Baseline Household Survey

Khuzdar
District

May 2010

Family Advancement for Life and Health (FALAH)

Khuzdar

Baseline Household Survey

May 2010

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Population Council

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Glossary of Terms

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

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

Executive Summary

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

The survey was conducted between March and June of 2008 in a probability sample of 520 households in 40 clusters in Khuzdar. It included interviews with 639 currently married women aged 15-49 ("married women of reproductive age", or MWRA), along with 198 married men, of whom 189 were married to the women included in the sample. As a separate activity, a mapping study was also carried out in Khuzdar during the period between May and July, 2008. The FALAH project is primarily focused on birth spacing and family planning.

Household and Respondent Characteristics

Khuzdar is a primarily rural district of Baluchistan. 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 Khuzdar household survey

Variable	Value
Percentage of household population in rural areas	75.1
Percentage of households with electricity	66.1
Percentage of households with indoor water supply	36.9
Percentage of households with flush toilet	17.2
Percentage of households with a television	29.4
Percentage of literate female respondents	5.9
Percentage of respondents with literate husbands	41.4
Total fertility rate	**5.7**

Electricity was available in 66 percent of the sampled households. Thirty-seven percent of the households had some indoor water supply and only 17 percent had a flush toilet, while 55 percent had some type of latrine. According to the Planning Commission's Pakistan Millennium Development Goals Report 2006, Khuzdar stood 59th nationally in sanitation rankings. On the other hand, literacy was relatively low as only 6 percent of the female

respondents were literate while 41 percent of their husbands were literate. Twenty-nine percent of the households in Khuzdar reported owning a television and 36 percent reported owning a radio. About 18 percent of the respondents said they watched TV, 4 percent listened to radio, and less than 2 percent read newspapers or magazines. Overall, 21 percent of the women reported access to at least one form of media and 11 percent had exposure to FP messages through any of these mediums.

Fertility

In Khuzdar, the crude birth rate was 39 births per thousand population, and the total fertility rate was 5.7 children per woman. Fertility was higher for illiterate women and wives of illiterate husbands. However, there was no urban-rural difference in fertility. Many births were spaced too closely; for example, almost 88 percent of the closed birth intervals were less than 36 months. About 46 percent of all current pregnancies in the sample were among women who already had at least two children under five years of age, and 14 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 448 sampled women who had delivered a child during the previous four years. Of these women, only 27 percent had visited a health provider at least once for antenatal care; 11 percent had at least two tetanus toxoid immunizations; 7 percent were delivered by a skilled birth attendant; and 5 percent were delivered in a health facility, public or private. On the other hand, only 6 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 Khuzdar baseline survey

Indicator	Value
Percentage of mothers with at least one antenatal care visit	27.0
Percentage of mothers who received at least two tetanus shots	11.0
Percentage of most recent deliveries conducted by a skilled birth attendant	6.7
Percentage of most recent deliveries carried out in a facility	4.7
Percentage of MWRA not wanting more children	31.0
Percentage of MWRA wanting to delay next birth for at least two years	28.0
Percentage of MWRA with knowledge of at least one contraceptive method	100.0
Contraceptive prevalence rate	17.4
Percentage of MWRA who were past users of contraception	7.4
Percentage of MWRA with unmet need for family planning	34.0
Percentage of MWRA with unmet need for spacing	18.6
Percentage of MWRA with unmet need for limiting	15.3
Total demand for family planning (CPR + unmet need)	**51.3**

Preference for Children

The median "ideal" family size, according to the women respondents, was 6 children. Regarding desire for more children in the future, 40 percent said they wanted another child soon (within two years), 28 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. Fifty percent of the women respondents thought that their husband wanted the same number of children that they did, while one-third 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 17 percent. The most common currently used methods were injectables (7 percent), pills (4 percent) and female sterilization (3 percent). Condom use was relatively low (2 percent). Past users comprised 7 percent of MWRA; injectables and pills were common past methods. Fifty-eight percent of current users did not want more children, while 42 percent

wanted more, but at a later time. Most users reported obtaining their supplies and services from DHQ/THQ hospitals, or their husband brought the supplies.

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 22 percent paid more than Rs.50 the last time they obtained their method). Regarding the time required to reach the supply point, 12 percent reported requiring more than 30 but less than 60 minutes. It is worth mentioning that 81 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. Seventy-three percent of clients reported being examined properly; however, one-third of the respondents reported that the staff was not 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, family planning against religion, fear of side effects and problems with management of side effects. Relatively less often mentioned were distance/cost and other people might find out about their contraceptive use. Least mentioned was probability of getting pregnant during use of contraceptives. Past users were most likely to discontinue use because they wanted more children followed by experience of side effects, husband's advice and rest from method. Past users' most common reason for current non-use was desire for another child; other reasons most often related to childbearing and rest from method. Never users were most likely to say they were not using for reasons related to desire for more children, husband's opposition, lack of access to the methods, fear of side effects, affordability and breastfeeding but only 1 percent mentioned religious concerns. All never users knew at least one FP method but knowledge of contraceptive sources was noticeably lower; only 39 percent of never users knew one place to obtain contraceptive supply/method. About 31 percent of never users expressed their intent to use contraception in the future. This indicates that a substantial number of women in Khuzdar 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, 34 percent of the women in this sample were in unmet need, 15 percent for limiting and 19 percent for spacing. Unmet need for limiting was higher in urban areas and among illiterate women. However, unmet need for spacing was higher among literate women.

Reproductive Preferences and Behavior of Men

The findings reveal that all men knew at least one modern contraceptive method. Male sterilization was one of the least known contraceptive methods among men in Khuzdar. Only 20 percent of the men did not want more children in the future or wanted to delay the next pregnancy. Sixteen percent of the male respondents reported that they or their wives were currently using any family planning method. Among the current users, more than 87 percent were very satisfied with their current contraceptive method.

Of those who were not using a contraceptive method, a majority (69 percent) reported that they were uncertain if they would use any FP method in future. Opposition from wives/parents/in-laws 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

Khuzdar district was characterized by a relatively weak infrastructure and low standard of living. Though knowledge and approval of family planning was very high in Khuzdar but 17 percent contraceptive prevalence rate was lower than that of Pakistan as a whole. There is much need for improvement: unmet need for family planning remains high at 34 percent. Among the important reasons that should be addressed in an improved program are the attitudes of husbands and in-laws, husband-wife communication, fear of side effects, and knowledge of various contraceptives and their sources. Also, the concept of birth spacing needs to be stressed to lengthen birth intervals, which are often too short.

Chapter 1

Introduction

Background

The FALAH Project

The Family Advancement for Life and Health (FALAH) 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, Liyari and Godap), 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 Khuzdar, district-level activities are being coordinated by Mercy Corps, with Greenstar providing information and service through social marketing and other partners supporting specific activities as needed.

Khuzdar District

Khuzdar is primarily a rural district of Balochistan province. The overall population of the district was estimated to be 0.53 million in 2008, with a population density of around 15 persons per kilometer. Geographically the district is bounded on the north and northwest by Kalat and Kharan districts, on the east by Bolan, Jhal Magsi and Lasbela districts, and Larkana and Dadu districts to the southeast.

In 1998 the district had 1 hospital, 17 BHUs, 38 dispensaries, 2 RHCs, and 5 sub-health centers. The district also provided education facilities, although the ratio for female education centers was low (Population Census Organization, 2000).

In the Planning Commission's Millennium Development Goals Report of 2006 (United Nations, 2006), Khuzdar stood 86th on literacy, 70th on immunization, and 85th on water supply and 59th on sanitation nationally (Planning Commission of Pakistan, 2006).

The Khuzdar Baseline Household Survey

In Khuzdar (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 Khuzdar 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 Khuzdar 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. The number of blocks selected in urban areas and the number of villages selected in rural areas are presented in Table 1.1. A total of 40 blocks/villages were selected, with 13 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 selected. The maps of these circles were obtained from the Population Census Organization and were already divided into blocks of approximately 250-300 households depending upon the

number of households in each circle. Following this, one block was randomly selected from each circle. The household listing of each block was then carried out by the enumeration teams before selecting the sampled households. A fixed number of 13 households was 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 a 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 13 households was selected from each sample enumeration village by the systematic random technique.

Selection of Respondents

Within each household, all married women aged 15-49 (MWRA) 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 13 sampled households, additional interviews were sought from neighboring households.

Table 1.1 presents the planned and enumerated number of households and eligible women of reproductive age in Khuzdar.

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

Result	Rural	Urban	Total
Sample blocks/villages	29	11	40
Planned households	377	143	520
Households interviewed	376	141	517
Households contacted	377	143	520
(Households refused)	1	2	3
Eligible women identified	478	173	651
(Eligible women refused)	5	7	12
Total women's interviews	**473**	**166**	**639**

Questionnaire Design

Two questionnaires, one for women and the other for men, were developed for this survey. 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 Quetta. 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 to interview 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 was conducted by the Population Council in Quetta. During the training, interviewers conducted 2-3 field interviews in order to prepare for the actual interview process.

Training regarding the importance of the criteria 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 Khuzdar district was carried out between March 17 and June 19, 2008.

Chapter 2

Household Characteristics

Geographic Distribution

The district of Khuzdar is primarily a rural district. Table 2.1 shows the distribution of the population of sample households according to residence (urban and rural).

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

Residence	Sample household population		1998 Census %
	N	%	
Rural	3107	75.1	71.7
Urban	1030	24.9	28.3
Total	**4137**	**100.0**	**100.0**

As Table 2.1 shows, the distribution of the population of the sampled households by urban-rural residence closely follows the distribution recorded for the whole district in the 1998 Population Census (Population Census Organization, 2000), where Khuzdar district was about 72 percent rural, 28 percent urban.

Age-Sex Distribution

Table 2.2 shows the population distribution of the sampled households by age and sex. The population distribution was typical of a society with high fertility, with 50 percent of the population being under 15 years of age. Data show that there were 0.8 percent more children in age group 5-9 years as compared to the age group 0-4 years, with almost the same pattern for males and females. This suggests some decline in fertility levels.

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

| Age group | Sex of household member | | | | | |
| | Male | | Female | | Total | |
	N	%	N	%	N	%
00 – 04	403	19.0	382	18.9	785	19.0
05 – 09	422	19.9	395	19.6	817	19.8
10 – 14	244	11.5	218	10.8	462	11.2
15 – 19	166	7.8	142	7.0	308	7.5
20 – 24	153	7.2	195	9.7	348	8.4
25 – 29	153	7.2	209	10.4	362	8.8
30 – 34	153	7.2	126	6.3	279	6.7
35 – 39	88	4.2	79	3.9	167	4.0
40 – 44	69	3.3	50	2.5	119	2.9
45 – 49	38	1.8	58	2.9	96	2.3
50 – 54	63	3.0	79	3.9	142	3.4
55 – 59	48	2.3	37	1.8	85	2.1
60 – 64	66	3.1	24	1.2	90	2.2
65 – 69	20	0.9	7	0.3	27	0.7
70 – 74	21	1.0	12	0.6	33	0.8
75+	11	0.5	3	0.1	14	0.3
Total	**2118**	**100.0**	**2016**	**100.0**	**4134**	**100.0**

Of the total population of the sampled households, 21 percent (859 women of the total population of 4134) consisted of females 15-49 years of age, and 19 percent consisted of children under 5 years of age. These 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 Khuzdar (as in Pakistan generally), two trends can be identified: first, in general women get married at an early age, and, second, that women marry men who are much older than they are. Table 2.3 shows that a higher proportion of women at younger ages were married than men of the same age. On the other hand, no men were married in the age group of 15-19, which shows that the marital age for men was higher than that of women. This difference may be a result of economic pressures. The singulate mean age at marriage was 25 years for men and 21 years for women.

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

Age group	Married		Widow/divorced/separated		Never married	
	Female	**Male**	**Female**	**Male**	**Female**	**Male**
15 – 19	17.7	0.0	0.0	0.0	82.3	100.0
20 – 24	66.7	26.8	0.5	0.0	32.8	73.2
25 – 29	91.9	77.1	1.9	1.3	6.2	21.6
30 – 34	97.6	99.3	1.6	0.7	0.8	0.0
35 – 39	98.7	96.6	1.3	1.1	0.0	2.3
40 – 44	95.9	100.0	2.0	0.0	2.0	0.0
45 – 49	93.1	97.4	6.9	2.6	0.0	0.0
50 – 54	92.3	96.8	7.7	3.2	0.0	0.0
55 – 59	55.6	97.9	41.7	2.1	2.8	0.0
60 – 64	60.9	98.5	39.1	1.5	0.0	0.0
65 – 69	71.4	85.0	28.6	15.0	0.0	0.0
70 – 74	33.3	90.5	66.7	4.8	0.0	4.8
75+	33.3	81.8	66.7	9.1	0.0	9.1
All ages 15+	**75.3**	**68.7**	**5.4**	**1.3**	**19.3**	**30.0**

Household Characteristics and Wealth Indicators

Several household characteristics were assessed that reflect the wealth and well-being of its inhabitants. Some of these may have a 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. Slightly more than one-third of households (37 percent) had an indoor water supply, although the considerable majority of these households were in urban areas (72 percent) as compared to rural area (24 percent). Motorized/hand pumps were negligible (only 2.3 percent), while most of the households had wells (29 percent), followed by those who used the government water supply (26 percent).

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

	Rural		Urban		Total	
Characteristic	N	%	N	%	N	%
Main source of drinking water						
Govt. supply (tap water inside)	56	14.9	67	47.9	123	23.9
Govt. supply (tap water communal)	7	1.9	3	2.1	10	1.9
Motorized/hand pump(inside)	11	3.0	1	0.7	12	2.3
Well (inside)	22	5.9	33	23.6	55	10.7
Well (outside)	87	23.2	6	4.3	93	18.1
Tube-well	73	19.5	16	11.4	89	17.3
River/canal/stream	43	11.5	8	5.7	51	9.9
Spring	76	20.3	6	4.3	82	15.9
Sanitation facility						
Flush to sewerage	7	1.9	22	15.7	29	5.6
Flush connected to septic tank	2	0.5	11	7.9	13	2.5
Flush connected to open drain	19	5.1	28	20.0	47	9.1
Raised latrine	10	2.7	0	0.0	10	1.9
Pit latrine	193	51.3	79	56.4	272	52.7
No toilet (in fields)	145	38.6	0	0.0	145	28.1
Main type of fuel used for cooking						
Firewood	366	98.1	125	89.3	491	95.7
Gas cylinder	3	0.8	14	10.0	17	3.3
Dry Dung	4	1.1	1	0.7	5	1.0
Electrical connection	205	54.7	136	96.5	341	66.1
Main material of the roof						
Iron sheet	1	0.3	11	7.9	12	2.3
Guarder and T-iron	39	10.4	72	51.8	111	21.6
Wood/bamboo and mud	334	89.3	56	40.3	390	76.0
Main material of the floor						
Earth/sand/mud	366	97.9	90	64.7	456	88.9
Chips/cement/bricks	8	2.1	49	35.3	57	11.2
Main material of the walls						
No walls	4	1.1	0	0.0	4	0.8
Burnt bricks/blocks	50	13.4	33	23.9	83	16.3
Mud bricks/mud	235	63.2	94	68.1	329	64.5
Wood/bamboo	68	18.3	11	8.0	79	15.5
Stones	15	4.0	0	0.0	15	2.9
Total	**376**	**100.0**	**140**	**100.0**	**516**	**100.0**

Figure 2.1 show that a very small number of households (17 percent) had some type of flush toilet. The situation was better in urban areas (44 percent), while in rural areas only 7 percent had some kind of flush toilet, which is indicative of an unhygienic environment. About 55 percent of households had a raised or pit latrine, while 28 percent had no toilet at all.

Ninety-six percent of the households used firewood for cooking, 3 percent used gas, (urban - 10 percent; rural - 1 percent) and 1 percent used dry dung. Sixty-six percent of the households had electricity. In urban areas, almost all (97 percent) of the households had an electric connection, while in rural areas the figure was 55 percent. More than three-quarters of the houses were roofed with wood/bamboo and mud (76 percent), while only 16 percent of the walls were made of burnt bricks or cement blocks.

