USAID
FROM THE AMERICAN PEOPLE

FALAH
FAMILY ADVANCEMENT FOR LIFE & HEALTH

Baseline Household Survey

Gwadar District

May 2010

Population Council

Family Advancement for Life and Health

(FALAH)

Gwadar

Baseline Household Survey

May, 2010

Khan Mohammad

Irfan Masood

Population Council

Population Council

The Population Council, an international, non-profit, non-governmental organization established in 1952, seeks to improve the well-being and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources.

The Council analyzes population issues and trends; conducts research in the reproductive sciences; develops new contraceptives; works with public and private agencies to improve the quality and outreach of family planning and reproductive health services; helps governments design and implement effective population policies; communicates the results of research in the population field to diverse audiences; and helps strengthen professional resources in developing countries through collaborative research and programs, technical exchange, awards, and fellowships.

For inquiries, please contact:

Population Council

7, Street 62, F-6/3, Islamabad, Pakistan

Tel: 92 51 8445566

Fax: 92 51 2821401

Email: pcpak@popcouncil.org

Web: http://www.popcouncil.org

http://www.falah.org.pk

Layout and Design: Ali Ammad

Published: May,2010

Disclaimer

"This study/report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the Population Council, Islamabad and do not necessarily reflect the views of USAID or the United States Government."

Table of Contents

List of Tables

List of Figures

Acknowledgements

The FALAH project is a five year project funded by USAID to improve the survival and health of women and children in Pakistan and the well-being of families, communities and the country through increased demand and utilization of births spacing and quality family planning services. Population Council is leading a consortium of national and international NGOs to support family planning activities in both the public and private sector in Pakistan. The consortium members include Greenstar Social Marketing, Health and Nutrition Development Society (HANDS), Jhpiego, Mercy Corps, Rural Support Programmes Network (RSPN) and Save the Children US. The partners bring together a blend of technical expertise combined with a rich experience of working within Pakistan and internationally.

As with any major project, it is important to have a baseline study in order to assess the progress of the project in meeting the set goals and objectives over a 5-year period. The report is a collaborative effort involving partners, Population Council staff and district officials/workers who joined their hands to make this endeavor possible.

The Population Council was primarily responsible for designing the baseline study and managing the collection of data, its analysis and for producing the reports for the project districts. We are grateful to Chief of Party of the FALAH project who strongly encouraged and facilitated the baseline survey process. Dr. Zeba Sathar, Country Director Population Council Islamabad provided invaluable input and was instrumental in the quality of the report produced.

The baseline surveys were designed and implemented under the guidance and encouragement of Dr. Arshad Mahmood, Director Monitoring and Evaluation. Several staff of the Population Council contributed substantially at various stages of producing this report and we would like to thank them individually. At the level of the training of the field staff and monitoring the quality of the data collected, we would like to particularly acknowledge the efforts of Dr. Munir Afridi, Ms. Nayyer Farooq, Ms. Ashfa Hashmi and Mr. Muhammad Ashraf. Mr. Abdul Kashif dealt with all the financial matters during the survey process and Mr. Rahim Dad Malik was responsible for making the logistical arrangements for the survey. We thank Mr. Nadeem Akhtar and Mr. Imran Rashid who were involved at various stages of the survey.

We are grateful to Mr. Peter C. Miller and Dr. Arshad Mahmood for developing the main template for the report. Mr. Khan Mohammad prepared the first draft of the Gwadar report. Dr. Yasir Bin Nisar and Mr. Muhammad Jamil Arshad reviewed the report. Mr. Irfan Masood tabulated the data and figures for the report. Ali Ammad developed the report layout and design. We thank these colleagues for their immense contributions.

Finally, we must acknowledge the women and men of the households in the district Gwadar for sharing their lives and their information and giving life to the survey. We hope very much that our effort will be of use to provide the necessary information to improve the quality of peoples' lives and to provide better reproductive health and family planning services.

Glossary of Terms

ANC	Antenatal Care
ASFRs	Age-specific Fertility Rates
BHU	Basic Health Unit
CBR	Crude Birth Rate
CEB	Children Ever Born
CPR	Contraceptive Prevalence Rate
DHQ	District Headquarter
EC	Emergency Contraception
ECP	Emergency Contraceptive Pill
EmOC	Emergency Obstetric Care
FALAH	Family Advancement for Life and Health
FP	Family Planning
HANDS	Health and Nutrition Development Society
IUD	Intra Uterine Device
LAM	Lactational Amenorrhea Method
LHW	Lady Health Worker
MCH	Maternal and Child Health
MNH	Maternal and Neonatal Health
MoH	Ministry of Health
MoPW	Ministry of Population Welfare
MSU	Mobile Service Unit
MWRA	Married Women of Reproductive Age
NGO	Non Governmental Organization
NIPS	National Institute of Population Studies

PAIMAN	Pakistan Initiative for Mothers and Newborns
PC	Population Council
PDHS	Pakistan Demographic and Health Survey
PNC	Postnatal Care
PSLMS	Pakistan Social and Living Standard Measurement Survey
PSU	Primary Sampling Unit
Pvt.	Private
RH	Reproductive Health
RHC	Rural Health Center
RHSC-A	Reproductive Health Services Center- A
RSPN	Rural Support Programmes Network
SMAM	Singulate Mean Age at Marriage
TBA/*Dai*	Traditional Birth Attendant
TFR	Total Fertility Rate
THQ	Tehsil Headquarter
ToR	Terms of Reference
TT	Tetanus Toxoid
UC	Union Council
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

The Family Advancement for Life and Health (FALAH) project conducted a baseline household survey for Gwadar, one of the 26 project districts.

The survey was conducted between November 2009 and January 2010 in a probability sample of 600 households in 40 clusters in Gwadar. It included interviews with 691currently married women 15-49 years ("married women of reproductive age" or MWRA), along with 200 married men, of whom 195 were married to women included in the sample. As a separate activity, a mapping study[1] was also carried out in Gwadar during the period between February and March, 2008. Selected data from that study are included in this report, although a separate report is also available. The FALAH project is primarily focused on birth spacing and family planning.

Household and Respondent Characteristics

More than two-fifth of Gwadar District is rural. It ranked 78th of 92 districts on the overall Human Development Index, according to the UNDP's Pakistan National Human Development Report ,2003. The characteristics of our sample are generally similar to those found in other surveys; some key indicators are presented in Table A.

Table A: Selected key district characteristics from Gwadar household survey

Indicator	Value
Percentage of households population in rural areas	44.6
Percentage of households with electricity	72.8
Percentage of households with indoor water supply	60.5
Percentage of households with flush toilet	58.2
Percentage of households with television	61.0
Percentage of literate female respondents	22.3
Percentage of respondents with literate husbands	44.9
Total fertility rate	4.3

[1] Mapping Survey of Health and Reproductive Health Services.

Gwadar is a not densely populated district of Pakistan; Electricity was available to 73 percent of the sampled households. More than half of households (61 percent) had some indoor water supply, and 58 percent had flush toilets . According to the MDG report, Gwadar ranked 66th on sanitation. On the other hand, literacy was relatively low. Only 22 percent of females and 45 percent of their husbands were literate. Fifty-three percent of the respondents said they watched TV, 12 percent listened to the radio, and 3 percent read newspapers or magazines; whereas most women who heard of any FP message, heard it on television.

Service Availability

There was a good range of health and reproductive health facilities in Gwadar district. Of the 154 facilities in the district,135 were public while 19 were in the private sector. These health facilities included health houses of Lady Health Workers and were widely scattered around the district, so the simple services such as antenatal check-ups, iron tablets for anemia, and non-clinical contraceptive methods were readily available in both public and private sectors. However, access to services requiring specialized care was difficult. For example, there was only 1 facility in private sector – which was able to offer Caesarean section deliveries. There was no facility for female and male sterilization.

Fertility

The crude birth rate was 29 per thousand populations, and the total fertility rate was 4.3 children per woman. However, CBR of the district was lower and TFR was slightly higher than the national figure. Fertility was higher for illiterate women and wives of illiterate men, and in households with a lower standard of living. However, there was little urban-rural difference in fertility. Many births were spaced too closely for optimum health; for example, nearly 64 percent of closed birth intervals were less than 36 months. Among those who already had 2 living children less than 5 years of age 10 percent were currently pregnant.

Maternal and Neonatal Care

The household survey obtained data on selected key indicators of maternal and neonatal health from 436 sampled women who had delivered a child during the previous four years (see Table B). Of these women, 72 percent had visited a health provider at least once for antenatal care; about 69 percent had at least two tetanus toxoid immunizations; about 52 percent were delivered by a skilled birth attendant; and 38.3 percent were delivered in a health facility, public or private. On the other hand, about 83 percent had at least one postnatal check-up (including 38 percent of those delivering in facilities).No postnatal checkup has negative implications for family planning as well a s for maternal and neonatal health. Exclusive breastfeeding was reportedly widespread; 23 percent of mothers reported breastfeeding their last child for at least 6 months without supplementation.

Table B: Selected key MCH and family planning indicators from the Gwadar baseline survey

Indicator	Value
Percentage of mothers with at least one antenatal care visit	71.6
Percentage of mothers with at least two tetanus shots	68.6
Percentage of most recent deliveries conducted by a skilled birth attendant	51.6
Percentage of most recent deliveries in a facility	38.3
Percentage of MWRA not wanting more children	33.6
Percentage of MWRA wanting to delay next birth for at least two years	34.4
Percentage of MWRA knowing at least one contraceptive method	99.1
Contraceptive prevalence rate	18.5
Percentage of MWRA who are past users of contraception	17.9
Percentage of MWRA with unmet need for family planning	42.1
Percentage of MWRA with unmet need for spacing	22.6
Percentage of MWRA with unmet need for limiting	19.5
Total demand for family planning (CPR + unmet need)	60.6

Preference for Children

The median "ideal" family size according to the women respondents was 6 children. Regarding desire for more children in the future, almost one-third said they wanted another child soon (within two years), 34 percent said they wanted another child, but only after two years, and about 34 percent also said they did not want more children. The proportion

wanting more children soon decreased with the number of living children, while the proportion not wanting more increased and the proportion wanting more children later was the highest for women with one or two children. More than three-fourths of women respondents said their husband wanted the same number of children than they did, while 11 percent said their husband wanted more children than they did.

Contraceptive Knowledge and Use

Nearly all currently married women knew of at least one contraceptive method. The contraceptive prevalence rate (the percentage of MWRA currently using some method of contraception) was about 19 percent, which is higher than the average for Balochistan and lower for Pakistan. The most commonly methods being used were the Pills (6.2 percent), Condoms (4.8 percent) and injectables (3.2 percent). Past users comprised 18 percent of MWRA; pills, injectables and condoms, were all common past methods. Fifty-two percent of current use was for limiting purpose, while 48 percent was for spacing. Most users reported to obtain their supplies from their Husbands (especially condoms and pills) as they bring from various sources (28 percent), followed by LHWs (about 20 percent) and Pharmacy/Chemist (18 percent).

Experience with Contraceptive Methods

Stated reasons for a respondent's choice of her current or past method varied by method, but commonly cited reasons included easy availability, suitability for respondent and husband, convenience to use, low cost, method always available and no/fewer side effects. Costs were generally low (only 10 percent paid more than Rs.50 the last time they obtained their method) and did not appear to be a major obstacle to contraceptive use. Similarly, travel time was usually not excessive; 13 percent reported requiring more than 30 minutes reaching their service. Information provided at acceptance of FP method often did not include information on side effects or method choice. Clients generally reported being reasonably treated by providers but two-third reported they were examined properly. Almost half of respondents felt that providers were not capable of dealing with side effects. One-third of users and past users reported side effects with injectables and about 30 percent with pills and it did not appear that these were effectively dealt with by providers.

Reasons for Non-use

Asked hypothetically about hindrances a couple might face if they wanted to avoid or delay pregnancy, women typically mentioned husband's disapproval, religion, side effects and method failure and almost half cited distance and travel cost as a hindrance. Past users were most likely to discontinue their last method because of experience of side effects, desire for more children, and fear of side effects. Most common reasons for current non-use were fear of side effects , desire for another child and breastfeeding .Never users were most likely to say they were not using contraceptives for the reasons such as : desire for another child, fear of side effects and breastfeeding A majority of female current and past users said they could discuss family planning easily with their husbands. However, 71 percent of never users said they could also do so. More than one-fourth of never using women expressed their intent to use contraception in the future. The information obtained in this study indicates that a number of women in Gwadar were willing to practice birth spacing and family planning.

Unmet Need for Family Planning

A woman is said to be in "unmet need" for family planning if she says she does not want more children, or wants them later, and is at risk of conceiving, but is not using any method of contraception. By this definition, 42 percent of the women in this sample were in unmet need, 19 percent for limiting and 23 percent for spacing. Unmet need for limiting was higher in rural areas, among illiterate women, and among women with more than two children. However, unmet need for spacing was higher among literate women and younger women aged 15-24 years.

Reproductive Preferences and Behavior of Men

The findings reveal that 95 percent of the men knew at least one modern contraceptive method. Male sterilization and Norplant were the least known contraceptive methods among men in Gwadar. Twenty-two percent of the men did not want to have another child while two-third wanted to delay. One-fifth of the men reported that they or their wives were current users of any family planning method, and 19 percent were those who were using any modern contraceptive method. All current users were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, two-fifth reported that they were not intending to use any FP method in the future. Desire for more children and fear of side effects were the main reasons for not intending to use any FP method. It would be important to include specific interventions aimed at influencing men's attitude towards their role and responsibility in the overall health of the family and in birth-spacing and limiting needs.

Conclusion

Knowledge and approval of family planning were high and contraceptive prevalence rate (19 percent)was higher than that of Balochistan. Nevertheless, there is much need for improvement; unmet need for family planning remained very high at 42 percent. Among the important reasons that should be addressed in an improved program are the fear of side effects from the use of contraceptives, husbands' attitude, religious reasons, and knowledge of different contraceptives and their sources. Also, the concept of birth spacing needs to be stressed to lengthen birth intervals, which are often too short.

Chapter 1

Introduction

Background

The FALAH Project

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

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

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

The aims of the FALAH project are:

a) To increase demand for and practice of birth spacing;
b) To increase access to and quality of family planning services in the public sector;
c) To increase the coverage and quality of family planning services in the private sector;
d) To increase the coverage of social marketing of contraceptives, and provide support to the commercial sector for marketing contraceptives to strengthen contraceptive security.

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

Gwadar District

Gwadar is located on the southwestern coast of Pakistan, the coastline of Gwadar district is about 600 kilometers long. Geographically Gwadar is bounded on the north by Kech and Awaran districts, on the east by Lasbela district, on the south Arabian Sea and on the west by Iran. Total area of the district is 12,637 square kilometers. Gwadar has been notified as a district in July, 1977 (Population Census Organization, 2000). The district comprises four Tehsils, Gwadar, Pasni , Ormara and Gewani . The society is semi tribal and liberal as far as family decision making is concerned.

Leading job provider sectors of the district Gwadar include fisheries, cross border trade, real estate trading, construction, Transportation, service sector and Government and non-government agencies.

According to the Pakistan National Human Development Report 2003,[2] Gwadar stood 78th among 91 districts in Pakistan, and 15th of 22 districts within Balochistan (UNDP, 2003).

The Gwadar Baseline Household Survey

In Gwadar (as one of the 26 FALAH focus districts) Population Council implemented a baseline sampled household survey to learn about knowledge, attitudes, and practices regarding fertility, reproductive health, and child spacing/family planning. This represents one of two major studies to establish baseline indicators for the FALAH project. The other is

[2] In 2003, the districts of Pakistan were ranked according to a Human Development Index, consisting of: literacy rate; enrolment ratio; immunization ratio; infant survival ratio; real GDP per capita; educational attainment index; health index; and income index.

a mapping exercise to compile complete, digitized maps of all facilities providing reproductive health services, including maternal health, neonatal and child health, and birth spacing/family planning. This baseline survey will be compared with an end line survey towards the end of the project to assess progress.

Objectives

The objectives of the Gwadar Baseline Household Survey are:

- To obtain baseline measurements for those FALAH indicators that can best be measured through such surveys;
- To obtain detailed information on the knowledge, attitudes andpractices of married couples of Gwadar district regarding reproductive health, so as to meet their needs more effectively;
- More specifically, to obtain information needed to improve reproductive health services and to design appropriate social mobilization activities.

Methodology

Study Population

FALAH is primarily a district-level project which intends to improve the health of women and children of the district over a five-year period. The baseline household survey covers married women of reproductive age (15-49 years old) and their husbands living in the community. The objective is to understand and measure general knowledge, attitudes and practices of these married couples regarding family planning.

Sample Design and Size

The systematic stratified sample technique was used to select a representative sample of the district. The universe consisted of all urban and rural households of the district. A total of 40 blocks/villages were selected, with 15 households selected per block/village. The selection procedure is described below.

Urban Sample

The required number of enumeration blocks was selected with probability proportional to size (number of circles) by adopting a multistage stratified sampling design. The

"enumeration circles," i.e., the smallest units available in the 1998 Population District Census Reports, as demarcated by the Population Census Organization, were then selected. The maps of these circles were obtained from the Population Census Organization which were already divided into blocks of approximately 250-300 households depending upon the number of households in each circle. Next one block was randomly selected from each circle. The household listing of each randomly chosen block was then carried out by the enumeration teams before selecting the sampled households. A fixed number of 15 households were drawn from each sample enumeration block by using systematic random sampling.

Rural Sample

The 1998 Population Census list of villages was used as the sampling frame for the selection of the rural sample. Villages in rural areas have been treated as primary sampling units (PSUs). Sample PSUs were selected with probability proportional to size (number of households). Households within the sample PSUs were considered secondary sampling units. The household listing of each village was then prepared by the enumeration teams before selecting the sampled households. A fixed number of 15 households were selected from each sample enumeration village by the systematic random technique.

Selection of Respondents

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

Table 1.1 presents the numerated number of households and eligible women of reproductive age in Gwadar.

Table 1.1: Results of households and eligible women (MWRA) interviews

Results	Rural	Urban	Total
Sample blocks/villages	18	22	40
Households interviewed	270	330	600
Eligible women identified	355	431	786
Eligible women not interviewed	40	54	94
Eligible women refused	0	1	1
Eligible women interviewed	315	377	692
Total completed women's interviews	**315**	**376**	**691**

Questionnaire Design

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

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

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

Hiring of Interviewers and Supervisors

Since the respondents in the baseline survey were currently married women and their husbands, female interviewers were hired to interview female respondents and male interviewers were used for male respondents. The required number of interviewers as hired locally by advertising through local newspapers. A logistics supervisor and a data quality supervisor were also hired for each team.

Training of Interviewers and Supervisors

In order to ensure that the training provided for interviewers was of high quality, and that interviewers understood the definitions and concepts underlying the language of the questions, a two-week training of the Gwadar team was conducted by the Population Council in Karachi. During the training, interviewers conducted 2-3 field interviews in order to prepare for the actual interview process.

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

Quality Assurance

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

Data Entry and Edit Procedures

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

Fieldwork

Fieldwork for Gwadar district was carried out between November 02, 2009 and January 06, 2010.

Chapter 2

Household Characteristics

Geographic Distribution

The Gwadar district is about 45 percent rural and 55 percent urban. Table 2.1 shows the distribution of the sample population according to residence (urban and rural), with comparisons to the population distribution of the 1998 National Population and Housing Census.

Table 2.1: Distribution of population in sample households by residence

	Sample household population		
Residence	**N**	**%**	**1998 Census %**
Rural	2326	44.6	46.0
Urban	2895	55.4	54.0
Total	**5221**	**100**	**100**

Table 2.1 shows that the distribution of the population of the 600 households in the sample by urban-rural residence which closely follows the distribution recorded for the whole district in the 1998 Population Census (Population Census Organization, 2000).

Age-Sex Distribution

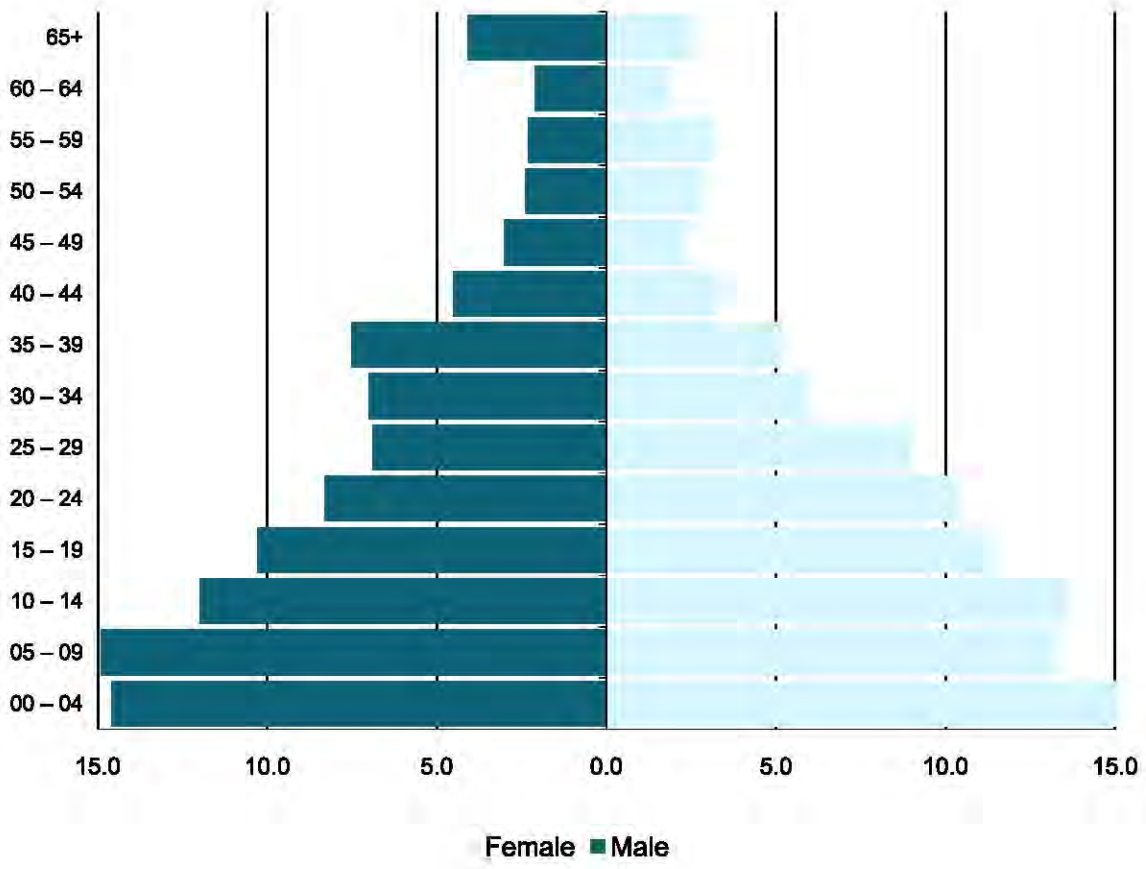
Table 2.2 shows the population of the sampled households by age and sex. Figure 2.1 shows the same information in the form of an age-sex pyramid.

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

	Sex of household member		
Age group	**Male**	**Female**	**Total**
00 – 04	14.6	15.1	14.9
05 – 09	14.9	13.3	14.1
10 – 14	12.0	13.6	12.8
15 – 19	10.3	11.3	10.8
20 – 24	8.3	10.3	9.3
25 – 29	6.9	9.0	7.9
30 – 34	7.0	6.0	6.5
35 – 39	7.5	5.2	6.3
40 – 44	4.5	3.4	3.9
45 – 49	3.0	2.4	2.7
50 – 54	2.4	2.9	2.6
55 – 59	2.3	3.1	2.7
60 – 64	2.1	1.9	2.0
65 +	4.1	2.6	3.3
N	**2600**	**2621**	**5221**

The population is typical of a society with past high fertility, with sharply declining percentages by age; the median age was 18 years old. Table 2.2 shows that as with many Pakistani populations, there are somewhat more males than females in older ages. Of the total population of the sampled households, 24 percent consisted of females 15-49 years of age, and 15 percent consisted of children under 5 years old. These women and children, and their husbands/fathers, comprise the population of primary interest to the FALAH project, and most of the analysis in this report will focus on them.

Figure 2.1: Percentage of sample household population by sex and age group



Marital Status

Table 2.3 shows, higher proportions of females at younger ages were married than males. The singulate mean age at marriage (SMAM) for men was 27 years and for women it was recorded as 23 years. Total 63 percent women were married and 8 percent were widow/ divorced or separated.

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

	Married		Widow/Divorced/Separated		Never married	
Age group	Men	Women	Men	Women	Men	Women
15 - 19	0.0	10.4	0.0	1.0	100.0	88.6
20 - 24	14.3	59.3	0.0	1.1	85.7	39.6
25 - 29	61.5	77.5	0.6	1.7	38.0	20.8
30 - 34	83.4	90.4	2.8	2.5	13.8	7.0
35 - 39	93.4	88.9	0.0	4.4	6.6	6.7
40 - 44	93.1	94.4	2.6	3.4	4.3	2.2
45 - 49	98.7	85.9	1.3	12.5	0.0	1.6
50 - 54	90.5	78.7	7.9	20.0	1.6	1.3
55 - 59	91.7	67.9	6.7	32.1	1.7	0.0
60 - 64	90.7	60.0	5.6	38.0	3.7	2.0
65 - 69	86.4	65.9	13.6	34.1	0.0	0.0
70 +	85.4	22.7	8.3	68.2	6.3	9.1
All ages 15+	**60.1**	**62.7**	**2.2**	**8.0**	**37.7**	**29.3**

Household Characteristics and Wealth Indicators

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

Physical Characteristics of Households

Table 2.4 shows selected physical characteristics of the sample households. A majority of households (61 percent) had an indoor water supply, followed by 15 percent those using community water supply source. However about 11 percent households purchase water for their need (see also figure 2.2). About three-fifth of the households had some type of flush toilet but 56 percent of rural and 10 percent of urban population still goes to fields. While a vast majority of rural households (96 percent) and about 62 percent of urban used firewood for cooking and only one-fifth used gas cylinders (4 percent rural compared to 35 percent urban). About three-fourth of the households had electricity. Most houses, four-fifth rural and almost two-fifth urban were roofed with wood/bamboo and mud, while three-fifth of the walls were made of burnt bricks or cement blocks, and one-third were of mud or mud bricks.

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

Characteristic	Rural	Urban	Total
Main source of drinking water			
Govt. supply (tap water inside)	24.4	82.1	56.2
Govt. supply (communal)	25.9	7.0	15.5
Motorized/Hand pump (inside)	9.6	0.0	4.3
Well (outside)	14.1	0.0	6.3
River/Canal/Stream	8.5	0.0	3.8
Purchased water	14.1	8.2	10.8
Others	3.3	2.7	3.0
Sanitation facility			
Flush to sewerage	1.1	10.3	6.2
Flush connected to septic tank	22.6	76.1	52.0
Raised latrine	16.7	3.0	9.2
In fields	55.6	9.7	30.3
Others	4.1	0.9	2.3
Main type of fuel used for cooking			
Fire wood	95.6	61.8	77.0
Gas cylinder	4.4	35.5	21.5
Others	0.0	2.7	1.5
Electrical connection			
Yes	40.7	99.1	72.8
No	59.3	0.9	27.2
Main material of the roof			
Guarder and T-iron	18.5	61.5	42.2
Wood/Bamboo and mud	80.0	37.6	56.7
Others	1.5	0.9	1.2
Main material of the floor			
Earth/Sand/Mud	44.1	5.8	23.0
Cement	54.4	92.7	75.5
Others	1.5	1.5	1.5
Main material of the walls			
Burnt bricks/Blocks	29.3	88.2	61.7
Mud bricks/Mud	60.7	10.6	33.2
Wood/Bamboo	9.6	1.2	5.0
Stones	0.4	0.0	0.2
Total	**100.0**	**100.0**	**100.0**
N	**270**	**330**	**600**

Figure 2.2: Distribution of water supply for Gwadar households

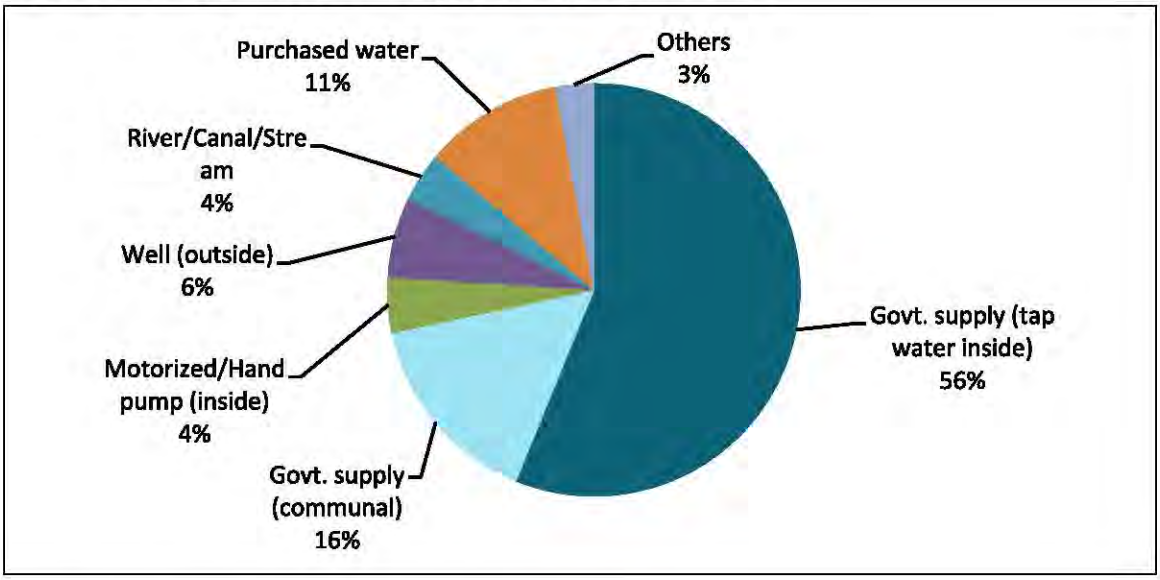
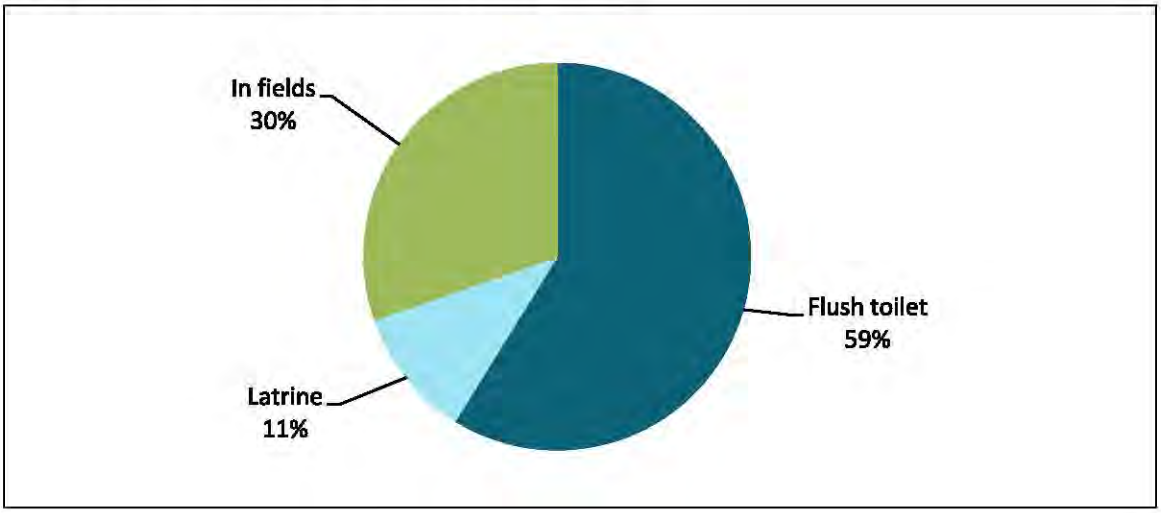


Figure 2.3: Toilet facilities for Gwadar households



Ownership of Household Assets

Another indicator of household wealth can be the ownership of durable consumer goods, as shown in Table 2.5. These 18 items are suggestive of wealth in a variety of ways. They represent different types of need – e.g., transport, communications, comfort – along with different tastes and levels of expenditure. Some have specific relevance to the FALAH

objectives; for example, electronic media can be used to access health messages to reach health facilities, and telephones to summon help when needed. Others are suggestive of more general well-being.

