leadership, as have other political views and issues that the Ayatollah has spoken about. Even though a large number of Islamic countries belong to other sects of Islam, fatwas still play an important role in these countries in forming the views, attitudes and practices of common people.

In Iran, the ongoing support from the highest Islamic authority, the continuing political and financial commitment from the government, and the increasing demand for contraception among families should further the success of the national family planning program? However, the number of Iranian women currently of reproductive age—approximately 12 million in 1991—and a growth in their numbers of 3.4% annually pose a considerable demographic challenge (Iranian Statistical center: 1993; 5). Thus, the goal of the Islamic Republic's second development plan to reduce the annual growth rate to 1.8% in the next five years (roughly 1994-1999) seems very ambitious (Akbar Aghajanian: Jun., 1994; pp. 66-69).

j. Birth Control /Changes in Reproductive Behavior in Bangladesh: Family planning was introduced in the early 1950s in Bangladesh through the voluntary efforts of social workers and health workers. The government, recognizing the urgency of moderating population growth, adopted family planning as a government-sector program in 1965. Today the Bangladesh Ministry of Health and Family Welfare provides family-planning services through a network of more than 3,000 local and regional clinics and about 23,000 female field workers who visit women in their homes (BBS 1994b, 621). In addition, 120 nongovernmental organizations provide services at 324 sites. Condoms and birth-control pills are sold in 130,000 pharmacies and shops (Kalish 1994, 5).

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[13] To repeat again and again

Bangladeshi population policies and programs have evolved through a series of phases and have undergone changes in terms of strategy, structure, content, and goals. The five broad phases are: 1953-1960, private and voluntary clinic-based programs; 1960-1965, family-planning services through limited government health-care facilities; 1965-1975, large-scale, field-based government family-planning programs; 1975-1980, maternal and child health multi-sectoral family-planning programs; and, since 1980, functionally integrated health and family-planning programs with an emphasis on maternal and child health, primary health care, and family planning as a package. The latest approach has been a shift toward a family-planning social movement to raise and sustain awareness and interest in all segments of society about the reduction of fertility as a strategy for sustainable development (Mitra and others 1994, 3).

Numerous factors have contributed to the increase in contraceptive use over the past ten years: strong political commitment to family-planning programs by successive governments; successful promotion of the small-family norm through mass media, educational activities, and other multisectoral programs; establishment of a widespread infrastructure for delivering family planning and health services down to the village level; increased involvement of nongovernmental organizations to supplement and complement the government's efforts; flexibility to make policy and programmatic adjustments in response to emerging needs; and strong support of the program by the international aid community (GB 1994, 36) (Bimal Kanti Paul: Jan., 1997; pp. 100-104)

k. **A Qualitative Study Of Clandestine Contraceptive Use In Urban Mali:** This study shows that women who use contraceptives secretly require specifically tailored programs for sensitive support of their family planning efforts. The ideal solution would be eliminate the male opposition to family planning in order that women would not have to resort to clandestine use. Both covert and overt users in this study felt that if service providers could educate men and provide them with accurate information, male acceptance of family planning would be increased and the need for clandestine use reduced.

If local religious leaders authenticated relevant Islamic tenets through the local media, many men (and women) would be reassured that family planning is not prohibited by Islam, and contraceptive use probably would become more widely accepted. In light of the continuing resistance of some men despite these and other efforts, however, family plan-

ning programs should support women's clandestine use, if necessary. Those who use in secret have a particularly delicate problem, because if their husbands disapprove, then it really isn't good.

Providers, therefore, need to find out whether a woman's husband is aware of her use and to emphasize to secret users that they guarantee absolute confidentiality. For clandestine users, health practitioners must make clear to the woman that these individuals will not be contacted and that they assure complete secrecy. Integrating maternal and child health-care services with family planning services can facilitate clandestine use, so that the purpose of a woman's visit to the clinic can be masked.

The study shows that family planning is not simply a resource to improve maternal and child health. It is also a valuable tool that frees women from the constraints of childbearing and childcare and may enable them to improve their economic and social status. Clandestine users, by their very nature, are likely to live in the most traditional family settings where they stand at the bottom of the social hierarchy. Contraceptive use appears to endow them with a degree of autonomy. Therefore, although clandestine use is obviously not desirable, in societies where the fertility transition and associated improvements in women's status are just beginning, it is often a necessary means to an end when open communication between spouses is deemed impossible or unsuccessful. (Sarah C., Mamadou K. K., Priscilla R. Ulin and Sarah M; SFP: 30:3: Sep. , 1999; pp. 231-248).

I. Islamic Precepts and Family Planning in Jordan: (The Perceptions of Jordanian Religious Leaders and Their Constituents): The interpretations of the *Shari'a,* or Islamic law, set forth in this study reflect those of the respondents, all of whom are Sunni Muslims and most of whom abide by the *Hanifiya* or *Shafiya* schools of thought in their exegesis of Islamic law. With respect to contraception, Muslim scholars universally accept the legitimacy of a *hadith* in which the Prophet, when asked, noted that: withdrawal is permitted, for "if God wanted to create something, no one could avert it."(Ahmed L.: 1992;12). By analogy, this has been interpreted to imply that all non-permanent methods are in keeping with Islam. Furthermore, a number of *Qur'anic* verses emphasize the notion that: "God does not wish to burden believers, with the implication that the quality of children overrides concerns about quantity. Additionally, marriage is portrayed in the Qur'an as a source of companionship and mutual protection, rather than as primarily for procreation" (Sura 30:21). [Ali AY:1993;22].

The study shows that four of five Jordanians religious leaders and the general public alike believe that family planning is consonant with Islam. The religious leaders in Jordan permit temporary or reversible measures and do not permit permanent or irreversible ones except extreme cases. The moral acceptability of family planning in Jordan is further demonstrated by how routinely family planning is discussed among family, friends and peers. Nearly nine of 10 religious leaders reported that they had discussed family planning with their congregants or their peers, and 36% noted that they had spoken in public about it within the past year.

The findings reported here confirm that the ideational atmosphere in Jordan is favorable toward family planning. Yet, knowledge about modern contraceptive methods is insufficient among the religious and lay populations alike in Jordan, Specific information about modern methods needs to be more widely disseminated if steady, measurable gains are to be made in contraceptive prevalence.

In sum, the findings reported here contradict the notion that Muslim religious leaders are more resistant to family planning than is the broader community in which they live. As Islamic texts are widely interpreted to support family planning, it has been traditional ways of life—rather than religious tenets—around which barriers to contraceptive use have been constructed. In particular, the notion that family planning contradicts the Islamic way of life has been widespread. This belief and other barriers, however, have been considerably reduced. Religious leaders, as scholars of religious texts, are particularly well positioned to separate tradition from religion—a role they have played very successfully in Jordan. Such religious leaders will continue to provide ethical guidance to their communities as together they confront the changes that scientific and technological innovations bring. It is vital to develop a full understanding of the interpretations that religious leaders share with their congregants regarding innovations, as the tenor and text of their communication may well influence the place of family planning within the community. (Carol Underwood: IFPP: 26: 3: Sep. , 2000; pp. 110-I17 +136).

m. Birth Control in Pakistan: The family planning program was started in Pakistan in 1950, when Pakistan Family Planning association was formed. The Govt. of Pakistan took initiative in 1955 and declared Family Planning a National Program. In 1960 it was under the ministry of Health and then with Women development. In 1990 the Village Based Family Planning and Lady Health Worker as well as Family Planning and primary Health Care and Mother-Child Health care programmes were initiated. The Ministry of

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Population Welfare was established and now on Federal as well as on Provincial levels the family planning program has made appreciable progress. During 2004 there were 1957 family welfare centers, 108 Reproductive Health Service centers, 146 Mobile Service Unites, 1336 Male Village Based Family Planning Workers and 24560 Registered Medical Practitioners in Pakistan. The fertility rate is 4.1, Population Growth Rate is 1.9% and Contraceptive Prevalence Rate is 34% during 2004 in Pakistan. (Hakim, NIPS: 2004; p-4)

2.11 Factors of Population Growth and Constraints to Family Planning

2.11.1 Economic Constraints to Family Planning:

a. Male Children an Economic Asset: There are various views of different scholars regarding male children as an economic asset for the parents and family. Davis has stated; "In familistic societies reproduction is considered a way to attain almost all goals in the life". (Davis: 1981: 561)

This could be further explained through Boserup study on "economic utility of children in Africa". According to him large family is an economic advantage, a provider of social security and of prestige in the local community. He mentioned;

"A large share of agricultural work was and is done by children. Even very young ones perform numerous tasks in rural areas. A man with many children can have his land cleared for long fallow cultivation he needs not to pay for hired labor or fear for lack of support in old age".(Boserup: 1981: 180)

Another study conducted by Daniel C. Clay and Jane. E. V in Rwanda. This study shows that high fertility behavior has strong relationship with economic value of children as: "Parents in this society maintain a high level of child bearing in order to improve their own social and economic well being. In Rwanda, where wealth flows in the direction of parents, where a formal system of social security is almost non-existent and where upward mobility is very restricted, bearing more children is a sensible strategy for survival". (Jane. E.V: 1993: 71)

Ramu has mentioned;

"The preference for small families is the consequent reduction on the value of children and increase in the cost to their parents. A reason of fertility decline exists most drastically, among the new professional and business class, due to the decreased value and increased

cost of children. The shift of productive function from household to the market reduced the economic value of children" (G.N. Ramu: 1988: 56).

b. Poverty and Desire of Maximum Male Children a reason of Large Family: Many scientists argue that poverty and desire of maximum children a reason of large family size. As Judith Blake (1972) contends that her data show that the poor desire large families than the non-poor. She says;

"Those in the lowest economic status group desire large family. This is so because children are regarded as economic assets and security in old age, even though it will mean more mouths to be fed". (Black; 1972:21)

Arthur McCormack supports this view in these words;

"Children are regarded as economic assets both in their adolescence, when they contribute their labor to the family's upkeep and in adulthood when they support their aged parents" (McCormack; 1970: 169).

Reele (1969) found in various studies in Asia that security in old age was one of the advantages of having a large family. He further stated;

"Although the well being of the children and the security of the parents in later years tended to exert opposing pressures on family size ideals, large families were viewed as economic investment for the future particularly in the rural low-income population". (Reele; 1969: 24)

This view was further supported by Mathew (1975) study in which he pointed out, on the basis of analysis of 173 surveys in family planning carried out in different states of India, during 20 years period (1950-1970) that the major reasons for large family norm were evaluation of children as the source of family strength, economic support, and security in the old age. He concluded that,

"The threat of insecurity in old age may be an important factor which dampens the enthusiasm of many couples for accepting family planning". (Mathew; 1975: 112)

Dr. Haq (1980) maintains that a couple may feel economically insecure if limits the family size. He stated that;

"Feeling of security is due to large family". (Haq; 1980:33)

c. Economic Advantages of Sons: Various scholars have extended their views on economic advantages of sons.

Arens and J.V. Beurden report that son preference exists in Bangladesh purely because of economic value of sons, they find that;

"Within the marriage a man expects from his wife to bear him male children, as a source of income" (Arens and Beurden. 1977:35).

Mahmood Mamdani in rural India (case studies, in Manupur village), describes that;

"Strong desire for sons exist since sons ensure economic and old age security. They are also considered a source of physical security. Daughters, on the other hand, are not regarded permanent earners for they are expected to leave after marriage along with dowry (Mamdani, 1979:109-143).

Barbara D. Miller, analyses "advantages and liabilities of sons versus daughters" indicates that these "advantages" and "liabilities" are considered to be factors behind sons' preference and daughter disfavors. She viewed;

"Son essential to inherit family name and property, for economic security and performance of ancestral rites, as well as financial benefit in terms of bringing wives, whereas daughters are considered impermanent members of the family and more expensive to marry off". (Miller. 1981:19-28)

There are many researchers who have found daughters more costly than son and thus "troublesome" for parents (Kuppuswamy, 1986:152; Varma. 1992:32; Wakil. 1991:63).

Dube hold the same idea. He defines son as an "asset" and daughter as a "liability", in the Indian village. This is because son "belongs' to his parents while daughter is expected to leave for her husband's family. He explains;

"In a large family having many sons, a girl is definitely desired and welcomed. A family having too many daughters and no son is unhappy, for a son is both a psychological and ritual necessity" (Dube. 1967:148)

A large family with many sons is highly valued in most of the villages. Thomas and Shirley Poffenberger also found that importance of sons might increase average Indian family size. They summarized that;

"It might get hard for parents to afford many children but they look forward to their sons who are expected to support them in future" (Pofferbeger. 1973:135-148).

Kondana Rao also describes importance of male child in Jalari families in South India. He found that the Jalaris are willing to have sons since patrilineage descent attaches "social position" with sons. The "social position" is expected to direct economic, political and

social life of parents. Since Jalaris believe that birth of a male child is "auspicious", they desire it greatly. Rao defines;

"Besides ensuring continuity and stability of the family, it also gives a sense of security, and therefore, any numbers of sons are welcomed to Jalari family" (Rao, 1990:38).

Gittins, Arens and Beurden have mentioned the Engle's concept of "private property" seems important in contributing towards desire for sons. Engle argued that:

"Children were wanted as heir of property. Since male members were considered property-holders, producing a male heir became necessity for passing on one's possessions" (Gittins. 1985:p. 94; Arens and Beurden. 1977:p. 3)

Rukhnuddin and Ali argue that Pakistan, like other Asian societies, displays strong desire for sons. This is because of the socio-economic and cultural value attached to sons. They mentioned:

"In the rural areas, specifically, sons are valued as farm laborers, for old age security and for advancing family lineage" (Rukhanuddin and Ali, 1992:p. 101)

S. P. Wakil defines "profound and intense desire" for sons in Pakistan. He indicates that;

"In a patrilineal society only the male child he keeps carries family name as well as the family property. At the same time in agricultural society, male children are considered helping hand in cultivation and thus "producers" for the family, unlike daughters who are said to be only "consumers". This situation leads towards preference for a male child, and may increase family size" (Wakil, 1991:pp 62-63).

The same idea has been hold by M. Iqbal Chudhry. He finds that;

"Urge for a male child is stronger in Pakistani society, which contributes towards large families. Parents, he says, in hope of having at least one son may have large number of children" (Chudhry: 1980:p. 289).

Tauseef Ahmad also explains desire for sons in Pakistan since they are considered necessary for perpetuation of lineage. He finds that:

"Preference for male child, emerges as strong factor in case of all female births or due to the loss of son" (Ahmad. 1992:p. 45)

Abdul Razzaque and Naseem Farooqui explain that;

"In Pakistani society daughters are perceived as an "economic burden", while sons are considered 'economic asset', since they ensure economic security" (Razzaque and Farooqui, 1988:268).

Zekiya Eglar describes importance of son in a Punjabi Village. She finds;

"Son necessary to 'continue the ancestral line, inherit the land, follow the father's craft, and maintain the tradition of the family". (Eglar, 1964:p. 101)

e. **Financial Constraints in FP:** UNFPA has estimated total spending on family planning and population activities in the developing countries up to $ 9 billion per year. The developing countries themselves would raise more than half of this sum, with the international community having to provide about $ 4 billion. (UNFPA: 2005:p. 5)

f. **Family Planning Program-An Economic Approach:** In order to improve and get success in family planning program, Ismail Sirageldin and Samuel Hopkins have outlined a system of providing family planning incentives and related services. Incentives are given to enhance acceptance rates and continuation rates. There are both direct and in-direct incentives for this purpose. The direct incentives are monetary payments to eligible women (married, under age 40, with one or more children) for as long as they avoid having births. Direct incentives also include free or subsidized family planning and MCH services for a limited time period. The indirect incentives are payments to medical personnel of a portion of the prices they charge for providing services. The prices charged are also indirect incentives to the clients to value the services and thereby show high continuation rates.(Ismail Sirageldin and Samuel Hopkins: Feb., 1972; pp. 17-24).

2.11.2. Religious Constraints to Family Planning:

a. **Religion a Source of Population Growth:** In addition to economic security another important factor, which proves to be a hindrance in family planning, is the religious belief. With regard to population restrictions in the developing countries, religious attitude and their effect on population policies are important.

McCormack (1970) says; "Children are regarded as a blessing in the natural order and gifts of God. As far as the Muslim faith is concerned; it is Allah who creates sexuality and determines procreation and barrenness and the number of souls is predestined'. Therefore, the question of deliberately restricting off spring seems to go against the will of Allah, and to plan the number of children seems an impious distrust of dividing providence. The Hindu teachings on the whole in spite of their world-renouncing character, lay great stress on the family and caste, and the begetting of sons is regarded as a religious duty. The Hindus had therefore, strong pro-nationalism and opposed restrictions of fertility". (McCormack: 1970:pp. 156-158)

It was found in a sample survey in Andhra Pradesh, India, conducted by S. Balakrishna (1971) that: "The most important reason given for unfavorable attitude is that family

planning is unnatural, sinful and against the will of God. The women who bear the brunt of child bearing and child rearing were more opposed to family planning than their husbands on moral grounds". (Balakrishna: 1971; p. 67)

Ritzer,Kammeyer and Yetman argue that; "The Catholic Church, through its doctrine pronouncements, makes it clear that the purpose of marriage, and sex within marriage, is primarily for procreation". (Ritzer, Kammeyer and Yetman; 1987:p. 487)

The general themes found in most religions are certainly supportive of child bearing. Nevertheless, there is sufficient flexibility in these faiths for modern reformers within these religions to put forward the case of scientific methods of family planning.

Gorn Ohlin contends; "The values and institutions of Muslim culture undoubtedly support high fertility quite strongly, although there is not theological condemnation of birth control as such". (Ohlin; 1967: p. 77)

Smith stated that the general view is that; "The Muslim religion strictly forbids family planning and the Muslims look on birth control as an interference with God's will". (Smith; 1973: 53)

Family Planning Supportive Views:

Dr. Sharabassy says; "All the laws or beliefs, concerning family planning with regard to Islam depends on the interpretation of the Islamic concepts." He further says, "Individual discretion or interpretation, should aim at securing what is of benefit and winding off what is of harm, without however, overstepping the limits set by the principles or sources of Islamic law. One of the established rule is that harm is to be removed, and that where good lies, there lies the law of God". He farther says, "Family Planning is not opposed to marriage or to the begetting of children, nor does its concept imply disbelief in the doctrine of fate and divine dispensation, for God Almighty had bestowed reason upon man to enable him to distinguish between the useful and the harmful, and to help him follow the path that would assure him happiness in this world as well as in the world to come. God did not intend that we should be made unhappy by following his religion, but that we should find happiness by it".(Dr. Sharabassy :1974:p. 55)

Omran, Abdul Rehman (1992) has supported his idea while quoting; The Holy Quran says, "God desireth not to lay a burden upon you, but he desireth to purify you, and He

would fill up the measure of His favor upon you, that you may be grateful". (Al-Quran; 5-6)

According to M. Iqbal Chaudhry (1980); "Misinterpretation of religious values pertaining to reproduction and attitudes towards the new population among the Muslims have stimulated the birth rate" (Chaudhry; 1980: p. 56)

According to Haji Nasruddin Latif; "Islam does not limit the number of children a family ought to have; the underlying reason for not fixing the maximum number of children is that this is closely linked with the exercise of human will in the family. Islam and Islamic laws whose objects are man's interest and well being in this world here as well as in the hereafter, seek to give the parents freedom of choice as to the number of children they can tend and raise, depending on their ability and capacity. (Latif; 1974:p. 30)

According to Zahurul Haq (1958); Islam is a rational religion. In all matters it adopts the middle course. In matters of procreation also there seems to be no objection in Islam to adopt the middle course without going into the extremes of unrestricted multiplication of children. (Haq; 1958:p. 33)

Sheikh Mohammad Mahdi Shamsuddin further supports this view as; "Islam is greatly concerned with producing generations of people who are sound and fit both physically and physiologically, for it is obvious that the ill-qualified in this respect and the maladjusted children are a burden to the state and a danger to society. It is natural that our efforts to produce healthy generation should start with the choice of husband and wife", (Shamsuddin; 1974: p. 61)

According to Sheikh Ali Jadel Haq in 1991; "There is no text in the Quran prohibiting prevention of pregnancy or diminution of the number of children. But there are several traditions of the Prophet (PBUH) that indicate its permissibility. Pregnancy prevention is not killing or contradictory to provision or reliance on Allah. Modern methods are by analogy, permissible". (Jadel Haq; 1991: p. 8)

In a report by Ministry of Health, Labour and Social Welfare, Government of Pakistan (1965-1970) it is written that; "At no point does the Holy Quran raise any objection to the family planning practice. There are specific statements in the Hadith that birth control used to be practiced during the Holy Prophet's lifetime. The Holy Prophet knew of this but, neither the Quran nor Holy Prophet raised any specific objections to it". (Ministry of Health Report; 1965-70:p. 34)

It was concluded in an International Islamic Conference, held in Morocco (1971) on 'Islam and Family Planning", that; "The Islamic law allows the Muslims family to be able to look after itself as regards the procreation of children, whether this is in the sense of having many or few of them. It also gives it the right to deal with sterility and to arrange suitably spaced out pregnancies, and to have recourse, when needed to safe and lawful medical means". (International Islamic Conference; 1971:p. 486)

Similarly in National Conference on "Islam and Child Spacing" held in Somalia, 1990 it was assured that; "There is no contradiction between the Islamic Shariah and Child Spacing as decreed by Muslim Jurists and on the account of its benefits to the health and welfare of the mother and child. Such is within the sphere of planning, which is one of the basic principles of Islam in matter of religion and daily life". (National Conference, Somalia; 1991:p. 224)

b. Fatalism and Family Planning: Different scholars have extended their views regarding fatalism and family planning.

Bogue (1973) is of the opinion that: "Family planning programs are not very much successful in the developing countries. One of the reasons which is most oftenly been stated for this failure according to him, is the belief of the people that the child bearing activity is beyond their control. Such people also believe that "fate determines everything and God determines how many children you have". (Bogue; 1973:p. 45)

Keller (1970) stated that: "This type of belief is called "Fatalism", and assume that such type of beliefs are very common in the developing countries like India, Pakistan, Bangladesh, Nigeria, Sudan, Egypt and Brazil. The belief of fatalism is very much popular in almost all the Muslim world. (Keller; 1970:P. 41)

According to Hamady (1959); "Teaching about determinism predominates in the Holy Quran. In fact contents of the Holy Quran explicitly explain that Allah created living organism and particularly human beings in various compartments. All the events in the lives of human beings and other creatures have been pre-arranged in the Divine Books. It is a firm belief of Muslims that Allah predetermines the happenings, which come in the lives of every person. Man can do nothing to modify or influence his future. Predestination makes people skeptical about controlling the coming events. The concept of predetermination becomes an excuse for him to shift his responsibility to external sources. In Muslim society people live at poverty level with bad health and ignorance concerning religion in particular. In contrast to above belief system, the social status of a person is usually determined by his family social hierarchy status and not merit. This kind of belief

may have adverse effect on his own aptitude, achievement and creativity and in turn he may be unable to utilize his abilities. The easiest attitude for him is that he leaves everything to God and does nothing". (Hamady; 1959: p. 23)

According to Ammar (1960); "Fatalism is still prevailing in Muslim communities. People believe in prescribed destiny and under-estimate their power to change their fate. He stated that orthodox Muslim scholars by means of persuasive communication attempted to develop positive attitude towards fatalism. Progressive thinkers have challenged this doctrine but the religious leaders are silent on this controversial issue. (Ammar; 1960: p. 23).

Massages of Change and Struggle: In fact, there are other explanations about fatalism in Islamic literature, which has not been recognized by many Muslim Scholars.

According to Quranic injunction (AlQuran: 53-39): "That man can have nothing but what he strives".

It has explicitly been explained that human beings are given numerous faculties. They are required to make the best use of their talents and capabilities so that they may be able to live in a decent way. The concept of struggle and strife for human beings has further been strengthened through another verse from the Holy Quran (Quran; 13-11): "Verily never will Allah change the condition of a people until they change themselves with their own souls".

Majority of the Muslims hold the belief of "fatalism" and ignored the teachings, which stimulates and encourage human beings for action and efforts for a better change.

Feeling of efficacy has been used to explain one's future. Keller (1989), argues that: "The 'feeling of efficacy' is the 'inner conviction that one is able to control one's own destiny', this principle explains that some people develop a belief that they themselves can control their fate by means of their own efforts. On the other hand, many people feel themselves that they are helpless to control their plans, which is due to lack of feelings of efficacy and they believe that their life is controlled by external circumstances". (Keller; 1989: p. 33)

c. Family Planning in Islamic Perspective: Islam is a complete code of life. In the Holy Quran there are numerous verses where clues are given to the wise. The Muslim world wants to solve this problem in the guidance of the Holy Quran, Sunnah and the followers of the Holy Prophet (SAW). And the Islamic scholars have studied this problem deeply and intelligently; they had written scholastic reviews and also had given verdict openly. This fact is very interesting and queer that in the early days of human civilization

when the population explosion was not a problem at all, Islam has given injunction clearly about family planning, and the interval between two conceptions (pregnancies). The traditional method of family planning (withdrawal) was practicing at the time of Prophet (SAW).

Muslims scholars have held numerous seminars and wrote many books on this issue, one of the books is written by an Egyptian scholar Dr. Abdur Rahim Imran, which elucidates all those steps concerning family planning right from the withdrawal, a source of population reduction, to the modern techniques in modern times. He stressed that in order to reduce the family burden Islam fully authorized us to practice withdrawal. In many Islamic countries such as Bangladesh, Iran, Indonesia, Malaysia, Turkey and Egypt the religious scholars have tried their level best to persuade the people to practice family planning and they have issued orders about its legality.

FATWA (A Decision Taken by Muslim Religious Scholars):

FATWA: Imam Shaffi has discussed very scholarly the problem of family planning and about the numbers of wives. He has related the two very skillfully. In order to support his judgment he has referred to the following verses of surt Nisaa; "If you fear that you can not treat orphans with fairness, then you may marry such women as seem good to you two, three or four of them. But if you fear that you cannot do justice, marry one only or those you possess. This will make it easier for you to avoid injustice".(AlQuran; 4-2).

FATWA: The Renowned Scholar Qazi Abubakar Jasas has quoted from Ibne Umer; that doing of withdrawal depends on people's consent, Abu Hanifa has quoted from Ibne Abbas who said; "In our opinion withdrawal *is only for maid,* wife must be consulted in the matter of withdrawal"(Muslim). (MOPW: Khanadana Mansooba Bandi Islam Ki Nazar Ma: p. 1).

FATWA: Shah Abdul Aziz Son of Shah Wali Ullah; "Withdrawal is allowed by Islam because it is proved from the sayings of the Prophet (SAW), so for that reason all those medicine and methods of family planning are, too, legal in the same manner".(1889-2). (MOPW: Khanadana Mansooba Bandi Islam Ki Nazar Ma: p. 2).

FATWA: Allama Muhammad Khalid; an eminent Egyptian scholar has authored a book: 'Mun Hina Banda'. This book was widely read in Egypt. In this book he has given his crystal clear view regarding family planning. Here the version of his verdict about family planning is reproduced; "We should keep in mind that if the rate of reproduction is

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greater than economic growth is definitely not a positive phenomenon. Unfortunately, none could rightly estimate the gravity of the problem is an impossible hurdle in the way of progress and prosperity; the staggering increase in reproduction is due to misinterpretation of religion, fate and blind faith. Hence we feel compelled to reveal the Islamic verdict about family planning. We assert that Islam allows family planning for betterment and uplift of individual and society". (MOPW: Khanadana Mansooba Bandi Islam Ki Nazar Ma: p. 5).

FATWA: Sheikh Abdul Majeed Salim: Here the version of his Fatwa that he issued on 12 Ziqada, 1355 A.H. is presented below:

Question: What is your opinion and views about the following problem?

"A man having one son fears that more than one child will be difficult to bring up properly; that his health would be affected; and that he may be able to discharge his obligations and responsibilities appropriately. Besides, he fears that deliveries in succession may ruin his wife's health". Is he allowed to consult doctor's help to wax the interval between deliveries so that his wife may have time, relax, and he is comparably free from undesirable strain of social, physical and economic burden?

Answer: We studied this problem closely and intensively, our define view is that according to *Hanafee* scholars those measures are permissible which are mentioned in questions; such as withdrawal, condoms and diaphragms. These prevent the sperm from entering into womb. From Islamic point of view a husband cannot practice withdrawal without his wife's permission, and wife without her husband's permission cannot use diaphragm or contraception. To sum up, a husband and a wife are allowed to employ contraception with mutual permission! However, near later *Hanafee* scholars a wife or husband may practice contraception without mutual permission provided the above difficulties were prevailing. Besides, Islam disapproves rather condemns increase in children while they are grinding in the perpetual mills of poverty and starvation. Withdrawal was the only way of contraception in those days. He allowed withdrawal, rope and horseback riding. One day Hazrat Ali (RA), Hazrat Saeed (RA) and some of the followers of Prophet Muhammad (SAW) were sitting with Hazrat Omar (RA), when discussion turned on withdrawal, Hazrat Omar (RA) declared that there is nothing bad in its practice. So, if Islam permits withdrawal, other methods of contraception should also be permissible, because withdrawal was aimed the prevention of sperms from entering into womb where a fetus is conceived. (MOPW: Khanadana Mansooba Bandi Islam Ki Nazar Ma:p. 6).

FATWA: Shiekh Attaullah Haki Baha-ud-Din Mahlathy of Iran:

"Keeping in view the injunctions and decrees of God, practicing the contraceptives temporarily is not illegal in Islam provided it does not affect the fertility of the woman and the woman may not become sterile for ever". (MOPW: Khanadani Mansooba Bandi Islam Ki Nazar Ma: p. 7).

FATWA: Advisory Council for Religious Affair of Turkey:

"Though withdrawal is a method of contraception, which has been regarded unwanted by some Sahaba and favored by other Ulema (Religious Scholar/Leader). Therefore, it is essential to consult the wife before hand, still in emergency and unfavorable conditions (like famine, war, and revolt there is no need to consult the wife even)".(MOPW: Khanadana Mansooba Bandi Islam Ki Nazar Ma: p. 8).

FATWA: Haji Abdul Jalil Bin Haji Hassan Mufthy Jahoor Malasia:

"Any medicine or method relating contraception for family planning is legal in Islam provided that it may not damage the women's fertility power because Islam does not allow any person to do so, yes, if the two registered doctors give their expert opinion after diagnosing the woman that fertility and conception will harm her health or may cause her death". (MOPW: Khanadana Mansooba Bandi Islam Ki Nazar Ma:p. 9)

FATWA: Al-Azhar University Cairo (Egypt): "Temporarily the use of contraceptive is legal in Islam because it is a source of happiness for the people and it keeps away people's worries, God Himself likes that his creature may lead a prosperous life". (Khanadana Mansooba Bandi Islam Ki Nazar Ma:9)

FATWA ALAMGIRI: One of the most important Islamic documents regarding family planning was the Al Fatwah, Al Hindiyya (Published in Egyptian Bulaq in 1970), Generally known as Fatwah Alamgiri. It was the joint effort of five hundred jurists of Islam: "There is no disapprobation in "AZI" with consent of the fare women to abort the child so long as no part of him has been formed and this does not take place before 120 days, that in the pregnancy not having complete 120 days. The term AZI includes the use of medicines for birth control purpose"(Al Fatawa, Al Hindiyya: Bulaq; 1970) (Khanadana Mansooba Bandi Islam Ki Nazar Ma:9)

FATWA Allama Shakh Mehmood Shaltoot Ex Shakh Alazher: "Quran has fixed two years for mother to feed her child; Prophet (SAW) has stoped the pragnent women to feed a child. On the basis of these orders during feeding a child women should stop

conception". (Alfatawa-i-Alazher-1389). (Khanadana Mansooba Bandi Islam Ki Nazar Ma:9)

Professor Rafi Ullah Shahab: According to him, "It is unfortunate that they (Ulema against family Planning) have not bothered to study the teachings of Islam on this issue because family planning is one of the issues on which jurists and scholars of all the Muslims sects totally agree. It is an accepted principle of Islamic Jurisprudence that what has not been forbidden is allowed. This principle has been endorsed by the Shariat appellant court in Pakistan. Birth Control has both been forbidden in Holy Quran or by the Holy Prophet (SAW). Therefore, there is no religious or legal basis for condemning family planning of course there is juristic opposition to birth control. (Zeb; 1997: pp 10-22)

The Interval between Two Conceptions: There is a verse in the Holy Quran, "Mothers shall give suck to their children for two whole years" Al-Bakara (V-233). "Allah desireth for your ease, He desireth not hardship for you". God desireth not to lay a burden upon you but he desireth to purify you and he would fill up the measure of his favor upon you, that you may be grateful (AlQuran 5-6).

The Prophet (PBUH) has warned the women who got conception during feeding period of a child. (Zeb; 1997:29)

Ahadis (Sayings of Prophet Mohammad 'SAW') related to Family Planning: A book entitled' "Al-Hadis" has written by Al-Haj Mulana Fazl-ul-Karim, in section 14- "Birth Control" has given Ahadis. Similarly Mulana Rafi-Ullah in his Article on "Birth control in the light of Islamic Jurisprudence" on page-47 in "Ummah" a Journal of The Central Institute of Islamic Research has given Ahadis and FATWAS related to Family Planning.

1. **Jaber reported:** We used to do "Azal" in the period when the Quran was being revealed. Agreed upon it, Muslim added: This reached the Messenger of Allah, but he did not prohibit us. 1355: Sahih Bukhari; 5208, Sahih Muslim; 1440.(Mulana Fazal Karim: p-636 and Mulan Rafullah: p-47)
2. **Jaber reported:** A man came to Prophet (SAW) and said: I have got a girl who is our slave and I am having sexual intercourse with her. I dislike that she should conceive. He said: Withdraw your penis from her if you like, but He will bring soon what has been decreed for her. The man stayed away for some time, and then came to him and said: Verify the girl has conceived. He said: I have indeed informed you that He would bring to her soon what was decreed for her. Muslim. (Mulana Fazal Karim: p-637 and Mulana Rafiullah p- 47)

3. **Abu Sayeed Al Kudri reported:** We came out to the Prophet in the battle of Banu Mustaliq. We acquired captive girls out of the girls of the beduin Arabs. We were eager for women, and our long absence (from home) became important to us. We loved "Azal" and so we wished to do Azal. We said before we asked him about it. He said: There is no sin on you if you do it or not. Allah has already pre-ordained all that is to be born up till the Day of Judgment". Related in Sahih Bukhari and Sahih Muslim. (Mulana Fazal Karim: p-637 and Mulana Rafiullah p- 47)

4. **Same reported:** Prophet (SAW) was asked about Azal. He said: It is not from every water that a child is born; and when Allah wishes to create a thing, nothing can prevent Him. Muslim. (Mulana Fazal Karim: p-638 and Mulana Rafiullah p- 47)

5. **Umar bin Al- Khattab reported:** The Prophet (SAW) has forbidden onanism with a free woman (not slave) without her permission. (Related in Musnad Imam Ahmad bin Hanbal and Sunan Ibn Majah, Mulana Fazal Karim: p-639 & Mulana Rafiullah p- 49).

6. **Judamah daughter of Wahab, reported:** I was present before the Prophet (who was) among men and he was saying: I wished to prohibit you from Ghailah-cohibition. Then I turned my attention towards Greeks and Persians who were then doing Ghaila-intercourse during the sucking period of children and that did not do their children any harm. Then they asked him about "Azal", The Massenger of Allah said: That is the secret burying alive of children. And that is: when those who were buried alive will be asked for what sin they have been killed (Muslim: 81; 910Q)

7. **Asma' a –bn-Yezid reported:** I heard the Prophet (SAW) said: Don't kill your children secretly, because Ghaila intercourse will overtake a horse and stumble him down from his horse. (Abu Daud: 1359)

8. **Sa'ad-b-Abi Waqas reported:** A man came to the prophet (SAW) and said: I practice "Azal" with my wife. The Prophet (SAW) asked him: Why do you do that? The man replied: I fear for her childbirth. The Messenger of Allah said: Were it to cause injuries, it would have injured the Persians and the Greeks.(Muslim) (Reference Hadith No. 1-8-Nail al-wtar, vol. VI, pp 208-209, published by the Mustafa al-Babi al-Hlabi press 1961).

Birth Control and Aimma-i-Mujtahidin: The four leading Imams of Islamic Jurisprudence agree that onanism is allowed in Islam, subject to the permission of the wife. Sha'ami which is the most authoritative work on the Hanafi School of Islamic Jurisprudence lays down that birth control is permissible in Islam without the permission of wife if there is the risk of the resulting issue adopting bad character due to bad social

influences. A commentary on the Sha'ami says "In case of free and half-free women, onanism is allowed with their permission. But according to Fatawa-e-Khaniya, even this permission is not necessary if there is any risk of the resulting issue to be of bad character. Imam-al-kamal ibn-e-Humam says that the condition of obtaining permission from free and half free woman has been annulled due to provision of this exception. (Mulana Rafiullah p- 49)

By these clarifications the Aimma have plainly express their views in favor of birth control for whatever reason and this sanction extend not only to onanism but also to all other methods of birth control. For instance the sealing of the womb has also been permitted by the jurists. Allama Ibn-e-Abideen says in the concluding remarks of his discussion on the birth control, "from this discussion as well as from Fatawa-e-Khaniya and Allama Ibn-e-Humam's observation, it appears that the womb may be sealed, as a measure of birth control journal practice among women. As apparently this is similar to onanism in effect let us guess that this should not be legal without permission of the man. The Fatawa-e-Bazazia says that; a man can restrain his woman from birth control. But, if there is risk of the resulting issue adopting bad character due to bad social atmosphere, both man and woman can resort to birth control." (Mulana Rafiullah p- 51)

"Allama Ibn-e-Humam writes that; abortion is legal so long as the limbs are not formed. He further says, that limbs are formed in 120 days." (Mulana Rafiullah p- 51)

The Ulemas of Deoband: Maulana Rashid Ahmad Sahib Gangohi in connection with Fitwa No. 637, says, abortion is legal before the soul enter the child in the womb, but after that it is haram.

Mufti Muhammad Shafi sahib has also issued a fatwa on these lines in reply to question No. 64199 and he has based his arguments on Sha'ami which has been quoted earlier-- (Fatwa-i-Dar-ul-Ulum Deoband, Vol III & IV, p. 97).

From Deoband, Mufti Aziz-ur Rahman has issued the following fatwa:

Question No. 7|1048: "If a divorced woman, whose iddat (days of waiting) would complete with giving birth to the child in her womb, takes medicine (before the completion of the 'iddat') to cause abortion, would her iddat be considered complete with such action?".

Answer: "If the divorced pregnant woman causes abortion by intentionally taking medicine to that effect or by using any other method, her iddat becomes complete with the

event provided that some limbs of the child in the womb had been formed"- (Aziz ul Fatawa, pp. 29-30).

Another fatwa of Mufti Aziz ur Rahman which appears on page 208, Vol. VII-VIII of the Fatawa-e-Dar ul Ulum Deoband in reply to question No. 1599|295, say that; as long as the limbs are not formed in the womb, the child is not to he consider a human life. The Mufti Saheb has based his arguments on those very findings of the jurist that have been quoted earlier. (Mulana Rafiullah p- 51)

Imam Ghazali on Birth Control: As regards those Ulama who do not consider onanism legal, the name of Imam Ghazali (May Allah bless him) is often mentioned. Surely Imam Ghazali considere onanism to be inhumane. His words are; "To resort to onanism is opposed to decent manners". However, he was not opposed to birth-control. As regards the combination of poor circumstances and family, he held the same opinion as was held by the Holy Prophet who prayed "O Allah! I seek They protection from the grave hardship". On enquiry from the Companions as to what that 'grave hardship' was, the Holy Prophet said that it was poor circumstance and a large family. (Mulana Rafiullah: p- 52).

The Salaf Salihin on Birth Control: Imam Ghazali, in support of his view, quotes Salaf Salihin (pious Muslims of the early times); "Some of the Salaf have said that, in some cases, if Allah is displeased with somebody, He plats on him many teeth (children) to gnaw at him". (Related in Sahih al-Bukhari and Sahih Muslim and Sunan Nasai, tradition by Hazrat Abdulla bin Umar, may Allah be pleased with him).

Even though Imam Ghazali considered onanism to be opposed to decent manners, he believed in the legality of abortion if resorted to for several reasons including birth control. He says; "if someone does not want to have too many issues or his earnings do not fulfill his requirements or he is afraid of being compelled to commit evil, he is allowed to resort to onanism for the purpose of birth-control". (Mulana Rafiullah p- 52)

Islamic View against Family Planning: Dr. S. Rizwan Ali Nadvi has written a book in Urdu, "Tahqeeq wa Thasorat". He cited various Quranic Verses and Ahadis against family planning, while critically evaluating the views of Dr. Rashid Jalandri on "Family Planning in Islamic Perspective" in Qahira conference held in September 1994. He stated that Athentic religious scholars of "Devband" India, i.e. Shakh-ul-Hind Mulana Mehmoodul Hassan, Mulana Shabir Ahmad Usmani and Mulan Hussain Ahmad Madani were against of family planning. He has given the Quranic Verse: "Allah has created wives for you, and

gave birth to your sons and daughters and your grand sons and daughters and gave you pure food". (AlQuran; Alnamal: 294) He has cited Ahadis:

1. "Prophet (SAW) said, Get marry and give birth to children, So that I get proud of you on doom day against other Umah (The Muslim Group)".

2. "Prophet (SAW) said, An Ugly woman is better than a beautiful woman, who is giving birth to children".

3. "Those who never marry due to the worry of children births, they are not from us (Muslim)".

Regarding FATWA Shakh Shaltut, " Quran and Hadis are against of family planning, Allah has stopped human from killing children due to poverty". (FATWA No. 294)

Quran says, "Yours wives are fertile land for you". (Alnisa: 223)

S. Rizwan says, "The claim of Dr. Rashid Jalandari that 'Azal' during Prophet (SAW) was practicing is wrong". Hazrat Usman (R.A), Hazrat Umar (R.A.), Hazrat Ali (R.A.), and Abdullah bn Masood (R.A) were against family planning. If the followers of Prophet (SAW) were in favor of family planning, then they would have lesser children. Islamic History shows that many sahaba were in favour of maximum children. (Ibni Hazan:83).

Dr S. Rizwan Ali Nadvi has criticized the views of Dr. Rashid Jalandri on the views of Dr. Abd-u-Rehman an Egeptian Muslim Scholar, who is working in "Pantagon" and as Head of Center for Development and Conflict Management, at Maryland University USA. He has written books and has organized various conferences on Islam favor family planning.

Dr. Rizwan has also given the views of Elezabath Sobo on "The population politics" in "The Minaret" magazine in USA. (Dr. S. Rizwan Ali Nadvi:462).

Ten Fundamental Rights of Children in Islam: Genetic purity, survival, good citizenship, good feeding, clothing and medical care, future security, better up bringing, training of self-defense, equality, separate lodging and legal sources of expenditures.

Perception of Religious Leaders about Population Welfare in Pakistan: The National Institute of Population Studies (NIPS) conducted a survey in 1999-2000. The study indicates that majority of religious leaders have desire for more children, interval of about 2-3 years, disapprove family planning, recommend breastfeeding. They take family planning to reduce high-risk birth and maternal deaths. (Hakim. NIPS; 2000:12)

A Survey of Modernization of Muslim Family Law: Modern family law reforms in Islam are aimed at improving the well-being of the family, which all Muslim peoples regard as the most important and basic unit of society. Family welfare, both from economic and social points of view, is also the purpose of the recent drives launched officially in most Muslim and other developing countries to curb and control population growth. The family-planning programs have met with stiff opposition in some Muslim countries at the hands of the conservatives, and the controversy still goes on. On the purely religious level, a great deal of important material can be found to support family planning as well as in its opposition, and the upholders of family planning are exploiting support to their advantage. The problem, however, is not purely religious, but is rooted in social environment and traditional attitudes. Several classical Muslim authorities allow abortion within 120 days of pregnancy but, on this point, the standing laws of modern Muslim states, which are very restrictive on abortion, need to be adjusted. On the whole, the present need of the Muslims is to recognize clearly that the interests of the community require not so much quantitative increase as qualitative improvement to meet the task that Islam has shouldered, and to make a positive contribution to the newly emerging world order. (Fazlur Rahman: IJME; Jul., 1980; pp. 451-465)

Reproductive Choice In Islam-Gender And State In Iran And Tunisia: The variability in indicators of reproductive choice in the Middle East contradicts the notion of a uniform effect of Islam on reproduction. As the cases of Tunisia and Iran illustrate, the conditions that affect women's options are the outcome of political strategies rather than the result of implementing a religious code. Like other religious doctrines, Islam has been used to legitimate conflicting positions on gender and reproductive choice. The ways in which the ethical code of the religion is translated into policies affecting women's status have been a function of the ideology of groups in power and have been influenced by changes in the economic, political, and social spheres. As in other societies, issues related to women and reproduction are the arena in which contrary views of the social order are played out. This is especially striking where groups who are in opposition to the state, to colonial powers, or to Western influence express their opposition dramatically through the veiling of Muslim women, and legitimate their position as a return to true Islam.

Typically women—and the reaffirmation of indigenous customs relating to women... are the centerpiece of the Islamist agenda at least in part because they were posed as central in the colonial discursive assault on Islam and Arab culture. (Ahmed, 1992:236-237)

Such a situation puts the topic of reproductive choice squarely in the middle of local and international politics, and lends the discussion a confrontational character. But while it is true that a return to a literal interpretation of the scriptures is likely to have adverse implications for women's choices, greater variability may exist in these positions than appears at first glance, and, as the case of Iran shows, even radical views may be tempered by practical realities. Therefore, the assumption cannot be made that all the groups labeled "fundamentalist"[14] advocate a curtailment of women's freedoms, just as "modernization"[15] is not unequivocally linked to greater reproductive choice. In all cultures, images of women are characterized by a degree of ambivalence[16], and government policies related to gender are sometimes inconsistent. Such contradictions make it possible for individuals to define their own strategies, either by manipulating the rules or by resisting them (Moghadam: 1992:12). Locating these contradictions is the key to understanding the potential for change and identifying the possibilities for an expansion of reproductive choices for women (Carla M.O.: Jan.- Feb., 1994; pp. 41-51).

Abortion, Islam, and the 1994 Cario Population Conference: Progressive Muslim theologians and modernists have examined the literature on abortion and believe that the diversity of opinion displayed most recently in the debate at the population conference may ultimately permit more flexibility in national attitudes. Debate on this subject is spirited and ongoing. The late Fazlur Rahman, a Pakistani scholar dedicated to integrating Islamic principles into daily life and reconciling Muslim needs with traditional theological stances, took a practical attitude toward abortion. As a Pakistani, he was intimately concerned with the strain that population pressures put on a developing government. As a theologian, he emphasized preserving the integrity of Islam in the face of strong Westernizing and modernizing movements. On the issue of abortion, he took a liberal attitude that is instructive. While predicting that the type of abortion present in China—aborting fetuses as part of an official policy—would never succeed in the Muslim world, he stated: "There does exist, it seems, the possibility of general acceptance of abortion within 120 days of pregnancy, which will go a long way in making population control effective."(Fazlur Rahman: 1987; Health and Medicen in Islamic Tradition; p. 118)

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[14] Those who believe on the literal truth of the Holy Book

[15] A social change that involves economic development through science and technology and change in attitude and social processes

[16] Co-existence in one person of opposing emotional attitudes towards the same object(Ambivert)

In line with Professor Rahman's reasoning, a liberal interpretation of abortion doctrine could be led by the increasingly vocal women's groups in the Muslim world. At this point, however, issues such as the reforming of personal status codes have a higher priority than abortion. In the future, Middle Eastern women agree, abortion may gain visibility as a women's issue.(Female from Morocco and Jordan: 1993; 184)

As the Cairo Population Conference showed, strong Muslim public opinion condemns abortion as murder of potential life and holds it to be un-Islamic. Nevertheless, it recognizes that abortion can be a necessary practice. Perhaps the best summary of the Muslim position is that abortion is not a good deed; it should be used only when necessary, and this should be rare. How "rare" and "necessary[17]". The process of policy formation depends on compromise, but discussion of highly emotional issues tends to eliminate the nuances of scholarly discourse in seeking a clear and easily enforceable policy. The legal barriers to abortion exist in most Muslim states and tend to truncate debate. Despite this, a market for abortion exists, and the women who seek abortions may act on their own volition. Some, in doing so, follow their own personal reasoning, which more closely approximates that of the minority religious scholars than that of the majority who forbid all but therapeutic abortions. (Donna Lee Bowen: 1997; Pp. 161-180)

Islam, Procreation And The Law: Current Islamic practice emphasizes tradition and interpretations already established, and it is therefore necessary to look at Islamic attitudes towards sexuality and reproduction from a historical perspective. Within the confines of marriage, sexuality is treated as one of the good things in life that a Muslim should enjoy. Marriage is commendable and is recommended for whoever can afford it. Its purpose is seen as twofold. First, it unites the two elements of humanity; this is reflected in the following verse of the Quran: "Amongst His signs is that He created consorts (in marriage) for you from amongst yourselves, so that you may find tranquility with them, and (He) set love and compassion between you. Verily, in this are signs for those who reflect". (Quran: 30:21)

The second purpose, also stated in the Quran, is the procreative function: "And God has created for you consorts (in marriage) from among yourselves, and through your *consorts* He created children and grand children for you, and provided you of His bounty. Will they then believe in vain things and be ungrateful to God's favours?" (Quran; 16:72).

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[17] At the time of mother or child life protection

The Quran does not specifically indicate the relative weight of either the procreative or the unitive aspects of intercourse and does not specifically address the permissibility of contraceptive practice. For that, the Muslim jurists relied on the second source of law, the hadith. Several hadiths of the following companions of the prophet are most often cited in addressing this issue.

According to Jabir; "We used to practice coitus interruptus during the Prophet's lifetime. News of this reached him and he did not forbid us." (T. Mahmood: 1977:p. 27). Also according to Jabir, "A man came to the Prophet and said, 'I have a slave girl, and we need her as a servant and around the palm groves. I have had sex with her, but I am afraid of her becoming pregnant.' The Prophet said, 'Practice coitus interruptus with her if you so wish, for she will receive what has been predestined for her.'"(B.F.Musallam: 1983:p. 15)

According to Abu Sa'id, "We rode out with the Prophet to raid Banu al-Mustal-iqu and captured some female prisoners ... We desired women, and abstinence became hard- (But) we wanted to practice coitus interruptus; and we asked the Prophet about it. He said, 'You do not have to hesitate, for God has predestined what is to be created until Judgement day"(T.Mehmood: 1977:p. 28). Abu Sa'id also said, "The Jews say that coitus interruptus is minor infanticide, and the Prophet answered, The Jews lie, for if God wanted to create something, no one can avert it (or, divert Him)."(B.F. Musallam:1983: p. 15).

Stated Judhama bint Wahab, "They asked him about coitus interruptus, and the Prophet answered, 'It is hidden infanticide " (B.F. Musallam: 1983: p. 15). Said Umar Ibn al-Khattab, "The Prophet forbade the practice of coitus interruptus with a free woman except with her permission"(B.F. Musallam: 1983: p. 15). According to Anas, "A man asked the Prophet about coitus interruptus, and the Prophet said, 'Even if you spill seed from which a child was meant to be born on a rock, *God* will bring forth from that rock a child"(B.F. Musallam: 1983: p. 15).

These hadiths were important but not decisive, since they did not give consistent guidance. In the absence of explicitly religious provision, Muslim jurists had to sort to the doctrines of ijmaa and qiyass. The Shafi'i jurist Ghazali (1058-1111) argued that there was no basis for prohibiting coitus interruptus. He reasoned that; pregnancy had four related causes: marriage, intercourse, emission of semen, and allowing semen to reach and settle in the womb. As far as procreation was concerned, abstention from the fourth was like abstention from the third, which was like abstention from the second, which in turn was like

abstention from the first. Since the first action was not obligatory, none of the ensuing acts could be obligatory (B.F. Musallam: 1983: p. 17).

The jurist Ibn Hazm (994-1063) argued that; coitus interruptus was prohibited because the Prophet had abrogated earlier permissive hadiths when he equated coitus interruptus to infanticide, which is condemned in the strongest terms by the Quran. Another jurist later explained that "the Prophet called coitus interruptus hidden infanticide because it shared with true infanticide the same motive: escape from additional dependents. But true infanticide was not prohibited because of this motive, which in itself was proper, but because it involved murder" (B.F. Musallam: 1983: p. 19).

Using the sources of quiyass, Muslim jurists of the major schools were able to reach ijmaa. They agreed that contraceptive practice was proper and classified it as permitted or disapproved but not forbidden. For the jurist Ghazali; health and even economic indicators, as well as a man's desire to ensure the physical appeal of the woman, were considered acceptable reasons for the practice of contraception. However, he disapproved of the use of a contraceptive method to avoid having female children or because the woman wanted to maintain her beauty. Ghazali's position makes it evident that Islam calls into question the motives for contraception, rather than the practice itself. (T.Mehmood: 1977: p. 43).

Initially, the practice of coitus interruptus was only permitted with the consent of the woman. Later, medieval jurists used the reason of "bad times" as unconditional permission for contraceptive practice: "Coitus interruptus is permitted without a free woman's consent because the times are bad" (B.F. Musallam: 1983: p. 118). The presence of a nursing child was an acceptable reason for almost all jurists (B.F. Musallam: 1983: p. 25).

So it could be said that contraceptive use has been sanctioned since the hadiths of the Prophet, but, at that time, the focus was on the all-powerful Allah (B.F. Musallam: 1983: p. 118). The economic, personal, social and medical reasons appeared in later reasoning and illustrate the dynamism of the Shari'ah.

In the absence of an explicit religious position, it is not surprising that there were, and continue to be, different viewpoints on issues of contraceptive practice. Some scholars argue that the procreative element is the major aspect of marriage, and contraceptive practice is unacceptable, The Quran supports such a position in this verse: "Your wives are

a tilth for you, so go into your tilth as you like and do good beforehand for yourselves". (Quran S. 2:223) [F. Muslim: 1976: p. 145].

"By describing women as a tilth, an important biological fact has been pointed out," writes the scholar Maududi; "Biologically, a man is a tiller and women is tilth and the foremost purpose of the interrelationship between the two is the procreation of the human race. This is an objective, which is common to all—human beings, animals and the world of vegetation. The tiller of the soil cultivates the land, not in vain, but for produce. Take away this purpose and the entire pursuit becomes meaningless". (A. Maududi: 1968: p. 80).

Other scholars argue that the use of a contraceptive method serves to frustrate Allah's will and reflects a lack of faith in the power and benevolence of the Creator; these conservative attitudes continue to exist in some schools of thought. However, the following fatwas (learned opinions) illustrate that temporary contraceptive methods are considered acceptable to most:

Islam, as the religion of pristine nature, has never been opposed to what is good to man. Indeed, it has always been ahead in the effort towards the achievement of this good so long as it is not in conflict with the purposes of God's Law. Shaikh Hasan Ma'mun says; I see no objection from the Shari'ah point of view to the consideration of family planning as a measure, if there is a need for it, and if the consideration is occasioned by the people's own choice and conviction, without constraint or compulsion, in the light of their circumstances, and on the condition that the means for effecting this planning is legitimate. (Fatwa of Shaikh Hasan Ma'mun, Rector of Al-Azhar, 1964)["Islam and Family Planning," Pamphlet issued by International Planned Parenthood Fedration, 1964].

There is agreement among the exponents of jurisprudence that coitus interruptus, as one of the methods for the prevention of child-bearing, is allowed. Doctors of religion inferred from this that it is permissible to take a drug to prevent childbearing, or even to induce abortion.

Mufti Abduallah Al-Qalqili says; We confidently rule in this *fatwa* that it is permitted to take measures to limit childbearing. (Fatwa of Shaik Abdullah Al-Qalqili, Grand Mufti of Jordan, 1964) ["Islam and Family Planning," Pamphlet issued by International Planned Parenthood Fedration, 1964].

The Quran and the hadiths make no reference to sterilization. The issue of permanent sterilization as a method of contraception remains an issue of controversy among Muslim

jurists. As one jurist argued, "permanent sterilization was allowed because there was no explicit and definitive text to prohibit it and because the preservation of reproductive power was not one of the obligations under the Islamic law". ("Islam and Family Planning," Summary of Proceeding of the international Islamic Conference, Rabat, Morocco, Dec. 1971). Some scholars reason that; "Since Islam does not place any time limits on contraceptive practice, and a couple has the right to use a temporary method permanently, they should have the right to adopt a permanent contraceptive method" (M. Mahran, "Ethics and Human Values in Family planning," background paper, CIOMS Conference, Bangkok, 1988,p. 62).

Other jurists cite an earlier judgment (viewed as binding), which stated that; "it is forbidden to use what stops childbearing altogether; but what slows down or delays childbearing without stopping it altogether is not forbidden, and if it is for a reason such as the bringing up of a child in a proper manner, it is not even disapproved of." ("Islam and Family Planning", Summary of Proceeding of the international Islamic Conference, Rabat, Morocco, Dec. 1971). Consequently, permanent sterilization is acceptable only if; "one of the spouses is suffering from a psychological, sexual or mental disease, proven medically to be inevitably transmissible by heredity, and not capable of being cured by any treatment at all." ("Islam and Family Planning, "Summary of Proceeding of the international Islamic Conference, Rabat, Morocco, Dec. 1971: p. 73).

The opinion that sterilization is unacceptable as a contraceptive method is held by many jurists from all four major schools within the Sunni sect and by a number of Shi'i sects as well. ("Islam and Family Planning," Summary of Proceeding of the international Islamic Conference, Rabat, Morocco, Dec. 1971: p. 70). In the absence of a specific religious prohibition against sterilization, this reluctance to allow sterilization stems from the deep belief that when man frustrates Allah's will, he oversteps his boundaries. However, of the six Islamic countries in Table 1, only two have made sterilization explicitly illegal—Iran and Saudi Arabia. It is allowed in most of the other countries, albeit with restrictions on the woman's age and family size, but it is widely promoted as a method of family planning only in Bangladesh.

Islam and Abortion: The Quran makes clear reference to the progressive development of the fetus: O mankind! If you are in doubt as to the Resurrection, [consider] that We have created you of earth; then of semen; then of a blood-like clot; then a lump of flesh, [which is] formed or unformed; so that We may demonstrate to you [our power]; and We establish

in the wombs what We will, till a stated term; then We bring you out as infants ... (Quran S. 22:4) [B.F. Musallam: 1983: pp. 53-54).

Muslims have viewed fetal development as occurring in three stages, each lasting 40 days: the semen, the blood-like clot and the lump of flesh. At the end of these stages, Muslims consider the fetus ensouled. (B.F. Musallam: 1983: p. 54). All schools within the Muslim community make a distinction between the stages before and after ensoulment. Every school agrees that abortion after the first 120 days is forbidden except to save the mother's life; there is, however, no consensus on abortion before the period of ensoulment. The Zadis (a small Shiite sect), maintain that an unensouled fetus is the same as semen, and abortion is possible unconditionally. Most other schools clearly distinguish between abortion and contraceptive practice, and most Muslims consider abortion at any stage to be an of-fens albeit of different degrees. (J.W. Bowker, "Religions and the Status of the Embryo," Human Embryo Research: yes or No? The Ciba Foundation: 1986).

Ghazali presented this view: Contraception is not like abortion. Abortion is a crime against an existing being. Now, existence has stages. The first stages of existence are the setting of the semen in the womb and it's mixing with the secretions of the woman. When it develops further and becomes as a lump, aborting it is a greater crime. When it acquires a soul and its creation is completed, the crime becomes more grievous. The crime reaches a maximum seriousness, when it is committed after it is separated alive (from the mother). (Al-Qaradawi, 1981, p. 202) [J.W. Bowker, "Religions and the Stateus of the Embryo," Human Embryo Research: yes or No? The Ciba Foundation: 1986: p. 73].

Some contemporary scholars argue that modern science presents different information regarding the "beginning of life" and suggest that the formation of the zygote rather than the "quickening" stage be considered the beginning of life.' (H. Hathout: 1989:p. 232). The concept of ensoulment has perplexed scientists and philosophers throughout the ages. A medieval scholar wrote that; the fetus was ensouled after 120 days and adds "this can be known only through revelation, for there is no reason in nature as such which requires it."(B.F. Musallam:1983: p. 57). Another wrote, "Ensoulment belongs to a different realm of meaning, outside science but at the center of religion" (B.F. Musallam: 1983: p. 57).

At the International Islamic Conference held in Morocco in 1971, views of the various jurists on abortion before ensoulment were summarized.(Islam and Family Planning," Summary of proceeding of international Islamic Conference, Rabat, Morocco, Dec, 1971)

Permission, without dependence on a reason, was granted by the Zadis, some Hanafis, some Shafi'is, some Malikis and some Hanbalis. Permission depending upon a reason, and disfavor when there was none, was the rule for some Hanafis and some Shafi'is. Abortion before ensoulment was looked upon with disfavor by some Malikis and prohibited by others, and disapproved of by many of the Shi'i sects. Thus, it is virtually impossible to state one Islamic viewpoint on the issue of abortion. Nonetheless, Tunisia is the only Muslim country to allow unrestricted first-trimester abortions. Most Muslim countries permit first-trimester abortion only to save the woman's life between God's realm and Caesar's, by citing the traditional adage, 'al-Islam din wa dawla/ or, Islam is religion and state." (A.E. Mayer, " Law and Religion in Mulim Middle East,": American Journal of Comparative Law, 35:130, 1987). Until the late 1960s, many Muslim countries appeared to have embarked on a course of secularization along Western lines. However, this change was not accepted by large segments of the Muslim population, and there has since been a dramatic upsurge in the call for the repudiation of Westernization and a return to Islam. These movements demand, at least, the reinstatement of the Shari'ah as the law of all Islamic lands, and many call for the establishment of an Islamic state. (A.E. Mayer, " Law and Religion in Mulim Middle East,": American Journal of Comparative Law, 35:130, 1987; p. 129).