Figure 2.1 Toilet facilities for Khuzdar households
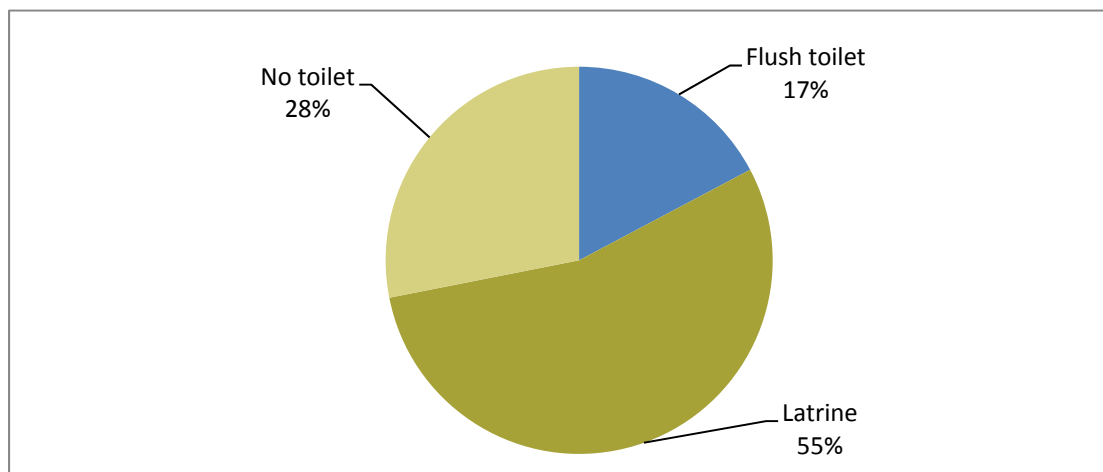
Ownership of Household Assets

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 appears to show the expansion in consumer purchasing power that has characterized Pakistan in recent years. Television was available to only 29 percent of the households, while radio was available to 36 percent of the households. This could be of particular interest to communications specialists in developing communication strategies for the district. The recent expansion of information technology in Pakistan was relatively less visible in Khuzdar district where only 18 percent of households had mobile phones, though residence made a big difference: in urban areas 60 percent of the households had a mobile phone compared to only 2 percent in rural areas. Only 1 percent of the sampled households had a computer. Motorized transport was fairly uncommon, suggesting difficulties in arranging for transport in health emergencies, though 59 percent of the households owned a motorcycle (55 percent rural; 72 percent urban).

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

Household item	Rural	Urban	Total
Wall clock	81.1	99.3	86.1
Chairs	1.6	5.0	2.5
Bed	24.6	48.6	31.1
Sofa	1.1	2.9	1.6
Sewing machine	40.4	70.2	48.5
Camera	2.7	14.2	5.8
Radio/tape recorder	27.4	59.6	36.2
Television	15.4	66.7	29.4
Refrigerator	4.5	49.6	16.8
Land line telephone	5.6	29.1	12.0
Mobile phone	1.9	59.6	17.6
Room cooler/air conditioner	1.6	9.9	3.9
Washing machine	17.8	70.2	32.1
Bicycle	37.9	26.2	34.7
Motorcycle	54.5	71.6	59.2
Jeep/car	4.8	12.8	7.0
Tractor	3.5	4.3	3.7
Computer	0.5	2.1	1.0
N	**376**	**141**	**517**

Standard of Living Index

It is worthwhile to use the above data to get an overall index of the economic well-being of a household, both for making 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 12. Table 2.6 gives the distribution of the SLI for the sample households according to urban and rural residence. The median index for all households was 4; the median index was 3 for rural households and 7 for urban households. Sixty-two 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 reproductive health knowledge and behavior.

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	47	12.5	0	0.0	47	9.1
1	39	10.4	0	0.0	39	7.5
2	69	18.4	2	1.4	71	13.7
3	72	19.1	14	9.9	86	16.6
4	51	13.6	7	5.0	58	11.2
5	47	12.5	24	17.0	71	13.7
6	21	5.6	22	15.6	43	8.3
7	20	5.3	15	10.6	35	6.8
8	4	1.1	22	15.6	26	5.0
9	3	0.8	20	14.2	23	4.4
10	1	0.3	13	9.2	14	2.7
11	2	0.5	2	1.4	4	0.8
Total	**376**	**100.0**	**141**	**100.0**	**517**	**100.0**
Median	3	na	7	na	4	Na

na = not applicable.

Chapter 3

Respondent Characteristics

The primary sources of data from the Household Survey are the interviews conducted with 639 currently married women of reproductive age. The background characteristics of these respondents are described in this chapter.

Age

Table 3.1 shows the age distributions of the female respondents for rural and urban areas. Since many younger women were not married yet, the numbers at age 15 - 19 years were relatively small. At older ages, the numbers declined. More than half of the sample respondents were under age 30.

Table 3.1: Age distribution of female respondents by residence

Age group	Rural		Urban		Total	
	N	%	N	%	N	%
15 - 19	20	4.2	4	2.4	24	3.8
20 – 24	95	20.1	33	19.9	128	20.0
25 – 29	145	30.7	43	25.9	188	29.4
30 – 34	84	17.8	38	22.9	122	19.1
35 – 39	56	11.8	20	12.0	76	11.9
40 – 44	29	6.1	17	10.2	46	7.2
45 – 49	44	9.3	11	6.6	55	8.6
Total	**473**	**100.0**	**166**	**100.0**	**639**	**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. The 6 percent literacy rate for

women was very low compared to the 41 percent for husbands. The literacy of females (aged 15+ years) recorded in PSLMS 2004-05 was 36 percent for Pakistan and 14 percent for Balochistan. For Khuzdar it was 7 percent. Similarly, only 3 percent of the female respondents reported having ever attended school up to secondary level. Table 3.2 also shows that younger women (aged 15-24 years and 25-34 years) were more literate than older women (35-49 years).

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

Variable	Age group			Residence		
	15 – 24	**25 - 34**	**35 - 49**	**Rural**	**Urban**	**Total**
Respondent(women)						
Proportion literate	8.8	6.9	1.7	4.3	10.2	5.9
Education level(women)						
No education	90.7	92.6	98.3	95.1	89.8	93.7
Up to primary	4.0	2.9	1.1	1.9	4.8	2.7
Up to secondary	4.0	3.9	0.6	2.8	3.6	3.0
Above secondary	1.3	0.6	0.0	0.2	1.8	0.6
N	**151**	**309**	**177**	**471**	**166**	**637**
Respondent's husband						
Proportion literate	47.0	40.3	38.3	35.1	59.7	41.4
Education level (husband)						
No education	56.7	64.2	64.7	67.0	50.3	62.5
Up to primary	10.0	6.4	9.4	7.0	11.0	8.1
Up to secondary	23.3	19.7	16.5	17.5	25.8	19.7
Above secondary	10.0	9.7	9.4	8.5	12.9	9.7
N	**150**	**299**	**170**	**458**	**163**	**619**

For both women and their husbands, the literacy and education levels were higher in urban areas. Literacy for women was substantially lower than that of men.

Figure 3.1: Literacy status of women and their husbands
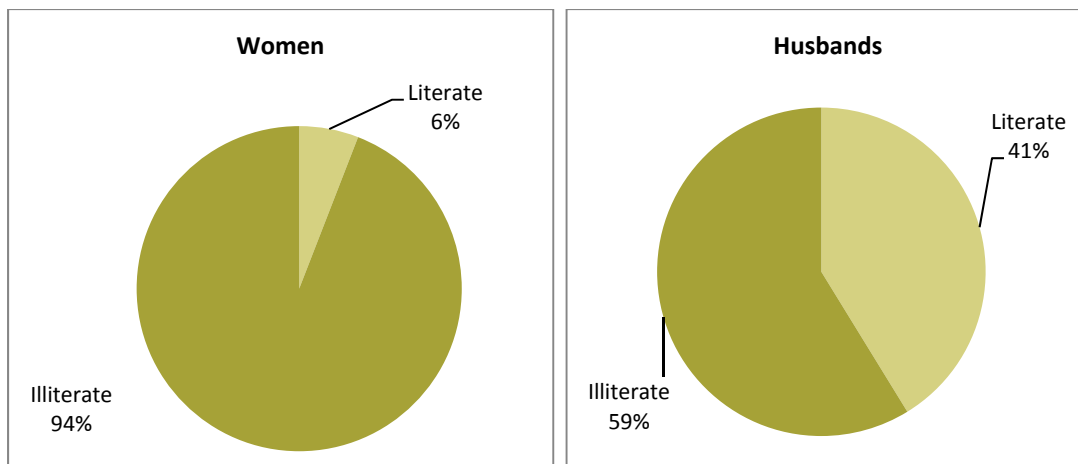
Occupation and Work Status

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 life-style. Men in general are expected to work for pay; the question is, doing what? In Khuzdar district 187 women out of the 639 total women (29 percent) were working for pay. Their occupations are shown in Figure 3.2. This shows higher female participation for economic survivability, women mostly did embroidery/stitching (67 percent) followed by livestock (19 percent).

In this situation, women's time spent working for pay 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.

Figure 3.2: Type of work of women working for pay (n=187)
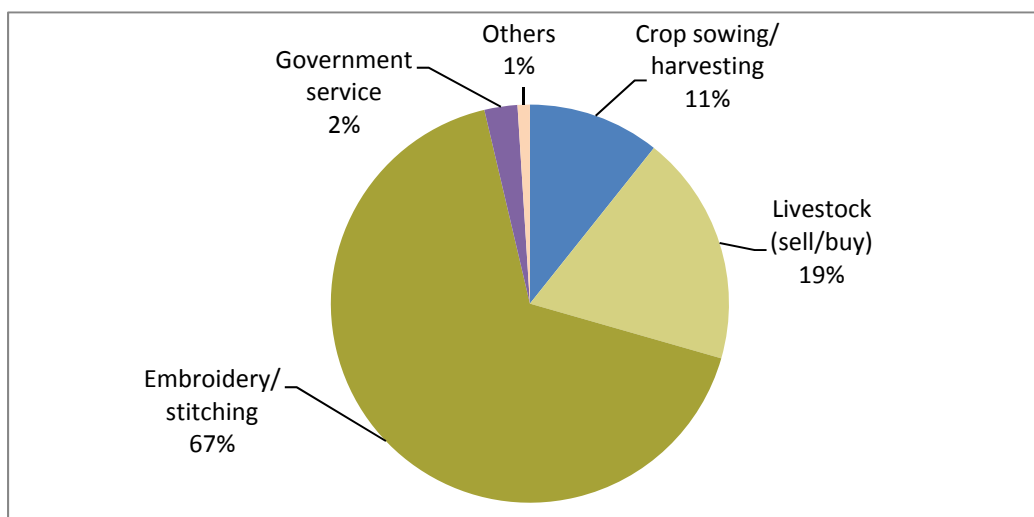
Table 3.3: Distribution of occupational categories of respondents' husbands by residence

Occupation/economic activity	Rural	Urban	Total
Agriculture/livestock/poultry	41.9	26.5	37.9
Petty trading	3.2	6.0	3.9
Labor (daily wages)	23.3	15.7	21.3
Government service	16.5	23.5	18.3
Private service	5.7	15.1	8.1
Own business	2.7	9.6	4.5
Working abroad	0.6	0.0	0.5
Unemployed	4.2	1.8	3.6
Other	1.9	1.8	1.9
N	**473**	**166**	**639**

About 38 percent of the men were working in agriculture/livestock/poultry. Eighteen percent of the men were in government service, while a substantial proportion was working as daily-wage laborers (21 percent). Overall, 65 percent of the rural men were either in agriculture or daily labor, which was mostly agricultural labor. About 4 percent of the husbands of respondents were unemployed, and less than 1 percent were working abroad.

Female Mobility

Women respondents were asked about their ability to go to places outside their homes, and what degree of permission was required. Only a few women reported being able to go to any of the places named, except relatives/friend, without permission. A few women reported not being able to go to the health centre or relatives/friends, while the vast majority could not go to the market or out of the village/town (78 percent and 47 percent respectively). Sixty-five percent of the women reported that they could go to the health center with someone, and 11 percent could do so with permission.

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

	Degree of permission				Total	
Destination	**Without permission**	**With permission**	**With someone**	**Can't go/ doesn't go**	**%**	**N**
Market	0.2	2.5	18.9	78.1	100.0	639
Health center	0.5	11.4	64.8	23.0	100.0	639
Relatives/friends	7.5	35.2	44.3	12.7	100.0	639
Out of village/town	0.2	5.5	47.3	46.8	100.0	639

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. Table 2.5 shows that 29 percent of households owned a television and 36 percent owned a radio. Figure 3.3 shows the proportion of women who reported that they watched TV, listened to the radio, or read newspapers or magazines. Television was the most commonly accessed medium, followed by radio and print media.

Figure 3.3: Distribution of MWRA according to exposure to media and FP messages, by type of media
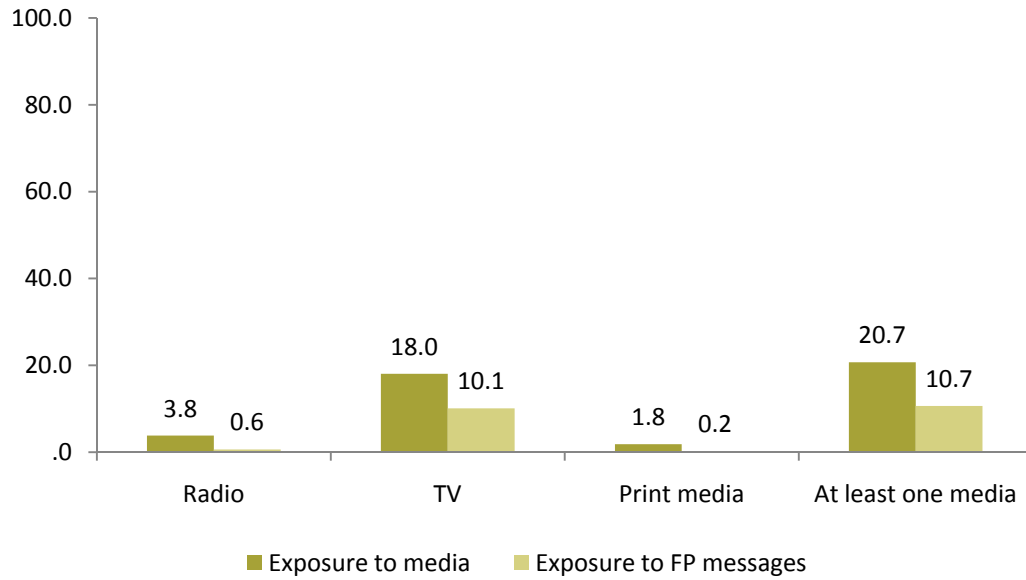
Women who reported access to any sort of media were asked if they had ever seen, heard or read any message about the methods of family planning through these mediums. Again, more women said that they had heard family planning messages on television (10 percent) followed by radio (0.6 percent) and print material (0.2 percent). Overall 21 percent of the women reported access to at least one of these mass media forms, and 11 percent had exposure to FP messages through them.

Chapter 4

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 4.1: 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	54.2	45.8	0.0	0.0	100.0	0.6	24
20-24	22.7	59.4	17.2	0.8	100.0	1.5	128
25-29	7.4	29.8	42.0	20.7	100.0	3.1	188
30-34	2.5	7.4	29.5	60.7	100.0	5.0	122
35-39	5.3	13.2	21.1	60.5	100.0	5.2	76
40-44	0.0	6.5	2.2	91.3	100.0	7.0	46
45-49	0.0	5.5	10.9	83.6	100.0	6.8	55
Total	**9.9**	**26.3**	**25.0**	**38.8**	**100.0**	**3.9**	**639**

Table 4.1 shows that early childbearing was common in Khuzdar and that the mean number of children ever born (Table 4.1) and living children (Table 4.2) 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 Khuzdar, the mean number of children ever born was 3.9 for currently married women. The mean number of children ever born increased steadily with age, reaching a high of 6.8 children among women aged 45-49. On average, these women also had 6.4 living children. Each woman of age group 45-49 had lost 0.4 children on average during her reproductive life.

