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Baseline Household Survey

Kech District

May 2010



Family Advancement for Life and Health (FALAH)

Kech

**Baseline Household Survey
May 2010**

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Layout and Design: Ali Ammad

Published: May 2010

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"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."

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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. Dr. Yasir Bin Nisar prepared the first draft of the Kech report. 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 Kech 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/Dal	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 Kech, 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 Kech. It included interviews with 644 currently married women aged 15-49 (“married women of reproductive age”, or MWRA), along with 200 married men, of whom 199 were married to the women included in the sample. As a separate activity, a mapping study¹ was also carried out in Kech during the period between March and April 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

Kech is a primarily rural district of Balochistan. 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 Kech household survey

Variable	Value
Percentage of household population in rural areas	80.0
Percentage of households with electricity	62.0
Percentage of households with indoor water supply	60.6
Percentage of households with flush toilet	58.7
Percentage of households with a television	47.0
Percentage of literate female respondents	27.5
Percentage of respondents with literate husbands	55.1
Total fertility rate	4.7

Electricity was available in 62 percent of the sampled households. Sixty-one percent of the households had some indoor water supply and 59 percent had a flush toilet, while 7 percent had some type of latrine. According to the Planning Commission’s Pakistan Millennium

¹ Mapping Survey of Health and Reproductive Health Services.

Development Goals Report 2006, Kech stood 35th nationally in sanitation rankings. About 28 percent female respondents were literate while 55 percent of their husbands were literate. Forty seven percent of the households in Kech reported owning a television and 35 percent reported owning a radio/tape recorder. About 27 percent of the respondents said they watched TV, 10 percent listened to radio, and less than 2 percent read newspapers or magazines. Overall, 36 percent of the women reported access to at least one form of media and 10 percent had exposure to FP messages through any of these mediums.

Service Availability

There was a wide range of health and reproductive health facilities in Kech district. Of the 433 facilities in the district, 419 were public while 14 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 were only 4 facilities - 1 public, 3 private - which were able to offer Caesarean section deliveries. There were only 2 facilities which were able to provide female sterilization, one from each sector. Though services were spread throughout the district, there were some areas where access was relatively difficult.

Fertility

In Kech, the crude birth rate was 28 births per thousand population, and the total fertility rate was 4.7 children per woman. Fertility was higher for illiterate women and wives of illiterate husbands. There were no urban-rural differences in fertility. Many births were spaced too closely; for example, almost 61 percent of the closed birth intervals were less than 36 months. About 14 percent of all current pregnancies in the sample were among women who already had two children under five years of age, and 4 percent of pregnant women already had three children under the age of five years.

Maternal and Neonatal Care

The household survey obtained data on selected key indicators of maternal and neonatal health from 441 sampled women who had delivered a child during the previous four years. Of these women, 60 percent had visited a health provider at least once for antenatal care; 59 percent had at least two tetanus toxoid immunizations; 36 percent were delivered by a

skilled birth attendant; and 36 percent were delivered in a health facility, public or private. On the other hand, 39 percent had at least one postnatal check-up. Exclusive breastfeeding was reportedly widespread and the median length of breastfeeding for the last child was 24 months.

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

Indicator	Value
Percentage of mothers with at least one antenatal care visit	60.0
Percentage of mothers who received at least two tetanus shots	59.0
Percentage of most recent deliveries conducted by a skilled birth attendant	30.5
Percentage of most recent deliveries carried out in a facility	36.3
Percentage of MWRA not wanting more children	30.9
Percentage of MWRA wanting to delay next birth for at least two years	29.8
Percentage of MWRA with knowledge of at least one contraceptive method	100.0
Contraceptive prevalence rate	18.8
Percentage of MWRA who were past users of contraception	21.6
Percentage of MWRA with unmet need for family planning	42.9
Percentage of MWRA with unmet need for spacing	28.0
Percentage of MWRA with unmet need for limiting	14.9
Total demand for family planning (CPR + unmet need)	61.6

Preference for Children

The median “ideal” family size, according to the women respondents, was 6 children. Regarding desire for more children in the future, 25 percent said they wanted another child soon (within two years), 46 percent said they wanted another child but after two years, and 31 percent did not want more children. The proportion wanting more children soon decreased rapidly with the number of living children, while the proportion not wanting more increased. The proportion wanting more children later was highest for women with 3 children. Forty six percent of the women respondents thought that their husband wanted the same number of children that they did, while 30 percent were of the view that their husband wanted more children than they did.

Contraceptive Knowledge and Use

All currently married women knew at least one contraceptive method. The contraceptive prevalence rate (the percentage of MWRA currently using some method of contraception) was 19 percent. The most common currently used methods were pills (8 percent), injectables (4 percent), and female sterilization (3 percent). Condom use was relatively low (2 percent). Past users comprised 22 percent of MWRA; pills and injectables were common past methods. Sixty two percent of current users did not want more children, while 38 percent wanted more, but at a later time. Most users reported their husband brought the supplies, or obtaining their supplies and services from private hospitals.

Experience with Contraceptive Methods

Stated reasons for respondents' choices of their current or past method varied by method, but commonly cited reasons included suitability for respondent and husband, ability to use for a long period, convenience of use, low side effects and easy availability.

Costs were generally low (only 10 percent paid more than Rs.50 the last time they obtained their method). Regarding the time required to reach the supply point, 7 percent reported requiring more than 30 but less than 60 minutes. It is worth mentioning that 49 percent of the respondents did not know about the time it took as their husbands brought the supply for them. The least information provided at acceptance of some method was on contraindications. Ninety four percent of clients reported being examined properly; and all the respondents reported that the staff was cooperative/friendly.

Reasons for Non-use

Asked hypothetically about hindrances a couple might face if they wanted to avoid or delay pregnancy, non-user women typically mentioned husband's disapproval, fear of side effects and problems with management of side effects and distance/costs to FP outlet. Relatively less often mentioned were FP against religion and other people might find out about their contraceptive use. Past users were most likely to discontinue use because they wanted more children followed by experience of side effects, infrequent sex/husband away and method failure. Past users' most common reason for current non-use was breastfeeding/lactational amenorrhea, followed by infrequent sex/husband away and desire for another child. Never users were most likely to say they were not using for reasons

related to desire for more children, breastfeeding/lactational amenorrhea, fear of side effects and infrequent sex/husband away. Almost all never users (99 percent) knew at least one FP method but knowledge of contraceptive sources was noticeably lower; only 37 percent of never users knew one place to obtain contraceptive supply/method. About 29 percent of never users expressed their intent to use contraception in the future. This indicates that a substantial number of women in Kech were ready to practice birth spacing or use family planning methods.

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, 43 percent of the women in this sample were in unmet need, 15 percent for limiting and 28 percent for spacing. Unmet need for limiting was higher in urban areas and among illiterate women. However, unmet need for spacing was higher in rural areas and among literate women.

Reproductive Preferences and Behavior of Men

The findings reveal that 95 percent of men knew at least one modern contraceptive method. Male sterilization was one of the least known contraceptive methods among men in Kech. About 67 percent of the men did not want more children in the future or wanted to delay the next pregnancy. Twenty three percent of the male respondents reported that they or their wives were currently using any family planning method. Among the current users, about 84 percent were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, a majority (40 percent) reported that they were uncertain if they would use any FP method in future. Desire for another child was one of the main reasons for not using any FP method. Of those who did intend to use contraceptives in the future, no one reported that they intended to use male methods. 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

The district of Kech is characterized by a relatively weak infrastructure and standard of living, a small number of public and private reproductive health facilities, and reasonable maternal and neonatal health care. Knowledge and approval of family planning were high, and contraceptive prevalence, at 19 percent, was less than that of Pakistan as a whole. Nevertheless, there is much need for improvement; unmet need for family planning remains high at 43 percent. Among the important reasons that should be addressed in an improved program are husbands' attitude, inter-spousal communication, fear of side effects, and knowledge of various contraceptive methods 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) project 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 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 Orangi, Lyari and Gadap), 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 in the 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 Kech, district-level activities are being coordinated by Mercy Corps and RSPN, with Greenstar providing information and service through social marketing and other partners supporting specific activities as needed.

Kech District

Kech district is predominately a rural district where more than 80 percent people live in rural areas. Total population of the district in 1998 was 0.4132 million which increased to 0.43 million in 2008 with an increase of about 5 percent. Since 1972 census to 2008, the population of district increased to about 193 percent. Highest intercensal increase was from 1972 to 1981 when population increased at the rate of about 12 percent; however this rate decreased to 0.50 in 1998.

Of the total female population of district in 1998, there were about 48 percent women of reproductive age (15-49) of these about 25 percent were never married. Literacy rate for women in district was about 16 percent although this was higher (about 29 %) in urban areas. The enrollment ratio for females was about 26 percent; 47 percent in urban areas.

Female economic activity was as low as 0.62 percent in urban areas and in rural areas it was a little better at 1.14 percent. This shows that economically females are less active and they depend on their immediate guardians.

The health statistics for the district in 1998 were as follows: One THQ and two Leprosy Hospitals, 5 RHCs, 23 BHUs, 4 MCH centers, and 45 Civil Dispensaries.

Human Development in Kech is reflected in Pakistan National Human Development Report 2003. According to report, Kech stands at 35th position among 91 districts of Pakistan. In Balochistan Province, it is positioned at 5th among 22 districts of the Province.

The Kech Baseline Household Survey

In Kech (as in other FALAH project focus districts), Population Council implemented a baseline sample 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 a mapping exercise to compile complete, digitized maps of all facilities providing health and reproductive health services, including maternal health, neonatal and child health and child spacing / family planning. This baseline survey will be compared with an endline survey toward the end of the project to assess progress.

Objectives

The objectives of the Kech 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 and practices of married couples of Kech 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 that 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 practice 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 (PSU). 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 enumerated number of households and eligible women of reproductive age in Kech.

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

Result	Rural	Urban	Total
Sample blocks/villages	33	7	40
Households interviewed	495	105	600
Eligible women identified	532	123	655
Eligible women not interviewed	7	4	11
Eligible women interviewed	525	119	644
Total women's interviews	525	119	644

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 was 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 Kech 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 Kech district was carried out between November 2009 and January 2010.

Chapter 2

Household Characteristics

Geographic Distribution

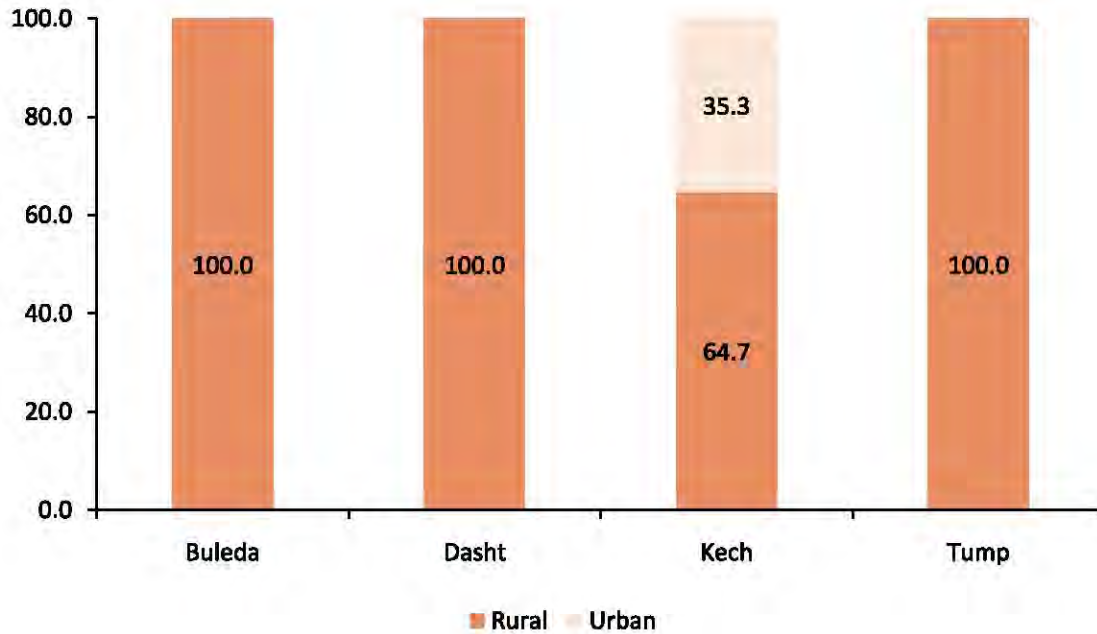
The District Kech comprises four tehsils, Buleda, Dasht, Kech and Tump. Table 2.1 and Figure 2.1 show the distribution of the sample population of sample households according to residence (urban and rural) and by tehsil, with comparisons to the population distribution of the 1998 National Population and Housing Census.

Table 2.1: Percentage distribution of the population of sample households by residence and tehsil

Tehsil	Rural			Urban			Total	
	N	%	1998 Census%	N	%	1998 Census%	N	%
Buleda	819	100.0	100.0	0	0.0	0.0	819	100.0
Dasht	440	100.0	100.0	0	0.0	0.0	440	100.0
Kech	1754	64.7	68.0	958	35.3	32.0	2712	100.0
Tump	828	100.0	100.0	0	0.0	0.0	828	100.0
Total	3841	80.0	83.4	958	20.0	16.6	4799	100.0

As Table 2.1 shows, the distribution of the population of the 600 households in the sample by urban-rural residence and tehsil which closely follows the distribution recorded for the whole district in the 1998 Population Census (Population Census Organization, 2000). The district of Kech is about 80 percent rural and 20 percent urban. About 57 percent of the sample population lived in Kech tehsil, followed by 17 percent in Tump and Buleda each and 9 percent in Dasht. Only the Kech tehsil had urban sample population.

Figure 2.1: Rural-urban distribution of population in sample households by residence and tehsil



Age-Sex Distribution

Table 2.2 shows the population of the sampled households by age and sex. The population is typical of a society with past high fertility, with sharply declining percentages by age; the median age was 18 years. As with many Pakistani populations, overall there are somewhat more males than females, especially at older ages. Since biologically females tend to have higher survival rates than males, the household survey figures suggest better care for males than females, particularly in early childhood.

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

Age group	Sex of household member				Total	
	Male		Female			
	N	%	N	%	N	%
00 - 04	323	13.2	329	14.0	652	13.6
05 - 09	349	14.3	302	12.8	651	13.6
10 - 14	356	14.6	328	13.9	684	14.3
15 - 19	306	12.5	298	12.7	604	12.6
20 - 24	234	9.6	248	10.5	482	10.0
25 - 29	178	7.3	199	8.5	377	7.9
30 - 34	116	4.7	111	4.7	227	4.7
35 - 39	112	4.6	109	4.6	221	4.6
40 - 44	74	3.0	63	2.7	137	2.9
45 - 49	60	2.5	52	2.2	112	2.3
50 - 54	66	2.7	121	5.1	187	3.9
55 - 59	74	3.0	74	3.1	148	3.1
60 - 64	59	2.4	56	2.4	115	2.4
65 - 69	51	2.1	48	2.0	99	2.1
70 - 74	51	2.1	8	0.3	59	1.2
75+	35	1.4	9	0.4	44	0.9
Total	2444	100.0	2355	100.0	4799	100.0

Of the total population of the sampled households, 23 percent consisted of females 15-49 years of age, and 14 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.

Marital Status

In Kech (as in Pakistan generally), women tend to marry men older than themselves. Therefore, as Table 2.3 shows, higher proportions of females at younger ages were married than males, whereas a larger number of elderly males were never married. The singulate mean age at marriage (SMAM) for men was 28 years and for women it was recorded as 22 years.

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

Age group	Married		Widow/divorced/separated		Never married	
	Male	Female	Male	Female	Male	Female
15 – 19	1.3	20.8	0	0.3	98.7	78.9
20 – 24	25.6	47.2	0.9	3.6	73.5	49.2
25 – 29	48.9	80.4	1.1	3	50	16.6
30 – 34	75.9	91	2.6	5.4	21.6	3.6
35 – 39	92	92.7	0.9	7.3	7.1	0
40 – 44	97.3	92.1	1.4	7.9	1.4	0
45 – 49	100	88.5	0	11.5	0	0
50 – 54	100	88.4	0	10.7	0	0.8
55 – 59	97.3	82.4	2.7	16.2	0	1.4
60 – 64	98.3	73.2	1.7	26.8	0	0
65 – 69	92.2	58.3	7.8	41.7	0	0
70 – 74	92.2	62.5	7.8	37.5	0	0
75+	82.9	22.2	17.1	77.8	0	0
All ages 15+	56.0	63.7	1.8	8.0	42.2	28.4

Household Characteristics and Wealth Indicators

Several household characteristics were assessed that reflected the wealth and well-being of its inhabitants. 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

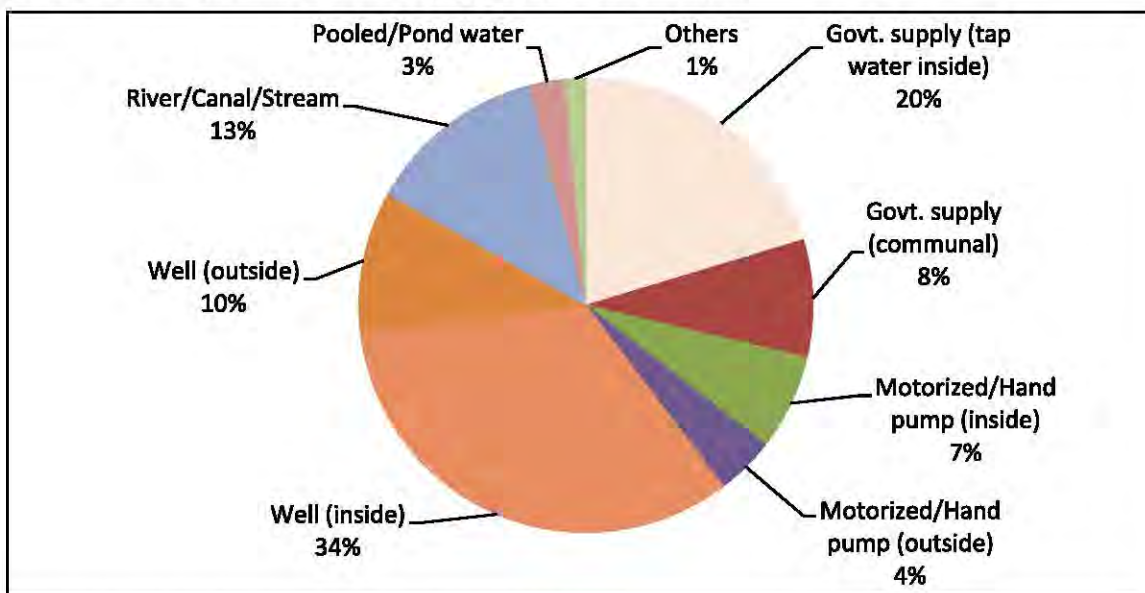
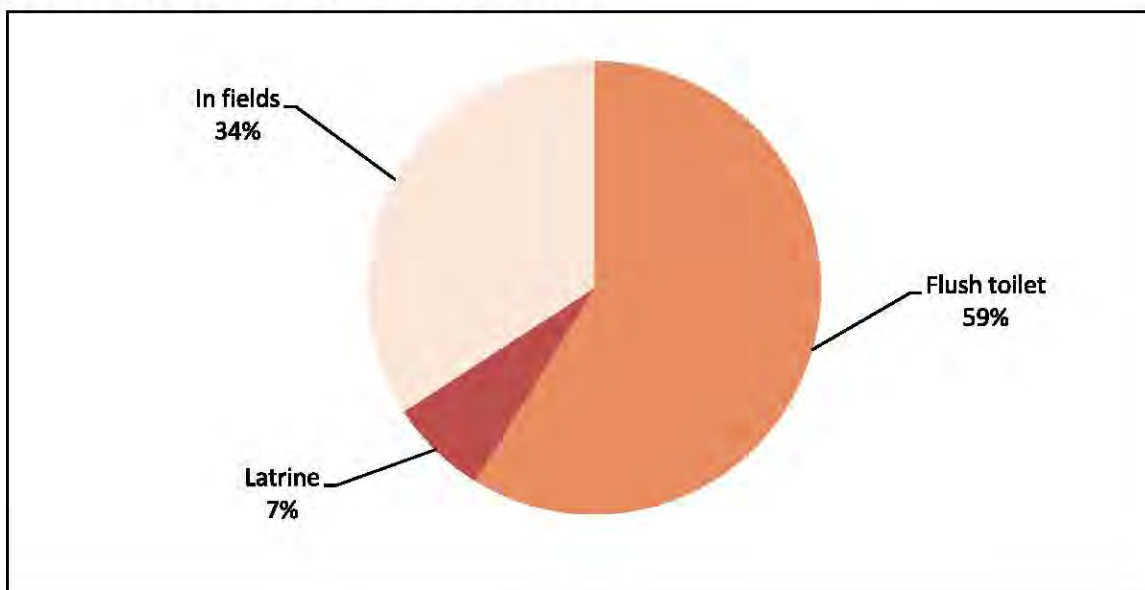
Physical Characteristics of Households

Table 2.4 shows selected physical characteristics of the sample households. A majority of households (34 percent) had a well inside, followed by 20 percent indoor tap water by Government. However about 8 percent households had communal water supply (see also Figure 2.3).

About three-fifth of the households had some type of flush toilet but 38 percent of rural and 12 percent of urban population had no toilet facility at all. While a significant proportion of households (98 percent) in rural and about 90 percent in urban used firewood for cooking and only three percent used gas cylinders (1 percent rural compared to 11 percent in urban). About three-fifth of the households had electricity. Most houses, 92 percent in rural and 71 percent in urban areas were roofed with wood/bamboo and mud, while three-quarters of the walls were made of mud bricks or mud.

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

Characteristics	Rural	Urban	Total
Main source of drinking water			
Govt. supply (tap water inside)	13.9	50.5	20.3
Govt. supply (communal)	9.3	3.8	8.3
Motorized/Hand pump (inside)	7.1	5.7	6.8
Motorized/Hand pump (outside)	4.8	1.0	4.2
Well (inside)	33.3	34.3	33.5
Well (outside)	11.3	3.8	10.0
River/Canal/Stream	15.6	0.0	12.8
Pooled/Pond water	3.0	0.0	2.5
Others	1.6	1.0	1.5
Sanitation facility			
Flush to sewerage	1.8	1.0	1.7
Flush connected to septic tank	51.3	83.8	57.0
Raised latrine	6.7	1.0	5.7
Pit latrine	1.6	0.0	1.3
In fields	37.8	12.4	33.3
Others	0.8	1.9	1.0
Main type of fuel used for cooking			
Fire wood	98.4	89.5	96.8
Gas cylinder	1.2	10.5	2.8
Others	0.4	0.0	0.3
Electrical connection			
Yes	54.1	99.0	62.0
No	45.9	1.0	38.0
Main material of roof			
Concrete	0.6	4.8	1.3
Guarder and T-iron	4.6	24.8	8.2
Wood/Bamboo and mud	92.1	70.5	88.3
Others	2.6	0.0	2.2
Main material of floor			
Earth/Sand/Mud	67.3	32.4	61.2
Cement	31.5	67.6	37.8
Others	1.2	0.0	1.0
Main material of walls			
Burnt bricks/Blocks	3.6	32.4	8.7
Mud bricks/Mud	79.4	61.0	76.2
Wood/Bamboo	13.9	5.7	12.5
Others	3.0	1.0	2.7
Total	100.0	100.0	100.0
N	495	105	600

Figure 2.2: Distribution of water supply for Kech households**Figure 2.3: Toilet facilities for Kech 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 Kech were not available to us. Several items requiring electricity were available in a substantial proportion of households, even in rural areas. About half 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 more than half (47 percent in rural and 81 percent in urban) of all households, and ownership of a computer by about 2 percent of all households mostly in urban. 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	55.4	61.9	56.5
Chairs	1.2	4.8	1.8
Bed	25.3	37.1	27.3
Sofa	0.2	1.0	0.3
Sewing machine	15.6	17.1	15.8
Camera	5.7	11.4	6.7
Radio/tape recorder	33.9	38.1	34.7
Television	42.0	70.5	47.0
Refrigerator	37.2	60.0	41.2
Land line telephone	4.4	12.4	5.8
Mobile phone	46.7	81.0	52.7
Room cooler/air conditioner	4.0	13.3	5.7
Washing machine	6.5	24.8	9.7
Bicycle	9.5	10.5	9.7
Motorcycle	50.7	63.8	53.0
Jeep/car	12.9	7.6	12.0
Tractor	0.2	0.0	0.2
Computer	0.8	7.6	2.0
N	495	105	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 as well as rural households was 5; for urban households, it was 8. About 60 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

Standard of living index	Rural		Urban		Total	
	N	%	N	%	N	%
0	45	9.1	0	0.0	45.0	7.5
1	46	9.3	0	0.0	46.0	7.7
2	52	10.5	1	1.0	53.0	8.8
3	42	8.5	5	4.8	47.0	7.8
4	51	10.3	5	4.8	56.0	9.3
5	44	8.9	10	9.5	54.0	9.0
6	46	9.3	13	12.4	59.0	9.8
7	44	8.9	13	12.4	57.0	9.5
8	66	13.3	20	19.0	86.0	14.3
9	42	8.5	31	29.5	73.0	12.2
10	16	3.2	7	6.7	23.0	3.8
11	1	0.2	0	0.0	1.0	0.2
Total	495	100.0	105	100.0	600	100.0
Median	5	na	8	na	5	na

na = not applicable.