The distribution of these items shows the expansion in consumer purchasing power that has characterized Pakistan in recent years, although comparable past data for Gwadar were not available to us. Several items requiring electricity were available in a substantial proportion of households, even in rural areas. About three-fifth of all households had television sets, a figure of particular interest to communications specialists. The recent expansion of information technology in Pakistan is reflected by the ownership of mobile phones by nearly three-fourth (53 percent in rural and 93 percent in urban areas) of all households. Ownership of computer was reported with only 5.2 percent of all households relatively more in urban locality. Motorized transport (four wheels), however, remained fairly uncommon suggesting difficulties in arranging for transport in health emergencies.

Table 2.5: Percentage of sample households owning selected items by residence

Household item	Rural	Urban	Total
Wall clock	85.6	97.3	92.0
Chairs	1.1	4.5	3.0
Bed	18.9	62.7	43.0
Sofa	0.4	6.4	3.7
Sewing machine	30.0	51.8	42.0
Camera	3.3	11.5	7.8
Radio/Tape recorder	50.0	64.2	57.8
Television	24.4	90.9	61.0
Refrigerator	17.0	65.5	43.7
Land line telephone	4.1	3.0	3.5
Mobile phone	52.6	92.7	74.7
Room cooler/ Air conditioner	0.7	7.3	4.3
Washing machine	5.2	49.7	29.7
Bicycle	2.2	5.5	4.0
Motor cycle	50.7	58.8	55.2
Jeep/Car	8.9	5.2	6.8
Tractor	1.5	0.6	1.0
Computer	1.1	8.5	5.2
N	**270**	**330**	**600**

Standard of Living Index

It is useful to use the above data to get an overall index of the economic well-being of a household, both for a general estimate of economic development for an area, and for use in investigating the relationship between household wealth and reproductive health behavior. One such index is the standard of living index (SLI), developed for international comparisons with data from the Demographic and Health Surveys (Rutstein, S.O., and K. Johnson, 2004). This index gives each household a score of 0-1 or 0-2 on each of the following: source of drinking water; toilet facilities; material of floor; availability of electricity; ownership of a radio; ownership of a TV; ownership of a refrigerator; and means of transportation. For the whole household, the value of the index can range from 0 to 11. Table 2.6 gives the distribution of the SLI for the sample households according to urban and rural residence. The median index for all households was 7; for urban households, it was 9 and for rural households it was 4. About 51 percent of all households fell in the range from 3 to 8. This index will be used later in this report to examine differences in knowledge and behavior regarding reproductive health.

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

	Rural		Urban		Total	
Standard of living index	**N**	**%**	**N**	**%**	**N**	**%**
0	12	4.4	0	0.0	12	2.0
1	26	9.6	0	0.0	26	4.3
2	42	15.6	3	0.9	45	7.5
3	44	16.3	4	1.2	48	8.0
4	28	10.4	6	1.8	34	5.7
5	28	10.4	15	4.5	43	7.2
6	25	9.3	24	7.3	49	8.2
7	17	6.3	33	10.0	50	8.3
8	19	7.0	61	18.5	80	13.3
9	18	6.7	80	24.2	98	16.3
10	10	3.7	101	30.6	111	18.5
11	1	0.4	3	0.9	4	0.7
Total	**270**	**100.0**	**330**	**100.0**	**600**	**100.0**
Median	**4**	**na**	**9**	**na**	**7**	**na**

na = not applicable.

Chapter 3

Respondent Characteristics

The primary sources of data from the Household Survey are the interviews conducted with 691 currently married women of reproductive age. The background characteristics of these respondents are described in this chapter.

Age

Table 3.1 shows the age distribution of the female respondents for rural and urban areas. Since many younger women were not married yet, the numbers at age 15-19 years were relatively small; at older ages, the numbers declined, as reflected in the overall shape of the age pyramid. Forty-five percent of the sample respondents were under age 30; urban areas had about 44 percent and rural areas had about 47 percent of women under the age of 30.

Table 3.1: Age distribution of female respondents by residence

	Rural		Urban		Total	
Age group	**N**	**%**	**N**	**%**	**N**	**%**
15 - 19	9	2.9	13	3.5	22	3.2
20 - 24	69	21.9	70	18.6	139	20.1
25 - 29	69	21.9	81	21.5	150	21.7
30 - 34	49	15.6	81	21.5	130	18.8
35 - 39	53	16.8	63	16.8	116	16.8
40 - 44	39	12.4	42	11.2	81	11.7
45 - 49	27	8.6	26	6.9	53	7.7
Total	**315**	**100.0**	**376**	**100.0**	**691**	**100.0**

Education and Literacy

Levels of schooling completed and literacy rates for the respondents and their husbands are given in Table 3.2. Literacy rates are also shown in Figure 3.1. Literacy rates for females were very low (22 percent) compared to their husband's literacy level which was about 45 percent. The literacy of females (aged 15+ years) recorded in PSLMS 2004-05 was 36 percent for Pakistan and 14 percent for Balochistan.

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

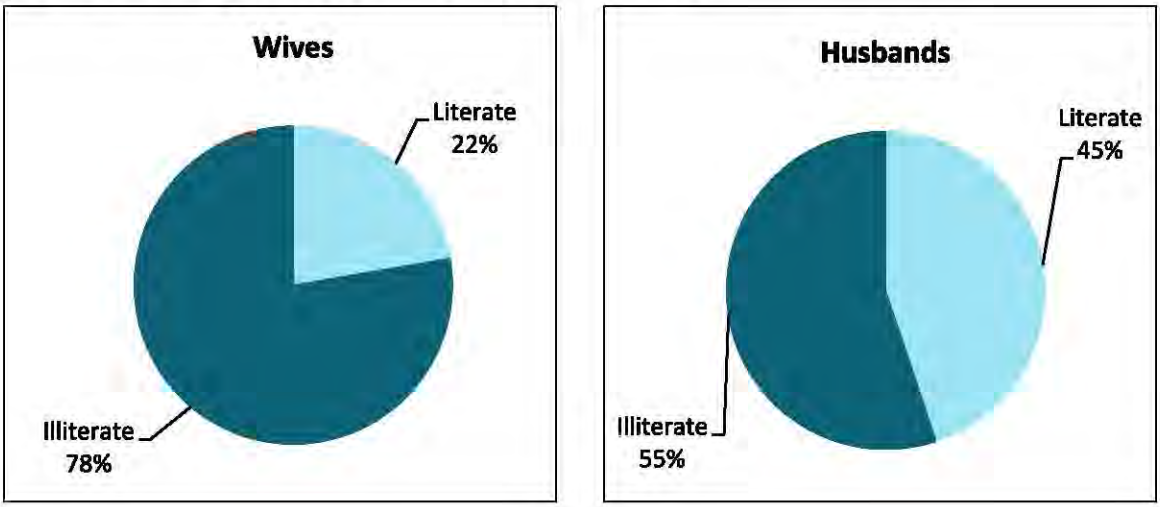
	Age group			Residence		
Variable	**15 - 24**	**25 - 34**	**35 - 49**	**Rural**	**Urban**	**Total**
Respondent (women)						
Proportion literate	36.0	26.4	8.8	9.2	33.2	22.3
Education level						
No education	55.9	73.6	92	87.9	66.2	76.1
Up to primary	14.9	11.1	3.6	7.3	10.9	9.3
Up to secondary	23	13.2	4.4	3.8	19.4	12.3
Above secondary	6.2	2.1	0	1.0	3.5	2.3
N	**161**	**280**	**250**	**315**	**376**	**691**
Respondent husband						
Proportion literate	57.1	51.8	29.2	28.3	58.8	44.9
Education level						
No education	41	49.6	73.6	73	42.3	56.3
Up to primary	13	8.6	4	7.6	8.2	8
Up to secondary	30.4	24.6	12.8	14.3	27.9	21.7
Above secondary	13	16.4	8.8	4.1	20.2	12.9
Don't know	2.5	0.7	0.8	1	1.3	1.2
N	**161**	**280**	**250**	**315**	**376**	**691**

It shows that literacy rate of female respondents was higher than reported literacy rate of the province of Balochistan as a whole. Similarly, about 24 percent of the female respondents reported having ever attended school. For men as well, literacy (about 45

percent) was lower than the PSLMS found for Balochistan in 2004-05 (49 percent), as well as the national average (63 percent) (Government of Pakistan, 2005).

For both men and women respondents, literacy and education levels as expected were higher in urban areas. Table 3.2 also shows that younger women aged 15-24 years and 25-34 years were significantly more literate than older women aged 35-49 years.

Figure 3.1: Literacy status of women and their husbands



Occupation and Work Status

For men, occupation is both an economic and social classification; some occupations usually indicate higher income levels than others, while at the same time may represent social status and lifestyle. Women's work, whether for necessary income or for career fulfillment, is likely to compete, at least to some degree, with time spent on household management and child care. Therefore, it is worthwhile to examine men and women's work separately. Only 287of 691 female respondents reported working for pay; their occupations are shown in Figure 3.2.

Figure 3.2: Type of work of women working for pay (n=287)

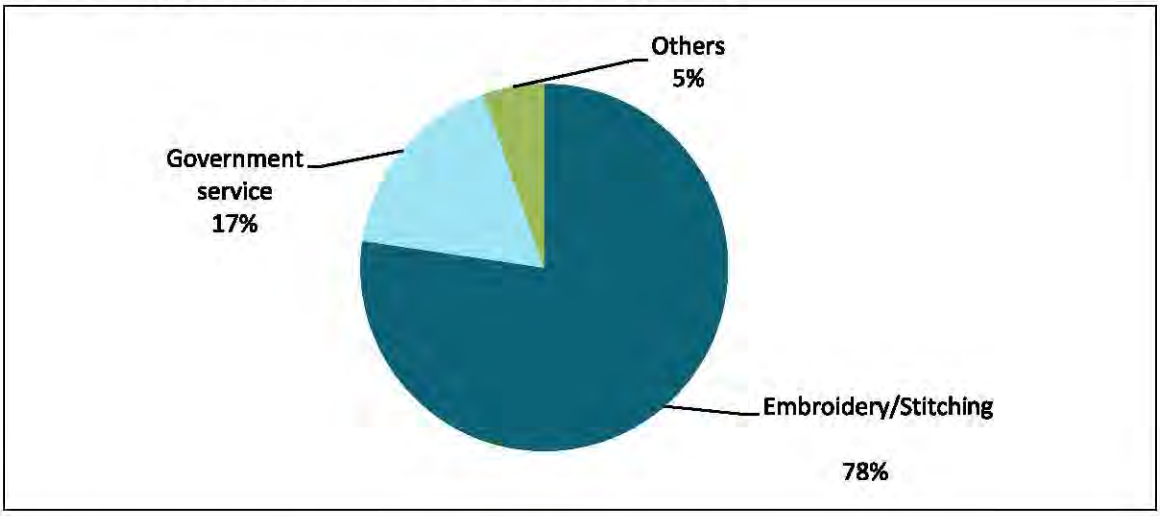


Table 3.3: Distribution of occupational categories of respondents' husbands by residence

Economic activity/Occupation	Rural	Urban	Total
Agriculture/Livestock/Poultry	5.7	0.0	2.6
Petty trader	5.1	8.8	7.1
Labor (Daily wages)	53.7	51.9	52.7
Government service	10.5	19.7	15.5
Private service	1.3	3.5	2.5
Own business	5.4	8.0	6.8
Abroad	3.5	1.9	2.6
Unemployed	12.4	5.1	8.4
Skilled worker	1.6	0.5	1.0
Others	0.6	0.8	0.7
Don't know	0.3	0.0	0.1
N	**315**	**376**	**691**

Only 2.6 percent of the women's husbands were working in agriculture/livestock or poultry. About 16 percent of those men were in government service while substantial proportion was working as daily-wage laborers (about 53 percent). A total of 7 percent of the women's husbands had their own business while 8 percent were reported as unemployed.

Female Mobility

Women respondents were asked about their ability to go to places outside their homes and what degree of permission was required. Only a few women reported being able to go to any of the places named without permission. On the other hand only 7 percent of the women reported not being able to go at all to the market. However, this number is very low for health center, and near to three-fifth could go there with someone. For each of the named destinations, more than fifty percent said they could gowith someone and one third could go with permission.

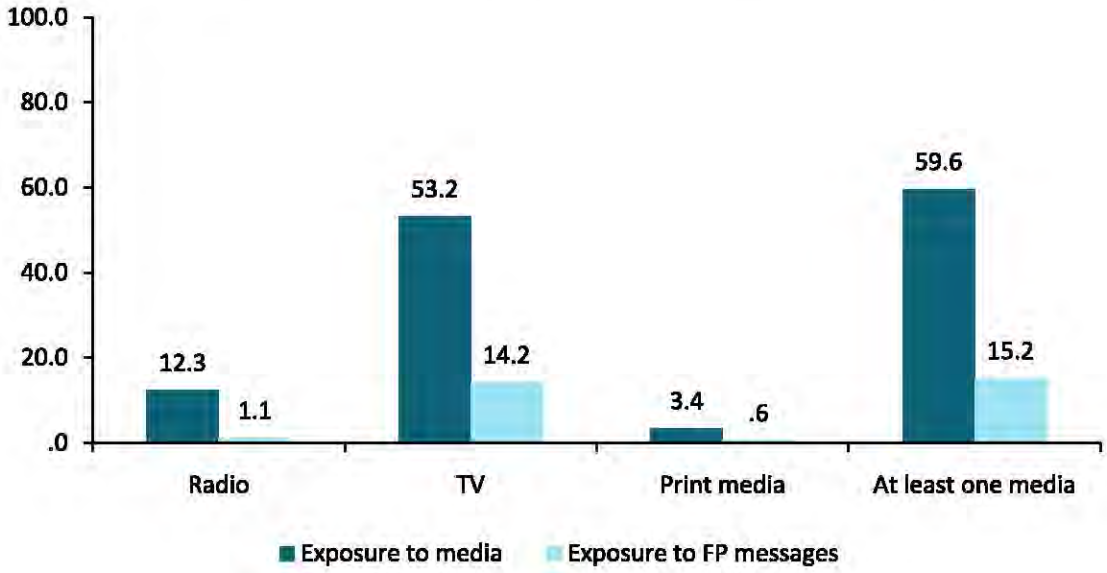
Table 3.4: Women's reports regarding mobility outside the home by degree of permission and destination

Destination	Degree of permission				Total	
	Without permission	With permission	With someone	Cant go/ Doesn't go	%	N
Market	4.5	33.0	55.4	7.1	100.0	691
Health center	5.6	35.5	58.0	0.9	100.0	691
Relatives/friends	10.7	38.2	50.1	1.0	100.0	691
Out of village/ town	3.6	35.9	51.5	9.0	100.0	691

Mass Media Access and Exposure to Family Planning Messages

For the development of communication activities, it is important to know which forms of mass media are available and to what extent they are used by various segments of the population. Table 2.5 shows that 61 percent of households owned a television, while 58 percent owned a radio. Figure 3.4 shows the proportion of women who reported that they watch TV, listen to the radio, or read newspapers or magazines. Television was the most commonly used medium (53 percent), while radio and print media were less common (12 percent and 3 percent respectively).

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



Furthermore, women who reported access to any sort of media were asked if they had ever seen, heard or read any message about methods of family planning through these mediums. Only 14.2 percent women reported being exposed to family planning messages on television and 1 percent on radio.

Chapter 4

Service Availability

Health status and practices in a district can only be understood in the context of the health facilities and trained personnel available to the population of that district. As a companion activity to the Gwadar Household Survey, the FALAH project undertook a mapping of health and reproductive health services study in the FALAH districts. The fieldwork in Gwadar was carried out from February to March, 2008. In this survey, all public and private facilities and providers for reproductive health, including family planning as well as maternal health, were identified and visited. Exact locations of these facilities were determined by using the global positioning system (GPS) device and the characteristics and activities of the facility and its staff were examined. The full results of this study are presented in a separate report titled "Mapping Survey of Health and Reproductive Health Services Gwadar district". In this section, some basic results are provided to give a rough context in which the knowledge, attitudes and behavior of the women of the household survey sample can be understood.

These results represent a range of maternal and reproductive health services being provided in Gwadar. The following tables summarize those findings, and are illustrated by maps indicating the location of various types of providers and facilities.

Gwadar District Data

There are total of 154 health facilities in Gwadar district, of which 135 are from the public sector and 19 from the private sector (4 - Greenstar Social Marketing; 15 - other private facilities). Some facilities provide only limited care, such as the LHW health houses and dispensaries in the public sector and traditional practitioners in the private sector.

Reproductive Health Facilities

The distribution of reproductive health facilities in the public and private sectors per union council is shown in Maps 4.1 to 4.3. Map 2.1 shows the distribution of government static facilities by union council population density. Similarly, Map 4.2 shows the availability of LHWs; the variation is considerable as only 3 union councils have more than 10 LHWs, while 5 have fewer than 10 LHWs. Moreover, there are 4 union councils having no LHW in the area. On average, there are about 7 LHWs per union council. Map 4.3 shows the distribution of private facilities in the district.

The gross density of reproductive health facilities in terms of the number of facilities per union council is shown in Map 4.4. There is only one union council having more than 40 reproductive health facilities, while all others have less than 20 facilities. There is no union council without any service delivery point. On average there are 13 reproductive health facilities per union council.

Family Planning Facilities

By and large, family planning services are available in a large number of facilities in Gwadar district. However, the availability of clinical methods, with the exception of injectables, is virtually non-existent; IUDs are available at only 1 private and 4 public facilities. Norplant and female and male sterilization services are not available at all. In contrast, non-clinical methods, particularly condoms and pills, are available in a large number of public facilities, and LHWs are the main contributing factor. These methods are less available at private facilities. Emergency contraceptive pills are available at only 4 public and 2 private facilities.

Table 4.1: Number and proportion of facilities providing specified family planning services in Gwadar district, by sector and MWRA per facility

	Sector										
	Government		LHWs		Private GSM		Private others		Total		MWRA per facility
Service	N	%	N	%	N	%	N	%	N	%	
Injectables	12	24.5	45	52.3	1	25.0	4	26.7	62	40.3	447
IUD/Copper T	4	8.2	na	na	0	0.0	1	6.7	5	3.2	5546
Norplant	0	0.0	na	na	0	0.0	0	0.0	0	0.0	na
Female sterilization	0	0.0	na	na	0	0.0	0	0.0	0	0.0	na
Male sterilization	0	0.0	na	na	0	0.0	0	0.0	0	0.0	na
Condom	11	22.4	85	98.8	1	25.0	2	13.3	99	64.3	280
Pills	12	24.5	86	100.0	1	25.0	3	20.0	102	66.2	272
ECP	4	8.2	0	0.0	0	0.0	2	13.3	6	3.9	4621
Any FP method	16	32.7	86	100.0	1	25.0	4	26.7	107	69.5	259
Any clinical method	12	24.5	45	52.3	1	25.0	4	26.7	62	40.3	447
Any non-clinical method	13	26.5	86	100.0	1	25.0	4	26.7	104	67.5	267
Total facilities	**49**	**100.0**	**86**	**100.0**	**4**	**100.0**	**15**	**100.0**	**154**	**100.0**	**180**

Note: Multiple responses possible. Clinical method include; injectables, IUDs, Norplant, female sterilization and male sterilization. na; not applicable

The geographic distribution of these services is as important as the number. Maps 4.5 to 4.7 show the availability of female sterilization, IUDs and injectables, as illustrations. Female sterilization is not available in any union council. IUD services are available in 3 union councils; this method is not available in 9 union councils. Availability of injectables is more widespread than other clinical methods; this method is available in 10 union councils, whereas in 2 union councils there is no facility providing this service. Methods like pills and condoms (not shown in the map) are readily available throughout the district, mainly from the public sector.

Maternal Health Facilities

The provision of maternal health care services is an essential component of reproductive health care. Maternal health care services are shown in Table 4.2. Anemia treatment is the most frequently available service, followed by antenatal check-up, both in public and private facilities. Service availability for tetanus protection is generally low, but it is higher

in public facilities, while only 1 private facility is providing this service. Normal delivery services are available at only 13 facilities. Overall, one normal delivery facility is available for every 2133 married women of reproductive age. On the other hand, Caesarean section, an important element of comprehensive obstetric care services, is available in only 1 private facility. Generally, the very limited availability of tetanus protection and Caesarean section services is a matter of serious concern in the district.

Table 4.2: Number and proportion of facilities providing specified maternal health care services in Gwadar district, by sector and MWRA per facility

	Sector										
	Government		LHWs		Private GSM		Private others		Total		MWRA per facility
Service	N	%	N	%	N	%	N	%	N	%	
Antenatal check-up	24	49.0	77	89.5	4	100.0	7	46.7	112	72.7	1155
Anemia treatment	42	85.7	86	100.0	4	100.0	12	80.0	144	93.5	193
TT injection	15	30.6	4	4.7	1	25.0	0	0.0	20	13.0	1386
Normal delivery	10	20.4	na	na	1	25.0	2	13.3	13	8.4	2133
Caesarean section	0	0.0	na	na	1	25.0	0	0.0	1	0.6	27728
Total facilities	**49**	**100.0**	**86**	**100.0**	**4**	**100.0**	**15**	**100.0**	**154**	**100.0**	**180**

Note: Multiple responses possible. MWRA; married women of reproductive age na; not applicable

Along with the sheer number of facilities, their geographic distribution is of critical importance. Map 4.8 shows the distribution of essential obstetric facilities in each union council of Gwadar district. There are 4 union councils with no obstetric care facilities, while there are 8 union councils that do have facilities providing these services. Map 4.9 shows that only 1 facility in the district provides comprehensive emergency obstetric care (EmOC) services.

Service Providers

The number of providers of different categories and number of women per provider are shown in Table 4.3. There are a total of 52 MBBS doctors; only 5 of these are women. There are fewer female paramedics than male paramedics. Of the total of 27 female paramedics serving the entire female population of the district, 74 percent are lady health visitors.

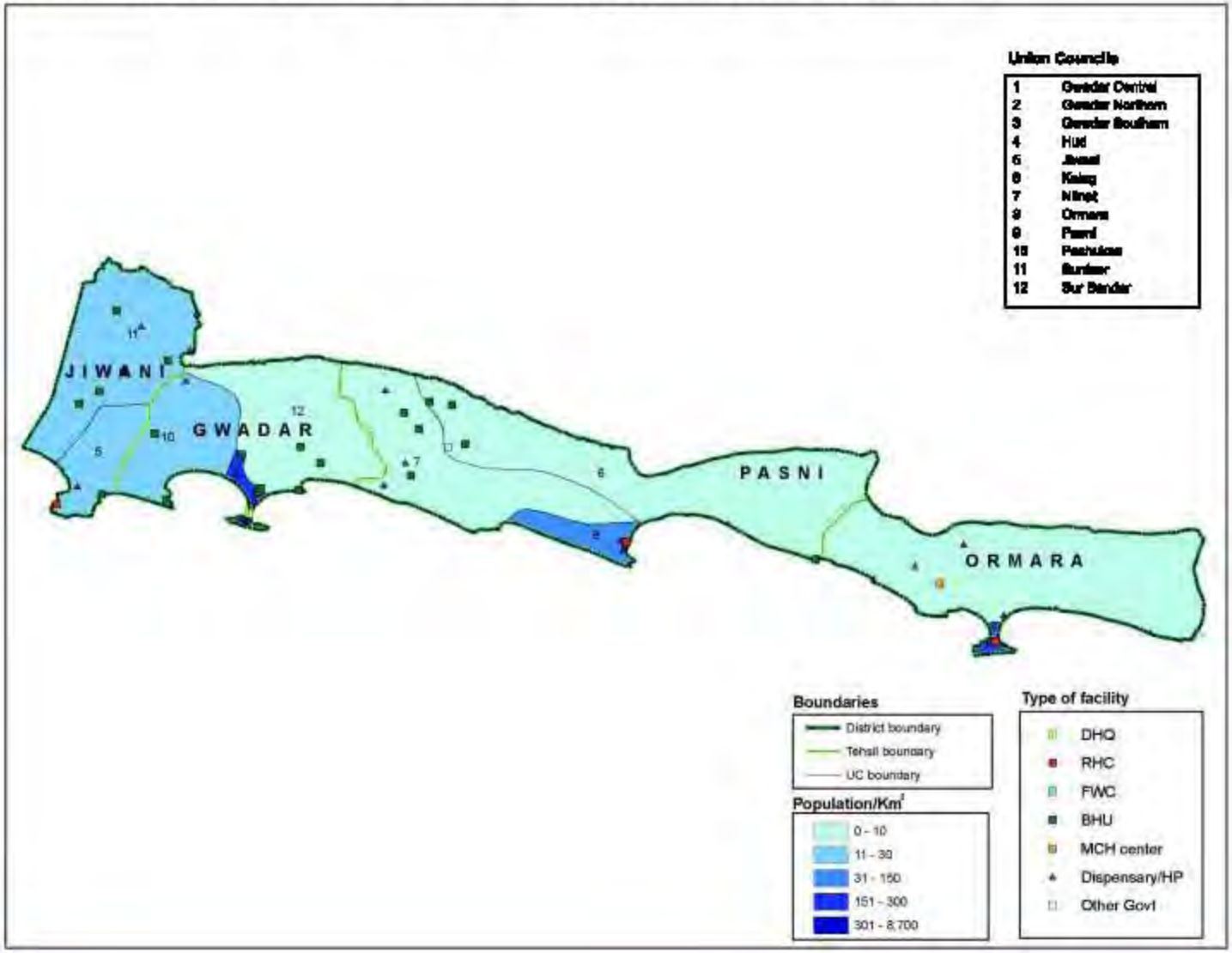
The number of married women per provider or facility is a good indicator of the status of health in the district. Table 2.3 shows that, overall, there is 1 MBBS doctor available to serve 533 married women of reproductive age. Since women usually prefer female service providers, especially for their reproductive health needs, this burden increases to 5546 MWRA per female MBBS doctor, indicating a serious dearth of female doctors in the district. For female paramedics, there are about 1027 MWRA per female paramedic. Map 4.10 shows the availability of MBBS doctors by gender in each union council. There are 3 union councils where male doctors are not available, while in 9 union councils there is no female MBBS doctor.