Table 4.1 also shows that more than 46 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, 16 percent had reached the end of childbearing with less than five children ever born, and 84 percent had five or more children ever born. Data show that all of the women aged 45-49 years of age had at least one live birth in their reproductive period, suggesting no primary infertility (i.e., the proportion of couples who are unable to have any children) in this sample in Khuzdar. The sex ratio at birth was 105 males per 100 females, which is consistent with international norms. The sex ratio of living children was 106 (from Table 4.3)

Table 4.2: 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	58.3	41.7	0.0	0.0	100.0	0.5	24
20-24	24.2	61.7	13.3	0.8	100.0	1.4	128
25-29	9.0	30.3	43.1	17.6	100.0	2.9	188
30-34	2.5	10.7	35.2	51.6	100.0	4.5	122
35-39	5.3	15.8	23.7	55.3	100.0	4.8	76
40-44	0.0	6.5	8.7	84.8	100.0	6.5	46
45-49	0.0	5.5	12.7	81.8	100.0	6.4	55
Total	**10.8**	**27.7**	**26.6**	**34.9**	**100.0**	**3.6**	**639**

Table 4.3: 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	0.4	0.2	0.6	0.3	0.1	0.5	24
20-24	0.8	0.6	1.5	0.8	0.6	1.4	128
25-29	1.6	1.5	3.1	1.5	1.4	2.9	188
30-34	2.4	2.5	5.0	2.2	2.3	4.5	122
35-39	2.8	2.4	5.2	2.6	2.3	4.8	76
40-44	3.6	3.4	7.0	3.2	3.3	6.5	46
45-49	3.4	3.4	6.8	3.2	3.2	6.4	55
Total	**2.0**	**1.9**	**3.9**	**1.8**	**1.7**	**3.6**	**639**

Differentials in Children Ever Born and Surviving

Table 4.4 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 1.6 fewer children than illiterate women. Those who had "up to primary" education had 2.5 children on average ever born as compared to 4 born to those who had no schooling. Those who had "above secondary" education had 0.8 children ever born. This might be surprising but may be attributed to a very small sampling number.

Table 4.4: 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 mother				
Literate	2.4	2.3	0.05	37
Illiterate	4.0	3.7	0.08	590
Schooling of mother				
No education	4.0	3.7	0.08	597
Up to primary	2.5	2.4	0.07	17
Up to secondary	2.7	2.6	0.04	19
Above secondary	0.8	0.8	0.00	4
Residence				
Rural	3.9	3.6	0.08	473
Urban	3.9	3.6	0.07	166
Literacy of husband				
Literate	3.5	3.2	0.06	223
Illiterate	4.1	3.8	0.08	318
Schooling of husband				
No education	4.1	3.8	0.08	389
Up to primary	4.1	3.9	0.05	50
Up to secondary	3.2	2.9	0.08	122
Above secondary	3.5	3.3	0.05	60
Standard of living index				
Low	3.9	3.5	0.09	284
Medium low	3.9	3.6	0.06	185
Medium high	4.3	4.0	0.06	101
High	3.4	3.2	0.07	69
Occupation/economic activity of husband				
Agriculture/livestock/poultry	4.3	3.9	0.08	242
Petty trader	2.7	2.5	0.06	25
Labor (daily wages)	3.5	3.3	0.07	136
Government service	3.9	3.6	0.06	117
Private service	3.9	3.4	0.12	52
Own business	3.9	3.8	0.03	29
Unemployed	3.2	2.7	0.14	23
Others	4.5	4.0	0.13	15
Total	**3.9**	**3.6**	**0.08**	**639**

Differentials were also observed on the basis of literacy and economic activity of husbands. Those who had literate husbands had 3.5 children compared to 4.1 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 (4.3) was in the occupational category of agriculture/livestock/poultry.

Table 4.5: 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	0.0	0.0	1	2.7	0.6	0.5	23	3.9
20 – 24	1.3	1.2	12	32.4	1.5	1.4	112	19.0
25 – 29	2.1	2.1	14	37.8	3.1	2.9	167	28.3
30 – 34	4.1	3.9	7	18.9	5.0	4.5	115	19.5
35 – 39	5.0	5.0	2	5.4	5.3	4.8	73	12.4
40 – 44	4.0	4.0	1	2.7	7.1	6.5	45	7.6
45 – 49	0.0	0.0	0	0.0	6.8	6.4	55	9.3
Total	**2.4**	**2.3**	**37**	**100.0**	**4.0**	**3.7**	**590**	**100.0**

Table 4.5 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 (2.4) compared to those mothers who were illiterate (4.0). Similarly, the survival of children with literate mothers was far better than those born to illiterate mothers. Literate mothers were younger than illiterate mothers. In the below-30 age group, 73 percent of the mothers were literate, as compared to 51 percent who were illiterate.

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 39.1 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 5.7 for the period 2004-2007 was obtained from the set of ASFRs calculated from the data presented in Table 5.6, compared with 4.1 for both Baluchistan and Pakistan as a whole reported in the PDHS (NIPS/PDHS, 2008).

Table 4.6: 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	142	11	25.8
20 – 24	195	112	191.5
25 – 29	209	194	309.4
30 – 34	126	102	269.8
35 – 39	79	40	168.8
40 – 44	50	20	133.3
45 – 49	58	6	34.5
Total	**859**	**485**	**na**
TFR: 5.7			
CBR: 39.1			

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 4.7 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, 20 percent were currently pregnant. Moreover, among women who had 3 living children under 5 years of age, 14 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 4.7: Distribution of mothers by pregnancy status and number of children under 5 years

	Currently pregnant		Currently not pregnant		Total	
Children < 5 years	**N**	**%**	**N**	**%**	**N**	**%**
0	21	11.7	158	88.3	179	100.0
1	39	22.3	136	77.7	175	100.0
2	38	20.1	151	79.9	189	100.0
3	13	14.4	77	85.6	90	100.0
4	0	0.0	6	100.0	6	100.0
N	**111**	**17.4**	**528**	**82.6**	**639**	**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 4.8 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 4.8: 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	0.0	100.0	0.0	0.0	0.0	100.0	1
20 – 24	43.9	19.7	31.8	4.5	0.0	100.0	66
25 – 29	12.4	32.7	41.5	8.8	4.6	100.0	217
30 – 34	14.9	22.0	52.5	5.7	5.0	100.0	141
35 – 39	12.9	19.4	53.2	4.8	9.7	100.0	62
40 – 44	13.2	18.4	47.4	10.5	10.5	100.0	38
45 – 49	8.3	25.0	41.7	16.7	8.3	100.0	12
Number of live births							
2	18.8	31.9	36.2	8.7	4.3	100.0	69
3	21.6	17.0	47.7	10.2	3.4	100.0	88
4	15.4	23.1	49.0	7.7	4.8	100.0	104
5	22.2	26.7	38.9	3.3	8.9	100.0	90
6+	12.4	28.5	47.3	7.0	4.8	100.0	186
Education level							
No education	15.7	26.3	46.0	7.0	5.0	100.0	502
Up to primary	27.3	9.1	36.4	27.3	0.0	100.0	11
Above primary	31.8	22.7	27.3	4.5	13.6	100.0	22
Standard of living index							
Low	17.7	25.9	42.4	9.1	4.9	100.0	243
Medium low	15.2	24.4	46.3	6.7	7.3	100.0	164
Medium high	17.3	19.8	53.1	6.2	3.7	100.0	81
High	18.4	38.8	38.8	2.0	2.0	100.0	49
Total	**16.9**	**25.7**	**44.9**	**7.3**	**5.2**	**100.0**	**537**

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 4.8 shows that almost 17 percent of children were born with a birth interval of less than 18 months. Almost 88 percent were born with a birth interval of less than 36 months, while 12 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 5

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 448 women (70 percent), out of the 639 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 5.1 and Figure 5.1 show the numbers of ANC visits for the last birth of women who had delivered during the previous four years. Only 27 percent of the sample respondents had received at least one antenatal care visit during their last pregnancy. The percentage was almost three times higher for urban mothers than for rural ones. The overall percentage of 27 percent was significantly higher than the level obtained for Khuzdar in the 2004-05 PSLM Survey (17 percent),but lower than the level for Baluchistan in the PDHS (41 percent) or the level obtained nationally in the PDHS (61 percent) (Government of Pakistan, 2006; NIPS/PDHS, 2008). Nine percent of the women had at least three such visits and 6 percent had four or more visits.

Table 5.1: Distribution of ANC check-ups during last pregnancy by residence

	Rural		Urban		Total	
Number of ANC visits	**N**	**%**	**N**	**%**	**N**	**%**
No visit	280	80.9	47	46.1	327	73.0
1-2 visits	50	14.5	30	29.4	80	17.9
3 visits	6	1.7	8	7.8	14	3.1
4 or more visits	10	2.9	17	16.6	27	5.9
Total	**346**	**100.0**	**102**	**100.0**	**448**	**100.0**

Figure 5.1: Distribution of MWRA by number of antenatal visits during last pregnancy
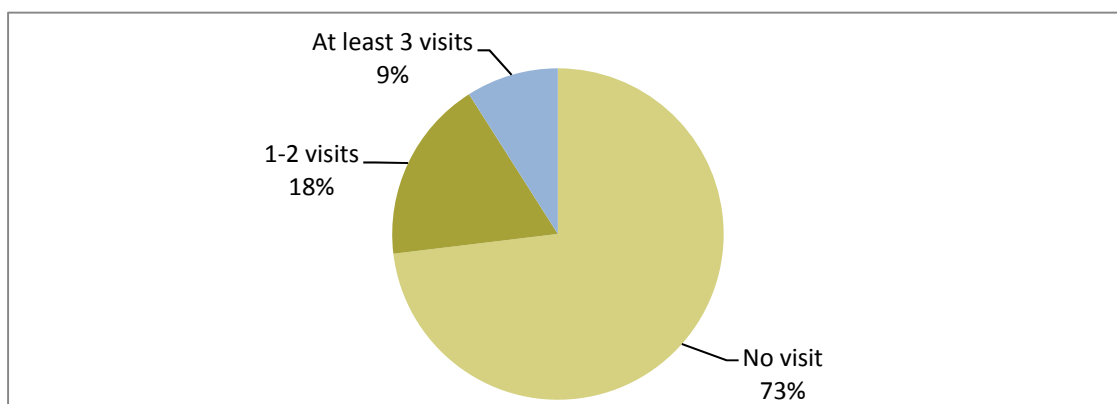
Figure 5.2 shows that many of these visits were in response to some health problem, rather than for a routine check-up. More than two-thirds (78 percent) of the first antenatal visits were for curative purpose.

Figure 5.2: Distribution of MWRA by reason of first antenatal visit during last pregnancy
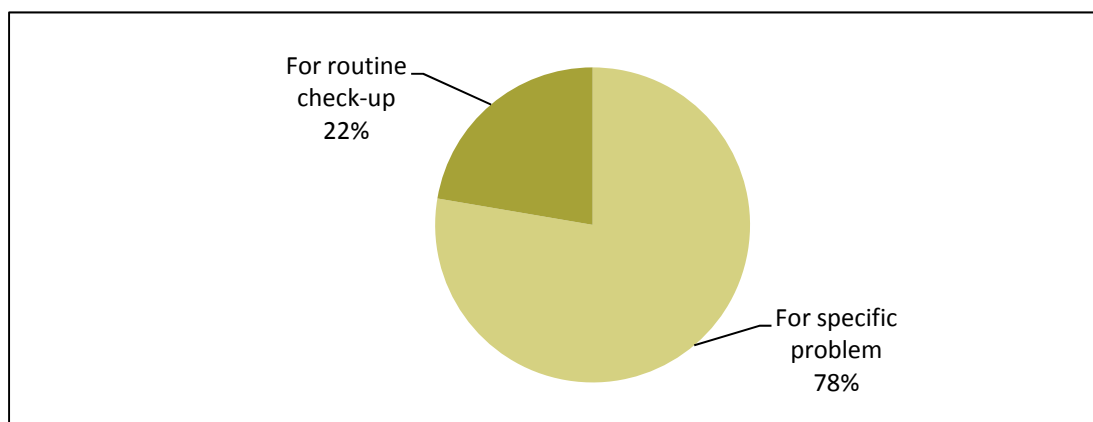
Figure 5.3 shows that for 35 percent of the women, the first visit took place within the first three months of gestation, and 25 percent of the women went for their first check-up during the third trimester of their pregnancy.

Figure 5.3: Distribution of MWRA by gestational age at first antenatal visit during last pregnancy
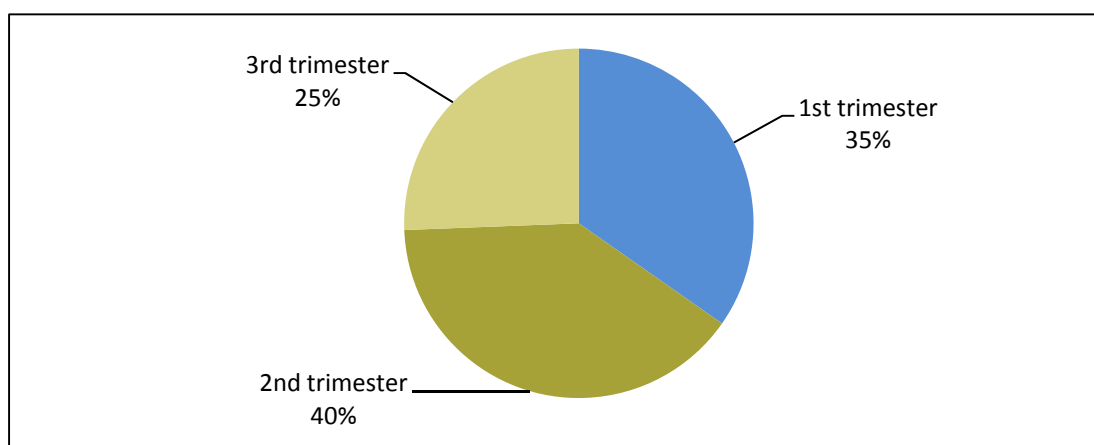
Table 5.2 shows the locations where respondents made one or more antenatal visits. . The most common providers of antenatal care were DHQ/THQ hospitals followed by TBA/dai or LHW, private hospitals/clinics and BHU/RHCs. Other providers were less common.

Table 5.2: Facilities/service providers mentioned for one or more antenatal visits by residence

	Rural		Urban		Total	
Facility/service provider	N	%	N	%	N	%
Dispensary/MCH center	4	6.1	7	12.7	11	9.1
BHU/RHC	20	30.3	4	7.3	24	19.8
DHQ/THQ hospital	13	19.7	44	80.0	57	47.1
Private hospital/clinic/doctor	16	24.2	16	29.1	32	26.4
TBA/dai/LHW	28	42.4	9	16.3	37	30.6
Nurse/LHV	8	12.1	9	16.4	17	14.0
Others	1	1.5	1	1.8	2	1.6
N	**66**	**na**	**55**	**na**	**121**	**na**

na=not applicable.

Figure 5.4: Location where respondents made one or more antenatal visits
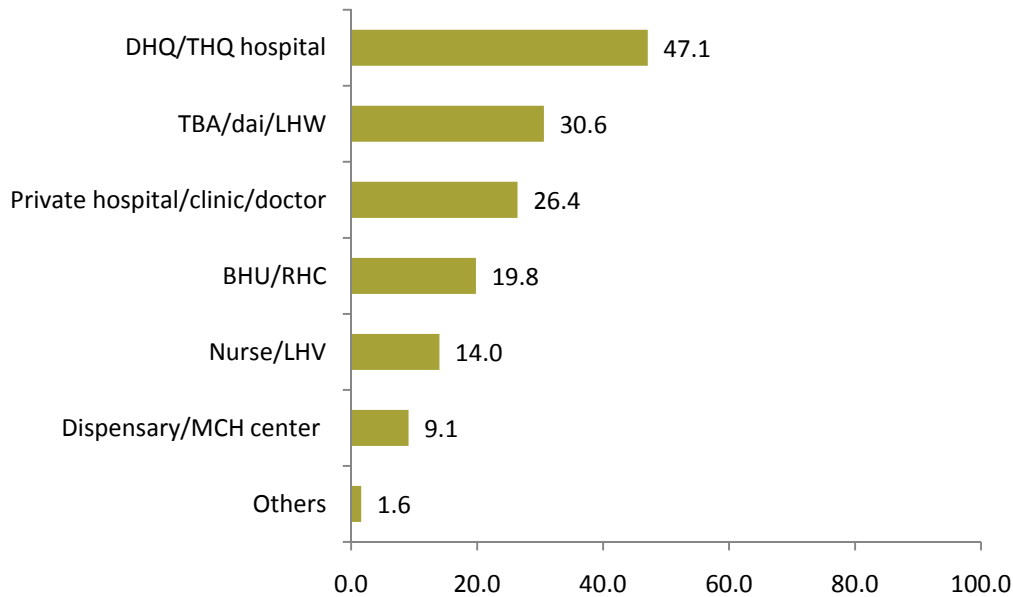
Tetanus Immunization

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, 13 percent of mothers in Khuzdar 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 5.3 shows that 12 percent of mothers had received at least one TT shot, while 11 percent received two or more TT shots during their last pregnancy. The immunization rate was higher in urban areas, while it was very poor in rural areas. A vast majority of mothers remained unprotected.