Chapter 3

Respondent Characteristics

The primary sources of data from the Household Survey are the interviews conducted with 644 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 were relatively small; at older ages, the numbers declined. Fifty three percent of the sample respondents were under age 30; urban areas had about 49 percent and rural areas had about 54 percent of women under the age of 30.

Table 3.1: Age distribution of female respondents by residence

Age group	Rural		Urban		Total	
	N	%	N	%	N	%
15 - 19	57	87.7	8	12.3	65	100.0
20 - 24	94	79.0	25	21.0	119	100.0
25 - 29	135	84.4	25	15.6	160	100.0
30 - 34	78	78.0	22	22.0	100	100.0
35 - 39	76	76.8	23	23.2	99	100.0
40 - 44	50	89.3	6	10.7	56	100.0
45 - 49	35	77.8	10	22.2	45	100.0
Total	525	81.5	119	18.5	644	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 rate for females was very low (27 percent) compared to their husband's literacy level which was about 55 percent. The literacy of females (aged 15+ years) recorded in PSLMS 2004-05 was 36 percent for Pakistan and 14 percent for Balochistan.

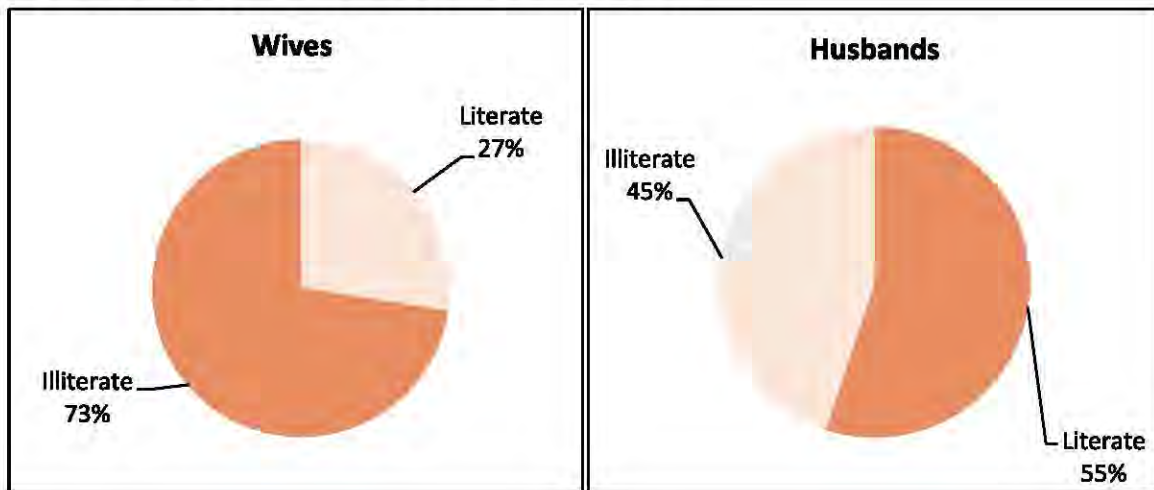
Table 3.2: Distribution of MWRA and husbands by educational achievement, literacy status, age and residence

Variable	Age of respondent			Residence		Total
	15 - 24	25 - 34	35 - 49	Rural	Urban	
Respondent (Women)						
Proportion literate	50.5	26.5	7.5	26.3	32.8	27.5
Education level						
No education	49.5	73.8	93.5	74.3	67.2	73.0
Up to primary	12.0	7.7	3.5	7.2	9.2	7.6
Up to Secondary	29.3	11.5	2.0	13.7	13.4	13.7
Above secondary	9.2	6.9	1.0	4.8	10.1	5.7
N	184	260	200	525	119	644
Respondent's husband						
Proportion literate	65.8	59.2	40.0	52.4	67.2	55.1
Education level						
No education	33.7	39.2	61.0	46.9	33.6	44.4
Up to primary	12.0	9.2	8.0	9.3	10.9	9.6
Up to Secondary	31.0	23.1	17.0	22.1	29.4	23.4
Above secondary	22.8	28.5	12.5	21.0	26.1	21.9
Don't know	0.5	0.0	1.5	0.8	0.0	0.6
N	184	260	200	525	119	644

It shows that literacy rate of female respondents was higher than reported literacy rate of the province of Balochistan as a whole. Similarly, about 27 percent of the female respondents reported having ever attended school. For men as well, literacy (about 55 percent) was higher than the PSLMS found for Balochistan in 2004-05 (49 percent), but lower as compared to 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 187 of 644 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=187)

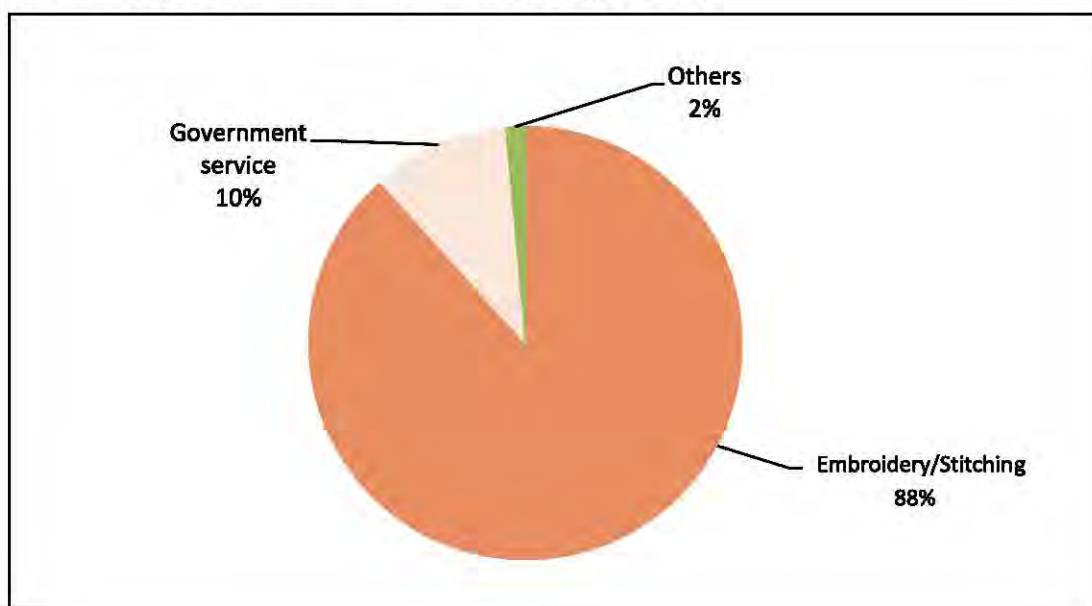


Table 3.3: Distribution of occupational categories of respondents' husbands by residence

Economic activity/ occupation	Rural	Urban	Total
Agriculture/Livestock/Poultry	7.8	2.5	6.8
Petty trader	5.5	10.1	6.4
Labor (Daily wages)	30.7	20.2	28.7
Government service	15.0	29.4	17.7
Private service	3.2	4.2	3.4
Own business	3.6	5.9	4.0
Abroad	15.4	11.8	14.8
Unemployed	16.8	13.4	16.1
Skilled worker	1.1	1.7	1.2
Others	0.2	0.0	0.2
Don't know	0.6	0.8	0.6
Total	100.0	100.0	100.0
N	525	119	644

Only 7 percent of the women's husbands were working in agriculture/livestock or poultry. About 18 percent of those men were in government service while substantial proportion was working as daily-wage laborers (about 29 percent). A total of 15 percent of the women's husbands were abroad while about 16 percent were reported unemployed.

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 35 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 four-fifth could go there with someone. For each of the named destinations, more than fifty percent said they could go with someone and one-fifth could go with permission except market.

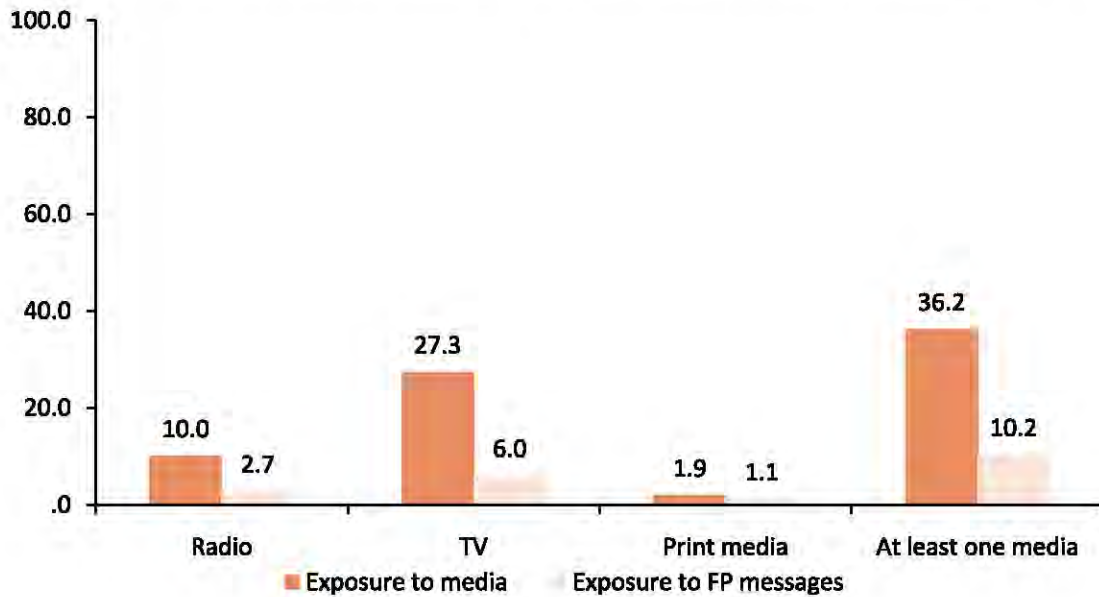
Table 3.4: Women's reports regarding mobility outside the home by degree of permission and destination

Destination	Degree of permission				Total	
	Without permission	With permission	With someone	Can't go/ Doesn't go	%	N
Market	1.1	12.9	50.8	35.2	100.0	644
Health center	0.9	19.1	79.0	0.9	100.0	644
Relatives/friends	5.9	20.2	73.1	0.8	100.0	644
Out of village/ town	0.2	19.4	77.8	2.6	100.0	644

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 47 percent of households owned a television, while 35 percent owned a radio/ tape recorder. 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 (27 percent), while radio and print media were less common (10 percent and 2 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 the methods of family planning through these mediums. Only 6 percent women reported being exposed to family planning messages on television and 3 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 Kech Household Survey, the FALAH project undertook a mapping of health and reproductive health services study in the FALAH districts. The fieldwork in Kech was carried out from March to April 2008. In this survey, all facilities and providers for reproductive health, public and private, including family planning as well as maternal health, were identified and visited. Exact locations of these facilities were determined by using a 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 of Health and Reproductive Health Services-Kech district”. Some basic results are provided to give an overview of the context in which the knowledge, attitudes and behavior of the men and women of the household survey sample can be understood.

These results represent a range of maternal and reproductive health services being provided in Kech. In this chapter the tables summarize these findings, and are illustrated by maps indicating the location of various types of providers and facilities.

District Data

There are total of 433 health facilities in Kech district, of which 419 are from the public sector and 14 from the private sector (8 - Greenstar Social Marketing; 6 - 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 4.1 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 20 LHWs, while 16 have fewer than 10 LHWs. Moreover, there are 7 union councils having no LHW in the area. On average, there are 9 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. The variation is considerable: only 4 union councils have more than 25 reproductive health facilities, while 15 union councils have fewer than 10 facilities. On the whole, however, there do not appear to be large geographic areas for which no reproductive health services are available. 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 Kech district. However, the availability of clinical methods, with the exception of injectables, is quite limited; IUDs are available at only 8 facilities, while female sterilization services are available at only 2 facilities, one from the each sector. Norplant and male sterilization 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 8 facilities mainly from the private sector. Generally, the choice of permanent methods is limited in Kech district.

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

Service	Sector										MWRA per facility
	Government		LHWs		Private GSM		Private others		Total		
	N	%	N	%	N	%	N	%	N	%	
Injectables	19	26.4	78	22.5	6	75.0	2	33.3	105	24.2	681
IUD/Copper T	2	2.8	na	na	4	50.0	2	33.3	8	1.8	8938
Norplant	0	0.0	na	na	0	0.0	0	0.0	0	0.0	na
Female sterilization	1	1.4	na	na	1	12.5	0	0.0	2	0.5	35753
Male sterilization	0	0.0	na	na	0	0.0	0	0.0	0	0.0	na
Condom	24	33.3	331	95.4	5	62.5	2	33.3	362	83.6	198
Pills	24	33.3	341	98.3	6	75.0	2	33.3	373	86.1	192
ECP	1	1.4	0	0.0	5	62.5	2	33.3	8	1.8	8938
Any FP method	24	33.3	341	98.3	6	75.0	2	33.3	373	86.1	192
Any clinical method	19	26.4	78	22.5	6	75.0	2	33.3	105	24.2	681
Any non-clinical method	24	33.3	341	98.3	6	75.0	2	33.3	373	86.1	192
Total facilities	72	100.0	347	100.0	8	100.0	6	100.0	433	100.0	165

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 available in only 1 union council while IUD services are available in 4 union councils. Availability of injectables is more widespread than other clinical methods, as it is available in 24 union councils, whereas in 14 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.

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 than in private facilities. Normal delivery services are available at only 18 facilities. Overall, one normal delivery facility is available for every 3973 married women of reproductive age. On the other hand, Caesarean section, an important element of comprehensive obstetric care services, is available in only 4 facilities, 1 from the public sector and 3 from the private sector.

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

Service	Sector										
	Government		LHWs		Private GSM		Private others		Total		MWRA per facility
	N	%	N	%	N	%	N	%	N	%	
Antenatal check-up	43	59.7	341	98.3	8	100.0	1	16.7	393	90.8	1663
Anemia treatment	45	62.5	339	97.7	8	100.0	5	83.3	397	91.7	180
TT injection	18	25.0	16	4.6	4	50.0	2	33.3	40	9.2	1788
Normal delivery	11	15.3	na	na	6	75.0	1	16.7	18	4.2	3973
Caesarean section	1	1.4	na	na	3	37.5	0	0.0	4	0.9	17876
Total facilities	72	100.0	347	100.0	8	100.0	6	100.0	433	100.0	165

Multiple responses possible.

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 Kech district. There are 29 union councils with no obstetric care facilities, while there are only 9 union councils that do have facilities providing these services. Map 4.9 shows that 4 comprehensive emergency obstetric care (EmOC) services are available in only 1 union council.

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 126 MBBS doctors; only 17 percent of these are women. There are fewer female paramedics than male paramedics. There are 67 female paramedics to serve the entire female population of the district; 70 percent of the female paramedics are LHVs.

The number of married women per provider or facility is a good indicator of the status of health in the district. Table 4.3 shows that, overall, there is 1 MBBS doctor available to serve 568 married women of reproductive age. Since women usually prefer female service providers, especially for their reproductive health needs, this burden increases to 3405 MWRA per female MBBS doctor, indicating a serious dearth of female doctors. For female paramedics, there are about 1067 MWRA per female paramedic. Map 4.10 shows the availability of MBBS doctors by gender in each union council. There are 13 union councils where male doctors are not available, while in 35 union councils there is no female MBBS doctor.

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

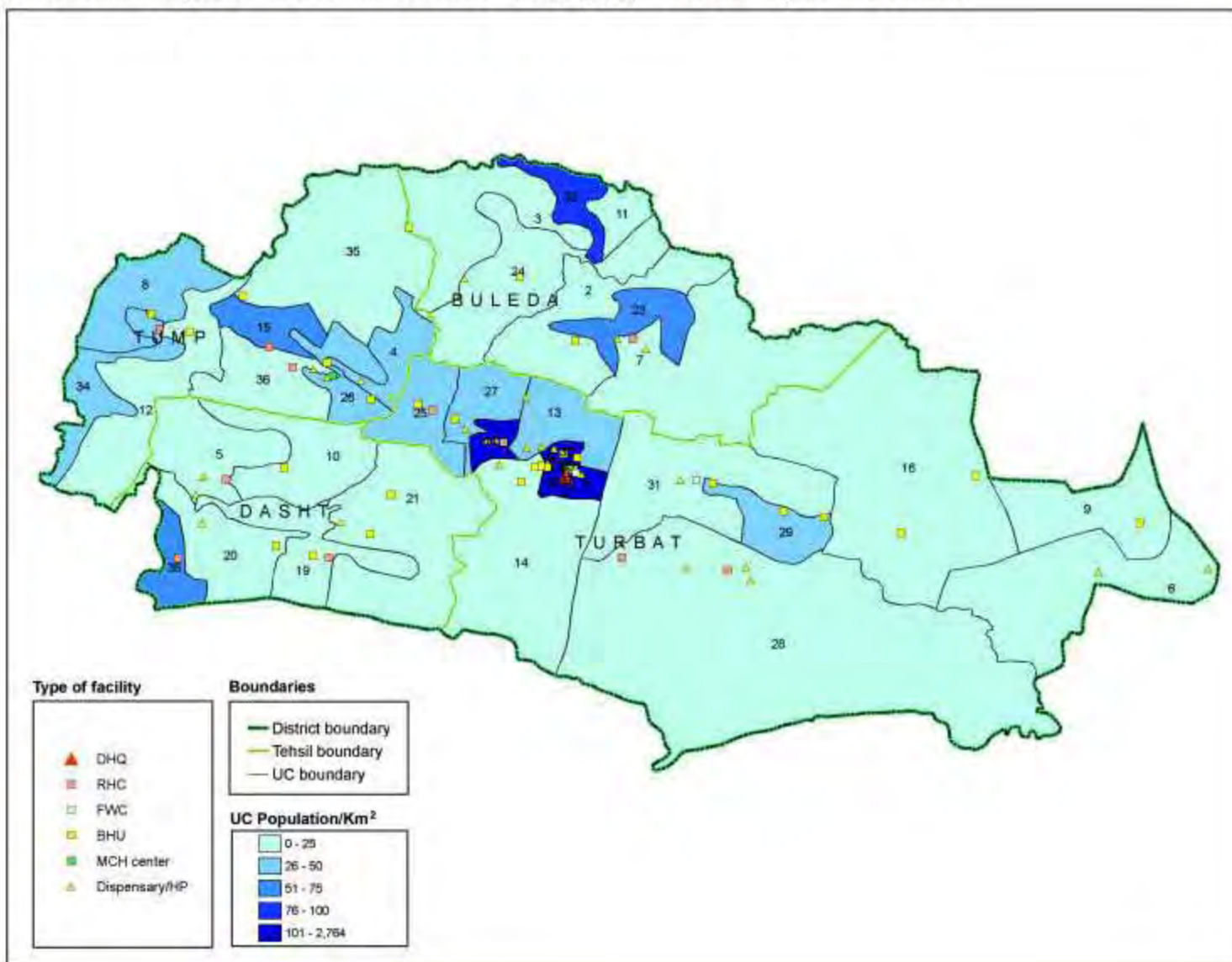
Provider	Sector						Total		MWRA per provider
	Government		Private GSM		Private others		N	%	
	N	%	N	%	N	%	N	%	
Doctors (MBBS)									
Male	83	89.2	21	65.6	1	100.0	105	83.3	681
Female	10	10.8	11	34.4	0	0.0	21	16.7	3405
Total	93	100.0	32	100.0	1	100.0	126	100.0	568
Female paramedics									
Medical assistant	0	0.0	0	0.0	0	0.0	0	0.0	0
Nurse	3	7.3	12	52.2	1	0.0	16	23.9	4469
Medical/ health technician	3	7.3	0	0.0	1	0.0	4	6.0	17876
Lady health visitor	35	85.4	11	47.8	1	0.0	47	70.1	1521
Total	41	100.0	23	100.0	3	100.0	67	100.0	1067
Male paramedics	84	100.0	7	100.0	4	100.0	95	100.0	753

MWRA; married women of reproductive age

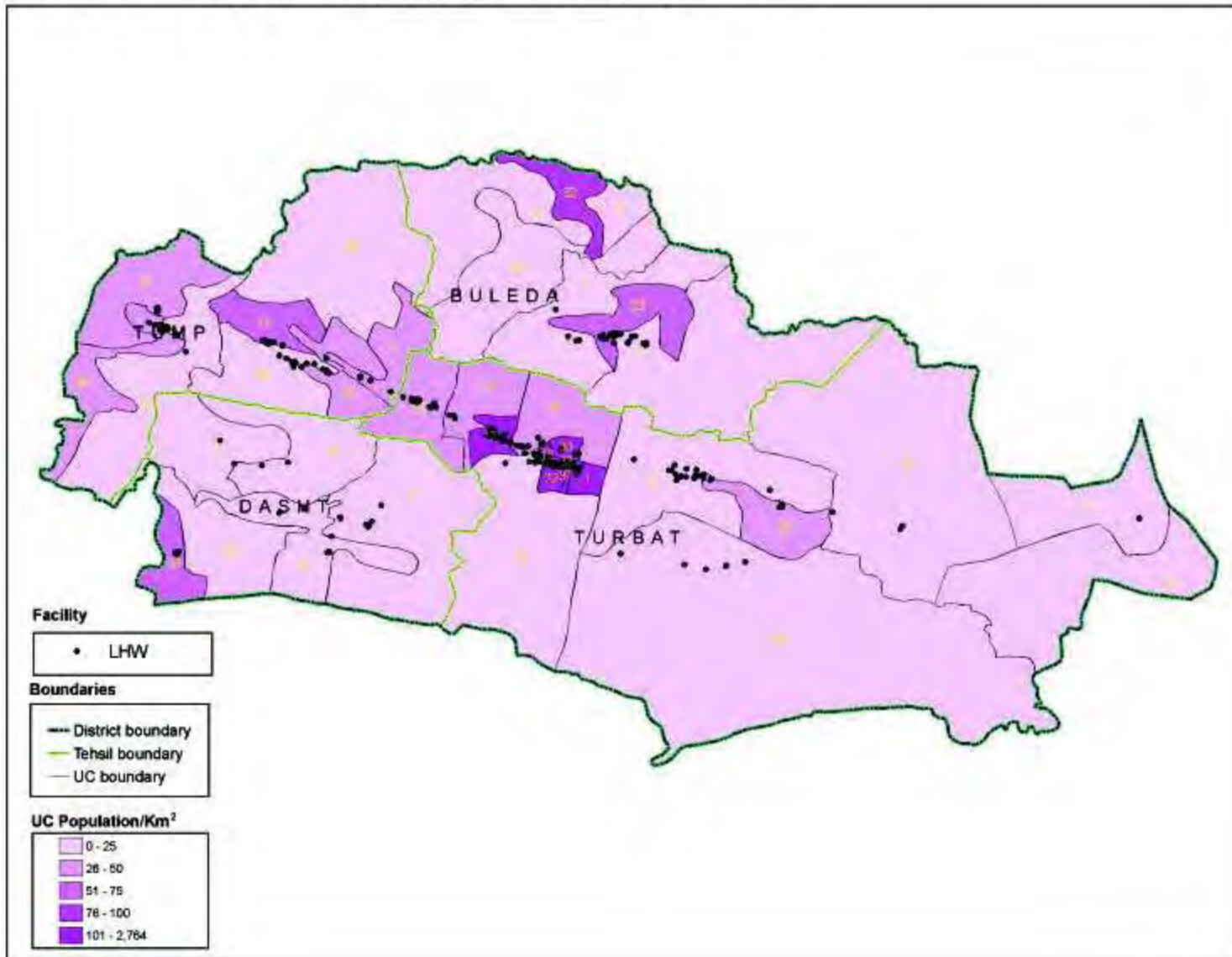
List of Union Councils

1	Absor	20	Kumbail
2	Alandoor	21	Kuncheti
3	Badai	22	Malikabad
4	Balicha	23	Manaz
5	Balnigore	24	Nagzamran
6	Balore	25	Nasir Abad
7	Bit	26	Nazarabad
8	Bullo	27	Nodiz
9	Dandar	28	Pidrak
10	Darachko	29	Sami
11	Darbuly	30	Sarikahn
12	Gayab	31	Shahrak
13	Ginna	32	Sieh Gisi
14	Gokdan	33	Singanisar
15	Gomazi	34	Soro
16	Hoshab	35	Tigran
17	Kalatuk	36	Tump
18	Koshkalat	37	Turbat
19	Kudan	38	Zarain Bug