In almost all countries of the world, control over fertility has tended to be the watershed issue as far as the status of women is concerned. Questions about women and their role in contemporary society are invariably at the heart of the debate surrounding procreation, a debate that will continue within the religious context in many Islamic countries. There is no one monolithic view that would summarize the response of Islam to the myriad of issues raised by procreation in the late 20th century. But it is evident that the position of Islam itself is much less rigid than it would appear at first. It should be clear to policymakers that the Shari'ah has always had the flexibility to address contemporary problems. The canons of interpretation of Shari'ah and the concept of naskh (abrogation) illustrate that reinterpretation and change is not untenable in Islam. The Shari'ah provides invaluable guidance but does not shackle policymakers forever.

As the scholar Iqbal said, "The teaching of the Quran that life is a process of progressive creation necessitates that each generation, guided but unhampered by the work of its predecessors, should be permitted to solve its own problems"(M. Iqbal, The

Reconstruction of Religious Thought in Islam," 1960, p. 168). [Zulie Sachedina: IFPP: 16:3. (Sep. , 1990), pp. 107-111].

Legitimacy of Family planning in Islam: Mufti Ghulam-ur-Rehman of Dar-ul-Ulum Usmania, Nothia, Peshawar, has presented his article (ideas) regarding 'family planning and Islam' in the sixth conference at Islamic center Bannu on 11-12 November, 2006.

He has given Islamic points in favour and against of family planning: "Islam never permit for family planning if it is due to security of resources (because resources are in the control of Allah), It is permissible for the health of mother and child. In Islam marriage is for reproduction of children". (Rehman: Alasar ; 1).

Legitimate factors of family planning: Family planning is allowed in the following cases:

1. **Health of women:** It is allowed, if it is required to save the life and health of a woman.
2. **Health of children:** It is also allowed, if it is needed for saving the life of a child.
3. **Rude behaviour of women:** Family planning is also allowed, if wife is ill-mannered and there are chances of divorce or separation.
4. **Socialization of children:** It is allowed, if parents can't properly socialize their children.
5. **Stability in Family affairs:** If the stability of family gets disturb due to more children, then family planning is allowed.
6. **Temporarily residency:** Family planning is legal, if someone gets married during his short residence abroad.
7. **Marrying Christian, Jew etc:** If a Muslim man marries a Christian, Jew etc. he is allowed to practice family planning
8. **Law of State:** If the government for a specific size of family formulates a law, then family planning is allowed.

Illegitimate Factors: Mufti Ghulam-ur-Rehman has also mentioned the following factors against family planning:

1. **Fear of poverty:** If the couple adopts family planning due to fear of poverty, then it is not allowed.

2. **Free life:** If a couple wants to live free life, and never want to get the responsibility of children, in that situation family planning is not allowed.

3. **Women employment:** If a woman (or couple) adopts family planning for the sack of woman's employment then it is not allowed.

4. **Shyness:** If a father or mother feels ashamed of fatherhood or motherhood and they adopt family planning, for this purpose it is banned.

5. **Abortion:** If the couple wants abortion, it is not allowed after one hundred and twenty (120) days of the development of zygote.

6. **Abnormal child:** If the screening or medical test report shows that the coming child will be abnormal (handicapped or retarded), in this situation family planning is banned.

7. **Vasectomy and Sterilization:** Vasectomy and sterilization are not allowed in Islam but only if it is needed for the health of male and female.

8. **Controlling minorities:** If the majority in the world or in a state wants to keep minority of that state and its population under control or feels minority as a threat or superiority on them, in this situation Islam does not allow the majority to practice family planning up minority. (Rehman: Alasar: pp. 1-15).

2.11.3 Socio-Cultural Constraints to Family Planning:

a. Socio-Economic Values of Children: Having children is delightful for parents in certain ways; more important is that having male children is considered a matter of pride.

Different Scholars have given their views regarding socio-economic values of children in the light of their studies.

Gerald Leslie defines that; society values all children because they are considered necessity for its survival, yet distinctions may be made among them. Male children, he finds, are preferred over female children (Leslie; 1979: p. 17).

Diana Gittin also makes the same finding while analyzing, "why do people have children?" She concludes that; Sex of child may influence family size. Sons, she notes, are preferred over daughters in most of societies. This is because mostly parents desire sons as "heirs, field hands, cannon-fodders, feeders of machinery, images and extension of themselves; their immortality" (Gittins; 1985: p. 107)

Desires for sons seem to be stronger in many cultures. The ancient Chinese tradition places high value to sons as well as a few daughters, since producing children gives parents an adult status. Cornelious Osgood finds that; rural China display stronger desire for sons. He states; a father's position, "If his first child was a son, he was adequately compensated for the difficulties of life" (Osgood; 1963: p. 262).

Similarly Royal Freedman and John Y. Takeshita cited this fact. They also viewed that; Chinese tradition like most pre-industrial societies displays strong preference for sons, which affect family size decisions (Freedman and Takeshita; 1969: p. 42).

Gerald Leslie has also found out; importance of sons in Chinese family system for family continuation and ancestor worship (Leslie; 1979: p. 88)

b. Maximum Male Children Desire Resultant Large Family: The findings of different studies indicate that maximum male children desire resultant large families, as given by researchers. Fred Arnold says; "Son preference is most prominent in a band of countries stretching from North Africa, through the Near East to South Asia. The most extreme preference of sons is found in India, Bangladesh, Nepal and Egypt, but a distinct preference for sons is also evident in Turkey, Tunisia, Pakistan, Sri Lanka, Jordan and Morocco". (Arnold; 1997: vi)

Arsala Sadiq mentions the reasons of desiring son particularly with reference to Narowal district of Punjab, Pakistan; "Parents usually think that a son will continue the family name, will not be given any dowry and he will earn money for the family. Then he will also be responsible to look after his old parents". (Sadiq 1992: p. 143).

Rukanuddin and Ali in their paper "Family size Preferences" also give reasons of preferring male child; "Pakistan like other Asian societies displays strong desire of sons. This is because of the socio-economic and cultural values attached to sons, in rural areas; specifically sons are valued as farm laborers, for old age security and for advancing family lineage". (Rukanuddin and Ali; 1992: p. 101).

Khalida Manzoor also gives the socio-economic and psychological reasons for the preference of sons by women in Pakistani society; "Women often desire to have sons in the expectation of which they end up having a large number of children. Their desire for sons emerges from two reasons. First the social pressure of son preference and second their own insecurity and dependency, which conditions them to perceive sons as economic and social support for old age". (Manzoor; 1994: p. 44).

Nausheen Mahmood and Karin Ringheim mention five factors along with son preference which effect contraceptive use, these are; extent of communication between spouses, son preference, religious beliefs, female autonomy and family planning services supply." (Mahmood and Ringheim; 1993: p. 3).

Mubashir Ali says; "The preference of at least one son in a family produced a marked difference in the demand for additional children". (Ali; 1989: p. 405).

Moni Nag did comparative study of Sex preference in India, Pakistan and Bangladesh. He says; "In Pakistan 71 percent preferred to have a boy, 5 percent a girl and 24 percent were undecided. The percent of women using contraception tends to increase with the number of living sons, indicating a widely prevalent preference for sons; Pakistan had a far higher son preference". (Nag; 1991: p. 23).

Thus desire of son effects adoption of family planning. There is a negative relationship between adoption of family planning and desire for son. And desire for son increases if there is no son in the family. Farooqui and Rukanuddin see this relationship in their article "Son Preference and Contraceptives Use in Pakistan" (Evidence from Pakistan Contraceptive Prevalence Survey 1984-1985). But at the same time they have also mentioned that there is also desire of at least one daughter as well; "Whether future fertility intentions of the women are consistent with their behavior. This can be examined with reference to the relationship between son preference and contraceptive use rate increases with family size yet within each category of number of living children, women with no sons are least likely to have practice contraception. Moreover, with in each category of number of living children, contraceptive use increases except among woman with all sons and no daughters". (Farooqui and Rukanuddin; 1990: p. 14).

Soomro and Farooqui also see similar relationship between son preference and contraceptive use. They in their article "Fertility Preferences and Contraceptive use in Pakistan", argued that, "At least one surviving son in the family positively affects the attitudes towards limiting the family size". (Soomro and Farooqui; 1985: p. 610).

Rukanuddin concluded; "Those who lost their male children compensated for the child lost comparatively more than those with female child losses, indicating that sex preference is an important factor in determining the fertility behaviour of couples". (Rukanuddin; 1982: p. 312).

Fariha Mujtaba quotes Engles concept of "private property" in her thesis, which support this arguments; "Children were wanted as heirs of property. Since male members were considered property – holders, producing male heir became necessity for passing on one's possessions". (Mujtaba; 1997: p. 12).

Hussain, Fikree and Berendes have measured this effect with the help of various predictor of unwanted-ness of the index pregnancy (present pregnancy) in their paper, "The role of son preference in reproductive behaviour in Pakistan". According to them; One basic predictor was the sex of the surviving children and it is found that those who had more number of sons showed their unwanted-ness for index pregnancy, "The sex of surviving children played an important role". (Hussian, Fikree and Berendes; 2000: p. 381).

The literature given above shows the various reasons for desiring son and how this desire affects use of contraceptive. Education, family type, socio-economic class or bradri, inheritance, security in old age, source of survival and land ownership are some of the contributing factors affecting the desire for son and leading to large family size, which as a result ensures the struggle for adoption of family planning.

c. **Women Low Status a Constraint to Family Planning:** Women low status is considered as one of the constraint to family planning. As it is clear from the various studies. Khalida Manzoor has discussed the effect of female education on fertility in her article, "An Attempt to Measure Female Status in Pakistan and its Impact on Reproductive Behaviour". She says; "Female education has been conventionally considered as an indicator of female status. There is a consensus in terms of the inverse relationship between female education and fertility that education even up to primary level leads to fertility decline". (Manzoor; 1993: p. 917)

She has further explained the effect of female education on sex preference of next child, "uplift in the status of females is likely to increase their economic and social independence leading to a lesser reliance for economic and social support". (Manzoor; 1993: p. 921).

Susan Hill Cochrane in her book "Fertility and Education – What Do We Really Know?" emphasizes the importance of education of the couple and son preference, "If preferences for sons decreases with increased education, the desired family size will also decrease, all other things being equal". (Cochrane; 1943: p. 105).

Naushin Mahmood also emphasizes the effect of women's education on demand for children in her doctoral dissertation, "The Desire for Additional Children and Fertility

Regulation in Pakistan"; "We expect women's education to be a forceful factor in reducing the net value and hence the ultimate demand for children". (Mahmood 1990: p.21).

She has also quoted Cochrane, to support her argument, "The impact of education on the demand for children is expected to be multi dimensional, the role of education in changing aspirations, values and fertility attitudes and behaviour of women has been amply documented". (Mahmood; 1990:p. 20)

Nausheen Mahmod also sees the effect of family type on the desire for additional children in her thesis, but she did not talk particularly about son preference; "The effect of family type on the desire for children is as predicted, although only among rural women. Nuclear family living in rural areas leads women to aspire to smaller families. This could effect the greater social and economic freedom enjoyed by women in nuclear as opposed to extended family or their greater espousal of an ideology of conjugal family". (Mahmood; 1990:p. 24)

Nausheen has also mentioned about the effect of wealth or land ownership on fertility or demand of more children; "Our results indicate that income/wealth differentials are not important in defining the demand for children for urban women, while income and land ownership bear a positive relationship with wanting no additional children for rural women". (Mahmood; 1992:p27)

d. Correlation of Socio-Economic Status and Education With Family Planning:

One of the reasons for less practicing of family planning and having large family size by the lower social status group is due to the fact that the social status of an individual in the rural community is determined mainly by the number of male members. Bringing daughters-in-laws for her sons from different families also raises the prestige of a mother.

The desire for more children in the lower income groups in Pakistan is because they consider the male children as their main assets and a symbol of economic prosperity particularly in old age. In agrarian society the greater numbers of male children help in controlling vast land for cultivation.

McClellan argues that; well-off and high level educated people are having greater knowledge of family planning techniques and its frequent practice.(McClellan;1970:p. 12)

The studies conducted by Balswick (1970) and Stoeckel (1970) suggest that; education is an important variable and affects the use of the contraceptive i.e. the higher the level of

education of the subjects, the more would be the adoption of family planning. Similar results were also found by Speidel (1970), He has concluded from his study that there was a positive correlation between greater educational attainment and the increasing knowledge about contraceptives.(Balswick,Stoeckel, Speidel; 1970: pp. 23,34,35)

Jain A.K. (1985) who studied the impact of development on fertility in India found that increase in adult female literacy and the decrease in infant mortality were the main factors for the high prevalence of contraceptives and decline in the fertility. According to him; the effect of female education helped in increasing the female age at marriage, followed by decrease in the infant mortality and ultimately there was increase in the users' contraceptives. The higher level of educated people use temporary methods like condom more than the subjects from low level of education. The role of education in the development of the belief in internal control of an individual, which will in the long run help in the adoption of family planning. It has been observed and statistically proved that those countries which have high literacy rate like Sri Lanka, Thailand etc. are practicing family planning more than the countries with low literacy.(Jain; 1985:p. 22)

e. **Women Status and Contraceptive Prevalence:** Hakim carried out a study on the women status and contraceptive prevalence. It is evident from this study that women's education, awareness and employment have significant effect on contraceptive use in rural areas. These also increase social and economic value of female in the society and at the household level. A very young age population, who has a high fertility rate, needs special focus. Investment in terms of education and skills to this young group in general and females in particular, will lead to adoption of small family norms and economic development in near future. (Hakim-NIPS; 1998:p. 35)

f. **Husband-wife Role as a Correlate of Contraceptive and Fertility Behavior:** The importance of gender-related factors in understanding fertility-regulating behaviour is now well recognized. The nature of the husband-wife relationships and woman's education are probably the most important factors (e.g. husband's education and media exposure) in facilitating increase in contraceptive prevalence. The husband's consent and her participation in important family decisions are strongly associated with the use of contraception and fertility preferences. (Backman; 1983:p. 23)

g. **Sex Preference And Fertility In Peninsular Malaysia:** Chinese parents prefer to have more sons than daughters. These findings make Malaysia's Chinese appear distinct

from populations in many other developing countries, where the most common preference is for at least one son and one daughter (Arnold, 1992).

Interestingly, fertility rates among Chinese remain the lowest among all ethnic groups in Malaysia, despite Chinese parents' son preference and the increased intensity of that preference over time. Malays, who show no evidence for sex preference, have higher fertility. Sex preference is unlikely to cause lower fertility. The opposite causal relation is more likely, because Malays tend to have more children, they are likely to bear a combination of sons and daughters, and thus they will be less conscious of their sex preference. By contrast, because Chinese parents tend to have only two or three children, they are probably more conscious of their preferences. This study suggests that family size has a greater impact on parents' concern for the sex of children than the reverse. Possibly the preferences for both family size and children's sex, rather than being causally related, are simultaneously determined by the degree to which there is a conscious calculus of choice within the boundary of a cultural tradition (Suet-ling Pong: May-Jun.1994; pp. 137-148).

h. Pakistan's Population Transition: Desired Number of children, Infant Mortality and Family Planning: This study indicates the role of diffusion in Pakistan fertility transition. The focus of the study was to see the desire for children, numbers, miscarriages, infant mortality and the use of contraceptives. Demographers agree that "the turning point has been reached and the dynamic of fertility change has at last begun", (Hakim and Miller 1998:18) One gets the impression from the existing literature on Pakistan fertility decline is the result of increased supply and prevalence of modern contraceptives (Hakim, A. and Peter C. Miller 1989, Population council 1997). Fertility transition means "those societies that experience modernization progress[18] from a pre-modern[19] regime of high fertility and mortality to a post-modern[20] one in which both are low", (Kirk 1996:361).

2.11.4 Program Development Constraints:

Obviously family planning programs cannot be successful in the absence of a comprehensive developmental strategy, one that includes reducing fertility rate, lowering

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[18] A change to get a specific goal in a specific direction
[19] Developed regime before the intervention and implementation of science and technology
[20] Developed regime after the intervention and implementation of science and technology

infant mortality, raising female literacy, improving maternal and child health and nutrition, providing clean water and sanitation as well as appropriate service providers.

One of the major constraints is the location of health services in most developing countries, through which contraceptives services are largely distributed. In countries where maternal and child health services reach only 30 percent of the population, family planning programs, even if they were fully integrated would still only reach the same percentage.

Some traditional families and fundamentalist religious groups discourage the education of girls and women and the employment of women outside the home; they are thus less likely to understand the benefits of family planning or to have any access to it. The patriarchal system that prevails in rural Bangladesh, Pakistan and Hindu communities in India as well as parts of Middle East certainly makes the delivery of family planning services more difficult. The observance of veil (purda) results in the seclusion[21] of women, which requires intensive outreach programs. Then female workers required delivering services at or near client's house. Other constraints is the potential harassment[22] of the family planning workers, perceived as violating norms of female behavior and transport difficulties in a society where women bicycling is considered immodest[23]. The non-availability of appropriate service providers hampers the situation and lead to failure of the program. To avid these constraints women education should be encouraged by taking religious leaders in confidence. All contraceptives strategies should be tailored to the cultural sensitivities of the people. The goal and success of the program should be with in the cultural reality of purda; purda may not necessarily be seclusion or oppression of women is an ethnocentric critique of Muslim societies; it could be a choice and assertion of Islamic identity. Moreover specific training should be arranged free of cost to get well-trained service providers for the development of the family planning program. (Hakim, NIPS; 1997: p. 25)

2.11.5 Governmental, Political and Policy Constraints:

At the global level, the major political influences for the contraceptives revolution have been international agencies through various conferences. The United Nation 1965 UN Debate on the population problem, the 1968 Tehran Declaration on the human rights to family planning

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[21] Oppression / privacy / withdrawal from observation
[22] To trouble and confuse a person by continual persistent attacks and questions
[23] Indecent behaviour of a person

and the Bucharest world population conference in 1974 that we have had a real international consensus on family planning.

Some important international organizations such as the organization of African Unity, the European Union, which are lukewarm[24] about population and family planning programs and some countries, such as France and Italy, which, because of national political constraints, make little contribution to international family planning efforts.(Population Council; 1998: p. 12)

Population Policy Shifts and Their Implications for Population Stabilization in Pakistan: The family planning efforts in Pakistan remained trapped in a vicious cycle for a long period of time. Fluctuating political support and frequent changes in programme strategies, particularly from 1970 to 1990, also contributed to ineffective programmes. Sustainability and continuity in policies support and program strategies to great extent during 1990s made few experts to argue 1990s as turning point for family planning in Pakistan [Hakim and Miller (1996)] when CPR use doubled from 12 percent in 1990-91 Pakistan Development Health Survey (PDHS) to 24 percent in 1996-97 Pakistan Fertility & Family Planning Survey (PFFPS). The latest result of 2000-01 Pakistan Reproductive Health & Family Planning Survey (PRHFPS), also demonstrates upward rise in CPR to 28 percent, yet the increase is not as substantial as witnessed during 1991-97.The main reason apparently appear being the slow program implementation, weak coordination between health and population welfare sectors, and inadequate supervision in the field during the last few years.(Zafar; 2001:p25)

2.11.6 Medical and Technical Constraints:

Regulation and attitude of the medical profession often hinder the expansion of the role of the health personnel and the extension of the service delivery outlets. In many countries, especially in Africa, regulation limits the right to prescribe oral contraceptives and to insert IUD to certified medical doctors, few of whom practice in rural areas. As early as the mid-1970's the International Planned Parenthood Federation (IPPF) central medical committee stated that 'the limitation of the oral contraceptive distribution to a doctor's prescription makes the method geographically, economically and sometimes culturally inaccessible to many women. Some countries, such as Bangladesh, Egypt, Nepal and Pakistan now allow

[24] Moderately warm and expressing little enthusiasm

the distribution of contraceptives without prescription. Other countries authorize trained health personnel (midwives, nurses and health workers) to issue prescription for oral contraceptives and/ or to insert IUDs. In Zaire, specially trained nurses are allowed to perform caesarean[25] operation and female sterilization in rural areas.

In many developing countries, regulations still require drugs (including contraceptives) to be supplied in pharmacies or medical centers, under the supervision of licensed pharmacies. These two conditions represent a major obstacle to the extension of service delivery outlets, especially in rural areas. In countries where regulation have been liberalized like Morocco and Zimbabwe effective outreach and community based distribution projects have been established, resulting a much higher use of contraceptives among rural population. The effect of such obstacles added to shortcomings in the health care infrastructure, are reflected in the percentage of a country population with access to family planning services, meaning that the recipient spends no more than an average of two hours per month to obtain contraceptive supplies and pays less than 1 percent of a month's wages for a one month supply of contraceptives. A 1989 survey suggested that wild fluctuation still exist between developing countries in ease of access, while most methods were available to 95 percent population in Botswana, less than 10 percent in Madagascar and Zaire had such easy access.

Finally the technology used could itself be an obstacle to the successful implementation of family planning programs. When the industrialized countries went through their fertility transition, the major methods of birth control were the withdrawal and the late condoms, both were under the influence of the men, and it was the man and his ability that helped women to control their fertility. With the Pill, IUD and the Injectable, method of fertility control passed to women, and some of the family and social conflicts over contraception arises from this fact and from men's unhappiness, in many societies women control their own fertility with out men's intervention. These methods also depend on good health service back up, and where this is not consistently available, problems and a high drop out rate are inevitable. (Hakim, NIPS; 1994:p. 22)

2.11.7 Quality of Services Constraints:

a. **Shift in Family Planning Program:** During the 1980's, there was a shift in focus of many family planning programs away from demographic targets to meet the unmet needs

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[25] Surgical incision through the abdominal and uterine walls to deliver a baby

and improve quality of care, and result in many cases was better acceptance figures. Indeed many recent reports have stressed that programs of high quality are not likely to lead to better uptake, fewer contraceptive failures and fewer dropouts. As a result resources are more likely to be forthcoming, and opposition can be countered more convincingly.

Demographic health surveys in 12 countries suggested that over half of all women were unsuccessful or dissatisfied with the contraceptive methods they had been using. Contraceptive technology or family planning delivery programs are falling short and not according to the women need. (IPPF 1992) Recently, IPPF has published its medical and service delivery guidelines, which cover training, method of contraception, counseling, and the rights of the client. Family planning association and other non-governmental organization are well placed to focus attention on the deficiencies of programs and to work side by side with governments in making their programs more clients-friendly. (Hashmi; 1990: p. 25)

b. Prevalence and Factors Associated with Dropouts in Contraceptive Use in Rural areas of Peshawar: Policies and programs to control population growth rate are adversely affected by number of factors. The predisposing factors associated with a woman's behaviour to dropout are multiple. The social set up and relationship with in-laws, friends, relatives and peers reinforce women's decision to continue use of contraceptives. Past experience of contraceptive use also affects a woman's decision. Accessibility to information and services is vital for a woman to continue contraceptives use.

This study indicates that dropout of modern contraceptives (except condoms) is quite high in rural areas of district Peshawar. The dropouts are mainly during first year of contraceptive use. Female community of this area is mainly illiterate. There is general desire for having more sons. Women who use contraceptives for longer duration mainly belong to the poor sector, which is quite distinct from earlier studies. There is misinformation about contraceptives among women and this is one of the main reasons for discontinuation. The service delivery factors influencing dropouts were poor access (more than thirty minutes walk or facility away from home), lack of counseling services and inability to manage side effects.(Najma, Naseem, and Inayat; 2001: p. 495).

c. Side Effects of Contraceptives / Attitudes Towards Reproductive Health Issues: A study conducted at a medical center in Karachi found that husbands and other

family members' opposition to hospital care was a factor in the death of recently delivered mothers (Jaffrey and Korejo 1995).

A number of studies show that men are concerned about the side effects of contraception. In the Unmet Need study the fear of side effects was the most common hindrance to contraceptive use identified by men. In the contraceptive prevalence and reproductive health survey (1996) men expressed concern about the safety of hormonal contraceptives and the IUD. In-depth interviews conducted with men about withdrawal use reveal a strong desire to avoid the adverse health consequences of modern methods on wife's health. Women withdrawal users often regard their husbands as caring and considerate because they perceive them as taking action to ensure they avoid additional pregnancies, as well as the side effects of modern methods. (Hakim; 1992:p. 32).

2.11.8 Psychological Constraints to Family Planning:

The acceptance of family planning by people is purely a psychological affair, which involves change in beliefs, attitudes and values and consequent change in behavior. Most important are the existing values prevailing in the society demonstrated through norms and taboos, which act as strong resistance to the adoption of family planning.

The value-wise resistance to family planning in Pakistan is given as under:

I. **Religious:** It is prohibited in Islam, interfere in Allah's doing, killing one's own children, children are blessing of Allah. It brings misfortune, No one can prevent, sustenance comes from Allah and it exposes the society to moral corruption.

II. **Socio-Economic:** Male children are a source of protection, security, income for parents in old age, a child comes into this world with one mouth and two hands and son is a symbol of prestige in our society.

III. **Theoretical (Myths, Misconception, and Rumors):** It is a conspiracy of Jews and Christians against Muslims fear of impotency and misunderstanding between couples. (Sarwar; 1996: p. 8)

b. **Population Psychology:** Couples all over the world have motives for children. But there are some people who desire for greater number of children and some who wish to have small number. The decision of having large and small number of children depends on individual's motives and social circumstances. A number of studies about preference for sons have been conducted in the Indian sub-continent, Middle East and Far East countries,

some of them are mentioned below: Biarai (1986) in Bangladesh, Ahmed (1981) in Bangladesh, Gadalla (1985) in Egypt, Williamson (1976), Sheps (1963), Coombs (1979) in Taiwan, Park (1983) in Korea, De Tray (1980) in Pakistan, Repetto (1982), Sidney Ruth Schuler (1986) in Nepal, Bogue (1975), Haifua Shahnawany, (1970); They conclude that traditional societies, economies and all religions favor more children". (Sarwar; 1996: p.12).

Part-E Contribution of Public and Private Organizations in Family Planning Implementation in Pakistan

2.12 Effectiveness of Media in Promoting Family Planning in Pakistan:

Information Education and communication (IEC) is an essential component of the Population Welfare Program of Pakistan with its aim to bring change in the behavior of the people. Since the inception of Pakistan's family planning program, planners and policy makers have mainly focused their attention on the supply side of the program. The demand side of the program thus remained quite weak. Although the program adopted many strategies yet these strategies were either not materialized or could not serve for demand creation. Hence, the IEC was considered as an integral part of the population welfare program during the seventh and eighth five-year plans 1988-1993 and 1993-1998 respectively.

NIPS has evaluated IEC component of the programme by undertaking a national level sample survey. The main objective was to find out the impact of IEC component. From 3150 households, detailed information from 2681 respondents (Currently Married Women aged 15-49 years) covering both urban and rural areas of all the provinces of Pakistan was collected during 1997 and analyzed.

The exposure to T.V. is higher, compared to radio. Because of illiteracy and lower level of education, as expected, newspapers and magazines are ever read by a less number of women in rural compared to urban areas.

Three television plays on the theme of population welfare were telecasted i.e. 'Sidraan' shows women need education, 'Bhaithak' indicates higher age at marriage and 'Ghar Bhati' indicates the limiting of family. Messages conveyed through television about family planning were effective. Knowledge about family planning methods is high but the use rate of contraceptives is still low. There were different reasons indicated for non-use of

family planning method with 5.6 percent female sterilization being highest, followed by condom 5.7 percent, followed by IUD 4.7 percent. It is observed that radio, television and newspapers contribute to the awareness and use of contraceptive. The women who watch television are much more likely to use contraceptives. Hence, in the light of this study, proper and effective use of mass media and interpersonal communication to accelerate use of family planning method is recommended (Hakim and Tanweer; 2000: p. 1).

2.13 Quality and Situation Analysis of Family Welfare Centers in Pakistan:

The survey on "Quality of Care by Family Welfare Centers" was conducted by NIPS during 1998-99. Out of 1375 FWCs, a sample of 73 FWCs was selected (NWFP 12, Punjab 41, Sindh 15 and Balochistan 5). Then 80 clients from each sampled FWC, were selected and contacted at their home addresses given in the clients "daily attendance registers" or in Client Record". These women were among those who had visited the respective FWC during January 1, 1996 to December 31, 1997.

The study indicates that the entry in register was not proper, repetitive names were common. Apart from clients who had accepted a method for the first time, FWW had the tendency of converting old cases to new cases, in particular, when an acceptor changed the method. This also increased the frequency of new acceptors artificially. (Hakim and Ayazuddin; 2000:p. 1)

2.14 Performance of Family Planning Related NGOs in Pakistan:

This study is focusing on assessment of status of NGOs, functional NGOs and score secured by them. The results reveal that out of 242 NGOs, 59 NGOs (24 percent) are non-functional. The regional distribution of these NGOs indicate that 46 percent are located in Punjab, 26 percent in Sindh, 15 percent in N.W.F.P, 9 percent in Balochistan, 2 percent each in AJK and Northern Area and only one NGO was found in federal capital territory, Islamabad.

Most of the NGOs have registration with relevant government department and it is noticeable that 3.8 percent NGOs are found without registration. Majority of the NGOs (63 percent) have either their own building or donated. It is found that 39 percent NGOs have membership with international organizations while 95 percent NGOs have membership with national organizations. It is also observed that most of the NGOs have

the organizational structure to manage their activities as 85 percent NGOs are run by the Executive Bodies while 13 percent by Board of Directors.

About 84 percent of the NGOs have separate family planning sections in their setup. It is observed that 90 percent of the NGOs have paid staff while 79 percent were volunteers. About 95 percent of the NGOs have family planning as one of their objectives and 58 percent NGOs have raised their own funds.

Overall 88 percent of the NGOs have been found providing reproductive health and family planning services with 96 percent in N.W.F.P, 91 percent in Punjab, 88 percent in Balochistan and 79 percent in Sindh. Above 66 percent NGOs have their outlets ranging from 1-5, while 7 percent NGOs 6-10 outlets and 8 percent NGOs have 11 and more outlets in different parts of the country. Most of the NGOs have supervision system and training facilities. Out of 183 NGOs, 24 NGOs fall in the category of 'very strong', 60 in 'strong', 71 in the 'moderate', while 28 in the 'weak' category. (Hakim, Saqib and Bhatti; 2001: p. 10).

2.15 Current Population Policy of Pakistan:

The present Government has set up a Review Assessment Committee of the National Population Welfare Program. One of the gaps identified was the absence of Population Policy. The situation has been remedied in that Pakistan's first ever Population Policy that has Cabinet approval was announced by President General Pervez Musharraf on World Population Day, 11th July, 2002.

Vision: Achievement of population stabilization by 2020 through declines both in fertility and mortality rates.

Goals: The goals of Population Policy are to attain a balance between resources and population, to address various dimensions of the population issue, to increase awareness of the adverse consequences of rapid population growth, to promote family planning, to attain a reduction in fertility, to reduce population momentum through a delay in the first birth, changing spacing patterns and reduction in family size desires.

Objectives: These are the following;

1. Short Term:

I. Reduce population growth to 1.9 percent per annum by 2004.

II. Reduce fertility through enhanced voluntary contraception to 4 births per woman by the year 2004.

2. *Long Term:*

I. Reduce population growth rate from 1.9 per cent per annum in 2004 to 1.3 percent per annum by the year 2020.

II. Reduce fertility through enhanced voluntary contraceptive adoption to replacement level 2.1 births per woman by 2020.

III. Universal access to safe family planning methods by 2010.

Strategies: To Develop and launch advocacy[26] campaigns, to promote the small family norm, enhancing the role of stakeholders, ensuring availability of quality family planning & RH services, to adopt a shift from target oriented to people-centered needs and services, to coordinate and monitor a comprehensive network of family planning & RH services in Pakistan, linkage program, strengthen contribution of NGOs and media, to expand the role of the private sector through social marketing and local manufacture of contraceptives, Decentralize program management and service delivery to provincial and district levels, to ensure availability of the four prioritized areas of the Reproductive Health Package, i.e. family planning, safe motherhood, infant health and Regional Training Institutes (RTI) / Sexually Transmitted Diseases (STDs) through nationwide service delivery outlets in the public & private sector, male involvement in small family size decision-making and to ensure Population and Family Life Education for school and college students

Area of Policy Focus:

a. Population mainstreaming in national planning and development program.

b. Service Delivery Expansion and Improvement of Quality

c. Advocacy

d. Training and Capacity Building

e. Decentralization

f. Coordination

g. Mechanisms

h. Research in Population and Development

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[26] Active support of an activity or program

i. *Funding:* A total of Rs. 49.5 billion requirements are estimated for the next 19 years for achieving the fertility replacement perceived under the Population Policy by the year 2020, (Govt. of Pakistan, MOPW; 2002: pp 1-9).

2.16 International Ulama Conference on Population and Development 2005, Islamabad:

Ulama from 21 Muslim countries met in Islamabad, Pakistan from 4-6 May 2005 to discuss issues concerning population and development. They declare that Islam, which has its origin in Quran and Sunnah, provides guidance on all aspects of life including issues of population and development. They recognized the sovereign right of each country to establish, in the context of Islam, its own population policy and programme responding to country-specific needs and conditions. They declared that; Islam provides guidelines on population and development, Islam ordains moderation and better quality of life, the demographic profile of Muslim World shows the requirement of population stabilization policy, Provide affordable and accessible mother and child healthcare facilities, the religious scholars / Ulama must mobilize their communities for adoption of such a family norm in order to improve maternal and child health and develop healthy progressive Islamic Ummah. At the end a Council of participating countries was setup to monitor and follow up the implementation status of the Conference recommendations by each country. Pakistan's offered to extend secretarial support till next meeting is agreed. (Govt. of Pakistan, MOPW; 2005: pp 1-5)

2.17 Public Private Partnership in Population and Health in Pakistan:

Dr. Mohsina Bilgrami, mentioned the importance of public-private sectors partnership to improve family planning in Pakistan and to bring stability in the population of Pakistan. Pakistan's population growth rate has declined to 1.90%, FWCs increased to 1969, Reproductive Health Centers (RHCs) increased to 114, MSUs increased to 146, Reproductive Medical Protectors (RMPs) increased to 24560 and contraceptive prevalence rate has risen to 34% with a decline from 6.8 births in 1980, to 4.1 births per woman (TFR) in 2005, showing a strong trend in fertility transition. Policy makers say that Pakistan needs to put more donor effort & support is needed in further reducing population growth, increase education and employment opportunities & improve health of the poor.

A strategy to increase coverage, improve quality of care and make services affordable in current situation is only possible by building public private partnerships. It is the co-

working relation among Govt, NGO'S and Private profit based medicines companies. They can jointly strengthen the population control / family planning program in the country. (Population Windows; 2005: p. 5)

2.18 Donor Institutions Role in Pakistan:

The population health and education development issue requires efforts and contribution from all the stakeholders and levels of society. President Gen. Pervez Musharraf, in his message on World Population Day, 10th July 2004, urged the public/private sectors and society at large to promote and participate in the national cause of population welfare for the well being of the people of Pakistan. In Pakistan, it is the partnership between the public and private sectors that works to create policies and programs aimed at creating a moderate, prosperous state and preventing terrorism. Multilateral lending and funding institutions like the Canadian International Development Agency (CIDA), Human Reproduction Program (HRP), Co-sponsored by the United Nations Development Program (UNDP), the United Nations Population Fund (UNFPA), the Department for International Development (DFID) UK, the United States Agency for International Development (USAID), the World Bank, International Monetary Fund (IMF) and Asian Development Bank (ADB) have played a major role in providing financial and development policy advice to Pakistan over the last half-century.(Population Windows; 2004:p. 3)

2.19 Far Too Many Women Risking Death to Give Life (UNFPA), Report on Millennium Development Goal (MDG):

According to a Report of United Nations in New York 2005, on the progress and challenges in attaining the Millennium Development Goals (MDGs), Dr. Thoraya Ahmed Obaid, Executive Director of UNFPA, stated that living in a world, in which, a woman risks death each minute in order to bring new life, must be transformed. 'We must create a better, more caring world by doing all we can, to prevent millions of our less fortunate sisters from losing their lives to pregnancy and childbirth, especially when we know how to avoid these tragic deaths. Dr. Obaid said at the launch. 'Countries have long agreed that no woman should be left to die for lack of reproductive health services, and today's Report reaffirms that universal access to reproductive health care, including family planning, is the starting point for maternal health and saving women's lives.

Currently, 200 million women have an unmet need for safe and effective contraceptive services. According to the World Health Organization, if these women used effective contraception, more than 100,000 maternal deaths, one-fifth of the world total could be avoided each year.

Assessing the progress report on the MDGs, based on input from 25 UN agencies and global organizations, it is evident that success in fighting poverty has been very uneven. (Population Windows; 2005:p. 5)

2.20 Call to Reduce Rate of Population Growth in Pakistan:

The World Bank (WB) and the Asian Development Bank (ADB) have urged the Government of Pakistan to devise a long term strategy to lower its population growth rate, which unofficially was still considered over two percent. The WB and the ADB have attributed the 1.9 per cent population growth rate in Pakistan to widespread poverty in the country. The ADB has promised an additional Rs. 387.1 million in 2005, to fund the Ministry of Population Welfare's new program to strengthen and expand its services, aimed at reducing the population growth rate from 1.9 per cent to 1.5 per cent.

The new program will provide quality care and increased access to family planning services for the poorest communities by upgrading reproductive health facilities and human resource development. It is important to address the unmet need for family planning, help reduce maternal and infant mortality and total fertility rate, and lower the population growth rate through the involvement of NGOs and by strengthening public-private organizations.

The outcome should be an improvement in the status of women and poverty reduction through harnessing NGOs, training their co-ordinators, doctors, paramedics, and other personnel involved in reproductive health issues.

Latest reports show that Pakistan's rapid population growth rate of 1.96 per cent per annum has exacerbated poverty and negated the impact of development over the last decade. 'While fertility is declining, it has the potential to show the reverse trend, given the high unmet demand (33 per cent) for family planning,' the donors' report warns.

The donors' community expects the Ministry of Population Welfare to implement the communication strategy and specific activities will be developed and launched to meet the requirements of the target population. The main purpose of the activities will be to provide

complete and correct information to overcome any inhibitions, fears, doubts, and misconceptions about family planning. (http://www.dawiLconi/2005/06/14/natl.ht)

2.21 Population Summit 2005, Islamabad, Pakistan:

Ministry of Population Welfare has organized a Population Summit to seek advice of national, international experts and heads of international organizations on mainstreaming population concerns, building broad based partnerships and effective inter-sectoral coordination. Population Summit focused on the important themes such as relevance of population policy for achieving economic development and millennium development goals, significance of population for other sectors, public and private partnerships and building international partnerships. Population summit brought together the collective wisdom both nationally and internationally to tackle Pakistan's future population and development trajectory. It will essentially take forward the objectives of the population policy 2002, which asks for greater partnerships between government, and civil society.

Objectives:

- Review and make recommendations on the basis of the Executive Seminars held nationwide in 2004 for improvements in the population sector.
- Worked out modalities of drawing in partners from the private sector including NGO's and the corporate sector.
- Ensure more effective coordination between the critical Ministries such as Planning, Education, Health, Women and Development, Youth, Finance and Manpower.
- Draw in international partners to assist Pakistan in achieving its population and development objectives. Theme: Building Partnerships in Population and Development. (Govt. of Pakistan MOPW; 2005: pp. 1-5)

Part-F Review of Community Based Distribution Model in Family Planning (Case Studies of CBD)

2.22 Risk / Benefit in the Choice of CBD Family Planning Methods in DCs and UDCs:

Modern contraceptive technologies such as combined oral contraceptives and IUDs were developed in the late 1950s and introduced on a large scale in industrialized countries

more than two decades ago (Huber and Huber; 1975: 4). When family planning services evolved in developing countries during the 1960s, a western physician-oriented model was frequently adopted. It soon became apparent that programs depending upon physician services could not reach the majority of the population in need of family planning. Nevertheless, studies in several countries showed that non-physicians could provide modern family planning methods such as oral contraceptives, IUDs, and sterilization as safely and effectively as physicians (Atkins et al., 1980; Kennedy and Rodriguez; 1981).

This led to the development of community based delivery (CBD) programs in which lay workers from the community use simplified procedures and provide family planning in a non-clinic setting. The programs have in common a non-clinic focus, which implies that trained lay workers, often with minimal direct supervision or referral back-up, and without the prestige or support of the medical system, make family planning widely available, frequently in circumstances where clients have no other source of services (Gillespie and Merrit, 1977; Foreit, 1978; Rahman 1980; Altman and Piotrow, 1980).

The consequences of family planning on health depend largely on the balance between contraceptive risks and benefits and the risks of childbearing.

Oral Contraceptives: The majority of CBD programs have provided oral contraceptives because they are highly effective, relatively simple to administer, and require minimal "clinical" skills. Also, they have a high margin of safety (Foreit 1978; Rosen 1980; Osborn and Reinke, 1981).

Injectable contraceptives: These are not provided by USAID, but supplies may be made available to CBD projects through other sources. The drugs in most frequent use are Depo-Provera[27] (150 mg of depot for three months). Following this regiment the pregnancy rates for both drugs are less than 1 per 100 women over one year (WHO, 1977; WHO, 1981b).

IUD: Several studies have shown that many categories of health workers can be trained to provide IUD services, and training manuals and procedures have been developed for this purpose (Akin 1980; Gray 1980). The IUD is particularly suited for women who want to delay the next birth for a considerable time, or who want no more children (WHO, 1980).

Barrier methods of contraception: It is a temporary physical or chemical barrier between the sperm and the ovum. The most commonly used barriers are condoms,

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[27] It is used as a contraceptive of long duration and for treatment in abnormal uterine bleeding and secondary amenorrhoea; it is not commonly used in Pakistan. It was used in CBD settings in Columbia, Zair and Brazil.

diaphragms, and spermicidal in cream, Jell, or foam. These methods are supplied in a CBD setting. CBD workers should explain the principles of how barriers work one-time use, usage before penetration and removal without leakage (Tatum and Connell-Tatum, 1981).

2.23 Review of CBD-Model Implementation (The Case of Colombia):

According to use prevalence survey Colombia 1978, in urban areas 55.5 percent while in rural areas 19.8 percent women were using modern methods / contraceptives (Pobalcion, 1979). According to another survey 1979, 23 percent in rural area stated that they intended to use contraceptives. Thus, the design of the Boyaca project assumed a great potential demand for contraceptives in rural areas, and the possibility of satisfying demand through household distribution of family planning methods by promoters.

Normally, promoters receive a 12-week training course at the State School of Auxiliary Nurses, given by staff of the school and personnel from the State Health Department. The course covers topics such as environmental sanitation, medical care, (MCH and first aid), information about family planning, delivery of drugs and supervision. Training is carried out using lectures, movies audiovisual aids, and practical experience.

Field supervision of promoters was originally the responsibility of auxiliary nurses; four nurses were put in charge of the 100 promoters. Supervisors are responsible for organizing the promoters' work schedules, setting targets, providing training, evaluating the promoters work, monthly reports, supplies, home visits and monthly meeting is held by the supervisor and her promoters to review the work and to organize ongoing activities.

Before initiating delivery of services, each promoter takes a census of the population in her area. This census gathered data on women 15 to 45 years of age, number of living children, marital status, literacy, pregnancy status, desire to become pregnant, use of contraceptive methods, and source of contraceptive supplies. For children one to five years of age, weight, height and age were recorded. A final part of the survey gathered information on environmental sanitation in the household, the source of water, and garbage disposal. The censuses were repeated annually and constituted the main tool for evaluation. Each promoter reported her monthly activities on the same forms used to gather census information of women 15 to 45 and children one to five.

Family planning results were measured by changes in prevalence of contraceptive use. The study demonstrated that trained and supervised community agents could distribute oral

contraceptives without the need for routine medical examination. Project results indicate that prevalence of use of effective methods increased during the study period, especially the use of oral contraceptives among users who received them directly from the promoter. The number of women referred to health centers for IUD insertion or female sterilization also increased in all four groups. The Boyaca research project provided useful information for future planning. (Gomez; 1985: 203)

2.24 Review of CBD-Model Implementation (The Piaui State Brazil):

In April 1979 a community-based distribution (CBD) family planning project was launched in the state of Piaui, in northeastern Brazil. The major goals of this project, funded by the Japanese Organization for International Cooperation in Family Planning (JOICFP), were to develop an integrated service delivery model. The project site is located in the county of Oeiras, which has 47,300 inhabitants and a population density of 9.3 per square km. The population is 74 percent rural and 26 percent urban. In rural areas, family planning services were gradually added to 15 of the rural schools during the eight-month period from September 1980 to April 1981. In the urban area, family planning activities were not located in the schools but remained in the health posts. Field workers included distribution of family planning information among their other activities. The family planning workers in the rural area were full-time schoolteachers. In the urban areas, they also included students' aged 16 to 20. In rural areas mothers came to the schools to collect the medication for the entire family, while in urban areas students distributed the medication to all households. At that time, family planning was available at 4 of the 31 rural schools participating in the project, being added to the other schools with integrated programs only after September. In the urban areas, the students offered family planning information (but not supplies) at each house they visited. (Rodrigues and Valladao; 1985: 215).

2.25 Review of CBD-Model Implementation (The Case of Zaire):

The family planning and reproductive health project in Zaire, begun in 1981, relies on home visits by trained distributors. Home delivery of family planning services is comprised of distribution of oral contraceptives, condoms, and foam, with referral for injectable Depo-Provera, IUDs, and tubal-ligation.

The home visitors were auxiliary schoolteachers. These workers have demonstrated good communication skills through role-plays and field practice before home visits began.

Supervisory personnel were trained by being included in part of the worker training. The household visitors are traditional midwives, to whom female clients will come for supply after the initial CBD visits, The dispensaries are directed by nurses who have received an additional four days of project-specific training regarding family planning. The area hospital serves as a final referral point for complicated cases and for surgical contraception. Household visits are evaluated by the field supervisor and occasionally by the project coordinator and project director. (Mangani; 1985: 365)

2.26 Review of CBD-Model Implementation (Rural Nigeria):

The need for low-cost family planning and maternal and child health (MCH) services is apparent in rural Nigeria. The broad consensus among national and international public health professionals working in sub-Saharan Africa is that family planning services can best be offered in an integrated health context. Some factors leading to the emphasis on integrated family planning, health service delivery are: the acuteness of basic health needs, the widespread ideal of large families, and low interest in family planning (FP) in terms of family limitation but a somewhat greater interest in contraception for birth spacing to promote maternal and child health (traditionally accomplished through prolonged breastfeeding and sexual abstinence during lactation).

The present project confronts these issues within the rural Nigerian context. Traditional birth attendants conduct the majority of deliveries in villages, and other local community agents have been recruited from their villages. Working under the supervision of government nurse-midwives, they deliver basic MCH and FP information, supplies, and services to village residents at the household-level and make referrals for additional MCH/FP services to the local health/maternity center. This project marks a sharp break with the tradition of institutional care based on the western model, moving toward extension of service delivery and community involvement. Thus, the training and reorientation of the nurse-midwives is a crucial step in creating and expanding the project. The training and supervision of TBAs in the provision of basic MCH/FP services in the household will greatly alter their job description. If the project succeeds, the implication for governmental midwifery training and for the entire medical system could be profound.

Family Planning: Reasons given for objecting to family planning included the belief that childbearing should be left up to Allah. Only 10 percent of the educated women having 35 years of age approved family planning. Virtually none of the women had discussed family

planning with their husbands. Knowledge of modern family planning was very meager i.e. 26% women and 17% men. The most common contraceptives were injection, oral pill, and the IUD. Use of the modern methods was minimal; 2.5 percent of the women had ever used a method while only 1.5 percent was currently using a method, one must recognize that many children are desired, and that the accepted technique of child-spacing is breastfeeding.

Use of Health Services: Most women had not used a government health facility during the past year. Among the users 19 percent were in child welfare services, 12 percent maternal health services while 19 percent had two or more rounds of immunization. The majority of mothers (68 percent) bottle-fed their infants, usually starting around three months of age. Among those who breastfeed, the practice lasted an average of 19 months. Among these women, 24 percent delivered their child in a hospital, 30 percent delivered in a government maternity, nearly half delivered in their own home. Surprisingly, many of these women (33 percent of all women) said they delivered with no assistance from another person. Only 14 percent of the mothers said they delivered with the assistance of a TBA. The effect of the CBD project's upgrading of TBAs skills on the number of TBA-assisted births and the utilization of the government health facilities will be followed closely. (Ladipo, Weiss, Delano, Reuson, Onadeko and Ayeni; 1985: 371)

2.27 Review of CBD-Model Implementation (Bali, Indonesia):

The Indonesian family planning program has evolved through several critical and overlapping stages with the addition of nutrition activities to the successful implementation of the family planning program. Prior to 1969 and 1970, limited family planning information and services were offered essentially through a privately funded and administered single-purpose program. Once the government became publicly committed to intervene in the population crisis undertaking a nationwide program to promote the voluntary limitation of fertility, family planning services were channeled through existing health facilities, with the Ministry of Health providing a major portion of the services and support.

The province of Bali has attained a high level of family planning use among its eligible couples. One reason for the high use rate is that a high proportion of Balinese women work outside the home performing labor-intensive jobs, including construction and roadwork. This has led Balinese women to delay marriage and to desire smaller families.

The implementation of the family planning program in Bali is based on the traditional banjar system. An extraordinarily strong social and administrative group, the banjar is a traditional center for mutual aid and cooperative work, as well as a gathering point for recreation and ceremony. The contraceptive situation is discussed at each monthly meeting of the household heads. If an apparently fertile couple is not trying to conceive and also not using contraception, the husband is questioned. During the Community Based Organizations (CBO; Banjar) meeting, held every 35 days and attended by all CBO (banjar)[28] members, community problems are discussed. The family planning program has built upon the prevailing socio-cultural system in Bali. In the first semester of 1981 as much as 79 percent of total eligible couples were recruited as family planning acceptors in Bali. Family planning practice extends to more than 76 percent of the eligible couples in over 64 percent of the nearly 4,000 CBO (banjars) in Bali. (Soejatni. D.; 1985: 273)

2.28 Review of CBD-Model Implementation (The case of Guatemala):

This study describes the System of Integrated Nutrition and Primary Health Service (SINAPHS). The Guatemalan program of Primary health care (SINAPHS) main purpose is to increase the effective converge of primary health care services in rural populations of Guatemala. SINAPHS activities are aimed at controlling the most important immediate causes of death and disability in the maternal and child group immunizations, food supplementation, oral dehydration, family planning, prenatal surveillance, and promotion of the community. The Reproductive Health Program (RHP) and the TBA have the main responsibility for these services at the primary level (community and household). The RHP provides services through periodic household visits (every two months) and through community meetings at two-month intervals. Health services delivery, supervision, and training are performed by Ministry of Health (MoH) personnel within the same previously existing physical and administrative infrastructure. The training of volunteers is based on one-day sessions limited to a single topic, followed by service delivery, supervisory activities, simple tabulation of data routinely collected through the internal information system, monthly requests of needs for materials and equipment, and preparation of the quarterly reports to the health district chief. In this way training is integrated into supervision, data flow, and management. The RHP is supervised by Reproductive Health

[28] It is a community based organization working for community health and family planning

Technician (RHT), regarded as under-utilized in the MoH delivery system (Lechtig, Townsend, Pineda, Arroyo, Klein and Leon; 1985: 287).

2.29 Review of CBD-Model Implementation (The case of Bangladesh):

The CBD program has not only reduced fertility, but has probably been responsible for reducing mortality as well. The family planning and mother child nutrition program was initiated in 1984 in Bangladesh under the Mathlab Project adopting the CBD model. It should also be noted that the success in implementing tetanus toxoid was due in no small part to the fact that the Matlab CBD project is part of a well-organized program with many manpower and logistic resources. The tight organization makes it possible to organize and ensure that workers are available to deliver the immunization at the required times and to distribute the contraceptives among the community members. (Shushum Bhatia; 1985: 323)

2.30 Review of CBD-Model Implementation (The case of India):

The organized family planning program is a fairly recent phenomenon in the developing world. Much has happened since India declared the first official population policy in 1952. In 1970's with the realization that a clinic-based system could never adequately serve the largely rural population, modifications began to be made. Outreach workers traveled into communities to recruit new and follow up old acceptors. Mobile clinic were in fashion for a time, taking the clinic to the people. This metamorphic trend continued and became quite intense and innovative in 1970s. Delivery systems were developed that was no longer tied to a stationary clinic or a physician. The system that evolved has been generally termed community-based distribution. In most community-based systems, Family planning services are provided by specially trained laypersons from the community. Having no physicians provide such services as oral contraceptives was unthinkable. Now, there is little exception's about it (Huber et al., 1975; Foreit et al., 1978 Rosen field et al., 1980). The first social marketing program was launched in India in 1970. This program provides subsidized contraceptives through retail outlets; in ten years (Altman and Piotrow, 1980). From tentative efforts with household visitation in India (Osborn, 1974; Population Council, 1964) many programs have developed which systematically canvass households, providing a wide variety of family planning services. (Gillespie. D. G.; 1985: 25)

2.31 Review of CBD-Model Implementation in Pakistan:

The CBD program was initiated in Pakistan during 1991, but practical steps were taken in 1992 with the introduction of VBMFPW, LHW, LHV, and Field Motivators. The village Based Family Planning Workers' Scheme was introduced in Pakistan in 1992 in order to increase the coverage of Family Welfare Program in rural areas and to improve its accessibility in Pakistan's Villages. The scheme was expanded during 8th Five Year Plan 1993-98 and it gradually built a promising foundation for the provision of family planning services in rural areas. However the scheme had a basic limitation that its efforts were directed towards female population only as the cadre consisted of only female workers. International Conference on Population and Development (ICPD) held in Cairo in 1994, emphasized the need of responsible male participation in Population Welfare Program to effectively motivate couples to adopt small family norm. Accordingly the cadre of Male Village Based family Planning Workers (MVBFPW) was created.

Ministry of Population Welfare launched Male Village Based Family Planning Workers project on pilot basis in few districts during 1998-99. It was planned to increase the number of MVBFPWs in a phased manner from 612 MVBFPWs in 1998-99 to 7012 in 2002-03 but the number could only be increased up to 787 by the end of 2000-2001.

A study of male workers conducted by NIPS during April-May 2002 shows that almost all the male workers received basic training required for the job in CBD settings, provide family planning information and motivation to the community, register eligible couples, and provide condoms. It is noted that Referral System is functioning satisfactorily. Overall, 48 percent of the male workers referred the cases to Family Welfare Centers, 16 percent referred to Basic Health Units, 13 percent to MSUs, 8 percent to Lady Health Workers, 7 percent to Rural Health Centers, 6 percent to Female Village Based Family Planning Workers and 4 percent to RHS-A Centers. For spacing, 82 % male workers are recommending condoms as a contraceptive method compared to pills 70%, injectables 48 % and IUD 45 %. Thirty seven percent male workers were charging fee for contraceptive methods. Seventy nine percent male workers confirmed that monthly group meetings are being held at Tehsil Office. (Amanullah, 2002)

A study was conducted in 1998-99 to introduce and test a protocol for training and instructing Village Based Family Planning Workers (VBFPWs) for providing injectables contraceptives to their clients. This was done in two districts, Multan in Punjab and

Mardan in North West Frontier Province. Doorstep provision of injectables within this system resulted in substantial short-term improvements in injectable use that do not appear to have been at the expense of use of other methods. Apart from the special training in injectables, improved training and supervision of VBFPWs in carrying out their existing responsibilities resulted in improved attention to their assigned tasks, which in turn resulted in overall increases in contraceptive prevalence and continuation of modern temporary methods. (Ameen and Safia. 2000: pp. 2-12).

Parallel with VBFPP the Lady Health Workers Program, Primary health care and family planning program and mother-child health care program were initiated in Pakistan in 1994, to achieve universal health coverage and access to primary health care, to expand family planning & safe motherhood activities. The programs recruit and train women from target communities to provide health education related to women & child health, to provide basic health services like antenatal care, immunization & contraceptives methods etc. After the initial enrolment training, program supervisors & periodical refresher training in CBD settings provide technical support and supervision to them. From 1994 to 2002, 70,000 workers have been trained which cover 48 % of population. The program has got extended to 2010 with allocation of sufficient funds to address the primary health care problems and participation of the community. The responsibilities of the LHVs, VBFPWs and Mobilizer are to provide door-to-door family planning and basic health care services especially to mothers in the community and ensure the provision of preventive, promotive, curative and rehabilitative services.

There were two cadres of community based health workers:

a) The Lady Health Workers (LHW) having linkages with the First Level Care Facilities (FLCF) and offering primary health care services.

b) The Village Base Family Planning Workers (VBFPW) focusing on family planning activities in rural areas.

Both these programs are success stories in their respective area of competency, but they remained parallel and vertical programs with the occasional duplication of services. Realizing this factor and in order to offer a comprehensive integrated PHC/RH services, the government has recently decided to integrate both the programs into one structure. Thus, both the cadres now called Family Health Workers (FHWs) have a standard job description outlined in the National Reproductive Health Services Package. Thus, this

Community-Based Program strengthened in terms of supervision and monitoring ensures the quality of services offered by the FHWs. The increase in the number of FHWs, the capacity of existing Program Managers need further improvement for addressing both efficiency and effectiveness of NP-FP and PHC (National Program for Family Planning and Primary Health Care, Ministry of Health).

This program is aimed to strengthen quality as well as coverage of LHWs for reproductive health services (through PHC system) by improving knowledge, skill and behavior through training and health education and by institutionalizing quality assurance in the NP-FP and PHC.

Lady Health Supervisors are also educated ladies with special qualification in medical dispensing/technologies as well as having at least HSSC education. They are responsible for monitoring, supervising and evaluating the activities of 20-30 LHWs in the community on day-to-day basis. At the end of each month these LHWs have a meeting in the district health office regularly. The important point is that, each Lady Health Supervisors (LHS) has been provided a vehicle by the government for day-to-day supervisory activity. The management for these vehicles also provides POL.

The LHW has very important role in the health of mothers in rural areas and urban slums as shown by the Pakistan household survey report 2001. The health of people of Pakistan has improved in general and health of mothers in particular, which reflected that the performance of Lady Health Worker in Mother-Child Health Care (MCHC) had been effective. (Save the Children USA; 2001: pp 211-216 and NIPS; 2001: pp 10-16)

CHAPTER-3

METHOD AND PROCEDURE

3.1 Nature of the Study:

The study was conducted under the descriptive method of research for the reason of its predominant position in the social sciences. Descriptive method is supposed to cover almost all realities and facts related to the study and that is why the social scientists have been practicing their investigative work under the descriptive research method. Descriptive research investigates how an existing phenomenon is related to some preceding event or what is the effect of that preceding event on the present condition? Its processes involve gathering and tabulating facts, elements of analysis and interpretation, and comparison or contrast as well as their measurement and classification. Data of descriptive research can be expressed both quantitatively and qualitatively. The importance of such research method in reference to the existing study can be seen in the form of bringing answer to some basic questions regarding the role of public and private sector organizations towards population control. The major objective of applying this method was to assess in easier way, the community based approach in population control / family planning implementation in target area. The prominent features of the method, which helped in study, included examining a problematic situation, selecting appropriate subjects and sources of materials, providing an opportunity to observe community distribution of contraceptives and reproductive health care, describing, analyzing and interpreting data, and arriving at findings and conclusions in the clear form.

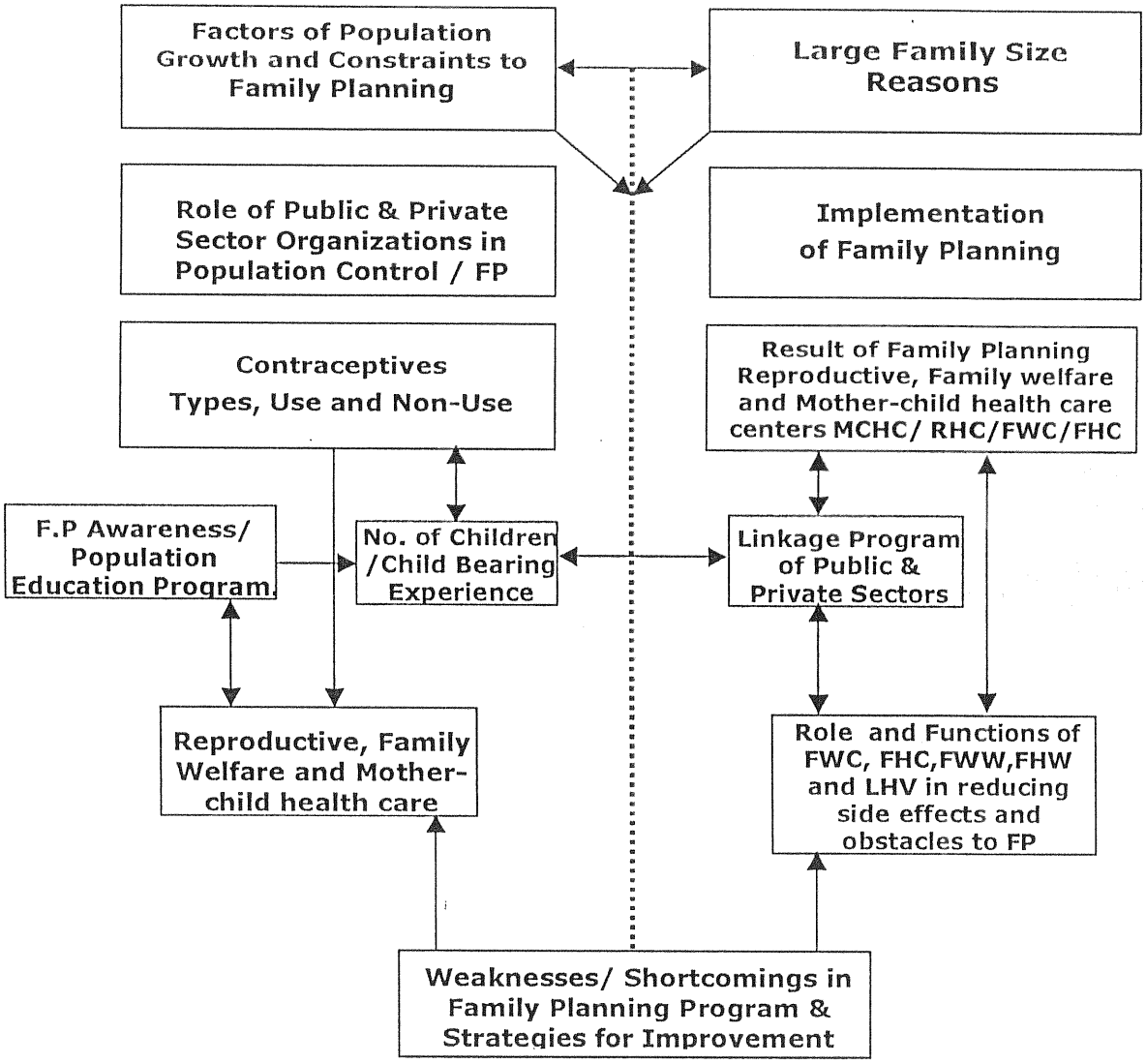
3.2 Universe:

This study was confined to the population control / family planning program of public and private sector organizations in the rural area of Peshawar, which is the top populated district of the province of the North-west Frontier. The major focus of the program is to control population through community based distribution services. In this program there are three active roles; Govt. family planning organizations Staff, NGOs (family planning organizations) Staff, and Community beneficiaries of family planning organizations and all of these were interviewed through different sheets of questions. These three decisive elements constitute the universe of the study.