Table 4.3: Number of reproductive health care providers in Gwadar district, by sector and category, and MWRA per service provider

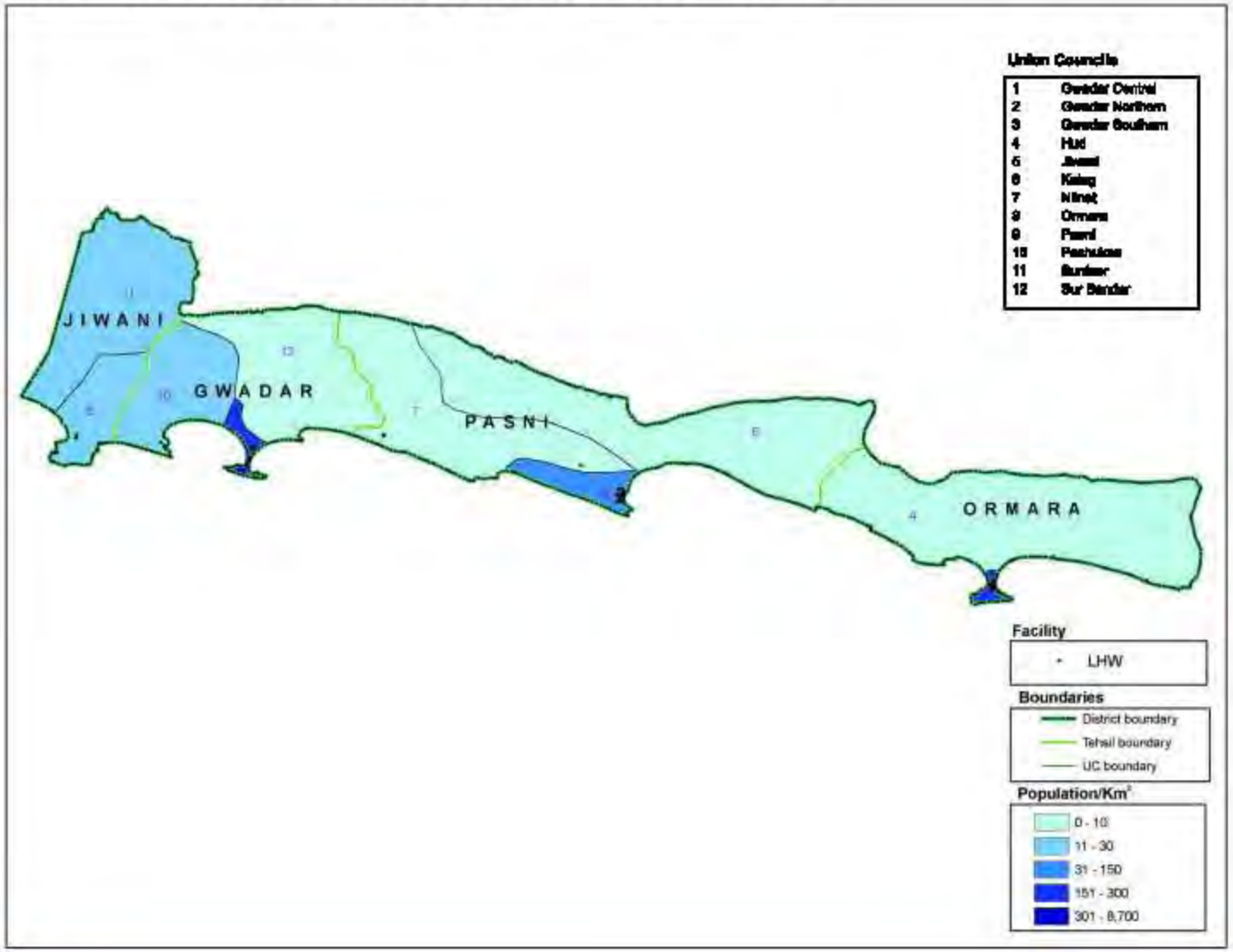
	Sector								MWRA per
	Government		Private GSM		Private others		Total		
Provider	N	%	N	%	N	%	N	%	provider
Doctors (MBBS)									
Male	29	87.9	9	100.0	9	90.0	47	90.4	590
Female	4	12.1	0	0.0	1	10.0	5	9.6	5546
Total	**33**	**100.0**	**9**	**100.0**	**10**	**100.0**	**52**	**100.0**	**533**
Female paramedics									
Medical assistant	0	0.0	0	0.0	0	0.0	0	0.0	0
Nurse	4	17.4	1	50.0	1	50.0	6	22.2	4621
Medical/ health technician	1	4.3	0	0.0	0	0.0	1	3.7	27728
Lady health visitor	18	78.3	1	50.0	1	50.0	20	74.1	1386
Total	**23**	**100.0**	**2**	**100.0**	**2**	**100.0**	**27**	**100.0**	**1027**
Male paramedics	**44**	**100.0**	**0**	**100.0**	**2**	**100.0**	**46**	**100.0**	**603**

MWRA; married women of reproductive age

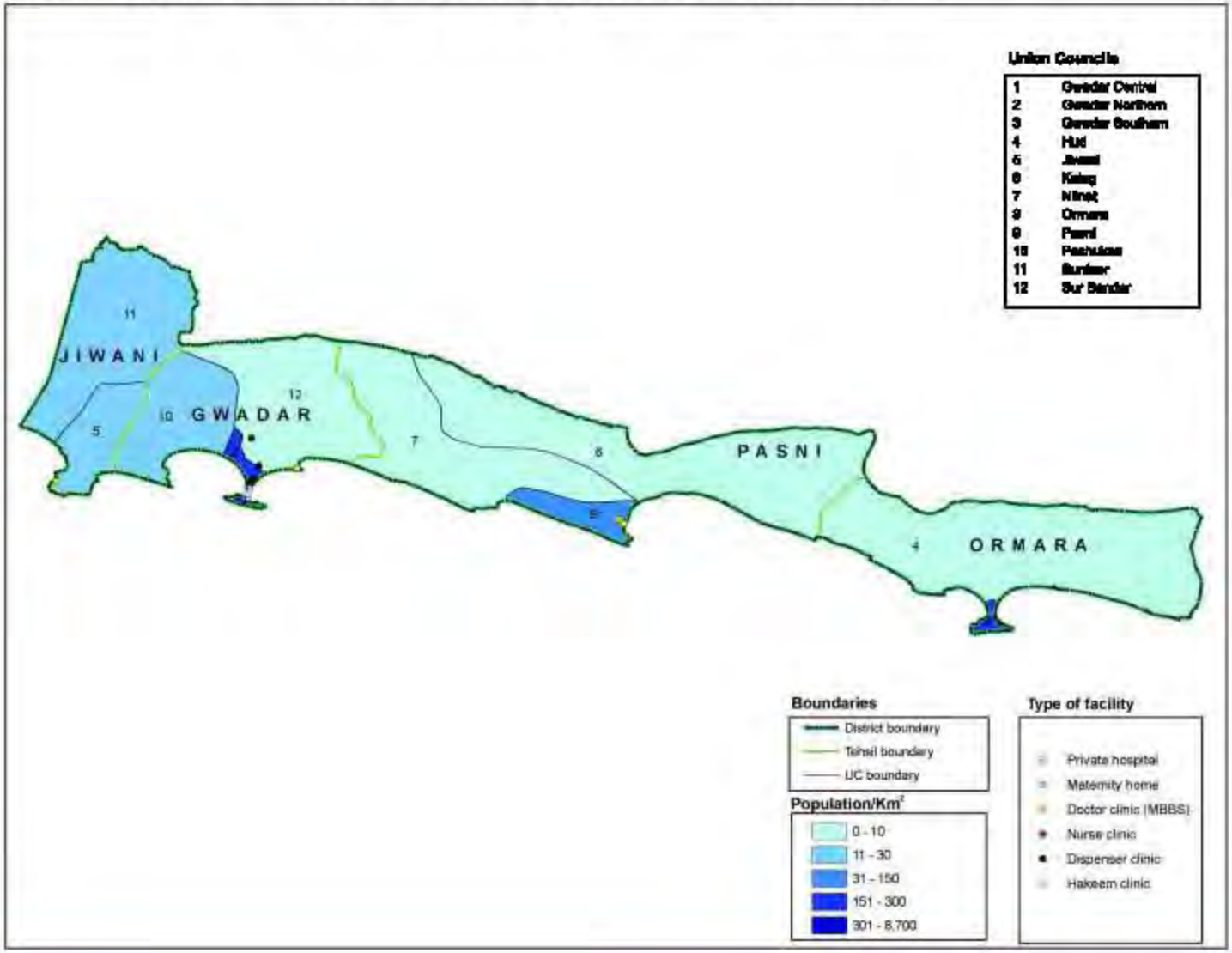
Map 4.1: Location of government facilities in Gwadar district, by population density of union council



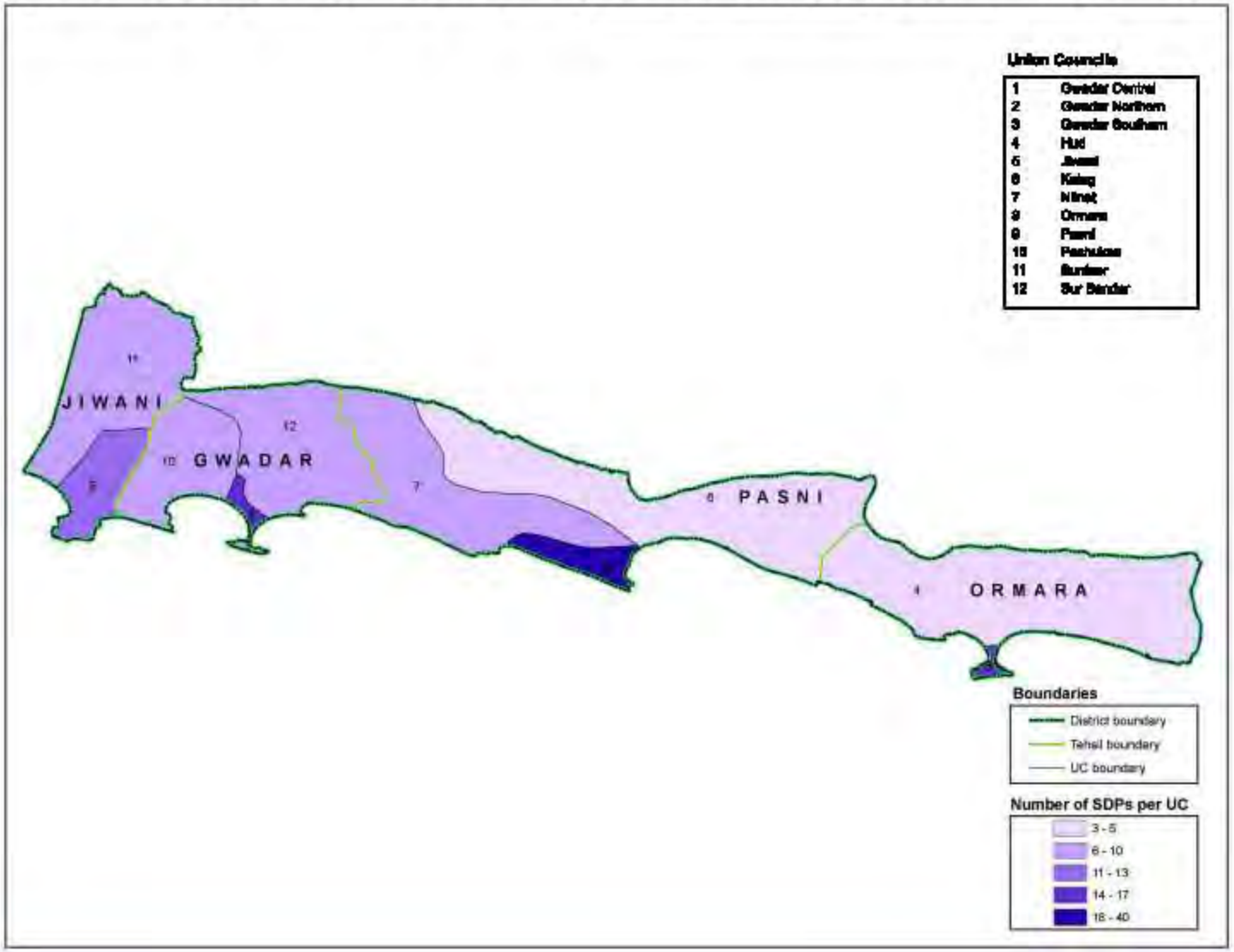
Map 4.2: Location of LHWs in Gwadar district, by population density of union council



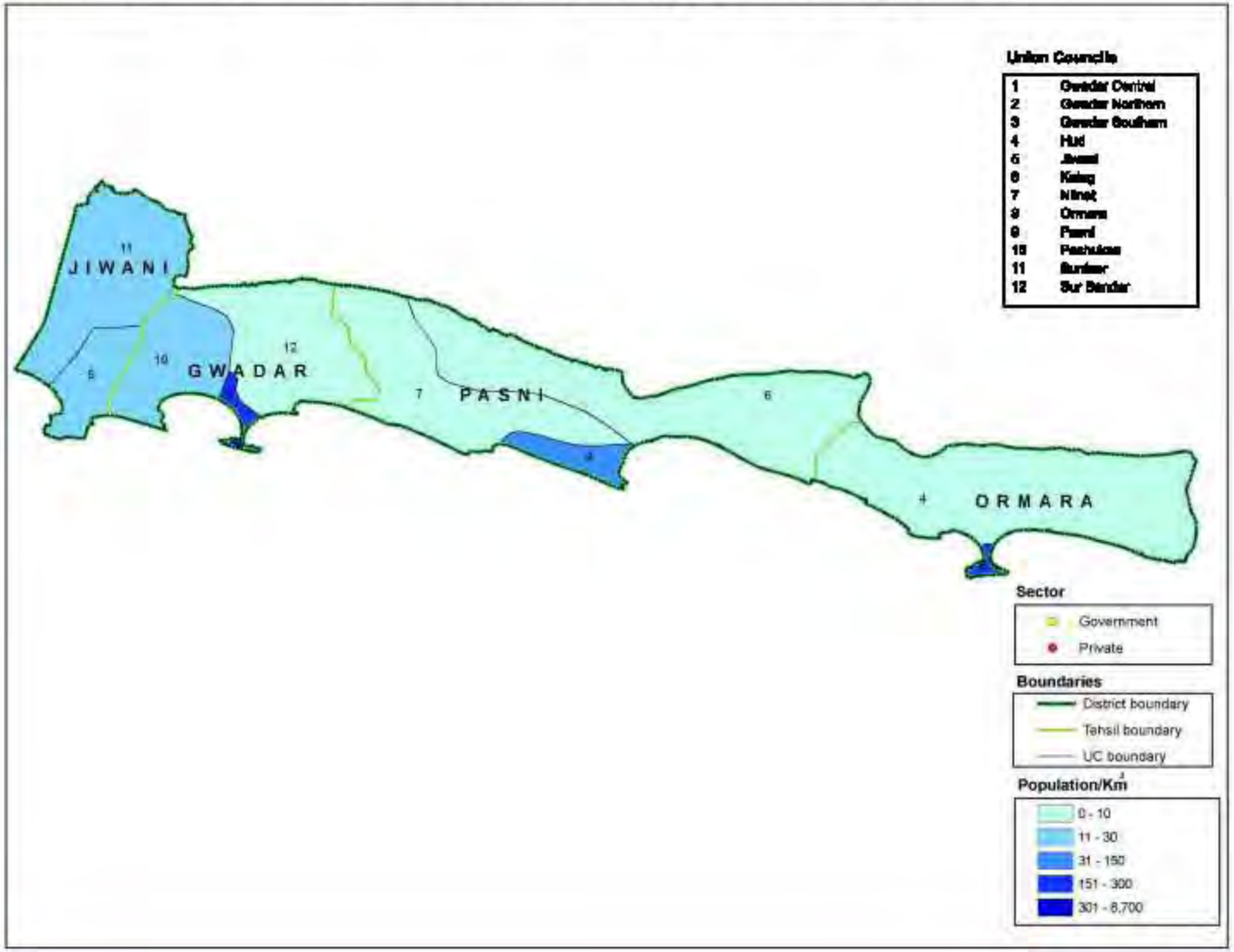
Map 4.3: Location of private facilities in Gwadar district, by population density of union council



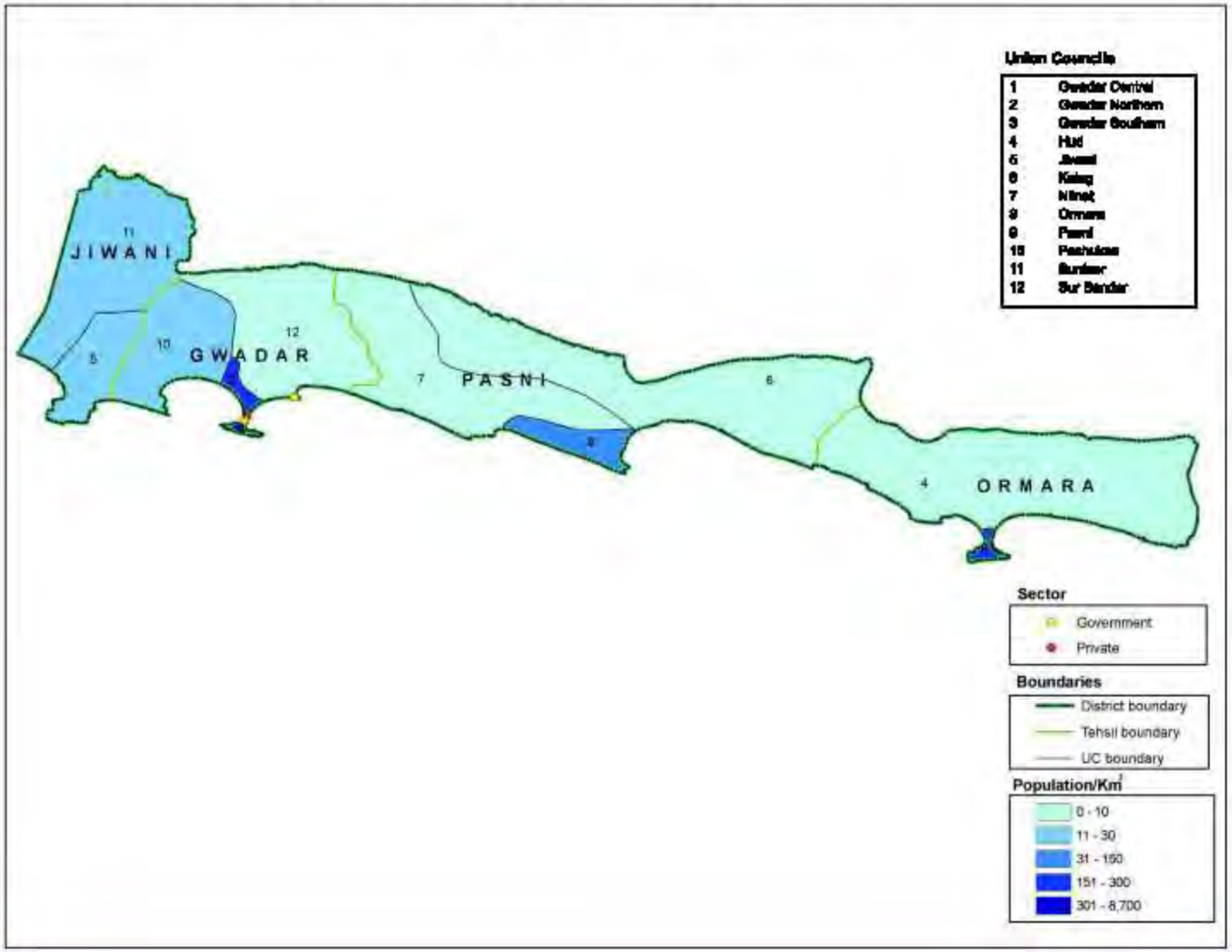
Map 4.4: Total number of reproductive health service delivery points (public and private) in Gwadar district, by union council



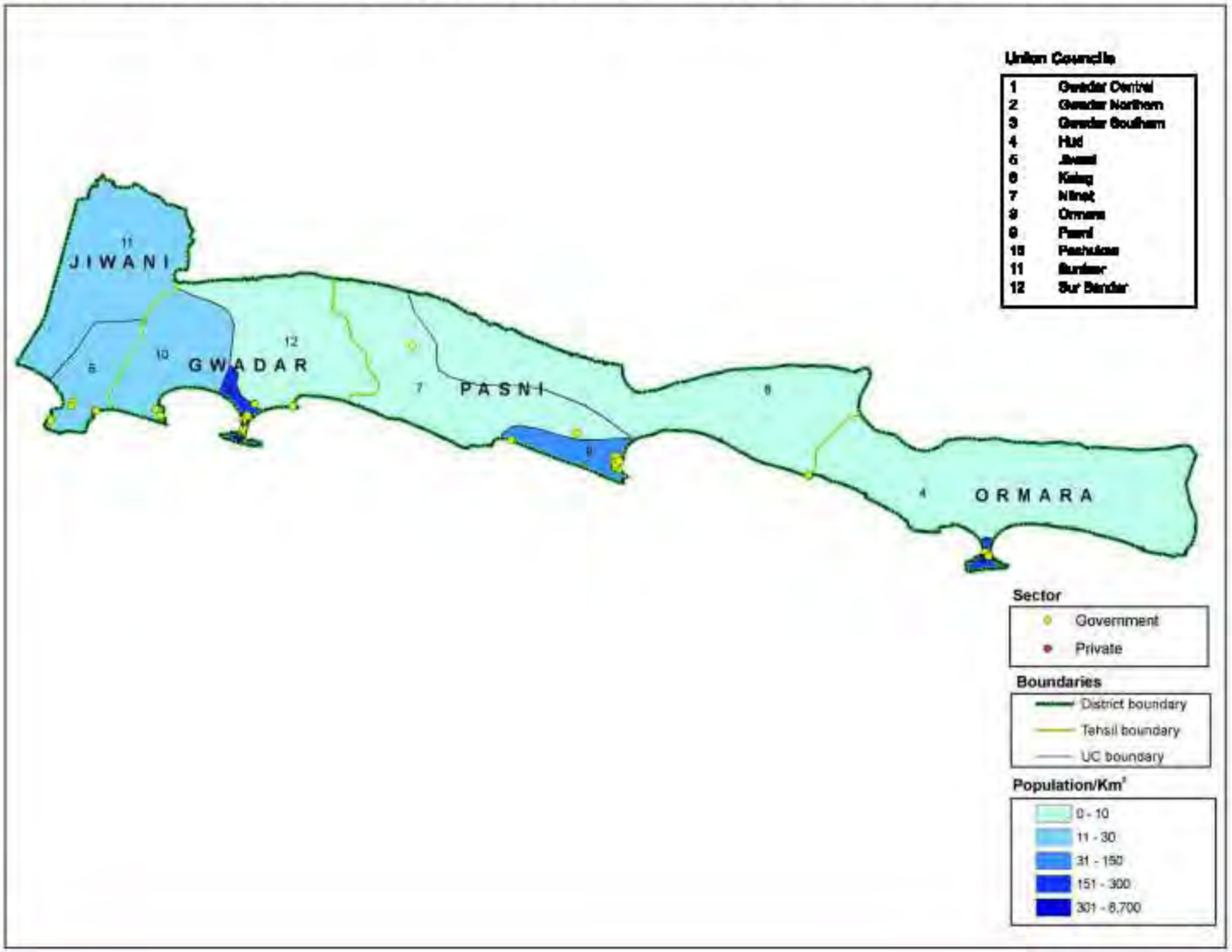
Map 4.5: Location of female sterilization facilities in Gwadar district, by population density of union council



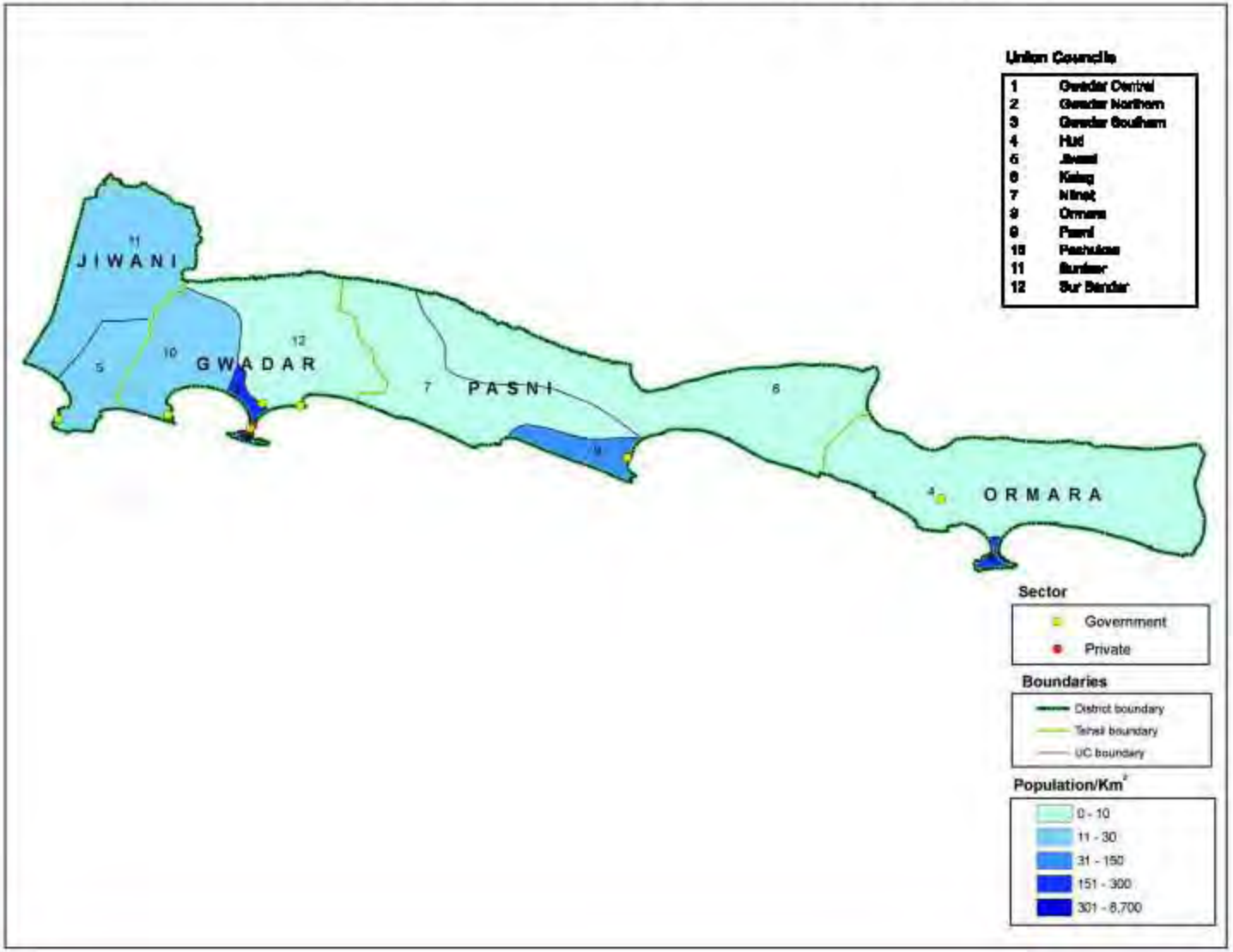
Map 4.6: Location of IUD facilities in Gwadar district, by population density of union council



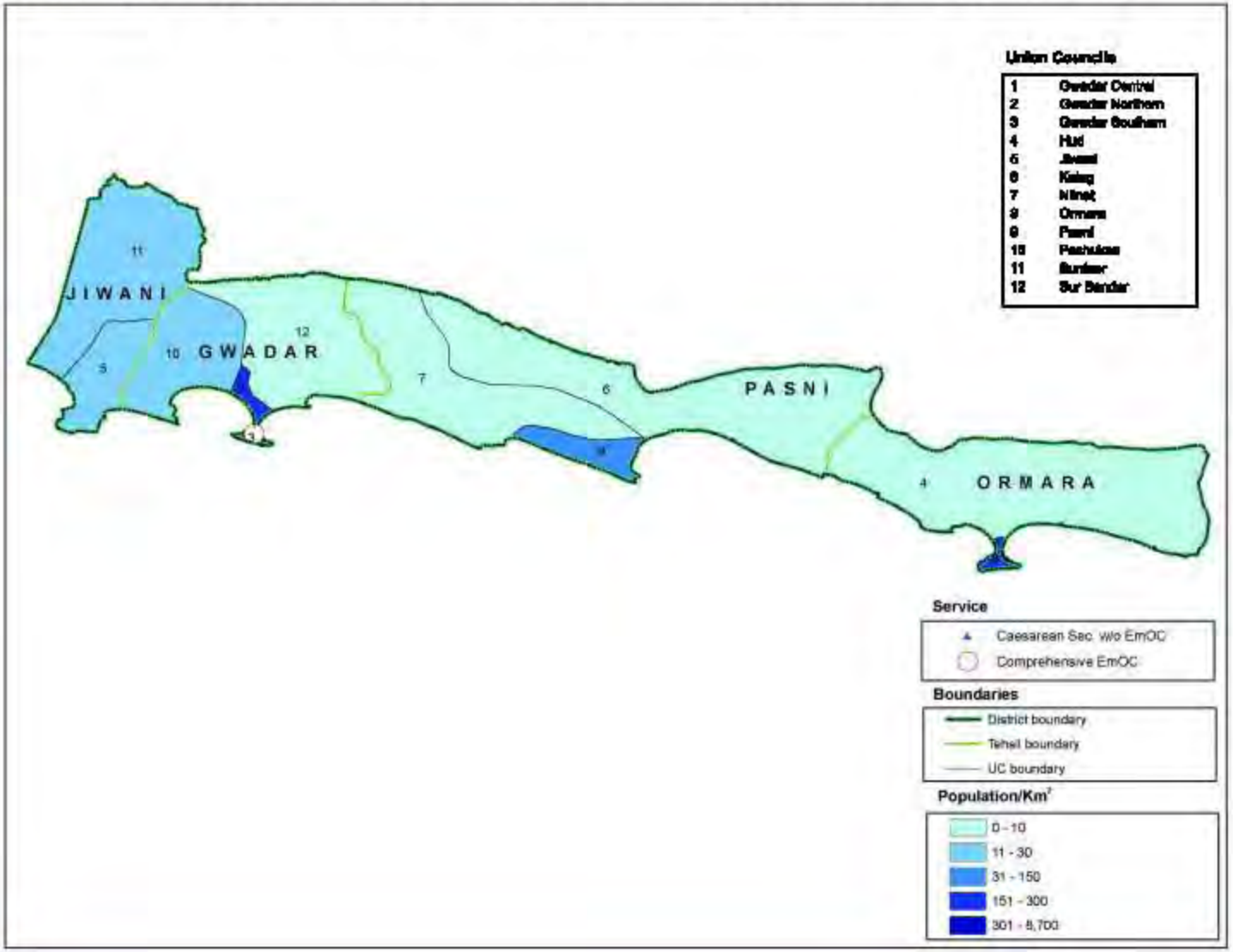
Map 4.7: Location of injectables contraceptive services in Gwadar district, by population density of union council