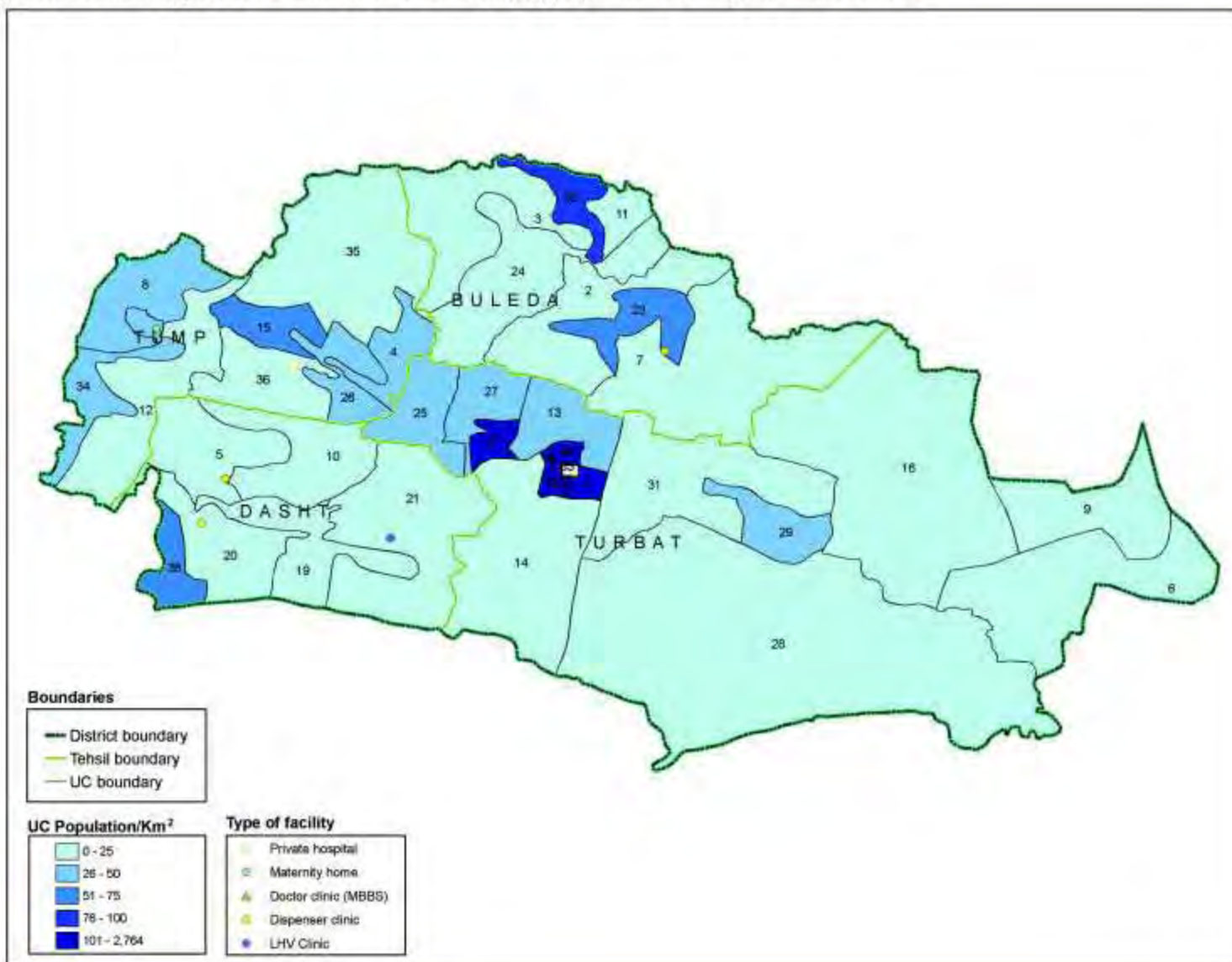
Map 4.1: Location of government facilities in Kech district, by population density of union council



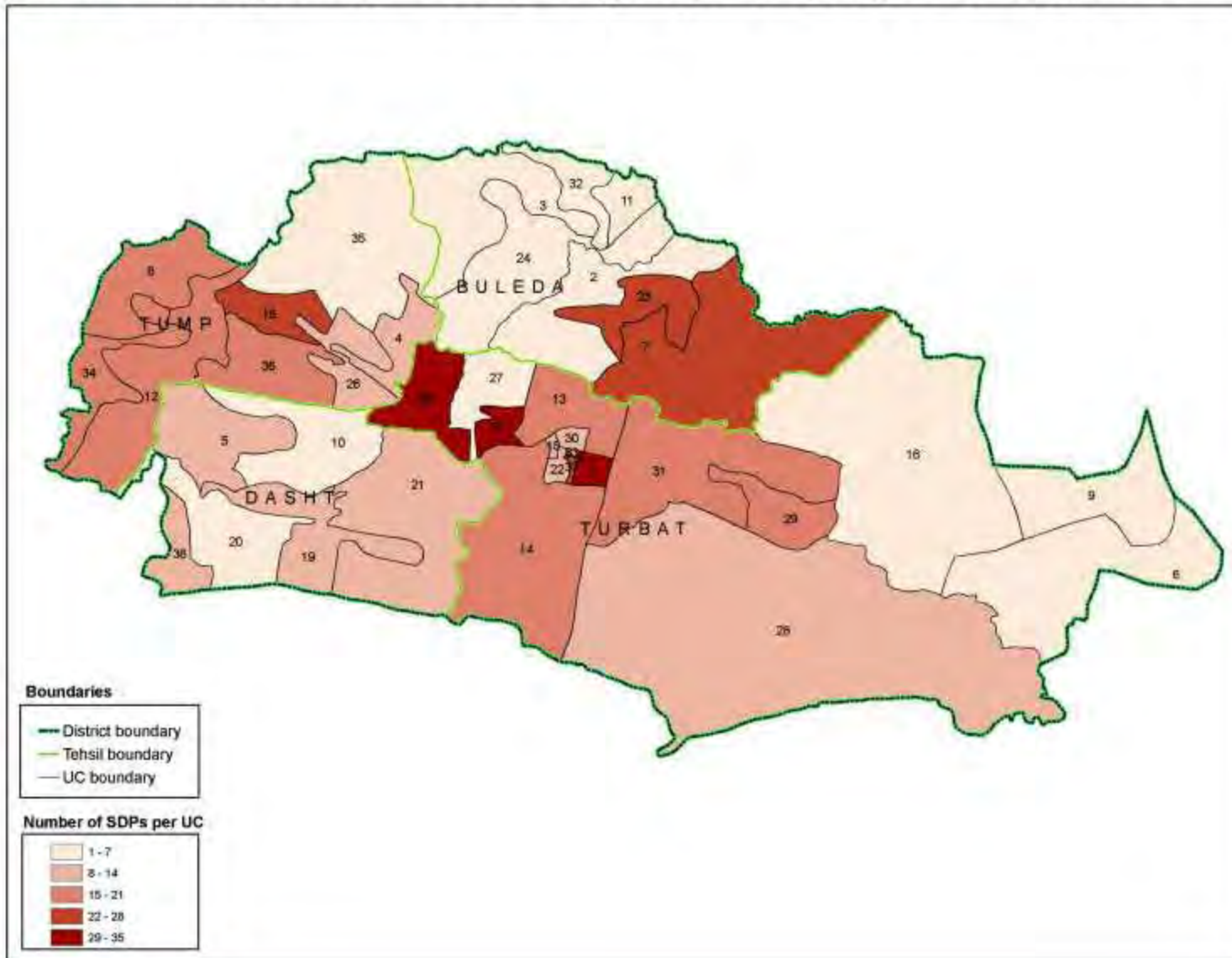
Map 4.2: Location of LHWs in Each district, by population density of union council



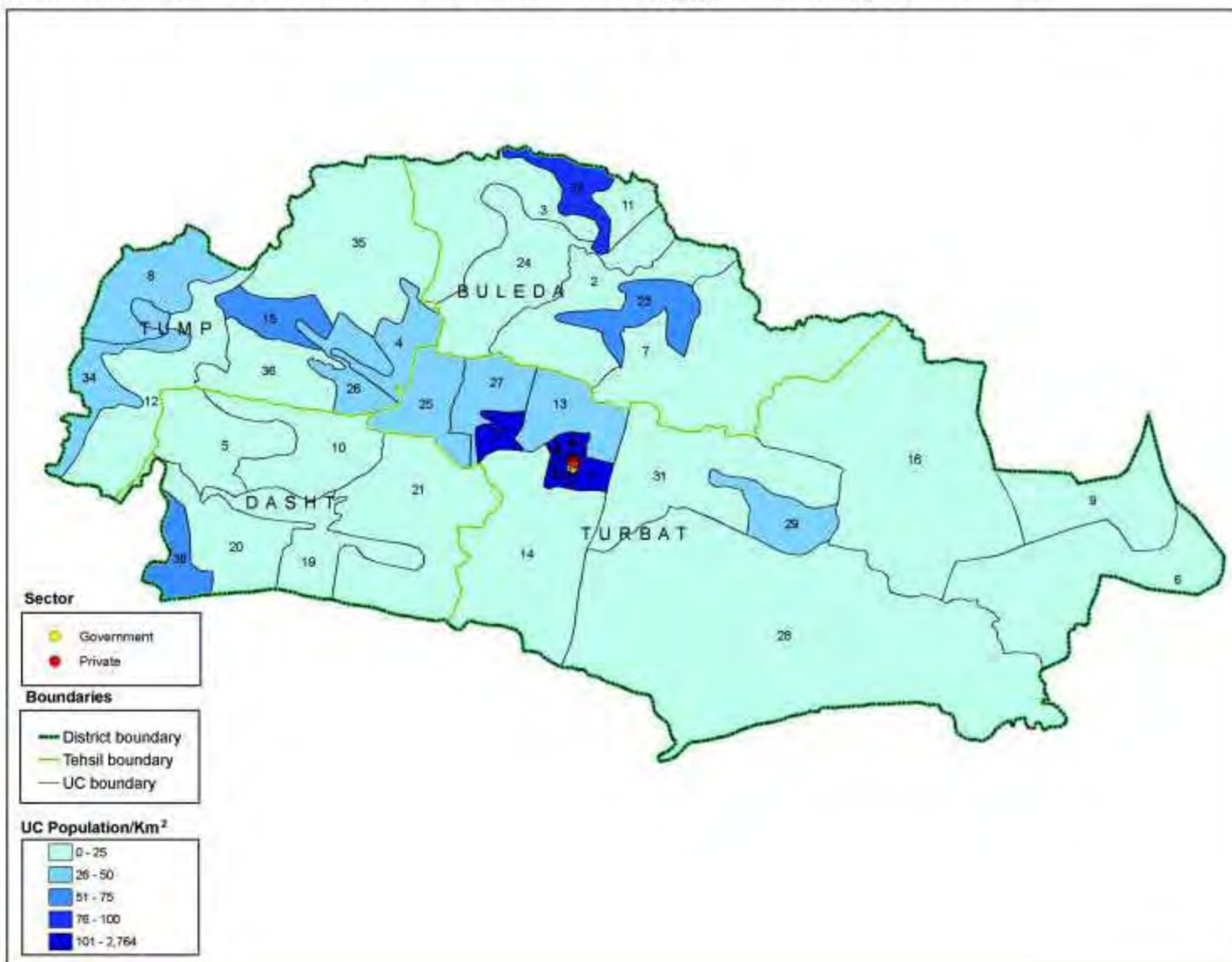
Map 4.3: Location of private facilities in each district, by population density of union council



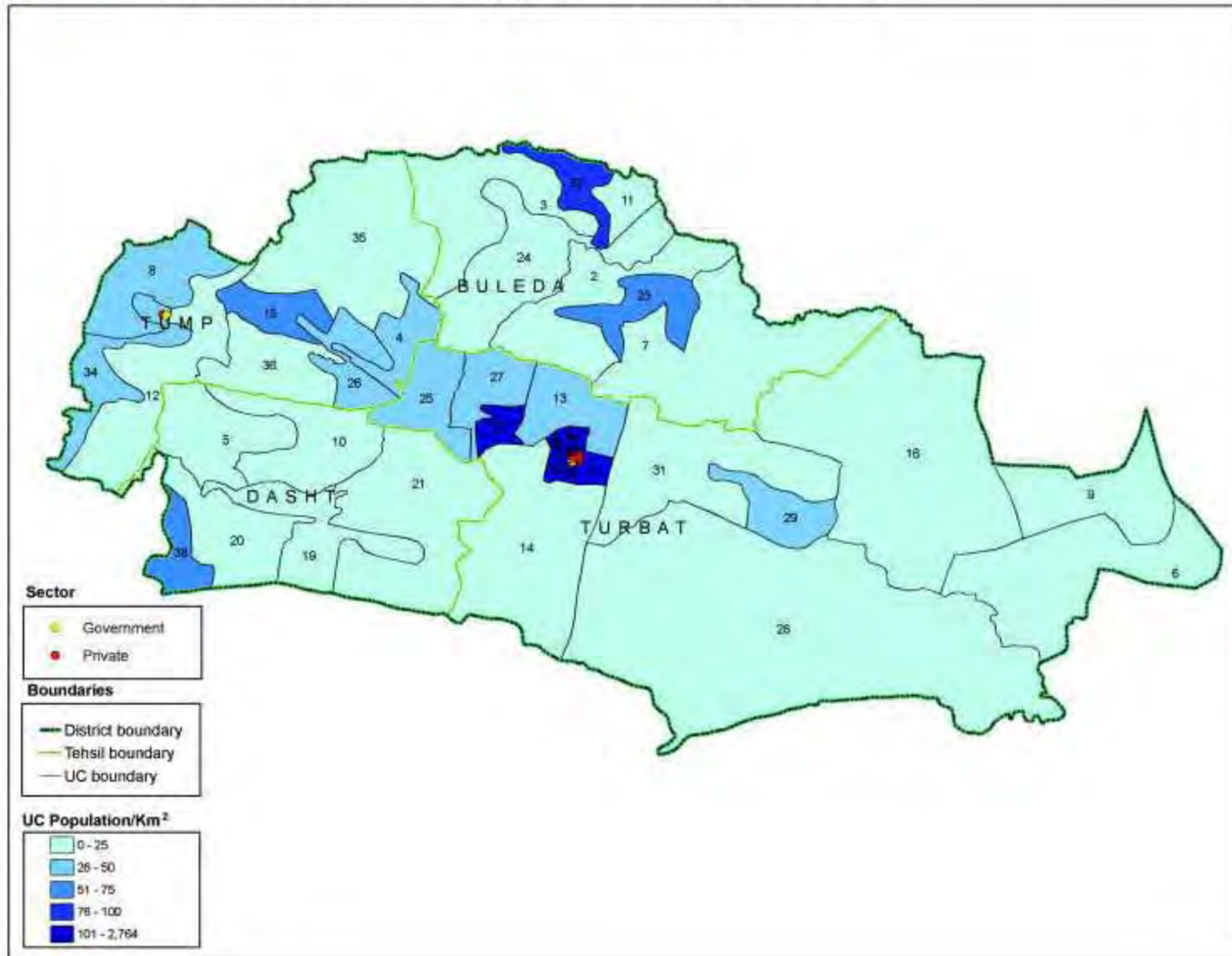
Map 4.4: Total number of reproductive health service delivery points (public and private) in Kech district, by union council



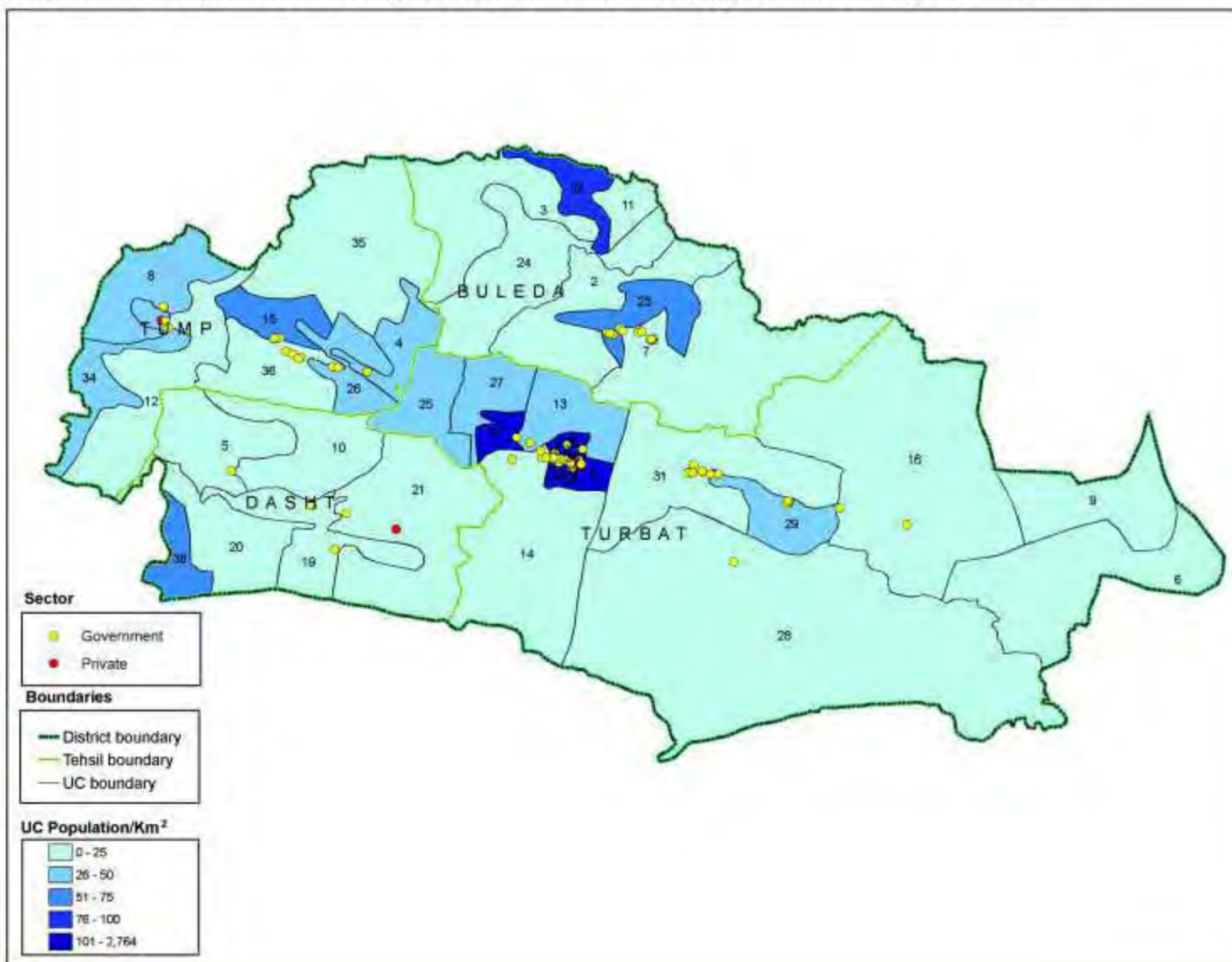
Map 4.5: Location of female sterilization facilities in Kech district, by population density of union council



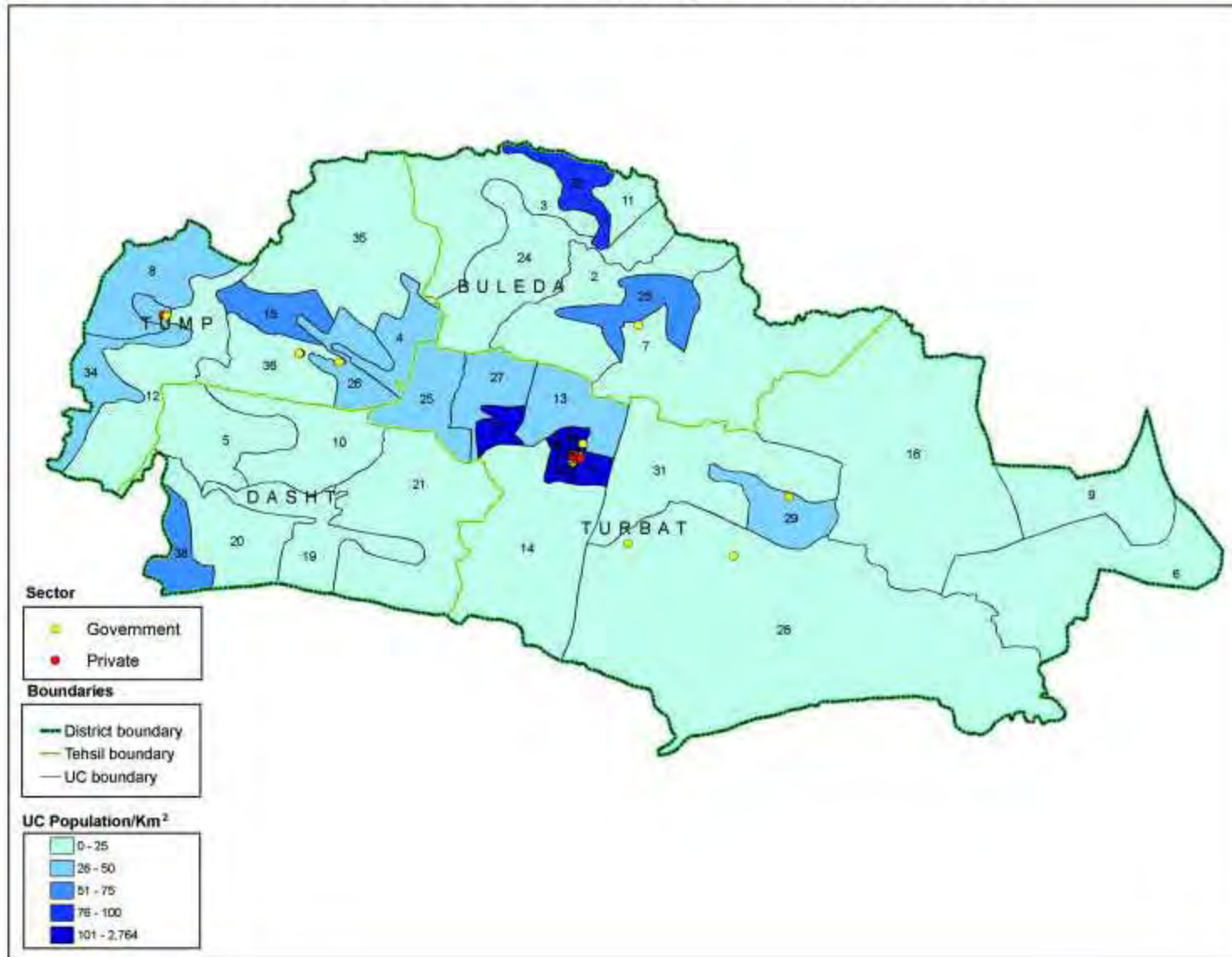
Map 4.6: Location of IUD facilities in Kech district, by population density of union council