Table 5.3: Tetanus Immunization at last delivery

	Rural		Urban		Total	
Number of injections	**N**	**%**	**N**	**%**	**N**	**%**
No TT shot	323	93.6	72	70.6	395	88.4
One TT shot	1	0.3	2	2.0	3	0.7
2+ TT shots	21	6.1	28	27.5	49	11.0
Total	**345**	**100.0**	**102**	**100.0**	**447**	**100.0**

Figure 5.5: Tetanus immunization at last delivery
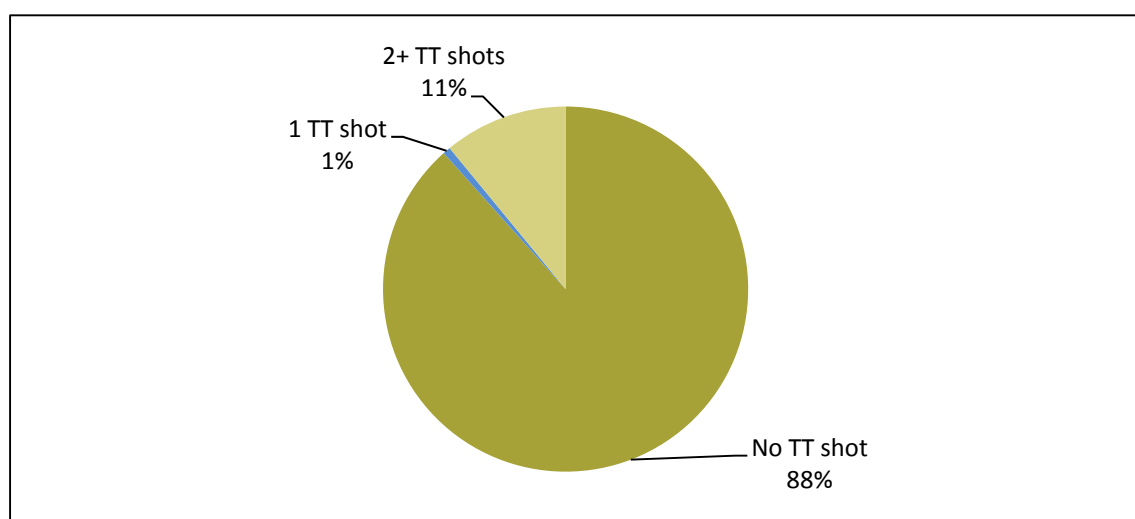
Location and Attendance at Delivery

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 Khuzdar, according to the 2004-05 PSLMS, 4 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, only 5 percent of the most recent deliveries were in a health facility (Table 5.4 and Figure 5.6). This is alarming, and the situation was even worse in rural areas.

Table 5.4: Distribution of mothers by place of last delivery and residence

	Rural		Urban		Total	
Place of delivery	**N**	**%**	**N**	**%**	**N**	**%**
At home	336	97.1	91	89.2	427	95.3
DHQ/THQ hospital	6	1.7	10	9.8	16	3.6
Pvt. hospital/clinic	4	1.2	1	1.0	5	1.1
Total	**346**	**100.0**	**102**	**100.0**	**448**	**100.0**

Figure 5.6: Distribution of mothers by location of delivery
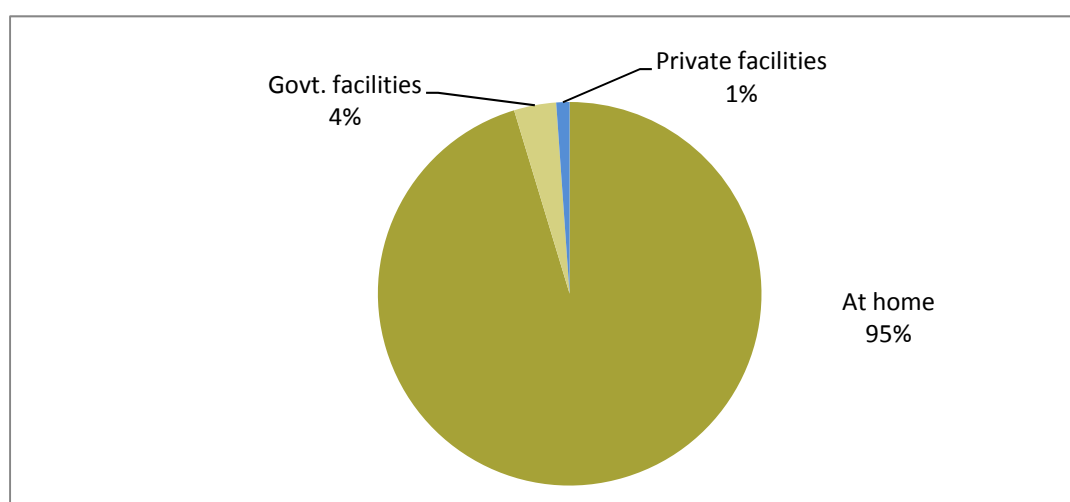
The proportion of births delivered by skilled attendants was extremely low (only 7 percent) (Table 5.5 and Figure 5.7). In the PSLMS 2004-05 for Khuzdar, only 5 percent of births were delivered by a skilled attendant; in the PDHS 2006-07, the corresponding figures were 23 percent for Balochistan and 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 79 percent of the births were delivered by dais (traditional birth attendants), while 14 percent, mostly in rural areas, the deliveries were carried out by a relative or neighbor who was not a dai.

Table 5.5: Distribution of mothers by attendent at last delivery and residence

	Rural		Urban			
Birth attendant and skill level	**N**	**%**	**N**	**%**	**N**	**%**
TBA/dai/LHW	281	81.2	75	73.5	356	79.5
Nurse/LHV	4	1.2	14	13.7	18	4.0
Lady doctor	8	2.3	4	3.9	12	2.7
Female relative/friend/neighbor(not dai)	53	15.3	9	8.8	62	13.8
Total	**346**	**100.0**	**102**	**100.0**	**448**	**100.0**
Skilled birth attendant	12	3.5	18	17.6	30	6.7
Unskilled birth attendant	334	96.5	84	82.4	418	93.3

Figure 5.7: Distribution of mothers by attendant at last delivery
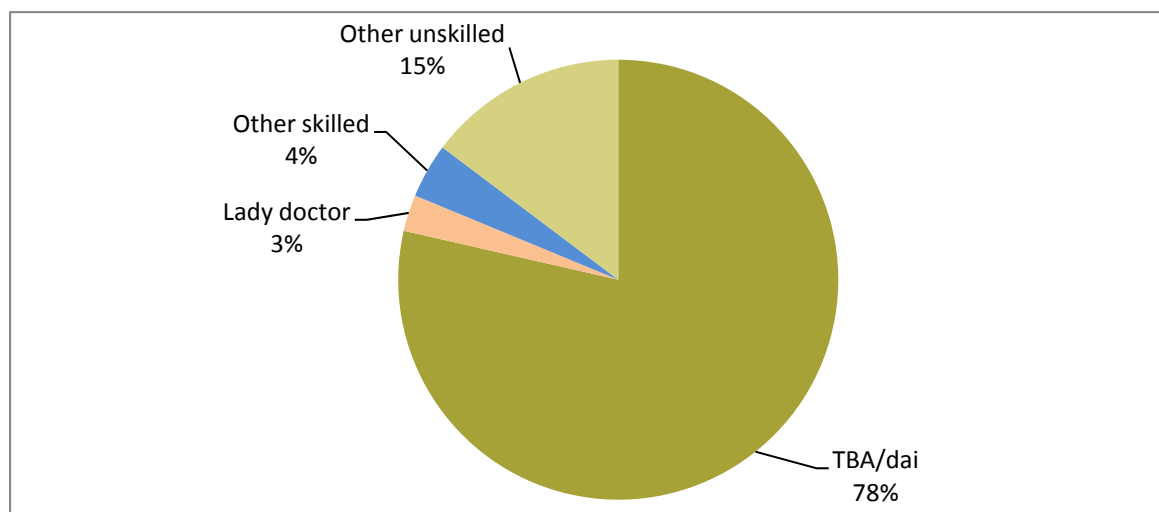
Postpartum Care

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. Khuzdar is no exception: only 6 percent of respondents reported having received postnatal care within 40 days after delivery (Table 5.6). In 5 percent of these cases, the first visit took

place within 24 hours, and 1 percent had a check-up after 24 hours of the delivery. Only 1 percent of the women who delivered at home reported one or more postnatal visits, whereas 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 5.6: 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	21	100.0	0	0.0	0	0.0	21	100.0
Non-institution	0	0.0	5	1.2	413	98.8	418	100.0
Total	**21**	**4.8**	**5**	**1.1**	**413**	**94.1**	**439**	**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 3 of 448 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. Three main reasons were given for discontinuing breastfeeding: child was old enough to stop (50 percent), mother became pregnant (18 percent) and child stopped (13 percent).

Figure 5.8: Distribution of mothers by reasons for discontinuing breastfeeding (n=219)
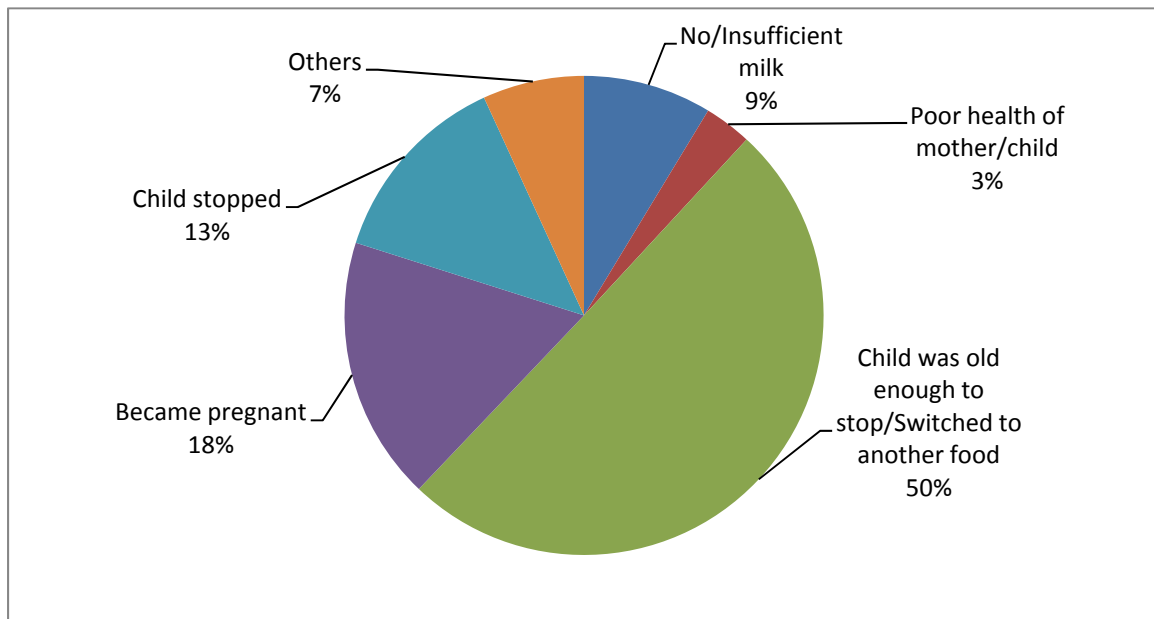
Chapter 6

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 6.1 shows the responses.

The median "ideal" number, in the sense indicated above, was 6 children; 35 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 one less child than their rural counterparts as median ideal number. Overall in Khuzdar, 3 percent of the women also gave a non-numeric response to this question such as up to God.

Table 6.1: Distribution of MWRA with ideal number of children for their family by residence

Number of children	Rural		Urban		Total	
	N	%	N	%	N	%
1	1	0.2	0	0.0	1	0.2
2	9	1.9	6	3.6	15	2.4
3	4	0.9	3	1.8	7	1.1
4	132	28.1	67	40.6	199	31.3
5	51	10.9	15	9.1	66	10.4
6	124	26.4	43	26.1	167	26.3
7+	130	27.7	29	17.6	159	25.0
Up to God	18	3.8	2	1.2	20	3.2
Total	**469**	**100.0**	**165**	**100.0**	**634**	**100.0**
Median	6	na	5	na	6	na

na = not applicable.

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 6.2 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 28 percent wanted to have but later. The proportion of women wanting more children soon declined sharply after the second birth. On the other hand, most women with five or more living children did not want to have more. For those with five children, the proportion wanting to stop was 54 percent. A majority of women (79 percent), however, wanted to stop at 6 or more children. This table indicates clearly the level of interest in both spacing and limiting births.

Table 6.2: 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	Don't know/Unsure	N	%
0	84.1	15.9	0.0	0.0	69	100.0
1	64.2	35.8	0.0	0.0	81	100.0
2	60.4	36.5	3.1	0.0	96	100.0
3	35.4	53.7	8.5	2.4	82	100.0
4	31.8	28.4	37.5	2.3	88	100.0
5	20.2	26.2	53.6	0.0	84	100.0
6 or more	10.8	9.4	79.1	0.7	139	100.0
Total	**40.2**	**28.0**	**31.0**	**0.8**	**639**	**100.0**
N	**257**	**179**	**198**	**5**	**639**	**na**

For those women who wanted more children, we also asked how many more they wanted to have. As shown in Figure 6.1, 45 percent of the women who wanted more children wanted one or two more children. Another 44 percent wanted three to five children. Only one percent were of the view that it was in God's hands. It would be useful to explore what such respondents mean, i.e., whether this is a religious statement, an indication that she has not thought about it, or a polite way of telling the interviewer that she did not want to give a specific answer .

Figure 6.1: Distribution of women by desire for more children in future
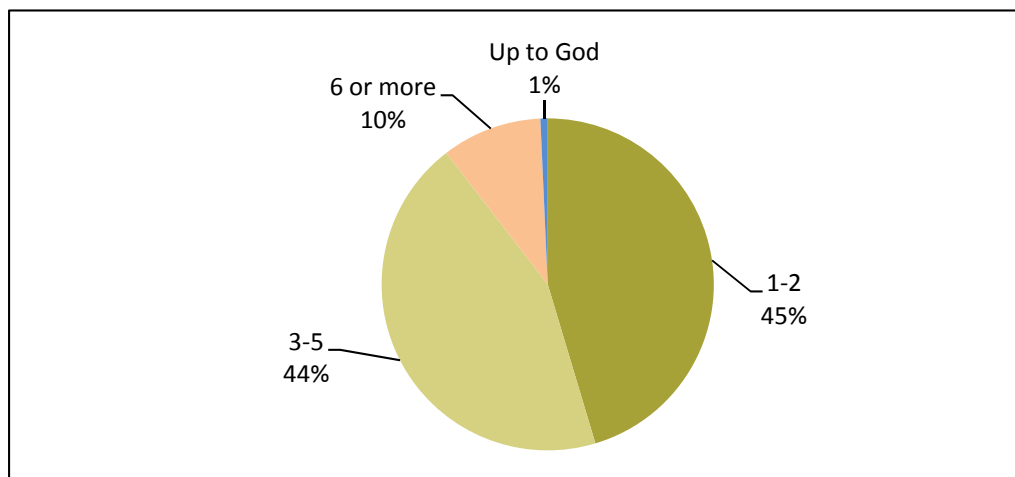
Socioeconomic Correlates of Desire for Children

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 6.3). The relationship between SLI and desire for more children was found to be moderate. 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 (35 percent) compared to illiterate women (27 percent). On the other hand, illiterate women were more likely to not have more children (33 percent) compared to literate women (16 percent).

Table 6.3: Distribution of MWRA by reported desire for more children and background characteristics

Characteristic	Soon	Later	Never	Don't know/ unsure	Total	N
Standard of Living Index						
Low	43.3	29.2	26.4	1.1	100.0	284
Medium low	39.5	28.6	30.8	1.1	100.0	185
Medium high	36.6	21.8	41.6	0.0	100.0	101
High	34.8	30.4	34.8	0.0	100.0	69
Age group						
< 25	57.2	39.5	3.3	0.0	100.0	152
25 or more	34.9	24.4	39.6	1.0	100.0	487
Literacy of respondent						
Literate	48.6	35.1	16.2	0.0	100.0	37
Illiterate	39.5	27.1	32.5	0.8	100.0	590
Residence						
Rural	43.1	27.1	28.8	1.1	100.0	473
Urban	31.9	30.7	37.3	0.0	100.0	166
Total	**40.2**	**28.0**	**31.0**	**0.8**	**100.0**	**639**
N	**257**	**179**	**198**	**5**	**na**	**639**

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: 54 percent of women said there would be no limit to the number of daughters before having a son, while 39 percent said there would be no limit to sons before having a daughter.