3.3 Study Matrix:

The study was conducted in the light of a model "Community Based Distribution Model" providing a proper footing to the study. This model, as seen the best in applying to the study, eased all the pre and post study difficulties, and made possible to reach the study objectives and indicators evaluation in appropriate way. The model is given in diagram form for further explanation of all basic contents.

Study Scheme / Matrix, the CBD Model:



Source: Huber (1975) in USA, Pobalcian (1979) in Columbia, Foreit, (1978), Rozen Field (1980) in Brazil, Soejati (1983) in Bali Indonisia, Lectig and Klein (1978-79) in Guatemala, Rehman (1982) and Ciro (1984) in Bangladesh, Gillespie (1985) in Maxico, Rajvida, Kumar and Rao (1985) in India, Hakim, Ruknudin and Hashmi (1987 and 1992) in Pakistan.

3.4 Introduction and Components of CBD Model:

The community based distribution model of family planning and population control was introduced in 1970's by USAID and UNFPA to accelerate the activities of family planning, reproductive and mother-child health care in different regions of the world. The first experiment was held in 1975 in USA, by Huber (1975), and then it was further implemented by Pobalcian (1979) in Columbia, Foreit, (1978), Rozen Field (1980) in Brazil, Soejati (1983) in Bali Indonisia, Lectig and Klein (1978-79) in Guatemala, Rehman (1982) and Ciro (1984) in Bangladesh, Gillespie (1985) in Maxico, Rajvida, Kumar and Rao (1985) in India, Hakim, Ruknudin and Hashmi (1987 and 1992) in Pakistan.

The different components of CBD model are explained as follow:

I. **Number of Children:** The central component of the model is the number of children. The model determined small number of children usually two, will lead to success of family planning program.

II. **Linkage Program of Public and Private Sectors:** The second major component of the CBD model is the linkage program of public and private sector. The model says that public private partnership will ensure success of the family planning program.

III. **Family Planning Awareness and Information Program:** The third major component of CBD model is the awareness and information program of family planning. Various sources of communication are used to advertise and popularize the family planning program. Only the successful and proper way of communication can ensure the success of family planning program.

IV. **Reproductive, Family Welfare and Mother-Child Health Care Centers and their Results:** The fourth component of CBD model is the availability of reproductive, family welfare, family health and mother-child health care centers. These are the service delivery outlets, the availability of these centers resultant to proper health of mother and child, before, during and after delivery. The reproductive health care and pre natal and post natal care is possible due to these centers. Moreover these centers provide different types of contraceptives and informative as well as curative services to the expectant mother and child. The positive result and proper strategies of these centers lead to success of family planning program.

V. Role and Functions of Reproductive, Family Welfare and Mother-Child Health Care Centers and staff in reducing the side effects and constraints to family planning: The major functions of family planning centers and staff are to inform the clients about the proper usage of contraceptives and to remove different types of worries and obstacles in its implementation. The staff give instructions to the clients about precautions and side effects of contraceptives on health and then also provide useful information for reducing the side effects of contraceptives.

VI. Contraceptives Types, Use and Non-Use: The sixth component of the CBD model is the availability of different types of contraceptives, their use and non-use. The model indicates that different types of contraceptives will be available in a community, but the clients will use those contraceptives which are convenient, beneficial, less costly and with low side effects. The model also focus on the sources of contraceptives if contraceptives are provided to them with in the community through mobile unites staff then the program will be successful.

VII. Factors of Population Dynamics, Constraints to Family Planning and Reasons of Large Family Size: One of the significant components of CBD model is the factors of population growth, constraints to family planning and reasons of large family size. The model says that this component attracts the policy makers, planners, scientists and demographers to organize and plan such a program of family planning and birth control to ensure the small size of the family, because constraints to family planning and reasons of large family size are responsible for population growth in a society.

VIII. Shortcomings in Family Planning Program and Strategies for Improvement: The last but not the least component of the CBD model is the shortcomings in family planning program and proper strategies of family planning organizations to overcome these shortcomings in the program.

3.5. Operationalization of Hypotheses:

I. Better awareness; information and popularization program of family planning organizations better would be the chances of family planning strategies implementation in the area.

Independent Variables:

a. Family planning awareness and popularization major sources: By awareness we mean to get informed, and to know about something needed and required, while

popularization means to do advertisements of some thing in such frequent way that it becomes the daily activity and no more remained new phenomena.

The major sources of awareness and popularization of family planning are TV, Radio, family planning staff (awareness, motivation, counseling, convincing, educating for family planning), and family planning literature (brushers, booklets, pump lets, posters, symbols, and guidelines for the usage of contraceptives

b. Family planning awareness and popularization minor but popular sources: Wall chalking, banners, signboards, posters, (Small family better life, two children are better and enough, small family better mother-child health, large family over burden), Newspapers, magazines (Advertisements, messages, information related to family planning can easily be disseminated to the masses), Seminars, workshops, conferences, friends, relatives, husband and wife (best sources of information, motivation, convincing, counseling and awareness about family planning).

Dependent Variables:

Strategies of Family Planning Organizations (FWCs): Women education, improvement in communication and remedy of constraints to family planning

II. Better the facilities and functions of family planning centers, higher would be the use of various contraceptives/ methods of family planning.

Independent variables:

Facilities and Functions of family planning Centers and Staff: Informative and curative (awareness, counseling, motivation, provision of contraceptives, treatment, checkup, medicines, MCHC and RHC, door-step service, camps and mobile service) functions and facilities in family planning organizations

Dependent Variables:

Contraceptives Types and practicing:

Male Contraceptives; Withdrawal, condom and vasectomy.

Female Contraceptives; Oral pills, injectables, sterilization and multi load / copper-T / IUD.

III. Problems and side effects of contraceptives lead to better strategies to overcome them.

Independent Variables:

a. **Side Effects of Contraceptives:** Weight gain, swelling, infection, irregular menses, bleeding, temperature, headache, vomiting, no hepatize and socio-psychological problem.

b. **Problems in reducing the side effects of contraceptives:** No proper treatment, care by service providers, no proper awareness and information, no care and follow up by patients/ clients.

Dependent Variables:

Strategies and Role of Family Planning Organizations: Informative and curative (counseling, awareness, proper usage of contraceptives, change the method / contraceptive, proper treatment and prescription of family planning staff). Proper check up, treatment and medicine for feed back, qualified and dedicated family planning staff, awareness program for proper usage of contraceptives, change the method/ contraceptive and use of preventive medicines.

IV. Better the mother-child health care program better would be the result and strategies.

Independent Variables:

a. **Mother-Child Health care program:**

i. **Mother Health Care:** Informative and curative (counseling, antenatal, postnatal, treatment, vaccination, iron tablets, medicines, balance diet to mother).

ii. **Child Health Care:** Before, during and after delivery (family planning staff visit home on payment/ free in RHC), vaccination on due time, immunization, breast feeding & additional nutrition to child.

b. **Problems in Mother-Child Health care Program:** Varies constraints to MCHC (ignorance, no proper treatment, checkup and medicine) and various constraints to family planning (eco-, socio-cultural, religious, psychological, medical-technical, quality of service).

Dependent Variables:

a. **Strategies/ Role of Family Planning Organizations:** Solution to various constraints in mother-child health care (health education, awareness, counseling and motivation through proper staff, proper treatment, checkup, tests, medicines, health facility at door step, free medical camps at rural areas etc.)and solution to various constraints in FP (free counseling, motivation, awareness, treatment, medicines, avoiding early marriage,

maximum male children, meeting with religious leader, solution of psychological worries, solution to side effects, improving quality of service)

b. **Results of Mother- Child Health Care Program:** proper health protection, safe delivery and trust on MCHC/ RHC

V. Higher the existence (Causes) of large family size problem, higher would be the acceleration in the role/ strategies of family planning organizations.

Independent Variables:

a. **Early marriage age as a reason of large family:** 13-22 years and 23-32 years

b. **Polygamy and maximum number of marriages as a reason of Large Family:** One, two and three marriages.

c. **Desire for maximum male children as a reason of large family:** (Sons are guns, power, prestige, inheritance of property, Source of Income, Support in old age and socio-psychological protection).

d. **Various Constraints to family planning as a reason of large family:** (Poverty / economic, religious, socio-cultural, governmental/ political, medical-technical, and quality of service)

Dependent Variable:

Strategies and role of Family Planning Organizations: Proper counseling, motivation for small family, contraceptives, large family economic burden , to avoid early marriage, maximum children, son and daughter are equals, proper checkup, treatment, medicines, home visits and solution of Constraints

VI. Higher the constraints and shortcomings in family planning, higher would be the struggle and strategies to overcome them.

Independent Variables:

a. **Economic Constraint/ Obstacle to Family planning:** Poverty, no income & employment, high expenses of the family, expensive medicines lack, no resources, infrastructure, building, equipments, treatment, medicines, and budget.

b. **Religious Constraints in Family Planning:** Family planning is sin, killing of humanity, illegitimate, against natural law, fatalism, God is food provider, no one can stop those souls to be produced, increase Muslims, immoral, plane of non Muslims.

c. **Socio-Cultural Constraints in Family Planning:** Desire for maximum male children (sons are guns/power/prestige/property source/dominance, income source, helping hand in old age, socio psychological protection etc), family planning disapproval by husband and in laws, women can not go out of home (Pardah),shyness and no decision by women, early marriage, wrong propaganda, negative public opinion.

d. **Governmental / Political Constraints in Family Planning:** No proper funds allocation, based on foreign aid and Policy change.

e. **Psychological Constraints in Family planning:** Worry of side effects of Contraceptives, conception and infertility.

f. **Medical-technical Constraints:** Health problems (irregularity of menses/bleeding, pregnancy problems, weight, swelling, weakness, no hepatize, vomiting, giddiness, headache etc), no family planning and health awareness, motivation, follow up, fear from taking medicine/ contraceptives due to side effects , no proper trained staff, equipments, medicine, checkup and treatment.

g. **Quality of Services Constraints:** No proper budget, no involvement of health outlets, coverage, outreach, information, supervision, monitoring and evaluation, strategy change, low quality contraceptives, questionable service, no proper services, doorsteps, less satisfaction, male involvement, proper trained family planning staff.

h. **Weaknesses and shortcomings in implementation of family planning:** Side effects of contraceptives, no proper policy, planning, research, strategy, involvement of religious leader, male interest, awareness and education programme about family planning, various obstacles to family planning, no role of media, related departments, health, district govt. and welfare organizations

Dependent Variables:

a. **Strategies and role of Family Planning Organizations for Economic Constraints:** Free counseling, checkup, treatment, natural gap by breast feeding (LAM), nominal charges, company rate contraceptives and foreign aid support

b. **Strategies and role of Family Planning Organizations for Religious Constraints:** Meeting and consulting with religious leaders (Ulema Project), motivation, awareness, counseling and convincing religious people, collection of

different statements/ fitwas and religious literature distribution in favor of family planning.

c. **Strategies and role of Family Planning Organization for Socio-Cultural Constraints:** Small family norms, small family better life, two kids are better, son & daughter are equal, maximize gap through motivation, to avoid early marriage and polygamy and women empowerment.

d. **Strategies and role of Family Planning Organizations for Governmental / Political Constraints:** Collaboration of public and private sector, struggle to continue, getting support of the govt. / foreign donors

e. **Strategies and role of Family Planning Organizations for Psychological Constraints:** Counseling, motivation, awareness for proper usage, change of contraceptive, reduce fear of side effects, proper check up, treatment, medicine, prescription of family planning staff.

f. **Strategies and role of Family Planning Organizations for Medical-technical Constraints:** Motivation, awareness and counseling for proper usage, change of contraceptives, proper checkup, treatment, medicine, multivitamins-iron tablets, prescription by qualified and trained family planning staff.

g. **Strategies and role of Family Planning Organization for Quality of Service Constraints:** Budget based on foreign assistance, proper supervision, monitoring and evaluation of family planning, proper, qualified & trained staff, male staff involvement for male motivation, proper awareness about contraceptives, doorstep service and mobile service units

h. **Strategies to overcome shortcomings and suggestions for improvement of FP:** Role of media, district government, religious leaders, family planning education, awareness, enlightened vision, counseling, motivation and communication programme of FP, qualified and trained staff and establishment of more family planning organizations

3.6 The Sample Size/Techniques:

It was very difficult to approach all the public and private sector family planning organizations in case of beneficiaries only. Hence under the sampling method, 9 out of 17 FWCs, 2 out of 3 RHS-As and 01 MSU in the public (Govt.) sector and 2 out of 3 FHCs, 01 RHS-B and 01 MHU in private sector (NGO) were selected as study units for the

purpose of data collection. Therefore only sampling method was a justified method for selecting the respondents.

At first stage the researcher did mapping of the whole district to see the location of the targeted family planning organizations, after locating the existence of the family planning organizations, staff strength and total number of beneficiaries in these family planning organizations during the FYs 1999-2003 on the register of the organizations. The researcher then used proportion allocation sampling technique for selecting the number of respondents from all the three categories of stakeholders i.e. Govt. family planning staff, NGO family planning staff and beneficiaries / users of family planning from these organizations. The sample size was 70 for Govt. Family Planning Staff, 60 for NGO staff and 300 registered beneficiaries / clients for five years i.e. 1999-2003 in these organizations were interviewed, in order to evaluate the role of public and private sectors organizations in family planning in the target area. The sampling method for all these three stakeholders can be justified, as in any research activity the whole of population is neither interviewed nor measured. Resultantly, the method of sampling is adopted to draw inferences or generalizations on the basis of careful observation. A sample is a smaller representation of the large whole. Sampling is the selection of a minute part from the large population. Though the list and physical presence of both staff and beneficiaries were available, but even then sampling was necessary because of large population and scarcity of time and resources to interview all of them.

The detail of the sample size and sampling technique used for the selection of the family planning Govt. staff, NGO staff and beneficiaries of these family planning organizations.

a. Sampling Design for Public Sector / Govt. Staff:

Area	Center/Institute	Staff Population	Sample Size	Representation
Peshawar	FWCs = 17	85	55	64.7%
RHS-A Peshawar	KTH, LRH, HMC = 03	18	11	61.1%
MSU	Peshawar = 1	6	4	66.6%
Total	**21**	**109**	**70**	**64.2%**

Proportional sampling formula was used i.e. $n_1 = N_1 / N_i \times n_i$

Staff designation and their number selected:

1. LHVs = 14	4. VBFMs = 14
2. FWWs = 14	5. TBAs = 10
3. VBMMs = 14	6. Gynecologist = 4

b. Sampling design for Private Sector Organizations / NGO'S Staff:

Area	Center/Institute	Staff Population	Sample Size	Representation
Peshawar	RHS-B / FHH (RK) = 01	27	22	81.0%
Peshawar	FHC (RK) = 03	21	17	80.9%
Peshawar	MHU RK = 01	06	05	83.3%
Total	**07**	**73**	**60**	**82.1%**

Proportional sampling formula was used i.e. $n_1 = N_1 / N_i \times n_i$

Staff designation and their number selected:

FHH (RK): 1. WMO = 04 2. MMO = 01 3. Nurse(Counseling) = 06 4. LHV = 06 5. TBAs = 05	**FHCS (RK)** 1. LHV = 06 1. TBAs = 11 **MHU Staff** 1. LHV = 02 TBAs = 03

c. Sampling design for Family planning beneficiaries Respondents:

Area	Center/Institute	Selected Centers	Representation	Beneficiaries Population P.A. (2003) Contraceptive users	Sample Size
Peshawar	FWCs = 17	9	52.9%	a. Condom (m) = 530	14
				b. Oral Pills (f) = 330	09
				c. IUD/Copper–T (f) = 360	09
				d. Injectables (f) = 1540	39
RHS-A Peshawar	KTH, LRH, HMC = 03	2	66.6%	a. Injectables (f) = 330	09
				b. Vasectomy (m) = 390	09
				c. Sterilization (f) = 1020	26
Peshawar	MSU = 01	1	100%	a. Injectables (f) = 1010	25
RHS-B Peshawar	FHH (RK) = 01	1	100%	a. IUD/Copper–T (f) = 1010	25
				b. Injectables (f) = 1020	26
				c. Vasectomy (m) = 300	08
				d. Sterilization (f) = 1005	25
FHCS Peshawar	FHCS (RK) = 03	2	66.6%	a. Oral Pills (f) = 220	05
				b. IUD/Copper–T (f) = 260	06
				c. Injectables (f) = 1105	28
Peshawar	MHU = 01	1	100%	a. IUD/Copper–T (f) = 350	09
				b. Injectables (f) = 1105	28
Total	**26**	**16**	**61.5%**	**11885**	**300**

300 Contraceptive users were selected out of the total 11885 users in district Peshawar Family Planning Centers (both public and private sectors) by the following proportional sampling formula: $n_1 = N_1 / N_i \times n_i$

3.7 Tools of Data Collection:

The data were collected through pre-designed questionnaire and interview schedule. **A. Questionnaire:** The questionnaire is a set of carefully selected and ordered questions prepared by an investigator to seek factual information from respondents or to find their opinion, attitude or interest. Whereas the close-ended form of questionnaire solves difficulties related to the very nature of questions and make it easy for respondents to fill in. It takes little time for a respondent to answer. The collected data is objective in nature and can easily be tabulated and analyzed. Three separate sheets of questionnaires in close-ended tabular form were developed for the staff working at the strength of family planning public and private organization centers as well as the educated beneficiaries of these organization centers.

B. The Interview Schedule: It is the same method with the addition of the presence of investigator in the field, mainly for the reason of uneducated or less educated status of the respondents. However, more accuracy of data and less consumption of time are the salient features of such practice. Three separate sheets of interview schedule were designed for the members of the family planning public and private low educated staff as well as the beneficiaries of these organization centers.

The questions of measuring scales in the study were thoroughly thought and finalized in the light of relevant literature, objectives and parameters of the study, and observation of the field regarding the perception of the staff and beneficiaries of family planning organizations. Although all the tools were designed in English, but interviewing respondents under the interview schedule method was conducted in the local language *Pashto*. It is imperative to mention that all the tools of data collections were compiled in the frame of the study model *Community bases distributions Model* and results were drawn accordingly. The study matrix proved very much helpful in the determination of study directions centered at the exact points of community adaptation of family planning in all-important activities mentioned in the contents of the model.

3.8 Modality:

The educated staff and beneficiaries were investigated through closed ended tabular questionnaire. Some of the staff and beneficiaries filled in the questionnaires directly on the spot, while some received and returned filled on the next day. The research scholar

personally interviewed the respondents from the entire stake holding strata through different tools of data collection. The prime purpose of this act by the researcher was to observe himself, the role of public and private organizations in population control, however, in some cases where there was difficulty to collect data from some of the female beneficiaries then female students collected data from such respondents.

3.9 Pre-testing:

Five copies of each tool of data collection were circulated among the concerned respondents for the purpose to tryout the applicability of questions included therein. After necessary omission and addition of questions, interviewing the respondents was initiated on regular basis. The tried out copies in the revised form were included in the total number of each group.

3.10 Data Analysis and Presentation Procedure:

After pre-testing the study went through data entry on SPSS Spread sheet, classification, tabulation, figures interpretation, description, verification of hypothesis, conclusion and recommendations.

CHAPTER-4

DATA ANALYSIS AND INTERPRETATION

4. 1 Part-I Data Analysis & Interpretation of Public (Govt.) Staff:

A. Number of Children:

Table-1 Number of Male Children:

Spec	Years			
	1999		2003	
	F	%	F	%
0-1	50	71.4	30	42.9
2-3	20	28.6	40	57.1
4<	-	-	-	-
Total	70	100	70	100

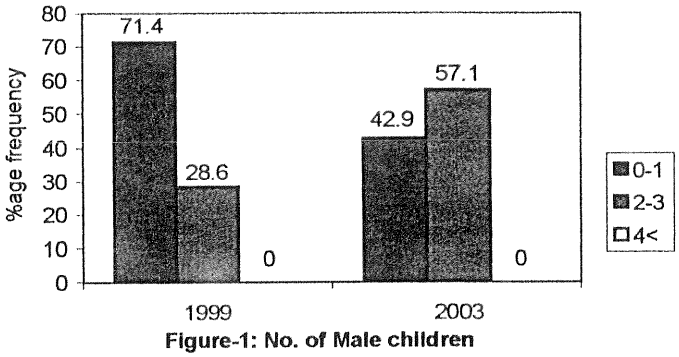


Figure-1: No. of Male children

Table-1 shows that 71.4 percent and 28.6 percent in 1999 and 42.9 percent and 57.1 percent in 2003 replied that they were having 0-1 and 2-3 numbers of male children respectively.

Table-2 Number of Female Children:

Spec	Years			
	1999		2003	
	F	%	F	%
0-1	60	85.8	45	64.2
2-3	10	14.2	25	35.8
4<	-	-	-	-
Total	70	100	70	100

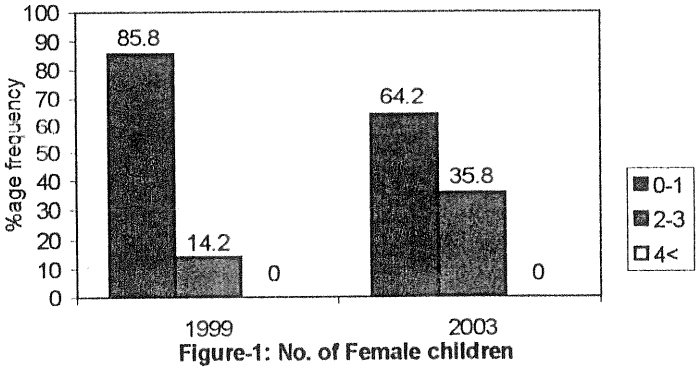


Figure-1: No. of Female children

Table-2 shows that 85.8 percent and 14.2 percent in 1999 and 64.2 percent and 35.8 percent in 2003 replied that they were having 0-1 and 2-3 numbers of female children respectively.

B. Educational Status and Practice of Family Planning:

Table-3 Uneducated and Practice of FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	13	18.6	38	54.3
No	57	81.4	32	45.7
Total	70	100	70	100

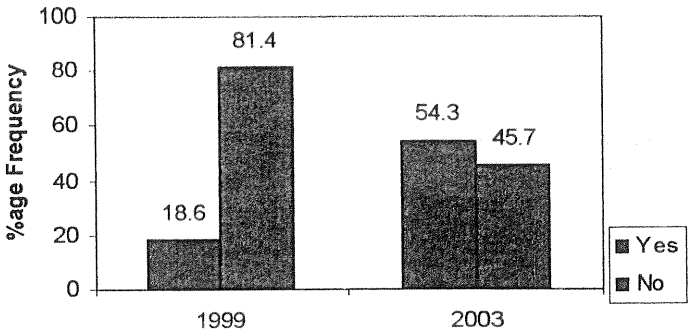


Figure-3: Uneducated and Practice of FP

Table-3 shows that 18.6 percent in 1999 and 54.3 percent in 2003 replied that uneducated respondents were practicing family planning, While 81.4 percent in 1999 and 45.7 percent replied negatively in this regard.

Table-4 Educated and Practice of FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	65	92.9	70	100
No	05	7.1	-	-
Total	70	100	70	100

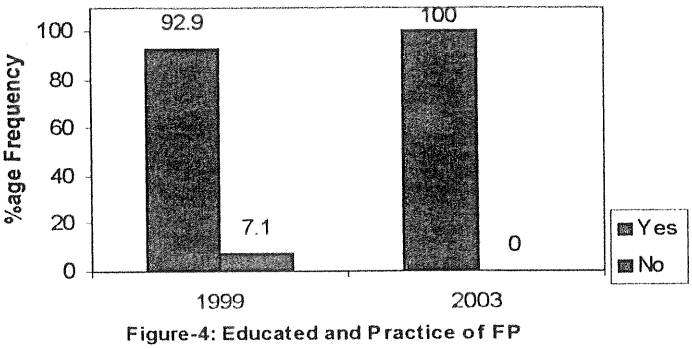


Figure-4: Educated and Practice of FP

Table-4 indicates 92.9 percent staff respondents 1999 and 100.0 percent in 2003 replied that educated respondents were practicing family planning, while only 7. 1 percent in 1999 replied negatively in this regard.

C. Sources of Awareness, Information and Popularization of FP:

Table-5 Major Sources of Awareness of FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	66	94.3	68	97.1
No	04	5.7	02	2.9
Total	70	100	70	100

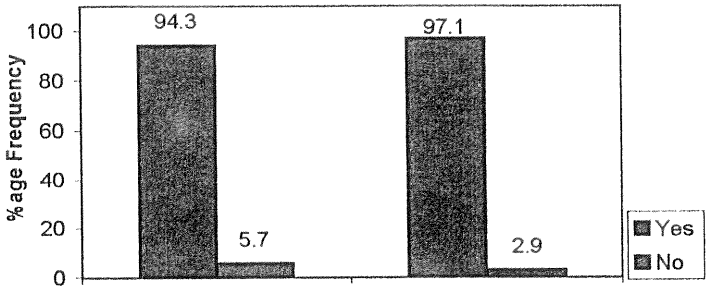


Figure-5: Major Sources of Awareness of FP

Table-5 indicates that 94.3 percent staff in 1999 and 97.1 percent in 2003 specified for family planning staff, literature, TV, radio, relatives, friends, husband and wife as the major sources of awareness and popularization of family planning, while 5.7 percent in 1999 and 2.9 percent in 2003 replied negatively.

Table-6 Minor Sources of Awareness of FP:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	39	55.7	42	60
No	31	44.3	28	40
Total	70	100	70	100

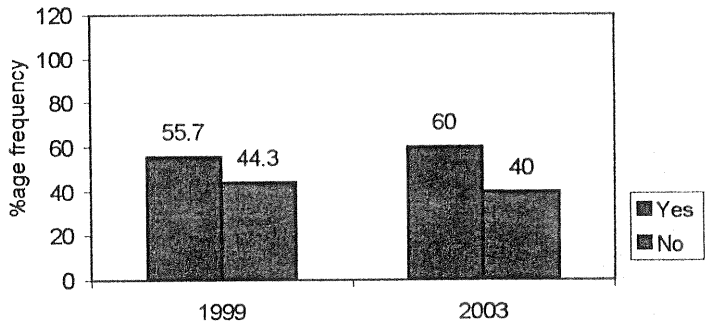


Figure-6: Minor Sources of Awareness of FP

Table-6 shows that 55.7 percent staff in 1999 and 60.0 percent in 2003 specified for wall chalking, banners, sign boards, seminars, workshops, conferences, news papers and magazines as minor sources of awareness and popularization of family planning, while 44.3 percent in 1999 and 40.0 percent in 2003 replied negatively.

D. Problems Faced During Awareness and Popularization of FP:

Table-7 Ignorance, Communication and FP Constraints:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	70	100	68	97.1
No	-	-	02	2.9
Total	70	100	70	100

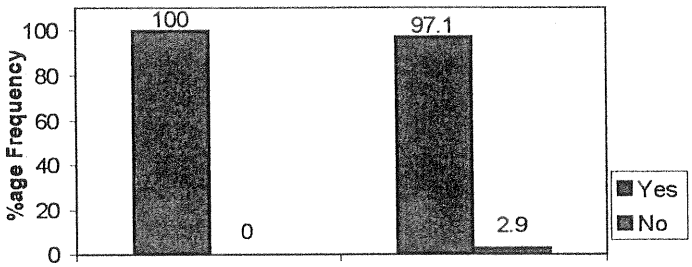


Figure-7: Ignorance, Communication and FP Constraints

Table-7 depicts that 100.0 percent staff in 1999 and 97.1 percent in 2003 replied positively regarding ignorance, improper communication and family planning constraints as problems during awareness, communication, advertisement and popularization of family planning, while 2.9 percent in 2003 replied negatively.

Table-8 Strategies of FWC and RHS-A:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	68	97.1	70	100
No	02	2.9	-	-
Total	70	100	70	100

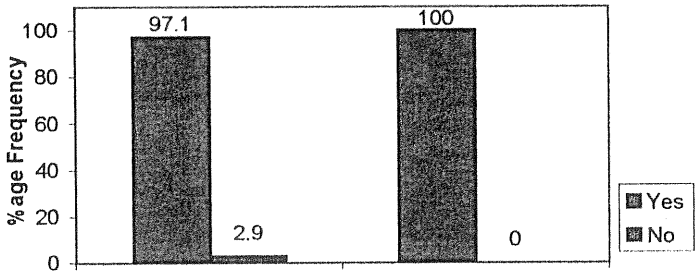


Figure-8: Strategies of FWC and RHS-A

Table-8 shows that 97.1 percent staff in 1999 and 100.0 percent in 2003 were in favor of women education, improvement in communication, effective sources of awareness and solution of family planning constraints as the strategy required for the solution of the problem during awareness, educating, communication, advertisement and popularization of family planning, while 2.9 percent in 1999 were against of it.

E. Problems, Functions and Facilities in FWC and RHS-A:

Table- 9 Problems in FWC and RHS-A:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	70	100	60	85.8
No	-	-	10	14.2
Total	70	100	70	100

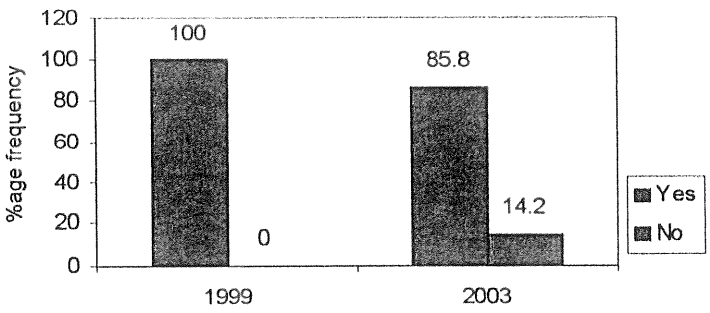


Figure-9: Problems in FWC and RHS-A

Table-9 indicates that 100 percent in 1999 and 85.8 percent in 2003 specified for different problems in FWC and RHS-A.

Table- 10 Informative and Curative Functions:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	68	97.1	70	100
No	02	2.9	-	-
Total	70	100	70	100

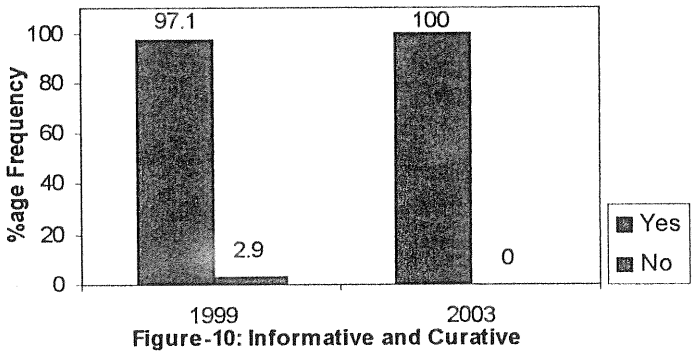


Figure-10: Informative and Curative functions.

Table-10 indicates that 97.1 percent in 1999 and 100.0 percent in 2003 specified for informative (counseling, awareness, motivation and MSU) and curative (provision of contraceptives, medicines, treatment, checkup and prescription) as the functions and facilities in FWC and RHS-A, while only 2. 8 percent replied negatively.

F. Problems & Role of FWW, LHW and LHV:

Table-11 Problems to FWW, LHW and LHV:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	70	100	65	92.9
No	-	-	05	07.1
Total	70	100	70	100

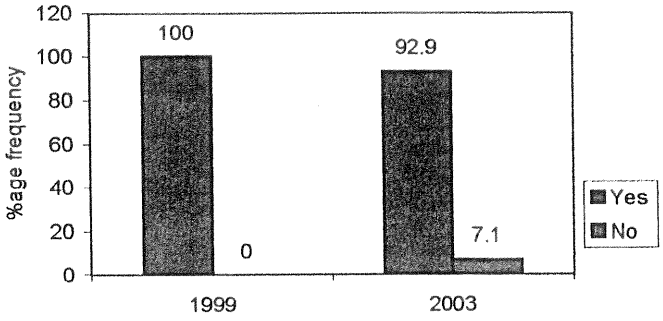


Figure-11: Problems to FWW, LHW and LHV

Table-11 indicates that 100 percent in 1999 and 92.9 percent in 2003 specified for different problems to FWW,LHV and LHW.

Table-12 Role of FWW, LHW and LHV:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	68	97.1	70	100
No	02	2.9	-	-
Total	70	100	70	100

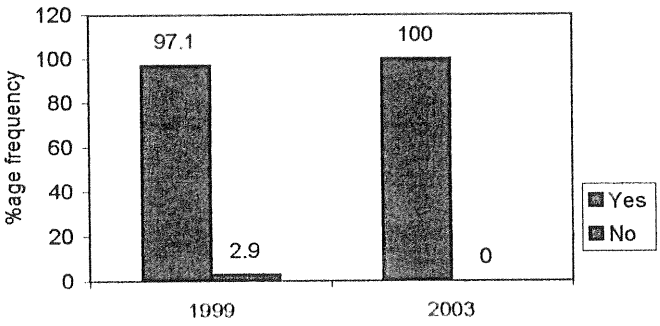


Figure-12: Role of FWW, LHW and LHV

Table-12 indicates that 97.1 percent in 1999 and 100.0 percent in 2003 specified for informative (counseling, awareness and motivation for FP) and curative (provision of contraceptives, medicines, treatment, checkup and prescription) as the role of FWW, LHV and LHW.

G. Various Contraceptives Practice:

Table-13 Traditional Method (Withdrawal):

Res	Years			
	1999		2003	
	F	%	F	%
Yes	38	54.3	37	52.9
No	32	45.7	33	47.1
Total	70	100	70	100

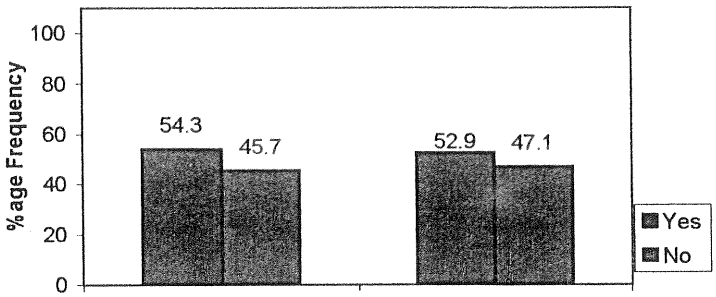


Figure-13: Traditional Method (Withdrawal Male)

Table-13 shows that 54.3 percent staff in 1999 and 52.9 percent in 2003 were in favor of withdrawal (Male) method practice, quantity used (50-100) and free of cost by beneficiaries, While 45.7% percent in 1999 and 47.1 percent in 2003 were against of it.

Table-14 Condom (Male Contraceptive):

Res	Years			
	1999		2003	
	F	%	F	%
Yes	65	92.9	70	100
No	05	7.1	-	-
Total	70	100	70	100

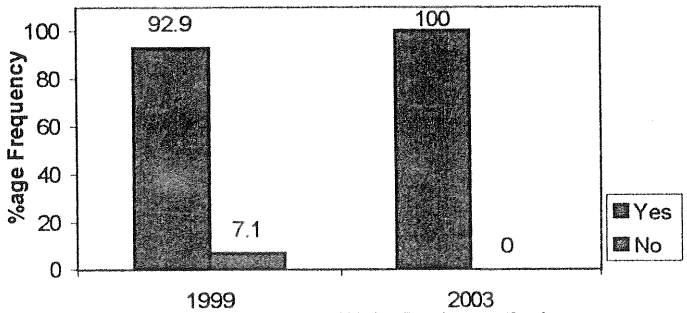


Figure-14: Condom (Male Contraceptive).

Table-14 shows that 92.9 percent staff in 1999 and 100.0 percent in 2003 were in favor of condom (Male Contraceptive) practicing, per individual quantity used (50-100) & cost per dozen= Rs. 6/-, While only 7.1 percent in 1999 were not in faviour of it, They replied for less than 50 usage.

Table-15 Vasectomy (Male Operation):

Res	Years			
	1999		2003	
	f	%	F	%
Yes	28	40	32	45.7
No	42	60	38	54.3
Total	70	100	70	100

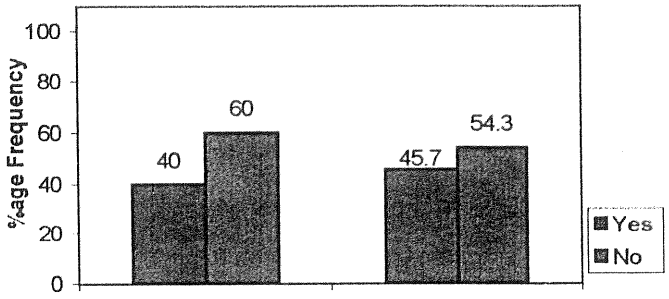


Figure-15: Vasectomy (Male operation)

Table-15 indicates that 40.0 percent staff in 1999 and 45.7 percent in 2003 replied that vasectomy (male operation) is practicing, once in life & free of cost, While 60.0 percent in 1999 and 54.3 percent in 2003 replied negatively in this regard.

Table-16 Oral Pills (Female Tablets):

Res	Years			
	1999		2003	
	F	%	F	%
Yes	65	92.9	70	100
No	05	7.1	-	-
Total	70	100	70	100

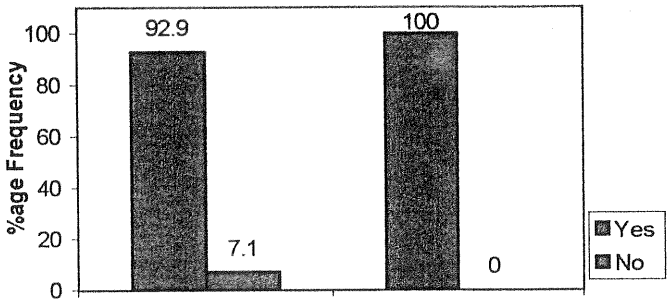


Figure-16: Oral Pills (Female Tablets).

Table-16 highlights that 92.9 percent staff in 1999 and 100.0 percent in 2003 replied positively regarding the availability and practice of oral pills (female tablets), per individual quantity used = 11 strips & cost per strip= Rs. 3/- , while 7.1 percent in 1999 replied negatively.

Table-17 Injectables (Female Contraceptives):

Res	Years			
	1999		2003	
	f	%	F	%
Yes	66	94.3	68	97.1
No	04	5.7	02	2.9
Total	70	100	70	100

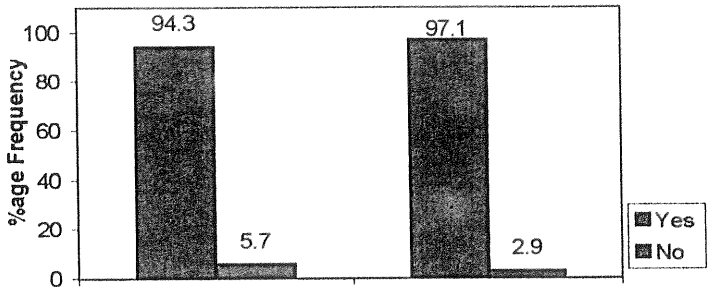


Figure-17: Injectables (Female Contraceptives)

Table-17 highlights that 94.3 percent staff in 1999 and 97.1 percent in 2003, Who were in favor of availability and Practice of injection nurajest (2 months duration), 6 injections per individual per annum usage and majestron/ DEPO (3 months duration), 4 injections per individual per annum usage 01 injection cost = Rs. 3/-, While 5.7 percent in 1999 and 2. 9 percent in 2003 replied negatively in this regard.

Table-18 Tub-legation/Sterilization:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	32	45.7	34	48.6
No	38	54.3	36	51.4
Total	70	100	70	100

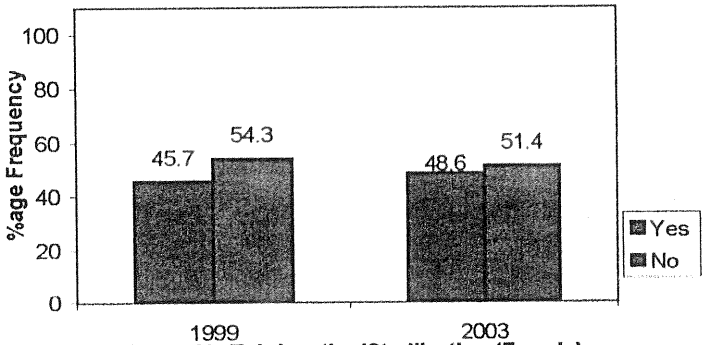


Figure-18: Tub-legation/Sterilization (Female)

Table-18 shows that 45.7 percent staff in 1999 and 48.6 percent in 2003, specified for availability and practice of Tub legation/sterilization (female operation), per individual practice= once in life & free of cost by the beneficiaries, While 54.3 percent in 1999 and 51.4 percent in 2003, replied negatively in this case.

Table-19 Multi Load/Copper-T/ IUD:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	58	82.9	65	92.9
No	12	17.1	05	7.1
Total	70	100	70	100

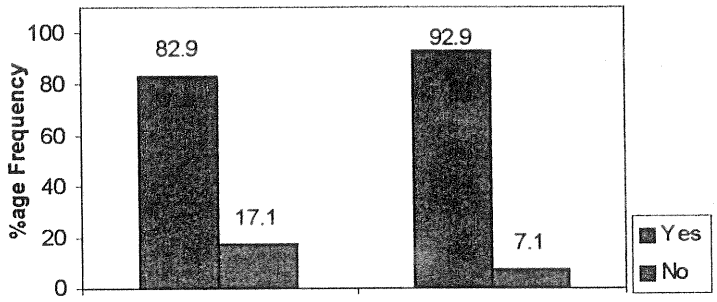


Figure-19: Multi Load / Copper-T / IUD

Table-19 depicts that 82.9 percent staff in 1999 and 92.9 percent in 2003 were in favor of availability and practice of multi load/copper-t/ IUD (Female contraceptive), usage per individual 01 for 5-10 years/ once with checking & 01 multi load/copper-t/ IUD cost= Rs. 3/-, While 17.1 percent in 1999 and 7.1 percent in 2003 were not in favor of it.

H. Reasons for Using and Non-using a Specific Method/ Contraceptive:

Table-20 Reasons of Using a Specific Method:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	55	78.6	65	92.9
No	15	21.4	05	7.1
Total	70	100	70	100

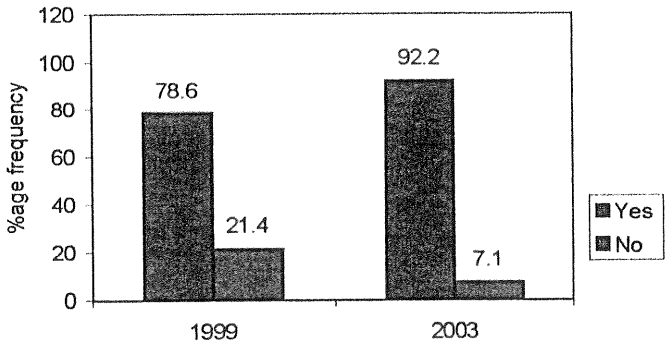


Figure-20: Reasons of Using a Specific Method

Table-20 indicates that 78.6 percent staff respondents in 1999 and 92.9 percent 2003 specified for no/less side effects, convenient, more effective and less costly as the reasons for using a specific method/ contraceptive, while 21.4 percent in 1999 and 7.1 percent in 2003 were against it.

Table-21 Reasons of Not-using a Method:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	64	91.4	55	78.6
No	06	8.6	15	21.4
Total	70	100	70	100

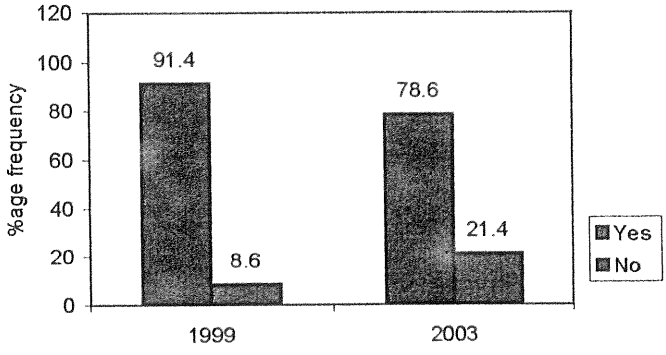


Figure-21: Reasons of Not-using a Method

Table-21 highlights that 91.4 percent staff respondents in 1999 and 78.6 percent in 2003, specified for side effects, permanent, not effective and costly as the reasons for not using a specific method/ contraceptive, while 8.6 percent in 1999 and 21.4 percent in 2003 were against of it.

I. Sources to Get Contraceptives:

Table-22 Major Sources of Contraceptives:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	62	88.6	68	97.1
No	08	11.4	02	2.9
Total	70	100	70	100

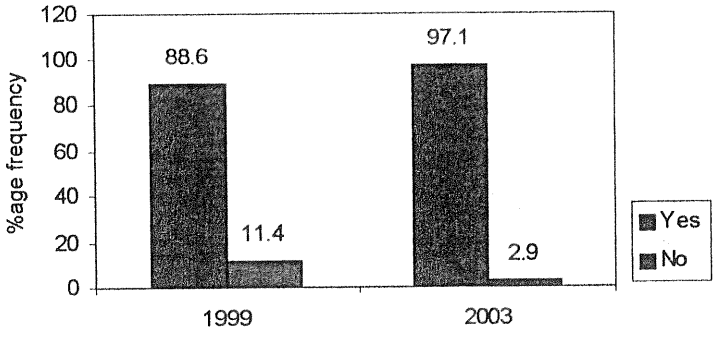


Figure-22: Major Sources of Contraceptives

Table-22 highlights that 88.6 percent staff respondents in 1999 and 97.1 percent in 2003, specified for major sources (family planning organization centers and mobile unit) to provide contraceptives, while only 11.4 percent in 1999 and 2.9 percent in 2003 were against it.

Table-23 Minor sources of contraceptives:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	20	28.6	10	14.3
No	50	71.4	60	85.7
Total	70	100	70	100

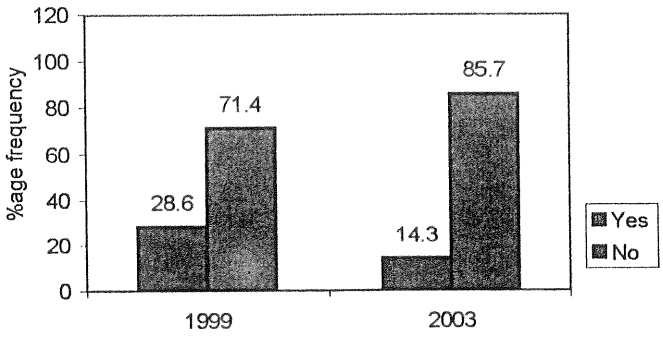


Figure-23: Minor sources of contraceptives

Table-23 shows that 28.6 percent staff respondents in 1999 and 14.3 percent in 2003, specified for minor sources (private medical store, general store, doctor / practitioner) to get contraceptives, while 71.4 percent in 1999 and 85.7 percent in 2003 were against it.

J. Side Effects of Contraceptives:

Table-24 Medical Health Problems:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	66	94.3	60	85.7
No	04	5.7	10	14.3
Total	70	100	70	100

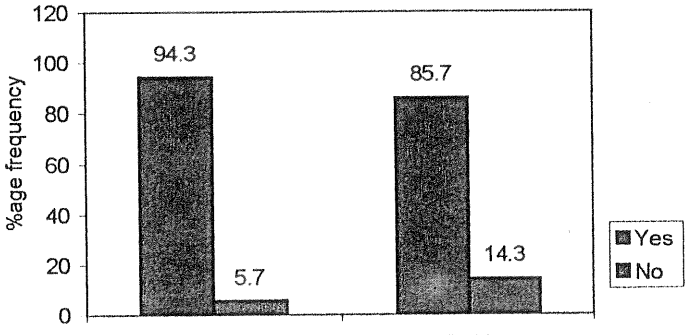


Figure-24: Medical Health Problems

Table-24 shows that 94.3 percent staff respondents in 1999 and 85.7 percent in 2003, specified for medical health problems (infection, irregular menses/ bleeding, weight gain, swelling, temperature, headache, vomiting, no starvation) as the side effects of contraceptives on users, while 5.7 percent in 1999 and 14.3 percent in 2003 were against it.

Table-25 Psychological Problems:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	68	97.1	50	71.4
No	02	2.9	20	28.6
Total	70	100	70	100

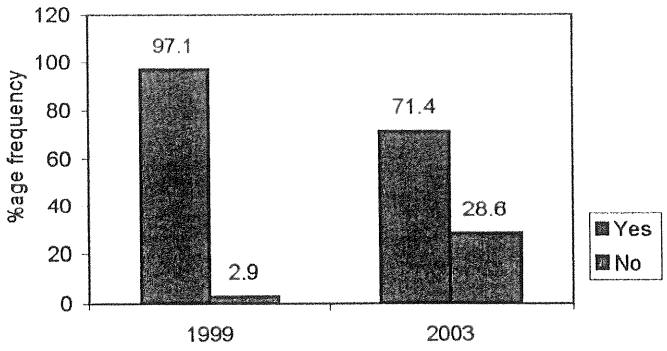


Figure-25: Psychological Problems

Table-25 shows that 97.1 percent staff respondents in 1999 and 71.4 percent in 2003, specified for psychological problems as the side effects of contraceptives on users, while 2.9 percent in 1999 and 28.6 percent in 2003 were against it.

Table-26 Strategies of FP Staff for Prevention:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	60	85.7	70	100
No	10	14.3	-	-
Total	70	100	70	100

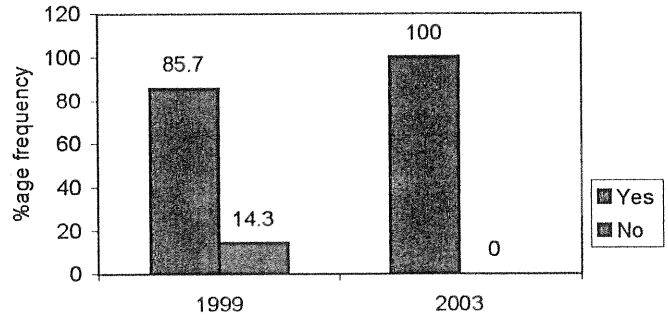


Figure-26: Strategies of FP Staff for Prevention

Table-26 indicates that 85.7 percent staff respondents in 1999 and 100 percent in 2003, specified for counseling, awareness for proper usage of contraceptives, change the method/contraceptive, proper treatment, prescription and preventive measures as strategies and role of family planning staff in prevention of side effects of contraceptives on users, while only 14.3 percent in 1999 were against it.

K. Problems & Strategies to Reduce the Side Effects of Contraceptives:

Table-27 Problems on the Part of Clients:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	59	84.3	55	78.6
No	11	15.7	15	21.4
Total	70	100	70	100

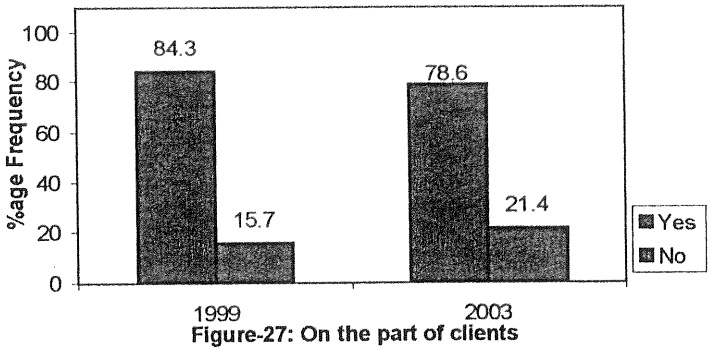


Figure-27: On the part of clients

Table-27 indicates that 84.3 percent staff in 1999 and 78.6 percent in 2003 were in favor of no care, proper usage and follows up by the clients, as the problems in reducing the side effects of contraceptive, While 15. 7 percent in 1999 and 21.4 percent in 2003 were against of it.

Table-28 On the Part of Service Provider:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	42	60	40	57.1
No	28	40	30	42.9
Total	70	100	70	100

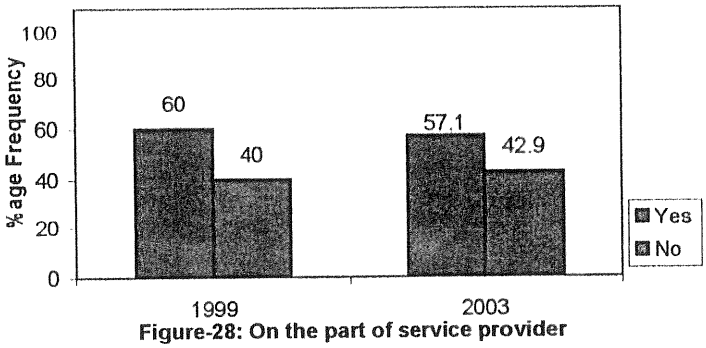


Figure-28: On the part of service provider

Table-28 demonstrates that 60.0 percent staff in 1999 and 57.1 percent in 2003 were in favor of no proper treatment; usage skill, medicine, provision by service provider, as the problems in reducing the side effects of contraceptives, While 40.0 percent in 1999 and 42.9 percent in 2003 were against of it.

Table-29 Strategy of FWC and RHS-A:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	68	97.1	70	100
No	02	2.9	-	-
Total	70	100	70	100

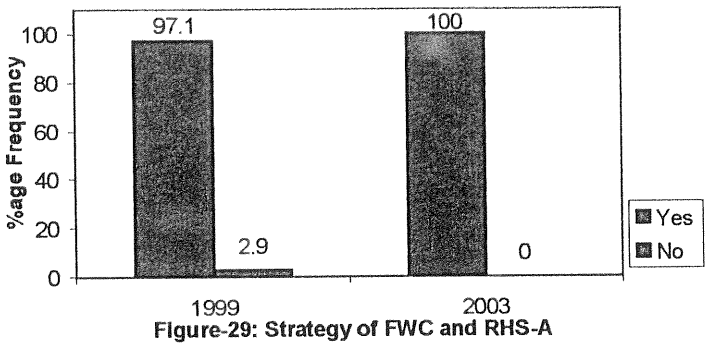


Figure-29: Strategy of FWC and RHS-A

Table-29 highlights that 97.1 percent staff in 1999 and 100.0 percent in 2003 specified for counseling and motivation for proper usage, receiving feedback from clients/patients, proper treatment, cleanliness, change the method/ medicine and preventive measures as the strategy of FWC and RHS-A, while 2.9 percent in 1999 replied negatively.

L. Mother-Child Health Care Program:

Table-30 Informative and curative:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	69	98.6	70	100
No	01	1.4	-	-
Total	70	100	70	100

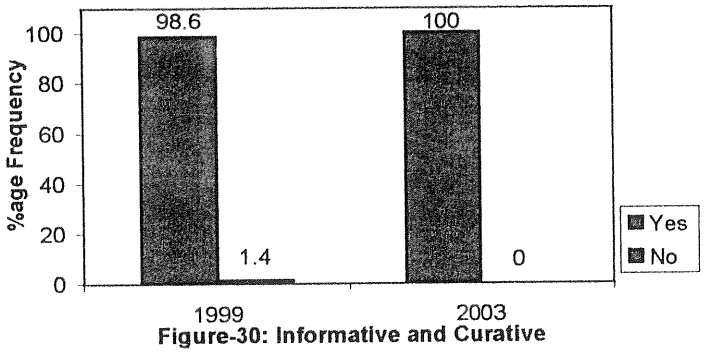


Figure-30: Informative and Curative

Table-30 indicates that 98.6 percent staff in 1999 and 100.0 percent in 2003 specified for informative and curative (counseling, antenatal, postnatal, treatment, vaccination and balance diet) as one of the component of mother-child health care program of FWC and RHS-A, while only 1. 4 percent in 1999 replied negatively.

Table-31 Before, During and After Delivery MCHC:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	65	92.9	69	98.6
No	05	7.1	1	1.4
Total	70	100	70	100

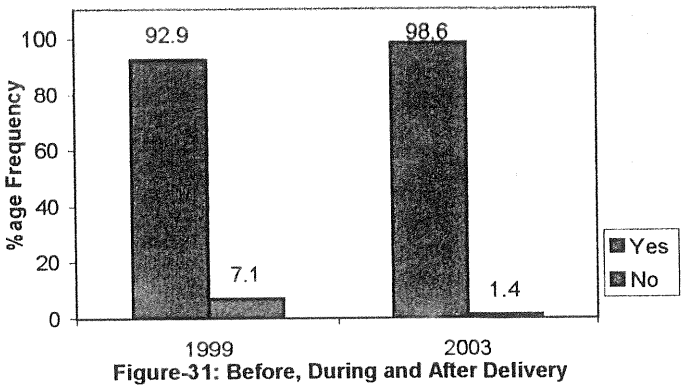


Figure-31: Before, During and After Delivery CHC

Table-31 depicts that 92.9 percent staff in 1999 and 98.6 percent in 2003 specified for before, during and after delivery child-mother health care (through checkup, treatment, prescription, vaccination on due time, immunization, breast feeding and additional nutrition to child) as the components of mother-child health care program of FWC and RHS-A, while only 7.1 percent in 1999 and 1.4 percent in 2003 replied negatively.

M. Result of Mother-Child Health Care:

Table-32 Proper Health Protection:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	68	97.1	69	98.6
No	02	2.9	1	1.4
Total	70	100	70	100

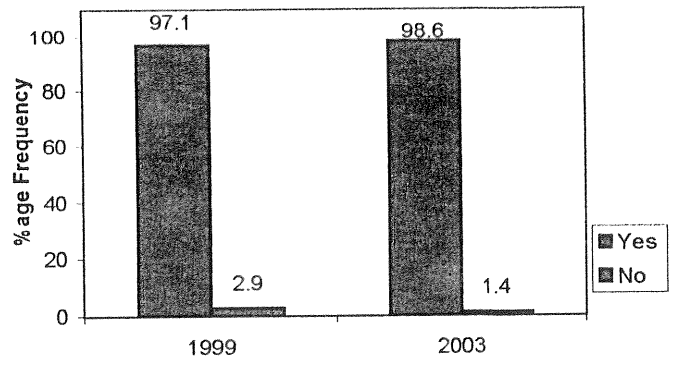


Figure-32: Proper Health protection

Table-32 indicates that 97.1 percent staff in 1999 and 98.6 percent in 2003 specified for proper health protection, safe delivery and trust on mother child health care, as a result of mother-child health care program of FP, while 2.9 percent in 1999 and 1.4 percent in 2003 replied negatively.

N. Problems in Mother-Child Health Care:

Table-33 Various Constraints to MCHC and FP:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	69	98.6	67	95.7
No	01	1.4	03	4.3
Total	70	100	70	100

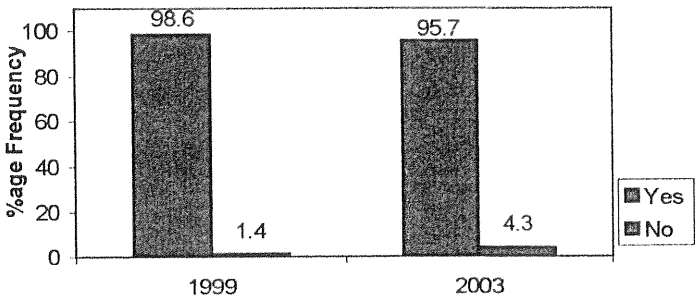


Figure-33: Various constraints to MCHC and FP

Table-33 indicates that 98.6 percent staff in 1999 and 95.7 percent in 2003 specified for various constraints to mother-child health care (ignorance, no proper treatment and check-up etc.) and constraints to FP as well as contraceptives side effects as problems in MCHC, while 1.4 percent in 1999 and 4.3 percent in 2003 replied negatively.

Table-34 Strategies of FWC and RHS-A:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	69	98.6	70	100
No	01	1.4	-	-
Total	70	100	70	100

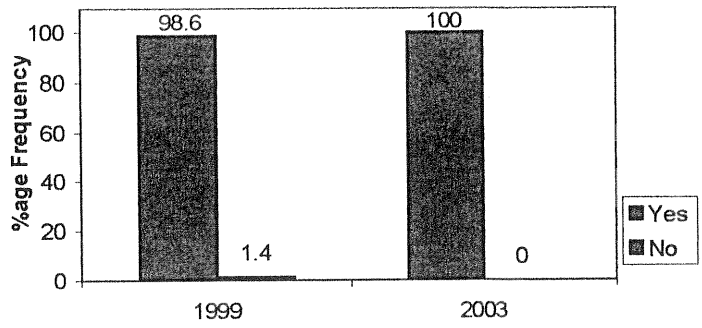


Figure-34: Strategies of FWC and RHS-A

Table-34 highlights that 98.6 percent staff in 1999 and 100.0 percent in 2003 specified for solution to various constraints in MCHC (health awareness, motivation, treatment, check up, medicines and mobile service units) and solution to various constraints in FP/reducing side effects (Free counseling, motivation, treatment, medicines, avoid early marriage, polygamy, maximum male children, meeting with religious leaders etc), as strategy of FWC and RHS-A in improvement of MCHC, while 4.4 percent in 1999 replied negatively.