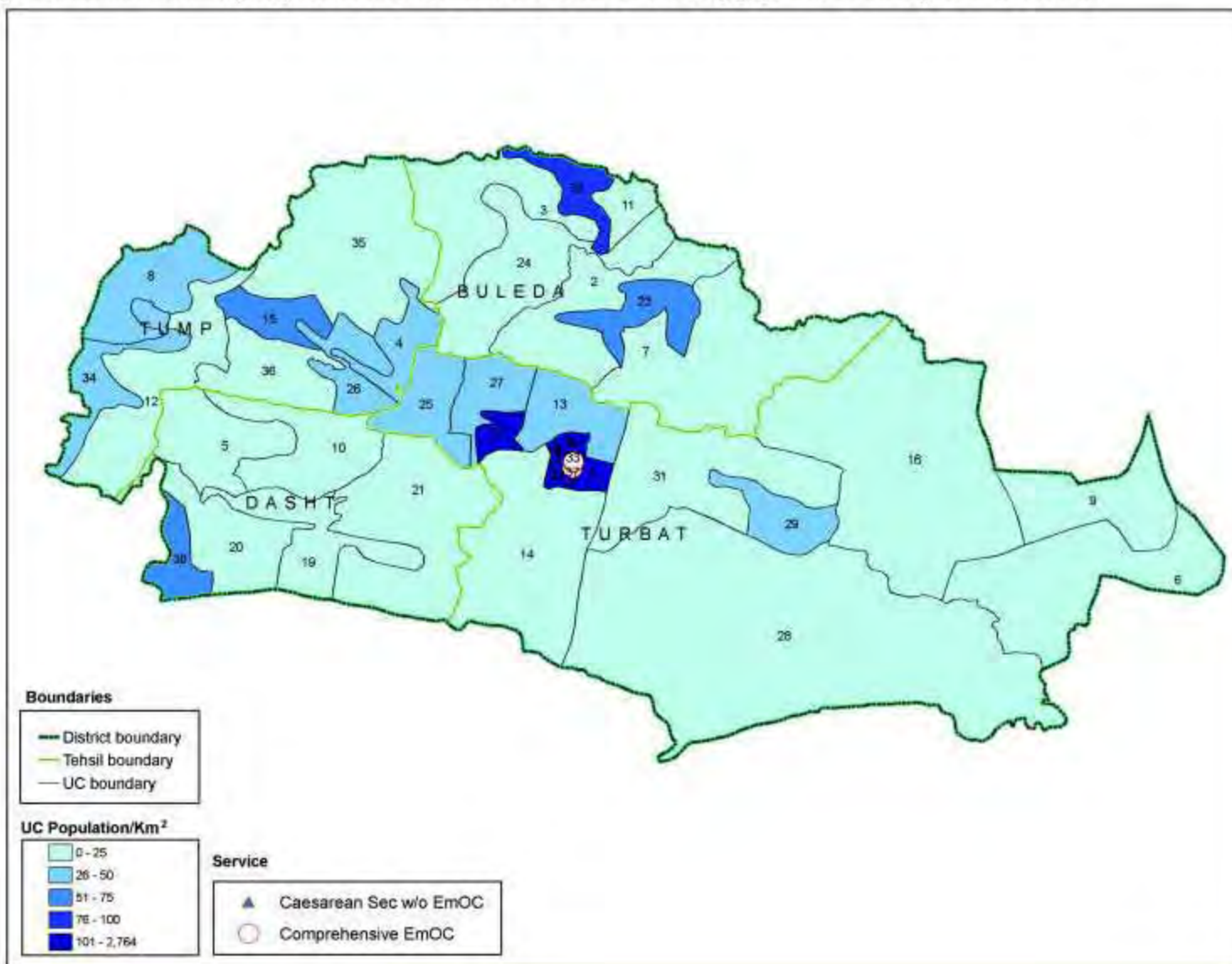
Map 4.7: Location of injectables contraceptive services in Kech district, by population density of union council



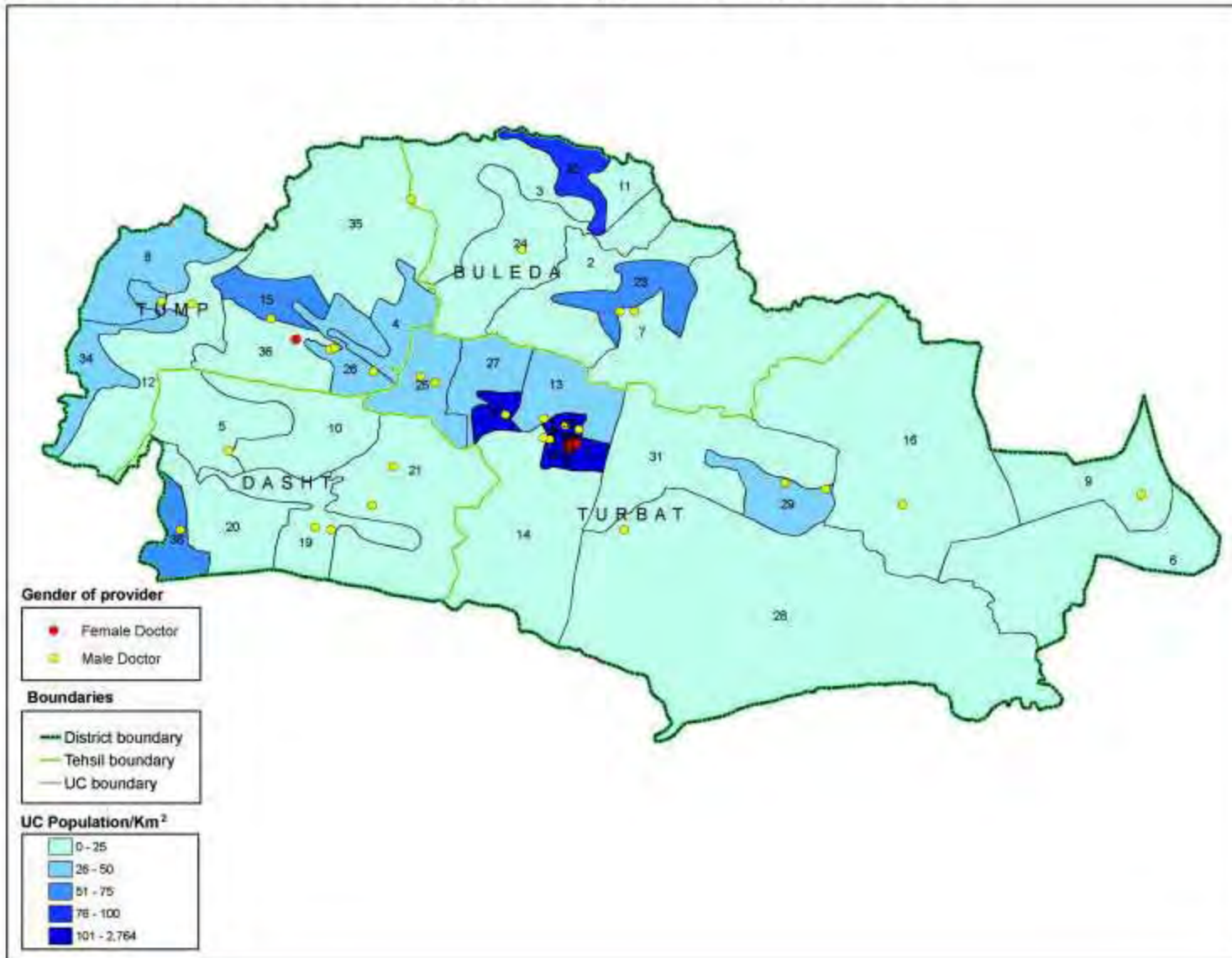
Map 4.8: Location of essential obstetric services in Koch district, by population density of union council



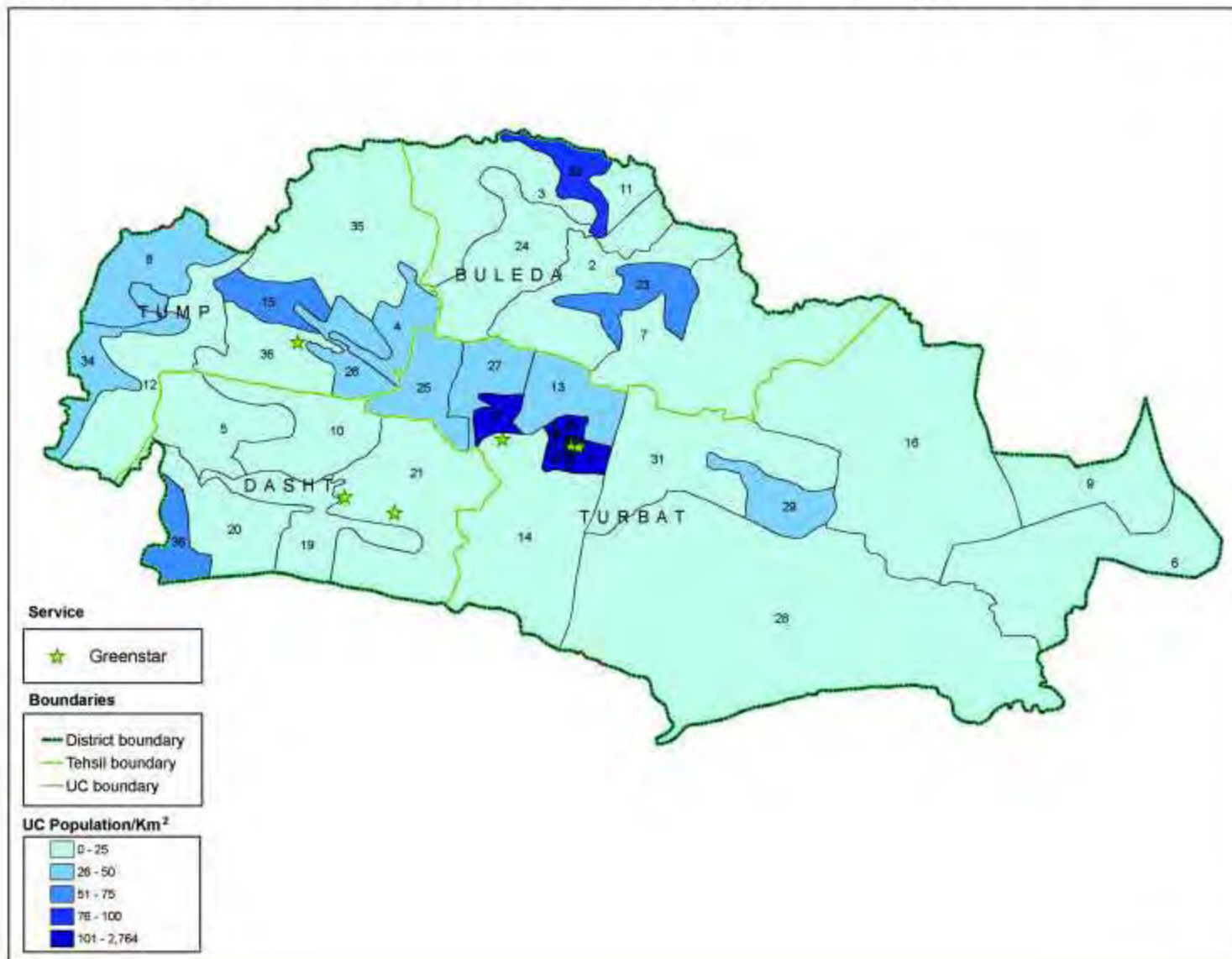
Map 4.9: Location of emergency obstetric care facilities in Kech district, by population density of union council



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



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



Chapter 5

Fertility

The main objective of this baseline survey was to monitor and evaluate progress 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 was 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 CBR and TFR. Table 5.1 shows the percentage distribution of all currently married women by the number of children ever born (CEB). The table shows these distributions 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) and mean CEB

Age group	Children ever born					Mean CEB	N
	0	1-2	3-4	5 or more	%		
15-19	52.3	47.7	0.0	0.0	100.0	0.6	65
20-24	18.5	65.5	15.1	0.8	100.0	1.5	119
25-29	15.6	22.5	40.0	21.9	100.0	3.0	160
30-34	2.0	16.0	29.0	53.0	100.0	4.7	100
35-39	4.0	12.1	22.2	61.6	100.0	5.4	99
40-44	1.8	3.6	12.5	82.1	100.0	6.5	56
45-49	2.2	2.2	4.4	91.1	100.0	7.4	45
Total	13.8	27.3	22.0	36.8	100.0	3.7	644

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

Age group	Number of living children					Mean LC	N
	0	1-2	3-4	5 or more	%		
15-19	53.8	46.2	0.0	0.0	100.0	0.5	65
20-24	20.2	67.2	11.8	0.8	100.0	1.4	119
25-29	16.3	28.1	41.3	14.4	100.0	2.7	160
30-34	3.0	16.0	33.0	48.0	100.0	4.4	100
35-39	4.0	13.1	34.3	48.5	100.0	4.8	99
40-44	1.8	5.4	16.1	76.8	100.0	6.0	56
45-49	2.2	2.2	4.4	91.1	100.0	6.7	45
Total	14.6	29.2	24.5	31.7	100.0	3.4	644

Early childbearing was common in Kech. The mean number of children ever born (Table 5.1) and living children (Table 5.2) increased with the age of the mother, as would be expected in data of good quality. Table 5.3 shows the mean number of sons and daughters. Among women aged 15-49 in Kech, the mean number of children ever born was 3.7 for currently married women. The mean number of children ever born increased steadily with

age, reaching a high of 7.4 children among women aged 45-49. On average, these women also had 6.7 living children. Each woman of age group 45-49 had lost 0.7 children on average during her reproductive life.

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

Age group	Mean number of children						N
	Ever born			Surviving			
	Boys	Girls	Total	Boys	Girls	Total	
15-19	0.3	0.2	0.6	0.3	0.2	0.5	65
20-24	0.8	0.6	1.5	0.7	0.6	1.4	119
25-29	1.5	1.5	3.0	1.4	1.3	2.7	160
30-34	2.5	2.2	4.7	2.3	2.1	4.4	100
35-39	2.8	2.6	5.4	2.5	2.3	4.8	99
40-44	3.1	3.4	6.5	2.8	3.2	6.0	56
45-49	4.0	3.5	7.4	3.5	3.2	6.7	45
Total	1.9	1.8	3.7	1.7	1.7	3.4	644

Table 5.1 also shows that 48 percent of the married women who were 15-19 years of age had already given birth to at least one child. Women aged 45-49 had virtually completed childbearing. Among currently married women in this age group, 7 percent had reached the end of childbearing with less than five children ever born, and 91 percent had five or more children ever born. Data show that 98 percent of the women aged 45-49 years had at least one live birth in their reproductive period, suggesting 2 percent primary infertility (i.e., the proportion of couples who are unable to have any children) in this sample in Kech. The sex ratio at birth was 105 males per 100 females, which is consistent with international norms. The sex ratio of living children was 100 (Table 5.3).

Differentials in Children Ever Born and Surviving

Table 5.4 shows that the differences in mean numbers of children by literacy and educational level of currently married women were pronounced. On average, literate women bore 2.2 fewer children than illiterate women. Those who had “up to primary”

education had 2.8 children on average ever born as compared to 4.3 born to those who had no schooling. Those who had “above secondary” education had 1.9 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 dead	N
Literacy of respondent				
Literate	2.1	1.9	0.0687	177
Illiterate	4.3	3.9	0.0966	467
Schooling of respondent				
No education	4.3	3.9	0.0974	470
Up to primary	2.8	2.5	0.0889	49
Up to secondary	1.7	1.6	0.0479	88
Above secondary	1.9	1.8	0.0429	37
Residence				
Rural	3.6	3.3	0.0952	525
Urban	4.1	3.8	0.0813	119
Literacy of respondent's husband				
Literate	3.3	3.0	0.0821	355
Illiterate	4.3	3.8	0.1019	289
Schooling of husband				
No education	4.3	3.8	0.1108	286
Up to primary	3.4	3.2	0.0529	62
Up to secondary	3.1	2.8	0.0905	151
Above secondary	3.3	3.1	0.0642	141
Standard of living index				
Low	3.7	3.2	0.1232	194
Medium low	3.4	3.0	0.1099	109
Medium high	4.0	3.7	0.0879	119
High	3.7	3.5	0.0603	222
Occupation/economic activity of husband				
Agriculture/livestock/poultry	4.7	4.4	0.0628	44
Petty trader	3.6	3.3	0.0743	41
Labor (daily wages)	3.6	3.2	0.1003	185
Government service	4.7	4.4	0.0813	114
Private service	2.8	2.5	0.1148	22
Own business	3.5	3.3	0.0761	26
Abroad	3.9	3.4	0.1117	95
Unemployed	2.4	2.1	0.1089	104
Others	4.8	4.5	0.0645	13
Total	3.7	3.4	0.0923	644

Differentials were also observed on the basis of literacy and economic activity of husbands. Those who had literate husbands had 3.3 children compared to 4.3 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. Highest number of children ever born (4.7) was in the occupational category of agriculture/livestock/poultry and government service.

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 (2.1) compared to those mothers who were illiterate (4.3). Similarly, the survival of children with literate mothers was better than those born to illiterate mothers. Literate mothers were younger than illiterate mothers. In the below-30 age group, 81 percent of the mothers were literate, as compared to 43 percent who were illiterate.

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	30	16.9	0.7	0.6	35	7.5
20 - 24	1.4	1.3	63	35.6	1.6	1.5	56	12.0
25 - 29	2.4	2.3	50	28.2	3.2	2.9	110	23.6
30 - 34	2.8	2.7	19	10.7	5.2	4.8	81	17.3
35 - 39	5.5	4.8	11	6.2	5.4	4.8	88	18.8
40 - 44	7.0	6.8	4	2.3	6.5	5.9	52	11.1
45 - 49	0.0	0.0	0	0.0	7.4	6.7	45	9.6
Total	2.1	1.9	177	100.0	4.3	3.9	467	100.0

Current Fertility

Crude Birth Rate

The crude birth rate (CBR), though a crude measure of fertility, is the most widely 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 28 births per thousand population.

Age-specific Fertility Rates and Total Fertility Rate

Total fertility rate (TFR) is a more refined fertility measure than CBR. Age-specific fertility rates (ASFRs) and TFR have been 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 developing countries; rates rose rapidly till age 25-29 and then declined with increasing age. A TFR of 4.7 for the period 2005-2008 was obtained from the set of ASFRs calculated from the data presented in Table 5.6, compared with 4.1 for both Balochistan and Pakistan as a whole reported 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	298	34	38.0
20 - 24	248	97	130.4
25 - 29	199	123	206.0
30 - 34	111	66	198.2
35 - 39	109	47	143.7
40 - 44	63	26	137.6
45 - 49	52	12	76.9
Total	1080	405	na
TFR: 4.7			
CBR: 28.1			

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 young children. Among those who already had two living children under 5 years of age, 14 percent were currently pregnant. Moreover, among women who had 3 living children under 5 years of age, 4 percent were currently pregnant. For such mothers, it is particularly important for their health and that of their children to ensure that birth spacing is part of their married life at this 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	30	15.2	167	84.8	197	100.0
1	33	13.0	221	87.0	254	100.0
2	23	13.9	142	86.1	165	100.0
3	1	4.0	24	96.0	25	100.0
4	0	0.0	3	100.0	3	100.0
N	87	13.5	557	86.5	644	100.0

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 both mothers and their babies. Table 5.8 shows the length of 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 group							
15 - 19	50.0	25.0	25.0	0.0	0.0	100.0	4
20 - 24	7.8	37.3	27.5	21.6	5.9	100.0	51
25 - 29	15.0	9.3	35.5	20.6	19.6	100.0	107
30 - 34	9.6	14.5	34.9	14.5	26.5	100.0	83
35 - 39	8.3	16.7	28.3	16.7	30.0	100.0	60
40 - 44	0.0	6.9	51.7	17.2	24.1	100.0	29
45 - 49	23.1	0.0	30.8	15.4	30.8	100.0	13
Number of live births							
2	15.2	26.1	34.8	15.2	8.7	100.0	46
3	12.5	18.8	21.9	21.9	25.0	100.0	64
4	5.9	13.2	38.2	17.6	25.0	100.0	68
5	10.9	13.0	32.6	23.9	19.6	100.0	46
6+	11.4	12.2	38.2	14.6	23.6	100.0	123
Education level							
No education	11.1	14.4	35.2	16.3	23.0	100.0	270
Up to primary	4.2	29.2	37.5	12.5	16.7	100.0	24
Up to secondary	13.5	18.9	27.0	24.3	16.2	100.0	37
Above secondary	12.5	6.3	25.0	37.5	18.8	100.0	16
Standard of living index							
Low	9.0	16.2	44.1	11.7	18.9	100.0	111
Medium low	10.5	21.1	31.6	24.6	12.3	100.0	57
Medium high	22.2	14.3	22.2	17.5	23.8	100.0	63
High	6.9	12.9	31.9	20.7	27.6	100.0	116
Total	11.0	15.6	34.0	17.9	21.6	100.0	347

A short interval has traditionally been viewed as a risk factor for poor pregnancy outcomes, particularly neonatal mortality, in developing countries (Cleland and Sathar, 1984). It has been observed in several studies that the death risks of an index child whose birth closes a short birth interval are higher than those experienced by an index child whose birth closes a longer birth interval (Mahmood, 2002). It has 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 11 percent of children were born with a birth interval of less than 18 months. Almost 61 percent were born with a birth interval of less than 36 months, while 39 percent were born after three years or more. The differentials by mother's age, educational level and standard of living index are also shown.

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 411 women (64 percent), out of the 644 total women interviewed, had borne a child during the past four years, and these women were asked 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. 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. About 60 percent of the sample respondents had received at least one antenatal care visit during their last pregnancy. The percentage was higher for urban mothers than for rural ones. The overall percentage of 60 percent was significantly higher than the level obtained for Kech in the 2004-05 PSLM Survey (42 percent) and the level for Balochistan in the PDHS (41 percent), but slightly less than the level obtained nationally in the PDHS (61 percent) (Government of Pakistan, 2006; NIPS/PDHS, 2008). Thirty four percent of the women had at least three such visits and 20 percent had four or more visits.

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

Number of visits	Rural		Urban		Total	
	N	%	N	%	N	%
No visit	151	45.6	14	17.5	165	40.1
1-2 visits	84	25.4	22	27.5	106	25.8
3 visits	45	13.6	14	17.5	59	14.4
4 or more visits	51	15.4	30	37.5	81	19.7
Total	331	100.0	80	100.0	411	100.0

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

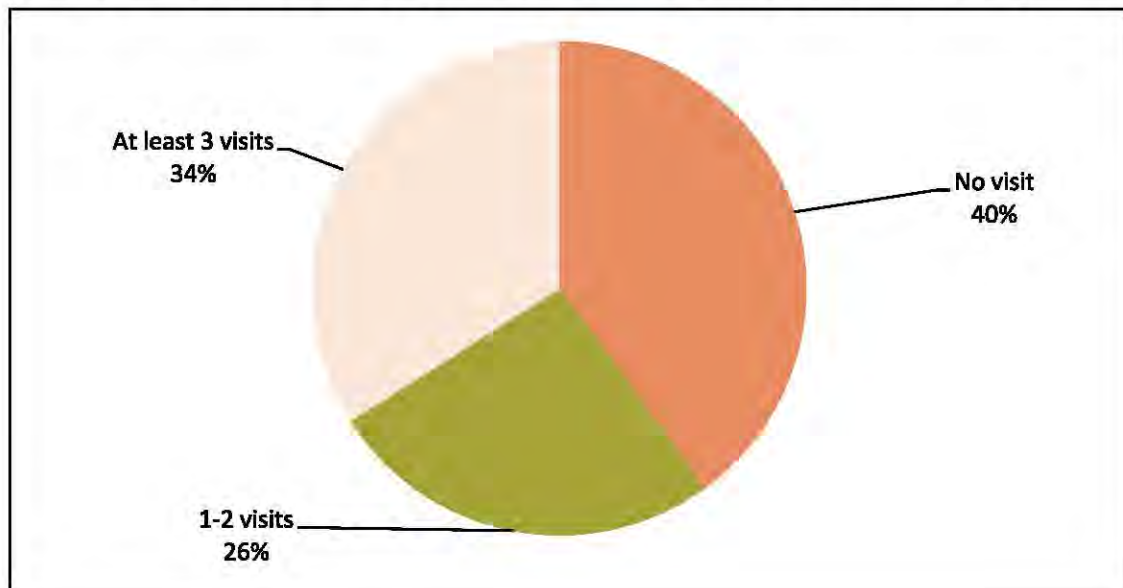


Figure 6.2 shows that many of these visits were in response to some health problem, rather than for a routine check-up. More than two-thirds (78 percent) of the first antenatal visits were for curative purpose.