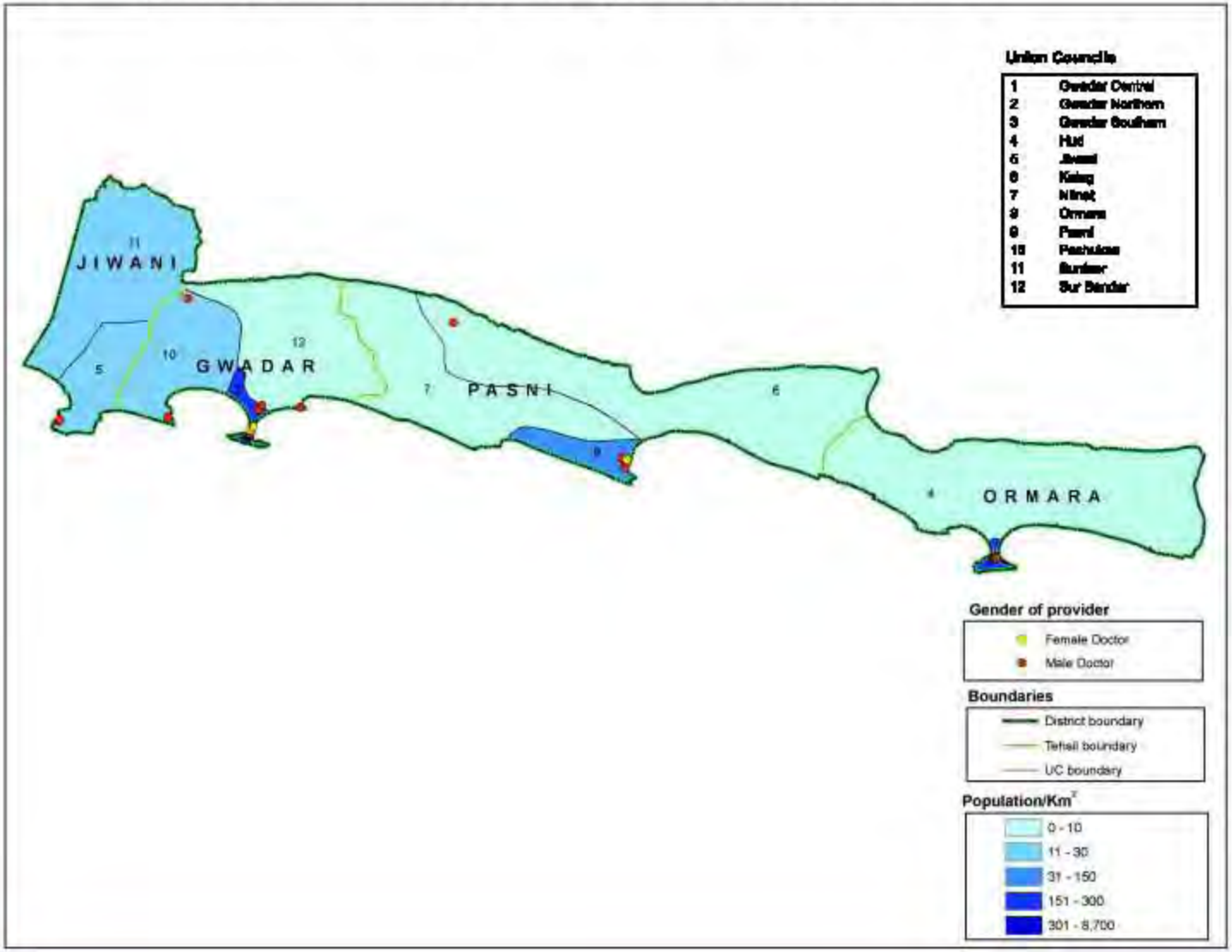
Map 4.8: Location of essential obstetric services in Gwadar district, by population density of union council



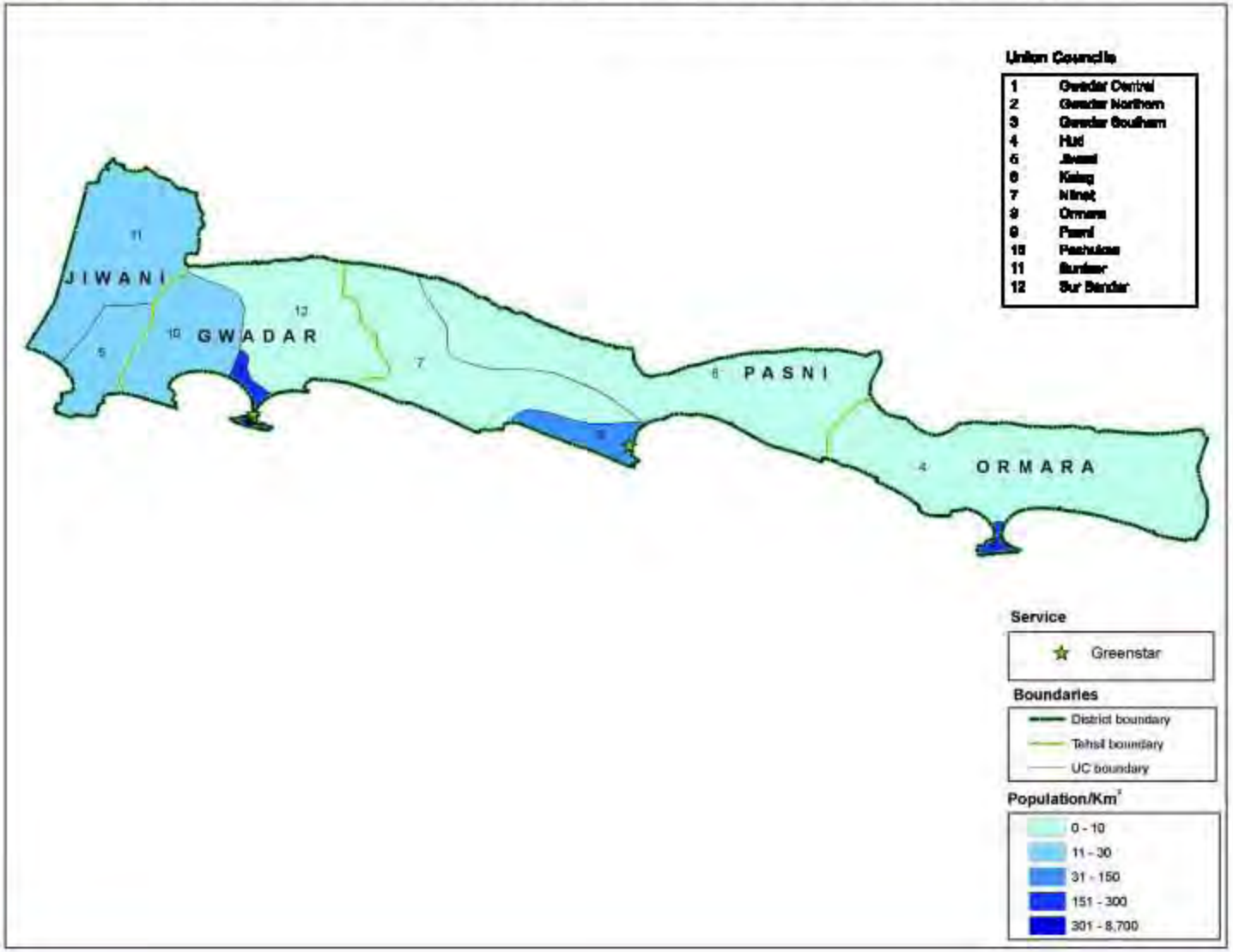
Map 4.9: Location of emergency obstetric care facilities in Gwadar district, by population density of union council



Map 4.10: Location of doctors in Gwadar district, by gender and population density of union council



Map 4.11: Location of Greenstar Social Marketing SDPs in Gwadar district, by population density of union council



Chapter 5

Fertility

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

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

Cumulative Fertility

Children Ever Born and Living

The number of children a woman has ever borne reflects fertility in the past; it therefore provides a somewhat different picture of fertility levels, trends and differentials than do period measures of fertility such as the CBR and the TFR. Table 5.1 shows the percentage distribution of all currently married women by the number of children ever born (CEB). The table shows this distribution by the age of the woman at the time of the survey.

Table 5.1: Distribution of MWRA by age of mother and number of children ever born (CEB)

	Children ever born						
Age group	0	1-2	3-4	5 or more	%	Mean CEB	N
15-19	59.1	40.9	0.0	0.0	100	0.5	22
20-24	28.8	51.8	18.0	1.4	100	1.3	139
25-29	12.0	48.0	30.0	10.0	100	2.4	150
30-34	6.2	15.4	38.5	40.0	100	4.1	130
35-39	6.0	9.5	18.1	66.4	100	5.3	116
40-44	2.5	6.2	11.1	80.2	100	6.7	81
45-49	1.9	1.9	11.3	84.9	100	7.2	53
Total	**12.9**	**27.5**	**22.6**	**37**	**100**	**3.8**	**691**

Table 5.2: Distribution of MWRA by age of mother and number of living children (LC)

	Number of living children						
Age group	0	1-2	3-4	5 or more	%	Mean LC	N
15-19	63.6	36.4	0.0	0.0	100	0.4	22
20-24	30.2	53.2	15.1	1.4	100	1.3	139
25-29	12.7	50.7	28.0	8.7	100	2.2	150
30-34	6.2	18.5	38.5	36.9	100	3.8	130
35-39	6.0	10.3	23.3	60.3	100	4.9	116
40-44	2.5	7.4	13.6	76.5	100	5.9	81
45-49	1.9	3.8	15.1	79.2	100	6.4	53
Total	**13.5**	**29.2**	**23.0**	**34.3**	**100**	**3.5**	**691**

Early childbearing was common in Gwadar. The table, as expected, shows that the mean number of children ever born (Table 5.1) and living children (Table 5.2) increased with the age of the mother. Table 5.3 shows that the mean number of children ever born increased steadily from 0.5 in the age group 15-19 years to 7.2 in the age group 45-49. Among women aged 15-49 in Gwadar, the mean number of children ever born was 3.8 for currently married women. On average, the women aged 45-49 also had 6.4 living children; they had lost 0.8 children in their reproductive lives.

Table 5.3: Mean number of children ever born and children surviving by sex of child and age of mother

	Mean number of children						
	Ever born			Surviving			
Age group	Boys	Girls	Total	Boys	Girls	Total	N
15-19	0.2	0.3	0.5	0.2	0.2	0.4	22
20-24	0.6	0.7	1.3	0.6	0.7	1.3	139
25-29	1.2	1.2	2.4	1.1	1.2	2.2	150
30-34	2.0	2.1	4.1	1.8	2.0	3.8	130
35-39	2.7	2.7	5.3	2.4	2.5	4.9	116
40-44	3.3	3.4	6.7	2.9	3.0	5.9	81
45-49	3.7	3.5	7.2	3.2	3.2	6.4	53
Total	**1.9**	**1.9**	**3.8**	**1.7**	**1.8**	**3.5**	**691**

Table 5.1 also shows that about 41 percent of the married women who were 15-19 years of age had already had a child. Women aged 45-49 had virtually completed childbearing. Among the currently married women in this age group, 13.2 percent had reached the end of childbearing with fewer than five children ever born and about 85 percent had five or more children ever born. Data show that 98 percent of the women aged 45-49 had at least one live birth in their reproductive period, suggesting that primary infertility was 2 percent (i.e., the proportion of couples who are unable to have any children) in this sample in Gwadar. The sex ratio at birth was 106 males per 100 females, which is consistent with international norms. The sex ratio of living children was 100.

Differentials in Children Ever Born and Surviving

Table 5.4 and Table 5.5 show that differences in the mean number of children by literacy, and educational level of currently married women were pronounced. On average, literate women produced 2 fewer children than illiterate women. Also, fertility declined with the level of education. Those who had "up to primary" education had 2.8 children ever born on average as compared to 4.3 produced by those who had no schooling. Those who had "up to secondary" education had 2.1 children ever born.

Table 5.4: Mean number of children ever born, living and dead by background characteristics

Characteristic	Mean number of CEB	Mean number of LC	Proportion died	N
Literacy of respondent				
Literate	2.3	2.1	0.0546	154
Illiterate	4.3	3.9	0.0944	537
Schooling of respondent				
No education	4.3	3.9	0.0950	526
Up to primary	2.8	2.6	0.0670	64
Up to Secondary	2.1	2.0	0.0447	85
Above secondary	0.9	0.9	0.0000	16
Residence				
Rural	4.0	3.6	0.0911	315
Urban	3.7	3.3	0.0874	376
Literacy of respondent's husband				
Literate	3.0	2.8	0.0647	310
Illiterate	4.5	4.0	0.1025	381
Schooling of husband				
No education	4.5	4.1	0.1022	389
Up to primary	3.1	2.8	0.0947	55
Up to Secondary	2.9	2.7	0.0603	150
Above secondary	2.8	2.7	0.0474	89
Don't know	2.6	2.5	0.0476	8
Standard of living index				
Low	4.4	4.0	0.0972	140
Medium low	3.6	3.3	0.0949	87
Medium high	3.6	3.3	0.0907	114
High	3.7	3.4	0.0834	350
Economic activity/ occupation of husband				
Agriculture /Livestock/Poultry	5.2	4.8	0.0745	18
Petty trader	3.9	3.6	0.0582	49
Labor (Daily wages)	3.8	3.4	0.1069	364
Government service	3.7	3.5	0.0482	107
Private service	3.2	2.8	0.1111	17
Own business	3.7	3.4	0.0581	47
Abroad	3.0	2.8	0.0741	18
Unemployed	4.5	4.0	0.1145	58
Skilled worker	2.1	2.1	0.0000	7
Others	3.4	3.4	0.0000	5
Don't know	0.0	0.0	0.0000	1
Total	**3.8**	**3.5**	**0.0892**	**691**

Differentials were also observed on the basis of literacy and economic activity of husbands. Those who had literate husbands had 3 children compared to 4.5 children ever born to those who had illiterate husbands. The differentials relating to the background characteristics of husbands were somewhat smaller than those relating to the background characteristics of the currently married women themselves. Women with illiterate husbands had the higher number of children ever born (4.5) compared to the women who themselves were illiterate (4.3). Women with husbands in agriculture/livestock/poultry had the highest number of children ever born (5.2 children), while women whose husbands were working in the private sector had the lowest number of children ever born (3.2 children) after those women who had husbands working abroad.

A comparison of mean numbers of children ever born and surviving children shows that survival of children increased with the literacy of mothers. The survival of children was also better if the husband was literate.

Table 5.5 further explains the relationship of age of mothers and literacy with mean number of children ever born and their survival. It is evident that the mean number of children ever born to literate mothers was lower (2.3 children) compared to those mothers who were illiterate (4.3 children). Similarly, the survival of children of literate mothers was far better than those born to illiterate mothers. The mean number of children ever-born to younger literate mothers was lower and their survival was better than children born to mothers in older age groups (25-39). Literate mothers were younger than illiterate mothers. In the below 30 age group, about 69 percent of the mothers were literate, as compared to 38 percent who were illiterate. It is not only that literate women had fewer children overall, but younger literate women also had fewer children ever born compared to illiterate women.

Table 5.5: Mean number of children ever born and living by age and literacy of mother

Age group	Literate				Illiterate			
	Mean number of CEB	Mean number of LC	N	%	Mean number of CEB	Mean number of LC	N	%
15 – 19	0.4	0.4	9	5.8	0.5	0.4	13	2.4
20 – 24	0.9	0.9	49	31.8	1.6	1.5	90	16.8
25 – 29	2.2	2.1	48	31.2	2.5	2.3	102	19.0
30 – 34	3.4	3.0	26	16.9	4.3	4.0	104	19.4
35 – 39	4.6	4.4	18	11.7	5.5	4.9	98	18.2
40 – 44	5.7	5.7	3	1.9	6.7	5.9	78	14.5
45 – 49	4.0	4.0	1	0.6	7.3	6.4	52	9.7
Total	**2.3**	**2.1**	**154**	**100.0**	**4.3**	**3.9**	**537**	**100.0**

Current Fertility

Crude Birth Rate

The Crude Birth Rate, though a crude measure of fertility, is the most commonly understood and used fertility measure. In this survey, it is calculated from the number of births that occurred during the last three years before the survey and the mid-period total population in the sample households. The baseline survey provides an estimate of 29 births per thousand population.

Age-specific Fertility Rates and Total Fertility Rate

The TFR is a more refined fertility measure than CBR. ASFRs and the TFR are based on births to currently married women and the number of women living in the sample households. One of the limitations of measuring ASFRs is the low number of births in the sample during the last three years. The findings show a pattern of ASFRs common in international data; rates rose rapidly till age 30-34, and then declined with increasing age. A TFR of 4.3 for the period of 2005-2008 obtained from the set of ASFRs calculated from the data presented in Table 5.6 can be compared with 4.1 for Balochistan and Pakistan as a whole found in the PDHS (NIPS/PDHS, 2008).

Table 5.6: Number of women in sample households and number of births during the last three years before the survey, by age of women, and ASFRs, TFR and CBR

Age group	Women	Births	Age specific fertility rates(ASFRs)
15 – 19	297	9	10.1
20 – 24	270	118	145.7
25 – 29	236	132	186.4
30 – 34	157	96	203.8
35 – 39	135	64	158.0
40 – 44	89	29	108.6
45 – 49	64	9	46.9
Total	**1248**	**457**	**na**
TFR: 4.3			
CBR: 29.2			

na= not applicable.

Mothers with Children Under Five Years

If mothers have a child while breastfeeding an older child, they are often less able to produce breast milk for the older child (Adair et al., 1994). When children are weaned too soon, their growth suffers; they are more likely to suffer from diarrheal diseases (Bohiler et al., 1995). Milk diminution is more likely to occur as women have more children and are undernourished (Garner et al., 1994). In addition, when children are close in age, they compete for resources as well as for maternal care. The mother may also not be able to breastfeed the newborn properly, placing the newborn at higher risk for nutritional deficiency and infectious diseases contracted from older siblings.

Table 5.7 shows a significant number of women with the burden of caring for several young children. Among those who already had two living children less than five years of age, 10 percent were pregnant. For such mothers, it is particularly important for their health and that of their children to ensure that birth spacing is a part of their married life at that point.

Table 5.7: Distribution of mothers by pregnancy status and number of children under 5 years

Number of children <5 years	Currently pregnant		Currently not pregnant		Total	
	%	N	%	N	%	N
0	10.7	24	89.3	201	100.0	225
1	9.2	22	90.8	216	100.0	238
2	10.4	19	89.6	163	100.0	182
3	2.3	1	97.7	43	100.0	44
4	50.0	1	50.0	1	100.0	2
N	**9.7**	**67**	**90.3**	**624**	**100.0**	**691**

Preceding Birth Interval

Women with short birth intervals are at higher risk for delivering premature, low-birth-weight or small-for-gestational-age infants (Fuentes-Affelick and Hessol, 2000; Miller et al., 1995; Zhu et al., 1999). The length of the preceding birth interval is very important for the health of mothers and their babies. Table 5.8 shows the length of the last closed birth interval for women with two or more births by background characteristics of mothers at the time of the survey.

Table 5.8: Distribution of women with preceding birth intervals (birth to birth) by background characteristics

Characteristic	Less than 18 months	18 - 23 months	24 - 35 months	36 - 47 months	48 or more months	Total	N
Age							
15 – 19	100.0	0.0	0.0	0.0	0.0	100.0	1
20 – 24	22.7	21.2	40.9	10.6	4.5	100.0	66
25 – 29	12.6	20.2	35.3	18.5	13.4	100.0	119
30 – 34	14.6	12.2	32.5	17.1	23.6	100.0	123
35 – 39	13.3	14.5	21.7	16.9	33.7	100.0	83
40 – 44	10.9	19.6	28.3	17.4	23.9	100.0	46
45 – 49	23.1	0.0	38.5	15.4	23.1	100.0	13
Number of live births							
2	7.4	16.2	45.6	20.6	10.3	100.0	68
3	17.2	17.2	32.3	11.8	21.5	100.0	93
4	16.7	15.3	40.3	11.1	16.7	100.0	72
5	13.0	15.2	21.7	17.4	32.6	100.0	46
6+	16.9	16.9	26.2	19.2	20.9	100.0	172
Education level							
No education	16.0	17.1	28.7	16.0	22.1	100.0	362
Up to primary	14.0	14.0	41.9	20.9	9.3	100.0	43
Up to Secondary	9.1	11.4	50.0	15.9	13.6	100.0	44
Above secondary	0.0	50.0	50.0	0.0	0.0	100.0	2
Standard of living index							
Low	14.7	18.3	32.1	17.4	17.4	100.0	109
Medium low	18.2	18.2	31.8	13.6	18.2	100.0	66
Medium high	13.9	15.3	34.7	13.9	22.2	100.0	72
High	14.7	15.2	31.4	17.6	21.1	100.0	204
Total	**15.1**	**16.4**	**32.2**	**16.4**	**20.0**	**100.0**	**451**

A short interval has traditionally been viewed as a risk factor for poor pregnancy outcomes, particularly affecting neonatal mortality in developing countries (Cleland and Sathar, 1984). It has been observed in several studies that the risk of death for an index child whose birth closes a short birth interval is higher than those experienced by an index child whose birth closes a longer birth interval (Mahmood, 2002). It has also been found that children born within the preceding interval of 18 months experienced higher mortality risks during infancy than those born in an interval of two to three years (Cleland and Sathar, 1984).

Table 5.8 shows that almost 15 percent of the children were born with a birth interval of less than 18 months. Almost 64 percent were born with a birth interval of less than 36 months, while 36 percent were born after three years or more. The differentials by mother's age, educational level and standard of living index are also shown. Younger and lower-parity women – particularly women aged 15-19 years and of parity 3 – were more likely to have short birth intervals.

Chapter 6

Maternal and Neonatal Care

Birth spacing is an integral part of maternal and neonatal care. Adequate spacing of births improves the health of mothers and babies; at the same time, the survival of mothers and babies allows for longer birth intervals. In this survey, a small battery of questions was asked regarding the most recent child born during the past four years, reflecting some of the essential indicators of maternal and neonatal care. A total of 436 women out of the 691 total women interviewed had borne a child during the past four years, and these women were asked additional questions about maternal and neonatal care.

Antenatal Care

Antenatal check-ups allow for skilled health personnel to advise expecting mothers as to how to best take care of themselves and their unborn baby during pregnancy, to prepare them for childbirth and care of the newborn, and to identify possible problems during pregnancy and delivery. The Ministry of Health recommends at least three antenatal visits during pregnancy, preferably four. Traditionally, many women, understanding childbirth as a natural experience and perhaps not finding health providers nearby, have not gone to skilled providers for antenatal care, but in recent years those proportions have been increasing in Pakistan (NIPS/PDHS, 2008). Table 6.1 and Figure 6.1 show the numbers of ANC visits for the last birth of women who had delivered during the previous four years. Seventy-two percent of the sample respondents had received at least one antenatal care visit during the last pregnancy; the percentage was higher for urban mothers than for rural ones. This is the same as the level obtained for Gwadar in the 2004-05 PSLM Survey (72 percent) higher than the level for Balochistan in the PDHS (41 percent) or the level obtained nationally in the PDHS (61 percent) (Government of Pakistan, 2006; NIPS/PDHS, 2008). About 46 percent had at least three such visits and 34 percent had four or more visits. Urban residents were more likely to have had at least one check-up, and to have had more visits, than rural mothers.

Table 6.1: Distribution of ANC check-ups during last pregnancy by residence

	Rural		Urban		Total	
Number of visits	**N**	**%**	**N**	**%**	**N**	**%**
No visit	96	46.4	28	12.2	124	28.4
1-2 visits	56	27.1	56	24.5	112	25.7
3 visits	20	9.7	29	12.7	49	11.2
4+ visits	34	16.4	116	50.7	150	34.4
Total	**206**	**100.0**	**229**	**100.0**	**435**	**100.0**

Figure 6.1: Distribution of MWRA by number of antenatal visits during last pregnancy

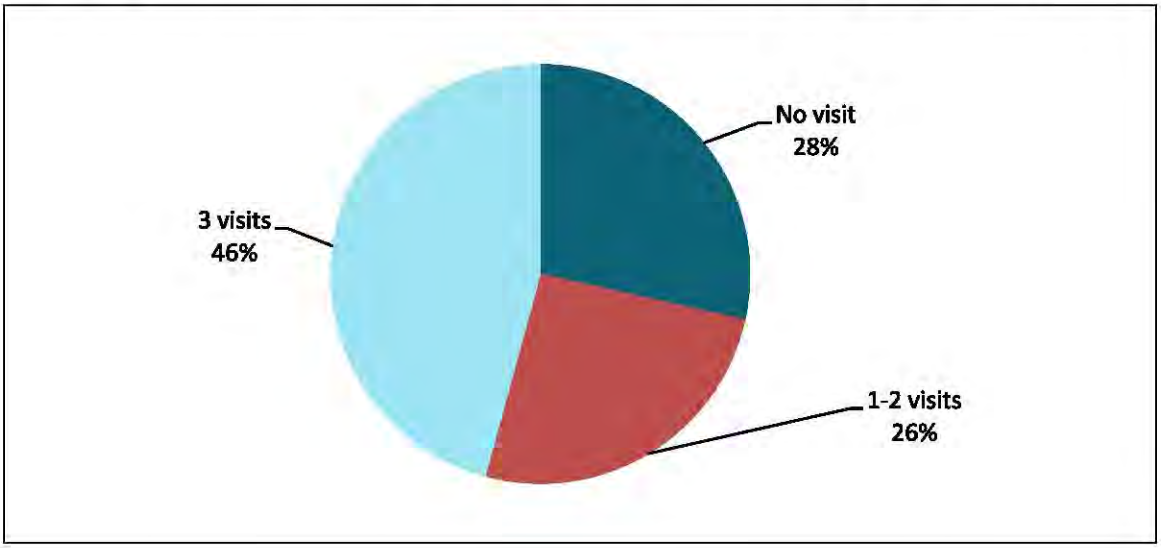
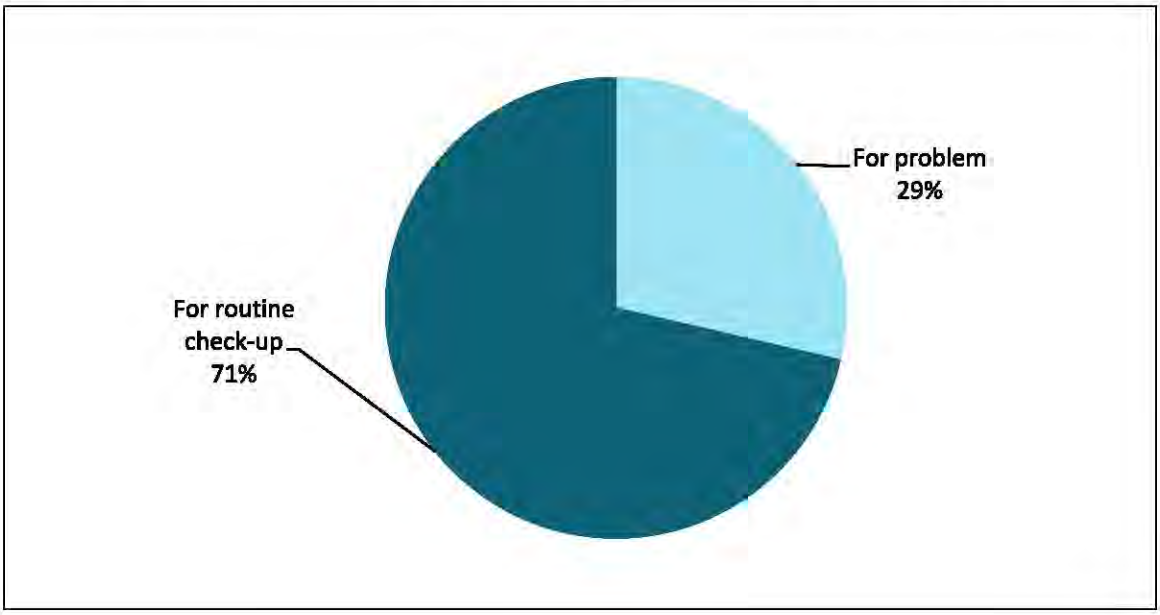


Figure 6.2 shows that many of these visits were in response to routine check-up, rather than for a problem. Twenty-nine percent of the first antenatal visits were for curative purpose.