O. Response and Causes of Large Family & Strategies of FWC and RHS-A:

Table-35 Large Family:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	70	100	66	94.3
No	-	-	04	5.7
Total	70	100	70	100

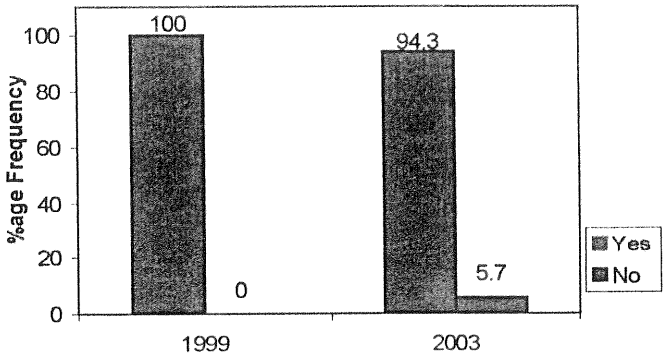


Figure-35: Large Size of the Family

Table-35 shows that 100.0 percent staff in 1999 and 94.3 percent in 2003 specified for large size of the family in the target area, while only 5.7 percent replied against of it (Specified for small family).

Table- 36 Marital Age 13– 22 Years:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	58	82.9	56	80
No	12	17.1	14	20
Total	70	100	70	100

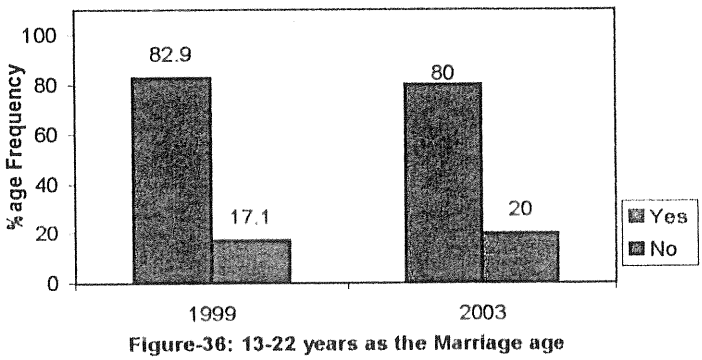


Figure-36: 13-22 years as the Marriage age

Table-36 demonstrates that 82.9 percent staff in 1999 and 80.3 percent in 2003 specified for 13-22 years as the marriage age in the area, while only 17.1 percent in 1999 and 20.0 percent in 2003 replied negatively for it (specified for 23-32 years as the marriage age).

Table- 37 Number of Marriages:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	63	90	65	92.9
No	07	10	05	7.1
Total	70	100	70	100

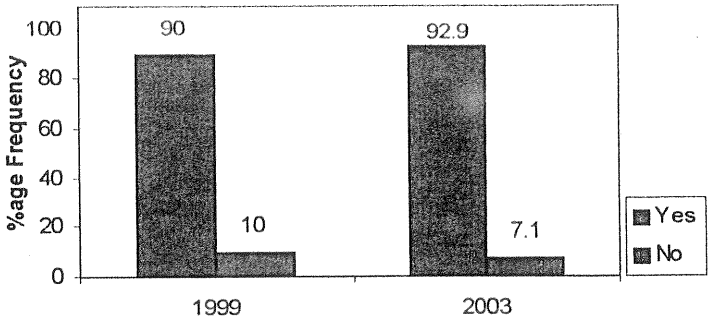


Figure-37: Number of Marriages

Table-37 shows that 90.0 percent staff in 1999 and 92.9 percent in 2003 specified for one/ one or single marriage in the area, while only 10.0 percent in 1999 and 7.1 percent in 2003 replied negatively for it (specified for two/ double and three / triple marriages respectively).

Table- 38 Desire for Male Children Leads to Large Family:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	70	100	66	94.3
No	-	-	04	5.7
Total	70	100	70	100

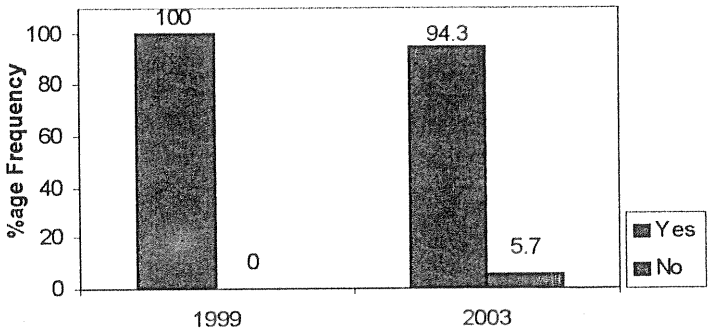


Figure-38: Desire for male children leads to Large Family

Table-38 shows that 100.0 percent staff in 1999 and 94.3 percent in 2003 replied that desire for male child reasons (Sons are power, prestige, source of income, psychological protection & inheritance of property) leads to large family, while only 5.7 percent in 2003 replied negatively.

Table-39 Various Constraints to FP. Leads to Large Family:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	70	100	66	94.3
No	-	-	04	5.7
Total	70	100	70	100

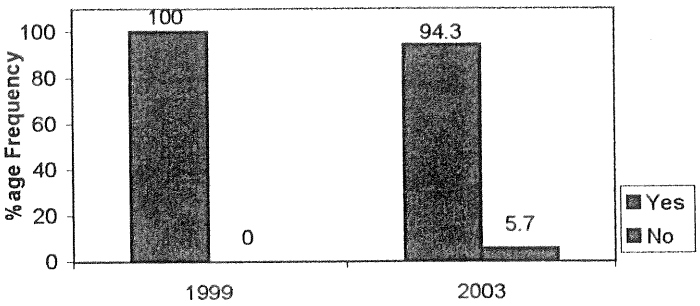


Figure-39: Various Constraints to FP Leads to Large Family

Table-39 depicts that 100.0 percent staff in 1999 and 94.3 percent in 2003 replied that various constraints to family planning (Economic, religious, socio- cultural, psychological, medical-technical, quality of service) leads to large size of the family, while 5.7 percent in 2003 replied negatively.

Table-40 Strategies of FWC and RHS-A:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	66	94.3	70	100
No	04	5.7	-	-
Total	70	100	70	100

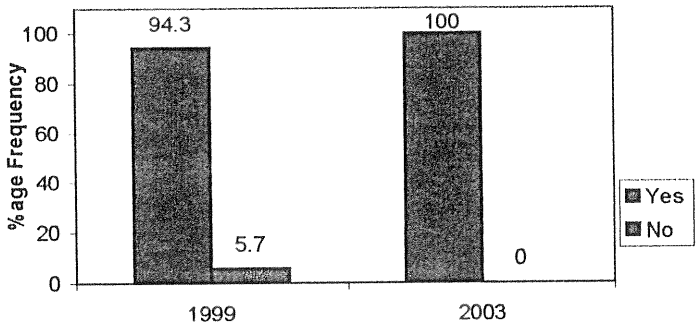


Figure-40: Strategies of FWC and RHS-A

Table-40 shows that 94.3 percent staff in 1999 and 100.0 percent in 2003 specified for proper awareness, counseling & motivation for small family, contraceptives, large family economic burden , registration of family member , to avoid early marriage, polygamy, maximum children, son and daughter are equal, equal rights of children, proper family planning, treatment, check up, medicines, community meetings, home visits, communication, awareness , solution of constraints as strategies and role of FWC and RHS-A to control and minimize the size of family, while only 5.7 percent replied negatively.

P. Various Constraints to Family Planning:

Table-41 Economic Constraints to FP:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	68	97.1	66	94.3
No	02	2.9	04	5.7
Total	70	100	70	100

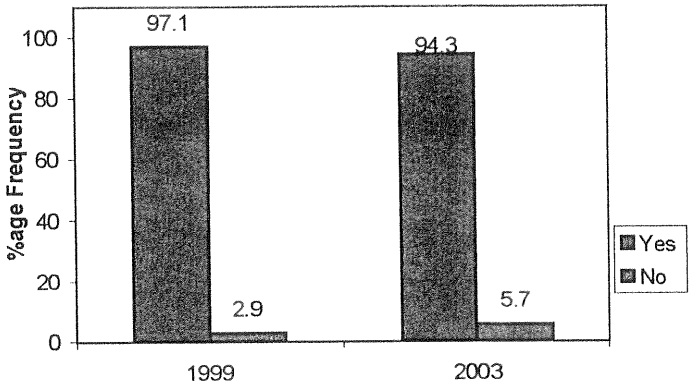


Figure-41: Economic Constraints to FP

Table-41 shows that 97.1 percent staff in 1999 and 94.3 percent in 2003, specified for sons are economic assets, source of income, helping hand in old age, inheritance of property, poverty, no source of income and employment, high expenses of family, no proper infrastructure, building, equipments, treatment equipments, medicines, tests equipments and budget as an economic constraints to family planning, while only 2.9 percent in 1999 and 5.7 percent in 2003, replied negatively.

Table-42 Strategies of FWC and RHS-A:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	67	95.7	68	97.1
No	03	4.3	02	2.9
Total	70	100	70	100

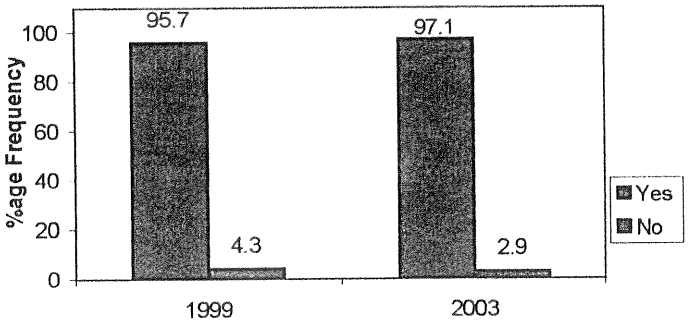


Figure-42: Strategies of FWC and RHS-A

Table-42 shows that 95.7 percent staff in 1999 and 97.1 percent in 2003 specified for free counseling, checkup, treatment, operation, natural gap by breast feeding, foreign aid support, nominal charges, company rate contraceptives provision as strategies and role of FWC and RHS-A to solve the economic constraints in family planning, while 4.3 percent in 1999 and 2.9 percent in 2003 replied negatively.

Table-43 Religious Constraints to FP:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	69	98.6	66	94.3
No	01	1.4	04	5.7
Total	70	100	70	100

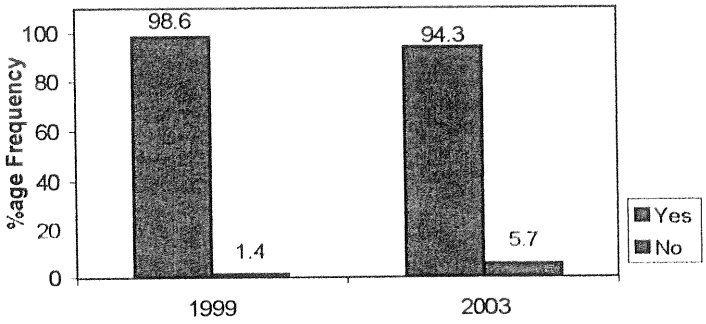


Figure-43: Religious Constraints to FP.

Table-43 demonstrates that 98.6 percent staff in 1999 and 94.3 percent in 2003 specified for family planning is killing of humanity, it is sin, illegitimate, against natural law, fatalism, God is food provider, one can not stop those souls to be produced, increase the number of Muslims, results immorality, plan of non-Muslims slogans use by religious leaders, which is a religious obstacle to family planning, While 1.4 percent in 1999 and 5.7 percent in 2003 replied against of it.

Table-44 Strategies of FWC and RHS-A:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	55	78.6	65	92.9
No	15	21.4	05	7.1
Total	70	100	70	100

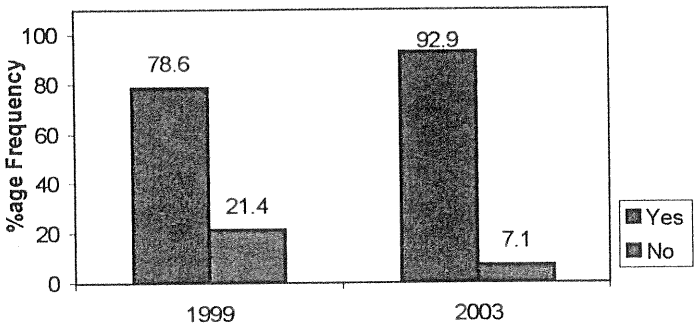


Figure-44: Strategies of FWC and RHS-A.

Table-44 highlights that 78.6 percent staff in 1999 and 92.9 percent in 2003, specified for meeting with religious leaders, awareness, counseling and convincing religious people, collection of different Fatwas, religious literature distribution in favor of family planning as strategies FWC and RHS-A to solve the religious constraints in family planning, while 21.4 percent in 1999 and 7.1 percent in 2003 replied negatively in this regard.

Table-45 Socio-Cultural Constraints to FP:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	70	100	66	94.3
No	-	-	04	5.7
Total	70	100	70	100

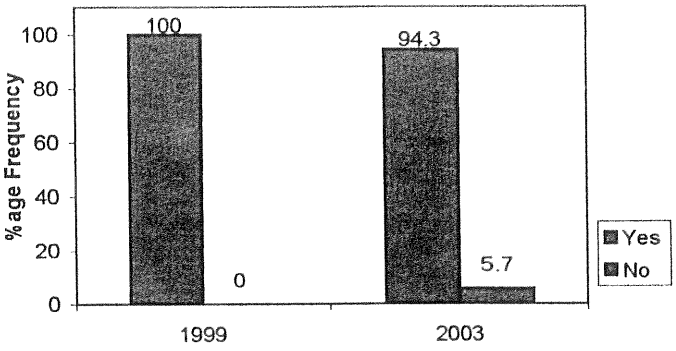


Figure-45: Socio-Cultural Constraints to FP.

Table-45 depicts that 100.0 percent staff in 1999 and 94.3 percent in 2003 specified for desire of male children (sons are power, prestige, source of protection and inheritance of property), early marriage, polygamy, high fertility, disapproval by husband and in-laws, Purdha, negative public opinion and wrong propaganda as socio-cultural obstacles in family planning, while only 5.7 percent in 2003 replied negatively.

Table-46 Strategies of FWC and RHS-A:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	68	97.1	70	100
No	02	2.9	-	-
Total	70	100	70	100

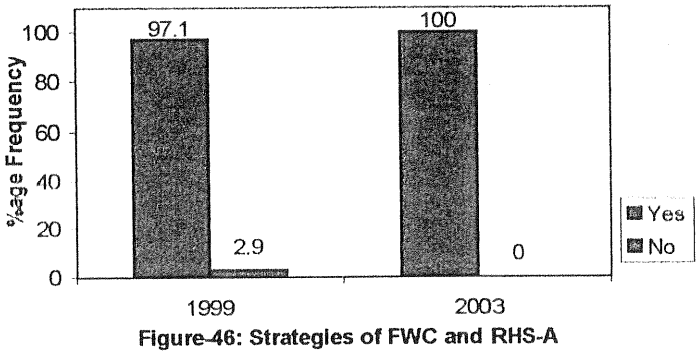


Figure-46: Strategies of FWC and RHS-A

Table-46 shows that 97.1 percent staff in 1999 and 100.0 percent in 2003 specified for small family norms, small family better life, two kids are better, son & daughter are equal, avoid early marriage a strategies of FWC and RHS-A to solve the socio-cultural constraints in family planning, while 2.9 percent in 1999 replied negatively.

Table-47 Govt. / Political Constraints to FP:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	37	52.9	36	51.4
No	33	47.1	34	48.6
Total	70	100	70	100

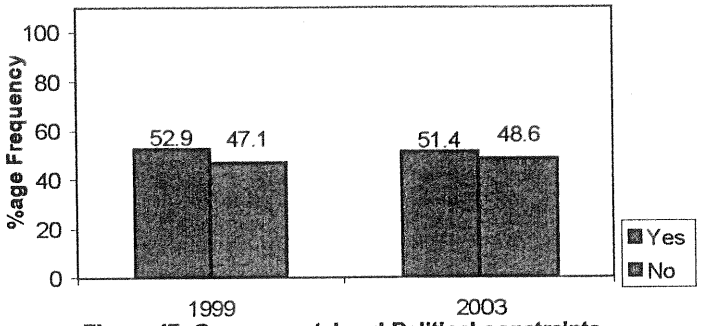


Figure-47: Governmental and Political constraints to FP

Table-47 demonstrates that 52.9 percent staff in 1999 and 51.4 percent in 2003 specified for no proper funds allocation, based on foreign aid, fluctuating support and policy change as Governmental and political constraints in family planning, while 47.1 percent in 1999 and 48.6 percent in 2003 replied negatively.

Table-48 Strategies of FWC and RHS-A:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	36	51.4	38	54.3
No	34	48.6	32	45.7
Total	70	100	70	100

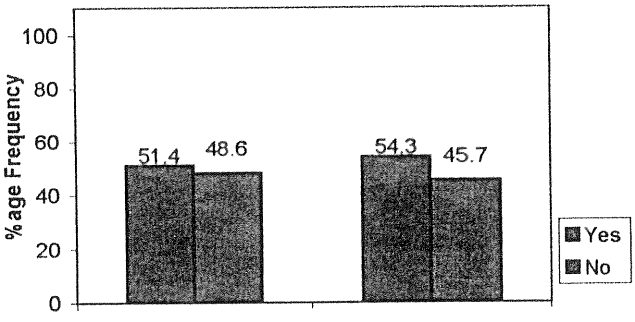


Figure-48: Strategies of FWC and RHS-A

Table-48 indicates that 51.4 percent staff in 1999 and 54.3 percent in 2003 specified for collaboration of public and private sectors, struggle to continue, getting support of foreign donor as a strategies of FWC and RHS-A to solve the political and Governmental constraints in family planning, while 48.6 percent in 1999 and 45.7 percent in 2003 replied negatively.

Table-49 Psychological Constraints to FP:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	54	77.1	53	75.7
No	16	22.9	17	24.3
Total	70	100	70	100

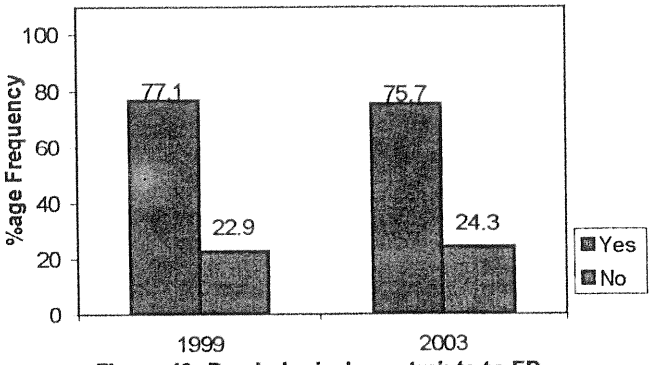


Figure-49: Psychological constraints to FP.

Table-49 highlights that 77.1 percent staff in 1999 and 75.7 percent in 2003 specified for worry of side effects of contraceptive/ medicines, conception and infertility as psychological constraints in family planning, While 22.9 percent in 1999 and 24.3 percent in 2003 replied negatively.

Table-50 Strategies of FWC and RHS-A:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	67	95.7	69	98.6
No	03	4.3	01	1.4
Total	70	100	70	100

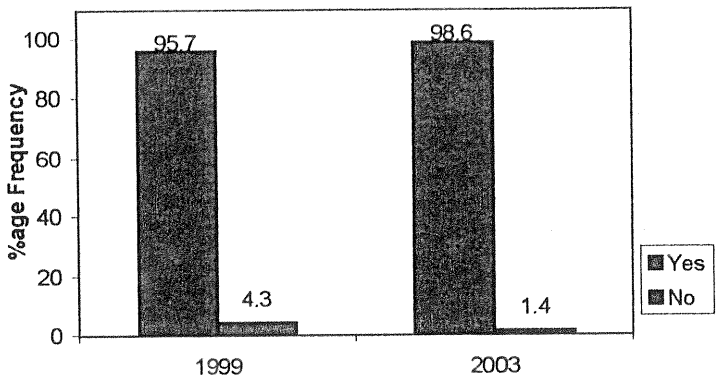


Figure-50: Strategies of FWC and RHS-A

Table-50 shows that 95.7 percent in 1999 and 98.6 percent in 2003 specified for motivation, awareness and counseling for proper usage, change of contraceptives, proper checkup, treatment, medicines and prescription by family planning staff a strategies of FWC and RHS-A to solve the psychological constraints in family planning, while only 4.3 percent in 1999 and 1.4 percent in 2003 replied negatively.

Table-51 Medical-Technical Constraints to FP:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	65	92.9	64	91.4
No	05	7.1	06	8.6
Total	70	100	70	100

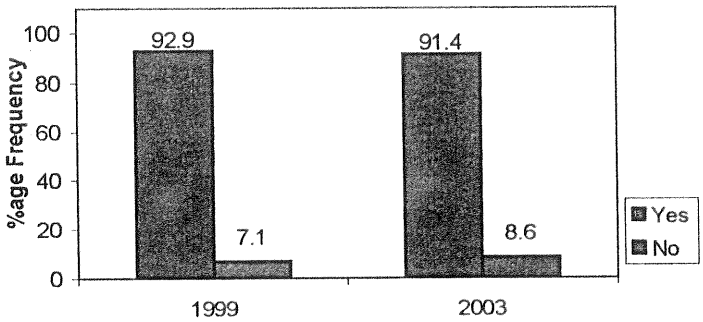


Figure-51: Medical-Technical constraints to FP

Table-51 shows that 92.9 percent staff in 1999 and 91.4 percent in 2003 specified for no family planning and health awareness, motivation, follow up fear from taking medicines, contraceptives due to side effects and no proper trained staff, equipments, medicines, checkup, treatment, diagnosing (tests) as medical & technical constraints in family planning, while only 7.1 percent in 1999 and 8.6 percent in 2003 replied negatively.

Table-52 Strategies of FWC and RHS-A:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	67	95.7	69	98.6
No	03	4.3	01	1.4
Total	70	100	70	100

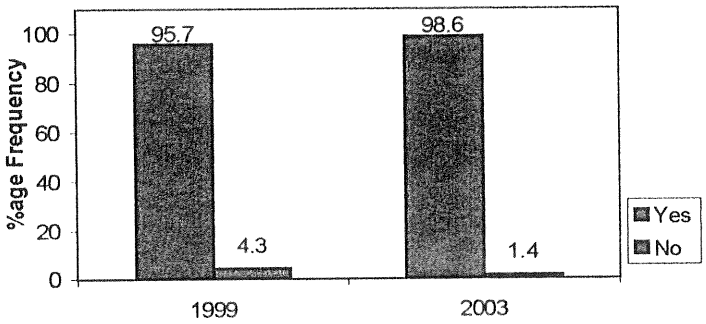


Figure-52: Strategies of FWC and RHS-A

Table-52 shows that 95.7 percent staff in 1999 and 98.6 percent in 2003 specified for motivation, counseling, awareness for proper usage, change of contraceptives and proper checkup, treatment, medicines, advise by qualified and trained staff as strategies of FWC and RHS-A to solve the medical & technical constraints in family planning, while only 4.3 percent in 1999 and 1.4 percent in 2003 replied negatively.

Table-53 Quality of Service Constraints to FP:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	69	98.6	68	97.1
No	01	1.4	02	2.9
Total	70	100	70	100

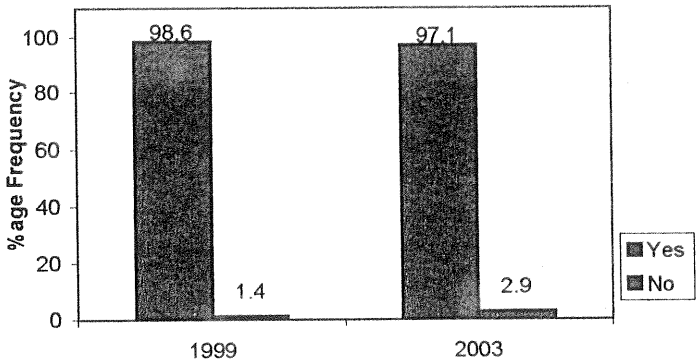


Figure-53: Quality of service constraints to FP

Table-53 depicts that 98.6 percent staff in 1999 and 97.1 percent in 2003 specified for no proper budget, no outlet, coverage, outreach, information, supervision, strategy changes, low quality contraceptives, questionable, no proper services, less satisfaction, doorstep, lack of male involvement, lack of proper trained staff and, no proper infrastructure as quality of service constraints in FP, while only 1. 4 percent in 1999 and 2.9 percent in 2003 replied negatively.

Table-54 Strategies of FWC and RHS-A:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	51	72.9	52	74.3
No	19	27.1	18	25.7
Total	70	100	70	100

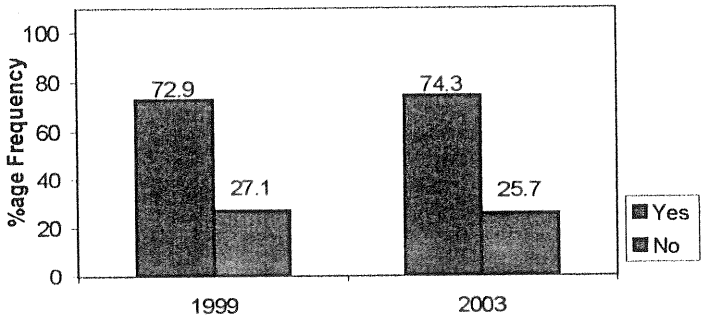


Figure-54: Strategies of FWC and RHS-A

Table-54 highlights that 72.9 percent staff in 1999 and 74.3 percent in 2003 specified for budget based on foreign assistance, proper supervision, monitoring & evaluation of family planning, proper, qualified & trained staff, male staff involvement as a strategies of FWC and RHS-A to improve the quality of service, while 27.1 percent in 1999 and 25.7 percent in 2003 replied negatively.

Q. Linkage Programs among Government, NGOs and Community:

Table-55 Public Private Partnership:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	22	31.4	43	61.4
No	48	68.6	27	38.6
Total	70	100	70	100

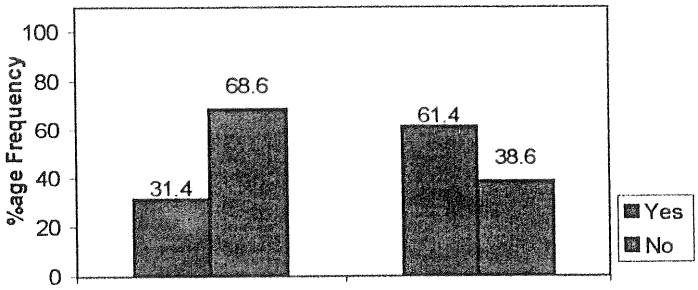


Figure-55: Public Private Partnership

Table-55 shows that 31.4 percent staff in 1999 and 61.4 percent in 1999 specified for public private partnership as linkage program among Government, NGOs and Community, while 68.6 percent in 1999 and 38.6 percent in 2003 replied negatively

R. Shortcomings in FP and Strategies for improvement:

Table-56 Shortcomings in FP:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	69	98.6	67	95.6
No	01	1.4	03	4.4
Total	70	100	70	100

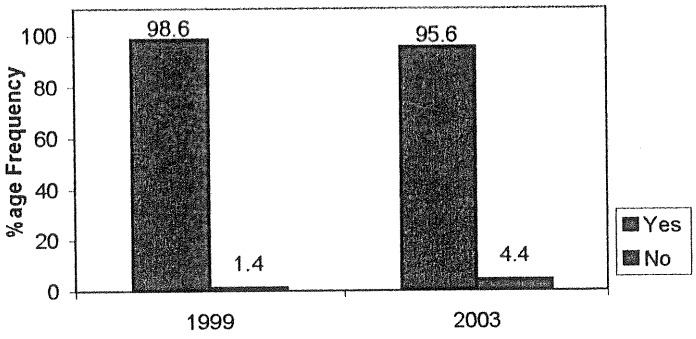


Figure-56: Shortcomings in FP

Table-56 demonstrates that 98.6 percent staff in 1999 and 95.7 percent in 2003 specified for side effects of contraceptives, no proper policy, planning, research, strategy, involvement of religious leaders, male interest, awareness of FP, various constraints, no role of media, related departments, health outlets, district Govt. and welfare organizations as shortcomings of the family planning program, while 1.4 percent in 1999 and 4.3 percent in 2003 replied negatively.

Table-57 Strategies to Improve FP:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	68	97.1	70	100
No	02	2.9	-	-
Total	70	100	70	100

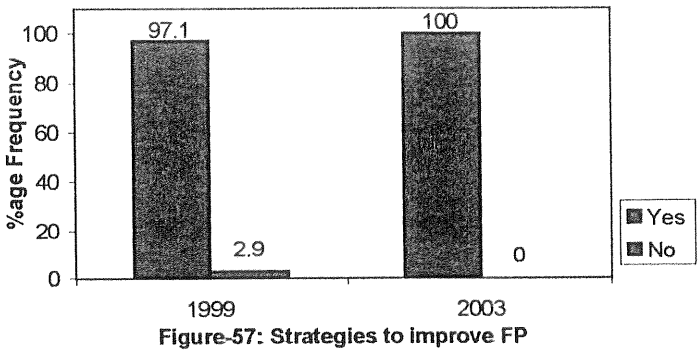


Figure-57: Strategies to improve FP

Table-57 shows that 97.1 percent staff in 1999 and 100.0 percent staff respondents in 2003 specified for role of media, District Govt., religious leaders, family planning education, enlightened vision, proper counseling, motivation & communication program of family planning, proper, qualified, trained staff and establishment of more family planning organizations as strategies for the improvement of family planning, while only 2.9 percent in 1999 were not in favor of it.

4.2 Part-II Data Analysis & Interpretation of Private Organizations (NGOs) Staff:

A. Number of Children:

Table-1 Number of Male Children:

Spec	Years			
	1999		2003	
	F	%	f	%
0-1	35	58.3	25	41.7
2-3	25	41.7	35	58.3
4<	-	-	-	-
Total	60	100	60	100

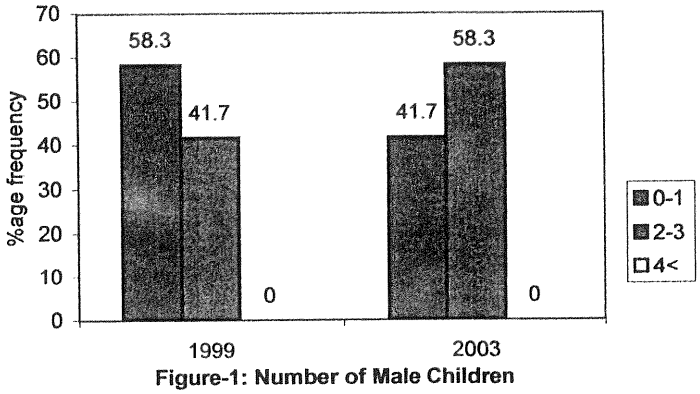


Figure-1: Number of Male Children

Table-1 shows that 58.3 percent and 41.7 percent staff respondents in 1999 and 41.7 percent and 58.3 percent in 2003 replied that they were having 0-1 and 2-3 numbers of male children respectively.

Table-2 Number of Female Children:

Spec	Years			
	1999		2003	
	F	%	F	%
0-1	40	66.7	30	50
2-3	20	33.3	30	50
4<	-	-	-	-
Total	60	100	60	100

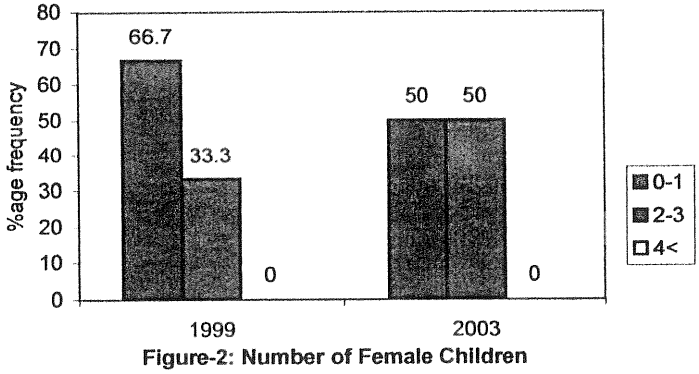


Figure-2: Number of Female Children

Table-2 shows that 66.7 percent and 33.3 percent staff respondents in 1999 and 50 percent each in 2003 replied that they were having 0-1 and 2-3 numbers of female children respectively.

B. Educational Status and Practice of Family Planning:

Table-3 Uneducated Practice FP:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	8	13.3	30	50
No	52	86.7	30	50
Total	60	100	60	100

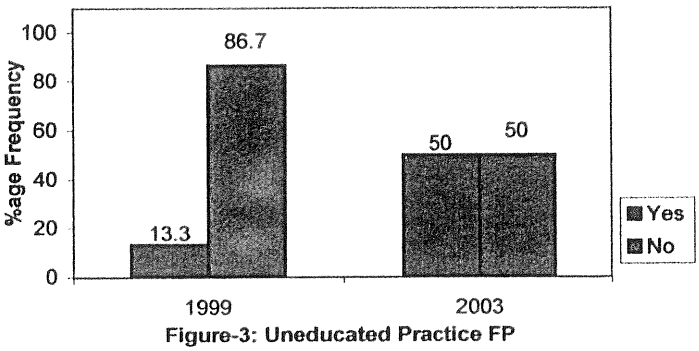


Figure-3: Uneducated Practice FP

Table-3 indicates that 13.3 percent staff in 1999 and 50.0 percent in 2003 replied that uneducated respondents were practicing family planning, While 86.7 percent in 1999 and 50.0 percent in 2003 replied negatively in this regard.

Table-4 Educated Practice FP:

Res	Years			
	1999		2003	
	F	%	f	%
Yes	55	91.7	60	100
No	05	8.3	-	-
Total	60	100	60	100

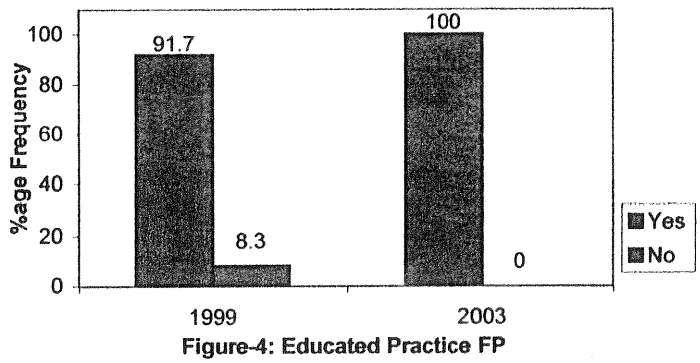


Figure-4: Educated Practice FP

Table-4 highlights that 91.7 percent staff in 1999 and 100.0 percent in 2003 replied that educated respondents were practicing family planning, while only 8.3 percent in 1999 replied negatively in this regard.

C. Sources of Awareness, Information and Popularization of FP:

Table-5 Major Sources of Awareness of FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	56	93.3	58	96.7
No	04	6.7	02	3.3
Total	60	100	60	100

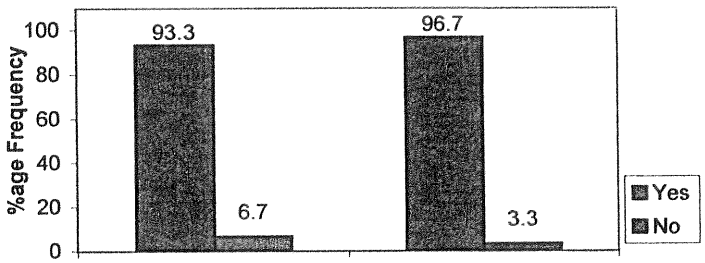


Figure-5: Major Sources of Awareness &Popularization of FP

Table-5 indicates that 93.3 percent staff in 1999 and 96.7 percent in 2003 replied positively for the role of family planning staff and literature, TV, radio, relatives, friends, husband and wife in popularization of Family Planning, while 6.7 percent in 1999 and 3.3 percent in 2003 replied negatively.

Table-6 Minor Sources of Awareness of FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	44	73.3	46	76.7
No	16	26.7	14	23.3
Total	60	100	60	100

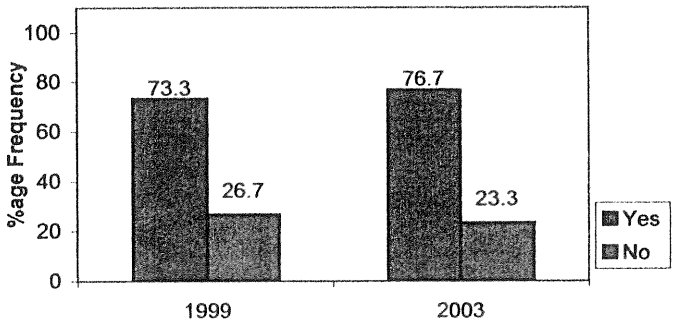


Figure-6: Minor Sources of Awareness and Popularization of FP

Table-6 demonstrates that 73.3 percent staff in 1999 and 76.7 percent in 2003 specified for the positive role of wall chalking, banners, sign boards, seminars, workshops, conferences, news papers and magazines in popularization of Family planning, while 26.7 percent in 1999 and 23.3 percent in 2003 replied negatively.

D. Problems Faced During Awareness, Communication & Popularization of FP:

Table-7 Ignorance, Communication and FP Constraints:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	60	100	57	95
No	-	-	03	05
Total	60	100	60	100

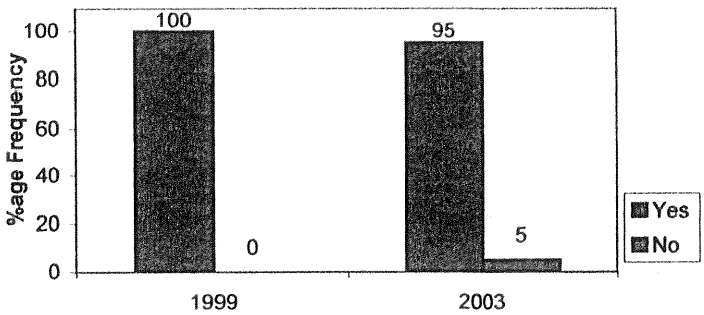


Figure-7: Ignorance, Communication and FP Constraints

Table-7 shows that 100.0 percent staff respondents in 1999 and 95.0 percent in 2003 replied positively regarding ignorance (women), improper way of communication and family planning constraints as problems during awareness, educating, convincing, communication, advertisement and popularization of family planning, only 5.0 percent in 2003 replied negatively in this regard.

Table-8 Strategies of FHC and RHS-B:

Res	Years			
	1999		2003	
	F	%	f	%
Yes	56	93.3	60	100
No	04	6.7	-	-
Total	60	100	60	100

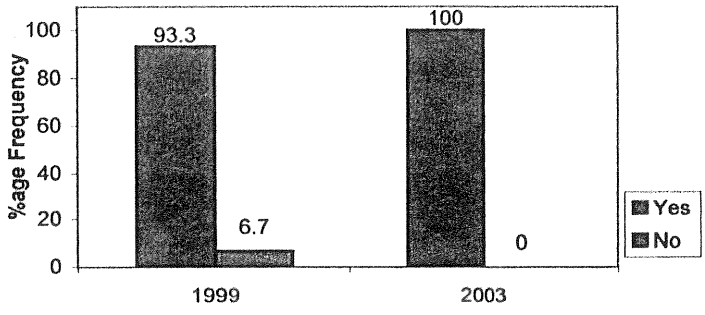


Figure-8: Strategies of FHC and RHS-B

Table-8 shows that 93.3 percent staff in 1999 and 100.0 percent in 2003 were in favor of women education, improvement in communication, better awareness sources and remedy of constraints to family planning as solution to the hurdles in popularization of family planning, while 6.7 percent were not in faviour of these strategies of FHC and RHS-B.

E. Problems, Functions and Facilities in FHC and RHS-B:

Table-9 Problems in FHC and RHS-B:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	60	100	50	83.3
No	-	-	10	16.7
Total	60	100	60	100

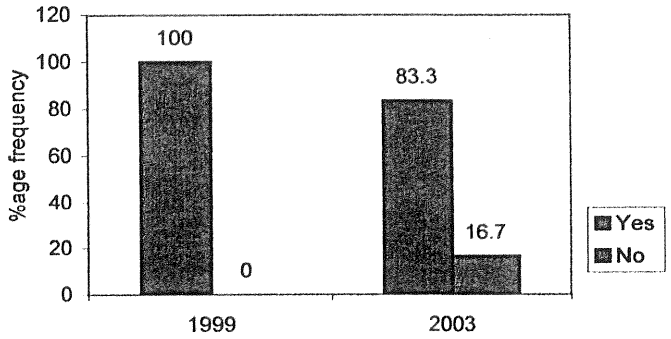


Figure-9: Problems in FHC and RHS-B

Table-9 indicates that 100 percent staff respondents in 1999 and 83.3 percent in 2003 specified for different problems in FWC and RHS-B, while only 16.7 in 2003 specified negatively in this regard.

Table-10 Informative and Curative Functions:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	57	95	60	100
No	03	05	-	-
Total	60	100	60	100

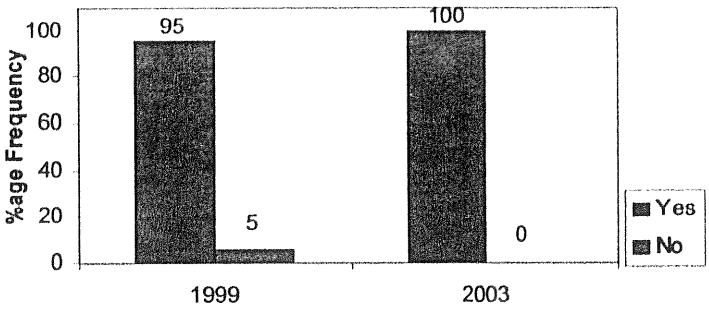


Figure-10: Informative and Curative Functions

Table-10 shows that 95.0 percent staff in 1999 and 100.0 percent in 2003 specified for informative (counseling, awareness & motivation for FP, door to door service and mobile service units) and curative (provision of contraceptives, treatment, checkup, medicines, MCHC) functions, facilities in FWC and RHS-B while only 5.0 percent in 1999, replied negatively.

F. Problems & Role of FWW, LHW and LHV:

Table-11 Problems to FWW, LHW and LHV:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	60	100	55	91.7
No	-	-	05	08.3
Total	60	100	60	100

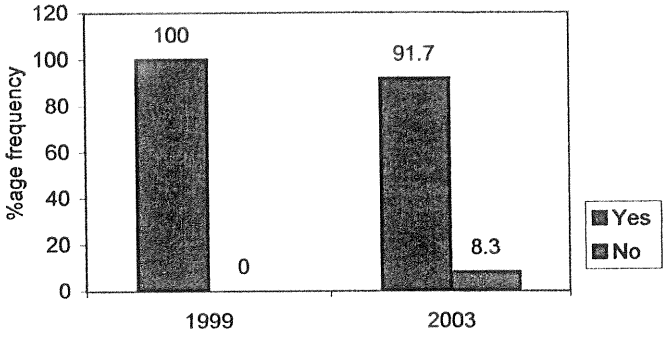


Figure-11: Problems to FWW, LHW and LHV

Table-11 indicates that 100 percent staff respondents in 1999 and 91.7 percent in 2003 specified for different problems to FWW, LHV and LHW, while only 8.3 percent in 2003 were against of it.

Table-12 Role of FWW, LHW and LHV:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	58	96.7	60	100
No	02	3.3	-	-
Total	60	100	60	100

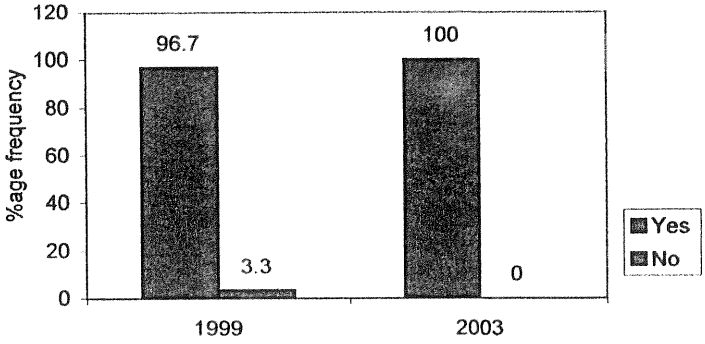


Figure-12: Role of FWW, LHW and LHV

Table-12 indicates that 96.7 percent staff respondents in 1999 and 100.0 percent in 2003 specified for informative (counseling, awareness and motivation for FP) and curative (provision of contraceptives, medicines, treatment, checkup and prescription) as the role of FWW, LHV and LHW.

G. Various Contraceptives Practice:

Table-13 Traditional Method (Withdrawal):

Res	Years			
	1999		2003	
	F	%	f	%
Yes	26	43.3	24	40
No	34	56.7	36	60
Total	60	100	60	100

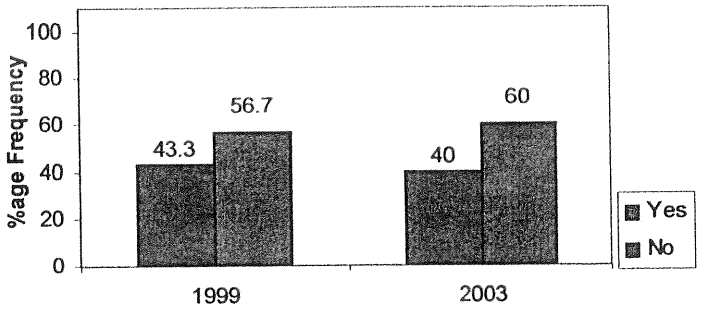


Figure-13: Traditional Method (Withdrawal Male)

Table-13 shows that 43.3 percent staff in 1999 and 40.0 percent in 2003 were in favor of traditional method (Withdrawal male) practice, quantity used (50-100) & free of cost by beneficiaries, while 56.7 percent in 1999 and 60.0 percent in 2003 were against of it.

Table-14 Condom (Male Contraceptive):

Res	Years			
	1999		2003	
	f	%	f	%
Yes	56	93.3	60	100
No	04	6.7	-	-
Total	60	100	60	100

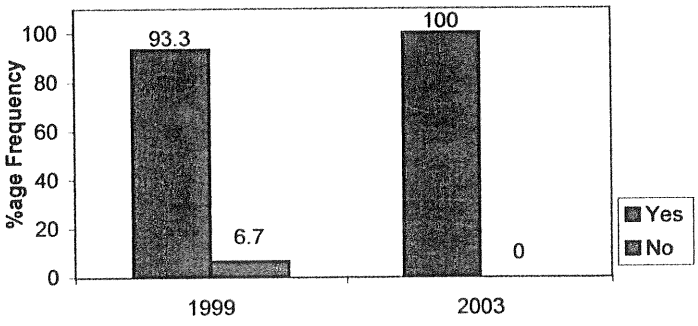


Figure-14: Condom (Male Contraceptive)

Table-14 indicates that 93.3 percent staff in 1999 and 100.0 percent in 2003 were in favor of condom (male contraceptive) practicing, per individual quantity used (50-100) & cost per dozen is Rs.6/-, while only 6.7 percent in 1999 were not in favor of it, they replied for less than 50 usage.

Table-15 Vasectomy (Male Operation):

Res	Years			
	1999		2003	
	f	%	f	%
Yes	20	33.3	23	38.3
No	40	66.7	37	61.7
Total	60	100	60	100

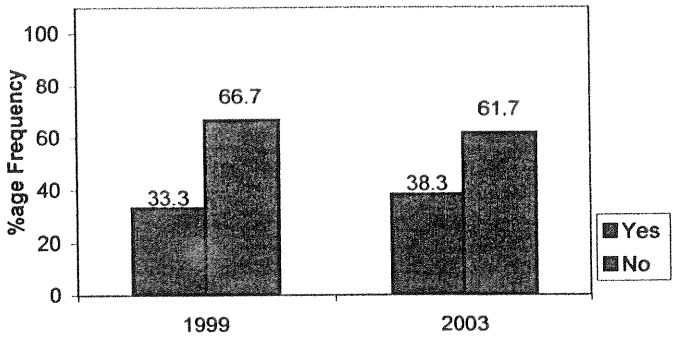


Figure-15: Vasectomy (Male Operation)

Table-15 highlights that 33.3 percent staff in 1999 and 38.3 percent in 2003 replied that vasectomy (male operation) is practicing, once in Life & free of cost, while 66.7 percent in 1999 and 61.7 percent in 2003 replied negatively in this regard

Table- 16 Oral Pills (Female):

Res	Years			
	1999		2003	
	F	%	f	%
Yes	58	96.7	60	100
No	02	3.3	-	-
Total	60	100	60	100

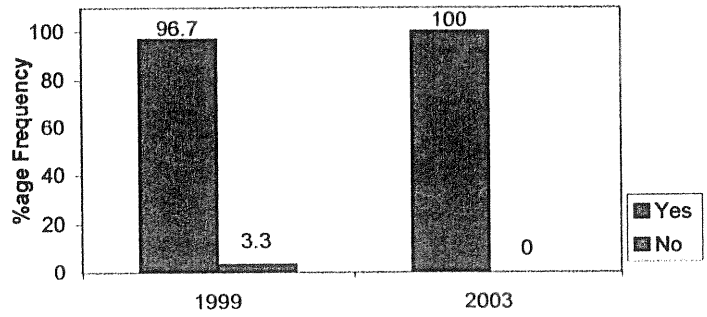


Figure-16: Oral Pills (Female Contraceptives)

Table-16 shows that 96.7 percent staff in 1999 and 100.0 percent in 2003 replied positively regarding the availability and practice of oral pills, per individual usage is 11 strips & cost per strip is Rs. 3/-, while only 3.3 percent in 1999 replied negatively in this regard.

Table-17 Injectables (Female):

Res	Years			
	1999		2003	
	f	%	f	%
Yes	55	91.7	57	95
No	05	8.3	03	05
Total	60	100	60	100

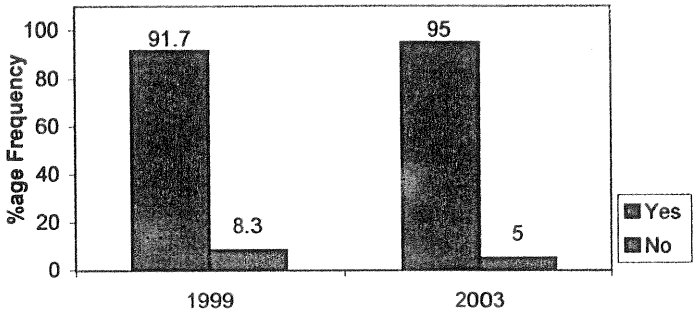


Figure-17: Injectables (Female Contraceptives)

Table-17 demonstrates that 91.7 percent staff in 1999 and 95.0 percent in 2003, were in favor of availability and practice of injection nurajest (2 months), 6 injections / majestron / DEPO (3 months) per individual per annum, usage & 01 injection cost is Rs.3/-, while 5.0 percent in 1999, replied negatively in this regard.

Table-18 Tub-legation/Sterilization:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	49	81.7	51	85
No	11	18.3	09	15
Total	60	100	60	100

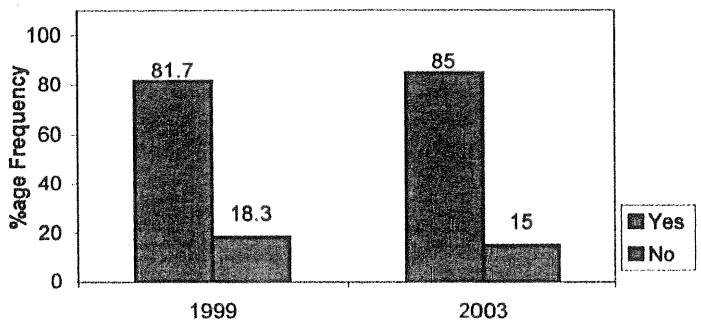


Figure-18: Tub-legation / Sterilization

Table-18 highlights that 81.7 percent staff in 1999 and 85.0 percent in 2003, specified for availability and practice of tub-legation/sterilization (female operation), per individual practice is once in life & free of cost by the beneficiaries, while 18.3 percent in 1999 and 15.0 percent in 2003, replied negatively in this case.

Table-19 Multi Load/Copper-T/ IUD:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	52	86.7	55	91.7
No	08	13.3	05	8.3
Total	60	100	60	100

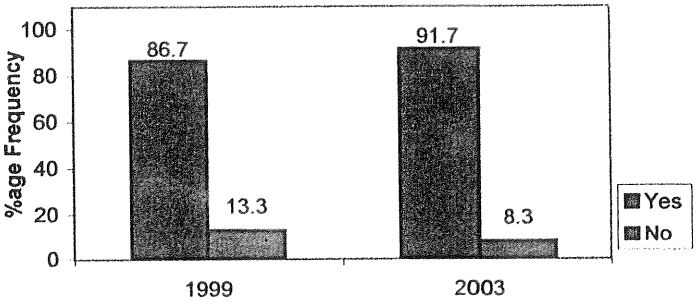


Figure-19: Multi Load/ Copper-T / IUD

Table-19shows that 86.7 percent staff in 1999 and 91.7 percent in 2003 were in favor of availability and practice of multi-load/copper-t/ IUD (female contraceptive), usage per individual 01 for 5-10 years/ once with checking & 01 multi- load/copper-t/ IUD cost is Rs.3/-, while 13.3 percent in 1999 and 8.3 percent in 2003 were not in favor of it.

H. Reasons for Using and Non-using a Specific Method/ Contraceptive:

Table-20 Reasons of Using a Specific Method:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	50	83.3	55	91.7
No	10	16.7	05	8.3
Total	60	100	60	100

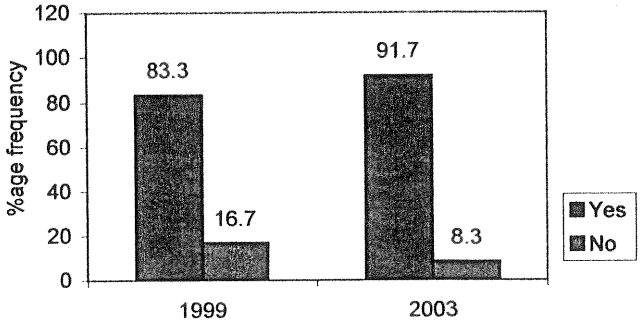


Figure-20: Reasons of Using a Specific Method

Table-20 indicates that 83.3 percent staff respondents in 1999 and 91.7 percent 2003 specified for no/less side effects, convenient, more effective and less costly as the reasons for using a specific method/ contraceptive, while 16.7 percent in 1999 and 8.3 percent in 2003 were against it.

Table-21 Reasons of Not-using a Method:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	55	91.7	50	83.3
No	05	8.3	10	16.7
Total	60	100	60	100

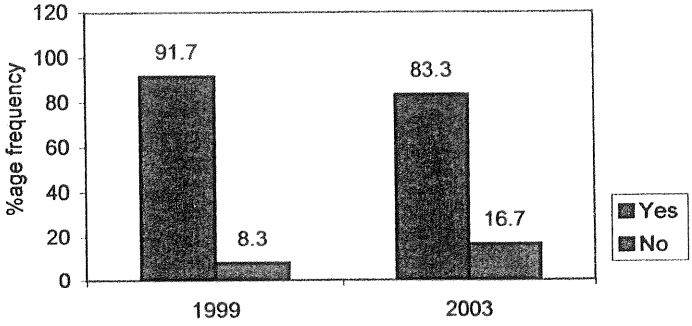


Figure-21: Reasons of Not-using a Method

Table-21 highlights that 91.7 percent staff respondents in 1999 and 83.3 percent in 2003, specified for side effects, permanent, not effective and costly as the reasons for not using a specific method/ contraceptive, while 8.3 percent in 1999 and 16.7 percent in 2003 were against of it.

I. Sources to Get Contraceptives:

Table-22 Major Sources of Contraceptives:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	52	86.7	58	96.7
No	08	13.3	02	3.3
Total	60	100	60	100

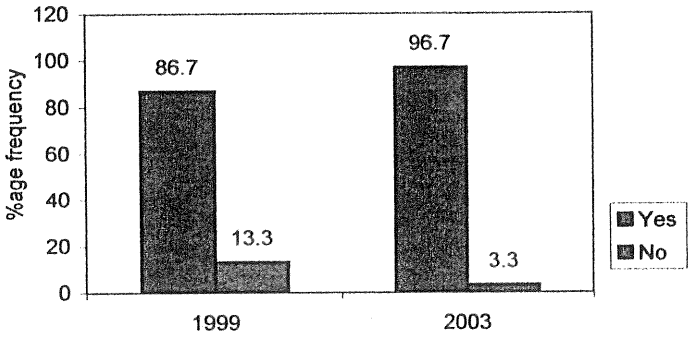


Figure-22: Major Sources of Contraceptives

Table-22 highlights that 86.7 percent staff respondents in 1999 and 96.7 percent in 2003, specified for major sources (family planning organization centers and mobile unit) to provide contraceptives, while only 13.3 percent in 1999 and 3.3 percent in 2003 were against it.

Table-23 Minor sources of contraceptives:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	20	33.3	10	16.7
No	40	66.7	50	83.3
Total	60	100	60	100

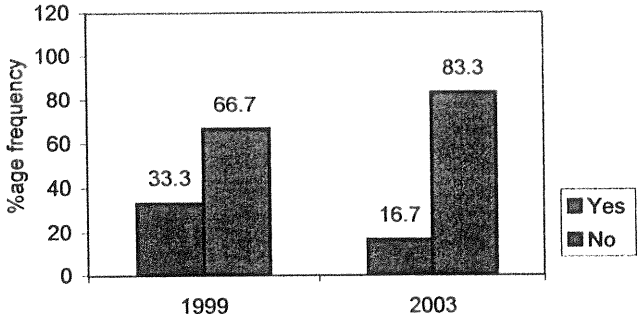


Figure-23: Minor sources of contraceptives

Table-23 shows that 33.3 percent staff respondents in 1999 and 16.7 percent in 2003, specified for minor sources (private medical store, general store, doctor / practitioner) to get contraceptives, while 66.7 percent in 1999 and 83.3 percent in 2003 were against it.

J. Side Effects of Contraceptives:

Table-24 Medical Health Problems:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	56	93.3	50	83.3
No	04	6.7	10	16.7
Total	60	100	60	100

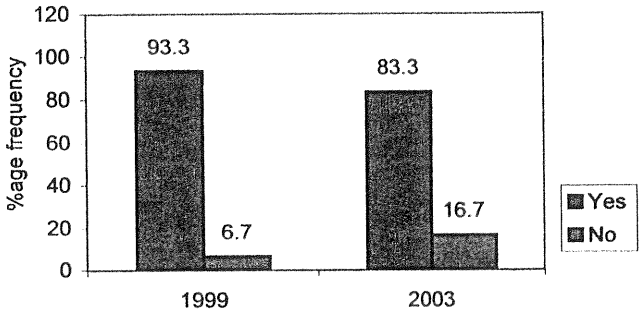


Figure-24: Medical Health Problems

Table-24 shows that 93.3 percent staff respondents in 1999 and 83.3 percent in 2003, specified for medical health problems (infection, irregular menses/ bleeding, weight gain, swelling, temperature, headache, vomiting, no starvation) as the side effects of contraceptives on users, while 6.7 percent in 1999 and 16.7percent in 2003 were against it.

Table-25 Psychological Problems:

Res	Years			
	1999		2003	
	F	%	F	%
Yes	58	96.7	40	66.7
No	02	3.3	20	33.3
Total	60	100	60	100

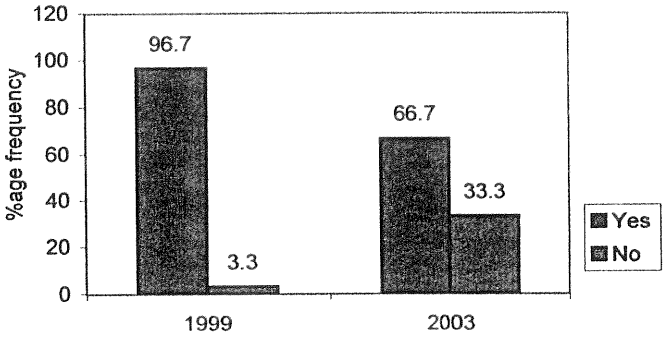


Figure-25: Psychological Problems

Table-25 shows that 96.7 percent staff respondents in 1999 and 66.7 percent in 2003, specified for psychological problems as the side effects of contraceptives on users, while 3.3 percent in 1999 and 33.3 percent in 2003 were against it.

Table-26 Strategies of FP Staff for Prevention:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	50	83.3	60	100
No	10	16.7	-	-
Total	60	100	60	100

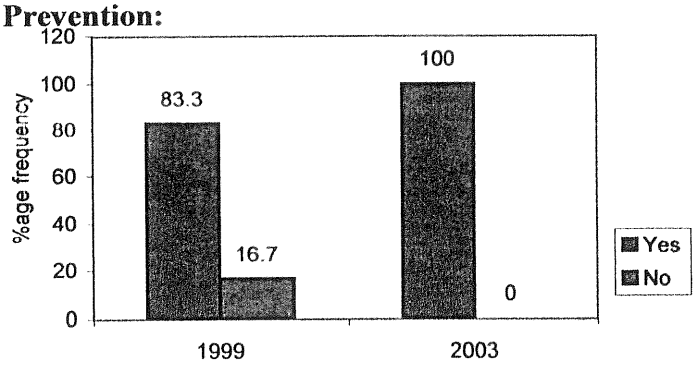


Figure-26: Strategies of FP Staff for Prevention

Table-26 indicates that 83.3 percent staff respondents in 1999 and 100 percent in 2003, specified for counseling, awareness for proper usage of contraceptives, change the method/contraceptive, proper treatment, prescription and preventive measures as strategies and role of family planning staff in prevention of side effects of contraceptives on users, while only 16.7 percent in 1999 were against it.