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

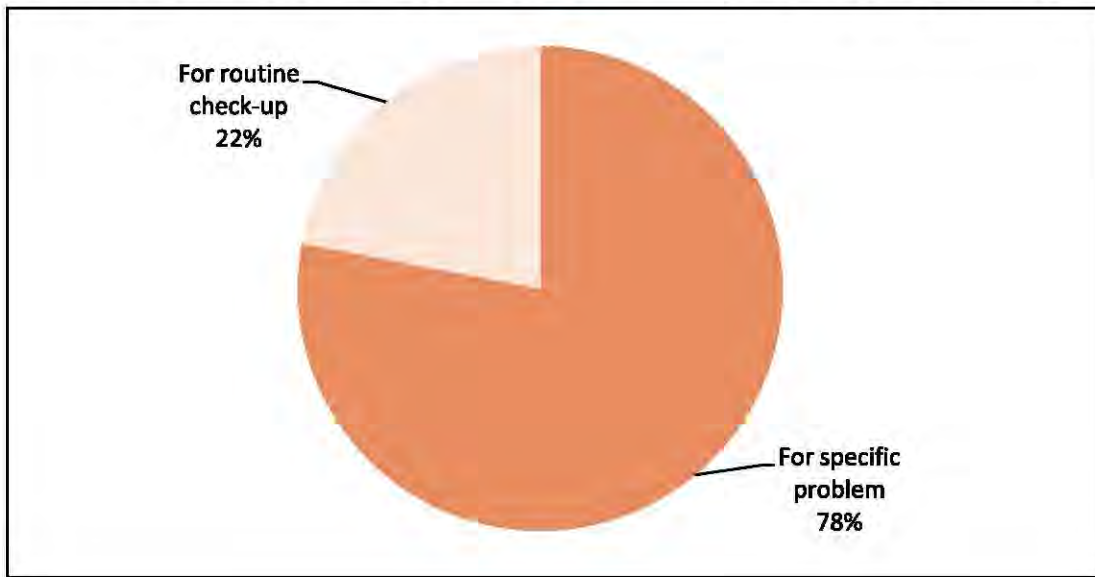


Figure 6.3 shows that for 31 percent of the women, the first visit took place within the first three months of gestation, and 23 percent of the women went for their first check-up during the third trimester of their pregnancy.

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

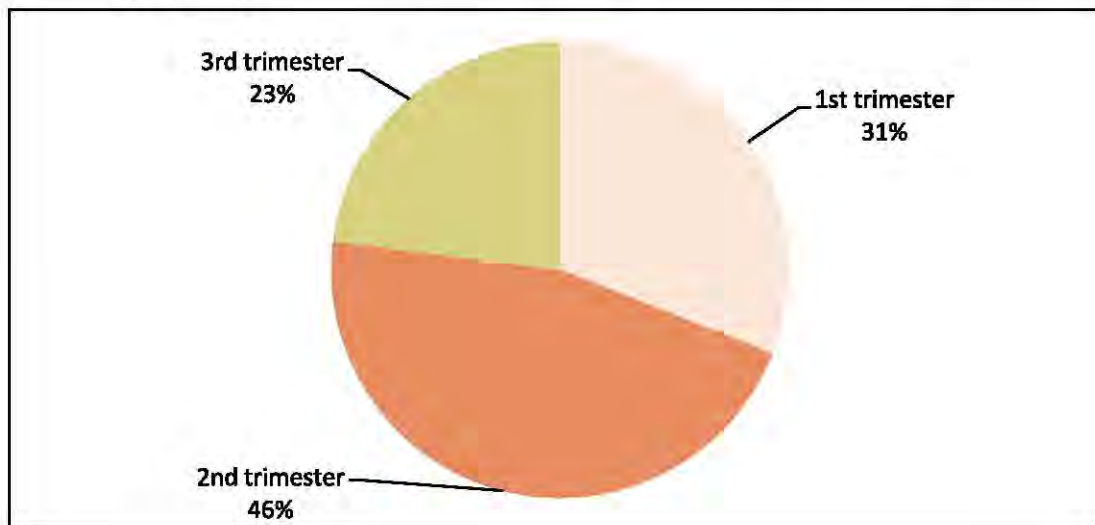
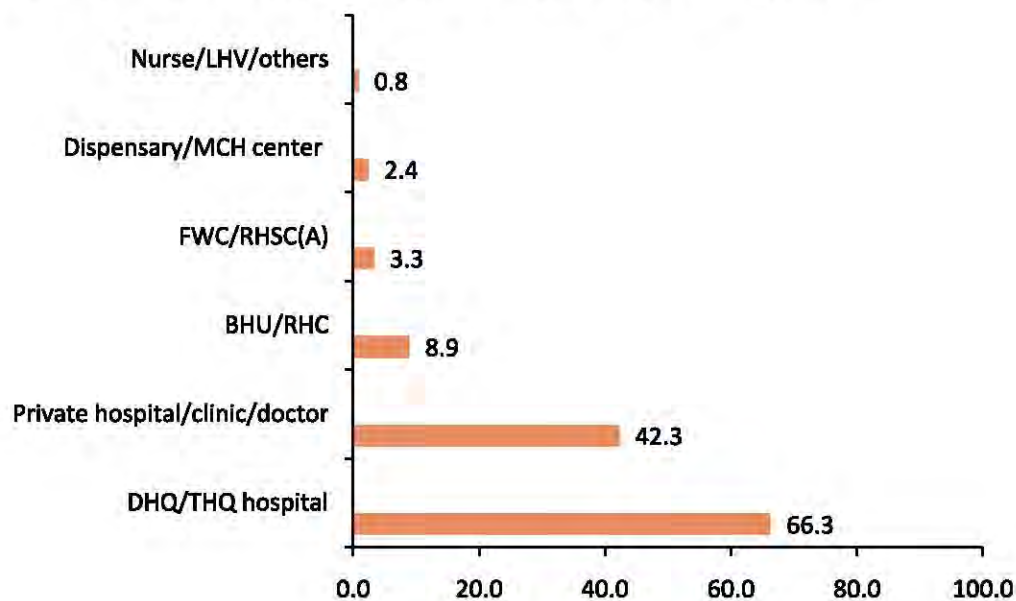


Table 6.2 shows the locations where respondents made one or more antenatal visits. The most common providers of antenatal care were DHQ/THQ hospitals followed by private hospitals/clinics and BHU/RHCs. Other providers were less common.

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

Facility/service provider	Rural	Urban	Total
Dispensary/MCH center	1.7	4.5	2.4
BHU/RHC	10.0	6.1	8.9
DHQ/THQ hospital	60.0	83.3	66.3
Private hospital/clinic/doctor	46.1	31.8	42.3
FWC/RHSC (A)	1.7	7.6	3.3
Nurse/LHV/others	1.2	0.0	0.8
N	180	66	246

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



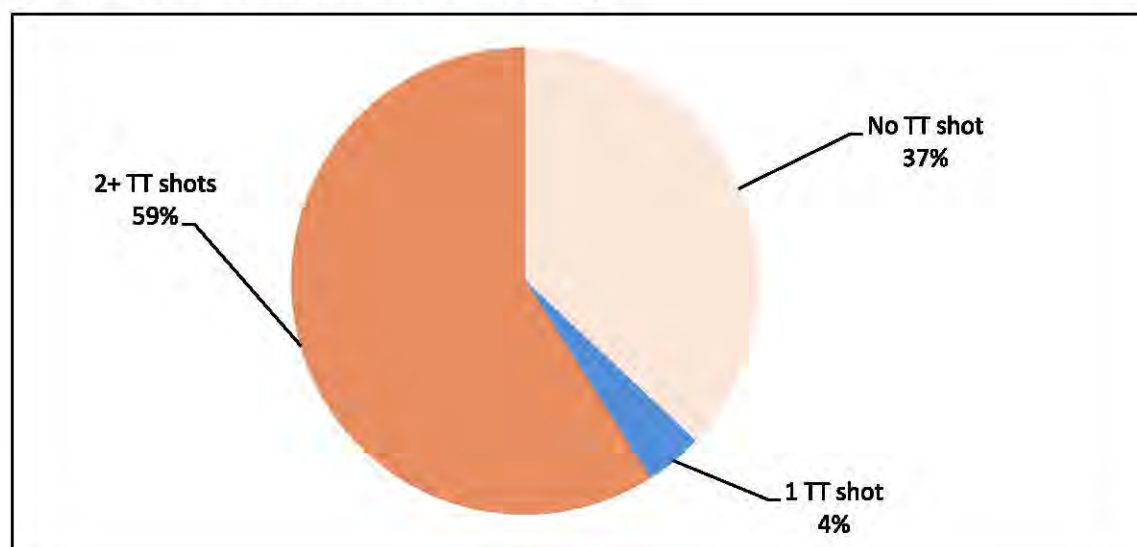
Tetanus Immunization

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, 25 percent of mothers in Kech had received at least one shot; according to the PDHS 2006-07, 30 percent in Balochistan and 53 percent nationally were appropriately protected from tetanus, according to guidelines (Government of Pakistan, 2006; NIPS/PDHS, 2008). Table 6.3 shows that 63 percent of mothers had received at least one TT shot, while 59 percent received two or more TT shots during their last pregnancy. Surprisingly, the immunization rate was slightly higher in rural areas compared to urban areas. Although tetanus immunization appears to be increasing in Kech, 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	121	36.6	32	40.0	153	37.2
One TT shot	14	4.2	1	1.3	15	3.6
2+ TT shots	196	59.2	47	58.8	243	59.1
Total	331	100.0	80	100.0	411	100.0

Figure 6.5: Tetanus immunization at last delivery



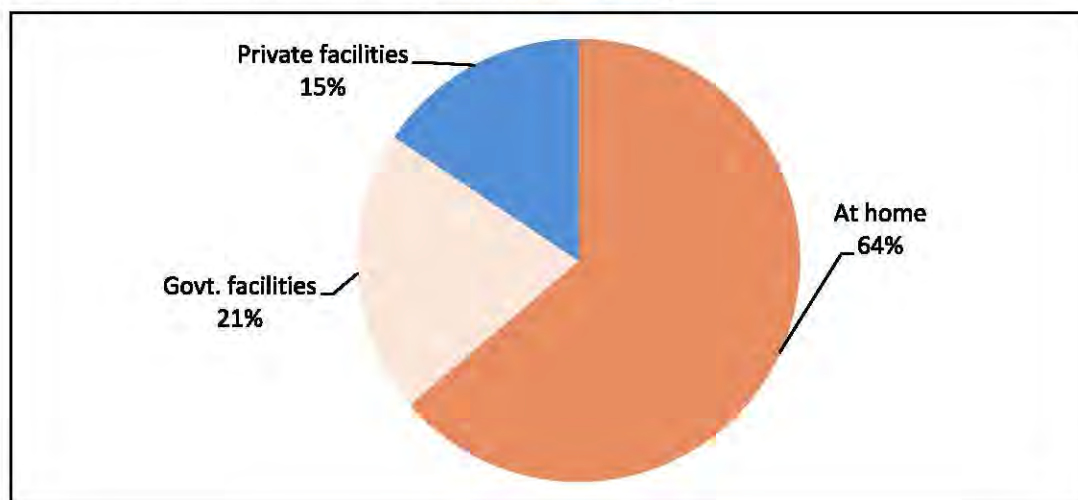
Location and Attendance at Delivery

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. These proportions have been historically low in Pakistan, contributing substantially to high maternal mortality. In Kech, according to the 2004-05 PSLMS, 20 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, 36 percent of the most recent deliveries were in a health facility, a substantially higher number (Table 6.4 and Figure 6.6).

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

Place of delivery	Rural		Urban		Total	
	N	%	N	%	N	%
At home	229	69.2	33	41.3	262	63.7
BHU/RHC	8	2.4	0	0.0	8	1.9
DHQ/THQ hospital	42	12.7	31	38.8	73	17.8
Pvt. hospital/clinic	50	15.1	14	17.5	64	15.6
Dispensary/ MCH center	2	0.6	2	2.5	4	1.0
Total	331	100.0	80	100.0	411	100.0

Figure 6.6: Distribution of mothers by location of delivery

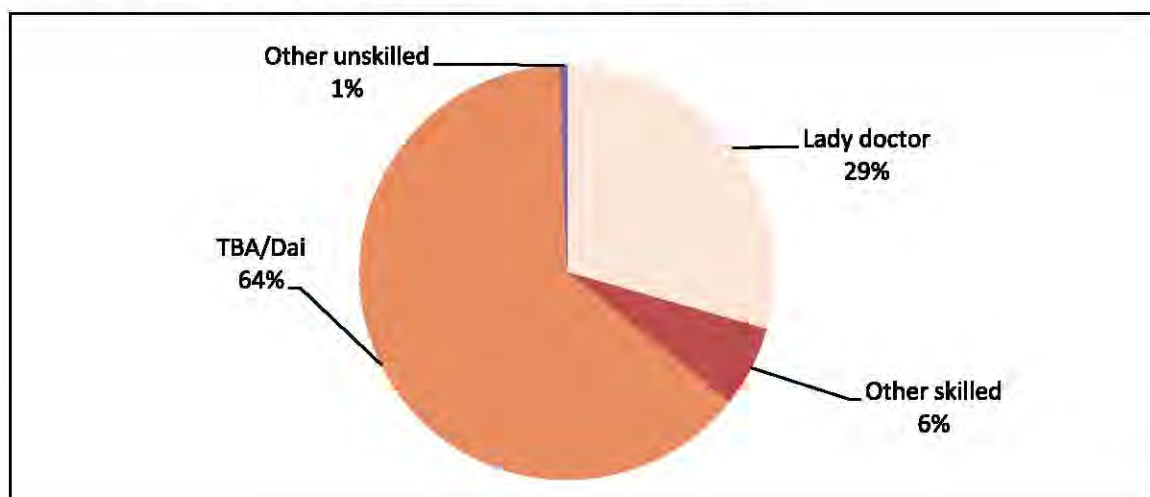


Likewise, the proportion of births delivered by skilled attendants was higher than expected from previous data. In this survey, 36 percent of reported deliveries in the previous 4 years were delivered by a skilled birth attendant. This is substantially higher in urban areas (Table 6.5 and Figure 6.7). In the PSLMS 2004-05 for Kech, 23 percent of births were delivered by a skilled 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 attendant in this household survey were reportedly attended by a lady doctor. The term “doctor,” however may mean a paramedic, such as a Lady Health Visitor, in such interviews. About 64 percent of the births were delivered by dais (traditional birth attendants).

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

Birth attendant and skill level	Rural		Urban		N	%
	N	%	N	%		
TBA/dai/LHW	230	69.5	34	42.5	264	64.2
Nurse/LHV	19	5.7	7	8.8	25	6.3
Lady doctor	82	24.8	39	48.8	121	29.4
Total	331	100.0	80	100.0	411	100.0
Skilled birth attendant	101	30.5	46	57.5	147	35.8
Unskilled birth attendant	230	69.5	34	42.5	264	64.2

Figure 6.7: Distribution of mothers by attendant at last delivery



Postpartum Care

For both the health of the mother and the health of the newborn, a newly delivered mother and baby should be followed up for at least 6 weeks after delivery; MoH guidelines recommend at least one postpartum visit after discharge during the first 42 days after delivery. However, this 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 will usually be seen while they are in the facility, but not after that. Kech is no exception. About 5 percent of respondents who had a non-institutional delivery reported having received postnatal care within 40 days after delivery (Table 6.6). In half of these cases, the first visit took place within 24 hours. However, all of the women delivering in facilities reported having a postnatal check-up 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 its role in the next birth interval, or on how and when to take steps to end childbearing (WHO, 2006).

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

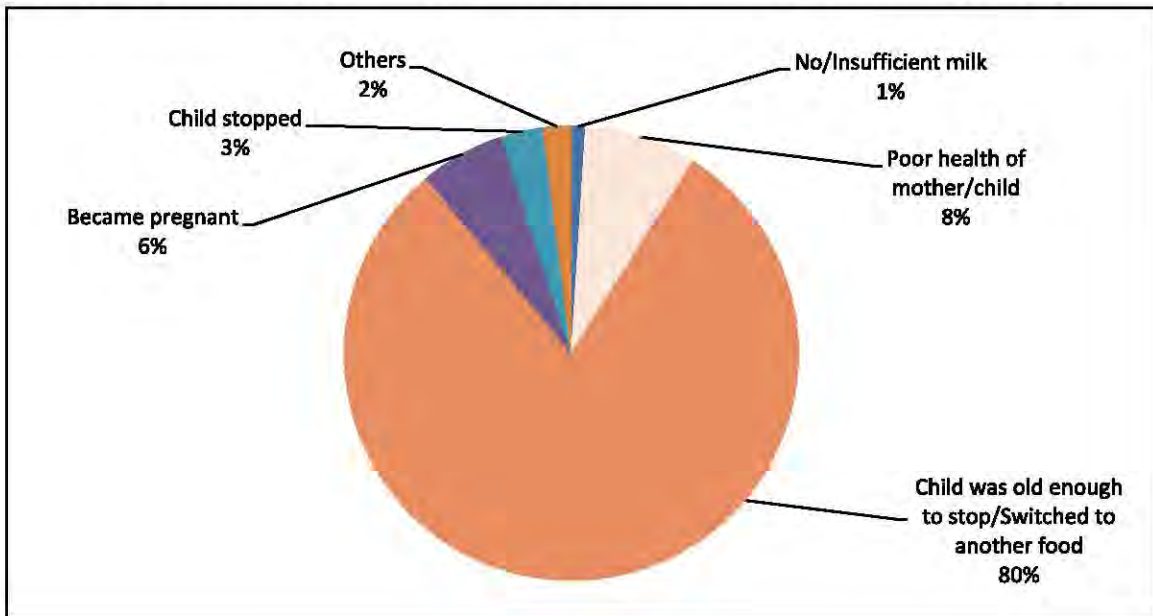
Place of delivery	Postnatal check-up within 24 hours		Postnatal check-up after 24 hours		Did not have a postnatal check-up		Total	
	N	%	N	%	N	%	N	%
Institution	146	100.0	0	0.0	0	0.0	146	100.0
Non-institution	6	2.3	8	3.0	251	94.7	265	100.0
Total	152	37.0	8	1.9	251	61.1	411	100.0

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 6 of 395 respondents reported not having breastfed their last child at all. Breastfeeding is normally done for a substantial period of

time. The median length of breastfeeding for the last baby (not currently being breastfed) was 24 months. Four main reasons were given for discontinuing breastfeeding: child was old enough to stop (80 percent), poor health of mother or child (8 percent), mother became pregnant (6 percent) and child stopped (3 percent).

Figure 6.8: Distribution of mothers by reasons for discontinuing breastfeeding (n=174)



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 toward the end of their reproductive lives, they are quite sure they want to stop. At some point, 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 6 children; 19 percent of the respondents wanted four or fewer children. However, substantial numbers cited six or even seven as the ideal number. These proportions did not vary much according to residence. Urban women wanted same number of children as their rural. Overall in Kech, 2 percent of the women also gave a non-numeric response to this question such as up to God.

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

Number of children	Rural		Urban		Total	
	N	%	N	%	N	%
2	1	0.2	1	0.8	2	0.3
3	8	1.5	5	4.2	13	2.0
4	76	14.5	29	24.4	105	16.3
5	85	16.2	12	10.1	97	15.1
6	156	29.7	36	30.3	192	29.8
7+	191	36.4	30	25.2	221	34.3
Up to God	5	1.0	1	0.8	6	0.9
Don't know	3	0.6	5	4.2	8	1.2
Total	525	100.0	119	100.0	644	100.0

Desire for More Children

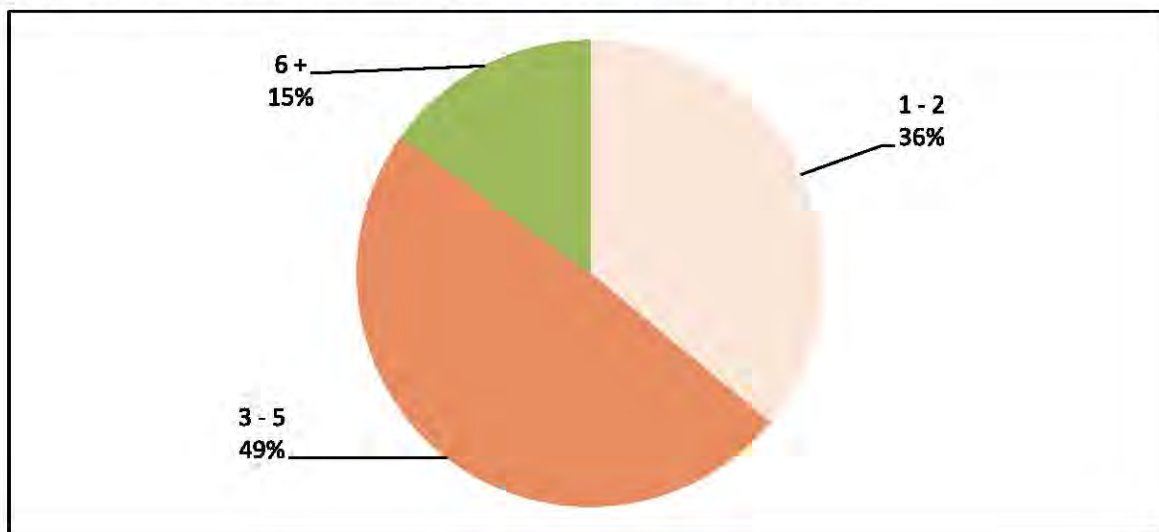
Levels of Desire for More Children

A more immediate measure of fertility preference is whether a couple wants more children; if so, do they want the next one 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, was based on the number of living children they already had. Thirty-one percent of the respondents did not want more children at all while 30 percent wanted to have but later. The proportion of women wanting more children soon declined sharply after the first birth. On the other hand, most women with six or more living children did not want to have more. For those with six or more children, the proportion wanting to stop was 85 percent. This table indicates clearly the 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	70.2	29.8	0.0	94	100.0
1	28.8	70.3	0.9	111	100.0
2	18.2	77.9	3.9	77	100.0
3	27.1	57.1	15.7	70	100.0
4	17.0	48.9	34.1	88	100.0
5	9.8	36.1	54.1	61	100.0
6 or more	4.2	11.2	84.6	143	100.0
Total	24.5	29.8	30.9	644	100.0
N	158	287	199	644	100.0

For those women who wanted more children, we also asked how many more they wanted to have. As shown in Figure 7.1, 36 percent of the women who wanted more children wanted one or two more children. Another 49 percent wanted three to five children and 15 percent wanted six or more children.

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

Socioeconomic Correlates of Desire for Children

A woman's stated desire for children was analyzed in relation to four possible socioeconomic determinants: standard of living index (SLI), respondent's literacy, age and residence (Table 7.3). The relationship between SLI and desire for more children was found to be weak. The age of a respondent was strongly associated with a desire not to have more children. Literate women were more likely to want the next child at a later time (58 percent) compared to illiterate women (39 percent). On the other hand, illiterate women were more likely to not have more children (38 percent) compared to literate women (13 percent).

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

Characteristic	Desire for next child			Total	
	Soon	Later	Never	%	N
Standard of living index					
Low	27.8	46.9	25.3	100.0	194
Medium low	28.4	45.9	25.7	100.0	109
Medium high	16.8	47.1	36.1	100.0	119
High	23.9	40.5	35.6	100.0	222
Age group					
< 25	27.7	69.0	3.3	100.0	184
25 or more	23.3	34.8	42.0	100.0	460
Literacy of respondent					
Literate	28.8	58.2	13.0	100.0	177
Illiterate	22.9	39.4	37.7	100.0	467
Residence					
Rural	27.0	44.6	28.4	100.0	525
Urban	13.4	44.5	42.0	100.0	119
Total	24.5	44.6	30.9	100.0	644

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 came out most strongly in the proportions saying that there would be no limit: 43 percent of women said there would be no limit to the number of daughters before having a son, while 37 percent said there would be no limit to sons before having a daughter. For those women who gave a number, the median numbers of daughters before having a son was 6 and the median number of sons before having a daughter was 5.

Table 7.4: Son and daughter preferences by the respondents

Response	Number of daughters for the desire of a son		Number of sons for the desire of a daughter	
	N	%	N	%
Numeric responses	365	56.7	406	63.0
Up to God	2	0.3	2	0.3
No limit	277	43.0	236	36.6
Total	644	100.0	644	100.0
Median*	6	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 it does not matter much to them. We asked respondents whether they would be pleased, worried, accepting, or indifferent if they became pregnant. Results are shown in Tables 7.5 and 7.6. (This question excludes those 268 of the total 644 women who wanted a child soon, who were currently pregnant, had been sterilized, had gone through menopause or had a hysterectomy.)

Among those who did not want more children at all, 78 percent said they would be worried if they became pregnant, while only 6 percent would be pleased. Among those who wanted

to delay their pregnancy for more than two years 37 percent would be worried, while 29 percent would be pleased.