Figure 6.2: Distribution of MWRA by reason of first antenatal visit during last pregnancy



Data also show that 42 percent of the first visits took place within the first three months of gestation, and 30 percent of the first visits occurred during the third trimester (Figure 5.3).

Figure 6.3: Distribution of MWRA by gestational age at first antenatal visit during last pregnancy

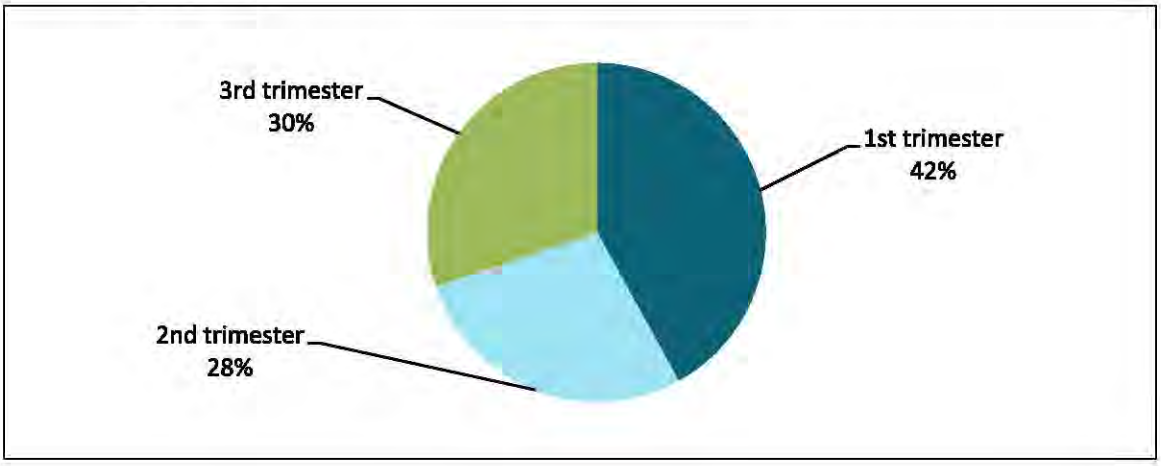


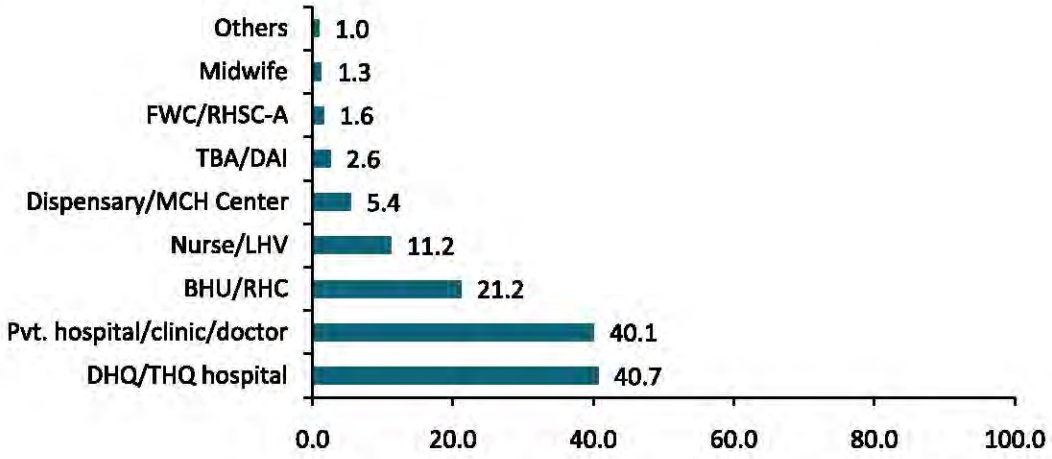
Table 6.2 shows the locations where respondents made one or more antenatal visits. Most antenatal visits took place in public sector facilities. The most common providers of

antenatal care were both private hospitals and DHQ/THQ hospitals, followed by BHUs and RHCs, (21 percent) and Nurse/LHVs (11 percent); other providers were less common.

Table 6.2: Facilities/service providers mentioned for one or more antenatal visits by residence

Facility/provider	Rural	Urban	Total
Dispensary/MCH Center	0.9	8.0	5.4
BHU/RHC	25.2	18.9	21.2
DHQ/THQ hospital	44.1	38.8	40.7
Pvt. hospital/clinic/doctor	38.7	40.8	40.1
FWC/RHSC-A	0.9	2.0	1.6
TBA/Dai	1.8	3.0	2.6
Midwife	0.9	1.5	1.3
Nurse/LHV	10.8	11.4	11.2
Others	0.9	1.0	1.0
N	**111**	**201**	**312**

Figure 6.4: Locations where respondents made one or more antenatal visits



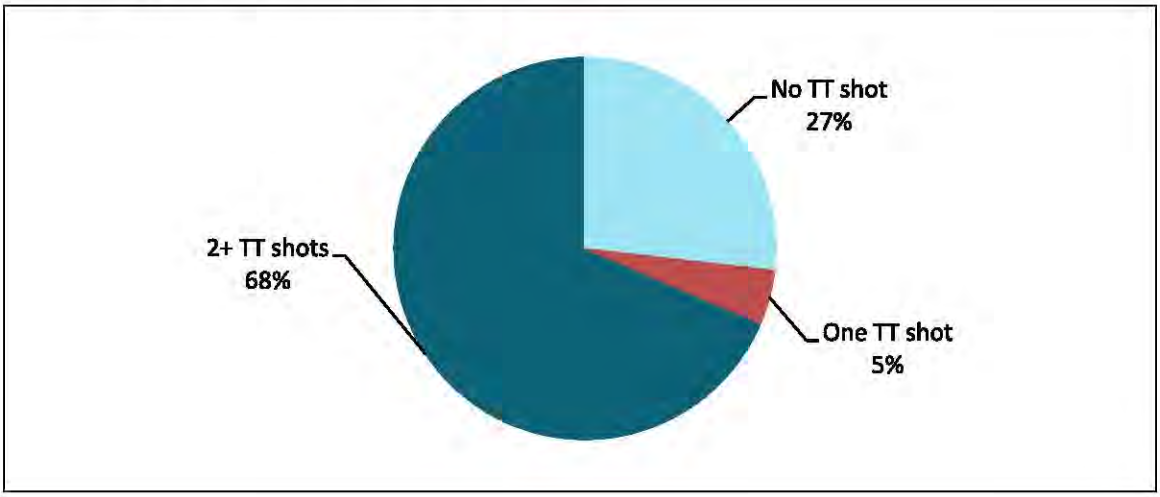
Tetanus Immunization

Tetanus toxoid immunization is important to avoid tetanus in the newborn or mother. Two doses in a pregnancy are sufficient to prevent tetanus; however, if the woman was immunized during her previous pregnancy only one dose may be needed, and five doses are sufficient for lifetime protection. According to PSLMS 2004-05, 39 percent of mothers in Gwadar had received at least one shot; according to the PDHS 2006-07, 29.7 percent in Balochistan and 53.4 percent nationally were appropriately protected from tetanus, according to guidelines (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 6.3 and Figure 6.5 show that 73 percent of mothers had received at least one shot during their last pregnancy, and about 69 percent had received two or more shots. The immunization rate was higher in urban areas. Although tetanus immunization appears to be increasing in Gwadar, a substantial proportion of mothers remain unprotected.

Table 6.3: Tetanus immunization at last delivery

Number of injections	Rural		Urban		Total	
	N	%	N	%	N	%
No TT shot	85	41.1	32	14.0	117	26.8
One TT shot	6	2.9	14	6.1	20	4.6
2+ TT shots	116	56.0	183	79.9	299	68.6
Total	**207**	**100.0**	**229**	**100.0**	**436**	**100.0**

Figure 6.5: Tetanus immunization at last delivery



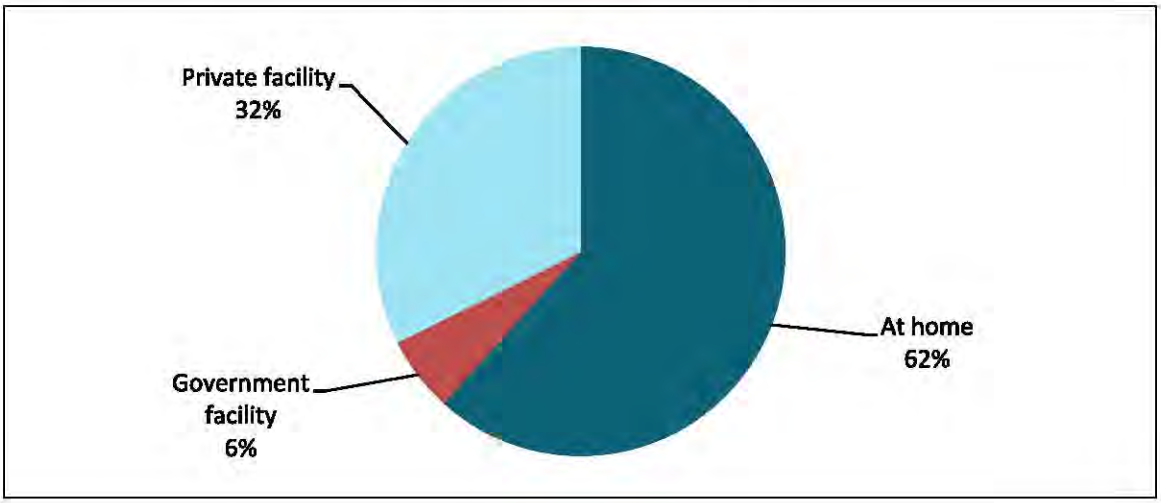
Location and Attendance at Delivery

One of the most important ways to reduce maternal mortality is to increase the proportion of mothers delivering in a health facility with the support of a trained birth attendant. Although these proportions have been rising in recent years, they have been historically low in Pakistan, contributing substantially to high maternal mortality. In Gwadar, according to the 2004-05 PSLMS, 22 percent of the deliveries took place in institutions, compared with PDHS 2006-07 figures of 18 percent for Balochistan and 34 percent nationally (Government of Pakistan, 2006; NIPS/PDHS, 2008). In the present survey, 38 percent of the most recent deliveries were in a health facility (Table 6.4 and Figure 6.6). This percentage was higher in urban areas (52 percent) than rural ones (23 percent). Thirty-two percent of deliveries took place in private hospitals/clinics followed by only 4 percent at DHQ/THQ hospital.

Table 6.4: Distribution of mothers by place of last delivery and residence

	Rural		Urban		Total	
Place of delivery	**N**	**%**	**N**	**%**	**N**	**%**
At home	160	77.3	109	47.6	269	61.7
DHQ/THQ Hospital	4	1.9	14	6.1	18	4.1
Pvt. hospital/clinic	43	20.8	97	42.4	140	32.1
Others	0	0.0	9	3.9	9	2.1
Total	**207**	**100.0**	**229**	**100.0**	**436**	**100.0**

Figure 6.6: Distribution of mothers by location of last delivery

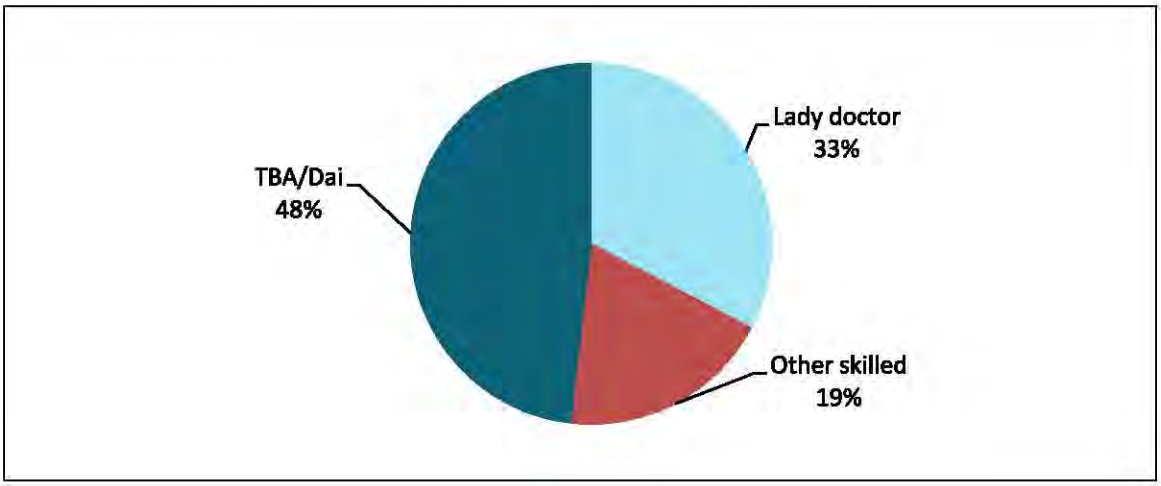


Likewise, the proportion of births delivered by skilled attendants was higher than expected from previous data. In this survey, about 52 percent of reported deliveries in the previous 4 years were delivered by a skilled birth attendant. This was higher in urban areas (Table 6.5 and Figure 6.7). In the PSLMS 2004-05 for Gwadar, only 15 percent of the births were delivered by a skilled birth attendant; in the PDHS 2006-07, the corresponding figures were 23 percent for Balochistan and 39 percent for Pakistan as a whole (Government of Pakistan, 2006; NIPS/PDHS, 2008). Most of the births attended by a skilled birth attendant in this household survey were reportedly by TBA/Dai (48 percent) followed by one-third by lady doctors. About one-fifth of births were delivered by Nurse/LHV.

Table 6.5: Distribution of mothers by attendant at last delivery and residence

	Rural		Urban		Total	
Birth attendant and skill level	**N**	**%**	**N**	**%**	**N**	**%**
TBA/Dai	135	65.2	74	32.3	209	47.9
LHW	2	1.0	0	0.0	2	0.5
Midwife	0	0.0	1	0.4	1	0.2
Nurse/LHV	30	14.5	52	22.7	82	18.8
Lady doctor	40	19.3	102	44.5	142	32.6
Total	**207**	**100.0**	**229**	**100.0**	**436**	**100.0**
Skilled birth attendant	70	33.8	155	67.7	225	51.6
Unskilled birth attendant	137	66.2	74	32.3	211	48.4

Figure6.7: Distribution of mothers by attendant at last delivery



Postpartum Care

For the health of both mothers and newborns, a newly delivered mother and baby should be followed up for at least about 6 weeks after delivery. MoH guidelines recommend at least one postpartum visit after discharge during the first 42 days after delivery. This, however, is a major weakness of maternal and newborn health care in Pakistan; women who deliver at home rarely go for any postnatal check-up, and women who deliver in facilities are usually seen while they are in the facility, but not after. Gwadar seems to be exceptional. About 83 percent of the respondents reported receiving postnatal care within 40 days after delivery (Table 6.6), compared with 43 percent nationally and 40.5 percent in Balochistan (NIPS/PDHS, 2008).Twenty- seven percent respondents who delivered at home reported postnatal visit within 24 hours.

In any case, with regard to family planning, the absence of postpartum visits represents a missed opportunity to talk to the mother about birth spacing. Much international evidence supports the value of the postpartum period as a critical time for the mother to focus on family planning and how it might assist in postponing the next pregnancy or in ending childbearing (WHO, 2006).

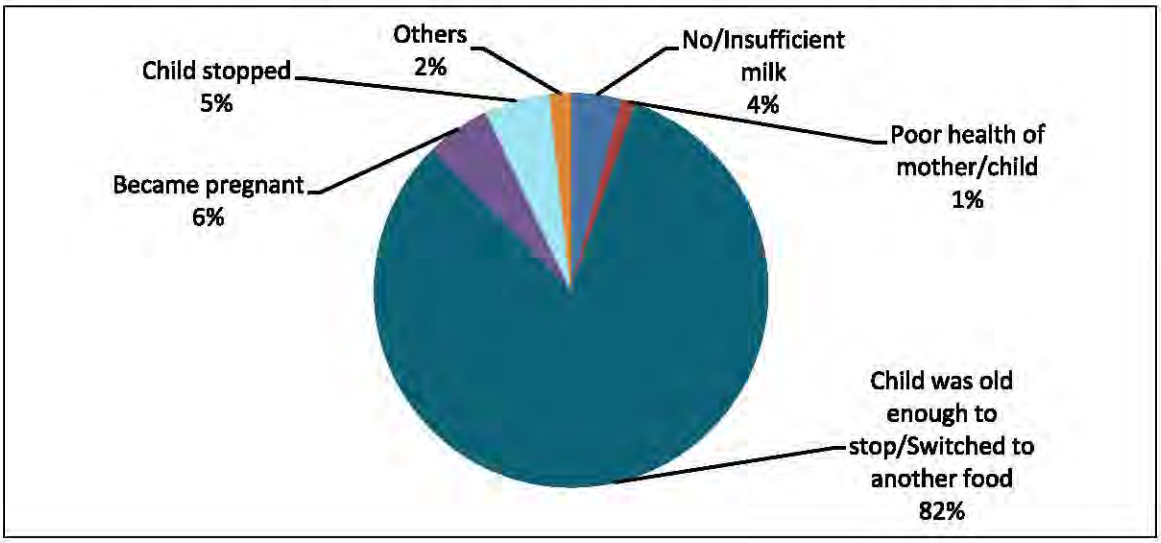
Table 6.6: Distribution of mothers by status of postnatal check-up and place of delivery

	Postnatal check-up within 24 hours		Postnatal check-up after 24 hours		Did not have postnatal check-up		Total	
Place of delivery	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Institution	164	100.0	0	0.0	0	0.0	164	100
Non institution	77	28.3	119	43.8	76	27.9	272	100
Total	**241**	**55.3**	**119**	**27.3**	**76**	**17.4**	**436**	**100**

Breastfeeding

Breastfeeding is a critical component of newborn and infant health. In addition, it is a primary determinant of the length of postpartum amenorrhea. In this aspect, breastfeeding can be deliberately used to delay pregnancy, either through a formal procedure such as "lactational amenorrhea method" (LAM), or more informally through the assumption that breastfeeding protects against pregnancy. Virtually all Pakistani women breastfeed their children to some extent; in our sample, only 4 of 426 respondents reported not having breastfed their last child at all. Breastfeeding is normally done for a substantial time; the median length of breastfeeding for the last baby (not currently being breastfed) was 24 months, and the most common length was also 24 months. Five main reasons were given for discontinuing breastfeeding: child was old enough (82 percent); mother became pregnant (6 percent); child stopped (5 percent); no or insufficient milk (4 percent) and poor health of mother or child (1 percent).

Figure 6.8: Distribution of mothers by reasons for discontinuing breastfeeding (n=169)



Chapter 7

Preference for Children

In order to meet the family planning needs of couples, it is essential to understand how they feel about the number and timing of children they want. Couples' views on this typically evolve over the course of their reproductive years; in the beginning, they want their first children quickly, while towards the end of their reproductive lives, they are quite sure they want to stop. At some point in the middle, they may go through a period of ambivalence where their views are uncertain and conflicted. Husbands and wives may or may not agree on these matters, and may or may not communicate well. Often it is difficult to learn what couples truly feel on these issues because they themselves may not be certain. We can, however, ask questions, record responses, and investigate in as much depth as possible.

Ideal Number of Children

One way of investigating fertility preference is to ask respondents, regardless of current fertility status, how many children they would ideally want. The exact wording, asked of female respondents, is (English translation): "If you could choose exactly the number of children to have in your whole life, how many would that be?" Table 7.1 shows the responses.

The median "ideal" number, in the sense indicated above, was six children; about 60 percent of respondents wanted six or fewer children. However, only 3 percent said they wanted two or fewer children. These proportions varied slightly according to residence; 10 percent urban and 14 percent rural women responded non-numeric answers to the ideal number of children they would like to have.

Table 7.1: Distribution of MWRA with ideal number of children for their family by residence

	Rural		Urban		Total	
Number of children	**N**	**%**	**N**	**%**	**N**	**%**
2	9	2.9	12	3.2	21	3.0
3	12	3.8	10	2.7	22	3.2
4	37	11.7	78	20.7	115	16.6
5	43	13.7	41	10.9	84	12.2
6	62	19.7	108	28.7	170	24.6
7+	106	33.7	84	22.3	190	27.5
Up to God	45	14.3	39	10.4	84	12.2
Don't know	1	0.3	4	1.1	5	0.7
Total	**315**	**100.0**	**376**	**100.0**	**691**	**100.0**

Desire for More Children

Level of Desire for More Children

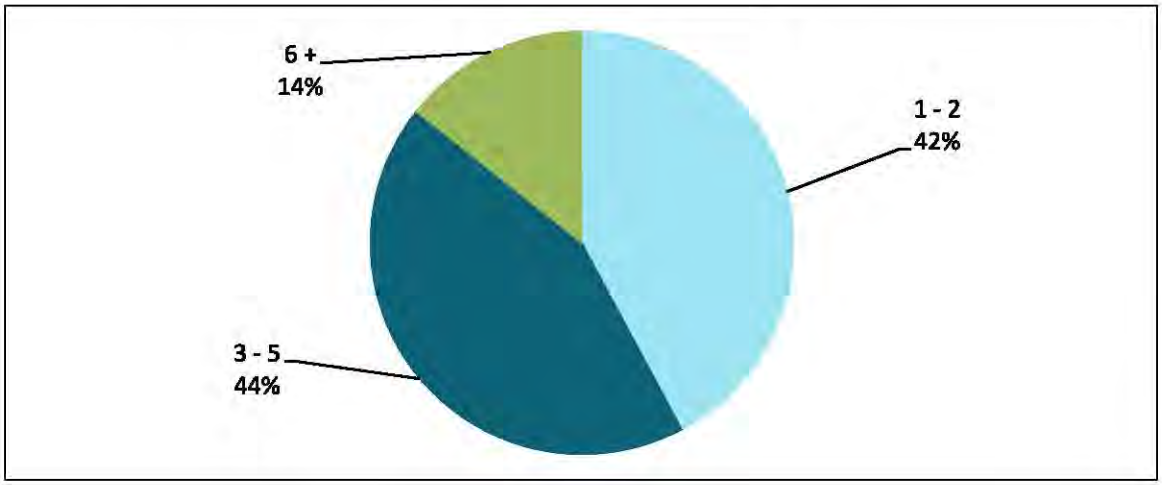
A more immediate measure of fertility preference is whether a couple wants to have more children; if so, do they want the next child now or later, and how many more do they want. The desire for future children is closely linked with the number of children a couple already has. Table 7.2 shows that whether respondents wanted more children soon, later (after 2 years or more) or not at all, this was based on the number of living children they already had. Thirty-four percent respondents did not want more children than they already had and almost the same percentage of respondents wanted to delay their next child. The proportion wanting more children sooner rather than later, declined sharply after the first birth. Table 7.2 shows that whether respondents wanted more children soon, later (after 2 years or more) or not at all was based on the number of living children they already had. The proportion not wanting more children may include more such women who have already completed their families. Among those who had between one and two living children, most of the respondents who want an additional child wanted to have it later, rather than right away. On the other hand, most women with five or more living children did not want to have more children; for those with six or more, the proportion wanting to stop was about 78 percent. This table clearly indicates the high level of interest in both spacing and limiting births.

Table 7.2: Distribution of MWRA by desire for next child and current number of living children

Number of living children	Desire for next child			Total	
	Soon	Later	Never	N	%
0	76.3	23.7	0.0	93	100
1	39.6	56.6	3.8	106	100
2	32.3	58.3	9.4	96	100
3	43.0	33.3	23.7	93	100
4	16.7	48.5	34.8	66	100
5	11.8	25.0	63.2	68	100
6+	10.7	11.8	77.5	169	100
Total	**32.0**	**34.4**	**33.6**	**691**	**100**
N	221	238	232	691	100

For those women who wanted more children, we also asked how many more. As shown in Figure 7.1 shows that 42 percent of the women who wanted more children, and who had an opinion, wanted one or two more children, another 44 percent wanted three to five children.

Figure 7.1: Distribution of women by desire for more children in the future



Socioeconomic Correlates of Desire for Children

A woman's stated desire was analyzed in relation to four possible socioeconomic determinants: standard of living index (SLI), respondent's age, literacy and residence (Table 7.3). There was an inconsistent relationship between SLI and desire for more children. Age of the respondent was strongly associated with desire not to have more children. Literate women were more likely to want the next child at a later time (50 percent) compared to the illiterate women (30 percent). On the other hand illiterate women were more likely not to have more children (38 percent) compared to the literate women (17 percent). Urban residents were more likely to want more children later than rural dwellers.

Table 7.3: Distribution of MWRA by reported desire for more children and background characteristics

	Desire for next child			Total	
Characteristic	**Soon**	**Later**	**Never**	**N**	**%**
Standard of living index					
Low	36.4	25.7	37.9	140	100
Medium low	39.1	31.0	29.9	87	100
Medium high	23.7	44.7	31.6	114	100
High	31.1	35.4	33.4	350	100
Age group					
<25	40.4	54.0	5.6	161	100
25 or more	29.4	28.5	42.1	530	100
Literacy of respondent					
Literate	32.5	50.0	17.5	154	100
Illiterate	31.8	30.0	38.2	537	100
Residence					
Rural	33.0	30.8	36.2	315	100
Urban	31.1	37.5	31.4	376	100
Total	**32.0**	**34.4**	**33.6**	**691**	**100**
N	221	238	232	691	100

Son Preference

In Pakistan, there is usually a substantial preference for sons over daughters. The belief that a family is incomplete without sons is stronger than the corresponding belief for daughters. In this questionnaire, respondents were asked how many daughters they would have before stopping if they did not have a son, and correspondingly for sons if they did not have a daughter. The son preference did not come out as strong as expected, 38 percent of women said there would be no limit to the number of daughters before having a son, while 36 percent said there would be no limit to sons before having a daughter. In both cases the median was 5 children

Table 7.4: Son and daughter preferences by the respondents

	Number of daughters for the desire of a son		Number of sons for the desire of a daughter	
Response	**N**	**%**	**N**	**%**
Up to God	56	8.1	58	8.4
No limit	263	38.1	251	36.3
Other non-numeric responses	8	1.2	7	1.0
Numeric responses	364	52.7	375	54.3
Total	**691**	**100**	**691**	**100**
Median*	5	na	5	na

*Of the numeric responses

na=not applicable.

Strength of Preference

The strength of preferences asked in such surveys can be questioned. The need for birth spacing can be presumed to be greater if a couple is strongly motivated not to have more children, or to delay the next pregnancy, than if this does not matter much to them. We asked respondents whether, if they became pregnant soon, would they be pleased, worried, accept it, or it did not matter. Results are shown in Tables 7.5 and 7.6. (This question excludes those 317 of the total 691 women who wanted a next child soon, were currently pregnant, had been sterilized, had gone through menopause or had a hysterectomy).

Table7.5: Distribution of MWRA who did not want more children soon by reaction if become pregnant in near future

	Desire for next child		Total	
Reaction if pregnant	**Later**	**Never**	**%**	**N**
Pleased	12.0	1.6	6.8	26
Worried	43.5	54.1	66.8	182
Accept it	43.5	41.5	25.4	159
Doesn't matter	1.0	2.7	1.1	7
Total	**100**	**100**	**100**	**374**
N	191	183	374	374

Table 7.6: Distribution of MWRA who do not want more children soon by problem faced if they became pregnant

	Desire for next child		Total	
Reaction if pregnant	**Later**	**Never**	**%**	**N**
Own health	76.2	89.8	82.8	314
Health of youngest child	87	65.1	76.3	289
Caring of children	72	67.2	69.7	264
Schooling of children	49.7	67.2	58.3	221
Family economic situation	53.4	78	65.4	248
Will feel shy because other kids are grown	0.0	1.6	0.8	3
N	**193**	**186**	**100**	**379**

Respondents could give more than one response.

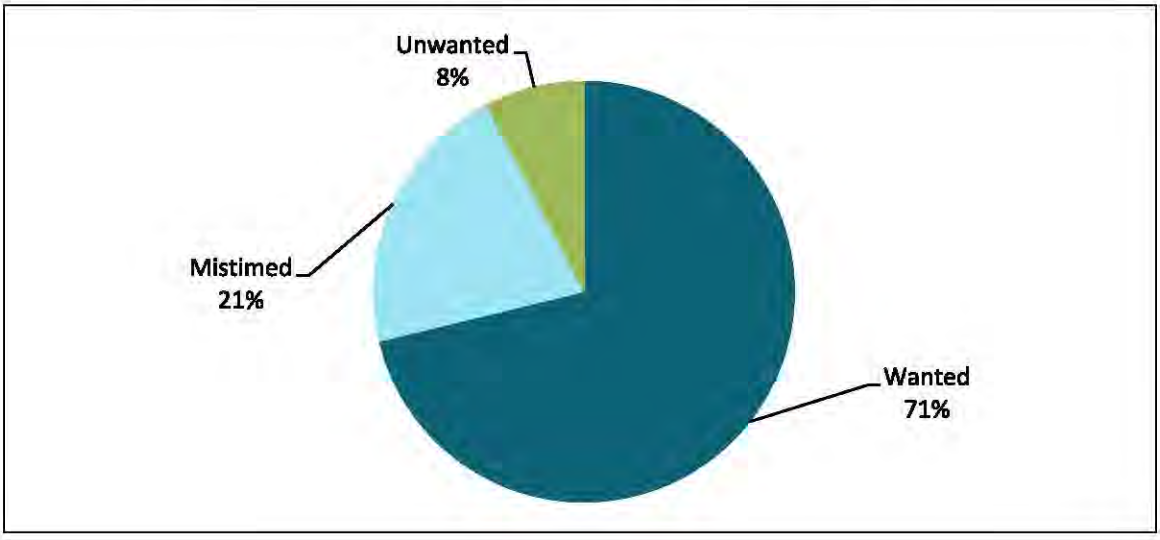
Among those who did not want more children at all 54 percent said that they would be worried if they became pregnant and about42 percent reported that they would accept the new pregnancy, while among those who did not want more children, only 1.6 percent said they would be pleased. Among those women who wanted to delay their next pregnancy for more than 2 years, 43 percent would be worried while 12 percent would be pleased and 43 percent would accept the pregnancy. This shows a weak motivation for spacing. However, the high proportion of those women who said they would be worried if they became pregnant supports their earlier statement that they wanted to delay or stop childbearing.