Table 6.4: 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	283	44.3	380	59.5
Other non-numeric responses	1	0.2	1	0.2
Up to God	11	1.7	9	1.4
No limit	344	53.8	249	39.0
Total	**639**	**100.0**	**639**	**100.0**
Median*	3	na	4	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 6.5 and 6.6. (This question excludes those 318 of the total 639 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, 49 percent said they would be worried if they became pregnant, while none would be pleased. Among those who wanted to delay their pregnancy for more than two years 17 percent would be worried, while 24 percent would be pleased.

Table 6.5: 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	23.9	0.0	11.9	32
Worried	17.2	48.5	33.0	89
Accept it	50.0	33.1	41.5	112
Doesn't matter	9.0	18.4	13.7	37
Total	**100.0**	**100.0**	**100.0**	**na**
N	134	136	270	270

Table 6.6: 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	80.1	97.1	88.6	241
Health of youngest child	85.3	72.8	79.0	215
Caring of children	81.6	89.7	85.7	233
Schooling of children	53.7	77.2	65.4	178
Family economic situation	68.4	88.2	78.3	213
Will feel shy because other kids are grown	0.0	1.5	0.7	2
Others	1.5	0.0	0.7	2
N	**134**	**136**	**270**	**270**

Respondents could give more than one response.

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 (97 percent), caring of children (90 percent) and the family's economic situation (88 percent). Health of the youngest child (85 percent), caring of children (82 percent) and their own health (80 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.

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, 14 percent of the women reported that their last pregnancy was unwanted, while another 14 percent said that their last pregnancy was mistimed.

Figure 6.2: Distribution of MWRA by their attitudes towards their last pregnancy
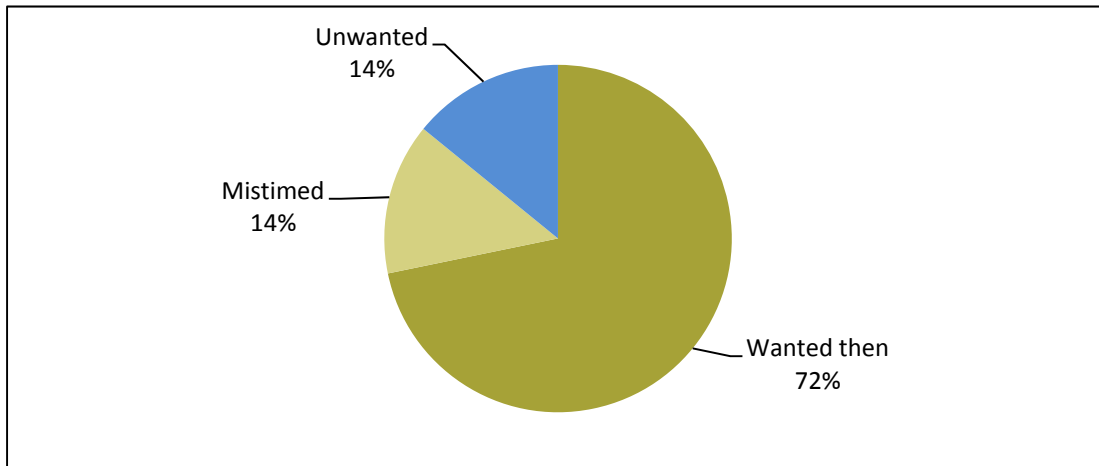
Women's Perception of Fertility Preferences of Husbands

Women were asked whether they thought their husbands wanted the same number of children as they did, or more, or fewer. In Table 6.7, their responses are tabulated according to their ideal family size. About 14 percent of the women did not know their husband's preference; while another 50 percent thought their husbands wanted the same number of children as they did. However, one-third thought their husbands wanted more children than they did, while only 3 percent thought their husbands wanted fewer children. Table 6.7

shows that almost half of the women felt that their decision and their husband's decision was the same.

Table 6.7: 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	31.3	0.0	18.8	100.0	16
3 - 4 children	54.9	34.5	1.0	9.7	100.0	206
5 + children	46.7	33.4	4.3	15.6	100.0	392
Others	100.0	0.0	0.0	0.0	100.0	1
Up to God	63.2	15.8	0.0	21.1	100.0	19
Don't know	0.0	20.0	0.0	80.0	100.0	5
Total	**49.6**	**33.0**	**3.0**	**14.4**	**100.0**	**639**
N	**317**	**211**	**19**	**92**	**na**	**639**

Chapter 7

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 Khuzdar 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 and IUDs. They knew about condoms as well but to a lesser degree. Knowledge of each contraceptive method was higher among women in Khuzdar 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 7.1: Distribution of MWRA by knowledge (prompted) of contraceptive methods, by method and residence

Method	Rural	Urban	Total
Female sterilization	91.1	95.8	92.3
Male sterilization	40.9	45.2	42.0
Pill	98.7	100.0	99.1
IUD	77.2	89.8	80.4
Injectables	96.2	100.0	97.2
Norplant	38.9	45.2	40.5
Condom	72.9	89.2	77.2
Rhythm	54.8	72.9	59.5
Withdrawal	77.9	91.0	81.3
Emergency pills	38.8	51.2	42.0
Other FP method	14.8	4.8	12.2
At least one method	100.0	100.0	100.0
At least one modern method	99.8	100.0	99.8
At least one traditional method	81.2	91.0	83.7
N	473	166	639

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, 25 percent reported having used some method of contraception during their married lives (Table 7.2). This figure was higher for urban women (32 percent) than for rural women (22 percent). It was substantially lower than the proportions obtained in the PDHS 2006-07 for Pakistan (48.7 percent) (NIPS/PDHS, 2008).

Table7.2: 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	8.2	12.7	9.4	60	3.8	3.6	3.8	24	4.4	9.0	5.6	36
IUD	3.4	3.6	3.4	22	1.9	2.4	2.0	13	1.5	1.2	1.4	9
Injectable	11.6	14.5	12.4	79	6.8	6.6	6.7	43	4.9	7.8	5.6	36
Nor plant	0.2	0.0	0.2	1	0.2	0.0	0.2	1	0.0	0.0	0.0	0
Condom	1.5	4.2	2.2	14	1.3	2.4	1.6	10	0.2	1.8	0.6	4
Rhythm method	0.2	0.0	0.2	1	0.0	0.0	0.0	0	0.2	0.0	0.2	1
Withdrawal	0.6	0.6	0.6	4	0.0	0.0	0.0	0	0.6	0.6	0.6	4
Female sterilization	3.0	3.6	3.1	20	3.0	3.6	3.1	20	0.0	0.0	0.0	0
Male sterilization	0.0	0.0	0.0	0	0.0	0.0	0.0	0	0.0	0.0	0.0	0
Other FP method	0.2	0.0	0.2	1	0.0	0.0	0.0	0	0.2	0.0	0.2	1
Any FP method	22.2	31.9	24.7	158	16.9	18.7	17.4	111	5.3	13.3	7.4	47
Any modern FP method	22.2	31.9	24.7	158	16.9	18.7	17.4	111	5.3	13.3	7.4	47
Any traditional FP method	1.1	0.6	0.9	6	0.0	0.0	0.0	0	1.1	0.6	0.9	6
N	**473**	**166**	**639**	**639**	**473**	**166**	**639**	**639**	**473**	**166**	**639**	**639**
Emergency pills	0.2	0.0	0.2	1	n.a	n.a	n.a	n.a	n.a	n.a	n.a	n.a

n.a: 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 Khuzdar as compared with Pakistan in general was low (see Table 7.2). Seventeen 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 19 percent, compared with 17 percent in rural Khuzdar.

Table 7.2 shows that the methods most commonly in use were injectables, pills and female sterilization. Overall, 17.4 percent of the married women were using modern methods and none were using traditional methods (withdrawal and rhythm). Distribution of current users by method mix may be seen in Figure 7.1, which shows that most of the current users were using injectables (39 percent) and pills (21 percent).

Figure 7.1: Distribution of current users by method mix
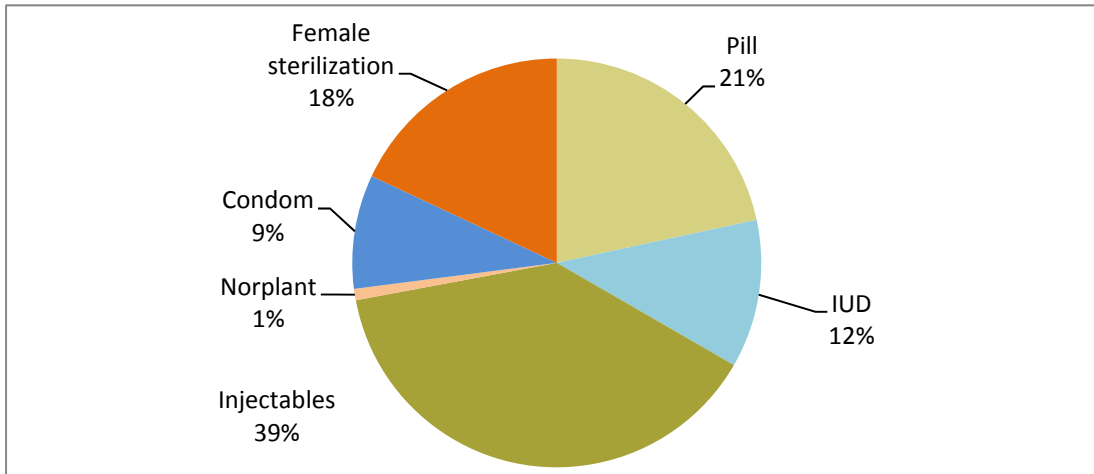
Current Use and Desire for Children

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 7.2 shows this by current method. Overall, 58 percent of current use was for limiting purpose compared with 42 percent for spacing.

Figure 7.2: Current use and desire for children (Khuzdar)
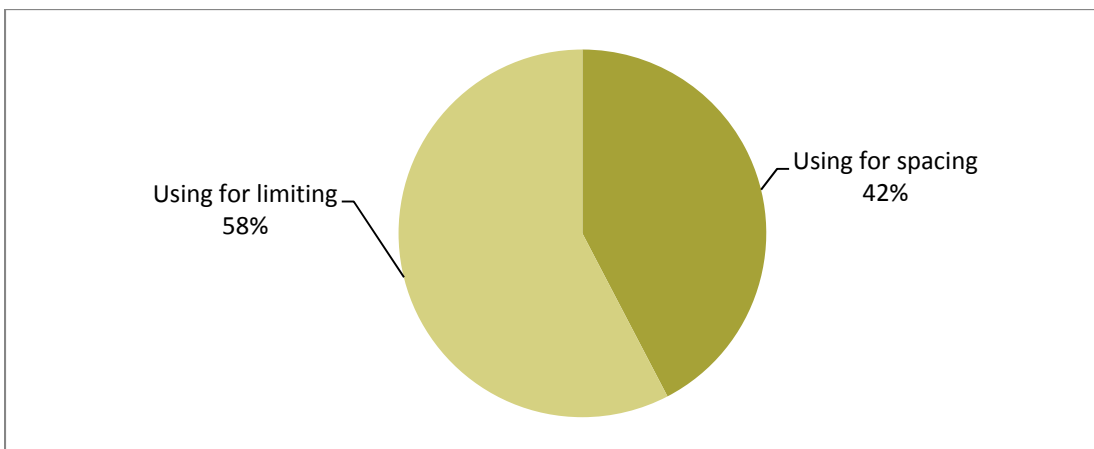
Correlates of Contraceptive Use

Figure 7.3 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 zero. The prevalence was highest among women in the age group 40 -44.

Figure 7.4 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 26 percent was recorded for women who had 3-4 children.

Figure 7.3: Contraceptive prevalence by age
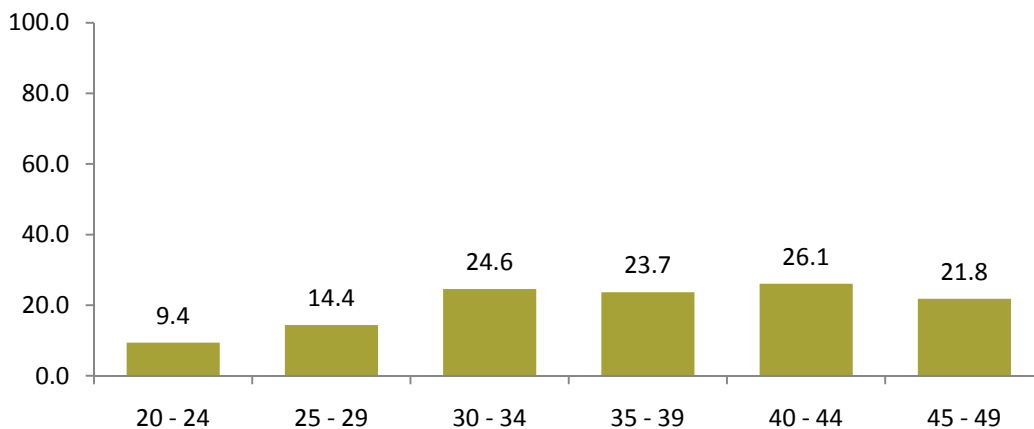
Figure 7.4: Contraceptive prevalence by number of living children
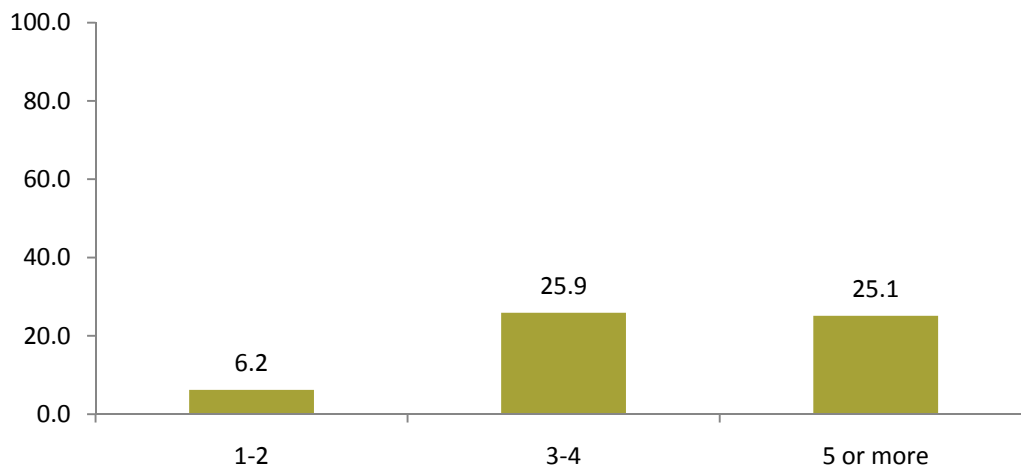
Contraceptive use was associated with socioeconomic status and residence. Respondents in households with the highest SLI had a substantially higher contraceptive prevalence (30 percent) than those with the lowest SLI (13 percent). Conversely, women from households with a low SLI (83 percent) were more likely to be never users. Similarly, respondents' literacy was associated with slightly higher current use and lower never use. An association of CPR was observed between SLI and literacy 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 7.3: 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	13.4	3.5	83.1	100.0	284
Medium low	18.4	8.6	73.0	100.0	185
Medium high	17.8	11.9	70.3	100.0	101
High	30.4	13.0	56.5	100.0	69
Ownership of television					
Yes	20.2	11.5	68.3	100.0	183
No	16.2	5.7	78.1	100.0	456
Literacy of respondent					
Literate	18.9	10.8	70.3	100.0	37
Illiterate	17.3	7.1	75.6	100.0	590
Residence					
Rural	16.9	5.3	77.8	100.0	473
Urban	18.7	13.3	68.1	100.0	166
Total	**17.4**	**7.4**	**75.3**	**100.0**	**639**

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 7.4 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; injectables were mostly obtained through husbands. Female sterilization was nearly always carried out at the DHQ hospital and to a lesser extent in private hospitals. These statements hold true for both current and past users.

Table 7.4: Distribution of ever users of specific contraceptive methods by most recent source of supply

Source	Family planning method						Total	
	Pill	IUD	Injectables	Norplant	Condom	Female sterilization	%	N
Govt. hospital (DHQ/THQ)	28.3	84.2	33.9	100.0	7.7	90.0	43.9	68
BHU/RHC/MCH center	8.7	0.0	3.6	0.0	0.0	0.0	3.9	6
LHW	6.5	0.0	0.0	0.0	46.2	0.0	5.8	9
Pvt. hospital/clinic/ doctor	0.0	15.8	9.0	0.0	0.0	10.0	6.4	10
Pharmacy/chemists / grocery shop	10.9	0.0	17.9	0.0	0.0	0.0	9.7	15
Husband brings method	45.7	0.0	35.7	0.0	46.2	0.0	30.3	47
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**155**
N	46	19	56	1	13	20	100.0	155

Chapter 8

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 8.1.