K. Problems in Reducing the Side Effects of Contraceptives & Strategies of FHC and RHS-B:

Table-27 On the Part of Clients:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	48	80	46	76.7
No	12	20	14	23.3
Total	60	100	60	100

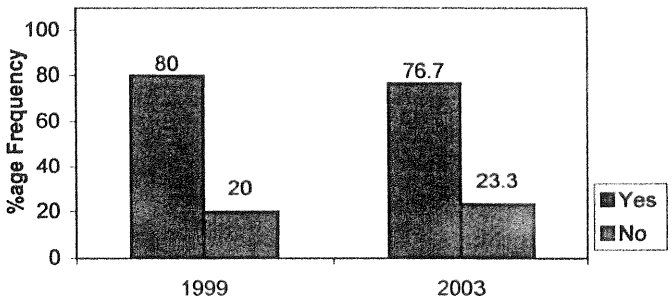


Figure-27: On the part of clients

Table-27indicates that 80.0 percent staff in 1999 and 76.7 percent in 2003 were in favor of no care, proper usage and follow-up by the clients as the problems in reducing the side effects of contraceptive, while 20.0 percent in 1999 and 23.3 percent in 2003 were against it.

Table-28 On the Part of Service Providers:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	37	61.7	35	58.3
No	23	38.3	25	41.7
Total	60	100	60	100

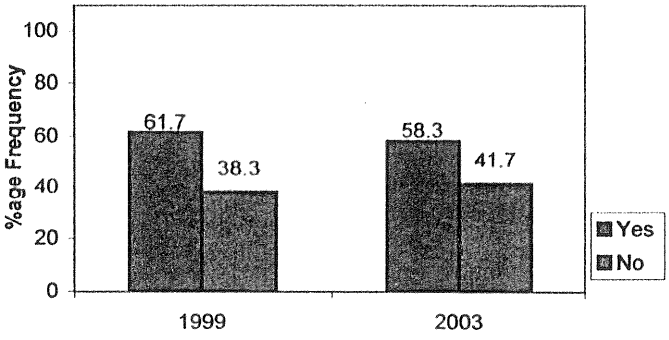


Figure-28: On the part of service providers

Table-28indicates that 61.7 percent staff in 1999 and 58.3 percent in 2003 were in favor of no proper treatment, usage skill, medicine provision by service provider as the problems in reducing the side effects of contraceptive, while 38.3 percent in 1999 and 41.7 percent in 2003 were against it.

Table-29 Strategies of FHC and RHS-B:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	57	95	60	100
No	03	05	-	-
Total	60	100	60	100

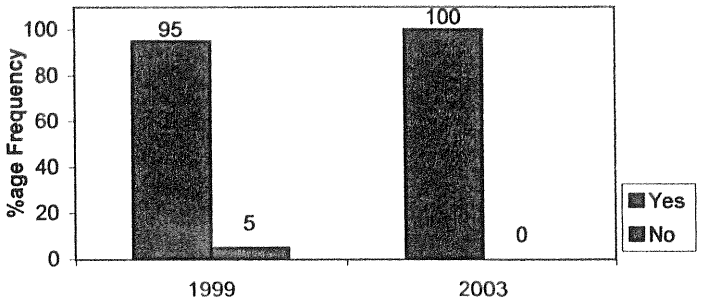


Figure-29: Strategies of FHC and RHS-B

Table-29 highlights that 95.0 percent staff in 1999 and 100.0 percent in 2003 specified for counseling & motivation for proper usage, receiving feedback from clients, proper treatment, cleanliness, change the method, preventive medicines as the strategy and role of FHC and RHS-B, while only 5.0 percent were against it

L. Mother- Child Health Care Program:

Table-30 Informative and Curative:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	58	96.7	60	100
No	02	3.3	-	-
Total	60	100	60	100

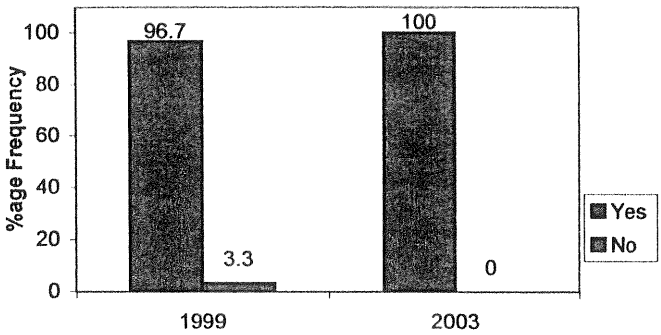


Figure-30: Informative and Curative

Table-30 indicates that 96.7 percent staff in 1999 and 100.0 percent in 2003 specified for informative and curative (counseling, antenatal, postnatal, treatment & vaccination on due time, balance diet) as one of the component of mother-child health care program of FHC and RHS-B, while only 3.3 percent in 1999 replied negatively.

Table-31 Before, During and After Delivery:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	55	91.7	59	98.3
No	05	8.3	01	1.7
Total	60	100	60	100

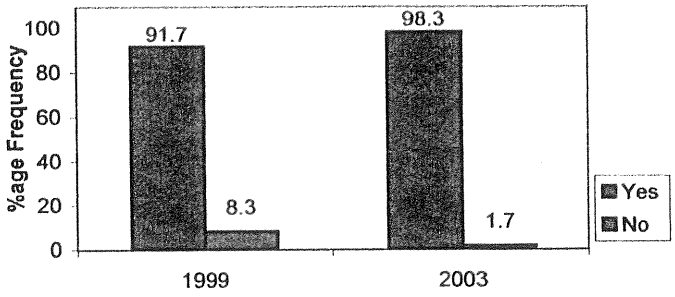


Figure-31: Before, during and after delivery

Table-31 depicts that 91.7 percent staff in 1999 and 98.3 percent in 2003 specified for before, during and after delivery child-mother health care, vaccination on due time, immunization, breast feeding & additional nutrition to child as one of the component of mother-child health care program of FHC and RHS-B, while 8.3 percent in 1999 and 1.7 percent in 2003 replied negatively.

M. Results of Mother-Child Health Care Program:

Table-32 Health Protection & Safe Delivery:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	57	95	59	98.3
No	03	05	01	1.7
Total	60	100	60	100

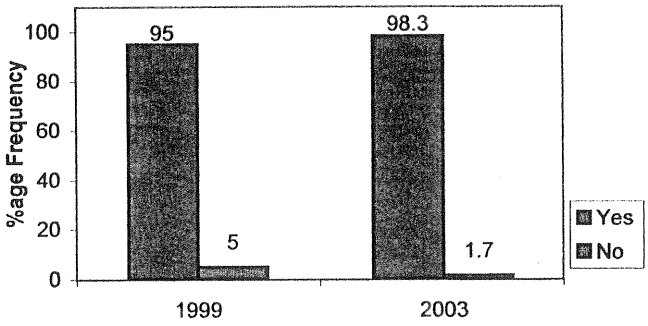


Figure-32: Health Protection and Safe Delivery

Table-32 displays that 95.0 percent staff in 1999 and 98.3 percent in 2003 specified for proper health protection, safe delivery and trust on mother child health care as a result of mother-child health care program of FHC and RHS-B, while 5.0 percent in 1999 and 1.7 percent in 2003 replied negatively.

N. Problems in Mother-Child Health Care & Strategies of FHC and RHS-B:

Table-33 Various Constraints to MCHC and FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	60	100	59	98.3
No	-	-	01	1.7
Total	60	100	60	100

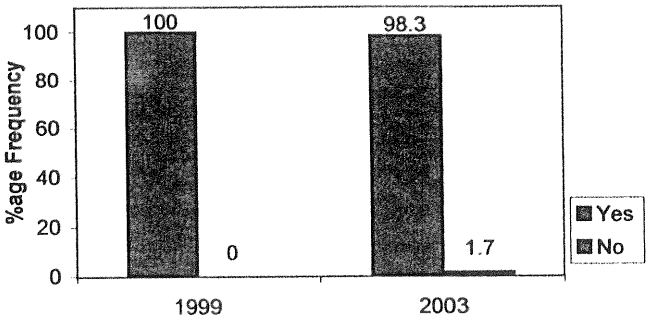


Figure-33: Various Constraints to MCHC and FP

Table-33 highlights that 100.0 percent staff respondents in 1999 and 98.3 percent in 2003 specified for various constraints to MCHC (ignorance, no proper treatment, checkup, medicines, staff etc.), various constraints to FP and side effects as problems in mother-child health care program of FHC and RHS-B, while only 1.7 percent in 2003 replied negatively.

Table-34 Strategies of FHCs and RHS-B:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	58	96.7	60	100
No	02	3.3	-	-
Total	60	100	60	100

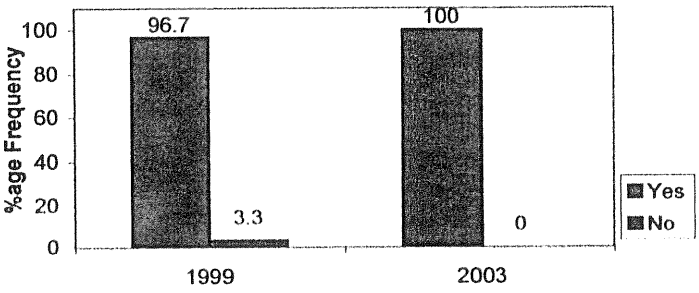


Figure-34: Strategies of FHCs and RHS-B

Table-34 exhibit that 96.7 percent staff in 1999 and 100.0 percent in 2003 specified for the solution of various constraints in MCHC (health awareness, proper treatment, checkup etc.) and solution to various constraints in FP (free counseling, treatment, medicine, avoid early marriage, maximum male children, meeting religious leaders, solution to side effects, quality service etc.) as strategy of FHC and RHS-B in improvement of mother-child health care program of FP., While only 3.3 percent in 1999 replied negatively.

O. Response Causes of Large Family & Role of FHC and RHS-B:

Table-35 Large Family Size:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	60	100	55	95
No	-	-	05	05
Total	60	100	60	100

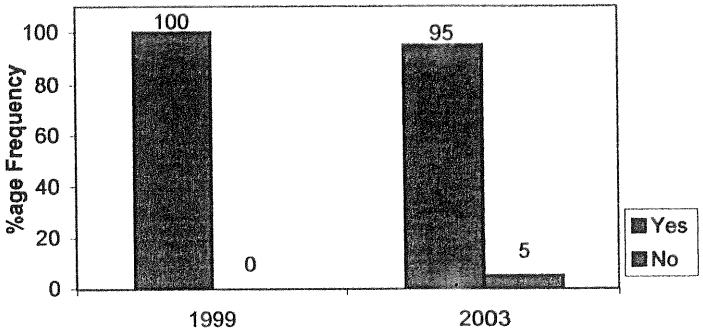


Figure-35: Large Family Size

Table-35 shows that 100.0 percent staff in 1999 and 91.7 percent in 2003 specified for large size of the family in the target area, while only 8.3 percent in 2003 replied negatively (Specified for small family).

Table- 36 Marital Age 13-22 Years (Early):

Res	Years			
	1999		2003	
	f	%	f	%
Yes	48	80	45	75
No	12	20	15	25
Total	60	100	60	100

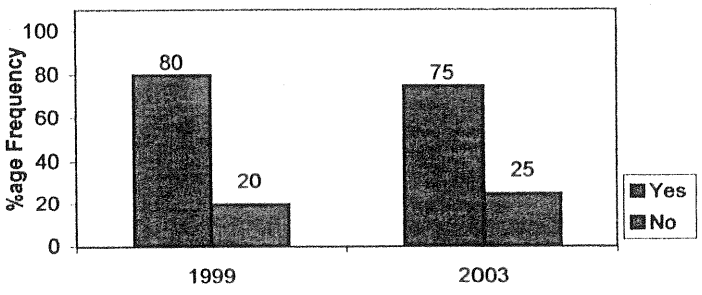


Figure- 36: Marital Age 13-22 Years (Early)

Table-37 indicates that 80.0 percent staff in 1999 and 75.0 percent in 2003 specified for 13-22 years as the marriage age in the area, this early time of marriage is the reason of large family size, while only 20.0 percent in 1999 and 25.0 percent in 2003 replied negatively for it (specified for 23-32 years as the marriage age).

Number of Marriages:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	53	88.3	55	91.7
No	07	11.7	05	8.3
Total	60	100	60	100

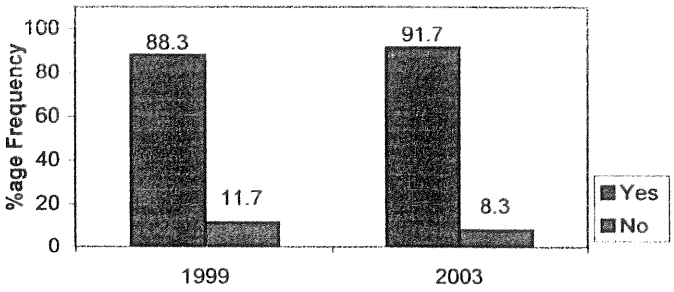


Figure-37: One / Single Marriage

Table-37 highlights that 88.3 percent staff in 1999 and 91.7 percent in 2003 specified for one/ single marriage in the area, while only 11.7 percent in 1999 and 8.3 percent in 2003 replied negatively for it (Specified for two/ double & three / triple marriages respectively as reasons of large family size).

Table- 38 Desire for Male Children Resultant Large Family:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	60	100	55	91.7
No	-	-	05	8.3
Total	60	100	60	100

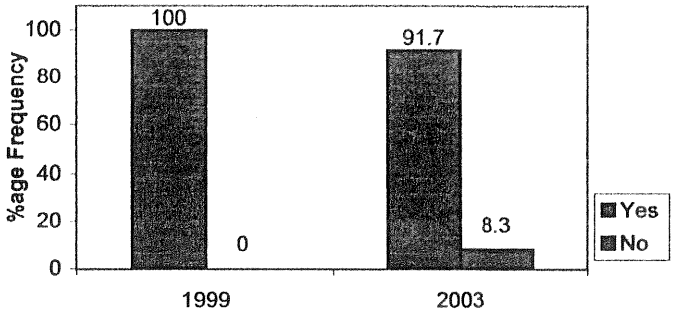


Figure-38: Desire for Male Children Resultant Large Family

Table-38 depicts that 100.0 percent staff respondents in 1999 and 91.7 percent in 2003 replied that desire for male child reasons (sons are power, prestige, source of income, psychological protection & inheritance of property of the family) resultant large family, while only 8.3 percent in 2003 replied negatively.

Table-39 Constraints to FP Resultant Large Family:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	60	100	55	91.7
No	-	-	05	8.3
Total	60	100	60	100

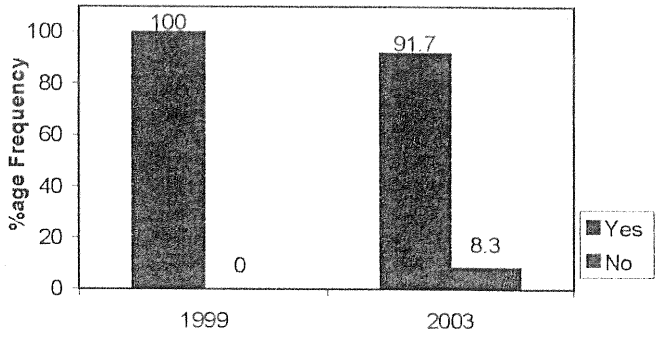


Figure-39: Various Constraints to FP resultant Large Family

Table-39 shows that 100.0 percent staff in 1999 and 91.7 percent in 2003 replied that various constraints in family planning (eco-, religious, socio-cultural, psychological, medical, technical, quality of service) leads to large size of the family, while only 8.3 percent in 2003 replied negatively.

Table-40 Strategies of FHC and RHS-B:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	55	91.7	60	100
No	05	8.3	-	-
Total	60	100	60	100

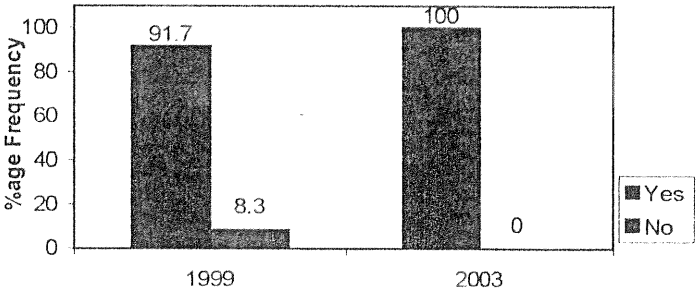


Figure-40: Strategies of FHC and RHS-B

Table-40 shows that 91.7 percent staff in 1999 and 100.0 percent in 2003 specified for proper awareness, counseling & motivation for small family, contraceptives, large family economic burden, avoid early marriage & maximum children, son and daughter are equal, equal rights of children, proper checkup, treatment, medicines, solution of constraints as strategies of FHC and RHS-B to control and minimize the size of family, and only 8.3 percent in 1999 replied negatively.

P. Various Constraints to Family Planning:

Table-41 Economic Constraints to FP:

Res	Years			
	1999		2003	
	F	%	f	%
Yes	59	98.3	58	96.7
No	01	1.7	02	3.3
Total	60	100	60	100

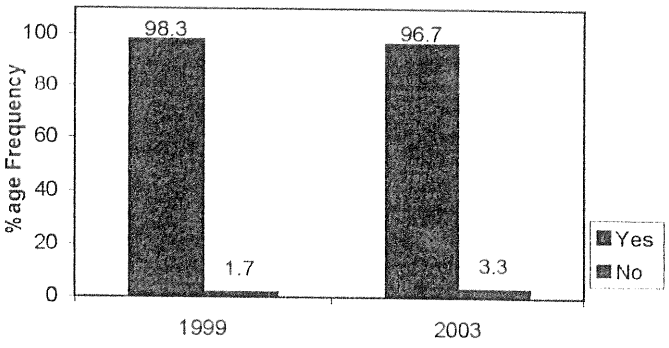


Figure-41: Economic Constraints to FP

Table-41 shows that 98.3 percent staff in 1999 and 96.7 percent in 2003 specified for male children economic assets and source of income, poverty, no income and employment, high expenses of family, no infrastructure, treatment, medicines, with NGO's as economic constraints to family planning, while 1.7 percent in 1999 and 3.3 percent in 2003 replied negatively.

Table-42 Strategies of FHC and RHS-B:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	52	86.7	55	91.7
No	08	13.3	05	8.3
Total	60	100	60	100

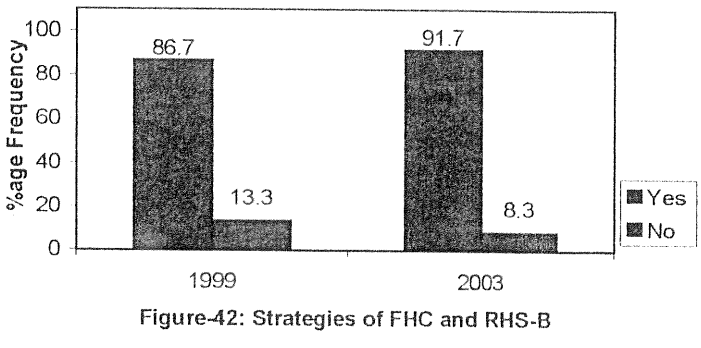


Figure-42: Strategies of FHC and RHS-B

Table-42 indicates that 86.7 percent staff in 1999 and 91.7 percent in 2003 specified for foreign aid, free counseling, check up, treatment, LAM, low rate contraceptives as strategies of FHC and RHS-B to solve the economic constraints in family planning, while 13.3 percent in 1999 and 8.3 percent in 2003 replied negatively

Table-43 Religious Constraints to FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	59	98.3	54	90
No	01	1.7	06	10
Total	60	100	60	100

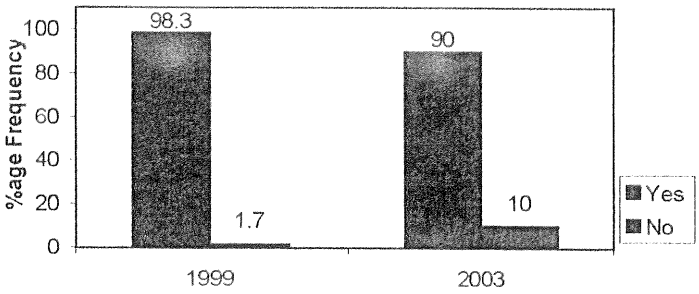


Figure-43: Religious Constraints to FP

Table-43 display that 98.3 percent staff respondents in 1999 and 90.0 percent in 2003 specified for family planning is sin, killing of humanity, illegitimate, Fatalism, Allah is food provider, no one can stop those souls to be produced, increase Muslims, immoral, plan of non Muslims slogans use by religious leaders, which are the religious obstacles to family planning, while 1.7 percent in 1999 and 10.0 percent in 2003 replied against of it.

Table-44 Strategies of FHC and RHS-B:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	54	90	60	100
No	06	10	-	-
Total	60	100	60	100

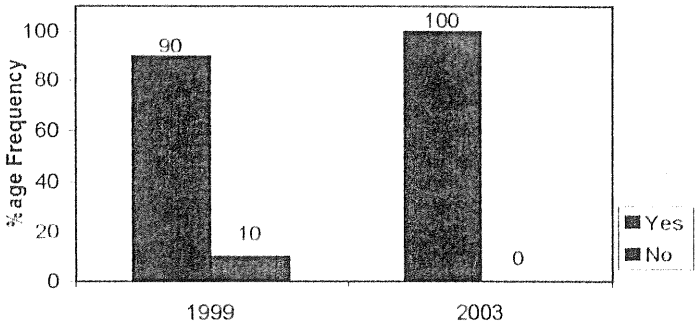


Figure-44: Strategies of FHC and RHS-B

Table-44 highlights that 90.0 percent staff in 1999 and 100.0 percent in 2003, specified for religious leaders project, counseling, motivating religious people, collection of different statements/ fatwas and religious literature distribution in favor of FP as strategies of FHC and RHS-B to solve the religious obstacles in family planning, while 10.0 percent in 1999 replied negatively.

Table-45 Socio-Cultural Constraints to FP:

Res	Years			
	1999		2003	
	F	%	f	%
Yes	60	100	55	91.7
No	-	-	05	8.3
Total	60	100	60	100

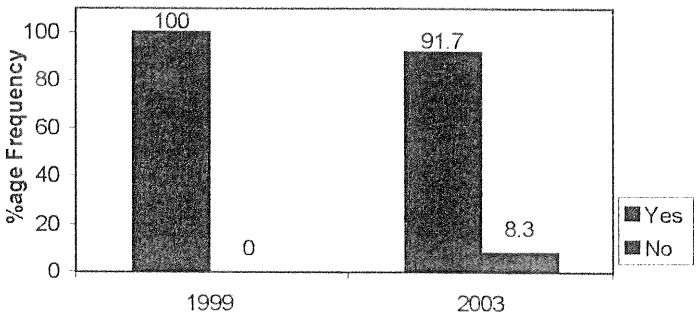


Figure-45: Socio-Cultural Constraints to FP

Table-45 depicts that 100.0 percent staff in 1999 and 91.7 percent in 2003 specified for desire for maximum male children (sons are guns, power, prestige, inheritance of property, psychological & social protection, dominancy, source of income, helping hands, natural desire), FP disapproval by husband and in-laws, veil (Purdha), shyness and no power of women, early marriage, negative public opinion, wrong propaganda as socio-cultural obstacles in family planning, while only 8.3 percent in 2003 replied negatively.

Table-46 Strategies of FHC and RHS-B:

Res	Years			
	1999		2003	
	F	%	f	%
Yes	57	95	60	100
No	03	05	-	-
Total	60	100	60	100

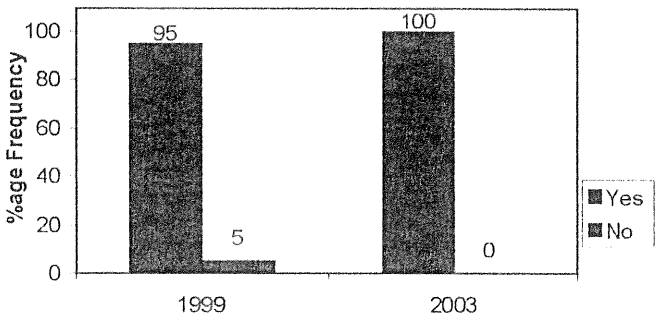


Figure-46: Strategies of FHC and RHS-B

Table-46 shows that 95.0 percent staff in 1999 and 100.0 percent in 2003 specified for small family norms, small family better life, two kids are better, son and daughter are equal, maximum gap, avoid early marriage and polygamy, women empowerment as a strategies of family planning centers to solve the socio-cultural obstacles in family planning, while only 5.0 percent in 1999 replied negatively.

Table-47 Govt. / Political Constraints to FP:

Res	Years			
	1999		2003	
	F	%	f	%
Yes	38	63.3	36	60
No	22	36.7	24	40
Total	60	100	60	100

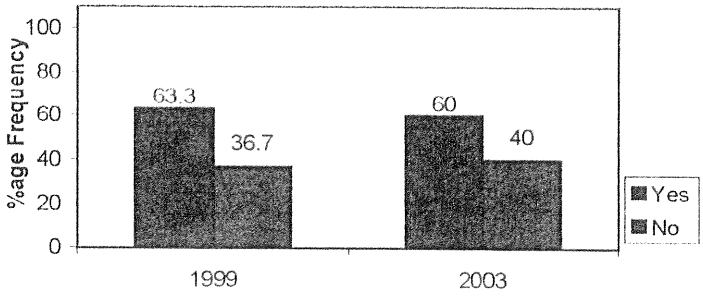


Figure-47: Political and Governmental Constraints to FP

Table-47 shows that 63.3 percent staff in 1999 and 60.0 percent in 2003 specified for foreign aid dependency, no proper funds allocation, fluctuating support and policy change as the political/ Governmental obstacles in family planning, while 36.7 percent in 1999 and 40.0 percent in 2003 replied negatively.

Table-48 Strategies of FHC and RHS-B:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	35	58.3	38	63.3
No	25	41.7	22	36.7
Total	60	100	60	100

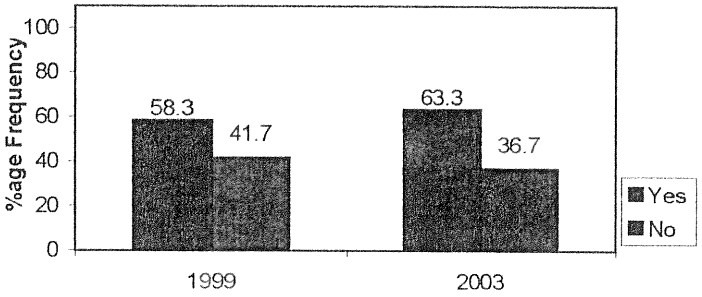


Figure-48: Strategies of FHC and RHS-B

Table-48 indicates that 58.3 percent staff in 1999 and 63.3 percent in 2003 specified for collaborations of public and private sectors, struggle to continue, getting support of foreign donors as strategies of FHC and RHS-B to solve the political / Governmental constraints in family planning, while 41.7 percent in 1999 and 36.7 percent in 2003, replied negatively.

Table- 49 Psychological Constraints to Family Planning:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	45	75	42	70
No	15	25	18	30
Total	60	100	60	100

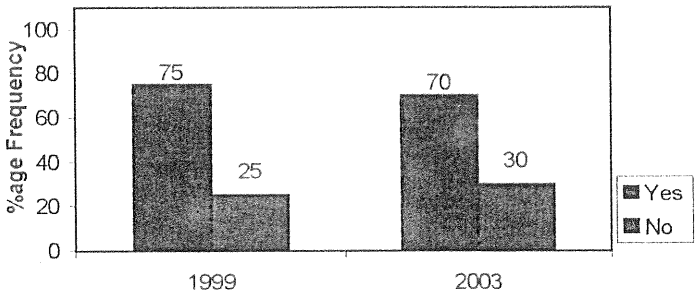


Figure-49: Psychological Constraints to FP

Table-49 demonstrates that 75.0 percent staff in 1999 and 70.0 percent in 2003 specified for worry of side effects of contraceptives/ medicines and worry of conception/ infertility as psychological obstacles in family planning, while 25.0 percent in 1999 and 30.0 percent in 2003 replied negatively.

Table-50 Strategies of FHC and RHS-B:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	58	96.7	59	98.3
No	02	3.3	01	1.7
Total	60	100	60	100

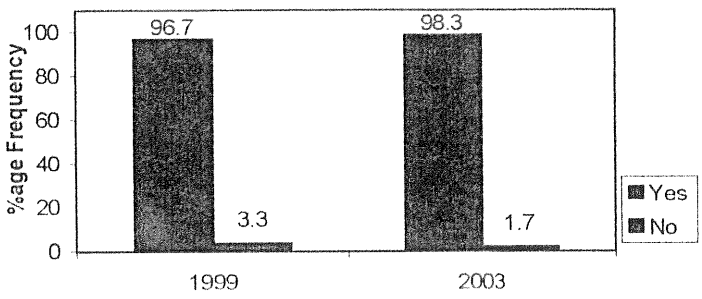


Figure-50: Strategies of FHC and RHS-B

Table-50 shows that 96.7 percent staff in 1999 and 98.3 percent in 2003 specified for counseling, motivation, awareness for proper usage/change of contraceptives, proper checkup, treatment, medicine and prescription of family planning staff as strategies of family planning centers to solve the psychological obstacles in family planning, while 3.3 percent in 1999 and 1.7 in 2003 replied negatively.

Table-51 Medical & Technical Constraints to FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	59	98.3	58	96.7
No	01	1.7	02	3.3
Total	60	100	60	100

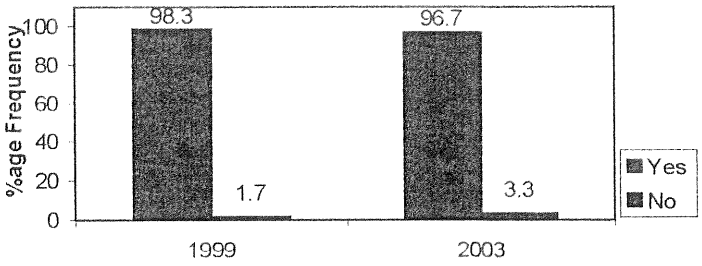


Figure-51: Medical and Technical Constraints to FP

Table-51 indicates that 98.3 percent staff in 1999 and 96.7 percent in 2003 specified for no family planning and health awareness, motivation, follow-up, fear from taking medicines, Contraceptives due to side effects, proper trained staff, equipments, medicines, checkup, treatment and diagnosing (tests), as medical & technical constraints in family planning, while only 1.7 percent in 1999 and 3.3 percent in 2003 replied negatively.

Table- 52 Strategies of FHC and RHS-B:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	58	96.7	59	98.3
No	02	3.3	01	1.7
Total	60	100	60	100

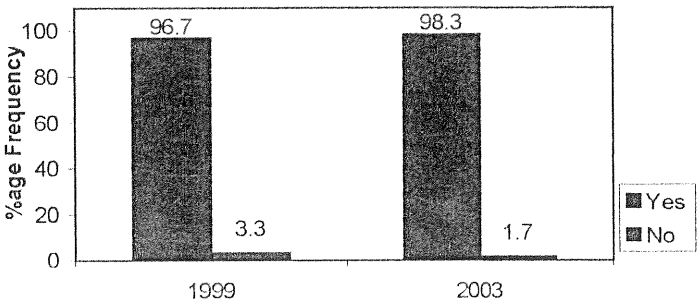


Figure-52: Strategies of FHC and RHS-B

Table-52 shows that 96.7 percent staff in 1999 and 98.3 percent in 2003 specified for motivation, counseling, and awareness for proper Usage, change of contraceptives, proper checkup, treatment, medicines, advise by qualified and trained family planning staff as strategies family planning centers to solve the medical-technical constraints in family planning, while only 3.3 percent in 1999 and 1.7 percent in 2003 replied negatively.

Table-53 Quality of Service Constraints to FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	59	98.3	57	95
No	01	1.7	03	05
Total	60	100	60	100

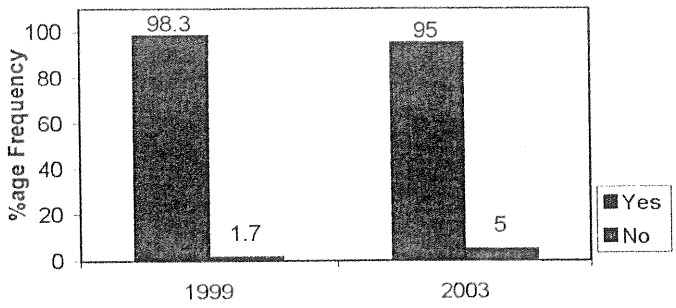


Figure-53: Quality of Service Constraints to FP

Table-53 display that 98.3 percent staff in 1999 and 95.0 percent in 2003 specified for no proper budget, involvement of health outlets, coverage, outreach, information, supervision, monitoring & evaluation, strategy change, low quality contraceptives, questionable/ no proper service, no door step service, less satisfaction, male involvement, infrastructure, building, proper trained staff, as quality of service constraints in family planning, while only 1.7 percent in 1999 and 5.0 percent in 2003, replied negatively.

Table-54 Strategies of FHC and RHS-B:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	55	91.7	58	96.7
No	05	8.3	02	3.3
Total	60	100	60	100

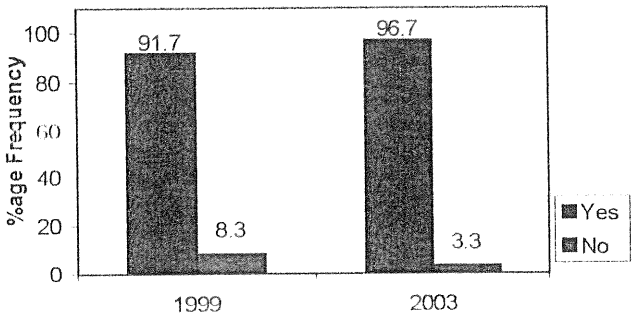


Figure-54: Strategies of FHC and RHS-B

Table-54 highlights that 91.7 percent staff in 1999 and 96.7 percent in 2003 specified for, budget based on foreign assistance, Proper supervision, monitoring, evaluation, proper, qualified & trained staff, male staff involvement for male motivation/ mobilization, as strategies family planning centers to solve the quality of services constraints in family planning, while 8.3 percent in 1999 and 3.3 percent in 2003 replied negatively.

Q. Linkage Programs among Govt. NGOs& Community:

Table-55 Public Private Partnership:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	22	36.7	56	93.3
No	38	63.3	04	6.7
Total	60	100	60	100

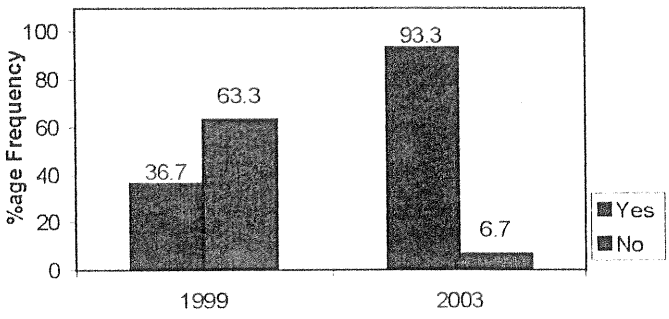


Figure-55: Public Private Partnership

Table-55 shows that 36.7 percent staff in 1999 and 93.3 percent in 2003 specified for combined seminars, workshops & partnership as linkage program among Govt., NGOs & community / beneficiaries, while 63.3 percent in 1999 and 6.7 percent in 2003 replied negatively.

R. Shortcomings in FP and Strategies for Improvement:

Table-56 Shortcomings in Implementation of FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	59	98.3	58	96.7
No	01	1.7	02	3.3
Total	60	100	60	100

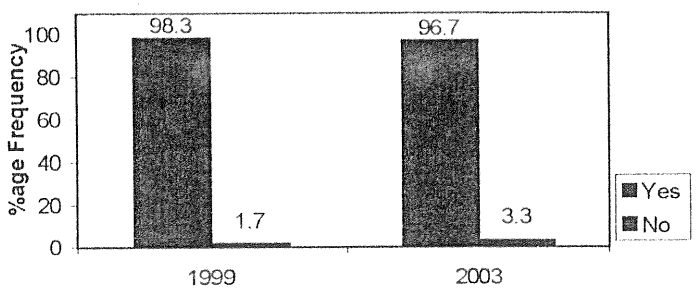


Figure-56: Shortcomings in Implementation of FP

Table-56 reveals that 98.3 percent staff in 1999 and 96.7 percent in 2003 were in favor of side effects of contraceptives, no proper policy, planning, research, strategy, involvement of religious leaders, male interest, awareness and education programme about family planning, various constraints/ obstacles to family planning, low/ no role of media, related departments, health, district govt., welfare societies, association, organizations, CBOs etc., as weaknesses and shortcomings of the family planning program, while 1.7 percent in 1999 and 3.3 percent in 2003 were against it.

Table-57 Strategies to Improve FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	58	96.7	60	100
No	02	3.3	-	-
Total	60	100	60	100

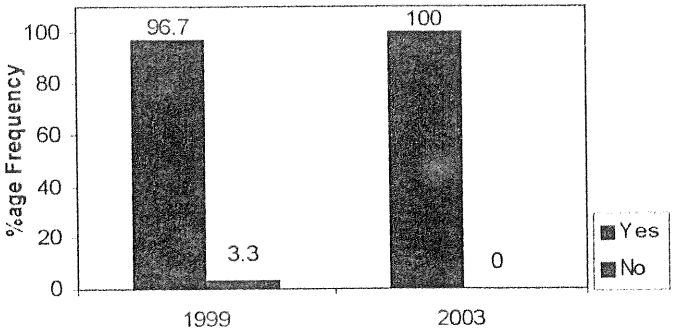


Figure-57: Strategies to Improve FP

Table-57 shows that 96.7 percent staff in 1999 and 100.0 percent in 2003 specified for role of media, district govt., religious leaders, family planning education, awareness, enlightened vision, counseling, motivation and proper communication programme of family planning, proper, qualified, trained staff and establishment of more family planning organizations as strategies for the improvement of family planning, while 3.3 percent in 1999 replied nil in this regard.

4.3 Part-III Data Analysis & Interpretation of Family Planning Organizations Beneficiaries:

A. Number of Children:

Table-1 Number of Male Children:

Spec	Years			
	1999		2003	
	F	%	F	%
0-1	50	16.7	45	15.0
2-3	170	56.7	180	60.0
4<	80	26.6	75	25.0
Total	300	100	300	100

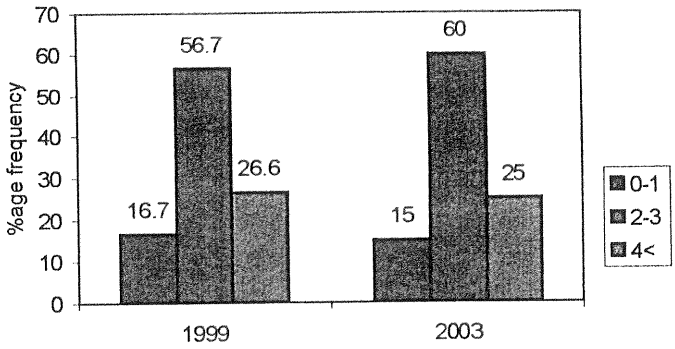


Figure-1: Number of Male Children

Table-1 shows that 16.7 percent, 56.7 percent and 26.6 percent beneficiaries in 1999 and 15.0 percent, 60.0 percent and 25.0 percent in 2003 replied that they were having 0-1, 2-3 and 4< numbers of male children respectively.

Table-2 Number of Female Children:

Spec	Years			
	1999		2003	
	F	%	F	%
0-1	60	20.0	55	18.3
2-3	160	53.3	170	56.7
4<	80	26.7	75	25.0
Total	300	100	300	100

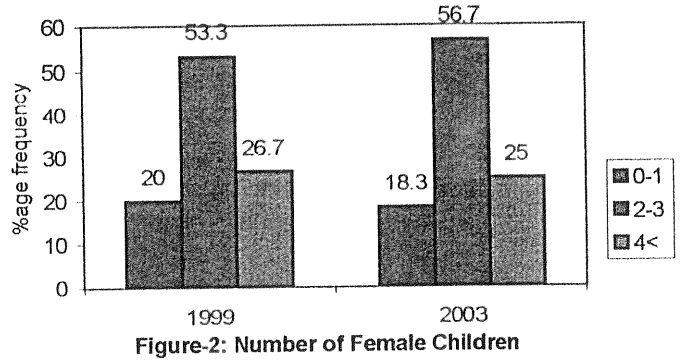


Figure-2: Number of Female Children

Table-2 shows that 20.0 percent, 53.3 percent and 26.7 percent beneficiaries in 1999 and 18.3 percent, 56.7 percent and 25.0 percent in 2003 replied that they were having 0-1, 2-3 and 4< numbers of female children respectively.

B. Educational Status and Practice of Family Planning:

Table-3 Uneducated and Practice of FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	80	26.7	180	60
No	220	73.3	120	40
Total	300	100	300	100

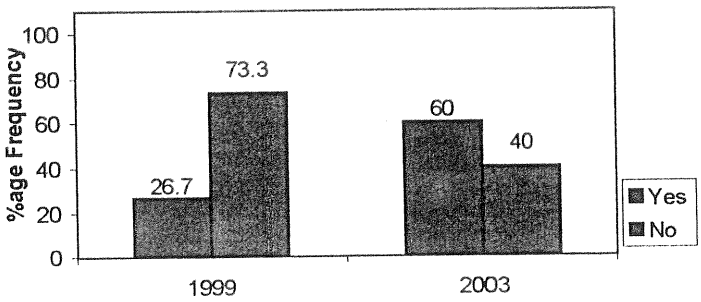


Figure-3: Uneducated and Practice of FP

Table-3 shows that 26.7 percent beneficiaries' respondents in 1999 and 60.0 percent in 2003 replied that uneducated respondents were practicing family planning, while 73.3 percent beneficiaries' respondents in 1999 and 40.0 percent replied negatively in this regard.

Table-4 Educated and Practice of FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	250	83.3	294	98
No	50	16.7	6	02
Total	300	100	300	100

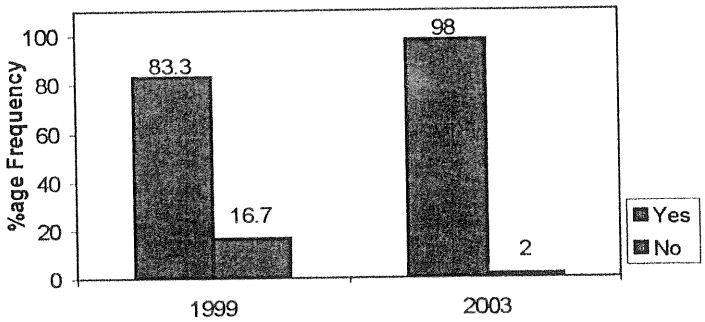


Figure-4: Educated and Practice of FP

Table-4 highlights that 83.3 percent beneficiaries' respondents in 1999 and 98.0 percent in 2003 replied that educated people were practicing family planning, while only 16.7 percent in 1999 and 2.0 percent in 2003, replied negatively in this regard.

C. Sources of Awareness, Advertisement and Popularization of FP:

Table-5 Major Sources of Awareness of FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	241	80.3	251	83.7
No	59	19.7	49	16.3
Total	300	100	300	100

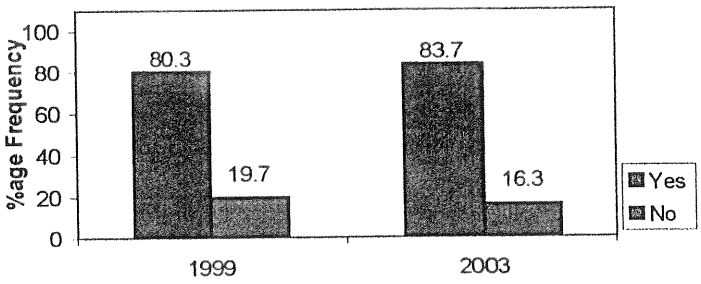


Figure-5: Major Sources of awareness & popularization of FP

Table-5 indicates that 80.3 beneficiaries' respondents in 1999 and 83.7 percent in 2003 replied positively for the role of family planning staff & literature, TV, radio, relatives, friends, husband and wife in popularization of family planning, while 19.7 percent in 1999 and 16.3 percent in 2003 replied negatively.

Table-6 Minor Sources of Awareness of FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	120	40	160	53.3
No	180	60	140	46.7
Total	300	100	300	100

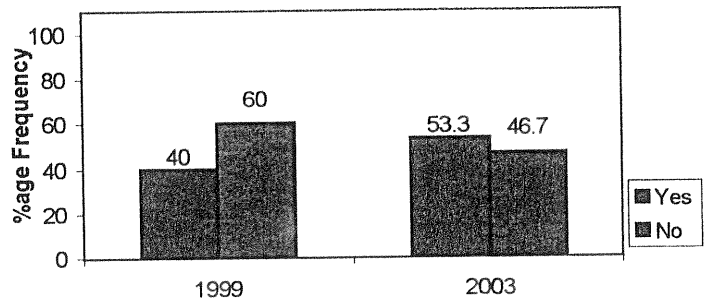


Figure-6: Minor Sources of awareness & Popularization of FP

Table-6 shows that 40.0 percent beneficiaries' respondents in 1999 and 53.3 percent in 2003 specified for the positive role of wall chalking, banners, sign boards, seminars, workshops, conferences, news papers and magazines in popularization of family planning, while 60.0 percent in 1999 and 46.7 percent in 2003 replied negatively.

D. Problems during Awareness, Communication& Popularization of FP:

Table-7 Ignorance, Communication & FP Constraints:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	300	100	290	96.7
No	-	-	10	3.3
Total	300	100	300	100

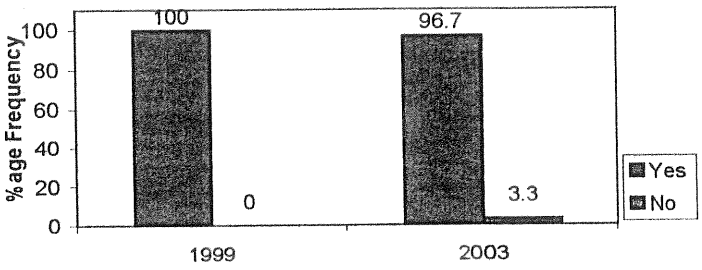


Figure-7: Ignorance, Improper Communication and FP Constraints

Table-7 shows that 100.0 percent beneficiaries' respondents in 1999 and 96.7 percent in 2003 replied positively regarding ignorance of women, improper communication and various constraints in family planning as problems during awareness, educating, convincing, communication, advertisement and popularization of family planning, while only 3.3 percent in 2003 replied negatively.

Table-8 Strategies of FP Organizations:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	237	79	285	95
No	63	21	15	05
Total	300	100	300	100

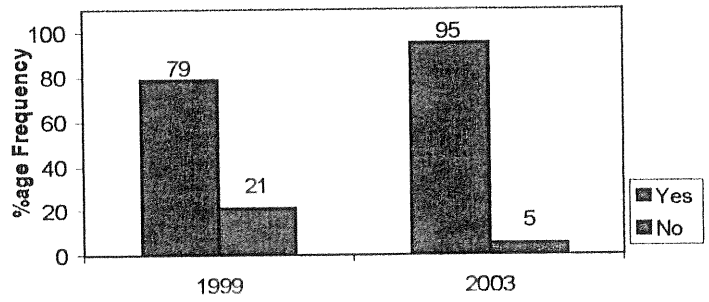


Figure-8: Strategies of Family Planning Organizations

Table-8 shows that 79.0 percent beneficiaries respondents in 1999 and 95.0 percent in 2003 were in favor of women education, improvement in communication and remedy of constraints to family planning as solution of problems in communication and popularization of family planning by FP organizations, while 21.0 percent in 1999 and 5.0 percent in 2003, were against of the view.

E. Problems, Functions and Facilities in Family Planning Organizations:

Table-9 Problems in FP Organizations:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	186	62	180	60
No	114	38	120	40
Total	300	100	300	100

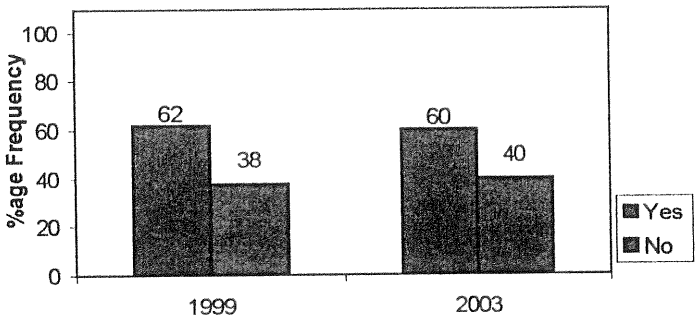


Figure-9: Problems in Family Planning Organizations

Table-9 shows that 62.0 percent beneficiaries respondents in 1999 and 60.0 percent in 2003, specified for no required facilities of family planning, people dislike it and staff issues as the problems of family planning organizations, while 38.0 percent in 1999 and 40.0 percent in 2003 were against it.

Table-10 Informative and Curative Functions:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	287	95.7	297	99
No	13	4.3	3	01
Total	300	100	300	100

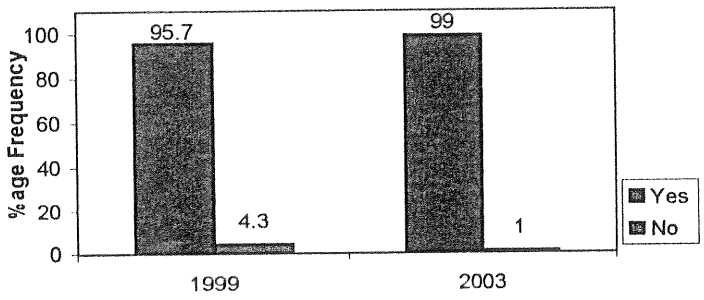


Figure-10: Informative and Curative Functions

Table-10 displays that 95.7 percent beneficiaries' respondents in 1999 and 99.0 percent in 2003 specified for informative and curative (awareness, counseling, motivation, provision of contraceptives, treatment, checkup, medicines, MCHC and RHC, door-step service, camps and mobile service) functions and facilities in family planning organizations, while 4.3 percent in 1999 and 1.0 percent in 2003 replied negatively.

F. Problems & Role of FWW, LHW and LHV:

Table-11 Problems to FWW, LHW and LHV:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	290	96.7	270	90
No	10	3.3	30	10
Total	300	100	300	100

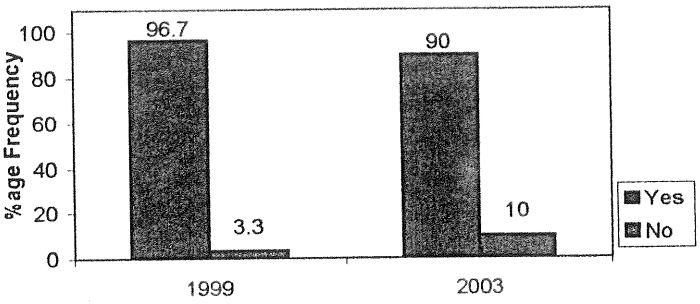


Figure-11: Problems related to FWW, LHW and LHV

Table-11 indicates that 96.7 percent beneficiaries respondents in 1999 and 90.0 percent in 2003 specified for no visit to home, absent and take charges in clinic are the complaints and problems faced to beneficiaries respondents from the FWW, LHW and LHV, while 3.3 percent in 1999 and 10.0 percent in 2003 were against it.

Table-12 Role of FWW, LHW and LHV:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	284	94.7	296	98.7
No	16	5.3	4	1.3
Total	300	100	300	100

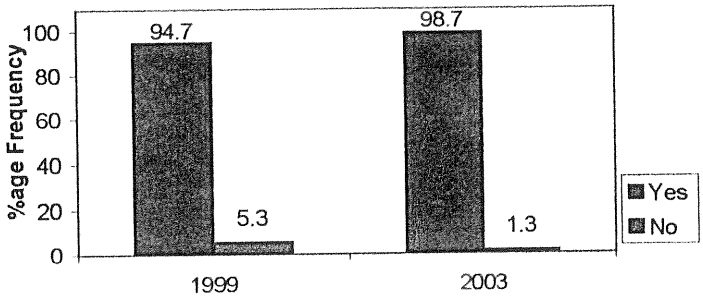


Figure-12: Role of FWW, LHW and LHV

Table-12 indicates that 94.7 percent beneficiaries' respondents in 1999 and 98.7 percent in 2003 specified for informative (motivation, counseling & convincing for family planning and curative (contraceptives provision, checkup, treatment, prescription, and provision of medicines) were the role, functions and performance of FWW, LHW and LHV, while 5.3 percent in 1999 and 1.3 percent in 2003 were against it.

G. Practice of Various Contraceptives:

Table-13 Traditional Method (Withdrawal):

Res	Years			
	1999		2003	
	f	%	f	%
Yes	19	6.3	18	6
No	281	93.7	282	94
Total	300	100	300	100

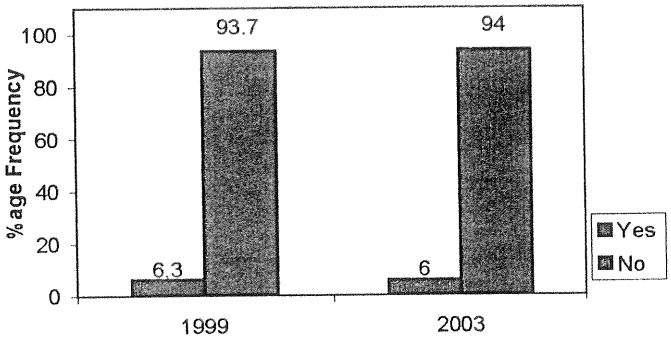


Figure-13: Traditional Method (Withdrawal)

Table-13 shows that 6.3 percent respondents in 1999 and 6.0% in 2003 were in favor of withdrawal (male) method practice, quantity used (50-100) & free of cost by beneficiaries, while 93.7 percent in 1999 and 94.0 percent in 2003, were against it.

Table-14 Condom (Male Contraceptive):

Res	Years			
	1999		2003	
	f	%	f	%
Yes	179	59.7	183	61
No	121	40.3	117	39
Total	300	100	300	100

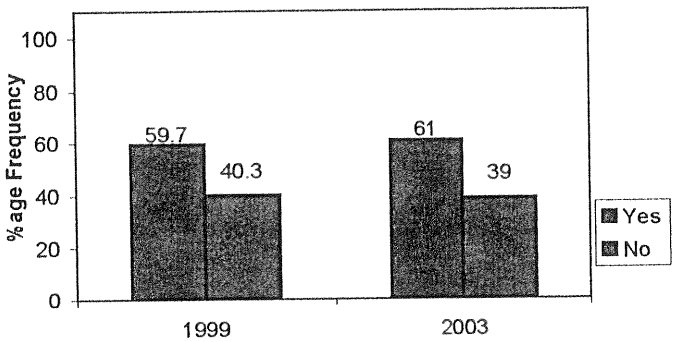


Figure-14: Condom (Male Contraceptive)

Table-14 indicates that 59.7 percent beneficiaries respondents in 1999 and 61.0 percent in 2003 were in favor of condom (male contraceptive) practicing, per individual quantity used (50-100) & cost per dozen= Rs.6/-, while 40.3 percent in 1999 and 39.0 percent in 2003 were not in favor of it, they replied for less than 50 usage.

Table-15 Vasectomy (Male Operation):

Res	Years			
	1999		2003	
	f	%	f	%
Yes	12	4.0	17	5.7
No	288	96.0	283	94.3
Total	300	100	300	100

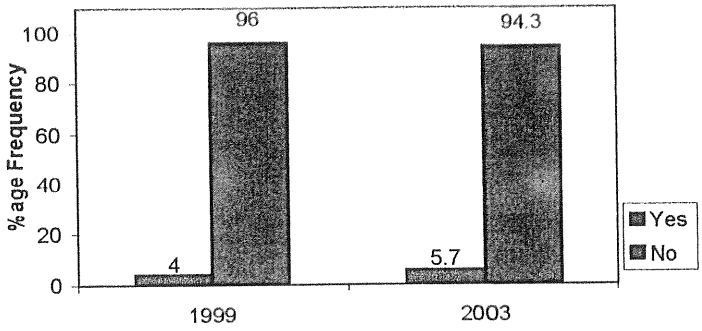


Figure-15: Vasectomy (Male Operation)

Table-15 highlights that 4.0 percent beneficiaries' respondents in 1999 and 5.7 percent in 2003 replied that they practiced vasectomy (male operation), once in life & free of cost, while 96.0 percent in 1999 and 94.3 percent in 2003 replied negatively in this regard.

Table- 16 Oral Pills (Female Tablets):

Res	Years			
	1999		2003	
	f	%	f	%
Yes	271	90.3	272	90.7
No	29	9.7	28	9.3
Total	300	100	300	100

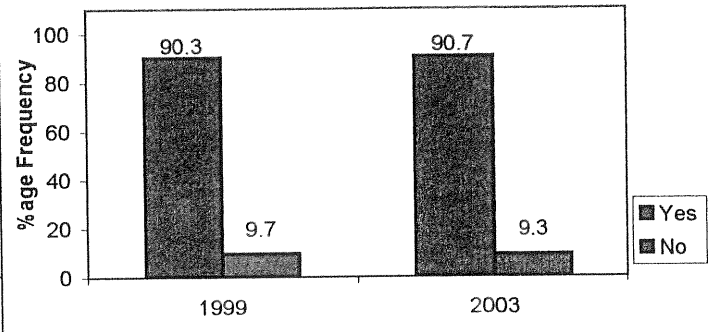


Figure-16: Oral Pills (Female Tablets)

Table-16 shows that 90.3 percent beneficiaries respondents in 1999 and 90.7 percent in 2003 replied positively regarding the availability and use of oral pills (female tablets), per individual quantity usage is 11 strips and cost per strip is Rs. 3/-(paid by the beneficiaries), while 9.7 percent in 1999 and 9.3 percent in 2003, replied negatively.

Table-17 Injectables (Female Contraceptives):

Res	Years			
	1999		2003	
	f	%	f	%
Yes	157	52.3	159	53
No	143	47.7	141	47
Total	300	100	300	100

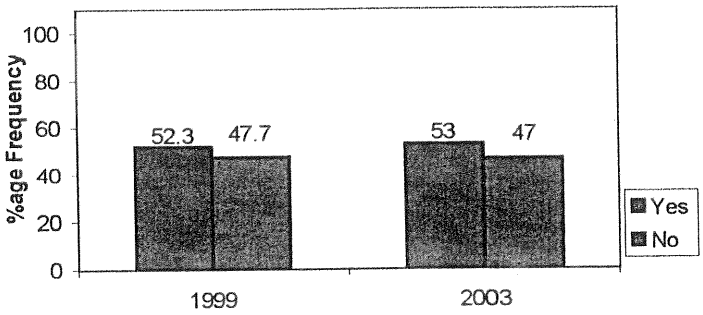


Figure-17: Injectables (Female Contraceptives)

Table-17 indicates that 52.3 percent beneficiaries respondents in 1999 and 53.0 percent in 2003, replied positively regarding the availability, use and practice of injection nurajest (2months, 6 injections per individual P.A. usage) and majestron / DEPO (3 months, 4 injections per individual P.A. usage) and 01 injection cost is Rs. 3/-(paid by the beneficiaries), while 47.7 percent in 1999 and 47.0 percent in 2003, replied negatively in this regard.

Table- 18 Tub-legation/Sterilization:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	50	16.7	52	17.3
No	250	83.3	248	82.7
Total	300	100	300	100

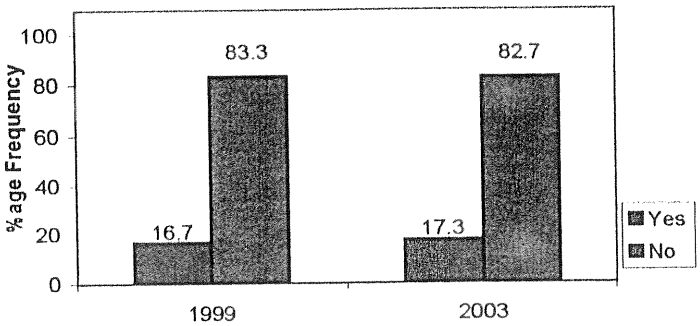


Figure-18: Tub-legation / Sterilization

Table-18 highlights that 16.7 percent beneficiaries respondents in 1999 and 17.3 percent in 2003, specified for availability and self practice of tub legation/sterilization (female operation), per individual practice is once in life and free of cost, while 83.3 percent in 1999 and 82.7 percent in 2003, replied negatively in this case.

Table-19 Multi Load/Copper-T/ IUD:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	39	13	40	13.3
No	261	87	260	86.7
Total	300	100	300	100

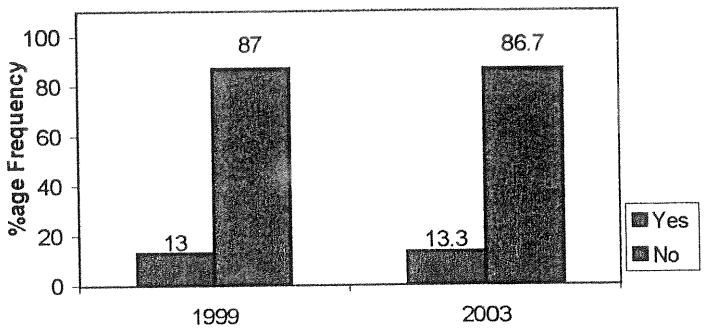


Figure-19: Multi Load / Copper-T / IUD

Table-19 shows that 13.0 percent beneficiaries respondents in 1999 and 13.3 percent in 2003 replied positively regarding the availability and self practice of multi load/copper-T/ IUD (female contraceptive), usage per individual 01 for 5-10 years/ once with checking & 01 multi load/Copper-T/ IUD cost is Rs.3/-, while 87.0 percent in 1999 and 86.7 percent in 2003 were against it.