Further, women who expressed a desire to not want more children, or to delay the next child, were asked what problems they would face if they became pregnant soon. Table 7.6 shows their responses. The problem most commonly faced was regarding, own health followed by health of their youngest child, while the least commonly faced issue was that the respondent would feel shy because other kids are grown.

Attitude towards Last Pregnancy

Another important dimension of fertility preference relates to whether the last pregnancy was wanted at the time, was mistimed (i.e., wanted later), or was not wanted at all. Pregnancies that are unwanted cause hardship in many ways, and represent a failure to realize a couple's right to have the number of children they want, at the time they want them. This can be somewhat difficult to determine precisely in surveys. Sometimes parents report that an unwanted pregnancy was actually wanted, but it is less common to report that a child was wanted when in fact it was not. In this survey, as shown in Figure 7.2, many women reported that their last pregnancy was unwanted (8 percent) or mistimed (21percent).

Figure 7.2: Distribution of MWRA by attitude towards their last pregnancy



Women's Perception of Fertility Preferences of Husbands

Women were asked whether they thought their husbands wanted the same number of children as they did, more, or fewer. In Table 7.7, their responses are tabulated according to the woman's ideal family size. About 10 percent did not know their husband's preference while 76 percent thought their husbands wanted the same number of children as they did. However, 11 percent of the women thought their husbands wanted more children than they did, while only 2 percent thought their husbands wanted fewer children. These proportions did not vary systematically according to women's ideal family size.

Table 7.7: Distribution of MWRA according to perception of husband's desire for more children by woman's ideal family size

	Perceived husband's desire for more children				Total	
Ideal family size of women	Same number	More children	Fewer children	Don't know	%	N
1-2 children	81.0	14.3	0.0	4.8	100	21
3-4 children	81.0	8.0	2.9	8.0	100	137
5+ children	77.3	12.4	2.0	8.3	100	444
Up to God	61.9	9.5	2.4	26.2	100	84
Don't know	40.0	40.0	20.0	0.0	100	5
Total	**76.0**	**11.4**	**2.3**	**10.3**	**100**	**691**
N	525	79	16	71	100	691

Chapter 8

Contraceptive Knowledge and Use

The FALAH baseline household survey obtained data on contraceptive knowledge and use by first asking what methods respondents knew, if any (spontaneous knowledge). For each method not mentioned, that method was named by the interviewer and described, and the respondent was asked if she knew that method, if she had ever used it, and if she was using it currently. This approach is standard in such surveys in Pakistan and elsewhere. In addition, respondents were asked to report their most recent source of contraceptive methods.

Knowledge

At least 95 percent of married women of reproductive age in Pakistan have known of at least one method of contraception for many years. Table 8.1 shows that this holds true for Gwadar as well; virtually all women (99.1 percent) knew of at least one method. A majority of the female respondents knew of the most commonly used program methods –injections, pills,, female sterilization and condoms. These methods and withdrawal were known to higher proportions in Gwadar than in the national PDHS 2006-07. Conversely, more women in the PDHS knew of the less-common methods, i.e., rhythm ("safe period"), male sterilization, Norplant, and emergency contraceptive pills (NIPS/PDHS, 2008). There was not much difference in knowledge of any method between rural and urban women.

Table 8.1: Distribution of MWRA by knowledge (prompted) of contraceptive methods, by method and residence

Method	Rural	Urban	Total
Female sterilization	80.3	92.8	87.1
Male sterilization	12.4	19.1	16.1
Pill	97.5	99.7	98.7
IUD	34.6	58.0	47.3
Injectables	97.8	99.7	98.8
Norplant	9.8	27.9	19.7
Condom	71.7	88.8	81.0
Rhythm	22.2	30.9	26.9
Withdrawal	53.0	68.9	61.6
Other FP method	7.0	7.2	7.1
Emergency Pills	9.2	31.4	21.3
Any FP method	98.4	99.7	99.1
Any modern FP method	98.4	99.7	99.1
Any traditional FP method	59.4	72.9	66.7
N	**315**	**376**	**691**

Use of Contraceptive Methods

Levels of Ever Use and Current Use

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

Of all the married women interviewed in our sample, 36.5 percent reported having used some method of contraception during their married lives (Table 8.2). This percentage was y as high for urban women (45 percent) as for rural women (26.3 percent). It was lower than the proportion obtained in the PDHS 2006-07 for Pakistan as a whole (48.7 percent) (NIPS/PDHS, 2008).

Table 8.2: Percentage distribution of MWRA by contraceptive use status and residence

	Ever use				Current use				Past use			
Method	Rural	Urban	Total	N	Rural	Urban	Total	N	Rural	Urban	Total	N
Female sterilization	1.9	4.0	3.0	21	1.9	4.0	3.0	21	0.0	0.0	0.0	0
Male sterilization	0.0	0.0	0.0	0	0.0	0.0	0.0	0	0.0	0.0	0.0	0
Pill	17.5	22.9	20.4	141	7.6	5.1	6.2	43	9.8	17.8	14.2	98
IUD	0.3	0.0	0.1	1	0.0	0.0	0.0	0	0.3	0.0	0.1	1
Injectable	8.9	18.9	14.3	99	2.9	3.5	3.2	22	6.0	15.4	11.1	77
Norplant	0.0	0.0	0.0	0	0.0	0.0	0.0	0	0.0	0.0	0.0	0
Condom	3.2	12.0	8.0	55	2.2	6.9	4.8	33	1.0	5.1	3.2	22
Rhythm method	0.0	1.1	0.6	4	0.0	0.0	0.0	0	0.0	1.1	0.6	4
Withdrawal	1.6	3.5	2.6	18	1.6	1.1	1.3	9	0.0	2.4	1.3	9
Other FP method	0.0	0.3	0.1	1	0.0	0.0	0.0	0	0.0	0.3	0.1	1
Any FP method	26.3	44.9	36.5	252	16.2	20.5	18.5	128	10.2	24.5	17.9	124
Any modern FP method	25.1	43.9	35.3	244	14.6	19.4	17.2	119	10.5	24.5	18.1	125
Any traditional FP method	1.6	4.5	3.2	22	1.6	1.1	1.3	9	0.0	3.5	1.9	13
Total	**315**	**376**	**691**	**691**	**315**	**376**	**691**	**691**	**315**	**376**	**691**	**691**
Emergency pills	0.0	0.0	0.0	0	na	na	na	na	na	na	na	na

na=not applicable.

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

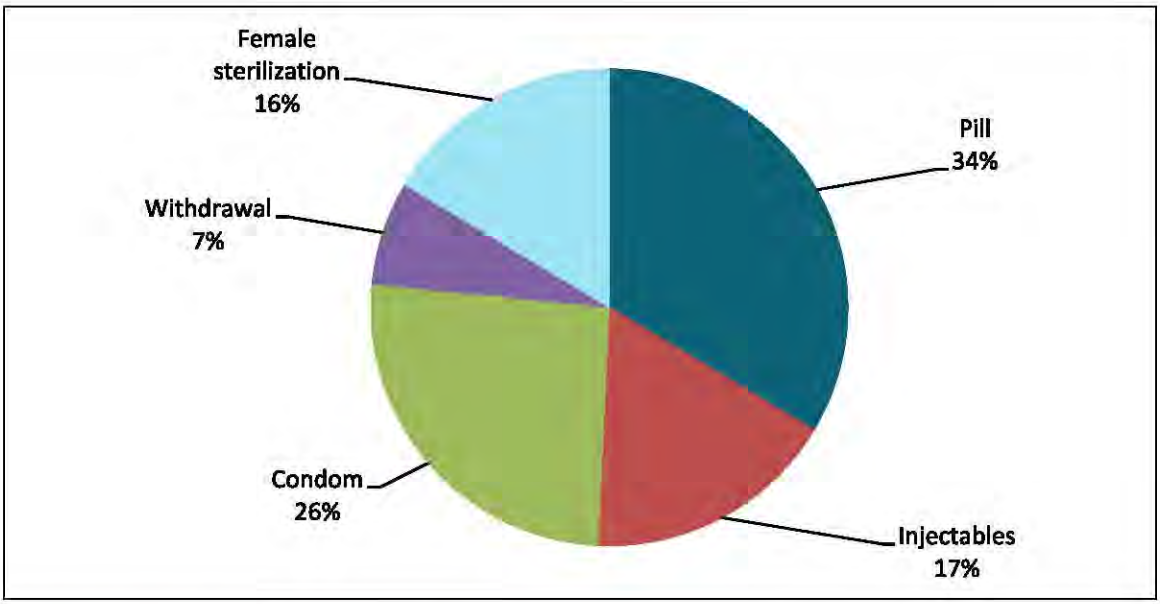
A total of 18.5 percent of all married women in the sample were current users of some method of contraception (the contraceptive prevalence rate or CPR), compared with 29.6 percent for Pakistan in the 2006-07 PDHS, and 14.4 percent for Balochistan as a whole (NIPS/PDHS, 2008). In urban areas, the CPR is 20.5 percent, compared with 16.2 percent in rural areas.

The methods most commonly being used were pills, condoms, and injectables (Table 8.2). The use of injectables 3.2 percent was high by national standards. Conversely, the use of

female sterilization, at 3 percent, was substantially lower than figures in national data. Overall, 17.2 percent of married women were using modern methods and 1.3 percent were using traditional methods (withdrawal). Figure 8.1 shows the distribution of the women who were using some contraceptive method by method mix.

If we compare ever use and the current use of individual methods, Table 7.2 shows that overall 141 women started using pills as their FP method but 98 discontinued it, meaning that about 70 percent of the pill users stopped using pills. Similarly, 78 percent and 100 percent, respectively, stopped using injectables and IUDs. The reasons for stopping these methods are given in Chapter 9.

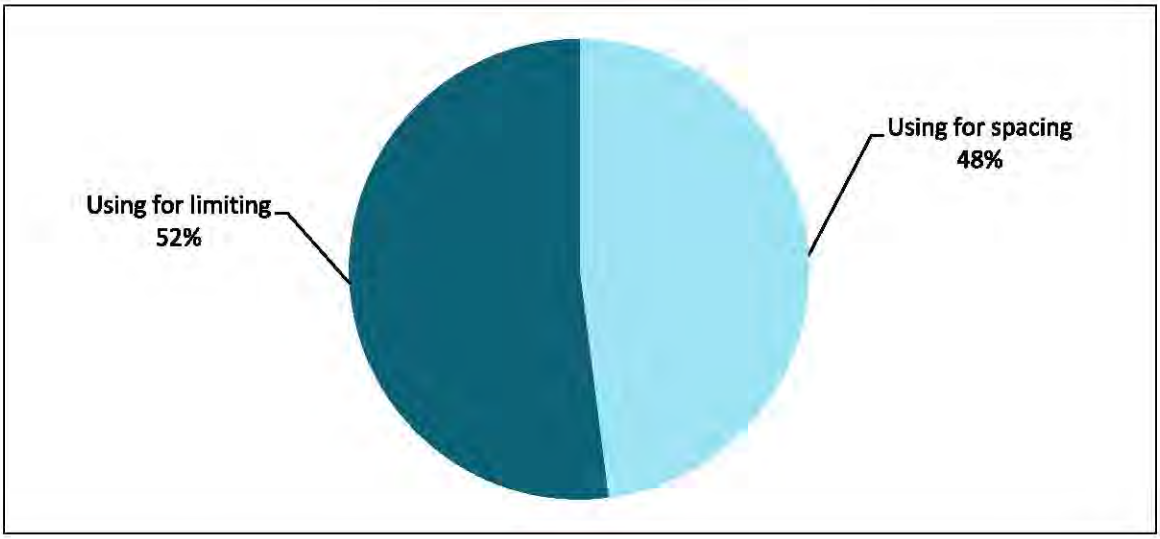
Figure 8.1: Distribution of current users by method mix



Current Use and Desire for Children

For current users of contraception, it is important to determine how many were using contraceptives for spacing purpose, and how many were using to stop having children altogether. Figure 8.2 shows that overall 52 percent of current use was for limiting purpose, compared with 48 percent for spacing.

Figure 8.2: Current use and desire for children



Correlates of Contraceptive Use

Figures 8.3 and 8.4 show the relationship between contraceptive prevalence and the woman's age and number of living children. The shape of the graph for age is similar to that seen in other Pakistani and international studies, with low prevalence among both younger and older women, and higher prevalence in between. Between ages 30 and 34, prevalence was more than one fourth of all the women in the age group.

Figure8.3: Contraceptive prevalence by age

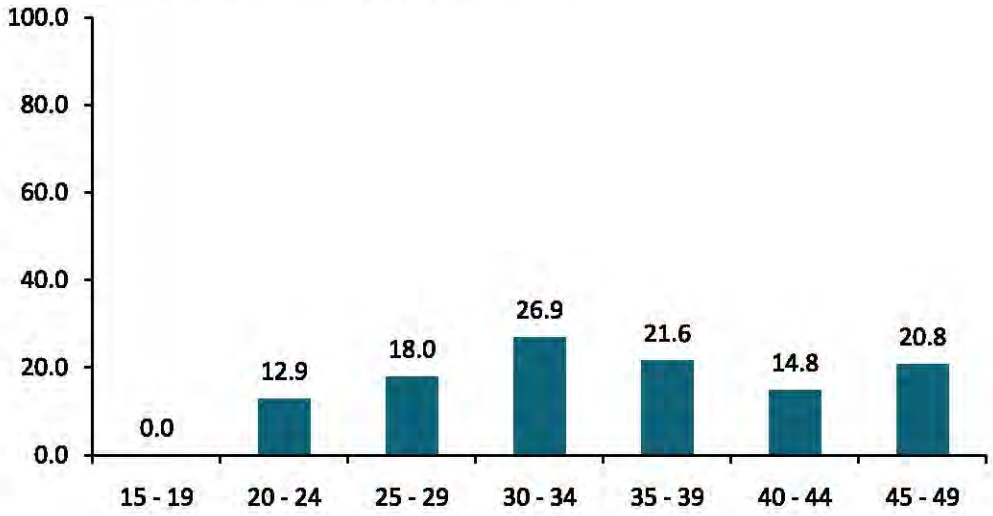
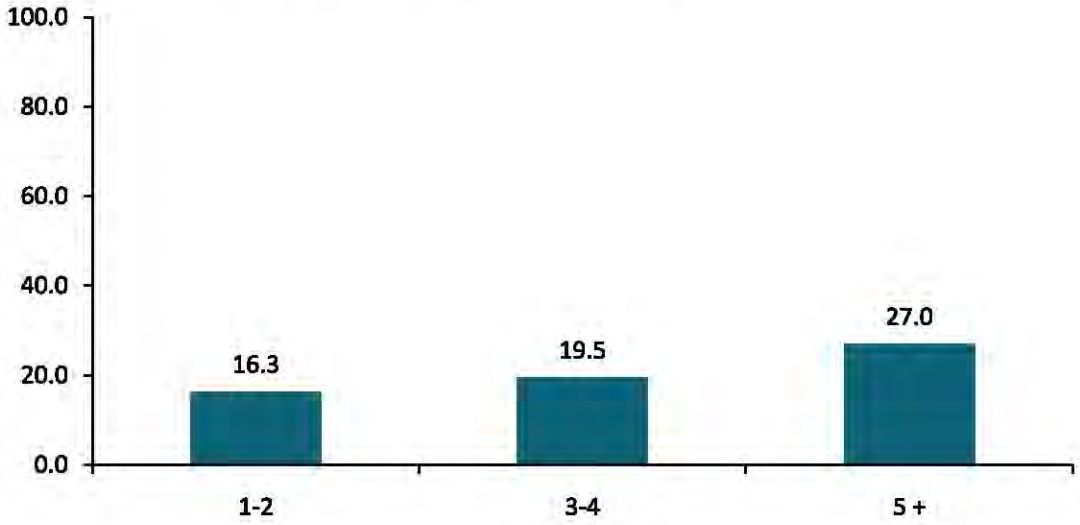


Figure 8.4 shows contraceptive prevalence by number of living children. Prevalence by number of living children was higher for women with five or more children. However, this is consistent with a high proportion of current use to unmet need for these women (from Chapter 11) and low age-specific fertility rates among women at older ages (from Chapter 5).

Figure 8.4: Current contraceptive use by number of living children



Contraceptive use is associated with higher socioeconomic status and urban residence, as shown in Table 8.3. Respondents in households with the highest SLI had substantially higher contraceptive prevalence (23 percent) than those with the lowest SLI (11 percent). Conversely, women from households with low SLI were more likely to be never users. Similarly, respondents' literacy was associated with higher current use and lower never use. Ownership of television was also associated with greater current or past use. However, past and current users were much more likely to live in urban areas.

Table 8.3: Distribution of women by contraceptive use status and selected characteristics

Characteristic	Current user	Past user	Never user	Total	N
Standard of living index					
Low	11.4	7.9	80.7	140	100.0
Medium low	16.1	12.6	71.3	87	100.0
Medium high	14.9	19.3	65.8	114	100.0
High	23.1	22.9	54.0	350	100.0
Ownership of television					
Yes	20.8	22.4	56.8	428	100.0
No	14.8	10.6	74.5	263	100.0
Literacy of respondent					
Literate	25.3	18.2	56.5	154	100.0
Illiterate	16.6	17.9	65.5	537	100.0
Residence					
Rural	16.2	10.2	73.7	315	100.0
Urban	20.5	24.5	55.1	376	100.0
Total	**18.5**	**17.9**	**63.5**	**691**	**100.0**

Source of Method

With many types of outlets available to obtain various contraceptives, it is important to know which ones are being used, and for which methods. Table 8.4 shows the place at which current and past users combined (i.e., ever users) lastly obtained their contraceptive method.

From this table, it is clear that the source depends on the method. Pills and condoms were mostly obtained through husband or LHW; injectables were obtained from the Pvt. Hospital/clinics and pharmacy/ chemists. Female sterilization was mostly carried out at Pvt. hospital/clinics. These statements hold true for both current and past users.

Table 8.4: Distribution of ever users of specific contraceptive method by most recent source of supply

Source	FP method ever used					Total	
	Pill	IUD	Injectables	Condom	Female sterilization	%	N
Govt. hospital (DHQ/THQ)	1.8	100.0	3.2	2.3	23.8	4.6	11
BHU/RHC/MCH Centre	2.7	0.0	6.3	0.0	0.0	2.9	7
FWC	1.8	0.0	0.0	0.0	0.0	0.8	2
MSU	0.9	0.0	1.6	0.0	0.0	0.8	2
LHW	25.0	0.0	9.5	29.5	0.0	19.5	47
Pvt. Doctor	0.0	0.0	1.6	0.0	4.8	0.8	2
Pvt. hospital/clinic	3.6	0.0	22.2	0.0	66.7	13.3	32
Dispenser/Compounder	0.0	0.0	7.9	0.0	0.0	2.1	5
NGO hospital	2.7	0.0	9.5	2.3	4.8	4.6	11
Pharmacy, chemists	21.4	0.0	20.6	13.6	0.0	17.8	43
Grocery shop/general store	3.6	0.0	0.0	4.5	0.0	2.5	6
Don't know/ Husband brings method	33.9	0.0	17.5	45.5	0.0	28.6	69
Others	2.7	0.0	0.0	2.3	0.0	1.7	4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**241**
N	**112**	**1**	**63**	**44**	**21**	**100.0**	**241**

Chapter 9

Experience with Contraceptive Methods

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

Reasons for Method Choice

In the survey current and past users were asked the reasons they chose a particular method. The list of possible reasons was read out to them and the results are shown in Table 9.1. Overall, the reasons for current and past users were similar, so the data has been combined. Among the most common reasons for choosing a method were easy availability, suitability for respondent and husband, convenience of use, low cost ,method always available and no or few side effects etc. For IUD users, suitability for respondent and husband, can be used for long time and provider's advice were cited by all. Cited less frequently was no other method available. Clients tend to make decisions according to the known attributes of the various methods, but not always. For example, about 70 percent of pill users cited lack of side effects, even though pills are in fact associated with a number of common side effects.

Table 9.1: Distribution of ever users of specific contraceptive method by reason for choosing that method

Reason for choosing	Contraceptive method					Total
	Pill	IUD	Injectables	Condom	Female sterilization	
Easily available	87.5	0.0	84.1	93.2	28.6	82.2
Low cost	83.9	0.0	79.4	93.2	14.3	78.0
Convenient to use	90.2	0.0	90.5	84.1	4.8	81.3
Suitable for respondent/husband	83.9	100.0	82.5	84.1	66.7	82.2
No/fewer side effects	69.6	0.0	69.8	93.2	66.7	73.4
Can be used for long period	70.5	100.0	74.6	65.9	71.4	71.0
No other method available	19.6	0.0	28.6	22.7	14.3	22.0
Method always available	78.6	0.0	82.5	90.9	9.5	75.5
Provider advised	47.3	100.0	63.5	11.4	76.2	47.7
Others	0.9	0.0	1.6	2.3	4.8	1.7
N	**112**	**1**	**63**	**44**	**21**	**241**

Respondents could give more than one reason.

To look more specifically at why some users preferred traditional methods to modern ones, 9 current traditional method users were asked why they were not using modern methods. Side effects were by far the main issue: 56 percent cited fear of side effects, and same percent reported methods not available. Husband's disapproval and cost too much (of the modern methods) was cited by 22 percent users, with other reasons (experienced side effect, lack of knowledge) cited by a few women.

Table 9.2: Distribution of MWRA using traditional methods by reasons for not using modern contraceptive methods

Reason	Percentage
Fear of side effects	55.6
Husband's disapprove	22.2
Experienced side effects	11.1
Method not available	55.6
Cost too much	22.2
Doesn't know about modern methods	33.3
N	**9**

Respondents could give more than one reason.

Cost, Distance and Time to reach a Facility

Costs to users of contraceptive methods vary widely in Pakistan, according to method, whether public or private sector, and the distance from home to facility. Table 9.3 and Figure 9.1 show women's reported costs the last time they obtained a method. About 29 percent of clients were not charged for their contraceptives, including female sterilization users (who are, in fact, typically reimbursed for expenses involved). For 39 percent, notably condom users, the husband obtained the method, so the wife did not know the cost. Another 23 percent of respondents paid, but not more than 50 rupees. Female injectable (32 percent) users paid more than 50 rupees for their method.

Table 9.3: Distribution of costs of current specific contraceptive method

Method	Cost (in rupees)					Total	
	No payment	1-20	21-50	51+	Don't know	%	N
Pill	14.0	27.9	16.3	7.0	34.9	100.0	43
Injectables	4.5	9.1	27.3	31.8	27.3	100.0	22
Condom	18.2	0.0	0.0	6.1	75.8	100.0	33
Female sterilization	100.0	0.0	0.0	0.0	0.0	100.0	21
Total	**28.6**	**11.8**	**10.9**	**10.1**	**38.7**	**100.0**	**119**

Figure9.1A: Cost in rupees of contraceptive supply for current method

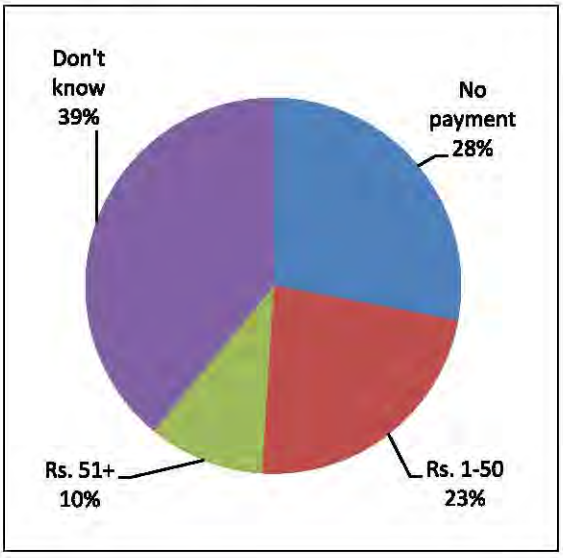
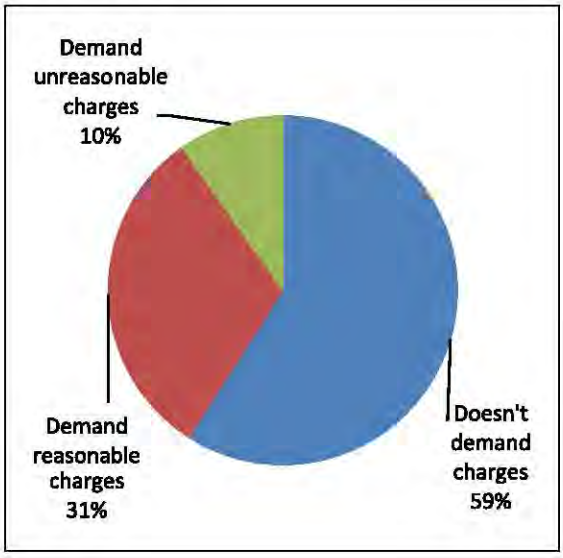


Figure 9.1B: Attitude towards service charges for current method other than contraceptive



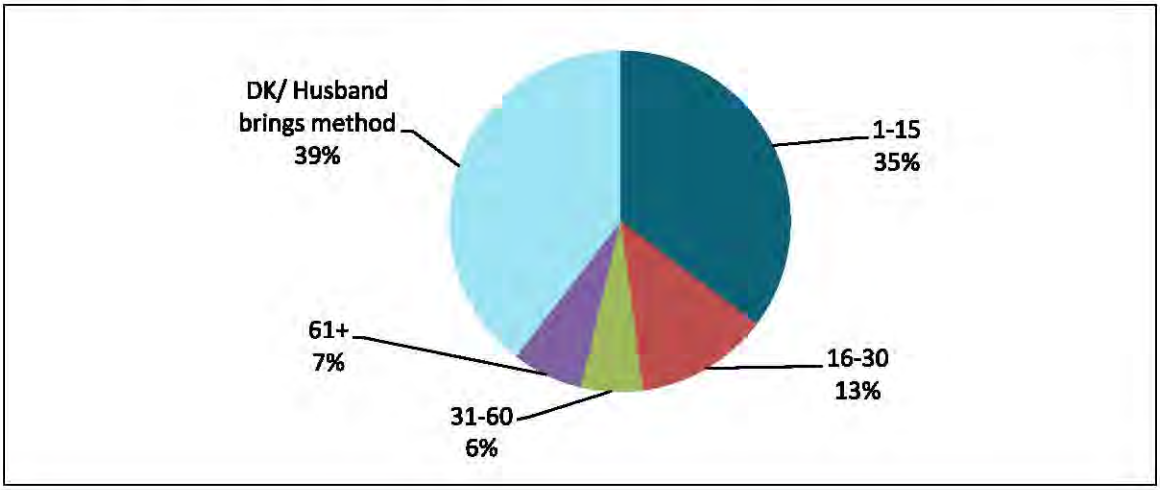
Current users were also asked whether their facility charged them for service, other than the method itself. Of the 61 users who were asked this question, 58 percent said they were not charged, 31 percent were charged a reasonable amount, and 10 percent said that they were charged an unreasonable amount.

The time usually needed for current users to obtain a specific method is shown in Table 9.4; Figure 8.2 shows the overall travel time in minutes to obtain the contraceptive methods. Thirty-five percent of the users needed no more than 15 minutes to obtain their method; this might have included methods from LHWs, who often brought injectables, pills, and condoms to the doorstep and for 39 percent respondents their husband brought the supply, so they did not know how long it took. For 24 percent female sterilization users, it took more than an hour to reach the service place; but in these cases, there was usually no need to visit the facility frequently.

Table 9.4: Distribution of current contraceptive users by time to reach specific contraceptive service

Method	Time (in minutes)					
	1-15	16-30	31-60	61+	DK/Husband brings method	N
Pill	34.9	11.6	4.7	2.3	46.5	43
Injectables	36.4	0.0	18.2	4.5	40.9	22
Condom	48.5	0.0	3.0	3.0	45.5	33
Female sterilization	14.3	47.6	0.0	23.8	14.3	21
Total	**35.3**	**12.6**	**5.9**	**6.7**	**39.5**	**119**

Figure9.2: Travel time (in minutes) for contraceptive supplies



Treatment by Provider

Information Provided

Current and past users were asked what information the service provider might have given them. For this purpose, a list of important topics was read out to them, and the results are shown in Table 9.5. The accuracy of clients' responses may be questioned, due to problems of recall or understanding; still, it appears that information provided is seriously deficient. The most common topics respondents said they were told about were effectiveness and how to use method. Some were told about advantages, how the method works, possible side effects, what to do if experienced side effects, about other methods they could use and the possibility of switching. A few women were told about contraindications. Condom users were given less information in general than users of clinical methods, perhaps because these were often obtained by husbands. There is a need to emphasize to providers that they provide comprehensible information on the method selected by the clients, especially hormonal contraceptives.