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 was 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 53 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 8.1: Distribution of ever users of specific contraceptive methods by reason for choosing that method

Reason	Contraceptive method					Total
	Pill	IUD	Injectables	Condom	Female sterilization	
Easily available	70.2	15.8	61.4	100.0	0.0	84
Low cost	63.8	36.8	50.9	100.0	15.0	82
Convenient to use	83.0	21.1	71.9	100.0	5.0	98
Suitable for respondent/husband	87.2	73.7	91.2	92.3	60.0	131
No/fewer side effects	53.2	47.4	77.2	100.0	25.0	96
Can be used for long period	74.5	84.2	75.4	38.5	70.0	113
No other method available	44.7	47.4	52.6	69.2	35.0	76
Method always available	55.3	31.6	40.4	76.9	45.0	74
Provider advised	21.3	36.8	33.3	38.5	80.0	57
Others	6.4	10.5	3.5	15.4	0.0	9
N	**47**	**19**	**57**	**13**	**20**	**156**

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 8.2 and Figure 8.1 show the reported costs the last time the women obtained the method. About 20 percent of the clients reported that they were not charged for the contraceptives. A great number (52 percent) did not know about charges. More than one quarter reported the payment. However, 22 percent paid more than 50 rupees.

Table 8.2: 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	0.0	8.3	12.5	29.2	50.0	100.0	24
IUD	7.7	0.0	0.0	7.7	84.6	100.0	13
Injectables	2.3	2.3	2.3	37.2	55.8	100.0	43
Norplant	0.0	0.0	0.0	0.0	100.0	100.0	1
Condom	0.0	0.0	0.0	0.0	100.0	100.0	10
Female sterilization	100.0	0.0	0.0	0.0	0.0	100.0	20
Total	**19.8**	**2.7**	**3.6**	**21.6**	**52.3**	**100.0**	**111**

Figure 8.1A: Cost of contraceptive supply for current method in rupees
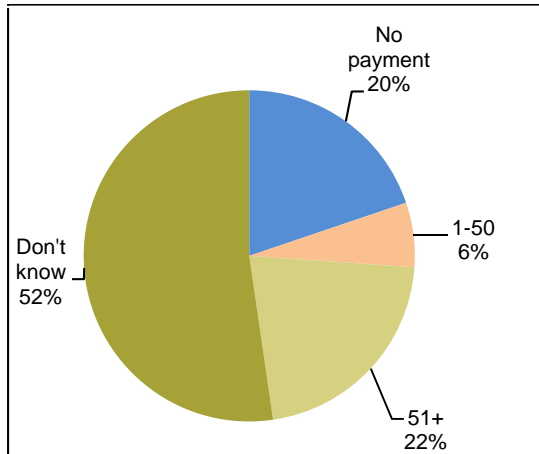
Figure 8.1B: Attitude towards service charges for current method other than contraceptive
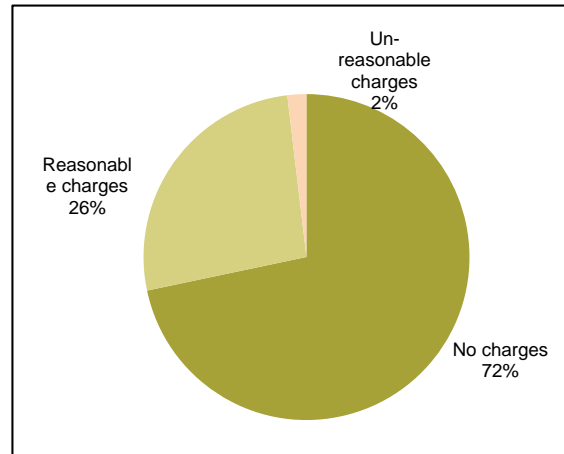
Current users were also asked whether their facility charged them for service, other than the method itself. Seventy-two percent said they were not charged, 26 percent were charged a reasonable amount, and only 2 percent said they were charged an unreasonable amount.

The time usually needed for current users to obtain a specific method is shown in Table 8.3, while Figure 8.2 shows the overall travel time in minutes to acquire the contraceptive method. A majority (81 percent) was ignorant of the time spent to get the contraceptive as husband brought the method. However, 12 percent claimed to have spent between 30-60 minutes to get the contraceptive.

Table 8.3: 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 method	%	N
Pill	0.0	0.0	25.5	4.2	70.8	100.0	24
IUD	0.0	0.0	7.7	15.4	76.9	100.0	13
Injectables	2.4	2.4	14.3	2.4	78.6	100.0	42
Condom	10.0	0.0	0.0	0.0	90.0	100.0	10
Female sterilization	0.0	5.0	0.0	0.0	95.0	100.0	20
Total	1.8	1.8	11.9	3.7	80.7	100.0	109

Figure 8.2: Travel time for contraceptive supplies
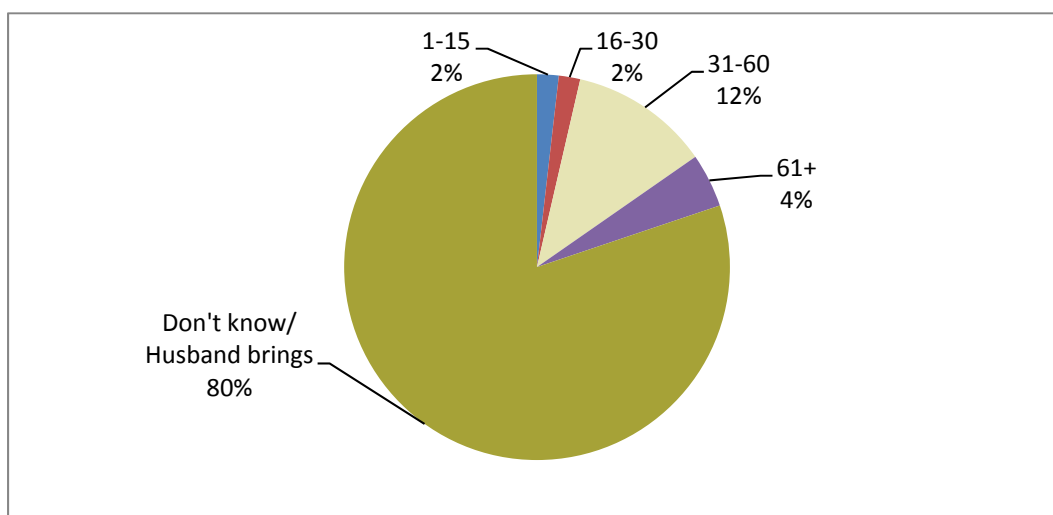
Treatment by Provider

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 8.4). 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 8.4: 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	36.2	73.7	42.1	61.5	65.0	48.7	76
How to use the method	57.4	78.9	47.4	61.5	20.0	51.9	81
Contraindications	8.5	31.6	22.8	38.5	30.0	21.8	34
Effectiveness	48.9	84.2	63.2	61.5	60.0	60.9	95
Advantages	38.3	73.7	49.1	69.2	80.0	54.5	85
Possible side effects	17.0	63.2	33.3	15.4	60.0	34.0	53
What to do if experienced side effects	10.6	63.2	31.6	23.1	20.0	26.9	42
Possibility of switching	12.8	84.2	26.3	23.1	0.0	25.6	40
About other FP methods you could use	23.4	52.6	17.5	15.4	45.0	26.9	42
N	**47**	**19**	**57**	**13**	**20**	**156**	**156**

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 8.5 shows responses were mainly positive. However, 13 percent of respondents said that the provider could not deal with side effects, 28 percent said that the provider demanded charges for services, and 34 percent were not satisfied with the behavior of the provider and 24 percent did not confirm the availability of staff at the time of their visit.

Table 8.5: Percent current users responding positively on treatment at last visit, by aspect of treatment

Aspect of treatment	Percentage
Cooperative/friendly	65.7
Staff always available	75.8
Attend/examine properly	73.4
Doesn't demand charges for services	71.7
Manage side effects properly	86.7

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. Six current users and 14 past users (13 percent of all current and past users) responded positively. As shown in Figure 8.3, side effects were most commonly reported by IUD (32 percent), pill (13 percent), injectable (11 percent) and female sterilization (11 percent) users.

Figure 8.3: Percent ever users who experienced side effects by method used
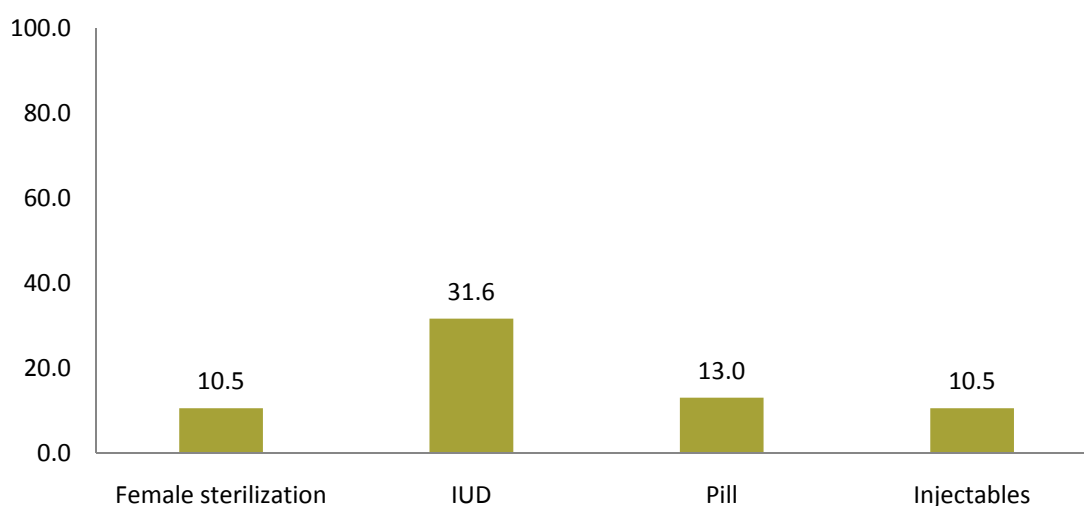
The past users who reported experiencing side effects and consulted someone for the management of side effects were asked if the provider had given any of a list of possible responses (Figure 8.4). Forty-three percent were advised to stop method, 29 percent were advised to rest from the method and 14 percent were asked to switch to another method.

Figure 8.4: Distribution of provider responses upon consultation for side effects among past users
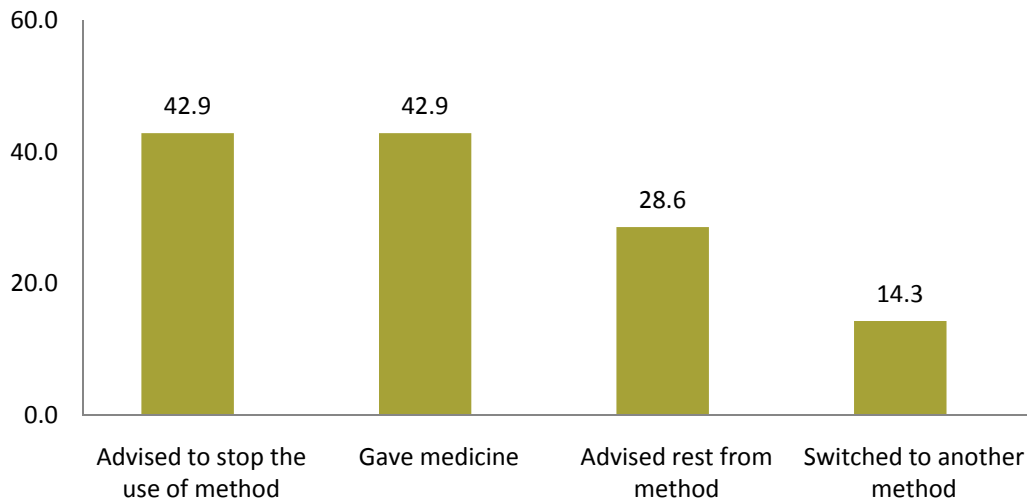
Chapter 9

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 9.1 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-eight percent of non-users mentioned husband's disapproval, followed by FP against religion (85 percent), fear of side effects (79 percent) and management of side effects (74 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 9.1: 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	107	96.4	44	93.6	472	98.1
Other people may find out about contraceptive use	34	30.6	14	29.8	195	40.5
Distance and travel costs to FP outlet	80	72.1	34	72.3	327	68.0
Probability of getting pregnant while using	24	21.6	16	34.0	106	22.0
Fear of side effects	71	64.0	38	80.9	381	79.2
Problem of managing side effects	64	57.7	37	78.7	355	73.8
FP is against religion	93	83.8	42	89.4	409	85.0
N	111	na	47	na	481	na

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

Past Users

Reasons for Discontinuing Contraceptive Use

Table 9.2 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 desire for another child (60 percent), followed by side effects experienced (30 percent), husband's advice (30 percent), rest from method (19 percent), and fear of side effects (15 percent). Other reasons carried less weight.

Table 9.2: Distribution of past contraceptive users by reason for discontinuing last method

Reason	Percentage
Wanted another child	59.6
Fear of side effects	14.9
Side effects experienced	29.8
Method failure	4.3
Cost not affordable	2.1
Method inconvenient to use	4.3
Rest from method	19.1
Missed the dose	10.6
Provider's advice	8.5
Infrequent sex/husband away	4.3
Husband's advice	29.8
In-laws oppose	2.1
Menopause	8.5
N	**47**

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 9.3). The most common reason was that they wanted another child (43 percent). Other reasons related to childbearing, e.g., currently pregnant (30 percent), breastfeeding/lactational amenorrhea (26 percent), menopause (13 percent) and rest from the method (11 percent). However, significant importance was accorded to fear of side effects (15 percent).

Table 9.3: Distribution of past users by reason for current non-use

Reason	Percentage
Fear of side effects	14.9
Want another child	42.6
Currently pregnant	29.8
Rest from method	10.6
Provider's advice	6.4
Infrequent sex/husband away	2.1
Breastfeeding/lactational amenorrhea	25.5
Menopause	12.8
Others	2.1
N	**47**

Respondents could give more than one reason.

Never Users

Reasons for Non-use

The 481 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 (71 percent). Other reasons cited frequently included husband's opposition (48 percent), lack of access (46 percent), fear of side effects (43 percent), affordability (34 percent) and lactational amenorrhea/ breastfeeding (34 percent). A few reported religious objections (1 percent), which are often cited in other literature as a barrier to family planning use (Table 9.4).

Table 9.4: Distribution of never users by reason for never use

Reason	Percentage
Husband opposes	48.4
In-laws oppose	26.8
Fear of side effects	43.2
Lack of access/unavailability	45.9
Cost not affordable	34.1
Shy to consult about family planning	12.5
Method inconvenient to use	12.7
Infrequent sex/husband away	5.0
Difficult/unable to conceive	13.1
Breastfeeding/lactational amenorrhea	34.1
Respondent/husband infertile	.8
Wanted (more) children	71.3
Against religion	1.0
Natural spacing	1.0
Others	2.9
N	**481**

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 9.5 shows this for never using respondents. Approval for limiting was greater than for spacing (74 percent and 64 percent respectively).

Table 9.5: Distribution of never users by attitude towards spacing and limiting birth

Attitude	Attitude towards spacing births		Attitude towards limiting births	
	N	%	N	%
Approve	305	63.5	356	74.2
Disapprove	175	36.5	124	25.8
Total	**480**	**100.0**	**480**	**100.0**

Knowledge of Contraceptive Users, Methods and Facilities

Of the 481 female never users in the sample, 47 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, 42 percent knew a relative, and 33 percent knew friends or neighbors.