H. Reasons for Using and Non-using a Specific Method/ Contraceptive:

Table-20 Reasons of Using a Specific Method:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	255	85	265	88.3
No	45	15	35	11.7
Total	300	100	300	100

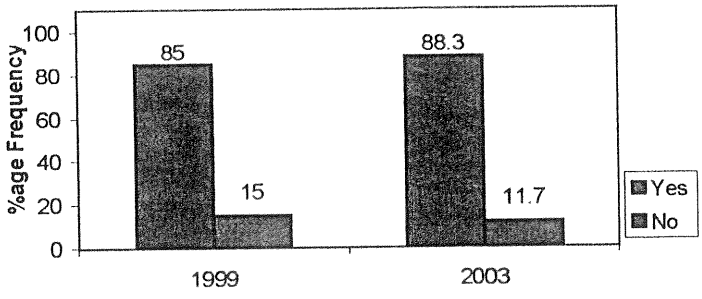


Figure-20: Reasons of Using a Specific Method

Table-20 indicates that 85.0 percent beneficiaries' respondents in 1999 and 88.3 percent 2003 specified for no/less side effects, convenient, more effective and less costly as the reasons for using a specific method/ contraceptive, while 15.0 percent in 1999 and 11.7 percent in 2003 were against it.

Table-21 Reasons of Not-using a Method:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	264	88	255	85
No	36	12	45	15
Total	300	100	300	100

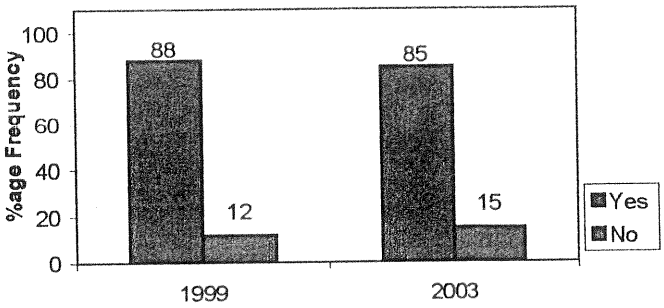


Figure-21: Reasons of Not Using a Method / Contraceptive

Table-21 highlights that 88.0 percent beneficiaries respondents in 1999 and 85.0 percent in 2003, specified for side effects, permanent, not effective and costly as the reasons for not using a specific method/ contraceptive, while 12.0 percent in 1999 and 15.0 percent in 2003 were against of the view.

I. Sources to Get Contraceptives:

Table-22 Major Sources of Contraceptives:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	272	90.7	282	94
No	28	9.3	18	06
Total	300	100	300	100

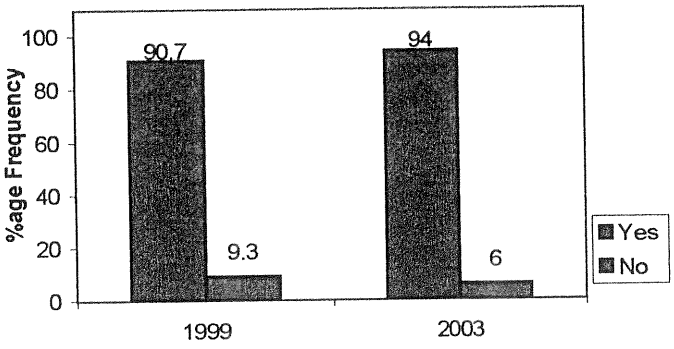


Figure-22: Major Sources of Contraceptives

Table-22 highlights that 90.7 percent beneficiaries respondents in 1999 and 94.0 percent in 2003, specified for major sources (family planning organization center and mobile unit) to get contraceptives, while only 9.3 percent in 1999 and 6.0 percent in 2003 were against it.

Table-23 Minor sources of contraceptives:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	178	59.3	170	56.7
No	122	40.7	130	43.3
Total	300	100	300	100

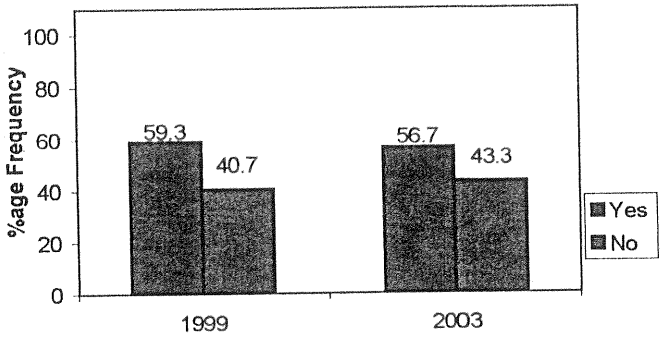


Figure-23: Minor Sources of Contraceptives

Table-23 shows that 59.3 percent beneficiaries respondents in 1999 and 56.7 percent in 2003, specified for minor sources (private medical store, general store, doctor / practitioner) to get contraceptives, while 40.7 percent in 1999 and 43.3 percent in 2003 were against it.

J. Side Effects of Contraceptives:

Table-24 Medical Health Problems:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	276	92	270	90
No	24	08	30	10
Total	300	100	300	100

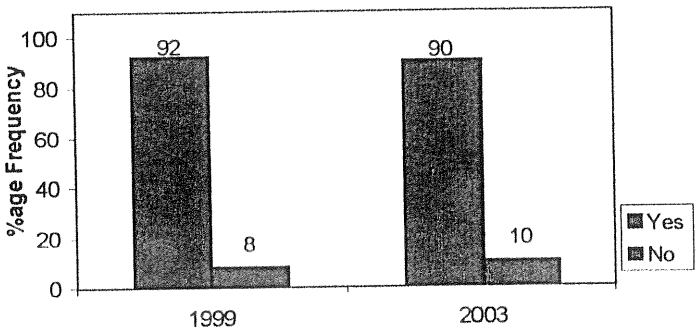


Figure-24: Medical Health Problems

Table-24 shows that 92.0 percent beneficiaries respondents in 1999 and 90.0 percent in 2003, specified for medical health problems (infection, irregular menses/ bleeding, weight gain, swelling, temperature, headache, vomiting, no hepatize) as the side effects of contraceptives on users, while 8.0 percent in 1999 and 10.0 percent in 2003 were against it.

Table-25 Psychological Problems:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	270	90	259	86.3
No	30	10	41	13.7
Total	300	100	300	100

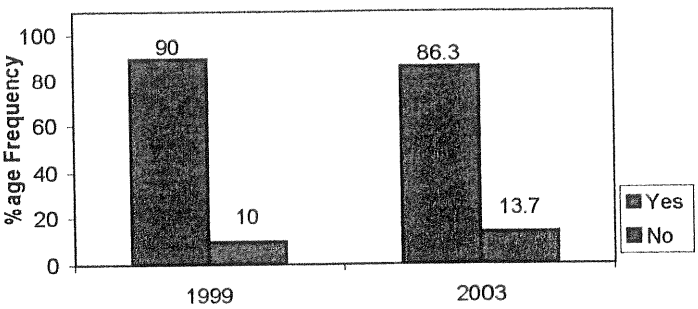


Figure-25: Psychological Problems

Table-25 shows that 90.0 percent beneficiaries respondents in 1999 and 86.3 percent in 2003, specified for psychological problems as the side effects of contraceptives on users, while 10.0 percent in 1999 and 13.7 percent in 2003 were against it.

Table-26 Strategies of FP Staff for Prevention:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	270	90	277	92.3
No	30	10	23	7.7
Total	300	100	300	100

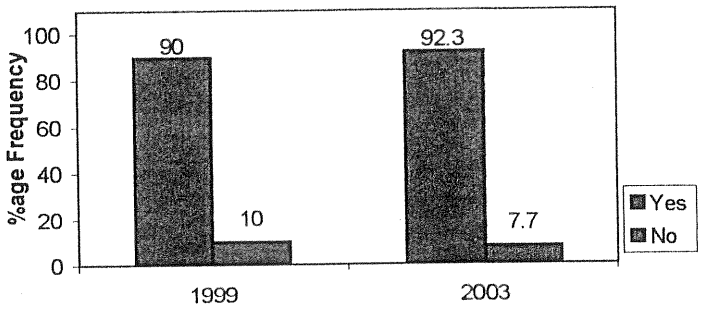


Figure-26: Strategies of FP Staff for Prevention

Table-26 indicates that 90.0 percent beneficiaries respondents in 1999 and 92.3 percent in 2003, specified for counseling, awareness for proper usage of contraceptives, change the method/contraceptive, proper treatment, prescription and preventive measures as strategies and role of family planning staff in prevention of side effects of contraceptives on users, while 10.0 percent in 1999 and 7.7 percent in 2003 were against it.

K. Problems & Strategies to Reduce the Side Effects of Contraceptives:

Table-27 Problems on the Part of Clients:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	271	90.3	257	85.7
No	29	9.7	43	14.3
Total	300	100	300	100

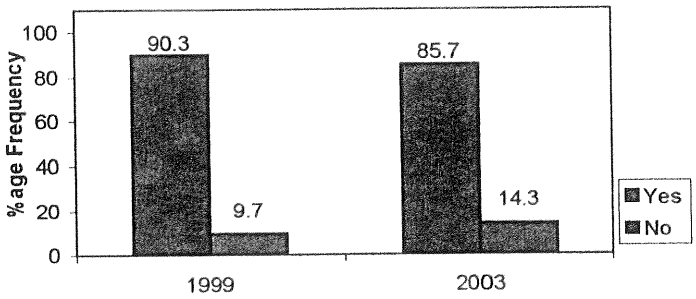


Figure-27: Problems on the part of Clients

Table-27 indicates that 90.3 percent beneficiaries' respondents in 1999 and 85.7 percent in 2003 specified for no care, proper usage and follow up by the clients/patients as the problems in reducing the side effects of contraceptive, while 9.7 percent in 1999 and 14.3 percent in 2003 were against it.

Table-28 Problems on the Part of Service Providers:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	280	93.3	270	90
No	20	6.7	30	10
Total	300	100	300	100

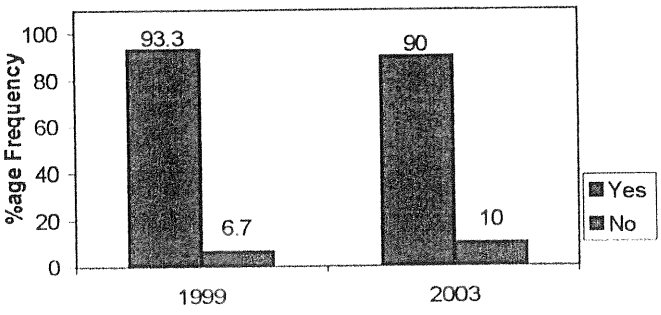


Figure-28: Problems on the part of service providers

Table-28 indicates that 93.3 percent beneficiaries' respondents in 1999 and 90.0 percent in 2003 specified for no proper treatment, usage skill, medicine provision by service providers as the problems in reducing the side effects of contraceptive, while 6.7 percent in 1999 and 10.0 percent in 2003 were against it.

Table-29 Strategies to overcome the side effects of contraceptives:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	258	86	280	93.3
No	42	14	20	6.7
Total	300	100	300	100

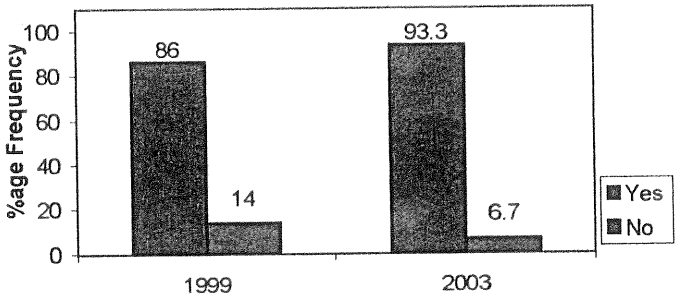


Figure-29: Strategies to overcome the side effects of Contraceptives

Table-29 highlights that 86.0 percent beneficiaries respondents in 1999 and 93.3 percent in 2003 specified for counseling and motivation for proper usage, receiving feed back from client/ patients, proper treatment, cleanliness, change the method and preventive medicines as the strategies and role of family planning staff and organizations, while only 14.0 percent in 1999 and 6.7 percent in 2003 were against it.

L. Mother- Child Health Care Program:

Table-30 Informative and Curative:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	282	94	292	97.3
No	18	18	08	2.7
Total	300	100	300	100

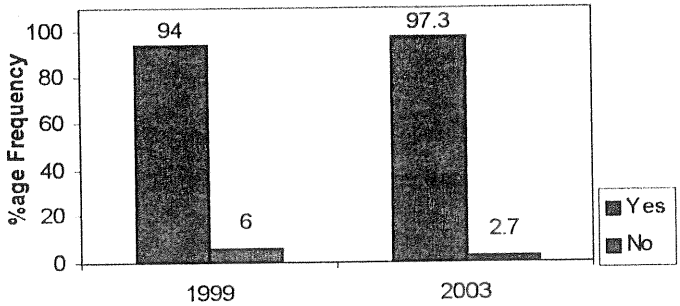


Figure-30: Informative and Curative

Table-30 indicates that 94.0 percent beneficiaries respondents in 1999 and 97.3 percent in 2003 specified for informative and curative (counseling, antenatal, postnatal, treatment, vaccination, iron tablets, medicines, balance diet to mother) as one of the component of mother-child health care program of family planning organizations center/ MCHC, while 6.0 percent in 1999 and 2.7 percent in 2003 replied negatively in this regard.

Table-31 Before, During and After Delivery:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	280	93.3	290	96.7
No	20	6.7	10	3.3
Total	300	100	300	100

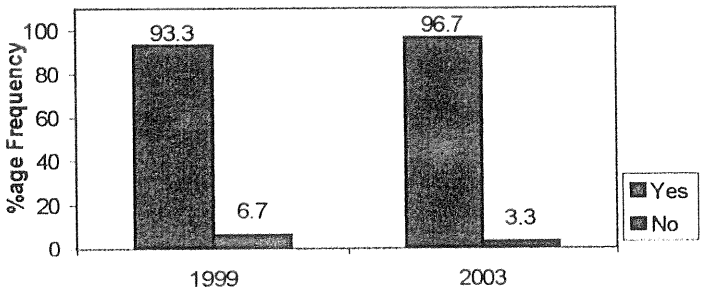


Figure-31: Before, during and after delivery

Table-31 depicts that 93.3 percent beneficiaries respondents in 1999 and 96.7 percent in 2003 specified for before, during and after delivery care, vaccination, immunization, breast feeding & additional nutrition to child as one of the component of mother-child health care program FP, while 6.7 percent in 1999 and 3.3 percent in 2003 replied negatively.

M. Results of Mother-Child Health Care Program:

Table-32 Health Protection and Safe Delivery:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	268	89.3	285	95
No	32	10.7	15	05
Total	300	100	300	100

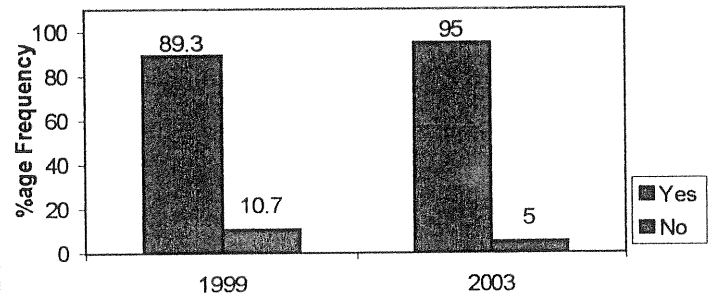


Figure-32: Health Protection and Safe Delivery

Table-32 indicates that 89.3 percent beneficiaries' respondents in 1999 and 95.0 percent in 2003 specified for proper health protection, safe delivery and trust on MCHC/ RHC as a result of mother-child health care program of family planning organizations centers, while 10.7 percent in 1999 and 5.0 percent in 2003, replied negatively in this regard.

N. Problems in Mother-Child Health Care:

Table-33 Constraints to MCHC and FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	280	93.3	261	87
No	20	6.7	39	13
Total	300	100	300	100

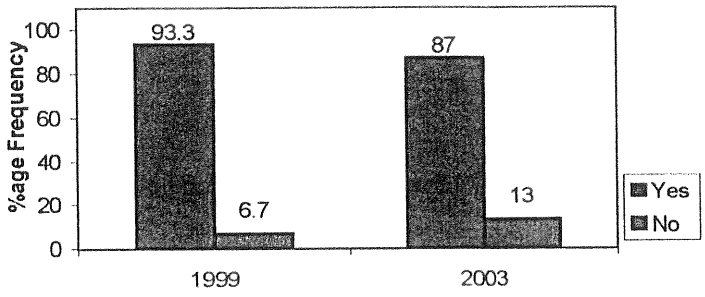


Figure-33: Various Constraints to MCHC and FP

Table-33 highlights that 93.3 percent beneficiaries respondents in 1999 and 87.0 percent in 2003 specified for varies constraints to mother-child health care (ignorance, no proper treatment, checkup and medicine) and various constraints to family planning as problems in mother-child health care program of FP, while 6.7 percent in 1999 and 13.0 percent in 2003 replied negatively.

Table-34 Strategies of FP Orgs Centers:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	280	93.3	296	98.7
No	20	6.7	04	1.3
Total	300	100	300	100

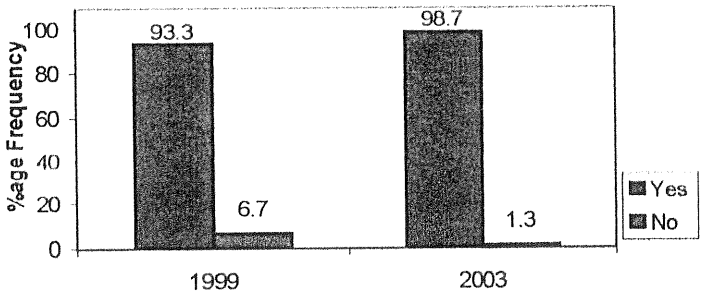


Figure-34: Strategies to FP Org Centers

Table-34 indicates that 93.3 percent beneficiaries' respondents in 1999 and 98.7 percent in 2003 specified for solution to various constraints in mother-child health care (health counseling, proper treatment, checkup, medicines, health facility at door step)and solution to various constraints in FP (free counseling, treatment, medicines, avoiding early marriage, maximum male children) as strategies of family planning organizations centers for the improvement of mother-child health care, while 6.7 percent in 1999 and 1.3 percent in 2003 replied negatively in this regard.

O. Response and Causes of Large Family & Role of Family Planning Organizations Centers Staff:

Table-35 Large Family Size:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	280	93.3	270	90
No	20	6.7	30	10
Total	300	100	300	100

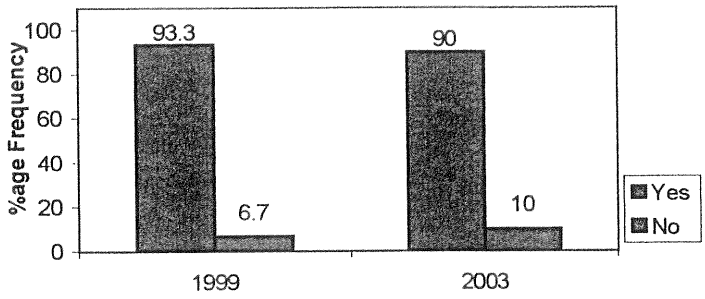


Figure-35: Large Family Size

Table-35 shows that 93.3 percent beneficiaries' respondents in 1999 and 90.0 percent in 2003 specified for large size of the family in the target area, while 6.7 percent in 1999 and 10.0 percent in 2003 replied negatively (specified in favor of small size of family).

Table-36 Marriage Age 13– 22 Years (Early):

Res	Years			
	1999		2003	
	f	%	f	%
Yes	247	82.3	237	79
No	53	17.7	63	21
Total	300	100	300	100

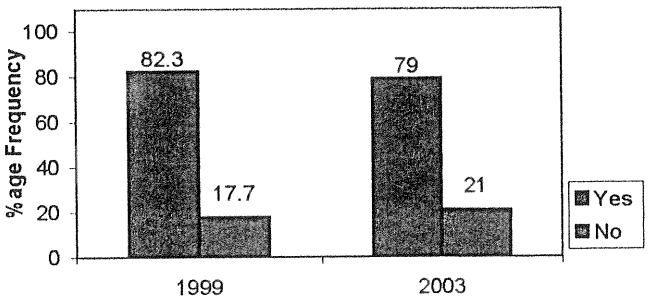


Figure-36: Marriage Age 13-22 Years (Early)

Table-36 indicates that 82.3 percent beneficiaries' respondents in 1999 and 79.0 percent in 2003 specified for 13-22 years as the marriage age in the area, while 17.7 percent in 1999 and 21.0 percent in 2003 replied negatively for it (specified for 23-32 years as the marriage age).

Table-37 One/Single Marriage:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	267	89	281	93.7
No	33	11	19	6.3
Total	300	100	300	100

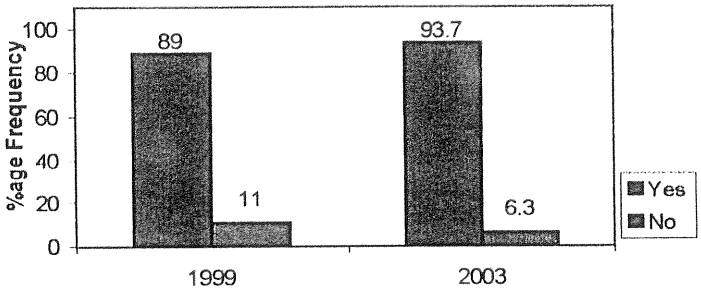


Figure-37: One / Single Marriage

Table-37 highlights that 89.0 percent beneficiaries respondents in 1999 and 93.7 percent in 2003 specified for one/ single marriage in the area, while 11.0 percent in 1999 and 6.3 percent in 2003 replied negatively for it, (specified for two/ double and three/ triple marriages respectively)

Table-38 Desire for Male Children Resultant Large Family:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	285	95	275	91.7
No	15	05	25	8.3
Total	300	100	300	100

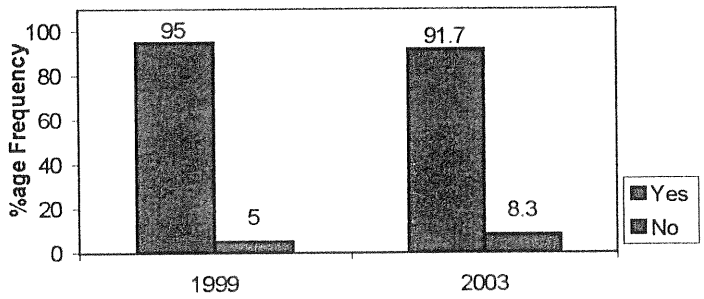


Figure-38: Desire for Maximum Male Children Resultant Large

Table-38 depicts that 95.0 percent beneficiaries respondents in 1999 and 91.7 percent in 2003 replied that desire for maximum male children (sons are power, prestige, dominant, property owners, income source, help in old age, socio-psychological protection etc.), leading to large family, while 5.0 percent in 1999 and 8.3 percent replied negatively.

Table-39 Constraints to FP Resultant Large Family:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	286	95.3	278	91.7
No	14	4.7	22	7.3
Total	300	100	300	100

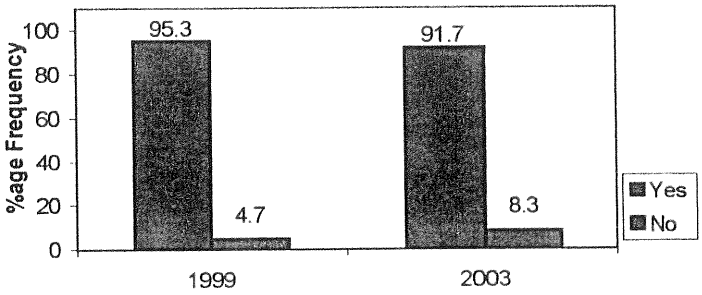


Figure-39: Various Constraints to FP Resultant Large Family

Table-39 shows that 95.3 percent in 1999 and 92.7 percent in 2003 replied that various constraints to family planning (Economic / poverty, religious, socio cultural, govt. / political, medical -technical, quality of service etc) lead to large size of the family, while 4.7 percent in 1999 and 7.3 percent in 2003 replied negatively.

Table-40 Strategies of FP Orgs Centers:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	285	95	290	96.7
No	15	05	10	3.3
Total	300	100	300	100

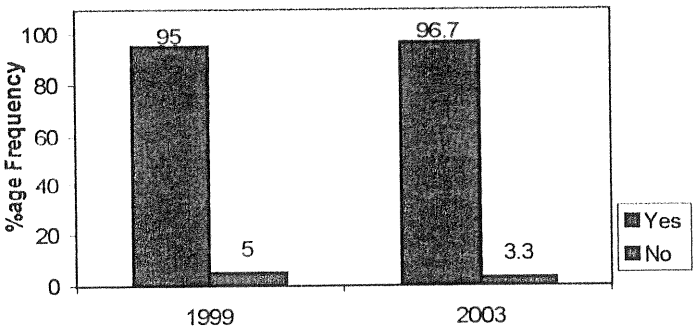


Figure-40: Strategies of FP Org Centers

Table-40 demonstrates that 95.0 percent beneficiaries' respondents in 1999 and 96.7 percent in 2003 specified for proper counseling, motivation for small family, contraceptives , large family economic burden , to avoid early marriage, maximum children, son and daughter are equals, proper checkup, treatment, medicines, home visits and solution of Constraints as strategies and role of family planning organizations centers to control / minimize the size of family and create small family norm, while 5.0 percent in 1999 and 3.3 percent in 2003 replied negatively.

P. Various Constraints to Family Planning:

Table-41 Economic Constraints to FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	220	73.3	180	60
No	80	26.7	120	40
Total	300	100	300	100

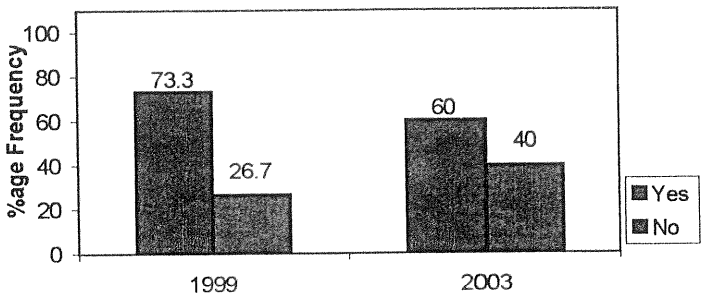


Figure-41: Economic Constraints to FP

Table-41 shows that 73.3 percent beneficiaries' respondents in 1999 and 60.0 percent in 2003 specified for poverty, no income & employment, high expenses of the family, expensive medicines lack, no resources, infrastructure, building, equipments, treatment, medicines, tests, budget as economic / financial constraints to family planning, while 26.7 percent in 1999 and 40.0 percent in 2003 replied negatively.

Table-42 Strategies of FP Orgs Centers:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	173	57.7	190	63.3
No	127	42.3	110	36.7
Total	300	100	300	100

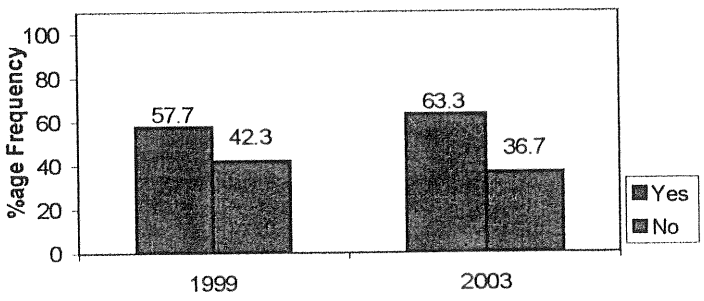


Figure-42: Strategies of FP Org Centers

Table-42 indicates that 57.7 percent beneficiaries' respondents in 1999 and 63.3 percent in 2003 specified for free counseling, checkup, treatment, natural gap by breast feeding (LAM), nominal charges, company rate contraceptives and foreign aid support as strategies and role of family planning organizations centers, to solve the economic problems of patients, NGOs & Govt. in family planning, while 42.3 percent in 1999 and 36.7 percent in 2003, replied negatively.

Table-43 Religious Constraints to FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	287	95.7	270	90
No	13	4.3	30	10
Total	300	100	300	100

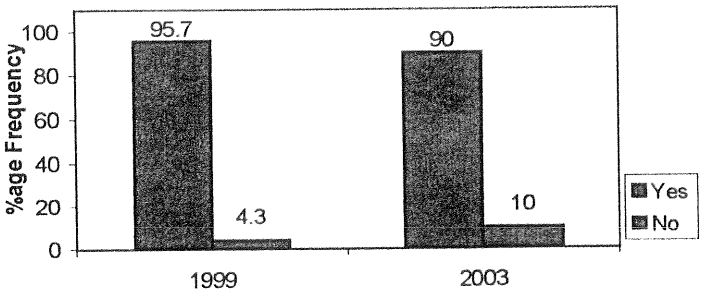


Figure-43: Religious Constraints to FP

Table-43 shows that 95.7 percent beneficiaries' respondents in 1999 and 90.0 percent in 2003 specified for family planning is sin, killing of humanity, illegitimate, against natural law, fatalism, Allah is food provider, no one can stop those souls to be produced, increase Muslims, immoral, plan of non Muslims slogans use by religious leaders, which are the religious obstacles to family planning, while 4.3 percent in 1999 and 10.0 percent in 2003, replied against it.

Table-44 Strategies of FP Orgs Centers:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	148	49.3	230	76.7
No	152	50.7	70	23.3
Total	300	100	300	100

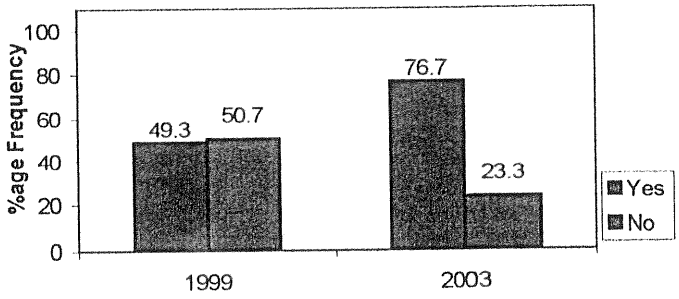


Figure-44: Strategies of FP Org Centers

Table-44 indicates that 49.3 percent beneficiaries respondents in 1999 and 76.7 percent in 2003 specified for meeting and consulting with religious leaders, motivation, awareness, counseling and convincing religious people, collection of different statements / fatwas, religious literature distribution in favor of FP as strategies of family planning organizations, to solve the religious constraints in family planning, while 50. 7 percent in 1999 and 23.3 percent in 2003 replied negatively.

Table-45 Socio-Cultural Constraints to FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	290	96.7	279	93
No	10	3.3	21	07
Total	300	100	300	100

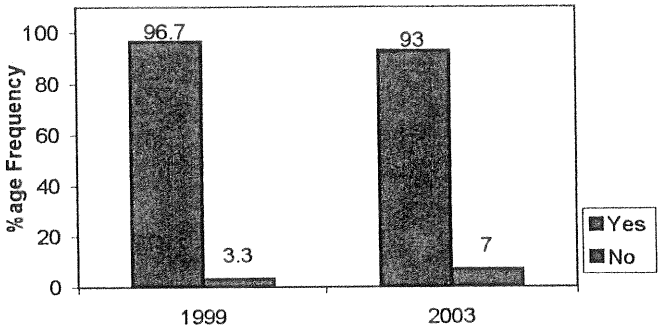


Figure-45: Socio-Cultural Constraints to FP

Table-45 depicts that 96.7 percent beneficiaries respondents in 1999 and 93.0 percent in 2003 specified for desire for maximum male children (sons are power, prestige, property source, dominance, income source, helping hand in old age, psychological protection), FP disapproval by husband and in laws, veil (Pardah), no power of women, early marriage, wrong propaganda, negative public opinion as socio-cultural obstacles in family planning, while 3.3 percent in 1999 and 7.0 percent in 2003, replied negatively in this regard.

Table-46 Strategies of FP Orgs Centers:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	290	96.7	295	98.3
No	10	3.3	05	1.7
Total	300	100	300	100

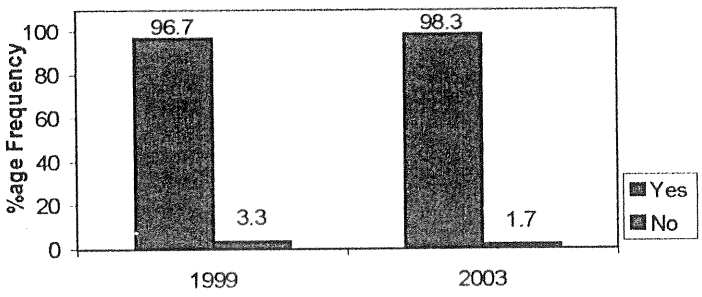


Figure-46: Strategies of FP Org Centers

Table-46 shows that 96.7 percent beneficiaries respondents in 1999 and 98.3 percent in 2003 specified for small family norms, small family better life, two kids are better, son & daughter are equal, maximize gap through motivation, to avoid early marriage and polygamy and women empowerment as strategies of family planning organizations centers, to solve the socio-cultural obstacles in family planning, while only 3.3 percent in 1999 and 1.7 percent in 2003 replied negatively.

Table-47 Political and Govt. Constraints to FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	156	52	150	50
No	144	48	150	50
Total	300	100	300	100

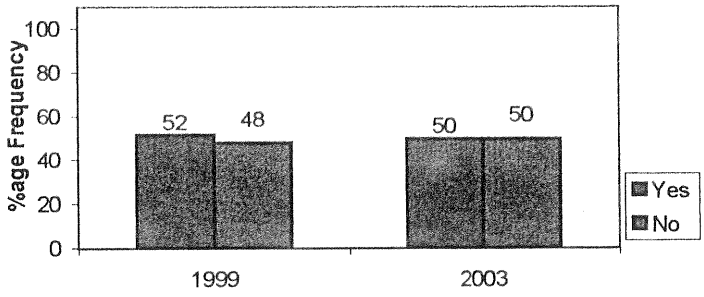


Figure-47: Political and Governmental Constraints to FP

Table-47 displays that 52.0 percent beneficiaries' respondents in 1999 and 50.0 percent in 2003, specified for no proper funds allocation, based on foreign aid and Policy change as the political / Governmental obstacles in family planning, while 48.0 percent in 1999 and 50.0 percent in 2003 replied negatively.

Table-48 Strategies of FP Orgs Centers:

Res	Years			
	1999		2003	
	f	%	F	%
Yes	150	50	155	51.7
No	150	50	145	48.3
Total	300	100	300	100

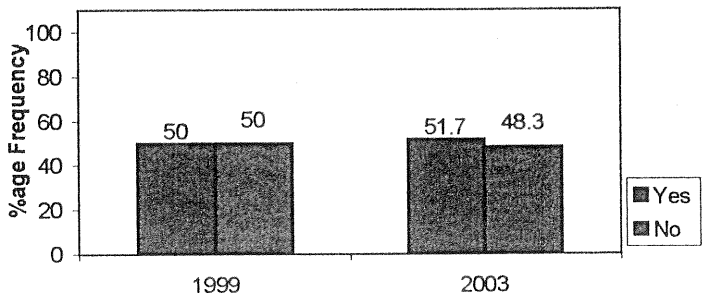


Figure-48: Strategies of FP Org Centers

Table-48 indicates that 50.0 percent beneficiaries' respondents in 1999 and 51.7 percent in 2003, specified for collaboration of public and private sector, struggle to continue, getting support of the govt. / foreign donors as strategies of family planning organizations, to solve the political and Governmental constraints in family planning, while 50.0 percent in 1999 and 48.3 percent in 2003, replied negatively.

Table-49 Psychological Constraints to FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	282	94	279	93
No	18	06	21	07
Total	300	100	300	100

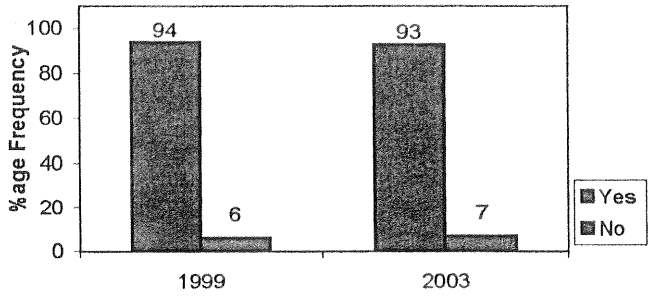


Figure-49: Psychological Constraints to FP

Table-49 highlights that 94.0 percent beneficiaries respondents in 1999 and 93.0 percent in 2003 specified for worry of side effects of Contraceptives, conception and infertility as psychological obstacles in family planning, while only 6.0 percent in 1999 and 7.0 percent in 2003 replied negatively.

Table-50 Strategies of FP Orgs Staff:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	275	91.7	280	93.3
No	25	8.3	20	6.7
Total	300	100	300	100

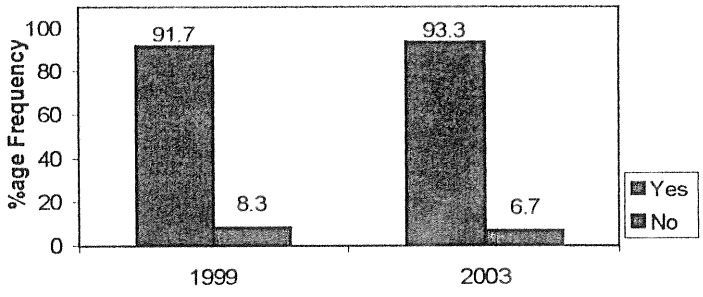


Figure-50: Strategies of FP Organizations Staff

Table-50 shows that 91.7 percent beneficiaries respondents in 1999 and 93.3 percent in 2003, specified for counseling, motivation, awareness for proper usage/change of contraceptive, reduce fear of side effects, proper check up, treatment, medicine, prescription of family planning staff, as the strategies and role of family planning organizations staff, to solve the psychological obstacles in family planning, while 8.3 percent in 1999 and 6.7 percent in 2003 replied negatively in this regard.

Table-51 Medical and Technical Constraints to FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	284	94.7	280	93.3
No	16	5.3	20	6.7
Total	300	100	300	100

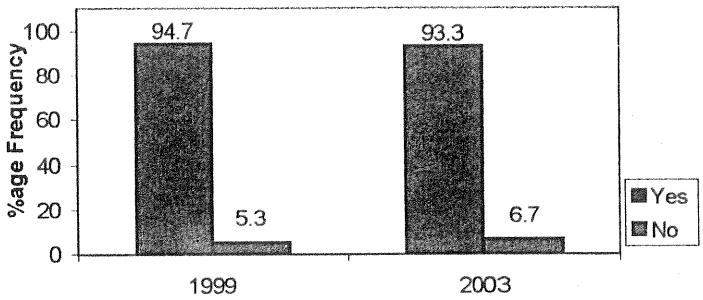


Figure-51: Medical and Technical Constraints to FPf

Table-51 indicates that 94.7 percent beneficiaries respondents in 1999 and 93.3 percent in 2003, specified for health problems (irregularity of menses, weight, weakness, no hepatize, vomiting, headache), no FP and health awareness, fear from taking medicine/ contraceptives due to side effects, no medicine, checkup and treatment as medical & technical obstacles in family planning, while 5.3 percent in 1999 and 6.7 percent in 2003 replied negatively.

Table-52 Strategies of FP Orgs Centers:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	276	92	281	93.7
No	24	08	19	6.3
Total	300	100	300	100

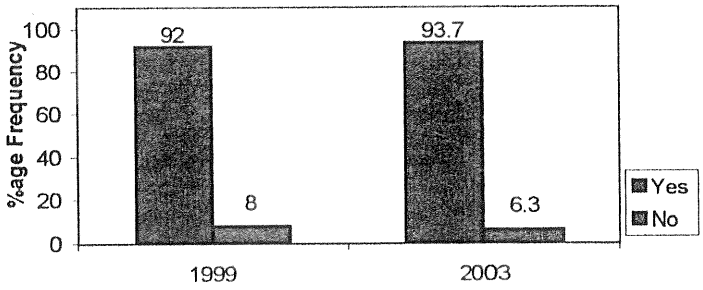


Figure-52: Strategies of FP Organizations Centers

Table-52 shows that 92.0 percent beneficiaries' respondents in 1999 and 93.7 percent in 2003, specified for motivation, awareness and counseling for proper usage/change of contraceptives, proper checkup, treatment, medicine, multivitamins-iron tablets, prescription by qualified and trained family planning staff as strategies of family planning organizations, to solve the medical-technical obstacles in family planning, while 8.0 percent in 1999 and 6.3 percent in 2003 replied negatively.

Table- 53 Quality of Service Constraints to FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	280	93.3	260	86.7
No	20	6.7	40	13.3
Total	300	100	300	100

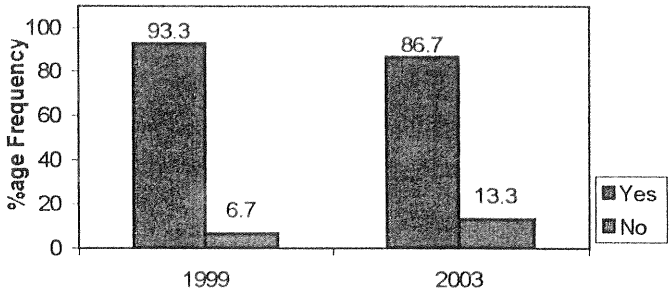


Figure-53: Quality of Service Constraints to FP

Table-53 highlights that 93.3 percent beneficiary's respondent in 1999 and 86.7 percent in 2003, specified for no budget, no outlets, coverage, outreach, information, supervision, monitoring, strategy change, contraceptives, questionable, doorsteps, less satisfaction, male involvement and low staff as quality of service constraint in family planning, while 6.7 percent in 1999 and 13.3 percent in 2003 replied negatively in this case.

Table-54 Strategies of FP Orgs Centers:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	258	86	278	92.7
No	42	14	22	7.3
Total	300	100	300	100

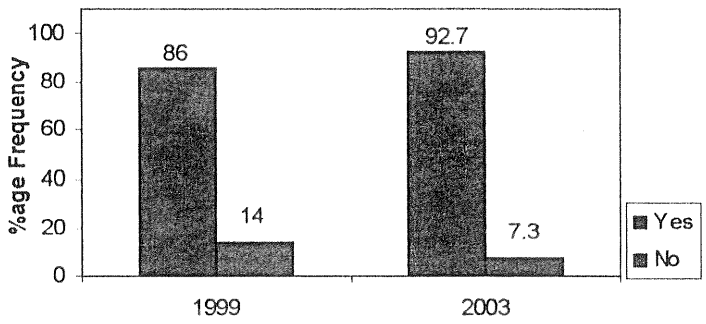


Figure-54: Strategies of FP Organizations Centers

Table-54 shows that 86.0 percent beneficiaries respondents in 1999 and 92.7 percent in 2003, specified for budget on foreign assistance, proper supervision, monitoring, trained staff, male involvement, proper awareness about contraceptives, doorstep service as strategies of family planning organizations to solve the quality of services constraint in family planning, while 14.0 percent in 1999 and 7.3 percent in 2003 replied negatively in this regard.

Q. Linkage Programs among Govt., NGOs and Community:

Table-55 Public Private Partnership:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	12	04	194	64.7
No	288	96	106	35.3
Total	300	100	300	100

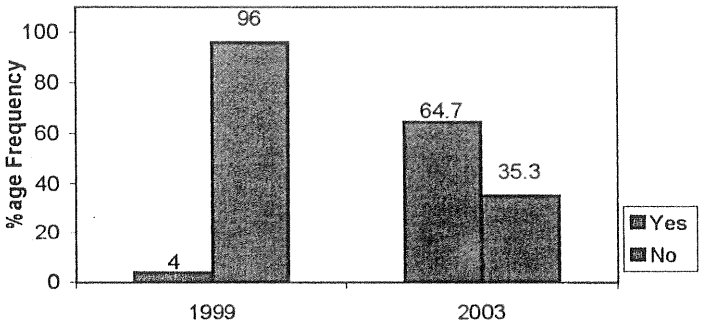


Figure-55: Public Private Partnership

Table-55 demonstrates that 4.0 percent beneficiaries' respondents in 1999 and 64.7 percent in 2003 specified public private partnership as linkage program among govt., NGO's and Community / beneficiaries, while 96.0 percent in 1999 and 35.3 percent in 2003 replied negatively.

R. Shortcomings in FP and Strategies for Improvement:

Table-56 Shortcomings in Implementation of FP:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	285	95	280	93.3
No	15	05	20	6.7
Total	300	100	300	100

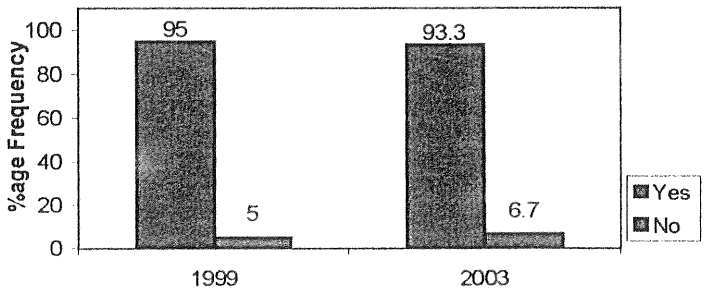


Figure-56: Shortcomings in Implementation of FP

Table-56 indicates that 95.0 percent beneficiaries respondents in 1999 and 93.3 percent in 2003 specified for side effects of contraceptives, no proper policy, planning, research, strategy, involvement of religious leader, male interest, awareness and education programme about family planning, various obstacles to family planning, no role of media, related departments, health, district govt. and welfare organizations as weaknesses and shortcomings of the family planning program, while 5.0 percent in 1999 and 6.7 percent in 2003 replied negatively.

Table-57 Strategies to Overcome these Shortcomings:

Res	Years			
	1999		2003	
	f	%	f	%
Yes	298	99.3	300	100
No	2	0.7	-	-
Total	300	100	300	100

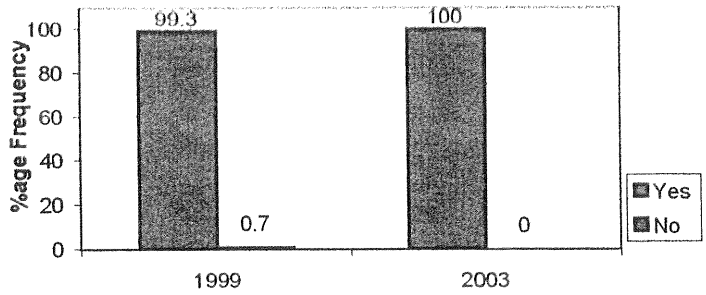


Figure-57: Strategies to Overcome these Shortcomings

Table-57 shows that 99.3 percent beneficiaries' respondents in 1999 and 100.0 percent in 2003 specified for role of media, district government, religious leaders, family planning education, awareness, enlightened vision, counseling, motivation and communication programme of FP, qualified and trained staff and establishment of more family planning organizations as strategies and suggestions for the improvement of family planning in the area.

CHAPTER-5

FINDINGS, VERIFICATION OF HYPOTHESES, CONCLUSION AND RECOMMENDATIONS

5.1. Findings of the Study:

The major results, which came forth from the three studied segments of the universe during data collection, are given below. It is pertinent to mention that the leading figures of the tables are placed here. Findings are presented segment wise.

5.1.1 Part-I Findings of FP Public Sector Organizations Staff:

A. Number of Children:

- Majority of the staff **i.e.** 71.4 percent in 1999 and 57.1 percent in 2003 replied that they were having 0-1 and 2-3 numbers of male children respectively. (Table-1)
- Maximum of the staff i.e. 85.8 percent in 1999 and 64.2 percent in 2003 replied that they were having 0-1 numbers of female children respectively. (Table-2)

B. Educational Status and Practice of Family Planning:

- Maximum of the staff i.e. 81.4 percent in 1999 replied that uneducated respondents were not practicing family planning, while majority of them i.e. 54.3 percent in 2003 replied that uneducated respondents were practicing family planning, because of proper counseling and motivation by FP. Staff. (Table-3)
- Majority of the staff i.e. 92.9 percent in 1999 and 100.0 percent in 2003 replied that educated respondents were practicing family planning, because of easy counseling, motivation, convincing and awareness creation among educated clients by FP. Staff. They are usually self motivated aware and need no extensive counseling.(Table-4)

C. Sources of Awareness, Information and Popularization of Family Planning:

- Maximum of the staff i.e. 94.3 percent in 1999 and 97.1 percent in 2003 specified for family planning staff, literature, TV, radio, relatives, friends, husband and wife as the major sources of information and awareness about family planning.(Table-5)
- Most of the respondents i.e. 55.7 percent staff in 1999 and 60.0 percent in 2003 specified for wall chalking, banners, sign boards, seminars, workshops,

conferences, news papers and magazines as the minor sources of information and awareness about family planning.(Table-6)

D. Problems Faced During Awareness, Communication and Information about Family Planning and Strategies of FWCs and RHS-As:

- 100.0 percent staff in 1999 and 97.1 percent in 2003 replied positively regarding ignorance, improper communication and family planning constraints as problems during awareness, communication and popularization of family planning.(Table-7)
- Highest number of the staff i.e. 97.1 percent in 1999 and 100.0 percent in 2003 were in favor of women education, improvement in communication, effective sources of awareness and solution of family planning constraints as the strategy for the solution of the problem during awareness, communication and popularization of family planning (Table-8)

E. Problems, Functions and Facilities in FWC and RHS-A:

- All of the staff i.e 100 percent in 1999 and 85.8 percent in 2003 specified for different problems in FWC and RHS-A.(Table-9)
- Maximum of the staff i.e. 97.1 percent in 1999 and 100.0 percent in 2003 specified for informative (counseling, awareness, motivation, door step service, camps and MSU) and curative (provision of contraceptives, medicines, treatment, checkup and prescription) as the functions and facilities in FWC and RHS-A.(Table-10)

F. Problems & Role of FWW, LHW and LHV:

- 100 percent staff in 1999 and 92.9 percent in 2003 specified for different problems to FWW, LHV and LHW.(Table-11)
- Majority of staff i.e. 97.1 percent in 1999 and 100.0 percent in 2003 specified for informative (counseling, awareness and motivation for FP) and curative (provision of contraceptives, medicines, treatment, checkup and prescription) as the role of FWW, LHV and LHW. (Table-12)

G. Various Contraceptives Practiced:

- Majority of the staff i.e. 54.3 percent in 1999 and 52.9 percent in 2003 were in favor of withdrawal (male) practice, quantity used 50-100 P.A. & free of cost by beneficiaries.(Table-13)

- Maximum of the staff i.e. 92.9 percent in 1999 and 100.0 percent in 2003 were in favor of condom (male) practicing, per individual quantity used 50-100 P.A. & cost per dozen= Rs. 6/-.(Table-14)
- Majority of the staff i.e. 60.0 percent in 1999 and 4.3 percent in 2003 replied negatively for the availability and practice of vasectomy (male operation), once in life & free of cost, while 40.0 percent in 1999 and 45.7 percent in 2003 replied that vasectomy facility is available with them and the beneficiaries practice it once in life & free of cost.(Table-15)
- Majority of the staff i.e. 92.9 percent in 1999 and 100.0 percent in 2003 replied positively regarding the availability and practice of oral pills (female tablets), per individual quantity used = 11 strips & cost per strip= Rs. 3/-.(Table-16)
- Maximum of the staff i.e. 94.3 percent in 1999 and 97.1 percent in 2003, were in favor of availability and practice of injection nurajest (2 months), 6 injections per individual P.A. usage & majestron or DEPO (3 months), 4 injections per individual P.A. usage 01 injection cost = Rs. 3/-.(Table-17)
- Majority of the staff i.e. 54.3 percent in 1999 and 51.4 percent in 2003 responded negatively, 45.7 percent in 1999 and 48.6 percent in 2003 specified positively for availability and practice of tub-legation/sterilization (female operation), per individual practice once in life & free of cost , Such cases are referred to RHS-A's.(Table-18)
- Most of the staff i.e. 82.9 percent in 1999 and 92.9 percent in 2003, were in favor of availability and practice of multi-load/copper-T/ IUD (female contraceptive), usage per individual 01 for 5-10 years/ once with checking & 01 multi load/copper-T/ IUD cost Rs. 3/-.(Table-19)

H. Reasons for Using and Non-using a Specific Method/ Contraceptive:

- Majority of the staff i.e. 78.6 percent in 1999 and 92.9 percent 2003 specified for no/less side effects, convenient, more effective and less costly as the reasons for using a specific method/ contraceptive.(Table-20)
- Maximum of the staff i.e. 91.4 percent in 1999 and 78.6 percent in 2003, specified for side effects, permanent, not effective and costly as the reasons for not using a specific method/ contraceptive.(Table-21)

I. **Sources to Get Contraceptives:**

- Majority of the staff I.e. 88.6 percent in 1999 and 97.1 percent in 2003, specified for major sources (family planning organization centers and mobile unit) to provide contraceptives.(Table-22)
- Some of the staff i.e 28.6 percent staff respondents in 1999 and 14.3 percent in 2003, specified for minor sources (private medical store, general store, doctor / practitioner) to get contraceptives, while 71.4 percent in 1999 and 85.7 percent in 2003 were against it.(Table-23)

J. **Side Effects of Contraceptives:**

- Maximum of the staff i.e. 94.3 percent in 1999 and 85.7 percent in 2003, specified for medical health problems (infection, irregular menses/ bleeding, weight gain, swelling, temperature, headache, vomiting, no hepatize) as the side effects of contraceptives on users.(Table-24)
- Majority of the staff i.e. 97.1 percent in 1999 and 71.4 percent in 2003, specified for psychological problems as the side effects of contraceptives on users.(Table-25)
- Maximum of staff i.e 85.7 percent in 1999 and 100 percent in 2003, specified for counseling, awareness for proper usage of contraceptives, change the method/contraceptive, proper treatment, prescription and preventive measures as strategies and role of family planning staff in prevention of side effects of contraceptives on users.(Table-26)

K. **Problems & Strategies to Reduce the Side Effects of Contraceptives:**

- Most of the staff i.e. 84.3 percent staff in 1999 and 78.6 percent in 2003 were in faviour of no care, proper usage and follow up by the clients, as the problems in reducing the side effects of contraceptive.(Table-27)
- Majority of the staff i.e. 60.0 percent staff in 1999 and 57.1 percent in 2003 were in favor of no proper treatment, usage skill, medicine, provision by service provider, as the problems in reducing the side effects of contraceptives.(Table-28)
- Highest number of the staff i.e. 97.1 percent staff in 1999 and 100.0 percent in 2003 specified for counseling and motivation for proper usage, receiving feedback

from clients/patients, proper treatment, cleanliness, change the method/ medicine and preventive measures as the strategy and role of FWC and RHS-A.(Table-29)

L. Mother-Child Health Care Program:

- Maximum of the staff i.e. 98.6 percent in 1999 and 100.0 percent in 2003 specified for informative and curative (counseling, antenatal, postnatal, treatment, vaccination and balance diet) as one of the component of mother-child health care program. (Table-30)
- Maximum of the staff i.e. 92.9 percent in 1999 and 98.6 percent in 2003 specified for before, during and after delivery child-mother health care (through checkup, treatment, and prescription, vaccination on due time, immunization, and breast feeding and additional nutrition to child) as the components of mother-child health care program.(Table-31)

M. Result of Mother-Child Health Care:

- Maximum of the staff i.e. 97.1 percent in 1999 and 98.6 percent in 2003 specified for proper health protection, safe delivery and trust on MCHC, as a result of mother-child health care program of family planning centers. (Table-32)

N. Problems in Mother-Child Health Care and Strategies of FWCs and RHS-As:

- Highest number of the staff i.e. 98.6 percent in 1999 and 95.7 percent in 2003 specified for various constraints to basic health & mother-child health care (ignorance, treatment, check up, medicines etc) and family planning (wrong propaganda, negative public opinion, religion, culture, economic, psychological, quality of service, medical & side effects of contraceptives etc), as problems in mother-child health care program of FP.(Table-33)
- Maximum of the staff i.e. 98.6 percent in 1999 and 100.0 percent in 2003 specified for solution to various constraints in MCHC (health awareness, counseling, proper treatment, check-up, medicines and MSU) and solution to various constraints in FP (Free counseling, treatment, medicines, avoid early marriage, maximum male children, meeting with religious leaders, solution of psychological worries, solution to side effects and improvement in quality of service), as strategy for improvement of mother-child health care program of FP.(Table-34)

O. Responses and Causes of Large Family and Strategies of FWCs and RHS-As:

- 100.0 percent staff in 1999 and 94.3 percent in 2003 specified for large size of the family in the target area.(Table-35)
- Majority of the staff i.e. 82.9 percent in 1999 and 80.3 percent in 2003 specified for 13-22 years as the marriage age in the area, which is the early one leading to large family size.(Table-36)
- Maximum of the staff i.e. 90.0 percent in 1999 and 92.9 percent in 2003 specified for single marriage in the area.(Table-37)
- 100.0 percent staff in 1999 and 94.3 percent in 2003 replied that desire for male child (Sons are guns, power, prestige, source of income, psychological protection & inheritance of property of the family) resultant to large family.(Table-38)
- 100.0 percent staff in 1999 and 94.3 percent in 2003 replied that various constraints to family planning (Economic, religious, socio- cultural, psychological, medical, technical, quality of service) lead to large size of the family.(Table-39)
- Most of the staff i.e. 94.3 percent in 1999 and 100.0 percent in 2003 specified for proper awareness, counseling & motivation for small family, contraceptives, large family economic burden ,registration of family member ,to avoid early marriage, polygamy, maximum children, son and daughter are equal , equal rights of children, proper family planning, treatment, check up, medicines, community meetings, home visits, communication, solution of constraints as strategies and role of FWCs and RHS-As to control and minimize the size of family.(Table-40)

P. Various Constraints to Family Planning and Strategies of FWCs and RHS-As:

i. Economic Constraints in Family Planning and Strategies of FWCs and RHS-As:

- Maximum of the respondents i.e. 97.1 percent in 1999 and 94.3 percent in 2003, specified for sons are economic assets, source of income, helping hand in old age, inheritance of property, poverty, no source of income and employment, high expenses of family, no proper infrastructure, building, equipments, treatment equipments, medicines, tests equipments and budget as economic constraint to family planning.(Table-41)

- Maximum of the staff i.e. 95.7 percent in 1999 and 97.1 percent in 2003 specified for free counseling, checkup, treatment, operation, natural gap by breast feeding, foreign aid support, company rate contraceptives provision as strategies and role of FWCs and RHS-As to solve and minimize the economic problems of patients in family planning.(Table-42)

ii. **Religious Constraints in Family Planning and Strategies of FWCs and RHS-As:**

- Highest number of the staff i.e. 98.6 percent in 1999 and 94.3 percent in 2003 specified for family planning is killing of humanity, it is sin, illegitimate, against natural law, fatalism, Allah is food provider, one can not stop those souls to be produced, increase the number of Muslims, results immorality, plan of non-Muslims slogans use by religious leaders, which is a religious obstacle to family planning.(Table-43)
- Majority of the staff i.e. 78.6 percent in 1999 and 92.9 percent in 2003, specified for meeting & consultation with religious leaders, motivation, awareness, counseling and convincing religious people, collection of different statements and Fatwas and religious literature distribution in favor family planning as strategies of FWCs and RHS-As to solve and minimize the religious obstacle in family planning.(Table-44)

iii. **Socio-Cultural constraints in FP and Strategies of FWCs and RHS-As:**

- 100.0 percent staff in 1999 and 94.3 percent in 2003 specified for desire of male children (male inheritance of property, socio-psychological protection, dominancy, sons are power, prestige, tradition of early marriage, FP disapproval by husband and in-laws, Purdha, no decision power of woman, negative public opinion, wrong propaganda as socio-cultural constraints in family planning.(Table-45)
- Most of the staff i.e. 97.1 percent in 1999 and 100.0 percent in 2003 specified for small family norms, small family better life, two kids are better, son & daughter are equal, maximize gap through motivation, avoid early marriage and polygamy, women empowerment as a strategy and role of FWCs and RHS-As to solve and minimize the socio-cultural obstacles in family planning.(Table-46)

iv. **Govt. and Political Constraints in FP and Strategies of FWCs and RHS-As:**

- Majority of the staff i.e. 52.9 percent in 1999 and 51.4 percent in 2003 specified for no proper funds allocation, based on foreign aid, fluctuating support and policy change as political/ Governmental constraints in family planning. (Table-47)
- Majority of the staff i.e. 51.4 percent in 1999 and 54.3 percent in 2003 specified for collaboration of public and private sectors, struggle to continue, getting support of foreign downer as a strategy of FWCs and RHS-As to solve and minimize the political and Governmental constraints in family planning. (Table-48)

v. **Psychological Constraints in FP and Strategies of FWCs and RHS-As:**

- Most of the staff i.e. 77.1 percent in 1999 and 75.7 percent in 2003 specified for the worries of side effects of contraceptives, conception and infertility as psychological constraints in family planning.(Table-49)
- Most of the staff i.e. 95.7 percent in 1999 and 98.6 percent in 2003 specified for motivation, awareness and counseling for proper usage, change of contraceptives, proper checkup, treatment, medicines and prescription of family planning staff as a strategy of FWCs and RHS-As to solve the psychological constraints in family planning.(Table-50)

vi. **Medical & Technical Constraints in FP and Strategies of FWCs and RHS-As:**

- Maximum of the staff i.e. 92.9 percent in 1999 and 91.4 percent in 2003 specified for no family planning and health awareness, motivation, follow up fear from taking medicines, contraceptives due to side effects and no proper trained staff, equipments, medicines, checkup, treatment, diagnosing (tests) as medical & technical constraints in family planning.(Table-51)
- Maximum of the staff i.e. 95.7 percent in 1999 and 98.6 percent in 2003 specified for motivation, counseling, awareness for proper usage, change of contraceptives and proper checkup, treatment, medicines, prescription by qualified and trained staff as strategies of FWCs and RHS-As to solve the medical & technical constraints in family planning.(Table-52)

vii. **Quality of Service Constraints in FP and Strategies of FWCs and RHS-As:**

- Maximum of the staff i.e. 98.6 percent in 1999 and 97.1 percent in 2003 specified for no proper budget, no involvement of health outlet, coverage, outreach,

information ,supervision, monitoring and evaluation, strategy changes, low quality contraceptives, questionable, no proper services, less satisfaction, on-availability of service at doorstep , lack of male involvement, lack of proper trained staff & gynecologists, no proper infrastructure & building as quality of service constraints in family planning.(Table-53)