Table 9.5: Distribution of ever users of contraceptives by information provided at acceptance for method

Information provided at acceptance	Family planning method					Total
	Pill	IUD	Injectables	Condom	Female sterilization	
How the method works	19.6	0.0	22.2	18.2	52.4	22.8
How to use the method	42.0	0.0	46.0	27.3	9.5	37.3
Contraindications	4.5	0.0	11.1	0.0	28.6	7.5
Effectiveness	28.6	100.0	54.0	6.8	95.2	37.3
Advantages	11.6	100.0	31.7	15.9	76.2	23.7
Possible side effects	16.1	100.0	25.4	9.1	47.6	20.3
What to do if experienced side effects	21.4	100.0	25.4	6.8	33.3	21.2
Possibility of switching	9.8	100.0	28.6	15.9	0.0	15.4
About other methods of FP you could use	16.1	100.0	20.6	11.4	47.6	19.5
N	**112**	**1**	**63**	**44**	**21**	**241**

Respondents could give more than one response.

Treatment at Facility

Current users were asked about various aspects of their treatment when they last time visited a provider for family planning. As Table 9.6 shows, responses were mainly positive, but with some exceptions. Only 3 percent of the respondents said that the attitude of staff was un-cooperative or hostile, and 2 percent of the respondents said that the provider was not available when they visited. One-third of the respondents said that they were not examined properly; and about 52 percent said the provider was unable to deal with side effects.

Table 9.6: Percent current users responding positively on treatment at last visit, by aspect of treatment

Aspect of treatment	Percent
Staff attitude cooperative	96.8
Provider available	97.6
Attend/examine properly	66.7
Doesn't demand charges	58.1
Can deal with side effects	48.4

Side Effects

Current users were asked if they had experienced, or were experiencing, any side effects from their current method; past users were asked if side effects were among the reasons for their discontinuation. If so, a list of possible side effects was read out to them, and they were asked if they had experienced them; multiple responses were allowed. About 19 percent current users and 18 percent past users (22 percent of all current and past users) responded positively. As shown in the Figure 8.3, side effects were most commonly reported by injectable and Pill users (33 percent and about 30 percent, respectively), and they were least commonly reported by female sterilization users (5 percent).

Figure 9.3: Percent ever users who experienced side effects by method used

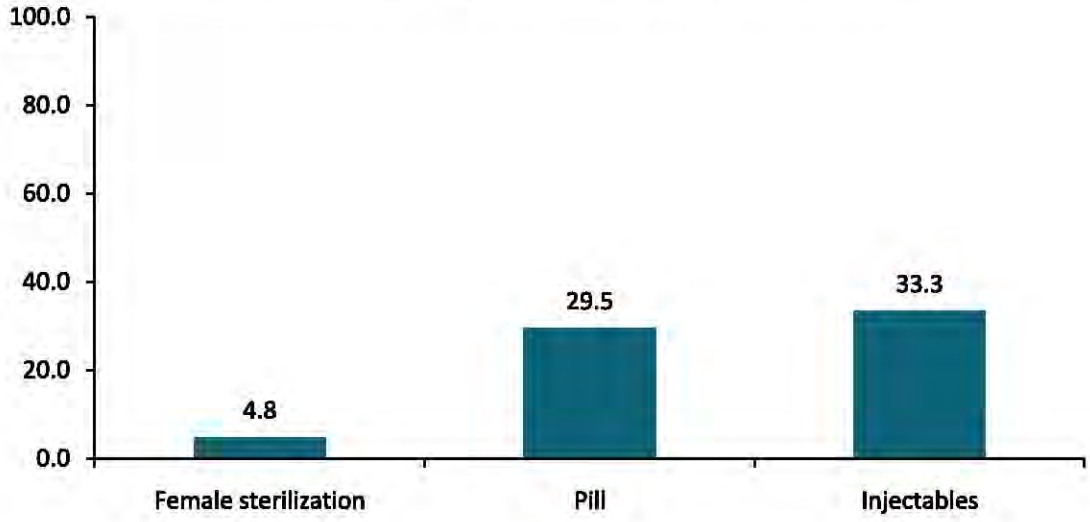
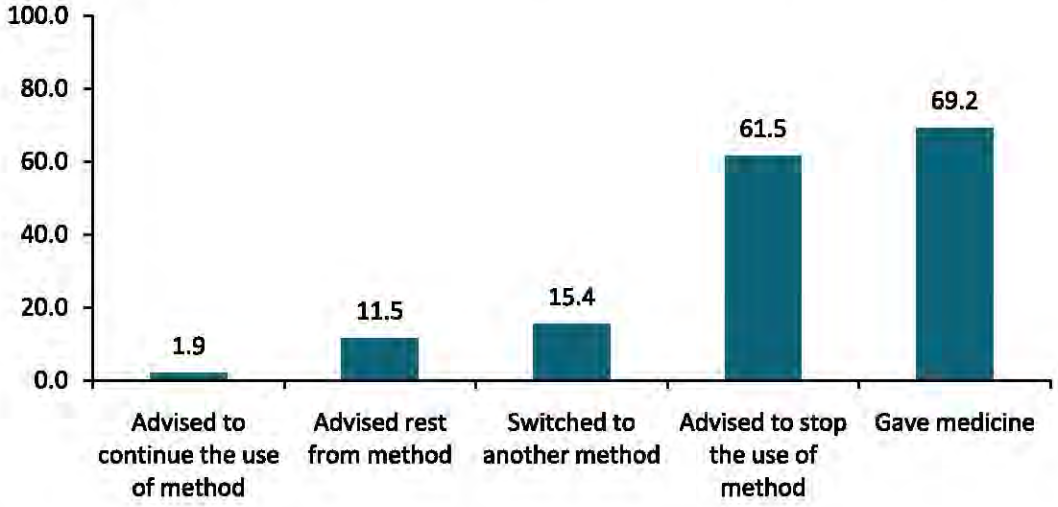


Figure 9.4: Distribution of provider responses upon consultation for side effects among past users



These respondents were asked if the provider responded in a manner included in a list read out to them (Figure 8.4). About sixty two percent were advised to stop, 15 percent were advised to switch to another method and about 12 percent were advised for rest. A very few respondents were advised to continue the method.

Chapter 10

Reasons for Non-use

There are many reasons why a couple may not be using birth spacing at any given time. The woman may already be pregnant, the couple may want another child soon, the woman may already have passed menopause, or believe herself to be sterile. Other reasons may prevent couples from using contraception even if they want to avoid having more children. Reasons may include: lack of knowledge of methods or inability to obtain them; fear of side effects; opposition of husband or family; and concern that birth spacing may be against Islam, or somehow wrong and so on. To understand how best to meet the needs of such people, it is important to understand the reasons why couples are not using birth spacing, in relation to the situation they are currently in.

Hindrances to Use

One way to understand common hindrances to contraceptive use is to ask respondents about their understanding of the concerns of people in general, with the view that people may feel less need to conceal their real concerns than when they are discussing their own situation. All respondents were asked, "If a couple wants to avoid or space a birth, which of the following hindrances might they face?" Each item on the list was read out to the respondent. Table 10.1 shows the responses of the female respondents, according to whether they were current users, past users or never users.

Table 10.1: Distribution of opinions of MWRA regarding hindrances faced by couples wanting to avoid or space a birth, by family planning use status

	Use of family planning					
	Current users		Past users		Never users	
Hindrance	N	%	N	%	N	%
Husband's disapproval	122	95.3	115	92.7	427	97.3
Other people may find out about contraceptive use	16	12.5	14	11.3	75	17.1
Distance and travel costs to FP outlet	50	39.1	47	37.9	209	47.6
Probability of getting pregnant while using contraceptives	54	42.2	51	41.1	234	53.3
Fear of side effects	90	70.3	90	72.6	333	75.9
Problem of managing side effects	84	65.6	79	63.7	294	67.0
FP is against religion	90	70.3	79	63.7	325	74.0
N	**128**	**na**	**124**	**na**	**439**	**na**

na = not applicable, respondents could give more than one response.

Some hindrances that couples might face were almost universally acknowledged. Nearly all respondents who were never users (97 percent) mentioned husband's possible disapproval, while 76 percent acknowledged fear of side effects, religious concerns (74 percent), and the problems of managing side effects (67 percent). For three other possibilities, however, proportion of women respondents thought them less likely to be a hindrance: these were that other people might find out about their contraceptive use; the distance and costs of going to an FP outlet; and the possibility of getting pregnant while using.

Past Users

Reasons for Discontinuing Contraceptive Use

Past users were asked about their reasons for discontinuing their last contraceptive method. Table 10.2 shows that the most commonly given reasons were experience of side effects (42 percent), desire for another child (36 percent), and fear of side effects about 19 percent. Other reasons carried less weight.

Table 10.2: Distribution of past contraceptive users by reason for discontinuing last method

Reason	Percentage
Wanted another child	35.5
Fear of side effects	18.5
Side effects experienced	41.9
Method failure	8.9
Lack of access/unavailability	4.8
Cost not affordable	0.8
Method inconvenient to use	0.8
Rest from method	8.9
Missed the dose	2.4
Provider's advice	11.3
Infrequent sex/Husband away	2.4
Husband's advice	8.1
In laws oppose	0.8
N	**124**

Respondents could give more than one reason.

Reasons for Current Non-use

It is important to know the reasons for non-use of those couples who have used contraceptive methods in the past but are not currently using them. Past users were read out a list of possible reasons for their not currently using contraceptives, with more than one reason possible (Table10.3). The most common and significantly important reason for discontinuation was fear of side effects (36 percent) followed by desire for more children (27 percent), lactational amenorrhea/ breastfeeding (19 percent).

Table10.3: Distribution of past users by reason for current non-use

Reason	Percentage
Fear of side effects	36.3
Want another child	26.6
Infrequent sex/husband away	6.5
Breastfeeding/lactational amenorrhea	19.4
Menopause/hysterectomy	0.8
N	**124**

Respondents could give more than one reason.

Never Users

Reasons for Non-use

The 439 women in the sample who reported never use were asked about various possible reasons for not using contraceptives, with each reason read out separately. As shown in Table 10.4, the most important reason was a desire for more children (72 percent), followed by fear of side effects of methods (36 percent) and breastfeeding (21 percent). Other reasons cited less frequently included: against religionand infrequent sex/ husband away.

Table 10.4: Distribution of never users by reason for never use

Reason	Percentage
Fear of side effects	36.0
Infrequent sex/Husband away	8.4
Breastfeeding/lactational amenorrhea	20.8
Respondent/Husband infertile	0.5
Wanted (more) children	72.4
Against religion	9.6
Natural spacing	1.4
Didn't know of any FP method	0.2
Others	2.3
N	**439**

Respondents could give more than one reason.

Attitude towards Birth Spacing and Limiting

It is important to see the extent to which never users disapprove of family planning in principle, as opposed to accepting it in principle but not using contraceptives for some other reason. Table 10.5 shows this for never using respondents, 44 percent of the women disapproved of spacing compared to 41 percent who disapproved of limiting. There seems to be more opposition to spacing rather than contraceptive use for the purpose of limiting children.

Table 10.5: Distribution of never users by attitude towards spacing and limiting birth

	Attitude towards spacing		Attitude towards limiting	
Attitude	**N**	**%**	**N**	**%**
Approve	243	55.4	252	57.4
Disapprove	193	44.0	180	41.0
Others	3	0.7	7	1.6
Total	**439**	**100.0**	**439**	**100.0**

Knowledge of Contraceptive Users, Methods and Facilities

Of the 439 female never users in the sample, 63 percent reported knowing some woman who had ever used a method to delay or avoid pregnancy; 41 percent of the respondents had a relative who had used some method, and 36 percent knew of a friend or neighbor who had used contraceptives. Eighteen percent of never users knew anyone (who was not relative) who had ever used an FP method to delay or avoid pregnancy.

Figure 10.1: Percent of never users who knew some woman who had ever used any FP method

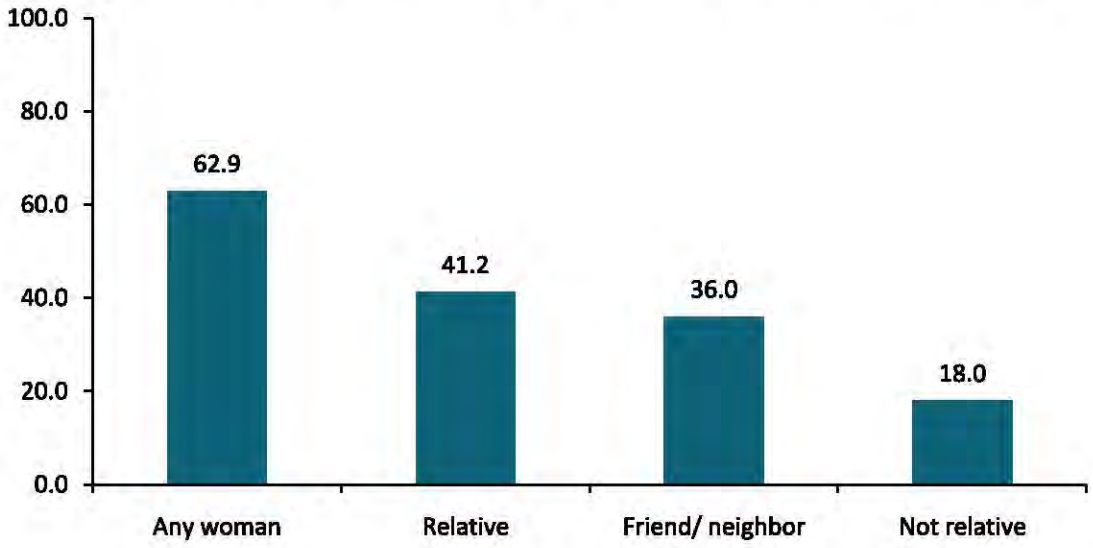


Table 10.6: Distribution of never users by knowledge of contraceptive methods

Method	Percentage
Pill	98.2
IUD	38.0
Injectables	98.4
Norplant	14.4
Condom	74.7
Rhythm	24.1
Withdrawal	55.1
Female sterilization	83.8
Male sterilization	13.9
Emergency Pills	17.5
Other FP method	5.0
Any FP method	98.6
N	**439**

Respondents could give more than one response.

Respondents who were never users had the same level of knowledge of at least one FP method as of general cited in Table 8.1 (99 percent) As might be expected but not by a great degree, for each method, a somewhat smaller percent of never users knew that method than the general distribution (Table 8.1); but most never users knew a variety of methods. These women's knowledge of where to get services and supplies was reasonable.

Of 439 never users, 39 percent did not know of a place to obtain a method. For those who did know, the places they were aware of are shown in Table 10.7. The sources best known were Homeopath/hakim, TBA/dai Pharmacy/chemists and the Lady Health Worker. A few women were aware of Mobile Service Camps, green star clinic.

Table 10.7: Knowledge of sources of contraception of never users by source of supply

Source	Percentage
Knowledge of at least one service provider	61.0
DHQ/THQ hospital	12.3
BHU/RHC/MCH Centre	11.2
Family Welfare Center	1.4
Mobile Service Unit Camp	0.7
Lady Health Worker	23.5
Greenstar clinic	0.5
Private Hospital/ Clinic/ Doctor	7.3
Dispenser/ Compounder	0.5
Pharmacy/ Chemists	42.8
Homeopathic/ Hakim	60.8
TBA/ Dai	60.6
Grocery shop (not pharmacy/ chemist)	0.9
Others	6.8
N	**439**

Respondents could name more than one source.

When asked which of the facilities named was nearest, the respondents were most likely to name DHQ/THQ hospitals and BHU/RHC/MCH centers. Mostly they would go there on foot, sometimes by car/motor cycle (Figure 10.2). Of the 268 respondents who indicated the time required to go to the nearest facility, 46 percent reported 15 minutes or less, 16 percent cited 16 to 30 minutes and 31 percent replied more than 30 minutes; the maximum was four hour (Figure 10.3).

Figure 10.2: Mode of transportation to the nearest facility/provider

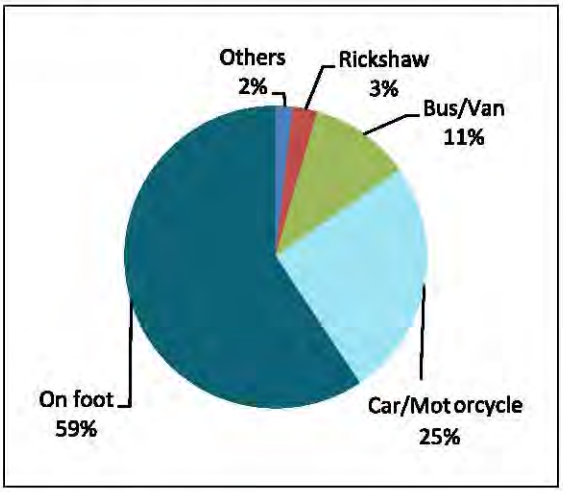
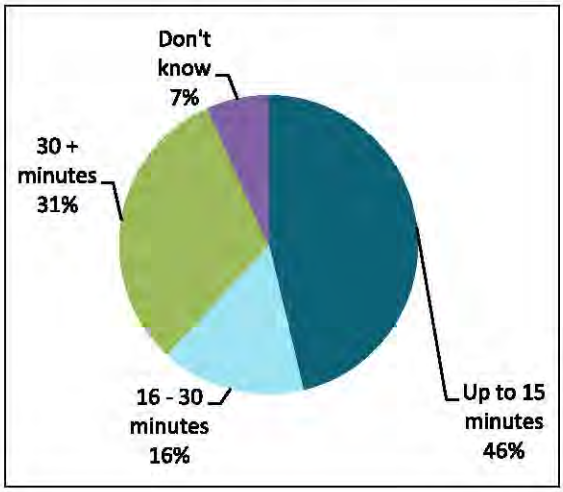


Figure10.3: Time taken to go to the nearest facility/provider



Intent to Use

Never users were asked about whether they intended to use contraceptives in the future. Table 10.8 shows that 27 percent of female respondents (120 out of 439 who believed they could get pregnant) said that they intended to use some method. Most of the low parity women who had not yet used a method (women with 2 or fewer children) expressed their intent to use in the future compared with women with 3 or more children.

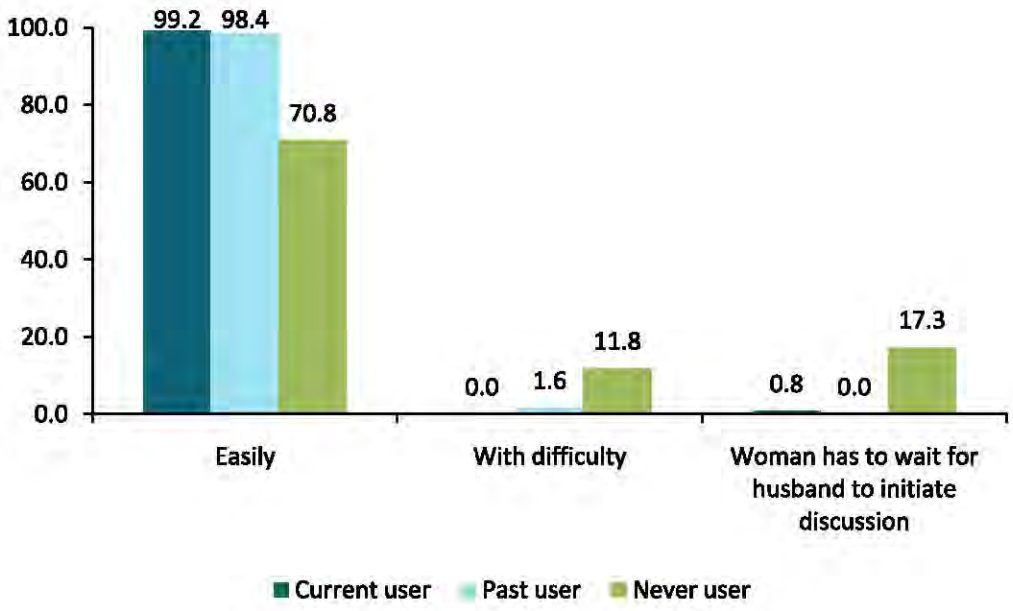
Table 10.8: Distribution of never users by intent to use a method in future and number of living children

Number of living children	Intention to use any FP method in future				Total	
	Yes	No	Unsure/ uncertain	Can't get pregnant	%	N
0	37.4	36.3	26.4	0.0	100	91
1-2	31.8	54.3	13.2	0.7	100	151
3-4	16.5	70.3	11.0	2.2	100	91
5 or more	21.7	59.4	15.1	3.8	100	106
Total	**27.3**	**55.1**	**15.9**	**1.6**	**100**	**439**
N	120	242	70	7	100	439

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Women were also asked whether they could approach their husbands to discuss family planning easily, with difficulty, or if they had to wait for their husbands to initiate the discussion. Most women said they could do so easily (Figure 10.4). However, this varied by use status. Almost all current users, and 98 percent of the past users, said they could approach their husbands easily, and very few said they had to wait for their husband to initiate the discussion. But for never users, 71 percent reported being able to approach their husbands easily, about 12 percent reporting that they could only do so with difficulty and another 17 percent saying they had to wait for him to begin the conversation.

Figure 10.4: Women's reports regarding ease of approach to husband to discuss family planning



Chapter 11

Unmet Need

"Unmet need" for family planning is a term long used to help focus attention in a family planning program on those who need it. Conceptually, unmet need refers to women who say they do not want more children, or want them later, and are at risk of conceiving, but are not currently using contraceptives. Women currently pregnant or who are experiencing postpartum amenorrhea are said (in this formulation) to be in unmet need if their current (if pregnant) or last (if amenorrheic) pregnancy was said to be unwanted or mistimed. Women who want to delay their next pregnancy are said to be in unmet need of spacing; those who do not want more children at all are said to be in unmet need of limiting. Women in unmet need in this sense are those for whom there is an inconsistency between what they say they want and what they are doing; these women would appear to be in need of some support to avoid unwanted pregnancies.

Levels and Correlates

Table 11.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in Gwadar. Of the 691 women, 291 (42.1 percent) were judged to be in unmet need. This proportion was higher than is typically found in Pakistan, where unmet need tends to be around 37 percent of MWRA. The higher proportion may be a reflection of the relatively low contraceptive prevalence; lower levels of use may mean that less of the total demand for family planning is being met. This is supported by the relatively high level of unmet need for women with 5 or more children, where contraceptive prevalence was particularly high.

Of the 42.1 percent women who had unmet need, 22.6 percent was for spacing, while 19.5 percent was for limiting. Unmet need for spacing was concentrated among younger women and women with one or two living children. Unmet need for limiting, unsurprisingly, was highest among women with three or more children, because at that stage couples begin to not want to have more children.

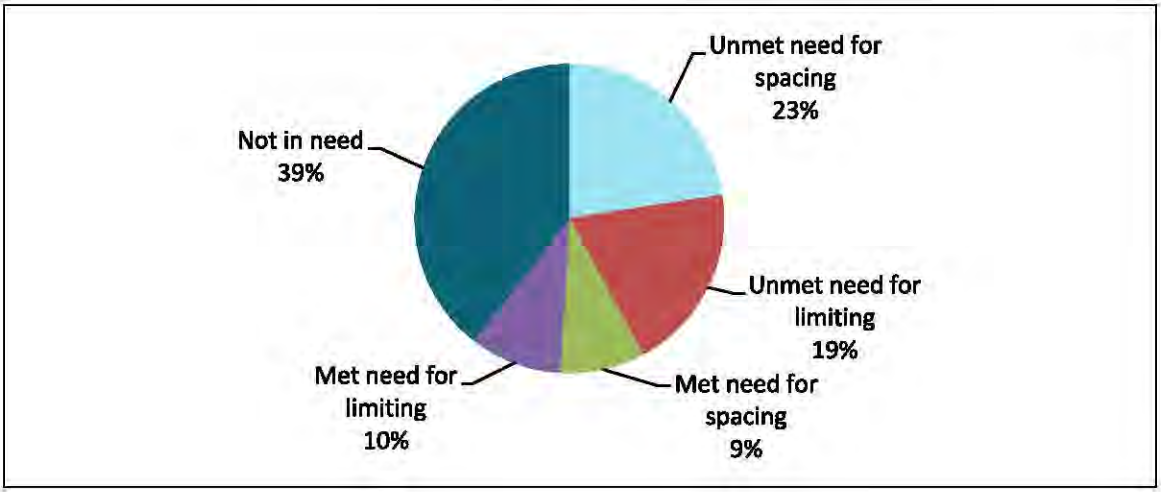
Table 11.1: Distribution of women with unmet need for spacing and limiting by background characteristics

Characteristic	Unmet need			Met need			Total demand	Not in need	Total	
	For spacing	For limiting	Total	For spacing	For limiting	Total			%	N
Age of respondent										
15 – 24	37.9	3.1	41.0	9.9	1.2	11.2	52.2	47.8	100	161
25 – 34	23.9	12.1	36.1	12.9	9.3	22.1	58.2	41.8	100	280
35 – 49	11.2	38.4	49.6	3.6	15.6	19.2	68.8	31.2	100	250
Residence										
Rural	21.0	23.5	44.4	8.3	7.9	16.2	60.6	39.4	100	315
Urban	23.9	16.2	40.2	9.3	11.2	20.5	60.6	39.4	100	376
Literacy of respondent										
Literate	29.2	6.5	35.7	16.2	9.1	25.3	61.0	39.0	100	154
Illiterate	20.7	23.3	43.9	6.7	9.9	16.6	60.5	39.5	100	537
Education of respondent										
No education	20.0	23.8	43.7	7.0	10.1	17.1	60.8	39.2	100	526
Up to primary	31.3	7.8	39.1	6.3	10.9	17.2	56.3	43.8	100	64
Up to Secondary	30.6	5.9	36.5	21.2	8.2	29.4	65.9	34.1	100	85
Above secondary	31.3	0.0	31.3	12.5	0.0	12.5	43.8	56.3	100	16
Children ever born										
None	6.7	0.0	6.7	0.0	0.0	0.0	6.7	93.3	100	89
1 – 2	39.5	3.2	42.6	15.3	0.5	15.8	58.4	41.6	100	190
3 – 4	26.3	13.5	39.7	12.8	7.1	19.9	59.6	40.4	100	156
5 or more	13.3	42.2	55.5	4.7	21.5	26.2	81.6	18.4	100	256
Ownership of TV										
Yes	23.6	17.5	41.1	9.8	11.0	20.8	61.9	38.1	100	428
No	20.9	22.8	43.7	7.2	7.6	14.8	58.6	41.4	100	263
Standard of living index										
Low	21.4	22.1	43.6	2.9	8.6	11.4	55.0	45.0	100	140
Medium low	14.9	21.8	36.8	11.5	4.6	16.1	52.9	47.1	100	87
Medium high	35.1	21.1	56.1	9.6	5.3	14.9	71.1	28.9	100	114
High	20.9	17.4	38.3	10.3	12.9	23.1	61.4	38.6	100	350
Total	**22.6**	**19.5**	**42.1**	**8.8**	**9.7**	**18.5**	**60.6**	**39.4**	**100**	**691**

The correlations between unmet need and various socioeconomic indicators varied by whether the unmet need was for spacing or for limiting. Unmet need for limiting was

associated with low SLI, illiteracy, Education of respondent, rural residence and number of children, while unmet need for spacing, on the other hand, was strongest with age of respondent and with number of children, while association with SLI was weak. It is possible that educated women were more aware of the need to space their births, but were inhibited from doing so for various reasons. Once they have reached their desired family size, educated women may be more able to use a family planning method than those who are uneducated. However, conclusions should be tentative, given the small sample sizes involved. Figure 11.1 shows the need and demand for family planning of the sampled women.

Figure 11.1: Need and demand for family planning



Total Demand

The sum of current use ("met need") and unmet need is often called "total demand" for family planning. It would normally be expected to rise with the number of living children a couple has. Table 11.1 also shows total demand by background characteristics of the women. Overall, total demand was 60.6 percent of all married women of reproductive age. As the table shows, total demand did rise rapidly, and fairly consistently, by number of children.

Strength of Preference

It is of interest to look at the responses of women in unmet need (those not currently pregnant) according to their reaction if they became pregnant in the near future (Table

11.2). Forty percent of the women with unmet need for spacing said they would be worried if they became pregnant again; 43 percent would accept it, and about 15 percent would be pleased. Of those with unmet need for limiting, 52 percent said they would be worried if they became pregnant. It is perhaps not unreasonable for women to be more concerned about the consequences of an unwanted pregnancy than about the consequences of a wanted pregnancy coming too soon. However, the responses of women who wanted to delay their next child for 2 or more years and those who wanted to stop childbearing were not strong enough to use family planning.

Table 11.2: Distribution of non-pregnant women with unmet need for spacing and limiting, by strength of desire to avoid pregnancy

Reaction if become pregnant in near future	Unmet need for spacing		Unmet need for limiting	
	N	%	N	%
Pleased	20	14.7	1	0.8
Worried	54	39.7	69	51.9
Accept it	59	43.4	57	42.9
Doesn't matter	3	2.2	6	4.5
Total	**136**	**100.0**	**133**	**100.0**

Reasons for Non-use

Past and never users were asked why they were not using some method of contraception; for those later classified as having unmet need, the results are shown in Table 11.3. Some of these reasons represent barriers as perceived by the women; the most important of these are fear of side effects (about 49 percent) and husbands' opposition (22 percent). On the other hand, many women with defined unmet need gave reasons that did not reflect perceived need, at least at present. Such reasons included wanted more children, infrequent sex/husband away, natural spacing, and currently breastfeeding. Some of these women may have had more need than they realize; for example, women using "natural spacing" or breastfeeding may in fact be at substantial risk of pregnancy. Women currently pregnant or amenorrheic may be in need of contraception in the near future.