Figure 9.1: Percent of never user women who knew some woman who had ever used any FP method
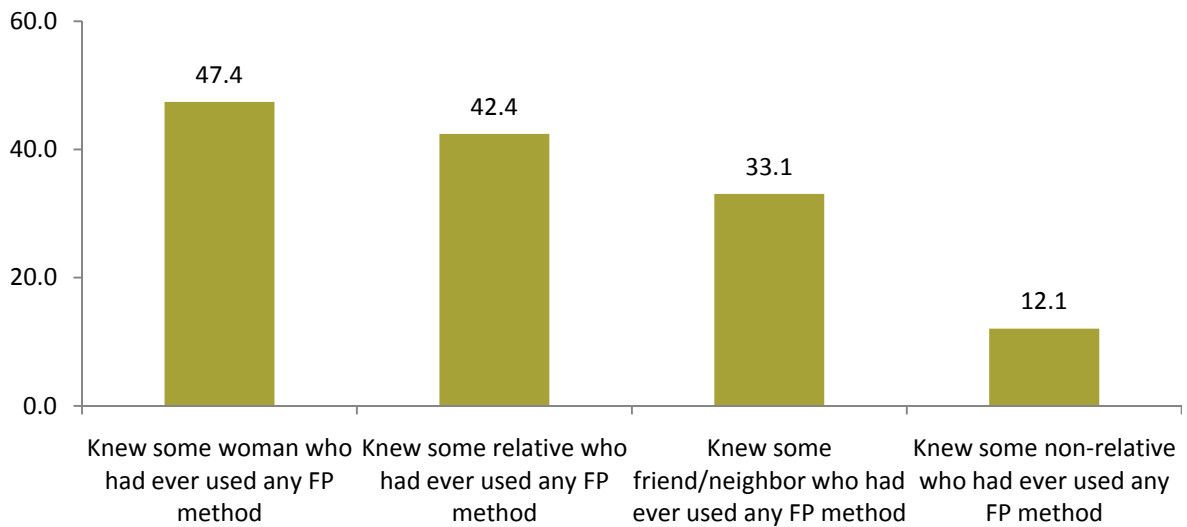
All never users knew of at least one method, but for each method there was a knowledge variation. Pills and injectables were the most widely known methods.

Table 9.6: Distribution of never users by knowledge of contraceptive methods

Method	Percentage
Female sterilization	91.5
Male sterilization	43.3
Pill	98.8s
IUD	76.5
Injectables	96.5
Norplant	39.9
Condom	74.2
Rhythm	55.1
Withdrawal	80.4
Emergency pills	42.1
Others	10.8
Know at least one FP method	100.0
N	**481**

Respondents could give more than one response.

The knowledge of different sources of contraception was poor. Only 39 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 9.7. The sources best known were health department outlets – the District/Tehsil Headquarters hospitals, BHUs/RHCs/MCH centers and private hospitals. A few knew about Family Welfare Centers of the Ministry of Population Welfare, Greenstar clinics as well as pharmacies/chemists.

Table 9.7: Knowledge of sources of contraception of never users

Source	Percentage
Knowledge of at least one service provider	38.5
DHQ/THQ hospital	33.1
BHU/RHC/MCH center	16.4
Family Welfare Center	2.5
Mobile service unit camp	0.4
Lady Health Worker	6.9
Greenstar clinic	2.7
Private hospital/clinic/doctor	13.7
Dispenser/compounder	1.7
Pharmacy/chemists	3.7
Homeopath/hakim	0.6
TBA/dai	6.7
Grocery shop (not pharmacy/chemist)	1.2
N	**481**

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 by bus/van or on foot (Figure 9.2). Of the 59(Is this the figure true?) respondents who indicated the time needed to go to the nearest facility, 5 percent gave a time of 15 minutes or less, 20 percent gave a time frame of 16 to 30 minutes, and 74 percent gave a time of more than 30 minutes (Figure 9.3).

Reasons for Non-use

Figure 9.2: Mode of transportation to the nearest facility/provider
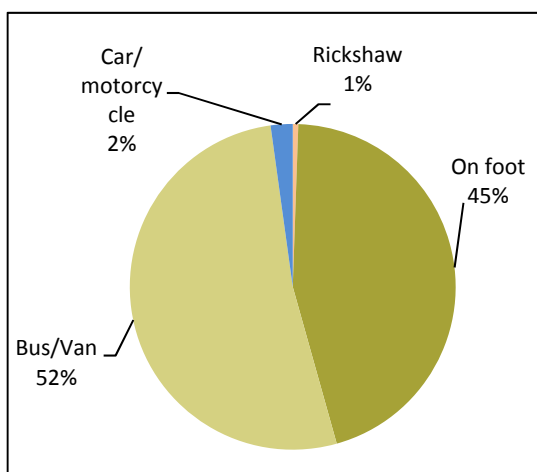
Figure 9.3: Time taken to the nearest facility/provider
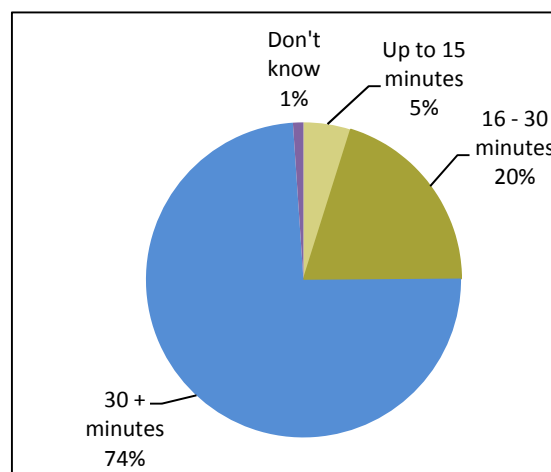
Intent to Use

When never users were asked about whether they intended to use contraceptives in the future, 31 percent of the female respondents did show their intention (150 out of 481 respondents who believed they could get pregnant) (Table 9.8). More of the high-parity women who had not yet used a method (40 percent of the women with 5 or more children) expressed their intent to use a method in the future compared to 27 percent of women with 1-2 living children.

Table 9.8: 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	23.2	40.6	34.8	1.4	100.0	69
1-2	27.0	47.2	25.2	0.6	100.0	159
3-4	30.8	29.8	38.5	1.0	100.0	104
5 or more	39.6	32.9	20.1	7.4	100.0	149
Total	**31.2**	**38.0**	**27.9**	**2.9**	**100.0**	**481**
N	150	183	134	14	na	481

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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 9.4). However, this varied by use status. Ninety-one percent of current users, and 85 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, only 40 percent reported being able to approach their husbands easily, with more than one-third (34 percent) reporting that they could only do so with difficulty, and another 26 percent saying they had to wait for their husband to begin the conversation.

Figure 9.4: Women's reports regarding ease of approach to husband to discuss family planning
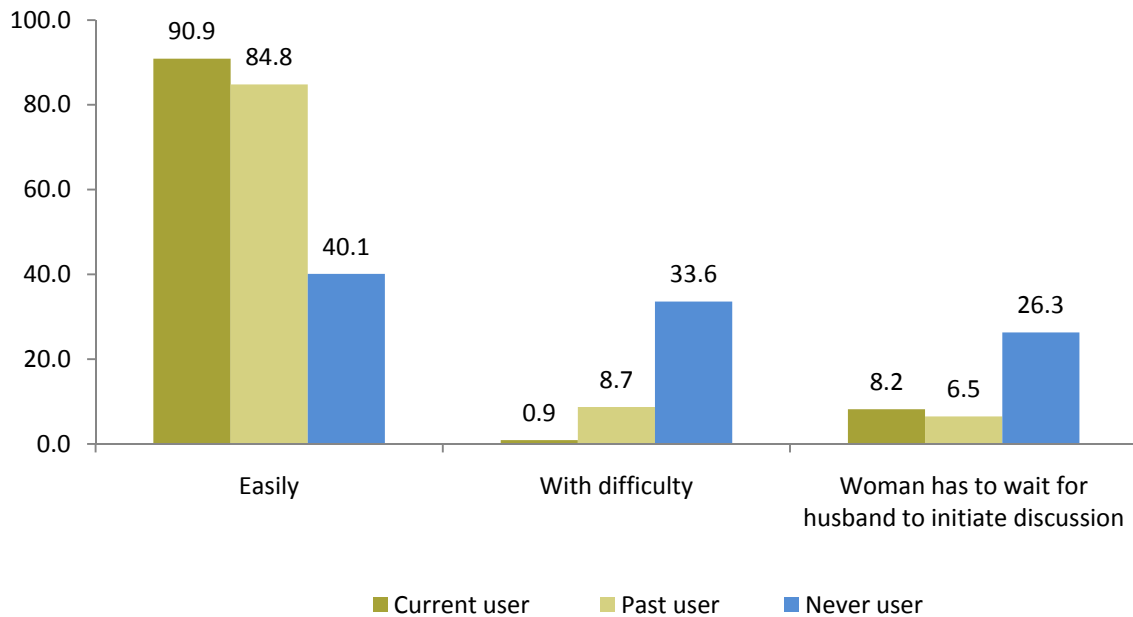
Chapter 10

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 10.1 shows the levels of unmet need for spacing and limiting among married women of reproductive age in Khuzdar. Of the total 639 women, 217 (34 percent) were judged to be in unmet need. This proportion was slightly lower than is typically found in Pakistan, where unmet need tends to be around 37 percent of MWRA. This lower proportion may be a reflection of the relatively higher contraceptive prevalence. Higher levels of use may mean that more of the total demand for family planning was being met.

Of the 34 percent women who had unmet need, 19 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 Khuzdar was high among women with five or more children.

Table 10.1: Need and demand for FP among MWRA by background characteristics

Characteristic	Unmet need For spacing	Unmet need For limiting	Unmet need Total	Met need For spacing	Met need For limiting	Met need Total	Total demand	Not in need	Total	N
Age group										
15 - 24	27.0	0.0	27.0	5.3	2.6	7.9	34.9	65.1	100.0	152
25 - 34	21.0	13.2	34.2	11.0	7.4	18.4	52.6	47.4	100.0	310
35 - 49	7.3	32.2	39.5	2.8	20.9	23.7	63.3	36.7	100.0	177
Residence										
Rural	17.3	14.4	31.7	7.6	9.3	16.9	48.6	51.4	100.0	473
Urban	22.3	18.1	40.4	6.6	12.0	18.7	59.0	41.0	100.0	166
Literacy of respondent										
Literate	29.7	2.7	32.4	8.1	10.8	18.9	51.4	48.6	100.0	37
Illiterate	17.6	16.4	34.1	7.1	10.2	17.3	51.4	48.6	100.0	590
Education of respondent										
No education	17.6	16.2	33.8	7.2	10.1	17.3	51.1	48.9	100.0	597
Up to primary	52.9	0.0	52.9	0.0	5.9	5.9	58.8	41.2	100.0	17
Up to secondary	21.1	5.3	26.3	15.8	10.5	26.3	52.6	47.4	100.0	19
Above secondary	25.0	0.0	25.0	0.0	25.0	25.0	50.0	50.0	100.0	4
Children ever born										
0	7.9	0.0	7.9	0.0	0.0	0.0	7.9	92.1	100.0	63
1-2	26.8	0.0	26.8	5.4	0.0	5.4	32.1	67.9	100.0	168
3-4	21.9	6.9	28.8	18.1	8.1	26.3	55.0	45.0	100.0	160
5+	13.7	35.1	48.8	3.6	20.6	24.2	73.0	27.0	100.0	248
Ownership of TV			0.0			0.0	0.0			
Yes	19.1	16.4	35.5	7.1	13.1	20.2	55.7	44.3	100.0	183
No	18.4	14.9	33.3	7.5	8.8	16.2	49.6	50.4	100.0	456
Standard of living index										
Low	18.3	15.5	33.8	6.3	7.0	13.4	47.2	52.8	100.0	284
Medium low	20.5	14.1	34.6	7.0	11.4	18.4	53.0	47.0	100.0	185
Medium high	15.8	19.8	35.6	7.9	9.9	17.8	53.5	46.5	100.0	101
High	18.8	11.6	30.4	11.6	18.8	30.4	60.9	39.1	100.0	69
Total	**18.6**	**15.3**	**34.0**	**7.4**	**10.0**	**17.4**	**51.3**	**48.7**	**100.0**	**639**

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 illiteracy and urban residence. Unmet need for spacing was associated with urban residence, and more literate women as compared to the illiterate women were in unmet need for spacing. However, conclusions should be tentative, given the small sample sizes involved. Figure 10.1 shows the need and demand for family planning of the sampled women.

Figure 10.1: Need and demand for family planning
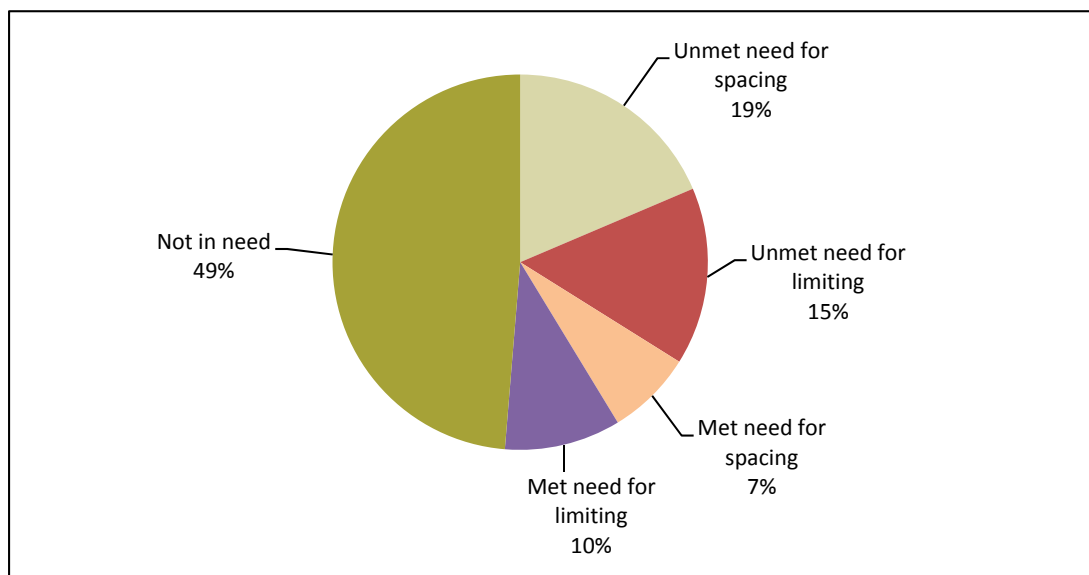
Total Demand

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 10.1 shows total demand by background characteristics of the women. Overall, total demand was 51 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 10.2). Slightly fewer than half of the women with unmet need for spacing said they would accept it if they became pregnant again. Twenty percent said they would be worried and 23 percent would be pleased. Of those with unmet need for limiting, 46 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 10.2: 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	23	22.5	0	0.0
Worried	20	19.6	41	46.1
Accept it	47	46.1	30	33.7
Doesn't matter	12	11.8	18	20.2
Total	**102**	**100.0**	**89**	**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 10.3. 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 10.3: 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	
	N	%	N	%	N	%
Fear of side effects	49	41.2	46	46.9	95	43.8
Husband opposes	41	34.5	28	28.6	69	31.8
In-laws oppose	24	20.2	10	10.2	34	15.7
Rest from method	2	1.7	0	0.0	2	0.9
Shy to consult about FP	13	10.9	6	6.1	19	8.8
Provider's advice	1	0.8	2	2.0	3	1.4
Against religion	1	0.8	1	1.0	2	0.9
Lack of access/unavailability	52	43.7	64	65.3	116	53.5
Cost not affordable	36	30.3	47	48.0	83	38.2
Method inconvenient to use	7	5.9	15	15.3	22	10.1
Infrequent sex/husband away	5	4.2	5	5.1	10	4.6
Natural spacing	1	0.8	1	1.0	2	0.9
Difficult/unable to conceive	2	1.7	7	7.1	9	4.1
Want (more) children	78	65.5	14	14.3	92	42.4
Currently pregnant	4	3.4	2	2.0	6	2.8
Breastfeeding/lactational amenorrhea	7	5.9	15	15.3	22	10.1
Others	3	2.5	6	6.1	9	4.1
N	**119**	**na**	**98**	**na**	**217**	**na**

na = not applicable; respondents could give more than one reason.

Unmet Need for Spacing: Profile

Women with unmet need for spacing comprise 119 (18.6 percent) of MWRA. As shown in Table 10.4, they were characterized by:

- **Living Children:** Most (39 percent) had 1 or 2 living children.

- **Family Planning Use:** More never users (86 percent) than past users (14 percent).

- **Strength of Preference:** Low (20 percent "worried" if they became pregnant earlier than they wanted compared to those who were pleased (23 percent) or accept (46 percent) the unwanted pregnancy).

- **Intent to Use FP in Future:** High (about 49 percent intended to use a FP method in future).

- **Approval of FP:** High (77 percent approved of using a FP method for spacing purpose).

- **FP Communication with Husband:** Moderate (only 41 percent had communicated with husbands on FP in the past one year; while 47 percent said approaching the husband was "not easy").

- **Obstacles to FP Use:** Fear of side effects (41 percent); husband and in-laws opposition (35 percent and 20 percent respectively) (Table 10.3).