- Majority of the staff i.e. 72.9 percent in 1999 and 74.3 percent in 2003 specified for budget based on foreign assistance, proper supervision, monitoring & evaluation of family planning, proper, qualified & trained staff, male staff involvement as a strategy of FWCs and RHS-As to improve the quality of services.(Table-54)

Q. Linkage Program among Govt., NGOs & Community:

- Majority of the staff i.e. 31.4 percent in 1999 and 61.4 percent in 1999 specified for combined seminars, workshops & public private partnership as linkage program among Govt., NGO'S & Community.(Table-55)

R. Weaknesses and Shortcomings & Strategies to improve Family Planning:

- Highest number of the staff i.e. 98.6 percent in 1999 and 95.7 percent in 2003 specified for side effect of contraceptives, no proper policy, planning, research, strategy, involvement of religious leaders, male interest, awareness and education programme about FP, various constraints to FP, no role of media, related departments, health outlets, district Govt., welfare societies, organization as weaknesses and shortcomings of the family planning program.(Table-56)
- High number of the staff i.e. 97.1 percent in 1999 and 100.0 percent staff respondents in 2003 specified for role of media, District Govt., religious leaders, family planning education, enlightened vision, proper counseling, motivation & communication program of family planning, proper, qualified, trained staff and establishment of more family planning organizations as strategies for the improvement of family planning.(Table-57)

5.1.2 Part-II Findings of Private Sector Organizations FP Staff

A. Number of Children:

- Majority of the staff i.e. 58.3 percent in 1999 and 58.3 percent in 2003 replied that they were having 0-1 and 2-3 numbers of male children respectively.(Table-1)

- Maximum of the staff i.e 66.7 percent in 1999 and 50 percent in 2003 replied that they were having 0-1 numbers of female children respectively. (Table-2)

B. Educational Status and Adoption of Family Planning:

- Maximum of the staff i.e. 86.7 percent in 1999 replied that uneducated respondents were not practicing family planning, while half of them i.e. 50.0 percent in 2003 replied that uneducated respondents were practicing family planning, because of counseling, motivation and information by family planning staff.(Table-3)
- Highest number of the staff i.e. 91.7 percent in 1999 and 100.0 percent in 2003 replied that educated respondents were practicing family planning, because of counseling, motivation and information by family planning staff. They are usually self motivated and aware and need no extensive counseling.(Table-4)

C. Sources of Awareness and Information about Family Planning:

- Majority of the staff i.e. 93.3 percent in 1999 and 96.7 percent in 2003 specified that family planning staff and literature, TV, radio, relatives, friends, husband and wife were the major sources of awareness and information about Family Planning.(Table-5)
- Majority of the staff i.e. 73.3 percent in 1999 and 76.7 percent in 2003 specified for wall chalking, banners, sign boards seminars, workshops, conferences, news papers and magazines as the minor sources of awareness and information about Family planning.(Table-6)

D. Problems Faced During Awareness, Communication and Popularization of Family Planning and Strategies of FHCs and RHS-B:

- 100.0 percent staff respondents in 1999 and 95.0 percent in 2003 replied positively regarding ignorance (women), improper way of communication and family planning constraints as problems during awareness, communication, advertisement and popularization of family planning.(Table-7)
- Majority of the staff i.e. 93.3 percent staff in 1999 and 100.0 percent in 2003 were in favor of women education, improvement in communication, better awareness sources and remedy of constraints to family planning as solution to the hurdles in popularization of family planning.(Table-8)

E. Problems, Functions and Facilities in FHCs and RHS-B:

- 100 percent staff respondents in 1999 and 83.3 percent in 2003 specified for different problems in FWC and RHS-B.(Table-9)
- Maximum of the staff i.e. 95.0 percent in 1999 and 100.0 percent in 2003 specified for informative (counseling, awareness & motivation for FP and MHU) and curative (provision of contraceptives, treatment, checkup, medicines, mother-child health) functions and facilities in FHCs and RHS-B.(Table-10)

F. Problems & Role of FWW, LHW and LHV:

- 100 percent staff respondents in 1999 and 91.7 percent in 2003 specified for different problems to FWW, LHV and LHW.(Table-11)
- Maximum i.e. 96.7 percent staff respondents in 1999 and 100.0 percent in 2003 specified for informative (counseling, awareness and motivation for FP) and curative (provision of contraceptives, medicines, treatment, checkup and prescription) as the role of FWW, LHV and LHW. (Table-12)

G. Various Contraceptives Practiced:

- Majority of the staff i.e. 56.7 percent in 1999 and 60.0 percent in 2003 were not in favor of withdrawal (male) practice, quantity used 50-100 P.A. & free of cost by beneficiaries, due to the introduction of new contraceptives.(Table-13)
- Maximum of the staff i.e. 93.3 percent in 1999 and 100.0 percent in 2003 were in favor of condom (male) practicing, per individual quantity used 50-100 P.A. & cost per dozen= Rs. 6/-.(Table-14)
- Majority of the staff i.e. 66.7 percent in 1999 and 61.7 percent in 2003 replied negatively for the availability and practice of vasectomy (male operation), once in life & free of cost, while only 33.3 percent in 1999 and 38.3 percent in 2003 replied that vasectomy facility is available with them and the beneficiaries practice it once in life & free of cost.(Table-15)
- Greater number of the staff i.e. 96.7 percent in 1999 and 100.0 percent in 2003 replied positively regarding the availability and practice of oral pills (female tablets), per individual quantity used = 11 strips & cost per strip= Rs. 3/-.(Table-16)

- Maximum of the staff i.e. 91.7 percent in 1999 and 95.0 percent in 2003, were in favor of availability and practice of injection nurajest (2 months), majestron or DEPO (3 months) 6 and 4 per individual P.A. usage & 01 injection cost = Rs. 3/-(Table-17)
- Majority of the staff i.e. 81.7 percent in 1999 and 85.0 percent in 2003, specified for availability and practice of tub-legation or sterilization (female operation), per individual practice= once in life & free of cost.(Table-18)
- Maximum of the staff i.e. 86.7 percent in 1999 and 91.7 percent in 2003, were in favor of availability and practice of multi load or copper-T or IUD (female contraceptive), usage per individual 01 for 5-10 years and cost of per copper-T is Rs. 3/-.(Table-19)

H. Reasons for Using and Non-using a Specific Method/ Contraceptive:

- Maximum i.e. 83.3 percent staff respondents in 1999 and 91.7 percent 2003 specified for no/less side effects, convenient, more effective and less costly as the reasons for using a specific method/ contraceptive.(Table-20)
- Majority i.e. 91.7 percent staff respondents in 1999 and 83.3 percent in 2003, specified for side effects, permanent, not effective and costly as the reasons for not using a specific method/ contraceptive.(Table-21)

I. Sources to Get Contraceptives:

- Maximum i.e. 86.7 percent staff respondents in 1999 and 96.7 percent in 2003, specified for major sources (family planning organization centers and mobile unit) to provide contraceptives.(Table-22)
- A few i.e. 33.3 percent staff respondents in 1999 and 16.7 percent in 2003, specified for minor sources (private medical store, general store, doctor / practitioner) to get contraceptives, while 66.7 percent in 1999 and 83.3 percent in 2003 were against it.(Table-23)

J. Side Effects of Contraceptives:

- Maximum i.e. 93.3 percent staff respondents in 1999 and 83.3 percent in 2003, specified for medical health problems (infection, irregular menses/ bleeding,

weight gain, swelling, temperature, headache, vomiting, no hepatize) as the side effects of contraceptives on users.(Table-24)

- Majority i.e. 96.7 percent staff respondents in 1999 and 66.7 percent in 2003, specified for psychological problems as the side effects of contraceptives on users.(Table-25)
- Maximum i.e. 83.3 percent staff respondents in 1999 and 100 percent in 2003, specified for counseling, awareness for proper usage of contraceptives, change the method/contraceptive, proper treatment, prescription and preventive measures as strategies and role of family planning staff in prevention of side effects of contraceptives on users.(Table-26)

K. Problems in Reducing the Side Effects of Contraceptives & Strategies of FHC and RHS-B:

- Majority of the staff i.e. 80.0 percent in 1999 and 76.7 percent in 2003 were in favor of no care, proper usage and follow up by the clients as the problems in reducing the side effects of contraceptive.(Table-27)
- Majority of the staff i.e. 61.7 percent in 1999 and 58.3 percent in 2003 were in favor of no proper treatment , usage skill , medicine provision by service provider as the problems in reducing the side effects of contraceptive.(Table-28)
- Highest number of the staff i.e. 95.0 percent in 1999 and 100.0 percent in 2003 specified for counseling & motivation for proper usage, receiving feedback from clients, proper treatment, cleanliness, change the method, preventive medicines as the strategy and role of FHCs and RHS-B.(Table-29)

L. Mother- Child Health Care Program:

- Highest number of the staff i.e. 96.7 percent in 1999 and 100.0 percent in 2003 specified for informative and curative (counseling, antenatal, postnatal, treatment & vaccination on due time, balance diet for mother health) as one of the component of mother-child health care program of FP.(Table-30)
- Most of the staff i.e. 91.7 percent in 1999 and 98.3 percent in 2003 specified for, before, during and after delivery child-mother health care, vaccination on due time, immunization, breast feeding & additional nutrition to child as one of the component of mother-child health care program.(Table-31)

M. Results of Mother-Child Health Care Program:

- Maximum of the staff i.e. 95.0 percent in 1999 and 98.3 percent in 2003 specified for proper health protection, safe delivery and trust on mother child health care as well as family planning as a result of mother-child health care program. (Table-32)

N. Problems in Mother-Child Health Care & Strategies of FHCs and RHS-B:

- 100.0 percent staff respondents in 1999 and 98.3 percent in 2003 specified for various constraints to MCHC (ignorance, no proper treatment, checkup, tests, medicines) and various constraints to FP (economic, socio-culture, religious, psychological, medical-technical, quality of service) and side effects as problems in mother-child health care program.(Table-33)
- Maximum of the staff i.e. 96.7 percent in 1999 and 100.0 percent in 2003 specified for the solution of various constraints in mother-child care (health education, awareness, counseling and motivation, proper treatment, checkup, tests, medicine) and solution to various constraints in FP (free counseling, motivation, awareness, treatment, medicine, avoid early marriage, maximum male children, meeting religious leaders, solution to side effects, quality service) as strategy and role of family planning centers in improvement of mother-child health care program.(Table-34)

O. Response and Causes of Large Family & Role of FHCs and RHS-B:

- 100.0 percent staff in 1999 and 91.7 percent in 2003 specified for large size of the family in the target area.(Table-35)
- Majority of the staff i.e. 80.0 percent in 1999 and 75.0 percent in 2003 specified for 13-22 years as the marriage age in the area, this early time of marriage is the reason of large family size.(Table-36)
- Maximum of the staff i.e. 88.3 percent in 1999 and 91.7 percent in 2003 specified for single marriage in the area, while only 11.7 percent in 1999 and 8.3 percent in 2003 replied negatively for it and specified for double & triple marriages respectively as reasons of large family size.(Table-37)
- 100.0 percent staff respondents in 1999 and 91.7 percent in 2003 replied that desire for male child reasons (sons are power, prestige, source of income, psychological

protection & inheritance of property of the family) leading to large family. (Table-38).

- 100.0 percent staff in 1999 and 91.7 percent in 2003 replied that various constraints in family planning (eco-, religious, socio-cultural, psychological, medical, technical, quality of service) leads to large size of the family.(Table-39)
- Majority of the staff i.e. 91.7 percent in 1999 and 100.0 percent in 2003 specified for proper awareness, counseling & motivation for small family, contraceptives, large family economic burden, to avoid early marriage & maximum children, son and daughter are equal, equal rights of children, proper checkup, treatment, medicines, solution of constraints as strategies of FHCs and RHS-B to control and minimize the size of family.(Table-40)

P. Various Constraints in Family Planning:

i. Economic Constraints in Family Planning and Strategies of FHCs and RHS-B

- Outstanding number of the staff i.e. 98.3 percent in 1999 and 96.7 percent in 2003 specified for male children economic assets and source of income, poverty, no income and employment, high expenses of family, no proper resources, infrastructure, building, equipments, treatment, medicines, budget with NGOs as economic constraints to family planning.(Table-41)
- Majority of the staff i.e. 86.7 percent in 1999 and 91.7 percent in 2003 specified for foreign aid, free counseling, service, check up, treatment, operation, natural gap by breast feeding, company rate of contraceptives as strategies of FHCs and RHS-B to solve and minimize the economic constraints in family planning.(Table-42)

ii. Religious Constraints in Family Planning and Strategies of FHCs and RHS-B:

- Outstanding number of the staff i.e. 98.3 percent respondents in 1999 and 90.0 percent in 2003 specified for family planning is sin, killing of humanity, illegitimate, Fatalism, God is food provider, no one can stop those souls to be produced, increase the number of Muslims, immoral, plane of non Muslims slogans use by religious leaders, which are the religious obstacles to family planning.(Table-43)
- Maximum of the staff i.e. 90.0 percent in 1999 and 100.0 percent in 2003, specified for meeting with religious leaders, counseling, motivating and convincing

religious people, collection of different statements and fatwas and religious literature distribution in favor of FP as strategies of FHCs and RHS-B to solve the religious obstacles in family planning.(Table-44)

iii. **Socio-Cultural Constraints in Family Planning and Strategies of FHCs and RHSB:**

- 100.0 percent staff in 1999 and 91.7 percent in 2003 specified for desire for maximum male children (sons are power, prestige, inheritance of property, psychological and social protection, dominancy, source of income, helping hands, natural desire), family planning disapproval by husband and in-laws, Purdha, no decision power of women, early marriage, negative public opinion, wrong propaganda as socio-cultural obstacles in family planning.(Table-45)
- Most of the staff i.e. 95.0 percent in 1999 and 100.0 percent in 2003 specified for small family norms, small family better life, two kids are better, son and daughter are equal, maximum gap, avoid early marriage and women empowerment as a strategies of FHCs and RHS-B to solve the socio-cultural obstacles in family planning.(Table-46)

iv. **Political/ Govt. Constraints in FP and Strategies of FHCs and RHSB:**

- Majority of the staff i.e. 63.3 percent in 1999 and 60.0 percent in 2003 specified for foreign aid dependency/no proper funds allocation/ fluctuating support and policy change as the political/ Governmental obstacles in family planning.(Table-47)
- Majority of the staff i.e. 58.3 percent in 1999 and 63.3 percent in 2003 specified for collaborations of public and private sectors, struggle to continue, getting support of govt. & foreign donors as strategies of FHC and RHC to solve /minimize the political / Governmental obstacles in family planning.(Table-48)

v. **Psychological Constraints in FP and Strategies of FHCs and RHSB:**

- Most of the staff i.e. 75.0 percent in 1999 and 70.0 percent in 2003 specified for the worries of side effects of contraceptives/ medicines and worry of conception/ infertility as psychological constraints in family planning.(Table-49)
- Highest number of the staff i.e. 96.7 percent in 1999 and 98.3 percent in 2003 specified for counseling, motivation, awareness for proper usage/change of

contraceptives, proper checkup, treatment, medicine and prescription of family planning staff as strategies of FHC and RHS-B to solve /minimize the psychological obstacles in family planning.(Table-50)

vi. **Medical & Technical Constraints in FP and Strategies of FHCs and RHSB:**

- Outstanding number of the staff i.e. 98.3 percent in 1999 and 96.7 percent in 2003 specified for no family planning and health awareness, motivation, follow-up, fear from taking medicines, Contraceptives due to side effects, proper trained staff, equipments, medicines, checkup and treatment as medical-technical constraints in family planning.(Table-51)
- Highest number of the staff respondents i.e. 96.7 percent in 1999 and 98.3 percent in 2003 specified for motivation, counseling, and awareness for proper Usage, change of contraceptives, proper checkup, treatment, medicines and prescription of qualified and trained family planning staff as strategies of FHC and RHS-B to solve and minimize the medical-technical constraints in family planning.(Table-52)

vii. **Quality of Service Constraints in FP and Strategies of FHCs and RHSB:**

- Outstanding number of the staff i.e. 98.3 percent in 1999 and 95.0 percent in 2003 specified for no proper budget, involvement of health outlets, coverage, outreach, information, supervision, monitoring & evaluation, strategy change, low quality contraceptives, questionable/ no proper service, no door step service, less satisfaction, male involvement, infrastructure, building, proper trained staff, as quality of service constraints in family planning.(Table-53)
- Maximum of the staff i.e. 91.7 percent in 1999 and 96.7 percent in 2003 specified for, budget based on foreign assistance, proper supervision, monitoring, evaluation, proper, qualified & trained staff, male staff involvement for male motivation as strategies of FHC and RHS-B to solve or minimize the quality of services constraints in family planning.(Table-54)

Q. **Linkage Program among Govt. NGOs & Community:**

- Only 36.7 percent staff in 1999 and 93.3 percent in 2003 specified for combined seminars, workshops and public private partnership as linkage program among Govt., NGOs & community / beneficiaries.(Table-55)

R. Shortcomings and Strategies to improve Family Planning:

- Outstanding number of the staff i.e. 98.3 percent in 1999 and 96.7 percent in 2003 were in favor of side effects of contraceptives, no proper policy, planning, research, strategy, involvement of religious leaders, male interest, awareness and education programme about family planning, various constraints/ obstacles to family planning, low/ no role of media, related departments, health, district govt. and welfare organizations as weaknesses and shortcomings of the family planning program.(Table-56)
- Greater number of the staff i.e. 96.7 percent in 1999 and 100.0 percent in 2003 specified for role of media, district govt., religious leaders, family planning education, awareness, enlightened vision, counseling, motivation and proper communication programme of family planning, proper, qualified, trained staff and establishment of more family planning organizations as strategies/ suggestions for the improvement of family planning.(Table-57)

5.1.3 Part-III Findings of Beneficiaries

A. Number of Children:

- Majority i.e. 56.7 percent beneficiaries in 1999 and 60.0 percent in 2003 replied that they were having 2-3 numbers of male children respectively.(Table-1)
- Maximum i.e. 53.3 percent beneficiaries in 1999 and 56.7 percent in 2003 replied that they were having 2-3 numbers of female children respectively. (Table-2)

B. Educational Status and Practice of Family Planning:

- Most of the beneficiaries' respondents i.e. 73.3 percent in 1999 replied that uneducated people were not practicing family planning, while majority i.e. 60.0 percent in 2003 replied that uneducated people were practicing family planning, because of counseling, motivation, and convincing and awareness creation among masses by family planning staff.(Table-3)
- Most of the beneficiaries' respondents i.e. 83.3 percent in 1999 and 98.0 percent in 2003 replied that educated respondents were practicing family planning, because of easy counseling, motivation, convincing and awareness creation among educated

clients by family planning staff and other sources of awareness. They are usually self motivated and aware and need no extensive counseling (Table-4)

C. **Sources of Awareness, Information and Popularization of Family Planning:**

- Majority of the respondents i.e. 80.3 percent in 1999 and 83.7 percent in 2003 specified for family planning staff & literature, TV, radio, relatives, friends, husband and wife as the major sources of awareness, information and popularization of family planning (Table-5)
- Maximum of the respondents i.e. 60.0 percent in 1999 specified negatively and 53.3 percent in 2003 specified positively for wall chalking, banners, sign boards, seminars, workshops, conferences, news papers and magazines as the minor sources of awareness, information and popularization of family planning.(Table-6)

D. **Problems during Awareness, Communication, information, Popularization of FP and Strategies of Family Planning Organizations Centers and Staff :**

- 100.0 percent beneficiaries' respondents in 1999 and 96.7 percent in 2003 replied positively regarding ignorance of women, improper communication and various constraints in family planning as problems during awareness, communication/, information and popularization of family planning.(Table-7)
- Maximum of the beneficiaries' respondents i.e. 79.0 percent in 1999 and 95.0 percent in 2003 were in favor of women education, improvement in communication and remedy of constraints to family planning as solution of problems in communication and popularization of family planning by FP organizations.(Table-8)

E. **Problems, Functions and Facilities in family planning organizations:**

- Majority of the beneficiaries respondents i.e. 62.0 percent in 1999 and 60.0 percent in 2003, specified for no required facilities of family planning, people dislike it and staff issues as the problems of family planning organizations.(Table-9)
- Outstanding number of the respondents i.e. 95.7 percent beneficiaries' respondents in 1999 and 99.0 percent in 2003 specified for informative and curative (awareness, counseling, motivation, provision of contraceptives, treatment, checkup, medicines, MCHC,RHC and mobile service) functions and facilities in family planning organizations.(Table-10)

F. **Problems & Role of FWW, LHW and LHV:**

- Maximum of the respondents' i.e. 96.7 percent in 1999 and 90.0 percent in 2003 specified for no visit to home, absent and take charges in clinic are the complaint and problems faced to beneficiaries respondents from the FWW, LHW and LHV.(Table-11)
- Highest number of the beneficiaries' respondents' i.e. 94.7 percent in 1999 and 98.7 percent in 2003 specified for informative (motivation, counseling & convincing for family planning and curative (contraceptives provision, checkup, treatment, prescription, and provision of medicines) were the role, functions and performance of FWW, VBMM, LHW and LHV.(Table-12)

G. **Various Contraceptives Introduced and Practiced:**

- Maximum of the beneficiaries respondents i.e. 93.7 percent in 1999 and 94.0 percent in 2003, were not in favor of traditional (withdrawal male) method practice, quantity used (50-100 P.A.) & free of cost by beneficiaries, due to the introduction of new methods/ contraceptives.(Table-13)
- Majority of the beneficiaries' respondents' i.e. 59.7 percent in 1999 and 61.0 percent in 2003 were in favor of condom (male contraceptive) practicing, per individual quantity used (50-100 p.a.) & cost per dozen= Rs. 6/-. (Table-14)
- Outstanding number of the beneficiaries' respondents' i.e. 99.3 percent in both 1999 and 2003 replied negatively for the practice of vasectomy (male operation), once in life & free of cost. It means this method is not preferred by the beneficiaries' respondents.(Table-15)
- Most of the beneficiaries respondents i.e. 90.3 percent in 1999 and 90.7 percent in 2003 replied positively regarding the availability and self use of oral pills (female tablets),per individual usage is 11 strips & cost per strip is Rs. 3/-.(Table-16)
- Majority of the beneficiaries respondents i.e. 52.3 percent in 1999 and 53.0 percent in 2003 replied positively regarding the availability and use of injection nurajest (2 months, 6 injections per individual p.a. usage)/ majestron or DEPO (3 months, 4 injections per individual p.a. usage) & 01 injection cost is Rs. 3/-(Table-17)
- Maximum of the beneficiaries' respondents i.e. 83.3 percent in 1999 and 82.7 percent in 2003 replied that tub-legation/sterilization (female operation) was not

practiced by them, though this facility was available, per individual practice is once in life & free of cost. Only 16.7 percent in 1999 and 17.3 percent beneficiaries' respondents practiced it by themselves during 1999 and 2003, it means this method is not preferred, due to its permanent nature.(Table-18)

- Majority of the beneficiaries respondents i.e. 87.0 percent in 1999 and 86.7 percent in 2003 were against of self practice/ usage of multi load/copper-T/ IUD (female contraceptive), usage per individual 01 for 5-10 years/ once with checking & 01 multi load/copper-T/ IUD cost is Rs. 3/-.Only 13.0 percent in 1999 and 13.3 percent in 2003 replied positively regarding this method.(Table-19)

II. Reasons for Using and Not Using a Specific Method:

- Maximum of the beneficiaries' respondents i.e. 85.0 percent in 1999 and 88.3 percent 2003 specified for no/less side effects, convenient, more effective and less costly as the reasons for using a specific method/ contraceptive (Table-20)
- Most of the beneficiaries' respondents i.e. 88.0 percent in 1999 and 85.0 percent in 2003, specified for side effects, permanent, not effective and costly as the reasons for not using a specific method/ contraceptive.(Table-21)

I. Sources to get Contraceptives:

- Maximum of the beneficiaries' respondents' i.e. 90.7 percent in 1999 and 94.0 percent in 2003, specified for major sources (family planning organization center and mobile unit) to get contraceptives (Table-22)
- Majority of the beneficiaries respondents i.e. 59.3 percent in 1999 and 56.7 percent in 2003, specified for minor sources (private medical store, general store, doctor /practitioner) to get contraceptives.(Table-23)

J. Side Effects of Contraceptives and Strategies of Family Planning Organizations Centers and Staff for Prevention:

- Greater number of the beneficiaries' respondents i.e. 92.0 percent in 1999 and 90.0 percent in 2003, specified for medical health problems (infection, irregular menses, bleeding, weight gain, swelling, temperature, headache, vomiting, no hepatize) as the side effects of contraceptives on users.(Table-24)

- Maximum of the beneficiaries' respondents i.e. 90.0 percent in 1999 and 86.3 percent in 2003, specified for psychological problems as the side effects of contraceptives on users(Table-25)
- Maximum of the beneficiaries' respondents' i.e. 90.0 percent in 1999 and 92.3 percent in 2003, specified for counseling, awareness for proper usage of contraceptives, change the method/contraceptive, proper treatment, prescription and preventive measures as strategies and role of family planning staff and centers in prevention of side effects of contraceptives on users.(Table-26)

K. Problems & Strategies to Reduce the Side Effects of Contraceptives:

- Majority of the beneficiaries' respondents i.e. 90.3 percent in 1999 and 85.7 percent in 2003 specified for no care, proper usage and follow up by the clients/patients as the problems in reducing the side effects of contraceptive.(Table-27)
- Most of the beneficiaries' respondents i.e. 93.3 percent in 1999 and 90.0 percent in 2003 specified for no proper treatment/usage skill/medicine provision by service providers as the problems in reducing the side effects of contraceptive.(Table-28)
- Majority of the beneficiaries' respondents' i.e. 86.0 percent in 1999 and 93.3 percent in 2003 specified for counseling and motivation for proper usage, receiving feed back from client/ patients, proper treatment, cleanliness, change the method and preventive medicines as the strategies and role of family planning staff and organizations.(Table-29)

L. Mother- Child Health Care Program:

- Higher number of the beneficiaries respondents, i.e. 94.0 percent in 1999 and 97.3 percent in 2003 specified for informative and curative (counseling, antenatal, postnatal, treatment, vaccination, iron tablets, medicines, balance diet to mother) as one of the component of mother-child health care program of family planning organizations center.(Table-30)
- Most of the beneficiaries respondents i.e. 93.3 percent in 1999 and 96.7 percent in 2003 specified for before and during delivery (LHV, FWW and Lady Doctor visit home on payment, while free in center), vaccination on due time, immunization,

breast feeding & additional nutrition to child as one of the component of mother-child health care program of family planning organizations centers. (Table-31)

M. Results of Mother-Child Health Care Program:

- Majority of the beneficiaries' respondents, i.e. 89.3 percent in 1999 and 95.0 percent in 2003 specified for proper health protection, safe delivery and trust on MCHC/ RHC as a result of mother-child health care program of family planning organizations centers.(Table-32)

N. Problems in Mother-Child Health Care and Strategies of Family Planning Centers:

- Maximum of the beneficiaries respondents, i.e. 93.3 percent in 1999 and 87.0 percent in 2003 specified for varies constraints to mother-child health care (ignorance, no proper treatment, checkup and medicine) and various constraints to family planning (eco-, socio-cultural, religious, psychological, medical-technical, quality of service) as problems in mother-child health care program of FP. (Table-33)
- Maximum number of the beneficiaries respondents i.e 93.3 percent in 1999 and 98.7 percent in 2003 specified for solution to various constraints in mother-child health care (health education, awareness, counseling and motivation through proper staff, proper treatment, checkup, medicines, health facility at door step and camps)and solution to various constraints in FP (free counseling, motivation, awareness, treatment, medicines, avoiding early marriage, polygamy, maximum male children, meeting with religious leader, solution of psychological worries, solution to side effects, improvement in quality of service) as strategies of family planning organizations centers for the improvement of mother-child health care program of FP.(Table-34)

O. Response and Causes of Large Family & Role of Family Planning Centers

- Maximum of the beneficiaries' respondents, i.e. 93.3 percent in 1999 and 90.0 percent in 2003 specified for large size of the family in the target area.(Table-35)
- Majority of the beneficiaries' respondents, i.e. 82.3 percent in 1999 and 79.0 percent in 2003 specified for 13-22 years as the marriage age in the area, which is the early one leading to large family size.(Table-36)

- Majority of the beneficiaries respondents, i.e. 89.0 percent in 1999 and 93.7 percent in 2003 specified for one/ single marriage in the area, while 11.0 percent in 1999 and 6.3 percent in 2003 replied negatively for it (specified for two/ double and three/ triple marriages respectively).(Table-37)
- Maximum number of the beneficiaries respondents, i.e. 95.0 percent in 1999 and 91.7 percent in 2003 replied that desire for maximum male children/high fertility/fecundity (Sons are guns, power, prestige, dominant, property, income source, help in old age, socio-psychological protection etc.), leading to large family.(Table-38)
- Most of the beneficiaries respondents i.e. 95.3 percent in 1999 and 92.7 percent in 2003 replied that various constraints to family planning (Economic/poverty, religious, socio cultural, govt. / political, medical -technical, quality of service etc) leading to large size of the family.(Table-39)
- Majority of the beneficiaries' respondents i.e. 95.0 percent in 1999 and 96.7 percent in 2003 specified for proper counseling, motivation for small family, contraceptives , large family economic burden , to avoid early marriage, maximum children, son and daughter are equals, proper checkup, treatment, medicines, home visits and solution of Constraints as strategies and role of family planning organizations centers to control / minimize the size of family and create small family norm.(Table-40)

P. Various Constraints to Family Planning and Strategies of Family Planning Organizations Centers:

i. Economic constraints in family planning and strategies of Family Planning Organizations Centers:

- Majority of beneficiaries' respondents, i.e. 73.3 percent in 1999 and 60.0 percent in 2003 specified for poverty, no income & employment, high expenses of the family, expensive medicines lack, no resources, infrastructure, building, equipments, treatment, medicines, tests, budget as economic constraints to family planning. (Table-41)
- Majority of beneficiaries' respondents, i.e. 57.7 percent in 1999 and 63.3 percent in 2003 specified for free counseling, checkup, treatment, natural gap by breast feeding (LAM), nominal charges, company rate contraceptives and foreign aid

support as strategies and role of family planning organizations centers, to solve the economic constraints in family planning. (Table-42).

ii. **Religious constraints in family planning and strategies of family planning organizations centers:**

- Greater number of the beneficiaries' respondents i.e. 95.7 percent in 1999 and 90.0 percent in 2003 specified for family planning is sin, killing of humanity, illegitimate, against natural law, fatalism, Allah is food provider, no one can stop those souls to be produced, increase Muslims, immoral, plane of non Muslims slogans use by religious leaders, which are the religious constraints to family planning.(Table-43)
- Majority of the beneficiaries' respondents, i.e. 50.7 percent in 1999 replied negatively, while majority i.e. 76.7 percent in 2003 specified positively for meeting and consulting with religious leaders, motivation, awareness, counseling and convincing religious people, collection of different statements, fatwas and religious literature distribution in favor of FP as strategies of family planning organizations, to solve the religious constraints in family planning.(Table-44)

iii. **Socio-Cultural constraints in family planning and strategies of family planning organizations centers:**

- Maximum number of the beneficiaries' respondents, i.e. 96.7 percent in 1999 and 93.0 percent in 2003 specified for desire for maximum male children (sons are power, prestige, property source, dominance, income source, helping hand in old age, socio psychological protection), family planning disapproval by husband and in laws, women can not go out of home (Pardah), shyness and no decision power by women, early marriage, wrong propaganda, negative public opinion as socio-cultural constraints in family planning.(Table-45)
- Greater number of the beneficiaries respondents, i.e. 96.7 percent in 1999 and 98.3 percent in 2003 specified for small family norms, small family better life, two kids are better/ son & daughter are equal, maximize gap through motivation, to avoid early marriage and polygamy and women empowerment as strategies of family planning organizations centers, to solve the socio-cultural constraints in family planning.(Table-46)

iv. **Political and Governmental constraints in family planning and strategies of family planning organizations centers:**

- Majority of the beneficiaries' respondents i.e. 52.0 percent in 1999 and 50.0 percent in 2003, specified for no proper funds allocation, based on foreign aid and Policy change as the political / Governmental constraints in family planning.(Table-47)
- Half i.e. 50.0 percent beneficiaries' respondents in 1999 and 51.7 percent in 2003, specified for collaboration of public and private sector, struggle to continue, getting support of the govt. and foreign donors as strategies and role of family planning organizations, to solve the political / Governmental constraints in family planning.(Table-48)

v. **Psychological constraints in family planning and strategies of family planning organizations centers:**

- Maximum of the beneficiaries' respondents, i.e. 94.0 percent in 1999 and 93.0 percent in 2003 specified for the worries of side effects of Contraceptives, medicines conception and infertility as psychological constraints in family planning.(Table-49)
- Most of the beneficiaries respondents i.e. 91.7 percent in 1999 and 93.3 percent in 2003, specified for counseling, motivation, awareness for proper usage, change of contraceptive, reduce fear of side effects, proper check up, treatment, medicine, prescription of family planning staff as the strategies of family planning organizations to solve the psychological constraints in family planning.(Table-50)

vi. **Medical and Technical constraints in family planning and strategies of family planning organizations centers:**

- Highest number of the beneficiaries respondents i.e. 94.7 percent in 1999 and 93.3 percent in 2003, specified for health problems (irregularity of menses, bleeding, pregnancy problems, weight, swelling, weakness, no appetite, vomiting and headache), no family planning and health awareness, motivation, follow up, fear from taking medicine/ contraceptives due to side effects , no proper trained staff, equipments, medicine, checkup and treatment as medical-technical constraints in family planning.(Table-51)

- Most of the beneficiaries' respondents i.e. 92.0 percent in 1999 and 93.7 percent in 2003, specified for motivation, awareness and counseling for proper usage, change of contraceptives, proper checkup, treatment, medicine, multivitamins-iron tablets, prescription by qualified and trained family planning staff as strategies of family planning organizations to solve the medical-technical constraints in family planning.(Table-52)

vii. Quality of Service constraints in family planning and strategies of family planning organizations centers:

- Maximum of the beneficiaries respondents i.e. 93.3 percent in 1999 and 86.7 percent in 2003, specified for no proper budget, no involvement of health outlets, coverage, outreach, information, supervision, monitoring and evaluation, strategy change, low quality contraceptives, questionable service, no proper services, doorsteps, less satisfaction, male involvement, proper trained staff, gynecologists as quality of service constraints in family planning.(Table-53)
- Most of the beneficiaries' respondents i.e. 86.0 percent in 1999 and 92.7 percent in 2003, specified for budget based on foreign assistance, proper supervision, monitoring and evaluation of family planning, proper, qualified and trained staff, male staff involvement for male motivation, proper awareness about contraceptives, supervision, doorstep service and mobile service units, as strategies and role of family planning organizations, to solve the quality of services constraints in family planning.(Table-54)

Q. Linkage Program among Govt., NGOs & Community:

- Majority of the beneficiaries' respondents i.e. 96.0 percent in 1999 replied negatively, while majority i.e. 64.7 percent in 2003 specified for combined seminars, workshops and public private partnership as linkage program among govt., NGOs and Community. It means combined linkage family planning program among Govt., NGOs and Community is a recent development. (Table-55)

R. Shortcomings in Family Planning and Strategies for Improvement:

- Highest number of the beneficiaries' respondents i.e. 95.0 percent in 1999 and 93.3 percent in 2003 specified for side effects of contraceptives, no proper policy, planning, research, strategy, involvement of religious leader, male interest, awareness and education programme about family planning, various constraints to

family planning, no role of media, related departments, health, district govt. and welfare organizations as shortcomings of the family planning program.(Table-56)

- 99.3 percent beneficiaries' respondents in 1999 and 100.0 percent in 2003 specified for role of media, district government, religious leaders, family planning education, awareness, enlightened vision, counseling, motivation and communication programme of FP, qualified and trained staff and establishment of more family planning organizations as strategies for the improvement of family planning in the area.(Table-57)

5.2. VERIFICATION OF HYPOTHESIS:

The given hypotheses can be verified on the basis of literature review and J.S.Mill's Logico-Experimental Methods through research findings as well as Chi Square Test application on various indicators of Hypotheses.

I. Better the family planning awareness / information/ popularization/ education sources better would be the chances of family planning strategies implementation.

Part-I: Supportive findings of public organizations staff Tables-6 and 9 are verifying the 1st hypothesis.

Pearson Chi-square value = 0.6 shows that there is no significant difference of association between responses and years having P = 0.41> 0.05 (Table-6)

Pearson Chi-square value = 2.0 highlights that there is no significant difference of association between responses and years having P = 0.15> 0.05 (Table-9)

Part-II: Supportive findings of private organizations (NGO's) staff tables 6 and 9 are verifying the 1st hypothesis.

Pearson Chi-square value = 0.7 shows that there is no significant difference of association between responses and years having P = 0.40> 0.05 (Table-6)

Pearson Chi-square value = 4.13 depicts that there is significant difference of association between responses and years having P = 0.04< 0.05 (Table-9)

Part-III: Supportive findings of family planning beneficiaries' tables-6 and 9 are verifying the 1st hypothesis.

Pearson Chi-square value = 1.12 shows that there is no significant difference of association between responses and years having P = 0.28 > 0.05 (Table-6)

Pearson Chi-square value = 33.95 indicates that there is significant difference of association between responses and years having P = 0.00< 0.05 (Table-9)

On the basis of the above supportive findings of Public & private sector organizations staff as well as beneficiaries of these organizations and Chi-square value testing, The 1st Hypothesis is valid.

II. Better the facilities and functions of family planning centers, higher would be the use of various Contraceptives/ methods of FP.

P art-I Supportive findings of public organizations staff tables-10, 12, 14, 15, 16, and 17 verifying the 2nd hypothesis.

Pearson Chi-square value = 2.02 shows that there is no significant difference of association between responses and years having P = 0.15 > 0.05 (Table-10)

Pearson Chi-square value = 5.18 indicates that there is significant difference of association between responses and years having P = 0.02 < 0.05 (Table-12)

Pearson Chi-square value = 5.18 shows that there is no significant difference of association between responses and years having P = 0.02 < 0.05 (Table-14)

Pearson Chi-square value = 0.69 highlights that there is no significant difference of association between responses and years having P = 0.40 > 0.05 (Table-15)

Pearson Chi-square value = 0.11 shows that there is no significant difference of association between responses and years having P = 0.73 > 0.05 (Table-16)

Pearson Chi-square value = 3.28 depicts that there is no significant difference of association between responses and years having P = 0.07 > 0.05 (Table-17)

Part-II Supportive findings of private organizations (NGO's) staff tables-10, 12, 13, 14, 15, 16 and 17 verifying the 2nd hypothesis.

Pearson Chi-square value = 3.7 shows that there is no significant difference of association between responses and years having P = 0.07 > 0.05 (Table-10)

Pearson Chi-square value = 4.13 indicates that there is significant difference of association between responses and years having P = 0.04 < 0.05 (Table-12)

Pearson Chi-square value = 2.03 shows that there is no significant difference of association between responses and years having P = 0.15 > 0.05 (Table-14)

Pearson Chi-square value = 0.53 highlights that there is no significant difference of association between responses and years having P = 0.46 > 0.05 (Table-15)

Pearson Chi-square value = 0.24 shows that there is no significant difference of association between responses and years having P = 0.62 > 0.05 (Table-16)

Pearson Chi-square value = 0.77 indicates that there is no significant difference of association between responses and years having P = 0.37 > 0.05 (Table-17)

Part-III Supportive findings of family planning beneficiaries tables-11, 15, 17, 18 and 20 verifying the 2nd hypothesis.

Pearson Chi-square value = 6.42 shows that there is significant difference of association between responses and years having P = 0.01 < 0.05 (Table-11)

Pearson Chi-square value = 0.11 depicts that there is significant difference of association between responses and years having P = 0.73 > 0.05 (Table-15)

Pearson Chi-square value = 0.01 shows that there is no significant difference of association between responses and years having P = 0.88 > 0.05 (Table-17)

Pearson Chi-square value = 0.27 highlights that there is no significant difference of association between responses and years having P = 0.87 > 0.05 (Table-18)

Pearson Chi-square value = 0.01 shows that there is no significant difference of association between responses and years having P = 0.90 > 0.05 (Table-20)

On the basis of the above supportive findings of Public & private sector organizations staff as well as beneficiaries of these organizations and Chi-square value testing, The 2nd Hypothesis is verified.

III. Problems and side effects of contraceptives lead to better strategies to overcome them.

Part-I Supportive findings of public organizations staff tables-18, 19 and 20 verifying the 3rd hypothesis.

Pearson Chi-square value = 0.75 shows that there is no significant difference of association between responses and years having P = 0.38 > 0.05 (Table-18)

Pearson Chi-square value = 0.11 depicts that there is significant difference of association between responses and years having P = 0.73 > 0.05 (Table-19)

Pearson Chi-square value = 2.02 shows that there is no significant difference of association between responses and years having P = 0.15 > 0.05 (Table-20)

Part-II Supportive findings of private organizations (NGO's) staff tables-18, 19 and 20 verifying the 3rd hypothesis.

Pearson Chi-square value = 0.19 shows that there is no significant difference of association between responses and years having P = 0.65 > 0.05 (Table-18)

Pearson Chi-square value = 0.13 indicates that there is significant difference of association between responses and years having P = 0.70 > 0.05 (Table-19)

Pearson Chi-square value = 3.07 shows that there is no significant difference of association between responses and years having P = 0.07 > 0.05 (Table-20)

Part-III Supportive findings of family planning beneficiaries tables-25, 26, 27, 28, 29 and 30 verifying the 3rd hypothesis.

Pearson Chi-square value = 0.73 shows that there is no significant difference of association between responses and years having P = 0.39 > 0.05 (Table-25)

Pearson Chi-square value = 1.93 highlights that there is significant difference of association between responses and years having P = 0.16 > 0.05 (Table-26)

Pearson Chi-square value = 1.01 shows that there is no significant difference of association between responses and years having P = 0.31 > 0.05 (Table-27)

Pearson Chi-square value = 3.09 depicts that there is no significant difference of association between responses and years having P = 0.07 > 0.05 (Table-28)

Pearson Chi-square value = 2.18 shows that there is no significant difference of association between responses and years having P = 0.14 > 0.05 (Table-29)

Pearson Chi-square value = 8.70 indicates that there is no significant difference of association between responses and years having P = 0.03 < 0.05 (Table-30)

On the basis of the above supportive findings of Public & private sector organizations staff as well as beneficiaries of these organizations and Chi-square value testing, The 3rd Hypothesis is proved true.

IV. Better the Mother-Child Health Care Program Better would be the result and strategies.

Part-I Supportive findings of public organizations staff tables-21, 22,23,24 and 25 verifying the 4th hypothesis.

Pearson Chi-square value = 1.00 shows that there is no significant difference of association between responses and years having P = 0.31 > 0.05 (Table-21)

Pearson Chi-square value = 2.78 highlights that there is significant difference of association between responses and years having P = 0.09 > 0.05 (Table-22)

Pearson Chi-square value = 0.34 shows that there is no significant difference of association between responses and years having P = 0.55 > 0.05 (Table-23)

Pearson Chi-square value = 1.02 indicates that there is no significant difference of association between responses and years having P = 0.31 > 0.05 (Table-24)

Pearson Chi-square value = 1.00 shows that there is no significant difference of association between responses and years having P = 0.31 > 0.05 (Table-25)

Part-II Supportive findings of private organizations (NGO's) staff tables-21, 22, 23, 24 and 25 verifying the 4th hypothesis.

Pearson Chi-square value = 2.03 shows that there is no significant difference of association between responses and years having P = 0.15 > 0.05 (Table-21)

Pearson Chi-square value = 2.80 indicates that there is significant difference of association between responses and years having P = 0.09 > 0.05 (Table-22)

Pearson Chi-square value = 0.03 shows that there is no significant difference of association between responses and years having P = 0.30 > 0.05 (Table-23)

Pearson Chi-square value = 1.00 highlights that there is no significant difference of association between responses and years having P = 0.31 > 0.05 (Table-24)

Pearson Chi-square value = 2.03 shows that there is no significant difference of association between responses and years having P = 0.15 > 0.05 (Table-25)

Part-III Supportive findings of family planning beneficiaries' tables-31, 32, 33, 34 and 35 verifying the 4th hypothesis.

Pearson Chi-square value = 4.02 shows that there is significant difference of association between responses and years having P = 0.04 < 0.05 (Table-31)

Pearson Chi-square value = 3.50 indicates that there is significant difference of association between responses and years having P = 0.06 > 0.05 (Table-32)

Pearson Chi-square value = 6.67 shows that there is significant difference of association between responses and years having P = 0.01 < 0.05 (Table-33)

Pearson Chi-square value = 6.78 highlights that there is no significant difference of association between responses and years having P = 0.09 > 0.05 (Table-34)

Pearson Chi-square value = 11.11 shows that there is significant difference of association between responses and years having P = 0.01 < 0.05 (Table-35)

On the basis of the above supportive findings of Public & private sector organizations staff as well as beneficiaries of these organizations and Chi-square value testing, The 4th Hypothesis is proved true.

V. Higher the existence (Causes) of large size family problem, Higher would be the acceleration in the role / strategies of family planning organizations.

Part-I Supportive findings of public organizations staff tables-26, 27, 28,29, 30 and 31 are verifying the 5th hypothesis.

Pearson Chi-square value = 4.11 shows that there is significant difference of association between responses and years having P = 0.04 < 0.05 (Table-26)

Pearson Chi-square value = 0.18 indicates that there is significant difference of association between responses and years having P = 0.66 > 0.05 (Table-27)

Pearson Chi-square value = 0.36 shows that there is no significant difference of association between responses and years having P = 0.54 > 0.05 (Table-28)

Pearson Chi-square value = 4.11 depicts that there is significant difference of association between responses and years having P = 0.04 < 0.05 (Table-29)

Pearson Chi-square value = 4.11 shows that there is significant difference of association between responses and years having P = 0.04 < 0.05 (Table-30)

Pearson Chi-square value = 4.11 highlights that there is significant difference of association between responses and years having P = 0.04 < 0.05 (Table-31)

Part-II Supportive findings of private organizations (NGO's) staff tables-26, 27, 28, 29, 30 and 31 verifying the 5th hypothesis.

Pearson Chi-square value = 5.21 shows that there is significant difference of association between responses and years having P = 0.02 < 0.05 (Table-26)

Pearson Chi-square value = 0.43 indicates that there is significant difference of association between responses and years having P = 0.51 > 0.05 (Table-27)

Pearson Chi-square value = 0.37 shows that there is no significant difference of association between responses and years having P = 0.54 > 0.05 (Table-28)

Pearson Chi-square value = 5.21 highlights that there is significant difference of association between responses and years having P = 0.02 < 0.05 (Table-29)

Pearson Chi-square value = 5.21 shows that there is significant difference of association between responses and years having P = 0.02 < 0.05 (Table-30)

Pearson Chi-square value = 5.21 indicates that there is significant difference of association between responses and years having P = 0.02 < 0.05 (Table-31)

Part-III Supportive findings of family planning beneficiaries' tables-36, 37, 38, 39, 40 and 41 verifying the 5th hypothesis.

Pearson Chi-square value = 2.18 shows that there is significant difference of association between responses and years having P = 0.14 > 0.05 (Table-36)

Pearson Chi-square value = 1.06 highlights that there is significant difference of association between responses and years having P = 0.30 > 0.05 (Table-37)

Pearson Chi-square value = 4.12 shows that there is significant difference of association between responses and years having P = 0.04 < 0.05 (Table-38)

Pearson Chi-square value = 2.67 depicts that there is no significant difference of association between responses and years having P = 0.10 > 0.05 (Table-39)

Pearson Chi-square value = 1.89 shows that there is no significant difference of association between responses and years having P = 0.16 > 0.05 (Table-40)

Pearson Chi-square value = 1.04 highlights that there is no significant difference of association between responses and years having P = 0.30 > 0.05 (Table-41)

On the basis of the above supportive findings of Public & private sector organizations staff as well as beneficiaries of these organization, and Chi-square value testing, The 5th Hypothesis stands valid.

VI. Higher the Constraints and Shortcomings in family Planning, Higher would be the struggle and Strategies to overcome them.

Part-I Supportive findings of public organizations staff tables-32, 33,34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47 and 48 verifying the 6th hypothesis.

Pearson Chi-square value = 0.69 shows that there is no significant difference of association between responses and years having P = 0.40 > 0.05 (Table-32)

Pearson Chi-square value = 0.20 indicates that there is significant difference of association between responses and years having P = 0.64 > 0.05 (Table-33)

Pearson Chi-square value = 1.86 shows that there is no significant difference of association between responses and years having P = 0.17 > 0.05 (Table-34)

Pearson Chi-square value = 5.83 highlights that there is no significant difference of association between responses and years having P = 0.01 < 0.05 (Table-35)

Pearson Chi-square value = 4.11 shows that there is no significant difference of association between responses and years having P = 0.02 < 0.05 (Table-36)

Pearson Chi-square value = 2.02 depicts that there is no significant difference of association between responses and years having P = 0.15 > 0.05 (Table-37)

Pearson Chi-square value = 0.02 shows that there is no significant difference of association between responses and years having P = 0.86 > 0.05 (Table-38)

Pearson Chi-square value = 0.11 shows that there is significant difference of association between responses and years having P = 0.73 > 0.05 (Table-39)

Pearson Chi-square value = 0.04 indicates that there is no significant difference of association between responses and years having P = 0.84 > 0.05 (Table-40)

Pearson Chi-square value = 1.02 shows that there is no significant difference of association between responses and years having P = 0.31 > 0.05 (Table-41)

Pearson Chi-square value = 0.09 highlights that there is no significant difference of association between responses and years having P = 0.75 > 0.05 (Table-42)

Pearson Chi-square value = 1.02 shows that there is no significant difference of association between responses and years having P = 0.31 > 0.05 (Table-43)

Pearson Chi-square value = 0.34 depicts that there is no significant difference of association between responses and years having P = 0.55 > 0.05 (Table-44)

Pearson Chi-square value = 0.03 shows that there is no significant difference of association between responses and years having P = 0.84 > 0.05 (Table-45)

Pearson Chi-square value = 12.66 highlights that there is significant difference of association between responses and years having P = 0.00 < 0.05 (Table-46)

Pearson Chi-square value = 1.02 shows that there is no significant difference of association between responses and years having P = 0.31 > 0.05 (Table-47)

Pearson Chi-square value = 0.69 indicates that there is no significant difference of association between responses and years having P = 0.40 > 0.05 (Table-48)

Part-II Supportive findings of private organizations (NGO's) staff tables-32, 33,34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47 and 48 verifying the 6th hypothesis.

Pearson Chi-square value = 0.34 shows that there is no significant difference of association between responses and years having P = 0.55 > 0.05 (Table-32)

Pearson Chi-square value = 0.77 highlights that there is significant difference of association between responses and years having P = 0.37 > 0.05 (Table-33)

Pearson Chi-square value = 3.79 shows that there is no significant difference of association between responses and years having P = 0.051 > 0.05 (Table-34)

Pearson Chi-square value = 6.31 indicates that there is no significant difference of association between responses and years having P = 0.01 < 0.05 (Table-35)

Pearson Chi-square value = 5.21 shows that there is no significant difference of association between responses and years having P = 0.02 < 0.05 (Table-36)

Pearson Chi-square value = 3.07 highlights that there is no significant difference of association between responses and years having P = 0.07 > 0.05 (Table-37)

Pearson Chi-square value = 0.14 shows that there is no significant difference of association between responses and years having P = 0.70 > 0.05 (Table-38)

Pearson Chi-square value = 0.31 indicates that there is significant difference of association between responses and years having P = 0.57 > 0.05 (Table-39)

Pearson Chi-square value = 0.37 shows that there is no significant difference of association between responses and years having P = 0.54 > 0.05 (Table-40)

Pearson Chi-square value = 0.34 highlights that there is no significant difference of association between responses and years having P = 0.55 > 0.05 (Table-41)

Pearson Chi-square value = 0.34 shows that there is no significant difference of association between responses and years having P = 0.55 > 0.05 (Table-42)

Pearson Chi-square value = 0.34 depicts that there is no significant difference of association between responses and years having P = 0.55 > 0.05 (Table-43)

Pearson Chi-square value = 1.03 shows that there is no significant difference of association between responses and years having P = 0.30 > 0.05 (Table-44)

Pearson Chi-square value = 1.36 indicates that there is no significant difference of association between responses and years having P = 0.24 > 0.05 (Table-45)

Pearson Chi-square value = 42.34 shows that there is significant difference of association between responses and years having P = 0.0 < 0.05 (Table-46)

Pearson Chi-square value = 0.34 highlights that there is no significant difference of association between responses and years having P = 0.55 > 0.05 (Table-47)

Pearson Chi-square value = 1.36 shows that there is no significant difference of association between responses and years having P = 0.24 > 0.05 (Table-48)

Part-III Supportive findings of family planning beneficiaries' tables-42, 43, 44, 45, 46, 47, 48,49, 50, 51,52, 53, 54, 55, 56, 57 and 58 are verifying the 6th hypothesis.

Pearson Chi-square value = 12.00 shows that there is no significant difference of association between responses and years having P = 0.00 < 0.05 (Table-42)

Pearson Chi-square value = 2.01 indicates that there is significant difference of association between responses and years having P = 0.15 > 0.05 (Table-43)

Pearson Chi-square value = 7.24 shows that there is no significant difference of association between responses and years having P = 0.00 < 0.05 (Table-44)

Pearson Chi-square value = 48.07 highlights that there is no significant difference of association between responses and years having P = 0.00 < 0.05 (Table-45)

Pearson Chi-square value = 4.11 shows that there is significant difference of association between responses and years having P = 0.04 < 0.05 (Table-46)

Pearson Chi-square value = 1.70 indicates that there is no significant difference of association between responses and years having P = 0.19 > 0.05 (Table-47)

Pearson Chi-square value = 0.24 shows that there is no significant difference of association between responses and years having P = 0.62 > 0.05 (Table-48)

Pearson Chi-square value = 0.16 highlights that there is significant difference of association between responses and years having P = 0.68 > 0.05 (Table-49)

Pearson Chi-square value = 0.24 shows that there is no significant difference of association between responses and years having P = 0.61 > 0.05 (Table-50)

Pearson Chi-square value = 0.60 highlights that there is no significant difference of association between responses and years having P = 0.43 > 0.05 (Table-51)

Pearson Chi-square value = 0.47 shows that there is no significant difference of association between responses and years having P = 0.49 < 0.05 (Table-52)

Pearson Chi-square value = 0.62 indicates that there is no significant difference of association between responses and years having P = 0.42 > 0.05 (Table-53)

Pearson Chi-square value = 0.40 shows that there is no significant difference of association between responses and years having P = 0.06 > 0.05 (Table-54)

Pearson Chi-square value = 6.99 depicts that there is no significant difference of association between responses and years having P = 0.00 < 0.05 (Table-55)

Pearson Chi-square value = 244.86 shows that there is significant difference of association between responses and years having P = 0.00 < 0.05 (Table-56)

Pearson Chi-square value = 0.75 indicates that there is no significant difference of association between responses and years having P = 0.38 > 0.05 (Table-57)

Pearson Chi-square value = 1.06 shows that there is no significant difference of association between responses and years having P = 0.30 > 0.05 (Table-58)

On the basis of the above supportive findings of Public & private sector organizations staff as well as beneficiaries of these organizations and Chi-square value testing, The 6th Hypothesis is valid.

5.3 Conclusion:

This study is focusing on the role of public and private organizations in population control. The government population department and NGO's staff related to family planning / population control were contacted. According to the respondents, there are some constraints to family planning program. These organizations have got success in recent periods by minimizing the fertility rates and family size, but more is needed to be done in the near future to control the higher population in the rural areas of Pakistan.

The study indicates that majority of the staff were having 0-1 children each male and female while majority of the beneficiaries were having 2-3 children each male and female. According to the respondents, educated people were easily adopting family planning, while uneducated were very slow in this regard. Thus education plays a vital role in the adoption of family planning, but some of the respondents also mentioned that if the family planning service providers properly motivate and educate the uneducated respondents then the results would be positive.

The study indicates that there were different sources of awareness about family planning, but most of the respondents specified that family planning staff and literature, TV, radio, relatives, friends, husband and wife were the best successful and major sources of awareness about family planning. They mentioned about Seminars, Workshops, Conferences, Wall Chalking, Banners, signboards, newspapers and magazines as the minor sources of awareness and popularization of family planning.

The common problems in awareness were ignorance, improper communication, and various constraints to family planning. The strategies adopted by family planning organizations to overcome these problems were women education, improvement in communication and solution of constraints to family planning.

There was scarcity of required facilities and staff. The functions were awareness, counseling, motivation, provision of contraceptives, treatment, checkup, medicines, door to door service, camps, mobile service, reproductive and mother-child health care etc.

The different contraceptives introduced and practiced were traditional (withdrawal), condom, vasectomy (male operation), oral pills (female tablets), injectables, tub legation/sterilization (female operation) and Multi Load/Copper-T/ IUD (female contraceptive).

The major reasons for using a specific method were no/less side effects, convenient, more effective and less costly, while the major reasons for not using a specific method were side effects, not effective and more costly. The major sources of contraceptives were the family planning organizations centers and mobile units, but some of them specified that private medical store, general store, doctor, practitioner as the minor sources to get Contraceptives.

The various side effects of contraceptives were infection, irregular menses, weight gain, swelling, temperature, headache, vomiting, no appetite and psychological problem. The different problems were no care, proper usage and follow up by the clients/patients, no proper treatment and guidance by service providers. The strategies were counseling and

motivation for proper usage, receiving feed back from client/patient, Proper treatment, cleanliness, change the method and preventive medicines.

Family planning also takes care of mother and child health. The mother health care includes counseling in antenatal/postnatal, check-up, treatment, and vaccination on due time and balance diet. The child health Care includes before, during and after delivery care, vaccination on due time, immunization, and breast feeding and additional nutrition. Mother-child health care program is resulting to proper health protection of mother-child, safe delivery and trust on family planning organization's centers. The confronting problems in mother-child health care were varies constraints to mother-child health care, (ignorance, no health awareness, low socio-economic status, no proper treatment, checkup, doctor and medicine) and various constraints to family planning (economic, socio-cultural, religious, psychological, medical- technical, quality of service etc.). The strategies of family planning organization's centers were solution to various constraints to mother-child health care and family planning.

There was large size of the family tradition in the target area, only a few cases were found with small size of family. The major causes of large size family were early marriage (13-22 years), number of marriage/ polygamy, desire for maximum male children, high fertility and fecundity (sons are guns, power, prestige, dominant, property inheritance, income source, help in old age, socio-psychological protection etc.) and various constraints to family planning (Economic/poverty, religious, socio cultural, govt. / political, medical -technical, quality of service etc). The strategies of family planning organization's centers include counseling and motivation for small family, contraceptives provision, large family economic burden, to avoid early marriage and maximum children, son and daughter are equal, proper checkup, treatment, prescription, medicines, community meetings/home visits, proper family planning awareness and solution of FP constraints.

There were different types of constraints to family planning, including economic (Poverty, no sources of income & employment, high expenses of the family, expensive medicines, infrastructure, building, equipments, treatment, tests equipments and budget), religious (it is sin, killing of humanity, illegitimate, against natural law, fatalism, Allah is food provider, no one can stop those souls to be produced, increase the number of Muslims, it results in immorality, it is the plan of non Muslims), socio-cultural; desire for maximum male children (Sons are guns, power, prestige, property inheritance, dominance, income source, helping hand in old age, socio psychological protection etc), FP disapproval by

husband and in laws, women can not go out of home (Pardah), shyness and no decision by women, early marriage, wrong propaganda, negative public opinion, political / government (no proper funds allocation, based on foreign aid and Policy change), psychological (worry of side effects of contraceptives/ medicines, conception and infertility), medical-technical; health problems (irregularity of menses/bleeding, pregnancy problems, weight, swelling, weakness, no hepatize, vomiting, giddiness, headache etc), no family planning and health awareness, motivation, follow up, fear from taking medicine/ contraceptives due to side effects, no proper trained staff, equipments, medicine, checkup, treatment, diagnosing (tests), quality of service; lack/no proper budget, involvement of health outlets, full coverage, outreach, information, supervision, monitoring and evaluation, strategy change, low quality contraceptives, questionable and no proper services, less satisfaction, non-availability of service at doorstep, lack of male involvement, no proper infrastructure & building, lack of proper trained and qualified staff.

The strategies of family planning organization's centers to overcome these constraints include: for economic; free counseling, checkup, treatment, natural gap by breast feeding, foreign aid support, nominal charges and company rate contraceptives, for religious; meeting and consulting the religious leaders (Ulema Project), motivation, awareness, counseling and convincing religious people, Collection of different religious statements (fatwas) and religious literature distribution in favor of family planning, for socio-cultural; small family norms, small family better life, two kids are better, son and daughter are equal ,maximize gap through motivation, avoid early marriage and polygamy, women empowerment and giving the example of developed nation girls to reduce desire for male children, for political-governmental; struggle to continue, getting support of the Govt. / Foreign donors and collaboration of public and private sector, for psychological and medical-technical; counseling, motivation, awareness for proper usage, change of contraceptive, reduce fear of side effects, Proper check-up, treatment, medicine and prescription, and for quality service; foreign assistance, proper awareness about contraceptives, doorstep mobile service units etc.