Table 7.5: Distribution of MWRA who did not want more children soon by reaction if become pregnant in near future

Reaction if pregnant	Future desire for children		Total	
	Later	Never	%	N
Pleased	28.8	6.4	19.4	73
Worried	37.0	77.7	54.0	203
Accept it	30.6	13.4	23.4	88
Doesn't matter	3.7	2.5	3.2	12
Total	100.0	100.0	100.0	na
N	219	157	376	376

na=not applicable.

Further, women who expressed a desire to not have more children or to delay the next child were asked what problems they would face if they became pregnant soon. Table 6.6 shows their responses. The problems most commonly faced by those who did not want more children at all were their own health (85 percent), schooling of children (68 percent), the family's economic situation (68 percent), and caring of children (62 percent). Health of the youngest child (73 percent), caring of children (65 percent) and their own health (64 percent) were commonly cited by those who wanted to delay the next child. This suggests that health was a priority for most of the women. This is a good sign for the project, which supports birth spacing with a focus on the health of the mother and child.

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

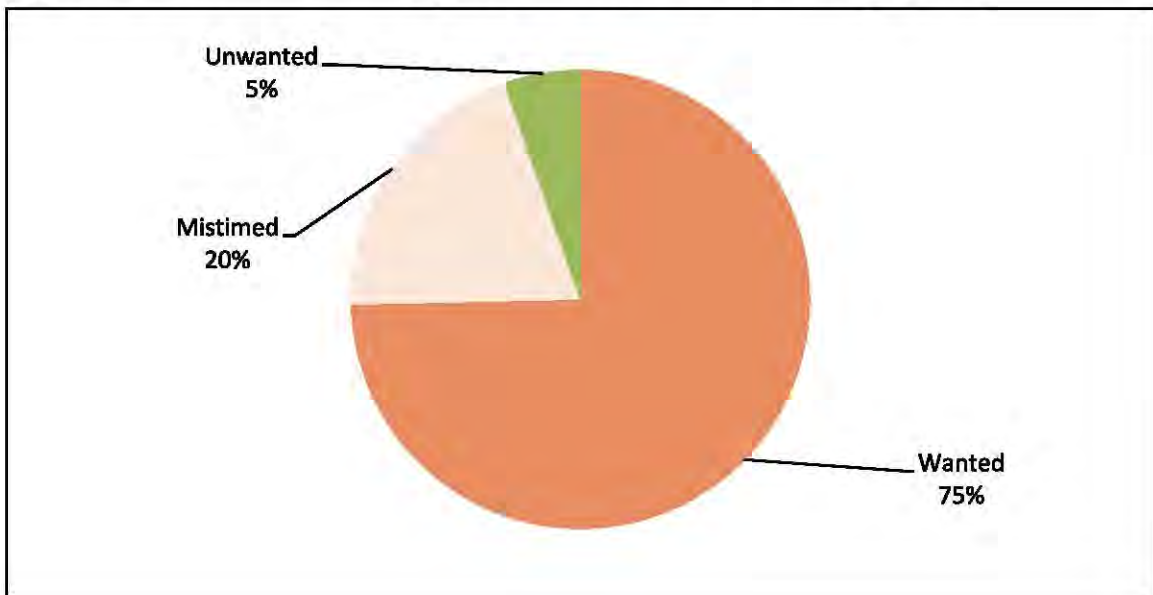
Problems faced if pregnant	Future desire for children		Total	
	Later	Never	%	N
Own health	63.9	85.4	72.9	274
Health of youngest child	72.6	60.5	67.6	254
Caring of children	64.8	62.4	63.8	240
Schooling of children	49.3	68.2	57.2	215
Family economic situation	47.0	68.2	55.9	210
N	219	157	376	376

Respondents could give more than one response.

Attitude towards Last Pregnancy

Another important dimension of fertility preference relates to whether the last pregnancy was wanted at the time, or 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 are wanted. 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, 5 percent of the women reported that their last pregnancy was unwanted, while another 20 percent said that their last pregnancy was mistimed.

Figure 7.2: Distribution of MWRA by their attitudes 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, or more, or fewer. In Table 7.7, their responses are tabulated according to their ideal family size. About 17 percent of the women did not know their husband's preference; while another 46 percent thought their husbands wanted the same number of

children as they did. However, 30 percent thought their husbands wanted more children than they did, while only 8 percent thought their husbands wanted fewer children. Table 7.7 shows that slightly less than half of the women felt that their decision and their husband's decision was the same.

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

Ideal family size of women	Perception of husband's desire for more children				Total	
	Same number	More children	Fewer children	Don't know	%	N
1 - 2 children	50.0	0.0	0.0	50.0	100.0	2
3 - 4 children	50.8	28.0	11.0	10.2	100.0	118
5 + children	46.1	30.0	6.7	17.3	100.0	510
Up to God	0.0	33.3	0.0	66.7	100.0	6
Don't know	0.0	50.0	12.5	37.5	100.0	8
Total	46.0	29.8	7.5	16.8	100.0	644
N	296	192	48	108	100.0	644

Chapter 8

Contraceptive Knowledge and Use

The FALAH baseline household surveys obtained data on contraceptive knowledge and use by first asking what methods they knew, if any (spontaneous knowledge). Then, 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. Besides providing detailed data on use problems, this approach provides a useful check on the accuracy of the information provided in the first set of questions.

Knowledge

For many years, at least 95 percent of the married women of reproductive age in Pakistan have known at least one method of contraception. Table 8.1 shows that this holds true for Kech as well; virtually all women knew at least one method. A majority of the female respondents knew the most commonly used program methods – pills, injections, female sterilization, condoms and IUDs. Knowledge of each contraceptive method was higher among women in Kech than in the national PDHS 2006-07 (NIPS/PDHS, 2008). Data show that there was a slight difference in knowledge of methods between rural and urban women with exceptions.

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

Method	Rural	Urban	Total
Female sterilization	95.2	97.5	95.7
Male sterilization	13.1	10.9	12.7
Pill	98.9	100.0	99.1
IUD	73.5	79.0	74.5
Injectables	97.9	100.0	98.3
Norplant	21.5	26.9	22.5
Condom	76.0	86.6	78.0
Rhythm	24.0	12.6	21.9
Withdrawal	42.3	42.0	42.2
Other FP method	6.9	15.1	8.4
Emergency pills	7.0	13.4	8.2
At least one method	99.0	100.0	99.2
At least one modern method	99.0	100.0	99.2
At least one traditional method	53.5	54.6	53.7
N	525	119	644

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, 40 percent reported having used some method of contraception during their married lives (Table 8.2). This figure was higher for

urban women (63 percent) than for rural women (35 percent). It was lower than the proportions obtained in the PDHS 2006-07 for Pakistan (48.7 percent) (NIPS/PDHS, 2008).

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

Method	Ever users				Current users				Past users			
	Rural	Urban	Total	N	Rural	Urban	Total	N	Rural	Urban	Total	N
Pill	22.9	44.5	26.9	173	5.9	16	7.8	50	17	28.6	19.1	123
IUD	1.9	2.5	2	13	0.4	0	0.3	2	1.5	2.5	1.7	11
Injectables	17.1	24.4	18.5	119	4	3.4	3.9	25	13.1	21	14.6	94
Condom	3.4	12.6	5.1	33	1.5	5	2.2	14	1.9	7.6	3	19
Rhythm	1	0.8	0.9	6	0.2	0	0.2	1	0.8	0.8	0.8	5
Withdrawal	2.1	1.7	2	13	1.1	1.7	1.2	8	1	0	0.8	5
Female sterilization	2.7	5.9	3.3	21	2.7	5.9	3.3	21	0	0	0	0
Other	0.6	0	0.5	3	0	0	0	0	0.6	0	0.5	3
Any method	35.2	63.0	40.4	260	15.8	31.9	18.8	121	19.4	31.1	21.6	139
Modern method	34.5	61.3	39.4	254	14.5	30.3	17.4	112	20	31.1	22	142
Traditional method	3.4	2.5	3.3	21	1.3	1.7	1.4	9	2.1	0.8	1.9	12
Emergency pills	0	0	0	0	na	na	na	na	0	0	0	0
N	525	119	644	644	525	119	644	644	525	119	644	644

na=not applicable

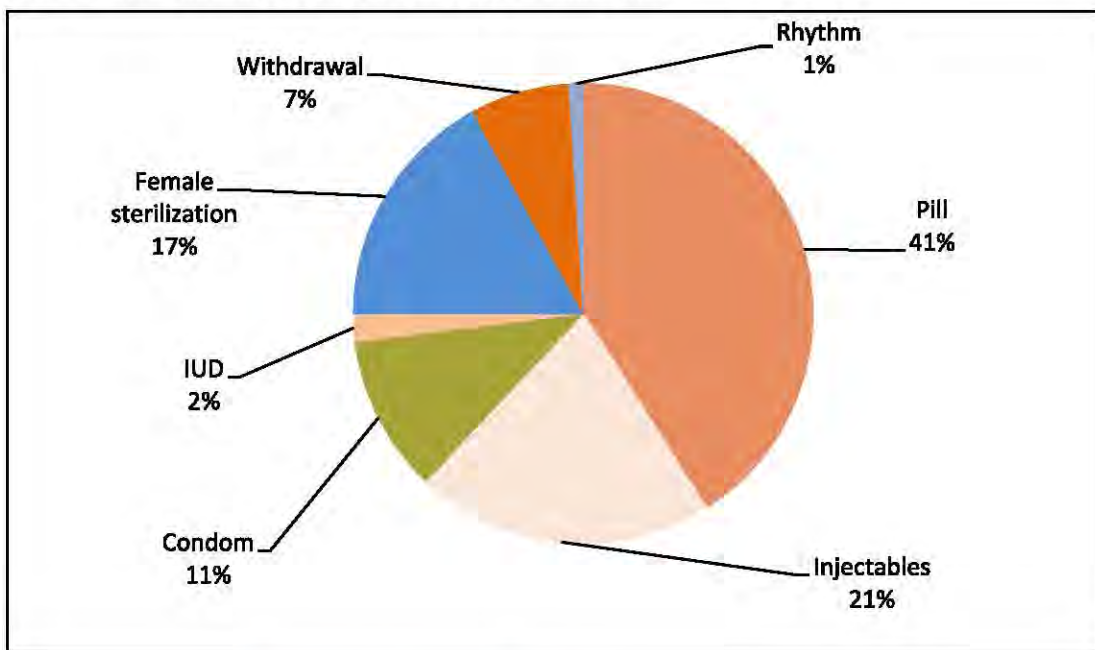
The proportion of currently married women of reproductive age who are presently using some form of contraception, commonly known as the contraceptive prevalence rate (CPR) is one of the central indicators of the status of family planning programs. It shows the degree to which couples are actively involved 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).

Current use of family planning methods in Kech as compared with Pakistan in general was low (see Table 8.2). Nineteen percent of all married women in the sample were currently using some method of contraception (CPR), compared with 14.4 percent for Balochistan

and 29.6 percent for Pakistan in the 2006-07 PDHS (NIPS/PDHS, 2008). In urban areas, the CPR was 32 percent, compared with 16 percent in rural Kech.

Table 8.2 shows that the methods most commonly in use were pills, injectables and female sterilization. Overall, 17.4 percent of the married women were using modern methods and 1.4 percent were using traditional methods (withdrawal and rhythm). Distribution of current users by method mix is seen in Figure 8.1, which shows that most of the current users were using pills (41 percent) and injectables (21 percent).

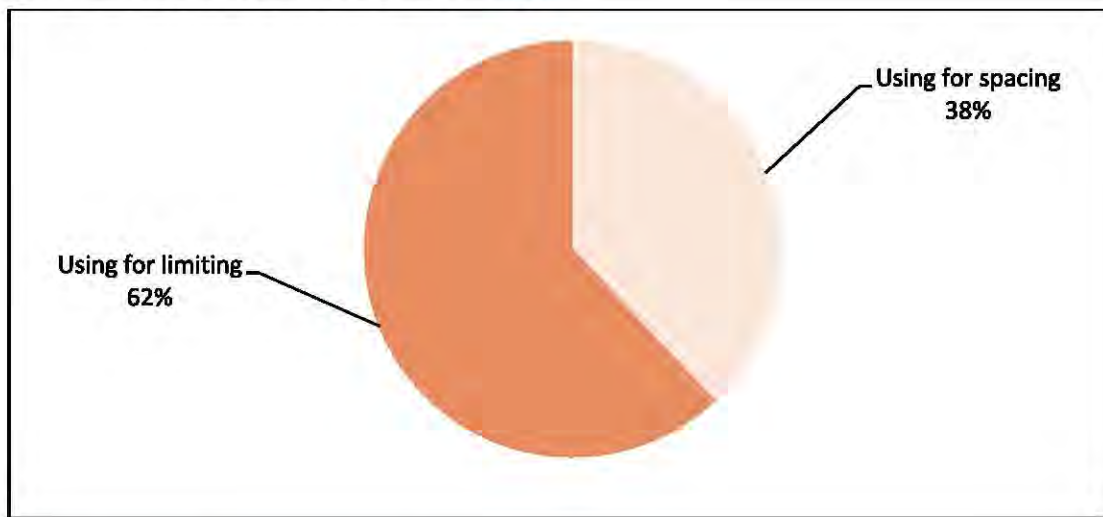
Figure 8.1: Distribution of current users by method mix



Current Use and Desire for Children

For current users of contraception, it is important to determine how many are using a contraceptive method for spacing purpose, and how many are using to stop having children altogether. Figure 8.2 shows this by current method. Overall, 62 percent of current use was for limiting purpose compared with 38 percent for spacing.

Figure 8.2: Current use and desire for children



Correlates of Contraceptive Use

Figure 8.3 shows the relationship between contraceptive prevalence and the women’s ages. The shape of the graph for age reflects the low prevalence among younger women and higher prevalence for older age women. The CPR for the age group 15-19 years was the lowest as 4.6 percent. The prevalence was highest among women in the age group 45-49 (31.1 percent).

Figure 8.3: Contraceptive prevalence by age

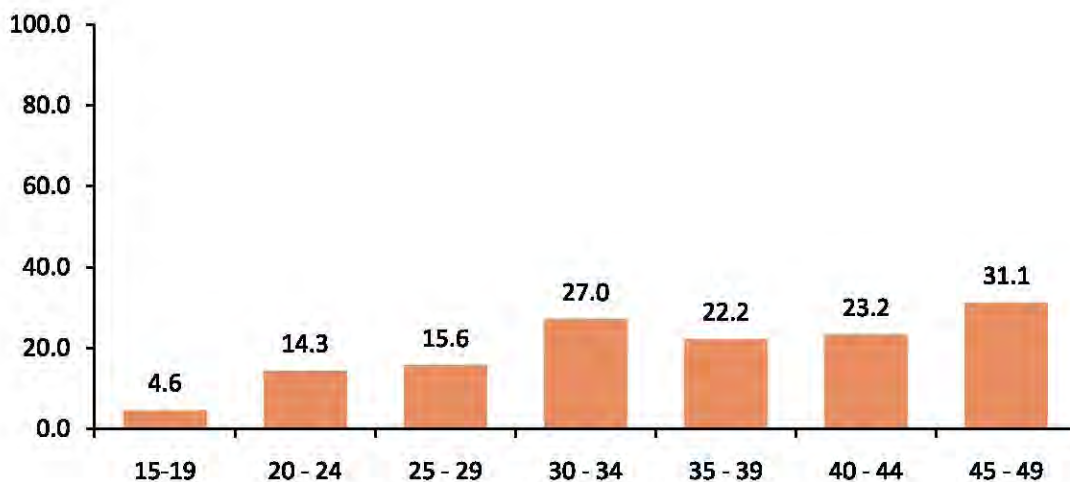
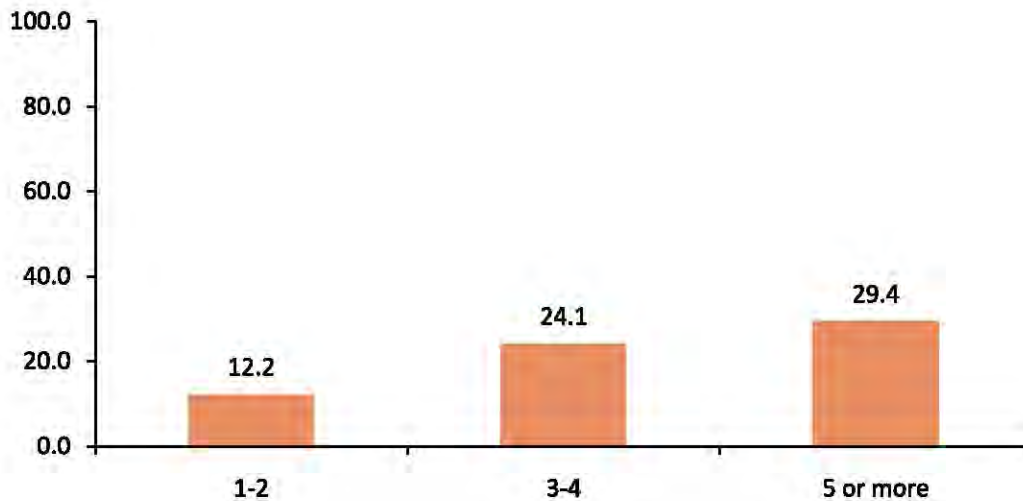


Figure 8.4 indicates the contraceptive prevalence by the number of living children. Those who had more children had a higher contraceptive prevalence rate. A maximum CPR of 29 percent was recorded for women who had 5 or more children.

Figure 8.4: Contraceptive prevalence by number of living children



Contraceptive use was associated with socioeconomic status and residence. Respondents in households with the highest SLI had a substantially higher contraceptive prevalence (25 percent) than those with the lowest SLI (11 percent). Conversely, women from households with a low SLI (71 percent) were more likely to be never users. Similarly, respondents' literacy was associated with slightly higher current use. An association of CPR was observed between SLI in the past users. Owning a television was positively associated with current or past use. Past and current users were more likely to live in urban areas, while more never users lived in rural areas.

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

Characteristic	Contraceptive use status			Total	
	Current user	Past user	Never user	%	N
Standard of living index					
Low	10.8	18.6	70.6	100.0	194
Medium low	19.3	18.3	62.4	100.0	109
Medium high	20.2	21.0	58.8	100.0	119
High	24.8	26.1	49.1	100.0	222
Ownership of television					
Yes	24.1	25.3	50.6	100.0	324
No	13.4	17.8	68.8	100.0	320
Literacy of respondent					
Literate	19.8	18.6	61.6	100.0	177
Illiterate	18.4	22.7	58.9	100.0	467
Residence					
Rural	15.8	19.4	64.8	100.0	525
Urban	31.9	31.1	37.0	100.0	119
Total	18.8	21.6	59.6	100.0	644

Source of Method

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

From this table, it is clear that the source depends on the method. Condoms were obtained mostly from the Lady Health Worker, or by the husband; IUDs were mostly inserted at government facilities or at private hospitals; injectables were mostly obtained through FWC/MSU or private hospitals/clinics/doctors. Female sterilization was nearly always carried out at the private hospitals and to a lesser extent in DHQ hospital. These statements hold true for both current and past users.

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

Source	Family planning method					Total	
	Pill	IUD	Injectables	Condom	Female sterilization	%	N
Govt. hospital (DHQ/THQ)	0.8	0.0	15.9	0.0	38.1	8.1	20
BHU/RHC/MCH center	0.0	33.3	13.0	0.0	0.0	4.1	10
FWC/MSU	3.8	0.0	23.1	0.0	4.8	8.9	22
LHW	10.0	0.0	1.4	8.7	0.0	6.5	16
Pvt. hospital/clinic/doctor	0.8	33.3	20.3	0.0	57.2	11.4	28
Dispenser/Compounder	0.0	0.0	10.1	0.0	0.0	9.7	24
Pharmacy/chemists/grocery shop	8.4	0.0	2.9	0.0	0.0	5.3	14
Husband brings method	64.6	0.0	11.6	91.3	0.0	45.9	112
Total	100.0	100.0	100.0	100.0	100.0	100.0	246
N	130	3	69	23	21	100.0	246

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 this survey, current and past users were asked the reasons they chose a particular method. A 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 suitability for respondent and husband, effectiveness for longer period, convenience of use, no or few side effects and easily available. For injectable users, suitability for respondent/husband and easily available were often cited. Less frequently cited were provider advice, method always available and no other method available. Clients tend to make decisions according to the known attributes of the various methods, but not always. For example, about 19 percent of both current and past pill users cited lack of side effects as a reason for choosing the pill, even though it is in fact associated with a number of common side effects.

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

Reason	Contraceptive method						N
	Pill	IUD	Injectables	Condom	Withdrawal	Female sterilization	
Easily available	83.1	33.3	71.0	91.3	0.0	0.0	179
Low cost	83.8	33.3	59.4	78.3	0.0	9.5	171
Convenient to use	65.4	33.3	53.6	65.2	0.0	0.0	138
Suitable for respondent/ husband	66.2	66.7	71.0	91.3	100.0	81.0	187
No/fewer side effects	18.5	0.0	39.1	65.2	75.0	28.6	81
Can be used for long period	30.0	66.7	49.3	47.8	8.3	81.0	104
No other method available	13.1	0.0	10.1	4.3	8.3	9.5	28
Method always available	62.3	33.3	42.0	60.9	0.0	4.8	126
Provider advised	16.9	0.0	27.5	8.7	0.0	61.9	56
Other	0.8	0.0	0.0	0.0	0.0	0.0	1
N	130	3	69	23	12	21	258

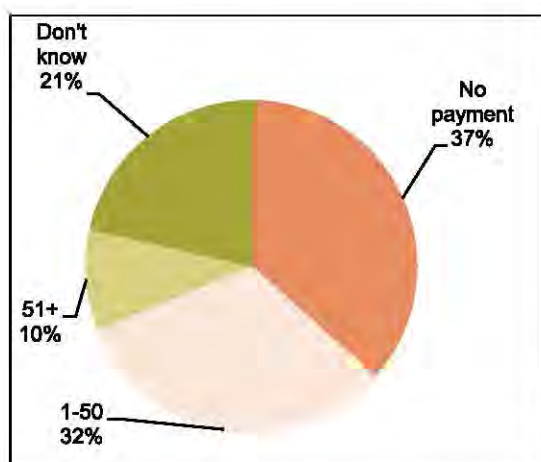
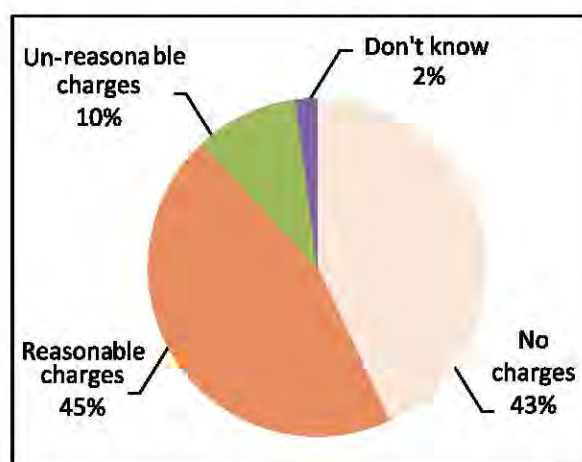
Respondents could give more than one reason.

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 the home to the facility. Table 9.2 and Figure 9.1 show the reported costs the last time the women obtained the method. About 37 percent of the clients reported that they were not charged for the contraceptives, including all female sterilization users (who are in fact typically reimbursed for expenses involved). A great number (21 percent) did not know about charges. However, 10 percent paid more than 50 rupees.