Table 11.3: Women with unmet need for spacing and limiting by stated reasons for non-use of contraception

Reason	Unmet need for spacing	Unmet need for limiting	Total unmet need
Fear of side effects	42.9	54.8	48.5
Husband opposes	23.1	20.7	22.0
In laws oppose	20.5	9.6	15.5
Rest from method	1.9	3.7	2.7
Shy to consult about FP	2.6	0.0	1.4
Provider's advice	2.6	5.2	3.8
Against religion	9.0	9.6	9.3
Lack of access/Unavailability	10.9	13.3	12.0
Cost not affordable	4.5	7.4	5.8
Don't know any FP method	0.0	0.7	0.3
Just not using/too lazy	1.9	1.5	1.7
Method inconvenient to use	7.1	5.9	6.5
Total perceived barriers	64.7	72.6	68.4
Infrequent sex/Husband away	5.1	14.8	9.6
Natural spacing	0.0	3.0	1.4
Difficult/Unable to conceive	4.5	5.2	4.8
Want (more) children	58.3	17.8	39.5
Currently pregnant	5.1	0.7	3.1
Breastfeeding/Lactational amenorrhea	7.1	6.7	6.9
Total no perceived need	67.9	40.7	55.3
Others	3.2	5.9	4.5
N	**156**	**135**	**291**

Respondents could give more than one reason.

Unmet Need for Spacing: Profile

Women with unmet need for spacing comprise 156 (22.6 percent) of MWRA. As shown in Table 11.4, they were characterized by:

- **Living Children:** Most (51percent) had 1 or 2 living children.
- **Family Planning Use:** More never users (79 percent) than past users (21 percent).
- **Strength of Preference:** Moderate (about 40 percent "worried" if they became pregnant earlier than they wanted compared to those who were pleased (about 15 percent) or would accept (43 percent) the unwanted pregnancy).
- **Intent to Use FP method in Future:** Moderate (about 42 percent intended to use an FP method in future).
- **Approval of FP:** High (64 percent approved of using an FP method for spacing purposes).
- **FP Communication with Husband:** Limited (about 37 percent had communicated with husbands on FP in the past one year; while 10 percent said approaching the husband was "difficult").
- **Obstacles to FP Use:** Fear of side effects (43 percent); husband and in-laws opposition (23 percent and 20 percent respectively) (Table11.3).

Table 11.4: Percent distribution of MWRA in unmet need for spacing and limiting by selected characteristics

Characteristic	Unmet need for spacing		Unmet need for Limiting	
	N	%	N	%
Number of living children				
0	6	3.8	0	0.0
1-2	79	50.6	6	4.4
3-4	42	26.9	25	18.5
5 or more	29	18.6	104	77.0
Contraceptive use status				
Current user	0	0.0	0	0.0
Past user	33	21.2	47	34.8
Never user	123	78.8	88	65.2
Reaction if become pregnant in near future				
Pleased	20	14.7	1	0.8
Worried	54	39.7	69	51.9
Accept it	59	43.4	57	42.9
Doesn't matter	1	0.7	4	3.0
Others	2	1.5	2	1.5
Intention to use a method in future				
Yes	66	42.3	32	23.7
No	63	40.4	78	57.8
Unsure/Uncertain	24	15.4	21	15.6
Can't get pregnant	3	1.9	4	3.0
Approval of FP				
Approve	100	64.1	85	63.0
Disapprove	56	35.9	47	34.8
Others	0	0.0	3	2.2
FP communication with husband in past one year				
Never	99	63.5	94	69.6
Once or twice	38	24.4	19	14.1
More often	19	12.2	22	16.3
Approach the topic of FP with husband				
Easily	119	76.3	104	77.0
With difficulty	15	9.6	19	14.1
Respondent has to wait for husband to initiate discussion	22	14.1	12	8.9
N	**156**	**100.0**	**135**	**100.0**

Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 135 (19.5 percent) of MWRA. As shown in Table 11.4, they were characterized by:

- **Living Children:** A strongly positive association with number of living children; 77 percent had 5+ living children.
- **Family Planning Use:** More never users (65 percent) than past users (35 percent).
- **Strength of Preference:** Moderate (52 percent would be "worried" if they became pregnant compared to those who were pleased (0.8 percent) or would accept (43 percent) the unwanted pregnancy).
- **Intent to Use FP method in Future:** Low (about 24 percent intended to use a FP method in future.
- **Approval of FP:** High (63 percent approved of FP for limiting purpose).
- **FP Communication with Husband:** Limited (30 percent had communication with husband on FP in the past year; while 14 percent said approaching the husband was "difficult").
- **Obstacles to FP Use:** Fear of side effects (55 percent); husbands and in-laws opposition (20.7 percent and 9.6 percent respectively) (Table 11.3).

Chapter 12

Reproductive Preferences and Behavior of Men

It is often the case that in matters relating to family planning the focus has too often been more on women, despite the fact that husbands are equal partners in the reproductive process and often have greater responsibility for decision-making in the family. In addition, women often mention their husbands as a constraint to the use of contraception (NIPS/PDHS, 2008; Population Council, 1995). The objectives of interviewing husbands/men in the FALAH baseline survey were to explore their perspectives on birth spacing/family planning and to use the information obtained to design the communication strategy for the FALAH project. Overall, the planned sample size was 200 husbands in each district .The intention was to interview as many husbands as possible who were available when the household interviews were undertaken. Knowing that some number of husbands might be at their places of work during the timing of the interviews, the plan was to then make up for any of the husbands who were unavailable by interviewing other married men available in the selected communities in order to come as close as possible to meeting the objective of interviewing 200 husbands/men in each FALAH district. In Gwadar, the field team was able to interview 195 men who were husbands of the married women of reproductive age who had been interviewed for the survey plus 5 married men living in the selected areas who were not husbands of the female respondents. In this chapter, the results for the respondents' husbands and the other married men who were interviewed (N= 200) are always grouped together, whether the reference is to "men," "male respondents," "married men," or "husbands."

A husband's approval of family planning is a powerful factor in explaining contraceptive use (Tawiah, 1997). In families, fertility decisions occur within specific social contexts and according to prevailing social norms that restrict individual decisions on fertility and behaviors related to spacing of births, stopping childbearing, and using contraception.. Earlier studies suggest that the husband's approval of and discussion about family planning

are important predictors of a woman's contraceptive use and fertility desire (Bongaarts and Bruce, 1995; Mahmood and Ringheim, 1997).

This baseline survey investigates social and demographic differentials, and knowledge, ever use and current use of family planning methods. It also explores how approval and discussion of birth spacing/family planning influence the use of contraceptive methods. Traditionally, the measurement of contraceptive use has been based on women's self-reports of current use. The rationale for interviewing men was to investigate their perspective on the issues of fertility and family planning.

Background Characteristics

Table 12.1 shows the background characteristics of the men interviewed in the survey. It shows that only 5.5 percent of the men were under 25 years of age and 3 percent were 50-54 years of age.

As shown in Table 12.1, men were substantially better educated than the sampled currently married women of reproductive age. Fifty-four percent of the men had not been to school, compared to 76 percent of the women (Table 3.2). About 13 percent of the men had above-secondary level education, whereas only 2 percent of the women had attained that level of education (Table 3.2).

The occupations of men are presented in Table 12.1. Fifty-seven percent of the men were working as daily wage laborers, while 15 percent were in Govt. Service and about 12 percent ran their own business.

Table 12.1: Background characteristics of male respondents

Characteristic	Percentage
Age	
15-19	0.5
20-24	5.0
25-29	18.5
30-34	21.5
35-39	24.5
40-44	13.5
45-49	13.5
50-54	3.0
Education	
Proportion literate	48.5
No education	54.0
Up to primary	14.0
Up to Secondary	19.5
Above secondary	12.5
Occupation	
Agriculture/Livestock/Poultry	7.0
Petty trader	2.0
Labor	57.0
Govt. Service	15.0
Pvt. Service	3.0
Own business	11.5
Unemployed	4.5
Total	**100.0**
N	200

Contraceptive Knowledge and Use

Almost all of the interviewed men (95 percent) in Gwadar knew of at least one method of contraception; 99 percent of the women knew of at least one method. As presented in Table 12.2, knowledge of modern methods was highest for pills (77 percent), followed by condoms (58 percent), female sterilization (53.5 percent) and injectables (50 percent). The

least known methods were Norplant (1.5 percent), male sterilization (2 percent), and IUD (3 percent). At least one traditional method was known to about 12 percent of the men.

The pattern of ever use and current use of contraception reported by husbands is also shown in Table 12.2. Of the MWRA respondents interviewed in our sample, 36.5 percent reported having used some method of contraception during their married lives (Table 8.2); 42.5 percent of the men reported ever use of a method. Pills were the most popular method ever used as reported by 26.5 percent of the men, followed by injectables (17.5 percent) and condom (only 7 percent).

Table 12.2: Distribution of male respondents by contraceptive knowledge, use status

Contraceptive method	Knowledge	Ever use	Current use
Female sterilization	53.5	3.0	2.5
Male sterilization	2.0	0.0	0.0
Pill	77.0	26.5	7.5
IUD	3.0	0.5	0.0
Injectables	50.0	17.5	5.0
Norplant	1.5	0.0	0.0
Condom	58.0	7.0	4.0
Rhythm	2.5	1.0	0.5
Withdrawal	8.5	1.5	1.5
Others	2.0	0.0	0.0
At least one FP method	94.5	42.5	21.0
At least one modern FP method	94.5	41.0	19.0
At least one traditional FP method	11.5	2.5	2.0
Emergency Pills	1.0	0.0	na
N	**200**	**200**	**200**

na=not applicable.

A total of 19 percent of the MWRA in the sample were currently using some method of contraception (Table 8.2). The current use reported by male respondents was slightly higher (21 percent). The most common current modern method in use as reported by male respondents was pills (7.5 percent), followed by Injectables (5 percent). Only 2 percent men reported using at least one traditional method. Since traditional methods are far less reliable than modern methods, an important goal of the FALAH project should be to shift users of traditional methods to more effective modern methods.

Table 12.3: Percentage of male respondents reporting ever use or current use of a contraceptive method, by selected background characteristics

Characteristic	Ever used at least one FP method	Currently using any FP method	N
Education level			
No education	44.4	18.5	108
Below secondary	32.6	21.7	46
Secondary and above	47.8	26.1	46
Number of living children			
None	0.0	0.0	25
1-2	29.0	22.6	62
3-4	52.0	16.0	50
5+	65.1	31.7	63
Future desire for children			
Soon	12.5	0.0	16
Later	33.3	18.9	132
Never	77.3	34.1	44
Don't know	62.5	25.0	8
Total	**42.5**	**21.0**	**200**

Table 12.3 shows ever use and current use of modern contraception among respondents by background characteristics. There was a positive relationship b etween education level and contraceptive use. More than 48 percent of the men who had secondary and above education, reported ever use of any contraceptive method, compared to about 33 percent and 44 percent who had below secondary and no education, respectively. Current use of family planning also shows the same pattern by education of men.

Table 12.3 also shows a positive relationship between the number of living children and ever use and current use. Of those who had 5 or more children, almost 65 percent reported ever use of family planning methods, compared to 52 percent who had 3-4 children and 29 percent who had 1-2 children. The pattern is a bit different among current users. Of those having 1-2 and more than 5 children the rate is high (about 23 percent and 32 percent respectively).

.

Source of Contraceptive Methods

As shown in Table 12.4, among those who reported the last source for obtaining contraceptive methods, about 46 percent reported that they had obtained it from the pharmacy/chemist. Other sources for contraceptives were LHWs, Private and Government, and hospital/clinics. About 9 percent men said that their wives brought the method.

Table 12.4: Distribution of male ever users by the last reported source of contraceptive supply

Source	Percentage
Govt. hospital (DHQ/THQ)	4.9
BHU/RHC/MCH Centre	3.7
FWC	1.2
LHW	14.8
Pvt. Doctor	1.2
Pvt. hospital/clinic	13.6
NGO hospital	1.2
Pharmacy, chemist	45.7
Wife brings method	8.6
Others	4.9
Total	**100.0**
N	81

Approval of Family Planning

Respondents were asked about their approval of birth spacing and use of any form of contraception for spacing purpose. A husband's opposition may prevent his wife from using contraception, even when she wants to delay or stop childbearing (Casterline, Perez, and Biddlecom, 1997). In Gwadar, about 90 percent men approved spacing between children (Table 12.5), but about 76 percent approved of the use of any contraceptive to space between children.

Table 12.5: Distribution of male respondents' attitude towards spacing and use of contraceptives for spacing

Variable	Percentage
Spacing between children	
Approve	89.5
Disapprove	10.0
Other	0.5
Total	**100.0**
N	200
Using FP methods for spacing	
Approve	75.5
Disapprove	24.5
Total	**100.0**
N	200

Satisfaction Level of Current Users

Satisfaction of the us er with his/her contraceptive method is an important factor in whether or not he/she continues with the method. Male contraceptive users were asked to report how satisfied they were with their present contraceptive method. Table 12.6 shows that all current users were very satisfied with their current method.

Table 12.6: Level of male respondents' satisfaction with their current method

Level of Satisfaction	Percentage
Very satisfied	100.0
Total	**100.0**
N	**38**

Table 12.7: Percentage distribution of male past contraceptive users by the reason for discontinuing last method

Reason	Percentage
Lack of access/unavailability	2.3
Experienced side effects	46.5
Fear of side effects	27.9
Want another child	55.8
Method failure	7.0
Rest from method	30.2
Health concern	14.0
Service provider's advice	14.0
N	**43**

Respondents could give more than one reason.

The reasons the male respondents reported to stop using the last method are presented in Table 12.7. The table shows that wanting another child was the main reason for stopping the use of a family planning method (about 56 percent). However, about 47 percent of male past users stopped using their method as they experienced side effects, and about 30 percent stopped because they wanted rest from their method and about 28 percent were those who had fear of the side effects of methods.

Inter-spousal Communication

One of the determinants of contraceptive use is inter-spousal discussion on fertility intentions and family planning. Husbands were asked if during the last one year their wives could approach them to discuss family planning easily, with difficulty, or if they had to wait for their husbands to initiate the discussion; the responses are shown in Figure 12.1. Seventy-six percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, more than 39 percent of the men reported that their wives had never approached them during the last year on this issue (Figure 12.2). Twenty- seven percent of the men reported that their wives had talked more often about this subject during the last year, and 34 percent reported they had talked once or twice.

Figure 12.1: Men's reports of ease of approach by their wives to discuss FP

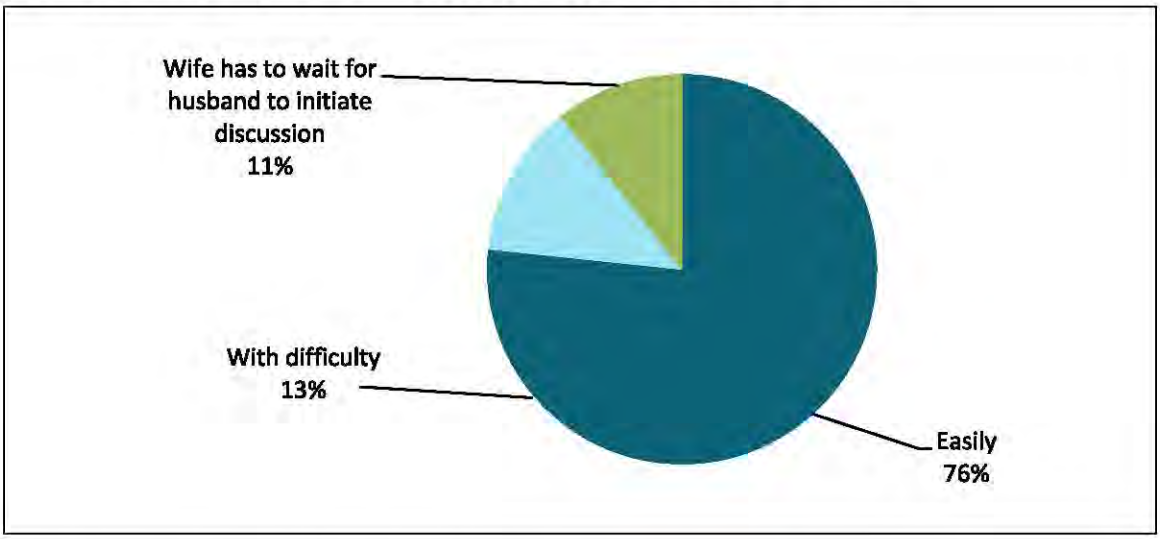
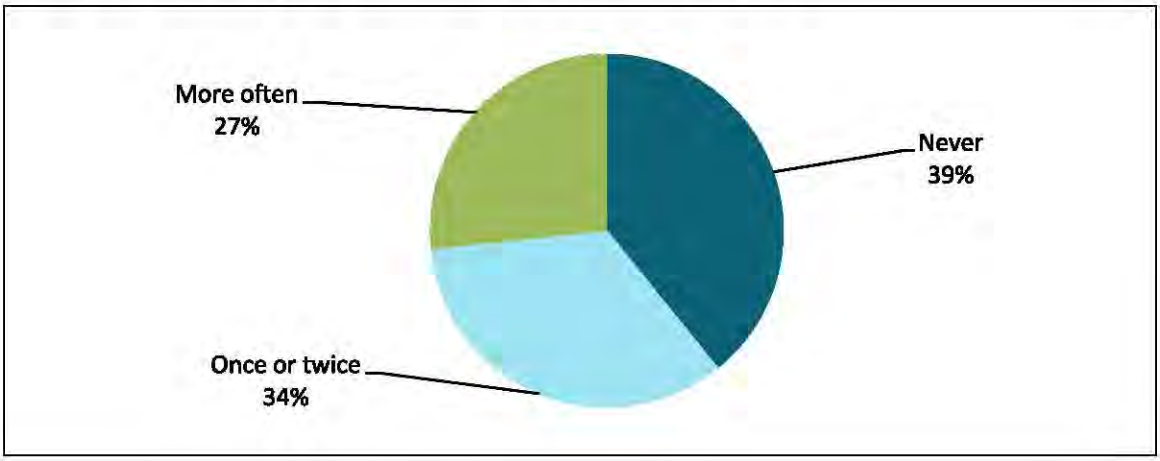


Figure 12.2: Frequency of discussion on FP with wife in last year



Potential Users

Men who had never used any contraceptive method were asked about their intention to use contraception in the future and their method preferences. Table 12.8 shows that 20 percent husbands intended to use contraception in the future, though a great number (about 42 percent) did not intend to use a contraceptive method in the future. Remaining 38 percent of the respondents were uncertain about their future use of contraception.

Table 12.8: Distribution of male never users by intent to use contraceptive methods in future

Intent	Percentage
Will use	20.0
Will not use	41.7
Unsure/Uncertain	38.3
Total	**100.0**
N	**115**

As shown in Table 12.9, the major reason men gave for not intending to use a contraceptive method in future was that they wanted another child (about 96 percent) followed by 56 percent those who had fear of side effects. Forty-six percent reported wife's opposition as reason for non use of contraception. Among other reasons, breastfeeding/lactation amenorrhea, difficult/ unable to conceive and shy about visiting a family planning clinic were the other main reasons for not using family planning methods.

Table 12.9: Distribution of male never users according to reasons for not intending to use contraceptive methods in future

Reason	Percentage
Wife opposes	45.8
In laws/parents oppose	4.2
Fear of side effects	56.3
Lack of access/unavailability	10.4
Cost too much	6.3
Shy to go to FP clinic	14.6
Difficult/unable to conceive	20.8
Breastfeeding/ Lactational amenorrhea	22.9
Respondent/wife infertile	4.2
Want more children	95.8
N	**48**

Respondents could give more than one reason.

Table 12.10 shows the distribution of the male respondents who intended to use a specific contraceptive method in the future. It is observed that a higher proportion wanted to use female methods and none intended to use male method.

Table 12.10: Distribution of male never users who intend to use specific contraceptive methods in the future

Method	Percentage
Female sterilization	17.4
Pills	65.2
Injectable	4.3
Not decided	13.0
Total	**100.0**
N	**23**

Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 12.11 shows that 8 percent of the respondents wanted another child soon (within two years). The largest proportion, 66 percent wanted to delay their next child for more than two years and 22 percent were those who did not desire for more children at all.

The desire to stop having children was positively associated with the number of living children. Of the respondents who had 3 children, 3 percent did not want more; of those who had 6 or more children, 59 percent did not want more.

The percentage of male respondents who wanted to postpone or did not want more children was much larger than the 21 percent who reported current use of contraception. If those who wanted to postpone having another child are combined with those who did not want any more, the sum would constitute a very high proportion of the interviewed men in Gwadar. This suggests that there is a strong need for family planning, but motivational programs and service delivery are not keeping pace with this need.

Table 12.11: Distribution of male respondents by desired timing for next child and number of living children

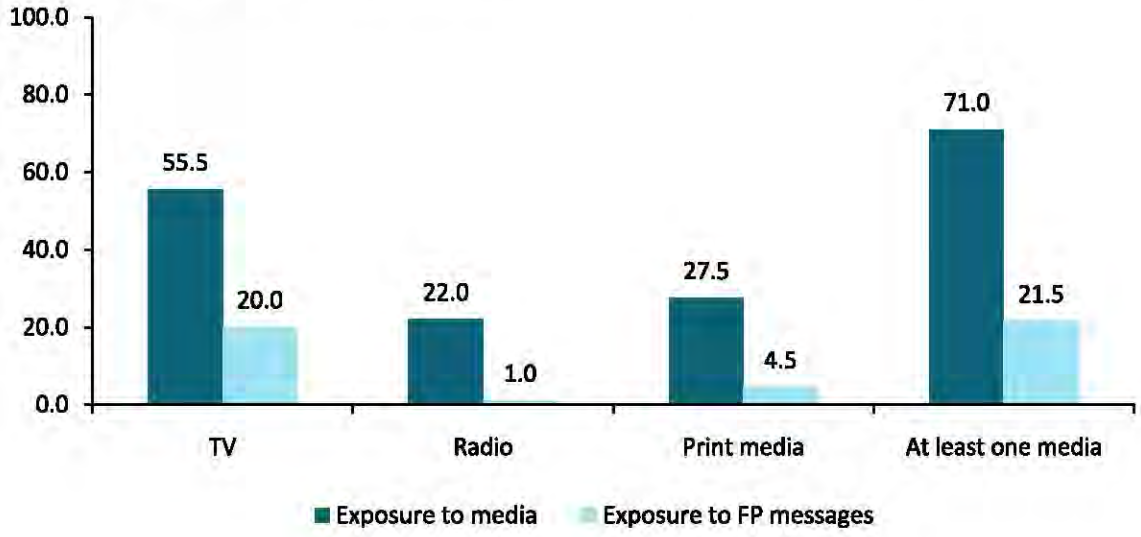
Number of living children	Desire for next child				Total	
	Soon	Later	Never	Don't know/ unsure	%	N
0	24.0	76.0	0.0	0.0	100.0	25
1	6.5	90.3	0.0	3.2	100.0	31
2	6.5	90.3	0.0	3.2	100.0	31
3	11.8	82.4	2.9	2.9	100.0	34
4	0.0	62.5	31.3	6.3	100.0	16
5	4.2	29.2	62.5	4.2	100.0	24
6+	2.6	30.8	59.0	7.7	100.0	39
Total	**8.0**	**66.0**	**22.0**	**4.0**	**100.0**	**200**

Mass Media Access and Exposure to FP Messages

For the development of communication activities, it is important to know which forms of mass media are available and to what extent they are used by various segments of the population. Figure 12.3 shows the proportion of men who reported that they watched TV, listened to the radio, or read newspapers or magazines. TV and print media were the most commonly accessed mediums: 55.5 percent of the men in Gwadar watched TV and 27.5 percent reported access to print media.

Furthermore, respondents who reported access to any sort of media were asked if they had ever seen, heard, or read any message pertaining to methods of family planning through these mediums. Twenty percent of the men had seen FP messages on the television, which is higher than the percentage for women (Figure 3.4). Overall, about 22 percent of men and about 15 percent of women had seen or heard any family planning message from at least one medium. Only one percent of the men reported that they had ever listened to a family planning message on the radio.

Figure 12.3: Distribution of male respondents according to exposure to media and FP messages, by type of media



References

Adair,L., Popkin, B., and Guilkey, D. 1994. *The duration of breastfeeding: How is it affected by biological, socioeconomic, health sector, and food industry factors?* Demography 30(1): 63.

Bohiler, E. and Bergstrom, S. 1995. *Subsequent pregnancy affects morbidity of previous child.* Journal of Biosocial Science 27(4): 431-442. Oct. 1995.

Bongaarts, J., and J. Bruce. 1995. *The Causes of Unmet Need for Contraception and the Social Content of Services.* Studies in Family Planning 26(2): 57-75.

Caldwell, J.C. 1976. *Toward a Restatement of Demographic Transition Theory.* Population and Development Review 2(3-4): 321-366.

Casterline, J.B., A.E. Perez, and A.E. Biddlecom. 1997. *Factors Underlying Unmet Need in the Philippines.* Studies in Family Planning 28(3): 173-191.

Casterline J. B., *et al* 2001. Obstacles to Contraceptive Use in Pakistan: A Study in Punjab. *Studies in Family Planning.* 32(2): 95-110.

Cleland and Sathar. 1984. *The Effect of Birth Spacing on Childhood Mortality in Pakistan.* Population Studies, Vol. 38, No. 3 (Nov., 1984), pp. 401-418.

Fuentes-Affelick, E. and Hessol, N.A. 2000. *Interpregnancy interval and the risk of premature infants.* Obstetrics and Gynecology 95(3): 383-390. Mar. 2000.

Garner, P., Smith, T., Baea, M., Lai, D., and Heywood, P. 1994. *Maternal nutritional depletion in a rural area of Papua New Guinea.* Tropical and Geographical Medicine 46(3): 169-171. 1994.

Government of Pakistan. 2005. *Pakistan Social and Living Standards Measurement Survey 2004-05: National/Provincial.* Islamabad: Federal Bureau of Statistics.

Government of Pakistan. 2006. *Pakistan Social and Living Standards Measurement Survey 2004-05: Provincial/District.* Islamabad: Federal Bureau of Statistics.

Mahmood, Arshad. 2002. *Determinants of Neonatal and Post-Neonatal Mortality in Pakistan.* The Pakistan Development Review, Vol. 41, No. 4, Part (Winter 2002), pp.723-744.

Mahmood, N. and K. Ringheim. 1997. *Knowledge, Approval and Communication about Family Planning as Correlates of Desired Fertility among Spouses in Pakistan*. International Family Planning Perspectives 23(3): 122-129, 145.

Miller, J.E. 1994. *Birth order, Interpregnancy Interval and Birth Outcomes among Filipino Infants*. Journal of Biosocial Science 26(2): 243-259. Apr. 1994.

NIPS (National Institute of Population Studies). 2001. *Pakistan Reproductive Health and Family Planning Survey 2000-01*. Islamabad.

NIPS (National Institute of Population Studies). 2007. *Status of Women, Reproductive Health and Family Planning Survey: Main Report*. Islamabad.

NIPS/ DHS (National Institute of Population Studies and MEASURE DHS, Macro International). 2007. *Pakistan Demographic and Health Survey 2006-07: Preliminary Report*. Calverton, Maryland: Macro International Inc.

Planning Commission of Pakistan. 2006. *Pakistan Millennium Development Goals Report 2006*. Islamabad: Center for Research on Poverty and Income Distribution.

Population Census Organization. 2000. *District Census Report of Gwadar*. Islamabad: Statistics Division, Government of Pakistan.

Population Council. 1997. *The Gap between Reproductive Intentions and Behavior: A Study of Punjab Men and Women*. Islamabad: The Population Council.

Population Council. 2006. Women's Health in Pakistan 2005. Islamabad. Unpublished.

Population Council. 2007. *Diversification of Family Planning Activities in Pakistan (DFPAP): Performance Monitoring Plan*. Islamabad: The Population Council. Unpublished.

Population Council. 2008. *Communication, Advocacy and Mobilization (CAM) Strategy for the FALAH Project: A Draft Strategy*. Islamabad: The Population Council. Unpublished.

Rutstein, S.O., and K. Johnson. 2004. *The DHS Wealth Index*. DHS Comparative Report No. 6. Calverton, Maryland, USA: ORC Macro.

Tawiah, E.O. 1997. *Factors Affecting Contraceptive Use in Ghana*. Journal of Biosocial Science 29(2): 141-149.

UNDP (United Nations Development Program). 2003. *Pakistan National Human Development Report 2003.* Karachi.

UNFPA/PC (United Nations Population Fund and Population Council). 2007. *Report of the Seminar on Unpacking Unmet Need for Family Planning in Pakistan.* Islamabad: The Population Council.

Westoff C. F. and Bankole A. 1999. *Mass Media and Reproductive Behavior in Pakistan, India, and Bangladesh.* Demographic and Health Surveys Analytic Reports No.10. Calverton, Maryland: Macro International Inc.

WHO. 2006. *Policy Brief on Birth Spacing- Report from a World Health Organization Technical Consultation.* WHO Department of Reproductive Health and Research and Department of Making Pregnancy Safe.

Zhu, B.P., Rolfs, R.T., Nangle, B.E., and Horan, J.M. 1999. *Effect of the Interval between Pregnancies on Perinatal Outcomes.* New England Journal of Medicine 340(8): 589-594. Feb 25, 1999.