Recently family planning organizations have started combined seminars, workshops and strategies as linkage program among Govt., NGOs & community. It means combined linkage family planning program among Govt., NGO'S & community is a recent development.

There were various weaknesses and shortcomings in family planning including; no proper communication, awareness and education programme, various constraints to family planning, large family, side effects of contraceptives, no proper policy, planning, research, strategy, no involvement of religious leader, male members, media, related departments, health outlets, district government and welfare organizations. To overcome these weaknesses and shortcomings family planning organizations developed certain strategies include; involving media, district government, religious leaders, enlightened vision, proper counseling, motivation and communication through proper, qualified, trained staff and establishment of more family planning organizations.

5.4 Recommendations:

On the basis of study findings and conclusion the researcher extends certain recommendations as follows:

I. **Improvement in Awareness and Communication of FP:** The study shows that all of the sources of awareness and communication of family planning in both the sectors were not effective in this regard it is recommended discussion and views of population experts and religious scholars should be telecast on TV. Internet should also be used for this purpose. Properly trained staff should be recruited to accelerate the information and service delivery. The literature should be in native language and easily understandable. There should be joint monthly program of seminars, workshops and conferences on different population and family planning issues.

II. **Improvement in facilities, functions, performances and Contraceptives:** The existing facilities in family planning organization's centers are not enough, More over, the quality and quantity of contraceptives are meager, in order to improve the performance and functions of family planning organization's centers and staff for better implementation of family planning in the area, it is recommended that the required facilities should be provided to the existing centers, centers should be established through proper planning on need basis, proper staff should be recruited, proper monitoring and evaluation system should exist, efficient mobile service should exist, proper motivation and counseling can raise the ratio of contraceptives usage and can eliminate the worries of side effects of contraceptives and contraceptives should be available at door step to the clients.

III. Reducing the side effects of contraceptives and improving mother-child health: The study highlights that there were some of the side effect of contraceptives, which impedes of family planning adoptability. It is suggested that family planning should be considered the mother-child health problem, proper usage of contraceptives, change of contraceptive, proper treatment & check-up by proper staff can reduce the side effects of contraceptive.

To improve the mother-child health care, For mother; proper antenatal & postnatal care, proper check-up & treatment, in time vaccination, balance diet to mother and home visits by staff are recommended For child; Check-up before, during and after delivery, immunization & in time vaccination, breast feeding and additional nutrition to child are recommended.

IV. Solution of large size family problem: During this study it was noticed that there is the tradition of large size family, every respondent was desiring more children in general and male children in particular, this is the main reason of higher population, which compels the management of family planning to expedite their activities. To create small family norm in the area, it is suggested that proper awareness & motivation for small family, maximum children economic burden, registration of new born in family, to avoid early marriage & polygamy, proper usage of contraceptives and solution to the family planning constraints and education can play a tremendous role in minimizing the size of family.

V. Solution of Various Constraints and weaknesses in Family Planning: Family planning is not acceptable to every body, because of various constraints and weaknesses in it. The following suggestions are extended to overcome these constraints, free counseling, motivation, check-up, treatment, medicines, natural gap by breast feeding and company rate contraceptives provision can solve the economic constraints.

Meetings with religious leaders for proper understanding of religion, supportive statements (fatwas), message of change and best quality of life can solve the religious constraints.

Proper motivation, awareness and counseling for small family norms, save the life of mother-child, equality of son and daughter, proper socialization (education) of children, avoiding early marriage, positive propagation and public opinion can solve the socio-cultural constraints.

Foreign donors' interest, support and collaboration of public and private sector can solve the political and governmental constraints.

Proper counseling to reduce the fear of side effects of contraceptives, preparing for adoption of family planning through proper motivation, skill provision for Proper usage and change of contraceptive, proper check-up, treatment, preventive medicines & measures can reduce the psychological constraints.

Proper awareness and counseling about contraceptives use, proper service through well equipped & trained staff, proper usage of contraceptives & medicines, multi vitamins, iron tablets and balanced diet can solve the medical-technical constraints.

Proper supervision, monitoring & evaluation, budget arrangement, qualified & trained staff, male mobilization, communication, information, awareness, counseling & motivation for family planning, best quality contraceptives provision, and door step service through mobile service unit can improve the quality of service.

In order to overcome the weaknesses and shortcomings of family planning these measures are recommended; combined seminars, workshops, public-private partnership, proper awareness, counseling, motivation, communication and popularization program, involvement of media, religious leaders, and district government, establishment of more family planning organizations, recruitment of proper staff, involvement of health and education departments, women education, family planning education and enlightened vision should be given to the masses.

VI. Improvement in CBD Model: The CBD model has certain limitations; it is not applicable in every culture and religion, similarly. In Muslim World it is necessary to take religious leaders, moralists, local leaders and elders of the society in confidence, then the intervention to the community will be easy and fruitful. The Model needs to have the women education a component in it.

VII. Recommendations for Further Studies: After this research study the researcher feels to recommend the following area for further detail study:

a. Islam and birth control.
b. Socio-Cultural and Economic Obstacles to Family Planning.
c. Problems and Prospects of Reproductive and Mother-child Health Care in Pakistan
d. Women Education and Family Planning
e. Women Empowerment and Family Planning.
f. Analysis of Population Policy in Pakistan
g. Women Health and Higher Fertility in Pakistan
h. Assessment of Reproductive Health Units in Pakistan

i. Population and Environmental Degradation

j. Population and Unemployment

k. Population and Millennium Development Goals

l. Optimum allocation of Resources and Population

APPENDIX-A

MODEL QUESTIONNAIRES / INTERVIEW SCHEDULES

Part-I

QUESTIONNAIRE/ INTERVIEW SCHEDULE FOR PUBLIC ORGANIZATIONS (RHS-As & FWCs) Staff

Name of Organization: _____

Date of Interview: _____

Note: Please mark the correct option by (✓) & incorrect by (X) in both the Responses Columns for 1999 & 2003, after filling the Bio-data/ Personal Particulars.

Personal Bio-data of Govt. Staff at FWC'S/RHS-A

Particulars of Respondent	Responses
Name of Respondent	
Age	
Sex/Gender	
Qualification	
Profession/Occupation	
Monthly Income	

A. Number of Children:

Number of Children	1999	2003
	Responses	Responses
Male Children: a. 0-1 b. 2-3 c. 4 <		
Female Children: a. 0-1 b. 2-3 c. 4 <		

B. Educational Status & Practice/ Adoption of F.P.

Educational Status	Practice/ Adoption of F.P.	
	1999	2003
	Responses	Responses
a. Uneducated		
b. Educated		

C. Source of Awareness, Advertisement and Popularization of Family Planning

Sources Of Awareness, Advertisement and Popularization of FP.	1999	2003
	Responses	Responses
a. Major: TV, Radio, Friends, Relatives, Husband, Wife, Family Planning Staff and Literature		
b. Minor: Wall Chalking, Banner, Sign Board, Seminars, Workshops, Conferences, News Papers and Magazines		

D. Problems Faced During Awareness, Communication and Popularization of Family Planning & Strategies of FWCs and RHS-A.

Specification	1999	2003
Problems	**Responses**	**Responses**
a. Various constraints to Health (Ignorance, Improper way of communication). b. Various constraints in FP.(Eco-Socio-Cultural, Religious, Psychological, Medical / Technical, Quality of Service etc)		
Strategies	**Responses**	**Responses**
a. Women Education, Improvement in communication and Solution of constraints to FP.		

E. Problems, Functions and Facilities in FWCs and RHS-As.

Specification	1999	2003
	Responses	**Responses**
a. Problems in FWCs and RHS-As: b. Informative Functions: (Counseling, Awareness, Motivation for FP, mobile service). c. Curative Functions: (Provision of Contraceptives, Treatment, Check up, and Medicines)		

F. Problems and Role of FWW, LHW and LHV

Specification of Problems	1999	2003
	Responses	**Responses**
No visit to home, Absent and Take charges in clinic		
Role FWW, LHW and LHV:	**Responses**	**Responses**
Motivation, Counseling, Convincing for FP, Checkup, Treatment, medicines and Contraceptives Provision.		

G. Various Contraceptives / F.P Methods Introduced, Quantity used (P.A. Per Individual) & Per Unit Cost:

Contraceptive	Quantity	Cost in Rupees	1999	2003
Male:	Used	**Per Unit Cost**	**Responses**	**Responses**
a. Withdrawal b. Condom c. Vasectomy	50-100 50-100 Once	Free 1Dozen=Rs:6/- Free		
Female:	Used	**Per Unit Cost**	**Responses**	**Responses**
a. Oral pills b. Injection: i. Nurajest (2 months) ii. Majestron/Depo(3 months) c. Sterilization/ Tub legation d. Multi Load/ Copper-T/IUCD	11 Strips 6 Injects 4 Injects Once 01(5-10Y)	01 strip=Rs: 3/- 01injection=Rs: 3/ 01Injection=Rs:3/ Free Free/ 01=Rs:3/-		

H. Reasons for using and not using a specific method?

Reasons	1999	2003
	Responses	**Responses**
a. For Using: No Side effects, Convenient, More effective and Less costly		
b. For Not Using: Side effects, Permanent, Not effective and Costly		

I. Sources to get contraceptives

Sources	1999	2003
	Responses	Responses
a. Family Planning Organizations Centers and MSU.		
b. Private Medical store, General store and Doctor		

J. Specification of Side effects of Contraceptives and Strategies of FWC for Prevention:

Specification	1999	2003
	Responses	Responses
Irregular Menses, Weight, Temperature, Headache, Vomiting, No Hepatize and Psychological problem		
Strategies of Family planning Organizations for prevention:	**Responses**	**Responses**
Counseling for Proper usage of contraceptives, Change The Method, Contraceptive, Proper Treatment and preventive measures		

K. Problems in Reducing the side effects of Contraceptives & Strategies of the FWC'S/ RHS-A'S.

Specification	1999	2003
Problems	**Responses**	**Responses**
a. No care, Proper Usage & follow up by the Clients / patients b. No Proper Treatment, Usage Skill, medicines Provision by service providers		
Strategies	**Responses**	**Responses**
a. Counseling & Motivation for proper usage and receiving feed back from clients/ patients. b. Proper treatment, cleanliness, Change the method, Preventive Medicine/ Measures		

L. Mother-Child Health Care Programme Specification

Specification	1999	2003
Mother Health Care	**Responses**	**Responses**
Counseling, Antenatal, Post Natal, Treatment, Vaccination and Balance Diet		
Child Health Care	**Responses**	**Responses**
Before, During, and after Delivery Immunization Breast Feeding and Nutrition		

M. Results of Mother Child Health Care Programme

Results/Effects	1999	2003
	Responses	Responses
a. Proper Health Protection, Safe Delivery and Trust on MCHC of FP.		

N. **Problems in Mother -Child Health Care & Strategies of FWCs and RHS-As**

Specification	1999	2003
Problems	**Responses**	**Responses**
a. Various constraints to MCHC. (Ignorance, No proper treatment, check up and medicines) *b. Various constraints to FP.* (Eco-Socio-Cultural, Religious, Psychological, Medical-technical, Quality of Service).		
Strategies	**Responses**	**Responses**
a. Solution to Various constraints in MCHC. (Health Education, Counseling, Proper treatment, check up, medicines and MSU) ***b. Solution to Various constraints in FP.*** (Free counseling, treatment, medicines, Meetings with Religious Leaders, Solution of Psychological Worries, Solution to side effects, Quality of Service).		

O. **Size of Family, Reasons of Large Family & Role of FWCs and RHS-A.**

Specification of Family Size	1999	2003
	Responses	**Responses**
a. Large Family size b. Small Family Size		
Reasons of Large Family:	**Responses**	**Responses**
i. Age at the time of Marriage/Early Marriage a.13-22 Years b.23-32 Years **ii. Number of Marriage/s./ Polygamy** a. One /Single. b. Two /Double & Three/ Triple **iii. Desire for Maximum Male Children:** (Sons are power, prestige, source of income, helping hand in old age, socio-psychological protection, Male dominancy & Inheritance of property.) **iv. Various Constraints to FP:** (Eco- /Poverty /Religious/ Socio-Cultural/ Govt. Political/ Medical-Technical/Quality of Service)		
Role of FWCs and RHS-As	**Responses**	**Responses**
a. Informative; Motivation for small family, Avoid Early Marriage, Max Children, Son & Daughter are Equal and solution of constraints. b. Curative; Proper Check up, Treatment, Medicines.		

P. **Various Constraints to family Planning**

i. **Economic / Financial Constraints in F.P & Role of FWCs and RHS-A.**

Specification	1999	2003
A- Economic / Financial Constraints	**Responses**	**Responses**
Poverty, No Income and Employment, Expenses of the family, No Infrastructure, Building, Equipments, treatment, medicines and Budget.		
B- Role of FWCs and RHS-As.	**Responses**	**Responses**
Free Counseling, Checkup, Treatment, Natural gap by Breast feeding, Foreign Aid Support and Company Rate contraceptives		

ii. **Religious Constraints in F.P & Role of FWCs and RHS-As.**

Specification	1999	2003
A- Religious constraints	**Responses**	**Responses**
It is Sin, Killing of Humanity, Illegitimate, Against Natural Law, Fatalism, Allah is Food Provider, No one can stop those Souls to be produced, Increase Muslims, Immoral and It is the Plan of Non-Muslims.		
B- Role of FWCs and RHS-As.	**Responses**	**Responses**
a. Meeting and Consultation with Religious Leaders (Ulama Project), Collection of Different Statements/ Fatwas/Religious literature distribution in favor of FP.		

iii. **Socio- Cultural Constraints in F.P and Role of FWCs and RHS-As.**

Specification	1999	2003
A- Socio- Cultural Constraints	**Responses**	**Responses**
Desire for Maximum male Children (Sons are power, prestige, Inheritance of Property, Psychological & social protection, Dominancy, Source of Income, Helping hand in Old age). **No Acceptance;** (Disapproval by Husband & In-laws Purda, No power of women, Negative public opinion, Wrong propaganda, Early Marriage & Polygamy).		
B- Role of FWCs and RHS-As.	**Responses**	**Responses**
Small Family Norms, Two kids are better, Son & Daughter are equal, Maximize Gap, Avoid Early Marriage, Women Empowerment.		

iv. **Govt. / Political Constraints in F.P and Role of FWCs and RHS-As.**

Specification	1999	2003
A. Govt. / Political Constraints in F P	**Responses**	**Responses**
No Proper Funds Allocation and Policy change		
B- Role of FWs and RHS-As.	**Responses**	**Responses**
Struggle to continue, Getting Support of Govt. And Collaboration of Public & Private Sectors.		

v. **Psychological Constraints in FP. & Role of FWCs and RHS-As.**

Specification	1999	2003
A- Psychological Complaint/ Constraints	**Responses**	**Responses**
Worry of Side Effects of Contraceptives / Medicines, Conception and Infertility		
B- Role of FWCs and RHS-As	**Responses**	**Responses**
Motivation, Awareness & Counseling for Proper usage/ Change of contraceptives and Check up, treatment and medicine		

vi. **Medical-Technical Constraints in FP. & Role of FWCs and RHS-A.**

Specification	1999	2003
A- Medical & Technical Constraints	**Responses**	**Responses**
Fear from taking medicines/ Contraceptives due to side effects, No trained staff, equipments, medicines, Check up and treatment.		
B- Role of FWCs and RHS-As.	**Responses**	**Responses**
Motivation, Awareness & Counseling for Proper usage/ Change of contraceptives, Proper check-up, treatment and medicines.		

vii. Quality of Service Constraints in FP. & Role of FWCs and RHS-A.

Specification	1999	2003
A- Quality of Service Constraints	**Responses**	**Responses**
No Budget, involvement of health outlets, coverage, out reach, Supervision, monitoring, Strategy change, Quality contraceptives, Questionable, Less satisfaction, Male Involvement, and Trained Staff.		
B- Role of FWCs and RHS-A.	**Responses**	**Responses**
Budget on foreign Assistance, Supervision, Monitoring, Trained Staff, and Male staff Involvement, Contraceptive provision and MSU.		

Q. Linkage program among Govt., NGOs and Community.

Linkage programmes	1999	2003
	Responses	**Responses**
Combined seminars, workshops and Combined Strategies		

R. Weaknesses and Shortcomings in implementation of FP.

Weaknesses/Short comings	1999	2003
	Responses	**Responses**
Side Effects of Contraceptives, No proper Policy, Planning, Research, Strategy, Involvement of Religious Leader, Male interest, Awareness & Education program about FP, Various constraints to FP, No Role of Media, Related Departments, district Govt. and Welfare Organizations/ CBOs etc.		
Suggestions/Strategies	**Responses**	**Responses**
Role of Media, Dist. Govt., Religious Leaders, FP Education, Awareness, Enlightened Vision, Counseling, Motivation & Communication Program of FP, Trained Staff & Establishment of more family planning organizations		

Part-II

QUESTIONNAIRE / INTERVIEW SCHEDULE FOR PRIVATE ORGANIZATIONS (RHS-Bs & FHCs) STAFF OF ROKHANA KOR, MSS, FPHC AND SWWS

Name of Organization:_____

Date of Interview: _____

Note: Please mark the correct option by (✓) & incorrect by (X) in both the Responses Columns for 1999 & 2003, after filling the Bio-data/ Personal Particulars.

Personal Bio-data of NGO's Staff at FHC'S/RHS-B's

Particulars of Respondent	Responses
Name of Respondent	
Age	
Sex/Gender	
Qualification	
Profession/Occupation	
Monthly Income	

A. Number of Children:

Number of Children	1999	2003
	Responses	Responses
Male Children: a. 0-1 b. 2-3 c. 4 <		
Female Children: a. 0-1 b. 2-3 c. 4 <		

B. Educational Status & Practice/ Adoption of F.P.

Educational Status	Adoption of F.P	
	1999	2003
	Responses	Responses
a. Uneducated		
b. Educated		

C. Source of Awareness, Advertisement and Popularization of Family Planning

Sources	1999	2003
	Responses	Responses
a. Major: TV, Radio, Friends, Relatives, Husband, Wife, Family Planning Staff and Literature		
b. Minor: Wall Chalking, Banner, Sign Board, Seminars, Workshops, Conferences, News Papers and Magazines		

D. Problems faced during awareness, communication and popularization of Family Planning and Strategies of the FHCs and RHS-B

Specification	1999	2003
Problems	Responses	Responses
Ignorance (Women), Improper way of communication and Various constraints in FP.		
Strategies	Responses	Responses
Women Education, Improvement in communication and Solution of constraints.		

E. Problems, Functions and Facilities in FHCs and RHS-B

Specification	1999	2003
	Responses	Responses
a. Problems in FHC's and RHS-B's: b. Informative Functions: Counseling, Awareness, and Motivation for FP. c. Curative Functions: Provision of Contraceptives, Treatment, Check up, Medicines and MSU.		

F. Problems and Role of FWW, LHW and LHV

Specification of Problems	1999	2003
	Responses	Responses
No visit to home, Absent and Take charges in clinic		
Role FWW, LHW and LHV:	**Responses**	**Responses**
Motivation, Counseling, Convincing for FP, Checkup, Treatment, medicines and Contraceptives Provision.		

G. Various Contraceptives/F.P Methods Introduced, Quantity used (P.A. per Individual) & Per Unit Cost:

Contraceptive	Quantity	Cost in Rupees	1999	2003
Male:	Used	**Per Unit Cost**	**Responses**	**Responses**
a. Withdrawal	50-100	1Dozen=Rs:6/-		
b. Condom	50-100	Free		
c. Vasectomy	Once			
Female:	Used	**Per Unit Cost**	**Responses**	**Responses**
a. Oral pills	11 Strips	01 strip=Rs:3/-		
b. Injection:				
i. Nurajest(2 months)	6 Injects	01injection=Rs:3/		
ii. Majestron/Depo(3 months)	4 Injects	01Injection=Rs:3/		
c. Sterilization/ Tub legation	Once	Free		
d. Multi Load/ Copper-T/IUCD	01(5-10Y)	Free/ 01=Rs:3/-		

H. Reasons for using and not using a specific method?

Reasons	1999	2003
	Responses	Responses
a. For Using: No Side effects, Convenient, More effective and Less costly		
b. For Not Using: Side effects, Permanent, Not effective and Costly		

I. Sources to get contraceptives

Sources	1999	2003
	Responses	Responses
a. Family Planning Organizations Centers and MSU.		
b. Private Medical store, General store and Doctor		

J. Specification of Side effects of Contraceptives and Strategies of FWC for Prevention:

Specification	1999	2003
	Responses	Responses
Irregular Menses, Weight, Temperature, Headache, Vomiting, No Hepatize and Psychological problem		
Strategies of Family planning Organizations for prevention:	**Responses**	**Responses**
Counseling for Proper usage of contraceptives, Change The Method, Contraceptive, Proper Treatment and prevention		

K. **Problems in reducing the side effects of Contraceptives & Strategies of the FHCs and RHS-B.**

Specification	1999	2003
Problems	**Responses**	**Responses**
No care, Proper Usage & follow up by the Clients / patients and No Proper Treatment, Usage Skill, medicines Provision by service providers		
Strategies	**Responses**	**Responses**
Counseling for proper usage, receiving feed back from clients and Proper treatment, cleanliness, Change the method and Preventive Medicine		

L. **Mother-Child Health Care Programme Specification**

Specification	1999	2003
Mother Health Care	**Responses**	**Responses**
Counseling, Antenatal, Post Natal, Treatment, Vaccination and Balance Diet		
Child Health Care	**Responses**	**Responses**
Before, During and after Delivery, Immunization, Breast Feeding and Nutrition		

M. **Results of Mother Child Health Care Programme**

Results/Effects	1999	2003
	Responses	**Responses**
Proper Health Protection, Safe Delivery and Trust on MCHC of FP.		

N. **Major problems in Mother-Child Health Care and Strategies of FHCs and RHS-B.**

Specification	1999	2003
Problems	**Responses**	**Responses**
a. Various constraints to MCHC. (Ignorance, No proper treatment, check up and medicines etc) *b. Various constraints to FP.* (Eco-, Socio-Cultural, Religious, Psychological, Medical-technical, Quality of Service etc).		
Strategies	**Responses**	**Responses**
a. Solution to Various constraints in MCHC. (Health Education, Counseling, Proper treatment, check up, medicines and MSU) *b. Solution to Various constraints in FP.* (Free counseling, treatment, medicines, avoiding early Marriage, Maximum male children, Meeting Religious Leaders, Solution of Psychological Worries, Solution to side effects, Improving Quality of Service).		

O. Size of Family and Role of FHCs and RHS-B.

Specification of Family Size	1999 Responses	2003 Responses
a. Large Family Size b. Small Family size		
Reasons of Large Family:	**Responses**	**Responses**
i. Age at the time of Marriage/Early Marriage a.13-22 Years b.23-32 Years **ii. Number of Marriage/s. / Polygamy** a. One /Single. b. Two /Double& Three/ Triple **iii. Desire for Maximum Male Children:** (Sons are power, prestige, source of income, helping hand in old age, Socio-psychological protection, Male dominancy and Inheritance of property) **iv. Various Constraints to FP.** (Eco- /Poverty, Religious, Socio- Cultural, Govt./ Political, Medical-Technical, Quality of Service etc).		
Role of FHC/RHC	**Responses**	**Responses**
Counseling for small family, Avoid Early Marriage, Maximum Children, Son & Daughter are Equal, Proper Check up, Treatment, Medicines and Solution of Constraints.		

P. Various Constraints to family Planning

i. Economic / Financial Constraints in F.P and Role of FHC/RHC.

Specification	1999	2003
A- Economic / Financial Constraints	**Responses**	**Responses**
Poverty, No Income and Employment, High Expenses of family, No Infrastructure, Building, Equipments, Treatment, medicines and Budget.		
B- Role of FHC/RHC	**Responses**	**Responses**
Free Counseling, Checkup, Treatment, Operation, Natural gap by breast feeding, Foreign Aid Support and Company Rate contraceptives		

ii. Religious Constraints in F.P and Role of FHC/RHC.

Specification	1999	2003
A- Religious constraints	**Responses**	**Responses**
It is Sin, Killing of Humanity, Illegitimate, Against Natural Law, Fatalism, Allah is Food Provider, No one can stop those Souls to be produced, Increase Muslims, Immoral and It is the Plan of Non-Muslims.		
B- Role of FHC/RHC.	**Responses**	**Responses**
Meeting with Religious Leaders, Convincing religious people, Collection of Different Statements/ Fatwas and Religious literature distribution in favor of FP.		

iii. Socio- Cultural Constraints in F.P and Role of FHC/RHC.

Specification	1999	2003
A- Socio- Cultural Constraints	**Responses**	**Responses**
a. Desire for Maximum male Children: (Sons are power, prestige, Inheritance of Property, Psychological & social protection, Dominancy, Source of Income, Helping hand in Old age) **b. No Acceptance:** (FP. Disapproval by Husband & In-laws, Veil (Purda), No power of women, Early Marriage, Negative public Opinion and Wrong propaganda against FP).		
B- Role of FHC/RHC.	**Responses**	**Responses**
Small Family Norms, Son & Daughter are equal, Maximize Gap, Avoid Early Marriage and Women Empowerment		

iv. Govt./ Political Constraints in F.P and Role of FHC/RHC.

Specification	1999	2003
A. Political/Government Constraints in F P	**Responses**	**Responses**
No Proper Funds Allocation and Policy change		
B- Role of FHC/RHC	**Responses**	**Responses**
Struggle to continue, Getting Support of Govt. And Collaboration of Public & Private Sectors.		

v. Psychological Constraints in FP. & Role of FHC/RHC

Specification	1999	2003
A- Psychological Complaints/Constraints	**Responses**	**Responses**
Worry of Side Effects of contraceptives /Medicines, Conception and Infertility		
B- Role of FHC/RHC	**Responses**	**Responses**
Motivation, Awareness & Counseling for Proper usage/ Change of contraceptives and Proper check up, treatment and medicines.		

vi. Medical & Technical Constraints in FP. & Role of FHC/RHC

Specification	1999	2003
A- Medical & Technical Constraints	**Responses**	**Responses**
No FP. & Health awareness, Fear from taking medicines/ Contraceptives due to side effects, No trained staff, equipments, medicines, Check up and treatment.		
B- Role of FHC/RHC	**Responses**	**Responses**
Counseling for Proper usage, Change of contraceptives, check up, treatment, medicines and prescription of Trained Staff		

vii. Quality of Service Constraints in FP. & Role of FHC/RHC.

Specification	1999	2003
A- Quality of Service Constraints	**Responses**	**Responses**
No Budget, involvement of health outlets, coverage, out reach, information, Supervision, monitoring, Strategy change, low quality contraceptives, Questionable services, Less satisfaction, Male Involvement, Proper Trained Staff.		
B- Role of FHC/RHC.	**Responses**	**Responses**
Budget on foreign Assistance, Proper Supervision, Monitoring & Evaluation, Male staff Involvement, Contraceptive provision and MHU.		

Q. Linkage program among Government, NGOs & Community

Linkage program	1999	2003
	Responses	Responses
Combined seminars, workshops and Combined Strategies		

R. Weaknesses and Shortcomings in implementation of FP.

Weaknesses/Short comings	1999	2003
	Responses	Responses
Side Effects of Contraceptives, No proper Policy, Planning, Research, Strategy, Involvement of Religious Leader, Male interest, Awareness & Education program about FP, Various constraints to FP, No Role of Media, Related Departments, district Govt. and Welfare Organizations/ CBOs etc.		
Suggestions/Strategies	Responses	Responses
Role of Media, Dist. Govt., Religious Leaders, FP Education, Awareness, Enlightened Vision, Counseling, Motivation & Communication Program of FP, Trained Staff & Establishment of more family planning organizations		

Part-III

QUESTIONNAIRE/ INTERVIEW SCHEDULE FOR BENEFICIARIES OF SELECTED PUBLIC ORGANIZATIONS (RHS-As & FWCs) & PRIVATE ORGANIZATIONS (RHS-Bs & FHCs) IN POPULATION CONTROL

Note: Please mark the correct option by (✓) & incorrect by (X) in both the Responses Columns for 1999 & 2003, after filling the Bio-data/ Personal Particulars.

Personal Bio-Data of Respondent

Particulars of the Respondent	Responses
Name of Respondent: Age of Respondent: Sex/Gender Qualification Profession/Occupation Monthly Income	(Optional)

A. Number of Children:

Number of Children	1999	2003
	Responses	Responses
Male Children: a. 0-1 b. 2-3 c. 4 <		
Female Children: a. 0-1 b. 2-3 c. 4 <		

B. Educational Status and Adoption of F.P.

Educational Status	Adoption of F.P	
	1999	2003
	Responses	Responses
a. Uneducated		
b. Educated		

C. Sources of Awareness, Advertisement and Popularization of Family Planning

Sources	1999	2003
	Responses	Responses
a. Major: TV, Radio, Friends, Relatives, Husband, Wife, Family Planning Staff and Literature		
b. Minor: Wall Chalking, Banner, Sign board, Seminars, Workshops, Conferences, News Papers and Magazine		

D. Problems during awareness, Communication and Popularization of FP. & Strategy of Family Planning Organizations

Problems/Strategies	1999	2003
	Responses	Responses
Problems:		
Ignorance (Women), Improper way of communication, Various constraints in FP.		
Strategies:		
Women Education, Improvement in communication and Solution of constraints		

E. **Problems and facilities in Family Planning Organizations**

Specification of Problems	1999	2003
	Responses	Responses
No Required facilities, People dislike it and Staff problem		
Facilities/ Functions	**Responses**	**Responses**
Counseling, Provision of Contraceptives, Treatment, Check up, Medicines, reproductive, mother-child health care and MHU.		

F. **Problems and Role of FWW, LHW and LHV**

Specification of Problems	1999	2003
	Responses	Responses
No visit to home, Absent and Take charges in clinic		
Role FWW, LHW and LHV:	**Responses**	**Responses**
Motivation, Counseling, Convincing for FP, Checkup, Treatment, medicines and Contraceptives Provision.		

G. **Various Contraceptives/FP Methods Introduced, Quantity used (P.A. per Individual) & Per Unit Cost:**

Contraceptive	Quantity	Cost in Rupees	1999	2003
Male:	**Used**	**Per Unit Cost**	**Responses**	**Responses**
a. Withdrawal	50-100	Free		
b. Condom	50-100	1Dozen=Rs:6/-		
c. Vasectomy	Once	Free		
Female:	**Used**	**Per Unit Cost**	**Responses**	**Responses**
a. Oral pills	11 Strips	01 strip=Rs:3/-		
b. Injection:				
i. Nurajest(2 months)	6 Injects	01injection=Rs:3/		
ii. Majestron/Depo(3 months)	4 Injects	01Injection=Rs:3/		
c. Sterilization/ Tub legation	Once	Free		
d. Multi Load/ Copper-T/IUCD	01(5-10Y)	Free/ 01=Rs:3/-		

H. **Reasons for using and not using a specific method?**

Reasons	1999	2003
	Responses	Responses
a. For Using: No Side effects, Convenient, More effective and Less costly		
b. For Not Using: Side effects, Permanent, Not effective and Costly		

I. **Sources to get contraceptives**

Sources	1999	2003
	Responses	Responses
a. Family Planning Organizations Centers and MSU.		
b. Private Medical store, General store and Doctor		

J. **Specification of Side effects of Contraceptives and Strategies of family planning organization centers for Prevention:**

Specification	1999	2003
	Responses	Responses
Irregular Menses, Weight, Temperature, Headache, Vomiting, No Hepatize and Psychological problem		
Strategies of Family planning Organizations for prevention:	**Responses**	**Responses**
Counseling for Proper usage of contraceptives, Change The Method, Contraceptive, Proper Treatment and prevention		

K. Problems and strategies to reduce the side effects of contraceptive by Family Planning Organizations:

Specification	1999	2003
Problems	**Responses**	**Responses**
No care, Proper Usage & follow up by the Clients / patients, No Proper Treatment, Usage Skill, medicines, Provision by service providers		
Strategies	**Responses**	**Responses**
Counseling & Motivation for proper usage, receiving feed from clients/ patients, Proper treatment, cleanliness, Change the method and Preventive Medicine		

L. Mother-Child Health Care Programme Specification

Specification	1999	2003
Mother Health Care	**Responses**	**Responses**
Counseling, Antenatal, Post Natal, Treatment, Vaccination and Balance Diet		
Child Health Care	**Responses**	**Responses**
Before, During and after Delivery, Immunization, Breast Feeding and Nutrition		

M. Results of Mother Child Health Care Programme

Results/Effects	1999	2003
	Responses	**Responses**
Proper Health Protection, Safe Delivery/ and Trust on MCHC of FP.		

N. Major problems in Mother -Child Health Care and Strategies of Family Planning Organizations

Specification	1999	2003
Problems	**Responses**	**Responses**
a. Various constraints to MCHC (Ignorance, No proper treatment, check up and medicines) *b. Various constraints to FP.* (Eco-, Socio-Cultural, Religious, Psychological, Medical-technical, Quality of Service).		
Strategies	**Responses**	**Responses**
a. Solution to Various constraints in MCHC. (Health Education, Counseling & motivation, Proper treatment and check up) *b. Solution to Various constraints in FP.* (Free counseling, motivation, awareness, treatment, medicines, avoiding early Marriage, Maximum male children, Meeting Religious Leaders, Solution of Psychological Worries and side effects and Improvement in Quality of Service).		

O. Size of Family, Reasons of Large Family & Role of Family Planning organizations.

Specification	1999	2003
	Responses	Responses
Size: a. Large Family Size b. Small Family Size		
Reasons of Large Family:	**Responses**	**Responses**
i. Age at the time of Marriage/ Early Marriage. a. 13-22 years b. 23-32 years **ii. Number of Marriages/ Polygamy.** a. One / Single b. Two / Double c. Three/ Triple **iii. Desire for Maximum Male Children:** (Sons are Power, Prestige, Male Inheritance of Property, and Source of income, Help in old age and Socio-psychological Protection). **iv. Various Constraints to Family Planning.** (Eco-/ Poverty, Religious, Socio- Cultural, Govt. / Political, Medical-Technical, Quality of Service).		
Role of Family Planning Organizations.	**Responses**	**Responses**
Counseling & Motivation for small family, Avoid Early Marriage, & Max Children, Son & Daughter are Equal, Check up, Treatment, Medicines and Solution of Constraints		

P. Various Constraints in Family Planning:

i. Economic / Financial Constraints in FP & strategies of Family Planning Organizations.

Specification	1999	2003
A- Economic / Financial Constraints	**Responses**	**Responses**
a. Poverty, No Income and Employment, High Expenses of family, No Infrastructure, Building, Equipments, Treatment, medicines and Budget.		
B- Role of Family Planning Organizations	**Responses**	**Responses**
Free Counseling, Checkup, Treatment, Natural Gap by Breast Feeding, Foreign Aid Support, Company Rate contraceptives		

ii. Religious Constraints in F.P & strategies of Family Planning Organizations.

Specification	1999	2003
A- Religious constraints	**Responses**	**Responses**
It is Sin, Killing of Humanity, Illegitimate, Against Natural Law, Fatalism, God is Food Provider, No one can stop those Souls to be produced, Increase Muslims, Immoral and It is the Plan of Non-Muslims.		
B- **Role of FHC/RHC.**	**Responses**	**Responses**
Meeting with Religious Leaders,/Motivation, Counseling & Convincing religious people, Collection of Different Statements/ Fatwas , Religious literature distribution in favor of FP.		

iii. **Socio-Cultural Constraints in Family Planning & Strategies of Family Planning Organizations.**

Specification	1999	2003
A- Socio- Cultural Constraints	**Responses**	**Responses**
a. Desire for Maximum male Children (Sons are power, prestige, Inheritance of Property, Psychological & social protection, Dominancy, Source of Income, Helping hand in Old age). **b. No Acceptance:** (FP. Disapproval by Husband & In-laws, Purda, No power of women, Early Marriage & Polygamy, Negative public Opinion and Wrong propaganda against FP).		
B- Role of FHC/RHC.	**Responses**	**Responses**
Small Family Norms, Son & Daughter are equal, Avoid Early Marriage and Women Empowerment.		

iv. **Govt./ Political Constraints in F.P and Role of Family Planning Organizations.**

Specification	1999	2003
A. Political/Government Constraints in F P	**Responses**	**Responses**
No Proper Funds Allocation and Policy change		
B- Role of Family Planning Organizations	**Responses**	**Responses**
Struggle to continue, Getting Support of Govt. And Collaboration of Public & Private Sectors.		

v. **Psychological Constraints in FP. & Role/ strategies of Family Planning Organizations.**

Specification	1999	2003
A- Psychological Complaints/Constraints	**Responses**	**Responses**
A Worry of Side Effects of Contraceptives /Medicines, Conception and Infertility		
B- Role of Family Planning Organizations	**Responses**	**Responses**
Motivation, Awareness & Counseling for Proper usage/ Change of contraceptives, Reduce fear of side effects and check up, treatment and medicines		

vi. **Medical & Technical Constraints in FP. & Role / strategies of Family Planning Organization.**

Specification	1999	2003
A- Medical & Technical Constraints	**Responses**	**Responses**
No FP. & Health awareness, Fear from taking medicines/ Contraceptives due to side effects, No trained staff, equipments and medicines, Check-up and treatment.		
B- Role of Family Planning Organizations	**Responses**	**Responses**
Motivation, Awareness & Counseling for Proper usage, Change of contraceptives, Proper check-up, treatment, medicines, Multi vitamins-Iron Tablets and prescription by Trained Staff.		

vii. Quality of Service Constraints in FP. & Role of Family Planning Organizations.

Specification	1999	2003
A- Quality of Service Constraints	**Responses**	**Responses**
No proper Budget, involvement of health outlets, coverage, out reach, information, Supervision, monitoring & evaluation, Strategy change. Low quality contraceptives, Questionable services, Less satisfaction, No Male Involvement and No Proper Trained Staff.		
B- Role of Family Planning Organizations.	**Responses**	**Responses**
Budget on foreign Assistance, Proper Supervision, Monitoring & Evaluation, Trained Staff, and Male staff Involvement, Contraceptive provision and MSU.		

Q. Linkage program among Govt. NGO'S & Community.

Linkage programmes	1999	2003
	Responses	Responses
Combined seminars, workshops and Combined Strategies		

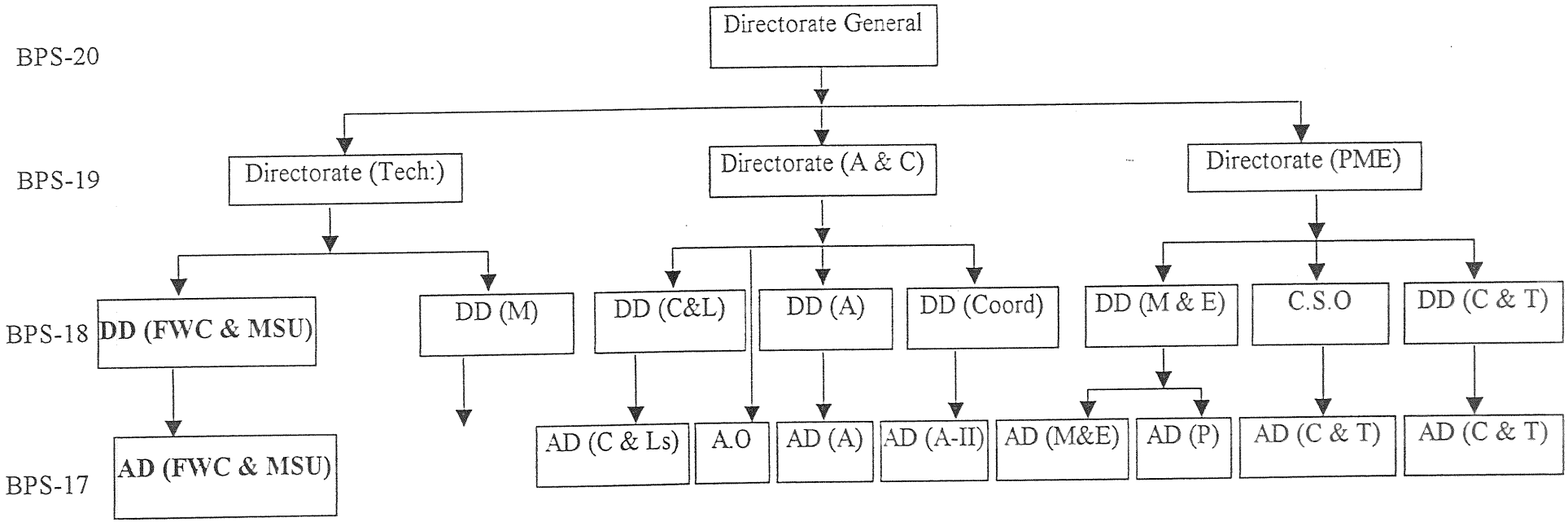
R. Short comings in implementation of FP and Strategies / Suggestions for the Improvement

Weaknesses/Short comings	1999	2003
	Responses	Responses
Side Effects of Contraceptive, No proper Policy, Planning, Research, Strategy, Involvement of Religious Leader, Awareness & Education program about FP, Various constraints to FP, No Role of Media, Related Departments, district Govt., Welfare Societies and Organizations.		
Suggestions/Strategies	**Responses**	**Responses**
Role of Media, Dist. Govt., Religious Leaders, FP Education, Awareness, Enlightened Vision, Counseling, Motivation & Communication Program of FP, Trained Staff & Establishment of more family planning organizations		

APPENDIX-B

ORGANIZATIONAL STRUCTURE PUBLIC (GOVT.) & PRIVATE (NGO'S)

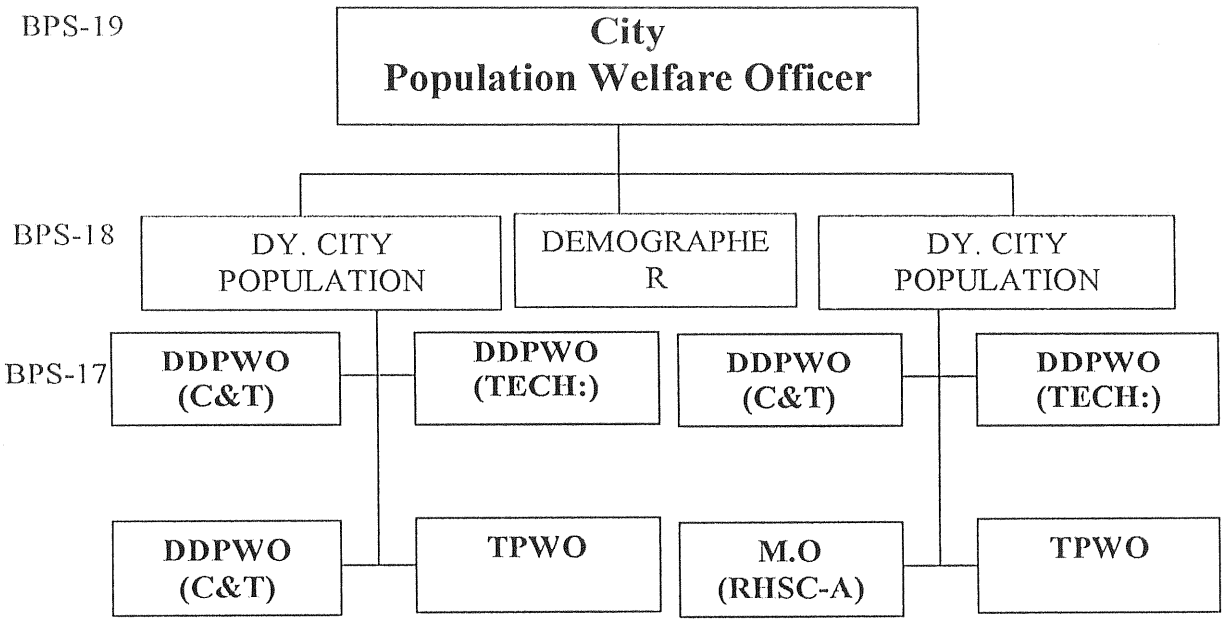
A. ORGANIZATIONAL CHART POPULATION WELFARE DEPARTMENT NWFP



KEY:

A & C	=	ADMINISTRATION & COORDINATION	(F)	=	FINANCE
A.D.	=	ASSISTANT DIRECTOR	(RH)	=	REPRODUCTIVE HEALTH
PME	=	PLANNING, MONITORING & EVALUATION	C&LS	=	CONTRACEPTIVE AND LOGISTICS
FWC	=	FAMILY WELFARE CENTRE	(P)	=	PLANNING
DD	=	DEPUTY DIRECTOR	M&E	=	MONITORING & EVALUATION
A.O	=	ACCOUNTS OFFICER	C.S.O	=	CHIEF STATISTICAL OFFICER
(M)	=	MEDICAL	C&T	=	COMMUNICATION & TRAINING
(A)	=	ADMINISTRATOR	COORD	=	COORDINATION

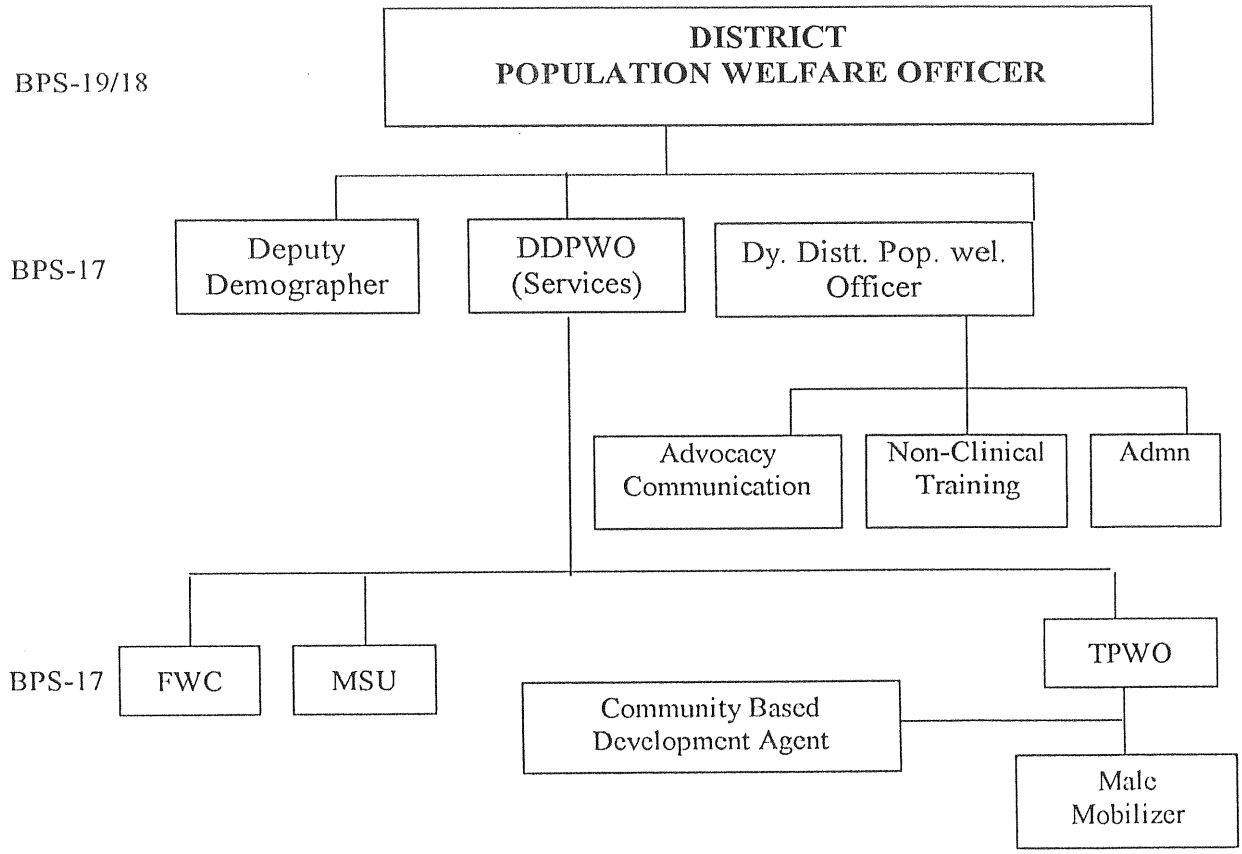
B. ORGANIZATIONAL CHART
CITY POPULATION WELFARE OFFICE PESHAWAR



KEY:

DDPWO	= DY. DIST. POPULATION WELFARE OFFICER
(TECH:)	= TECHNICAL
(C & T)	= COMMUNICATION & TRAINING
(M.O)	= MEDICAL OFFICER
(RHSC-A)	= REPRODUCTIVE HEALTH SERVICES CENTRES A-TYPE
TPWO	= TEHSIL POPULATION WELFARE OFFICER

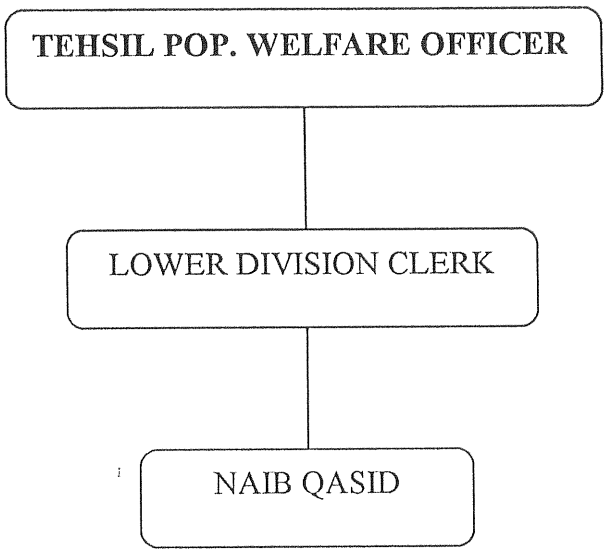
C. ORGANIZATION CHART
DISTRICT POPULATION WELFARE OFFICE



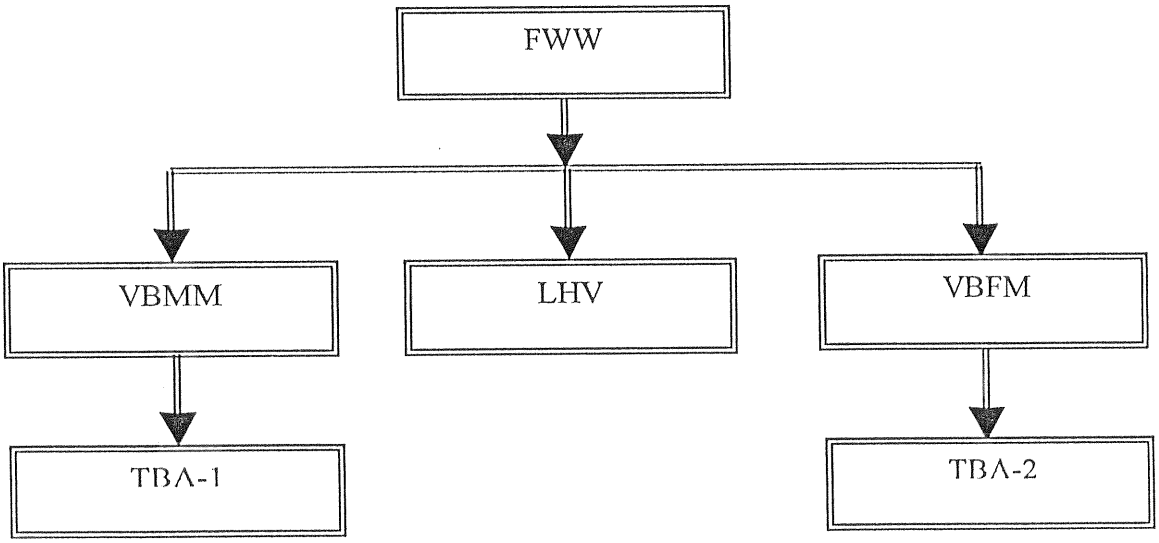
KEY:

M.O	= MEDICAL OFFICER
RHSCs-A	= REPRODUCTIVE HEALTH SERVICES CENTRE A-TYPE
DDPWO	= DY. DISTT. POPULATION WELFARE OFFICER
TPWO	= TEHSIL POPULATION WELFARE OFFICER
FWC	= FAMILY WELFARE CENTRE
MSU	= MOBILE SERVICE UNITS

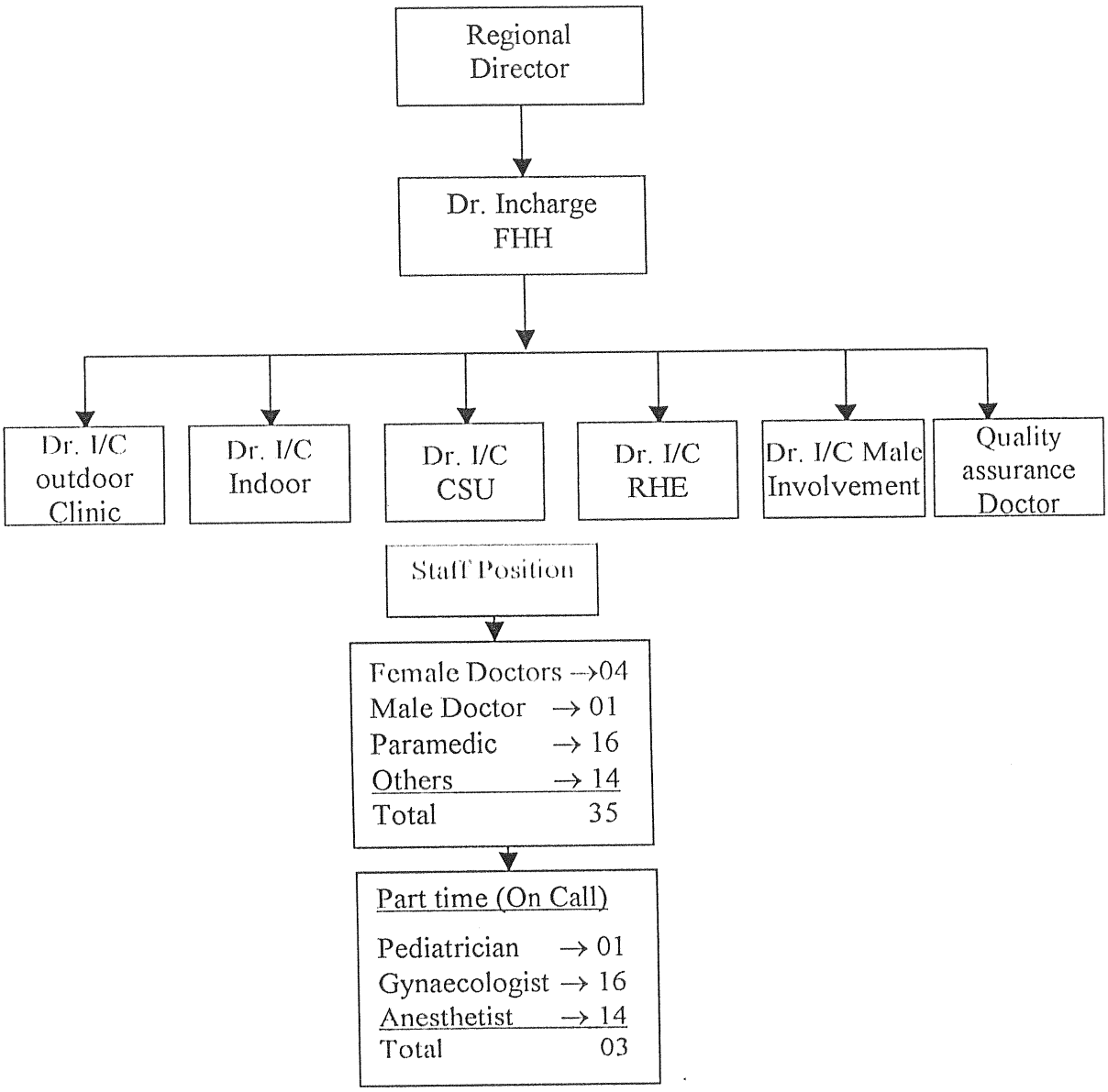
D. ORGANIZATIONAL CHART
TESIL TIER



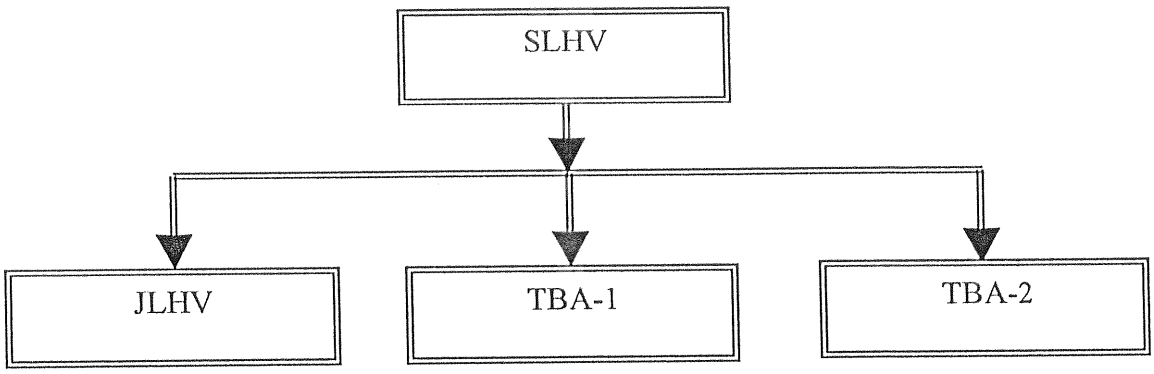
E. FAMILY WELFARE CENTER STRUCTURE



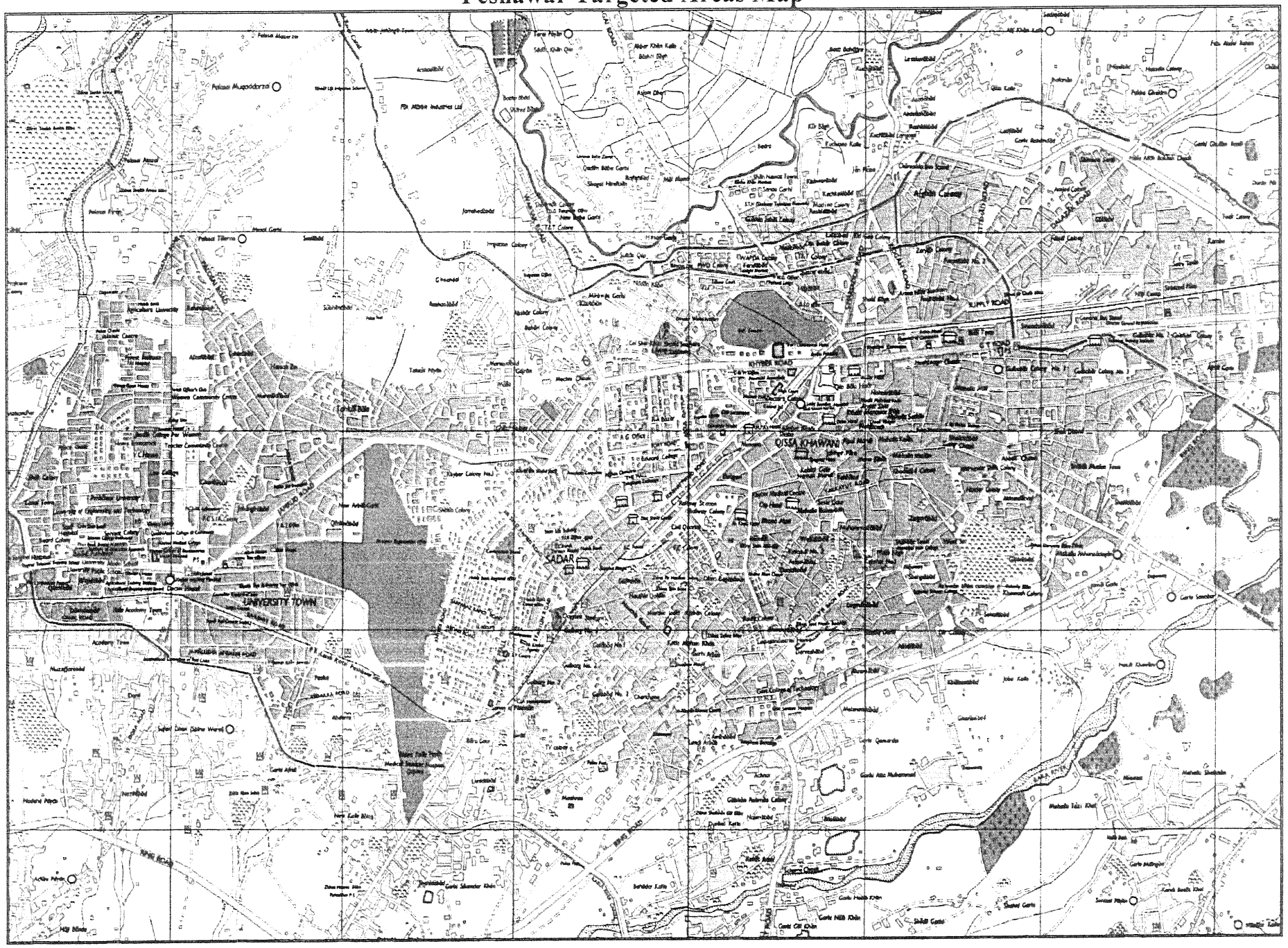
F. ORGANIZATIONAL STRUCTURE OF FAMILY HEALTH HOSPITAL



G. FAMILY HEALTH CENTER STRUCTURE



Peshawar Targeted Areas Map



Source: http://www.googlemap.com

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