Table 9.2: Distribution of cost of current specific contraceptive method

Method	Cost (in rupees)					Total	
	No payment	1-20	21-50	51+	Don't know	%	N
Pill	24.0	32.0	10.0	2.0	32.0	100.0	50
IUD	50.0	0.0	50.0	0.0	0.0	100.0	2
Injectables	20.0	4.0	40.0	36.0	0.0	100.0	25
Condom	14.3	7.1	14.3	7.1	57.1	100.0	14
Female sterilization	100.0	0.0	0.0	0.0	0.0	100.0	21
Total	36.6	16.1	16.1	9.8	21.4	100.0	112

Figure 9.1A: Cost of contraceptive supply for current method in rupees**Figure 9.1B: Attitude towards service charges for current method other than contraceptive**

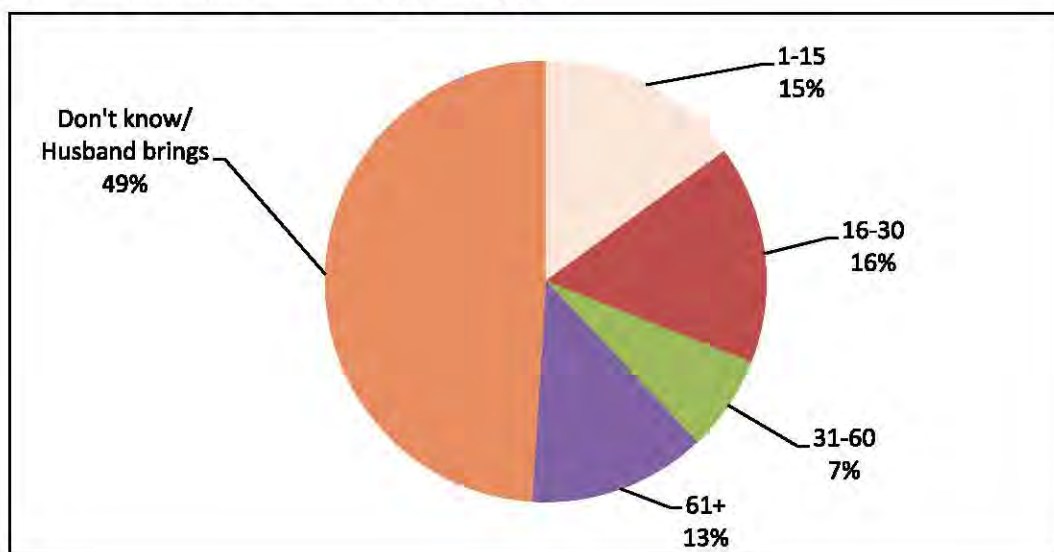
Current users were also asked whether their facility charged them for service, other than the method itself. Forty-three percent said they were not charged, 45 percent were charged a reasonable amount, and 10 percent said they were charged an unreasonable amount.

The time usually needed for current users to obtain a specific method is shown in Table 9.3, while Figure 9.2 shows the overall travel time in minutes to acquire the contraceptive method. Almost half of the respondents (49 percent) were ignorant of the time spent to get the contraceptive as husband brought the method. However, 7 percent claimed to have spent between 30-60 minutes to get the contraceptive.

Table 9.3: Distribution of current contraceptive users by time to reach specific contraceptive service

Method	Time (in minutes)					Total	
	1-15	16-30	31-60	61 or more	Don't know/ husband brought	%	N
Pill	22.0	10.0	2.0	4.0	62.0	100.0	50
IUD	0.0	50.0	0.0	50.0	0.0	100.0	2
Injectables	16.0	32.0	28.0	8.0	16.0	100.0	25
Condom	7.1	0.0	0.0	0.0	92.9	100.0	14
Female sterilization	4.8	19.0	0.0	42.9	33.3	100.0	21
Total	15.2	16.1	7.1	12.5	49.1	100.0	112

Figure 9.2: Travel time 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, list of important topics was read out to them (Table 9.4). The accuracy of clients' responses may be questioned due to problems of recall or understanding it; however, it appears that information provided is seriously inadequate.

The most common topics respondents said they were told about were effectiveness/duration, advantages, how to use the method and how the method works. Some were told about the possible side effects, what to do about them and possibility of switching. A few were told about contraindications.

Table 9.4: Distribution of ever users of contraceptives by information provided at acceptance for specific method

Information provided at acceptance	Family planning method					Total	
	Pill	IUD	Injectables	Condom	Female sterilization	%	N
How the method works	12.3	0.0	42.0	0.0	19.0	19.9	49
How to use the method	15.4	0.0	20.3	8.7	4.8	15.0	37
Contraindications	2.3	33.3	7.2	0.0	0.0	3.7	9
Effectiveness	7.7	66.7	59.4	0.0	85.7	28.9	71
Advantages	10.8	0.0	27.5	4.3	81.0	20.7	51
Possible side effects	8.5	0.0	17.4	0.0	23.8	11.4	28
What to do if experienced side effects	9.2	33.3	23.2	0.0	14.3	13.0	32
Possibility of switching	9.2	0.0	14.5	0.0	0.0	8.9	22
About other FP methods you could use	6.9	0.0	10.1	0.0	52.4	11.0	27
N	130	3	69	23	21	246	246

Respondents could give more than one response.

Treatment at Facility

Current users were asked about various aspects of their treatment when they last visited a provider for family planning. Table 9.5 shows responses were mainly positive. All the respondents were satisfied with the behavior of the provider and all respondents confirmed the availability of staff at the time of their visit. However, 23 percent of respondents said that the provider could not deal with side effects, 57 percent said that the provider demanded charges for services.

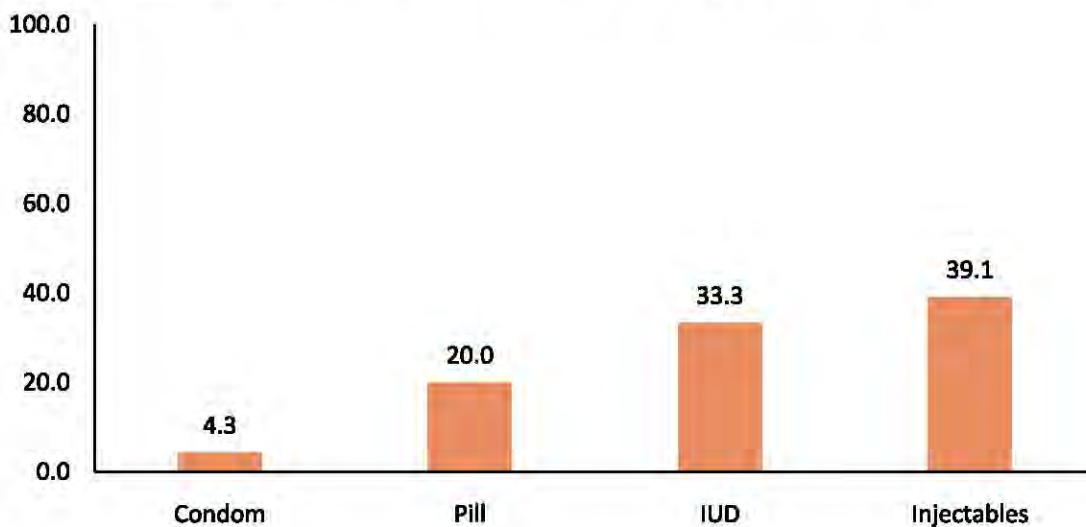
Table 9.5: Percent current users responding positively on treatment at last visit, by aspect of treatment

Aspect of treatment	Percentage
Cooperative/friendly	100.0
Staff always available	100.0
Attend/examine properly	93.6
Doesn't demand charges for services	43.1
Manage side effects properly	76.5

Side Effects

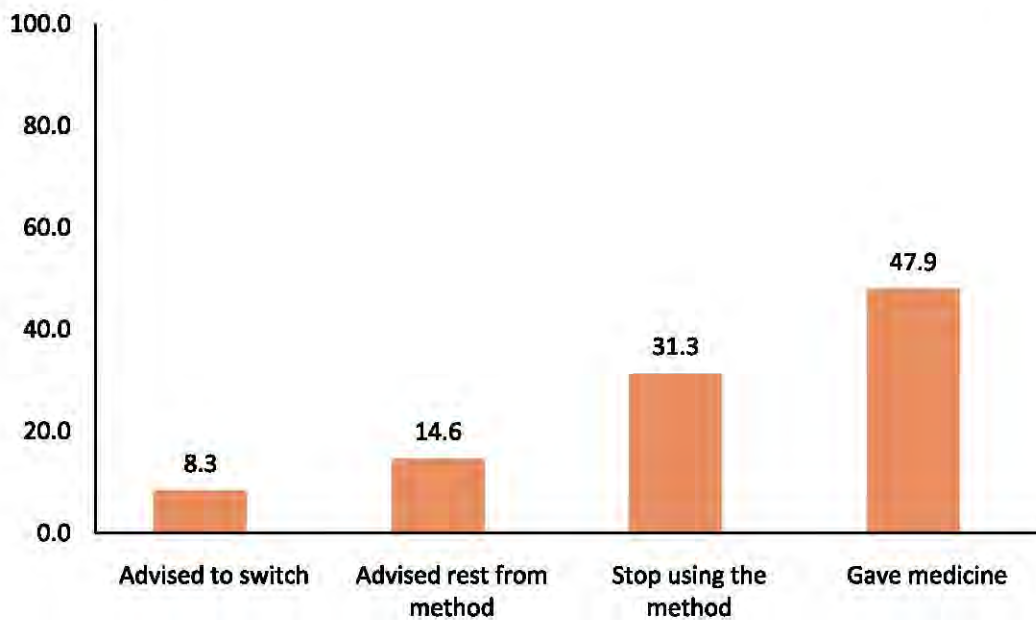
Current users were asked if they had experienced, or were experiencing any side effects from their current method. Past users were asked if side effects were among the reasons for their discontinuation. If so, a list of possible side effects was read out to them, and they were asked if they had experienced them. Multiple responses were allowed. Seven current users and 48 past users (21 percent of all current and past users) responded positively. As shown in Figure 9.3, side effects were most commonly reported by injectables (39 percent), IUD (33 percent), pills (20 percent) and condoms (4 percent) users.

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



The past users who reported experiencing side effects and consulted someone for the management of side effects were asked if the provider had given any of a list of possible responses (Figure 9.4). Forty-eight percent were given medicine, 31 percent advised to stop method, 15 percent were advised to rest from the method and 8 percent were asked to switch to another method.

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



Chapter 10

Reasons for Non-use

There are many reasons why a couple may not be using birth spacing at any given time. The women may already be pregnant, the couple may want another child soon, the women may already have passed menopause, or believe themselves 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.

Some obstacles that couples might face were almost universally acknowledged. Ninety-six percent of non-users mentioned husband's disapproval, followed by fear of side effects (90 percent), management of side effects (89 percent), distance and travel costs to FP outlet (86 percent), probability of getting pregnant while using (82 percent) and FP against religion (78 percent). Religious opposition carries much weight; following that, fear of side effects is the big hindrance. This calls for a strong IEC campaign and may be the subject of interest of communication experts for strategy formulation of IEC.

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

Hindrance	Current user		Past user		Never user	
	N	%	N	%	N	%
Husband's disapproval	119	98.3	135	97.1	370	96.4
Other people may find out about contraceptive use	51	42.1	64	46.0	184	47.9
Distance and travel costs to FP outlet	100	82.6	112	80.6	331	86.2
Probability of getting pregnant while using	96	79.3	110	79.1	314	81.8
Fear of side effects	108	89.3	128	92.1	347	90.4
Problem of managing side effects	109	90.1	121	87.1	342	89.1
FP is against religion	93	76.9	108	77.7	300	78.1
N	121	na	139	na	384	na

Respondents could give more than one response. na=not applicable.

Past Users

Reasons for Discontinuing Contraceptive Use

Table 10.2 shows past users by reason for discontinuing their last contraceptive method (more than one reason was permitted). Several reasons were given. The most common reason given was experienced of side effects (35 percent), followed by wanted another child (32 percent), infrequent sex/husband away (21 percent), method failure (14 percent), husband's advice (13 percent), fear of side effects (12 percent), and rest from method (10 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	31.7
Fear of side effects	11.5
Side effects experienced	34.5
Method failure	14.4
Lack of access/unavailability	3.6
Cost not affordable	2.2
Method inconvenient to use	1.4
Rest from method	10.1
Missed the dose	1.4
Provider's advice	5.0
Infrequent sex/husband away	20.9
Husband's advice	12.9
In-laws oppose	1.4
Menopause	0.7
N	139

Respondents could give more than one reason.

Reasons for Current Non-use

It is important to know the reasons why couples who had used contraception in the past but are not currently using any method. Past users were read out a list of possible reasons for their not currently using a method, with more than one reason possible (Table 10.3). The most common reason was that of breastfeeding/lactational amenorrhea (30 percent), followed by infrequent sex/husband away (24 percent), wanted another child (16 percent) and fear of side effects (15 percent).

Table 10.3: Distribution of past users by reason for current non-use

Reason	Percentage
Fear of side effects	15.1
Want another child	15.8
Infrequent sex/husband away	23.7
Breastfeeding/lactational amenorrhea	30.2
Menopause	0.7
N	139

Respondents could give more than one reason.

Never Users

Reasons for Non-use

The 384 women in the sample who reported never use were asked about various possible reasons for not using any method, with each reason read out separately. For these women, the most important reason was desire for more children (74 percent). Other reasons cited frequently included lactational amenorrhea/ breastfeeding (49 percent), fear of side effects (36 percent), and infrequent sex/husband away (23 percent). A very few reported religious objections (1 percent), which are often cited in other literature as a barrier to family planning use (Table 10.4).

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

Reason	Percentage
Fear of side effects	35.7
Infrequent sex/husband away	23.3
Breastfeeding/lactational amenorrhea	49.1
Respondent/husband infertile	0.3
Wanted (more) children	74.0
Against religion	1.3
Natural spacing	0.3
Others	2.1
N	384

Respondents could give more than one reason.

Attitude towards Birth Spacing and Limiting

It is important to see the extent to which never users disapproved of family planning in principle, as opposed to accepting it in principle but not using any method for some other reason. Table 10.5 shows this for never using respondents. Approval for limiting was greater than for spacing (81 percent and 71 percent respectively).

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

Attitude	Attitude towards spacing births		Attitude towards limiting births	
	N	%	N	%
Approve	271	70.6	311	81.0
Disapprove	110	28.6	69	18.0
Don't know	3	0.8	4	1.0
Total	384	100.0	384	100.0

Knowledge of Contraceptive Users, Methods and Facilities

Of the 384 female never users in the sample, 57 percent reported knowing some woman who had ever used a method to delay or avoid pregnancy. Of the women who knew someone who had used a FP method, 49 percent knew a relative, and 33 percent knew friends or neighbors.

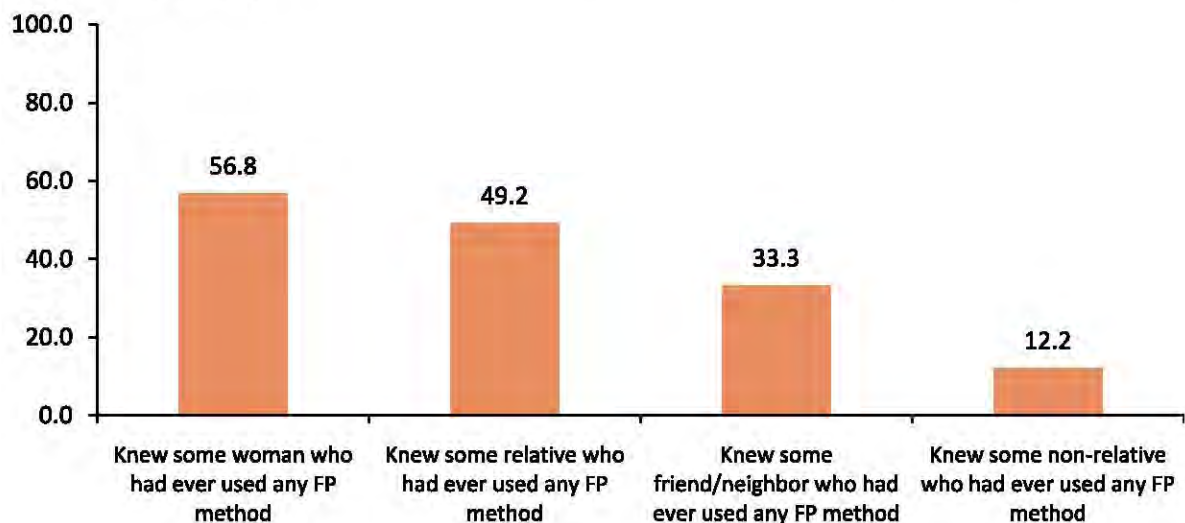
Figure 10.1: Percent of never user women who knew some woman who had ever used any FP method

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

Method	Percentage
Female sterilization	93.5
Male sterilization	9.9
Pill	98.7
IUD	68.2
Injectables	97.7
Norplant	17.7
Condom	71.6
Rhythm	19.8
Withdrawal	39.6
Emergency pills	4.7
Others	5.5
Know at least one FP method	98.7
N	384

Respondents could give more than one response.

Respondents who are never users had somewhat lower levels of knowledge of contraceptive methods (98.7 percent) than ever users (100 percent), as might be expected but not by a great degree. Pills and injectables were the most widely known methods. However, 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. Nevertheless, their knowledge of different sources of contraception was poor.

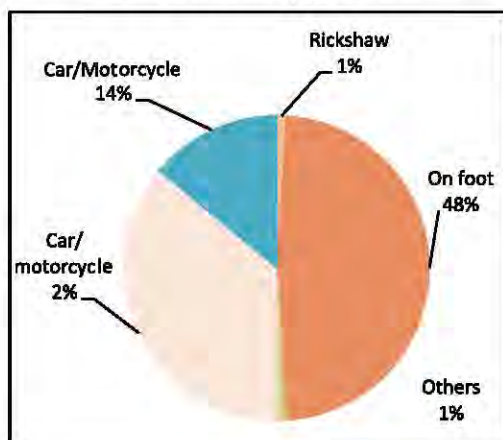
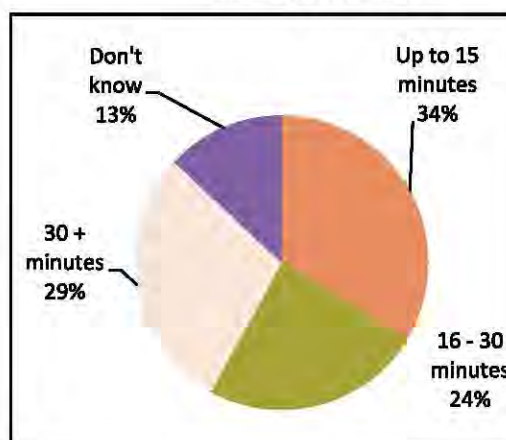
Only 37 percent of the never users knew at least one place to obtain a method. For those who did know, the places they were aware of are shown in Table 10.7. The sources best known were health department outlets – the District/Tehsil Headquarters hospitals, Lady Health Workers and BHUs/RHCs/MCH centers. Substantial numbers knew of pharmacy/chemists as well. A few knew about Family Welfare Centers of the Ministry of Population Welfare, as well as private facilities.

Table 10.7: Knowledge of sources of contraception of never users

Source	Percentage
Knowledge of at least one service provider	36.6
DHQ/THQ hospital	26.3
BHU/RHC/MCH center	8.6
Family Welfare Center	8.6
Lady Health Worker	9.9
Private hospital/clinic/doctor	5.7
Dispenser/compounder	1.8
Pharmacy/chemists	22.9
Homeopath/hakim	0.5
TBA/dai	0.3
Grocery shop (not pharmacy/chemist)	1.6
N	384

Respondents could give more than one response.

When asked which of the facilities named was nearest, the respondents were again most likely to name DHQ/THQ hospitals and BHU/RHC/MCH. Mostly they would go there on foot (Figure 10.2). Of the 140 respondents who indicated the time needed to go to the nearest facility, 34 percent gave a time of 15 minutes or less, 24 percent gave a time frame of 16 to 30 minutes, and 29 percent gave a time of more than 30 minutes (Figure 10.3).

Figure 10.2: Mode of transportation to the nearest facility/provider**Figure 10.3: Time taken to the nearest facility/provider**

Intent to Use

When never users were asked about whether they intended to use contraceptives in the future, 23 percent of the female respondents did show their intention (134 out of 384 respondents who believed they could get pregnant) (Table 10.8). Most of low parity women who had not yet used a method (women with 2 or fewer children) expressed their intent to use a method 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 the future and number of living children

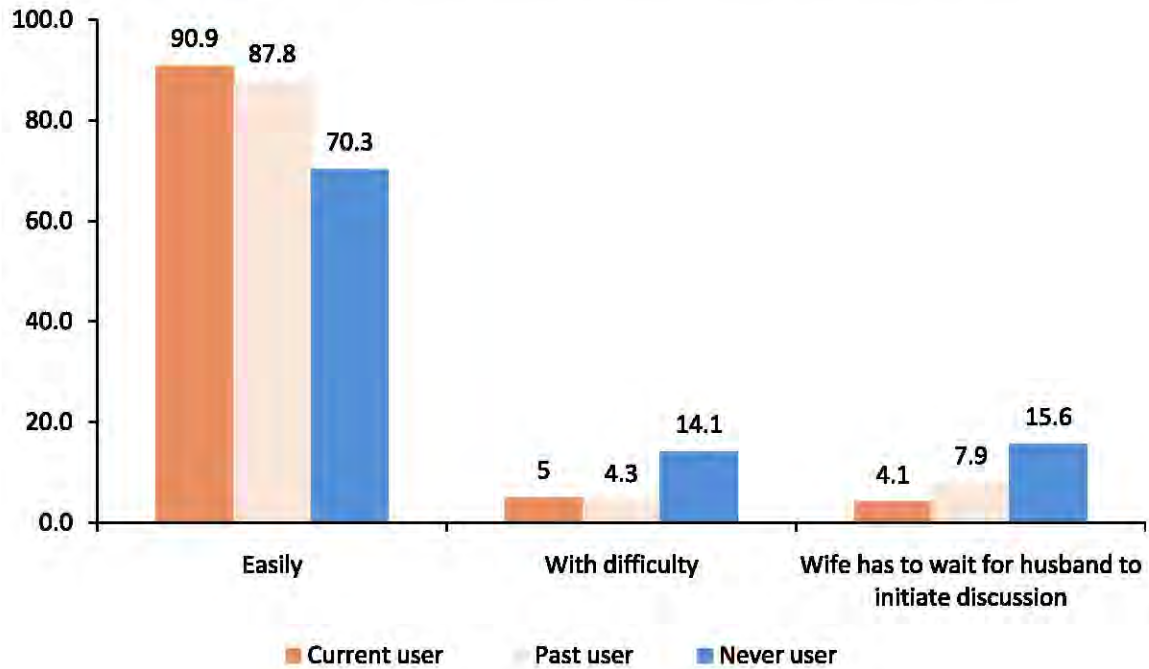
Number of living children	Intent to use any FP method in future				Total	
	Yes	No	Unsure/ uncertain	Can't get pregnant	%	N
0	30.9	36.2	33.0	0.0	100.0	94
1-2	39.0	37.6	23.4	0.0	100.0	141
3-4	15.2	62.1	22.7	0.0	100.0	66
5 or more	20.5	60.2	13.3	6.0	100.0	83
Total	28.9	46.4	23.4	1.3	100.0	384
N	150	183	134	14	na	384

na=not applicable.

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 of the women said they could do so easily (Figure 10.4). However, this varied by use status. Ninety-one percent of current users, and 88 percent of past users, said they could approach their husbands easily, and very few said they had to wait for their husband to initiate the discussion. For never users, 70 percent reported being able to approach their husbands easily, with 14 percent reporting that they could only do so with difficulty, and another 16 percent saying they had to wait for their husband 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 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 contraception. Women currently pregnant or who are experiencing postpartum amenorrhea are said (in this formulation) to be in unmet need if their current or last (if amenorrheic) pregnancy was said to be unwanted or mistimed. Women who want to delay their next pregnancy are said to have an unmet need of spacing; those who do not want more children at all are said to have an unmet need for 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 Kech. Of the total 644 women, 276 (43 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.

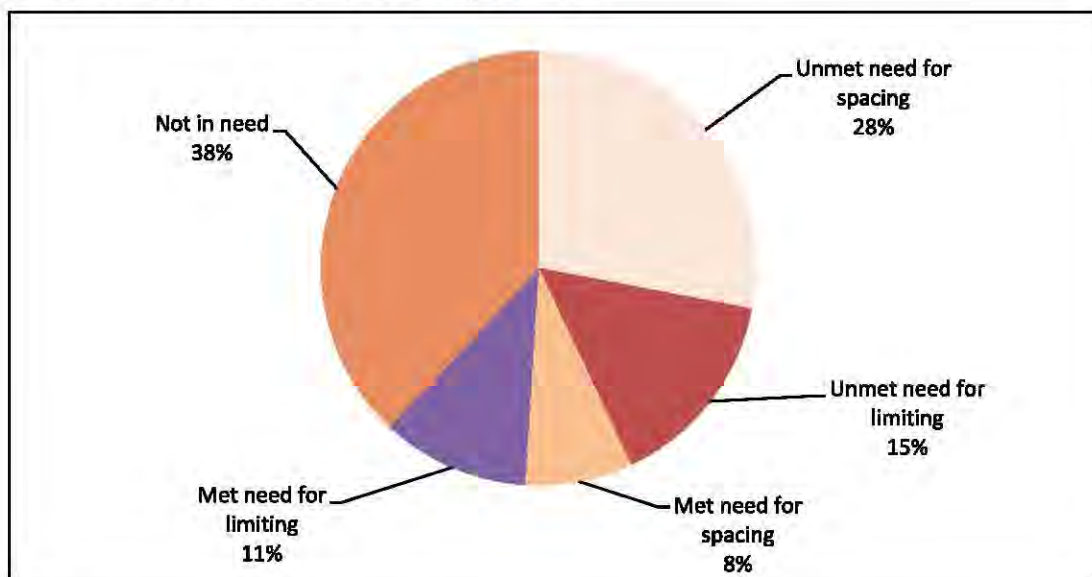
Of the 43 percent women who had unmet need, 28 percent was for spacing, while 15 percent was for limiting. Unmet need for spacing was concentrated among women with 1-4 children. Unmet need for limiting in Kech was high among women with five or more children.

Table 11.1: Need and demand for FP among MWRA by background characteristics

Characteristic	Unmet need			Met need			Total demand	Not in need	Total	N
	For spacing	For limiting	Total	For spacing	For limiting	Total				
Age group										
15 - 24	45.7	1.6	47.3	9.2	1.6	10.9	58.2	41.8	100.0	184
25 - 34	28.5	13.1	41.5	10.0	10.0	20.0	61.5	38.5	100.0	260
35 - 49	11.0	29.5	40.5	3.5	21.0	24.5	65.0	35.0	100.0	200
Residence										
Rural	29.0	14.9	43.8	6.5	9.3	15.8	59.6	40.4	100.0	525
Urban	23.5	15.1	38.7	13.4	18.5	31.9	70.6	29.4	100.0	119
Literacy of respondent										
Literate	31.6	5.1	36.7	13.0	6.8	19.8	56.5	43.5	100.0	177
Illiterate	26.6	18.6	45.2	5.8	12.6	18.4	63.6	36.4	100.0	467
Education of respondent										
No education	25.7	18.3	44.0	5.7	12.6	18.3	62.3	37.7	100.0	470
Up to primary	36.7	14.3	51.0	12.2	8.2	20.4	71.4	28.6	100.0	49
Up to secondary	35.2	2.3	37.5	13.6	4.5	18.2	55.7	44.3	100.0	88
Above secondary	27.0	2.7	29.7	13.5	10.8	24.3	54.1	45.9	100.0	37
Number of children										
0	10.1	0.0	10.1	0.0	0.0	0.0	10.1	89.9	100.0	89
1-2	50.0	0.6	50.6	11.4	1.1	12.5	63.1	36.9	100.0	176
3-4	31.7	9.9	41.5	14.1	7.7	21.8	63.4	36.6	100.0	142
5+	16.0	34.2	50.2	4.2	24.5	28.7	78.9	21.1	100.0	237
Ownership of TV										
Yes	24.1	16.0	40.1	8.6	15.4	24.1	64.2	35.8	100.0	324
No	31.9	13.8	45.6	6.9	6.6	13.4	59.1	40.9	100.0	320
Standard of living index										
Low	33.5	16.0	49.5	5.7	5.2	10.8	60.3	39.7	100.0	194
Medium low	26.6	10.1	36.7	8.3	11.0	19.3	56.0	44.0	100.0	109
Medium high	27.7	17.6	45.4	7.6	12.6	20.2	65.5	34.5	100.0	119
High	23.9	14.9	38.7	9.5	15.3	24.8	63.5	36.5	100.0	222
Total	28.0	14.9	42.9	7.8	11.0	18.8	61.6	38.4	100.0	644

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 strongly associated with age group 35-49 and illiteracy. Unmet need for spacing was associated with age group 15-24, rural residence, literacy and low SLI. 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 shows total demand by background characteristics of the women. Overall, total demand was 62 percent of all married women of reproductive age. As the table shows, total demand rose rapidly, and fairly consistently, by the 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). One third (32 percent) said they would be worried and 34 percent would be pleased if they became pregnant again. Another one-third of the women (31 percent) with unmet

need for spacing said they would accept it. Of those with unmet need for limiting, 75 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 years and those who did not want to have a child at all were not strong enough to adopt 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	56	33.5	5	5.4
Worried	54	32.3	70	75.3
Accept it	51	30.5	16	17.2
Doesn't matter	6	3.6	2	2.2
Total	167	100.0	93	100.0

Reasons of Non-use

Women with unmet need were asked (whether they were never users or past users) why they were not using some method of contraception; the results are shown in Table 11.3. Some of these reasons represent barriers as perceived by the women. The most important of these hindrances were lack of access/unavailability, fear of side effects and opposition by husbands and in-laws as well as cost not being affordable. 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 and currently breastfeeding.

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	36.1	46.9	39.9
Husband opposes	22.2	13.5	19.2
In-laws oppose	17.8	3.1	12.7
Rest from method	0.6	6.3	2.5
Shy to consult about FP	1.1	4.2	2.2
Provider's advice	0.6	10.4	4.0
Against religion	0.6	1.0	0.7
Lack of access/unavailability	20.6	16.7	19.2
Cost not affordable	10.0	3.1	7.6
Don't know any FP method	0.6	0.0	0.4
Just not using/too lazy	4.4	11.5	6.9
Method inconvenient to use	1.1	3.1	1.8
Infrequent sex/husband away	29.4	26.0	28.3
Natural spacing	0.6	0.0	0.4
Difficult/unable to conceive	9.4	5.2	8.0
Want (more) children	60.0	22.9	47.1
Currently pregnant	2.2	1.0	1.8
Breastfeeding/lactational amenorrhea	1.7	3.1	2.2
Others	2.2	3.1	2.5
N	180	96	276

Respondents could give more than one reason.

Unmet Need for Spacing: Profile

Women with unmet need for spacing comprise 180 (28 percent) of MWRA. As shown in Table 11.4, they were characterized by:

- **Living Children:** Most (52 percent) had 1 or 2 living children.
- **Family Planning Use:** More never users (78 percent) than past users (22 percent).
- **Strength of Preference:** Low (32 percent “worried” if they became pregnant earlier than they wanted compared to those who were pleased (34 percent) or accept (31 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** High (about 43 percent intended to use a FP method in future).
- **Approval of FP:** High (78 percent approved of using a FP method for spacing purpose).
- **FP Communication with Husband:** Limited (only 36 percent had communicated with husbands on FP in the past one year; while 23 percent said approaching the husband was “not easy”).
- **Obstacles to FP Use:** Fear of side effects (36 percent); husband and in-laws opposition (22 percent and 18 percent respectively) (Table 11.3).

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	9	5.0	0	0.0
1-2	94	52.2	2	2.1
3-4	50	27.8	18	18.8
5 or more	27	15.0	76	79.2
Contraceptive use status				
Current user	0	0.0	0	0.0
Past user	40	22.2	40	41.7
Never user	140	77.8	56	58.3
Reaction if become pregnant in near future				
Pleased	56	33.5	5	5.4
Worried	54	32.3	70	75.3
Accept it	51	30.5	16	17.2
Doesn't matter	5	3.0	2	2.2
Intention to use a method in future				
Yes	77	42.8	42	43.8
No	64	35.6	42	43.8
Unsure/uncertain	37	20.6	12	12.5
Can't get pregnant	2	1.1	0	0.0
Approval of FP				
Approve	141	78.3	74	77.1
Disapprove	38	21.1	22	22.9
FP communication with husband in past one year				
Never	115	63.9	66	68.8
Once or twice	48	26.7	19	19.8
More often	17	9.4	11	11.5
Approach the topic of FP with husband				
Easily	138	76.7	70	72.9
Not easily	42	23.3	26	27.1
Total	180	100.0	96	100.0

Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 96 (15 percent) of MWRA. As shown in Table 11.4, they were characterized by:

- **Living Children:** A strongly positive association with number of living children; 79 percent had 5+ living children.
- **Family Planning Use:** More never users (58 percent) than past users (42 percent).
- **Strength of Preference:** High (75 percent would be “worried” if they became pregnant compared to those who would be pleased (5 percent) or accept (17 percent) the unwanted pregnancy).
- **Intent to Use FP in Future:** Moderate (about 44 percent intended to use a FP method in future).
- **Approval of FP:** High (77 percent approved of FP for limiting purpose).
- **FP Communication with Husband:** Limited (31 percent had communication with husband on FP in the past year; while 27 percent said approaching the husband was “not easy”).
- **Obstacles to FP Use:** Fear of side effects (47 percent); husbands and in-laws opposition (14 percent and 3 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 Kech, the field team was able to interview 199 men who were husbands of the married women of reproductive age who had been interviewed for the survey, plus 1 married man living in selected areas who was not husband of the female respondent. 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 about 14 percent of the men were under 25 years of age and 12 percent were 50 years of age and above.

As shown in Table 12.1, the men were substantially better educated than the sampled currently married women of reproductive age. Thirty nine percent of the men had not been to school, compared to 73 percent of the currently married women (Table 3.2). It also shows that 14 percent of the men had more than primary education, whereas 8 percent of the currently married women had attained that level of education (Table 3.2).

The occupations of men are also presented in Table 12.1. The highest proportion (25 percent) of men were working as daily wage laborers, while 23 percent were in government service. However, one fifth (20 percent) of men were unemployed in Kech district. More than 14 percent were working either in the private service or their own business.

Table 12.1: Background characteristics of male respondents

Characteristics	Percentage
Age	
15-19	1.0
20-24	12.5
25-29	17.0
30-34	13.0
35-39	17.5
40-44	15.5
45-49	11.5
50-54	8.0
55+	4.0
Education	
Proportion literate	61.0
No education	38.5
Up to primary	14.0
Up to Secondary	27.0
Above secondary	20.5
Occupation	
Agriculture/livestock/poultry	9.5
Petty trader	1.0
Labor	24.5
Govt. service	23.0
Pvt. Service	6.0
Own business	9.5
Abroad	5.5
Unemployed	20.0
Others	1.0
N	200

Contraceptive Knowledge and Use

About 95 percent of the interviewed men in Kech knew of at least one modern method of contraception. As shown in Table 12.2, knowledge of modern methods was highest for pills (89 percent) followed by injectables (79 percent) and condoms (70 percent). The least known methods were Norplant (3 percent), IUD (6 percent) and male sterilization (8 percent). All currently married women of reproductive age interviewed in Kech knew at least one contraceptive method (Table 8.1).

The pattern of ever use and current use of contraception reported by husbands is also shown in Table 12.2. Forty percent of the MWRA reported having used some method of contraception during their married lives (Table 8.2); of the male respondents, 44 percent reported ever using some method of contraception in their married lives. For the men, among modern methods, pills was the most popular method ever used (31 percent), followed by injectables (19 percent) and condoms (13 percent).

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

Method	Knowledge	Ever use	Current use
Female sterilization	43.0	2.0	2.0
Male sterilization	7.5	0.0	0.0
Pill	89.0	31.0	9.5
IUD	6.0	1.0	0.0
Injectables	78.5	19.0	4.5
Norplant	3.0	0.0	0.0
Condom	70.0	13.0	5.5
Rhythm	6.0	1.5	0.5
Withdrawal	12.0	2.5	0.5
Others	1.0	0.0	0.0
At least one FP method	94.5	44.0	22.5
At least one modern FP method	94.0	44.0	21.5
At least one traditional FP method	15.5	4.0	1.0
Emergency Pills	2.0	0.0	na
N	200	200	200

na=not applicable.

As mentioned in Table 8.2, 19 percent of all MWRA in the sample were currently using some method of contraception, while for the male respondents this figure was slightly higher at 23 percent. The most common current modern methods reported by male respondents were pills (10 percent), followed by condoms (6 percent) and injectables (5 percent). Although, about 16 percent of the men knew about traditional methods, only 1 percent of men were using at least one traditional method in Kech. The Emergency pill was also known to 2 percent of the respondents but none of the men reported ever using it.

Table 12.3 shows ever use and current use of modern contraception among respondents by background characteristics. A higher proportion of urban men were currently using a family planning method compared to rural men. About 53 percent of the respondents who had secondary and above education reported ever use of any contraceptive method, compared to 35 percent of men with no education. The current use of family planning also showed the same pattern by education of men.

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

Characteristics	Ever used at least one FP method	Currently using any FP method	N
Residence			
Rural	32.0	15.5	165
Urban	12.0	7.0	35
Education level			
No education	35.1	15.6	77
Below secondary	43.8	20.8	48
Secondary and above	53.3	30.7	75
Number of living children			
None	0.0	0.0	32
1-2	39.5	18.4	38
3-4	56.8	31.8	44
5+	55.8	27.9	86
Future desire for children			
Soon	26.7	11.7	60
Later	39.0	19.5	77
Never	71.9	38.6	57
Don't know/unsure	16.7	16.7	6
Total	44.0	22.5	200

Table 12.3 also shows a positive relationship between the number of living children and ever use as well as current use. Of those who had 3-4 children, 57 percent reported ever use of family planning methods compared to 40 percent who had 1-2 children. The same pattern is observed for current contraceptive use and number of children.

Table 12.3 also shows contraceptive current use by the future desire for children. Highest current use was found among the male respondents who said they did not want any more children: 39 percent of those respondents who did not want more children were currently using a contraceptive method, and 72 percent had used some form of contraception in their reproductive life.

Source of Contraceptive Methods

As shown in Table 12.4, among those who reported the last source for obtaining contraceptive methods, 40 percent reported that they obtained it from pharmacy/ chemist and 19 percent obtained it from the LHWs. “Government hospital (DHQ/THQ)” and “grocery shop/general store” were reported by 8 percent each. FWC and BHU/RHC/MCH were reported by 5 percent and 2 percent, respectively. Only 1 percent of the male respondents reported that they obtained contraceptive methods from private doctors.

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

Source	Percentage
Government hospital (DHQ/THQ)	8.4
BHU/RHC/MCH	2.4
FWC	4.8
LHW	19.3
Pvt. Doctor	1.2
Pvt. hospital/clinic	2.4
Dispenser/Compounder	2.4
Pharmacy, chemist	39.8
Grocery shop/general store	8.4
Others	10.8
Total	100.0
N	83

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 Kech, about 92 percent of the men approved of spacing between children and 88 percent also approved of the use of any form of contraception for this purpose (Table 12.5).

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

Variable	Total
Spacing between children	
Approve	92.0
Disapprove	8.0
Total	100.0
N	200
Using family planning methods for spacing	
Approve	88.0
Disapprove	11.5
Others	0.5
Total	100.0
N	200

Satisfaction Level of Current Users

Satisfaction of the user 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 84 percent of the current users were very satisfied with their current method; only 2 percent reported that they were not satisfied with their current method. About 14 percent of the current users reported being somewhat satisfied with their current method. These users would seem to be in need of more information on their current method as well as on other available methods, so that they continue using a family planning method.

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

Level of satisfaction	Percentage
Very satisfied	83.7
Somewhat satisfied	14.0
Not satisfied at all	2.3
Total	100.0
N	43

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	34.9
Fear of side effects	30.2
Want another child	46.5
Method failure	20.9
Method inconvenient to use	9.3
Rest from method	67.4
Health concern	32.6
Service provider's advice	9.3
Wife opposes	4.7
In laws/parents oppose	2.3
N	43

Respondents could give more than one reason

The reasons why male respondents stopped using their last method are presented in Table 12.7. The table shows that rest from method (67 percent) was the main reason for stopping the use of a family planning method followed by desire for another child (47 percent). However, 35 percent of past male users stopped using their method because of side effects the couple experienced with their method and 31 percent due to fear of side effects. Twenty one percent of the past users stopped using a contraceptive due to method failure. Nine percent left the use on provider's advice.

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 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-four percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, 53 percent of the men reported that their wives had never approached them during the last year on this issue. Thirty nine percent of the men reported that their wives had talked more often about this subject during the last year, while 8 percent reported they had talked about it once or twice.

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

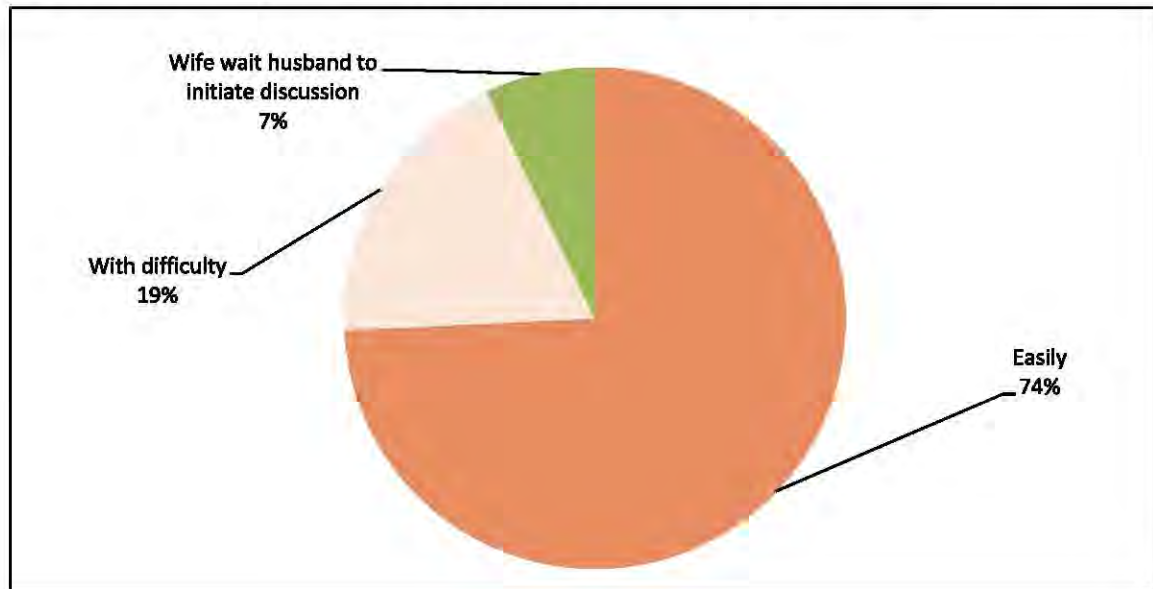
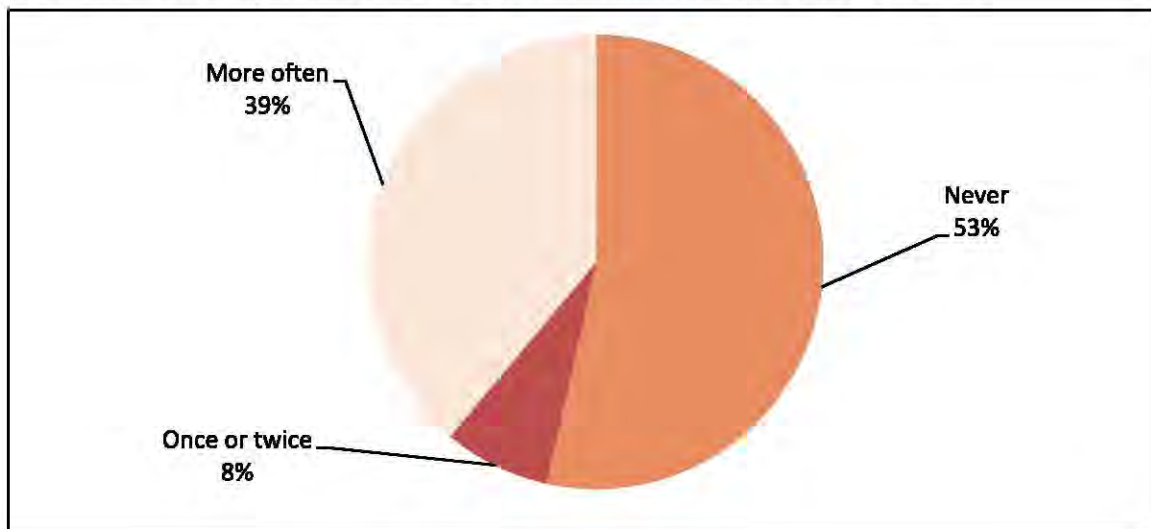


Figure 12.2: Men's reports of frequency of discussion on FP with wife in last year



Potential Users

Men who were non-users of contraception were asked about their intended future use of contraception and their method preferences. Table 12.8 shows that only 28 percent intended to use contraception in the future, while 32 percent did not intend to do so. A great majority (40 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	27.7
Will not use	32.1
Unsure/uncertain	40.2
Total	100.0
N	112

As shown in Table 12.9, the major reason husbands said they did not intend to use contraception was the desire for more children (92 percent), followed by fear of side effects (36 percent). Thirty one percent reported breastfeeding/lactational amenorrhea, while 25 percent reported difficult/unable to conceive. It is also pertinent to mention that 14 percent men were shy to go to FP clinic.

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

Reason	Percentage
Wife opposes	5.6
In laws/parents oppose	5.6
Fear of side effects	36.1
Lack of access/unavailability	11.1
Cost too much	11.1
Shy to go to FP clinic	13.9
Inconvenient to use	8.3
Infrequent sex/respondent away	13.9
Difficult/unable to conceive	25.0
Breast feeding/ lactational amenorrhea	30.6
Respondent/wife infertile	2.8
Want more children	91.7
N	36

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 no one reported the intention to use male methods. Pills and Injectables were the main contraceptive methods proposed to be used in future.

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

Method	Percentage
Pills	48.4
Injectable	25.8
Condom	19.4
Others	6.5
Total	100.0
N	31

Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 12.11 shows that 30 percent of the respondents wanted another child soon (within two years). About 39 percent of the respondents wanted to delay their next child for more than two years and 29 percent did not want any more children at all.

The desire to stop having children was positively associated with the number of living children. Thirteen percent of the respondents who had 3 children did not want more children, while 67 percent of those who had 6 or more children did not want more children.

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

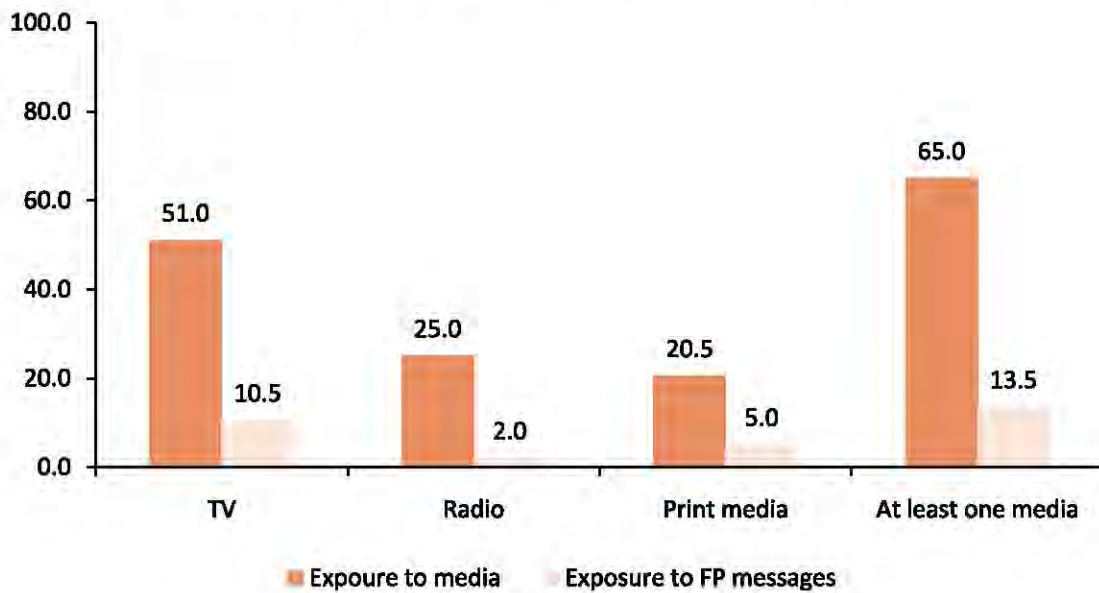
Number of living children	Desire for next child				Total	
	Soon	Later	Never	Don't know/ unsure	%	N
0	53.1	46.9	0.0	0.0	100.0	32
1	54.2	45.8	0.0	0.0	100.0	24
2	35.7	64.3	0.0	0.0	100.0	14
3	33.3	53.3	13.3	0.0	100.0	15
4	31.0	48.3	13.8	6.9	100.0	29
5	22.7	40.9	36.4	0.0	100.0	22
6+	9.4	17.2	67.2	6.3	100.0	64
Total	30.0	38.5	28.5	3.0	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 radio were the most commonly accessed mediums as 51 percent of the male respondents in Kech watched TV and 25 percent listened to the radio.

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. Eleven percent of the men had seen FP messages on television. Overall, 14 percent of the male respondents and 10 percent of the MWRA had seen a family planning message on at least one medium. Only 2 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



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