Table 10.4: 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	5	4.2	0	0.0
1-2	46	38.7	1	1.0
3-4	38	31.9	17	17.3
5 or more	30	25.2	80	81.6
Contraceptive use status				
Current user	0	0.0	0	0.0
Past user	17	14.3	7	7.1
Never user	102	85.7	91	92.9
Reaction if become pregnant in near future				
Pleased	23	22.5		
Worried	20	19.6	41	46.1
Accept it	47	46.1	30	33.7
Doesn't matter	12	11.8	18	20.2
Intention to use a method in future				
Yes	58	49.2	52	54.2
No	28	23.7	31	32.3
Unsure/uncertain	32	27.1	12	12.5
Can't get pregnant	0	0.0	1	1.0
Approval of FP				
Approve	92	77.3	90	91.8
Disapprove	27	22.7	8	8.2
FP communication with husband in past one year				
Never	70	58.8	28	28.6
Once or twice	29	24.4	37	37.8
More often	20	16.8	33	33.7
Approach the topic of FP with husband				
Easily	62	52.5	61	62.2
Not easily	56	47.5	37	37.8
Total	**118**	**na**	**98**	**na**

Unmet Need for Limiting: Profile

Women with unmet need for limiting comprise 98 (15.3 percent) of MWRA. As shown in Table 10.4, they were characterized by:

- **Living Children:** A strongly positive association with number of living children; 82 percent had 5+ living children.

- **Family Planning Use:** More never users (93 percent) than past users (7 percent).

- **Strength of Preference:** Moderate (46 percent would be "worried" if they became pregnant compared to those who would accept (34 percent) the unwanted pregnancy or 20 percent women to whom it would not matter.

- **Intent to Use FP in Future:** High (about 54 percent intended to use a FP method in future.

- **Approval of FP:** High (92 percent approved of FP for limiting purpose).

- **FP Communication with Husband: High** (71 percent had communication with husband on FP in the past year; while 38 percent said approaching the husband was "not easy").

- **Obstacles to FP Use:** Fear of side effects (47 percent); husbands and in-laws opposition (29 percent and 10 percent respectively) (Table 10.3).

Chapter 11

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 Khuzdar, the field team was able to interview 189 men who were husbands of the married women of reproductive age who had been interviewed for the survey, plus 9 married men living in selected areas who were not husbands of the female respondents. In this chapter, the results for the respondents' husbands and the other married men who were interviewed (N = 198) 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 11.1 shows the background characteristics of the men interviewed in the survey. It shows that more than 8 percent of the men were under 25 years of age and 12 percent were 50 years of age and above.

As shown in Table 11.1, the men were substantially better educated than the sampled currently married women of reproductive age. Fifty four percent of the men had not been to school, compared to 94 percent of the currently married women (Table 3.2). It also shows that 33 percent of the men had more than primary education, whereas 4 percent of the currently married women had attained that level of education (Table 3.2). Sixty-three percent of the urban men had received some schooling compared to 40 percent of the rural men.

The occupations of men are also presented in Table 11.1. The highest proportion (30 percent) of men were working in agriculture-related activities and 22 percent were working as daily wage laborers. More than 14 percent were working in the private service.

Table 11.1: Background characteristics of male respondents by residence

Characteristics	Rural	Urban	Total
Age			
20-24	9.0	5.6	8.1
25-29	18.8	16.7	18.2
30-34	31.9	27.8	30.8
35-39	14.6	16.7	15.2
40-44	10.4	18.5	12.6
45-49	4.9	0.0	3.5
50-54	6.3	9.3	7.1
55+	4.2	5.6	4.5
Education			
Proportion literate	38.9	59.3	44.4
No education	60.4	37.0	54.0
Up to primary	11.8	16.7	13.1
Up to Secondary	19.4	27.8	21.7
Above secondary	8.3	18.5	11.1
Occupation			
Agriculture/livestock/poultry	36.1	13.0	29.8
Petty trader	2.1	5.6	3.0
Labor	24.3	16.7	22.2
Govt. service	18.1	33.3	22.2
Pvt. Service	11.1	24.1	14.6
Own business	2.1	3.7	2.5
Abroad	0.7	0.0	0.5
Unemployed	3.5	0.0	2.5
Others	2.1	3.7	2.5
N	**144**	**54**	**198**

Contraceptive Knowledge and Use

Almost all of the interviewed men in Khuzdar knew of at least one modern method of contraception. As shown in Table 11.2, knowledge of modern methods was highest for pills (100 percent) followed by injectables (99 percent) and female sterilization (91 percent). The least known methods were Norplant (16 percent), IUD (39 percent) and male sterilization (40 percent). All currently married women of reproductive age interviewed in Khuzdar also knew at least one contraceptive method (Table 7.1).

Table 11.2: Distribution of male respondents by contraceptive knowledge, use status and residence

Method	Knowledge			Ever use			Current use		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Female sterilization	88.9	96.3	90.9	3.5	1.9	3.0	3.5	1.9	3.0
Male sterilization	38.2	43.4	39.6	0.7	0.0	0.5	0.7	0.0	0.5
Pill	100.0	100.0	100.0	9.0	13.0	10.1	4.2	7.4	5.1
IUD	34.3	52.8	39.3	2.1	0.0	1.5	1.4	0.0	1.0
Injectables	97.9	100.0	98.5	11.1	13.0	11.6	4.9	5.6	5.1
Norplant	11.1	27.8	15.7	0.0	0.0	0.0	0.0	0.0	0.0
Condom	80.6	90.7	83.3	0.7	5.6	2.0	0.7	3.7	1.5
Rhythm	43.1	48.1	44.4	0.0	0.0	0.0	0.0	0.0	0.0
Withdrawal	51.4	51.9	51.5	0.0	0.0	0.0	0.0	0.0	0.0
Others	1.4	5.6	2.5	0.0	0.0	0.0	0.0	0.0	0.0
At least one FP method	100.0	100.0	100.0	19.4	29.6	22.2	15.3	18.5	16.2
At least one modern FP method	100.0	100.0	100.0	19.4	29.6	22.2	15.3	18.5	16.2
At least one traditional FP method	52.1	51.9	52.0	0.0	0.0	0.0	0.0	0.0	0.0
Emergency Pills	27.8	33.3	29.3	0.0	0.0	0.0	na	na	na
N	144	54	198	144	54	198	144	54	198

na = not applicable

The pattern of ever use and current use of contraception reported by husbands is also shown in Table 11.2. A quarter (25 percent) of the MWRA reported having used some method of contraception during their married lives (Table 7.2); of the male respondents, 22 percent reported ever using some method of contraception in their married lives. For the men, among modern methods, injectables was the most popular method ever used (12 percent), followed by pill (10 percent) and female sterilization (3 percent).

As mentioned in table 7.2, 17 percent of all MWRA in the sample were currently using some method of contraception, while for the male respondents this figure was slightly lower at 16 percent. The most common current modern methods reported by male respondents were pills and injectables (5 percent each). Although, more than half of the men knew about traditional methods, these were not used at all in Khuzdar. The Emergency pill was also known to 29 percent of the respondents but none of the men reported ever using it.

Table 11.3 shows ever use and current use of modern contraception among respondents by background characteristics. A slightly higher proportion of urban men were currently using a family planning method compared to rural men. More than 32 percent of the respondents who had secondary and above education reported ever use of any contraceptive method, compared to 16 percent of men with no education. The current use of family planning also showed the same pattern by education of men.

Table 11.3: 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	19.4	15.3	144
Urban	29.6	18.5	54
Education level			
No education	15.9	9.3	107
Below secondary	23.1	15.4	26
Secondary and above	32.3	27.7	65
Number of living children			
None	0.0	0.0	19
1-2	8.5	5.1	59
3-4	28.8	19.2	52
5+	35.3	27.9	68
Future desire for children			
Soon	15.1	10.1	139
Later	40.0	30.0	10
Never	40.0	33.3	30
Don't know/unsure	36.8	26.3	19
Total	**22.2**	**16.2**	**198**

Table 11.3 also shows a positive relationship between the number of living children and ever use as well as current use. Of those who had 5 or more children, 35 percent reported ever use of family planning methods compared to 29 percent who had 3-4 children and 9 percent who had 1-2 children. The same pattern is observed for current contraceptive use and number of children.

Table 11.3 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: 33 percent of those respondents who did not want more children were currently using a contraceptive method, and 40 percent had used some form of contraception in their reproductive life.

Source of Contraceptive Methods

As shown in Table 11.4, among those who reported the last source for obtaining contraceptive methods, 50 percent reported that they obtained it from the "Government hospital (DHQ/THQ)" and 11 percent obtained it from the "grocery shop/general store". BHU/RHC/MCH and LHWs were reported by 9 percent and 5 percent, respectively. Seven percent of the male respondents reported that they obtained contraceptive methods from private doctors.

Table 11.4: Distribution of male ever users by last reported source of contraceptive supply

Source	Percentage
Government hospital (DHQ/THQ)	50.0
BHU/RHC/MCH	9.1
LHW	4.5
Pvt. Doctor	6.8
Pvt. hospital/clinic	4.5
Dispenser/Compounder	2.3
Pharmacy, chemist	6.8
Grocery shop/general store	11.4
Others	4.5
Total	**100.0**
N	44

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 Khuzdar, more than 50 percent of the men approved of spacing between children and 50 percent also approved of the use of any form of contraception for this purpose (Table 11.5).

Table 11.5: Distribution of male respondents by attitude towards spacing and use of contraceptives for spacing, by residence

Variable	Rural	Urban	Total
Spacing between children			
Approve	44.4	66.7	50.5
Disapprove	55.6	33.3	49.5
Total	100.0	100.0	100.0
N	144	54	198
Using family planning methods for spacing			
Approve	44.4	63.0	49.5
Disapprove	55.6	37.0	50.5
Total	**100.0**	**100.0**	**100.0**
N	144	54	198

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 11.6 shows 88 percent of the current users were very satisfied with their current method; only 6 percent reported that they were not satisfied with their current method. More than 6 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 11.6: Level of male respondents' satisfaction with their current method

Level of satisfaction	Percentage
Very satisfied	87.5
Somewhat satisfied	6.3
Not satisfied at all	6.3
Total	**100.0**
N	32

The reasons why male respondents stopped using their last method are presented in Table 11.7. The table shows that wanting another child was the main reason for stopping the use of a family planning method. However, 8 percent of past male users stopped using their method because of side effects the couple experienced with their method. Eight percent of the past users stopped using a contraceptive due to method failure. Seventeen percent left the use on provider's advice.

Table 11.7: Percentage distribution of male past contraceptive users by the reason for discontinuing last method

Reason	Percentage
Experienced side effects	8.3
Fear of side effects	8.3
Wanted another child	75.0
Method failure	8.3
Health concern	8.3
Service provider's advice	16.7
N	**12**

Respondents could give more than one reason

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 11.1. Forty-six percent of the men reported that their wives could talk to them about family planning and fertility-related issues easily. However, 55 percent of the men reported that their wives had never approached them during the last year on this issue. Seventeen percent of the men reported that their wives had talked more often about this subject during the last year, while 28 percent reported they had talked about it once or twice.

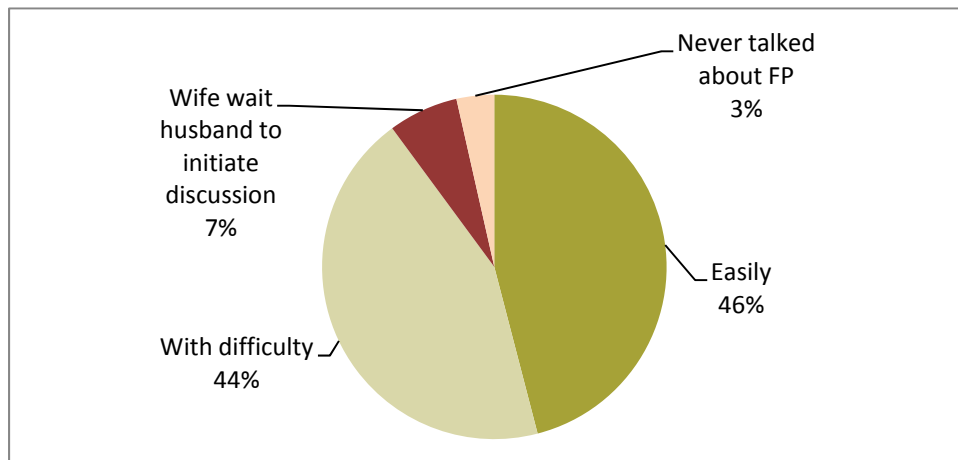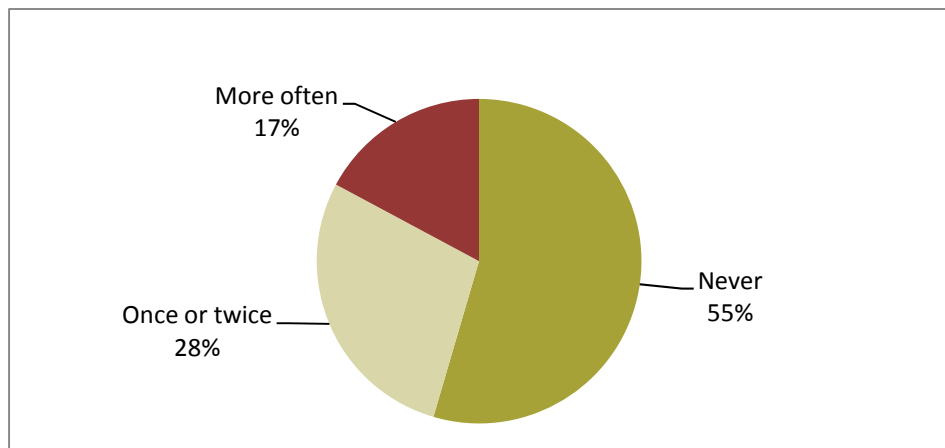**Figure 11.1: Men's reports of ease of approach by their wives to discuss FP**

Figure 11.2: 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 11.8 shows that only 14 percent intended to use contraception in the future, while 18 percent did not intend to do so. A great majority (69 percent) of the respondents were uncertain about their future use of contraception.

As shown in Table 11.9, the major reason husbands said they did not intend to use contraception was the opposition of in-laws/parents or from their wives. The desire for more children was cited by 78 percent of the husbands, while for 15 percent, fear of side effects was the reason for not using a contraceptive method. It is also pertinent to mention that 19 percent men were shy to go to FP clinic.

Table 11.8: Distribution of male never users by intent to use contraceptive methods in future

Intent	Percentage
Will use	13.6
Will not use	17.5
Unsure/uncertain	68.8
Total	**100.0**
N	154

Table 11.9: Distribution of male never users according to reasons for not intending to use contraceptive methods in future

Reason	Percentage
Wife opposes	40.7
In laws/parents oppose	51.9
Fear of side effects	14.8
Lack of access/unavailability	3.7
Cost too much	11.1
Shy to go to FP clinic	18.5
Inconvenient to use	11.1
Difficult/unable to conceive	11.1
Respondent/wife infertile	11.1
Want more children	77.8
N	**27**

Respondents could give more than one reason

Table 11.10 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. Pill and Injectables were the main contraceptive methods proposed to be used in future.

Table 11.10: Distribution of male never users who intend to use specific contraceptive methods in the future

Method	Percentage
Pills	57.1
Injectable	38.1
Others	4.8
Total	**100.0**
N	**21**

Fertility Desire

Men were asked about the number of their living children and their desire for more children. Table 11.11 shows that 70 percent of the respondents wanted another child soon (within two years). Only 5 percent of the respondents wanted to delay their next child for more than two years and 15 percent did not want any more children at all.

Table 11.11: 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	100.0	0.0	0.0	0.0	100.0	19
1	100.0	0.0	0.0	0.0	100.0	26
2	93.9	6.1	0.0	0.0	100.0	33
3	75.0	4.2	12.5	8.3	100.0	24
4	78.6	10.7	7.1	3.6	100.0	28
5	50.0	14.3	25.0	10.7	100.0	28
6+	22.5	0.0	45.0	32.5	100.0	40
Total	**70.2**	**5.1**	**15.2**	**9.6**	**100.0**	**198**

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 45 percent of those who had 6 or more children did not want more children.

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 11.3 shows the proportion of men who reported that they watched TV, listened to the radio, or read newspapers or magazines. Radio and print media were the most commonly accessed mediums as 55 percent of the male respondents in Khuzdar listened to the radio and 44 percent reported access to print media.

Furthermore, respondents who reported access to any sort of media were asked if they had ever seen, heard, or read any message pertaining to methods of family planning through these mediums. Twenty-six percent of the men had seen FP messages on television. Overall, 38 percent of the male respondents and 11 percent of the MWRA had seen a family planning message on at least one medium. Only 10 percent of the men reported that they had ever listened to a family planning message on the radio.

Figure 11.3: Distribution of male respondents according to exposure to media and FP messages, by type of media
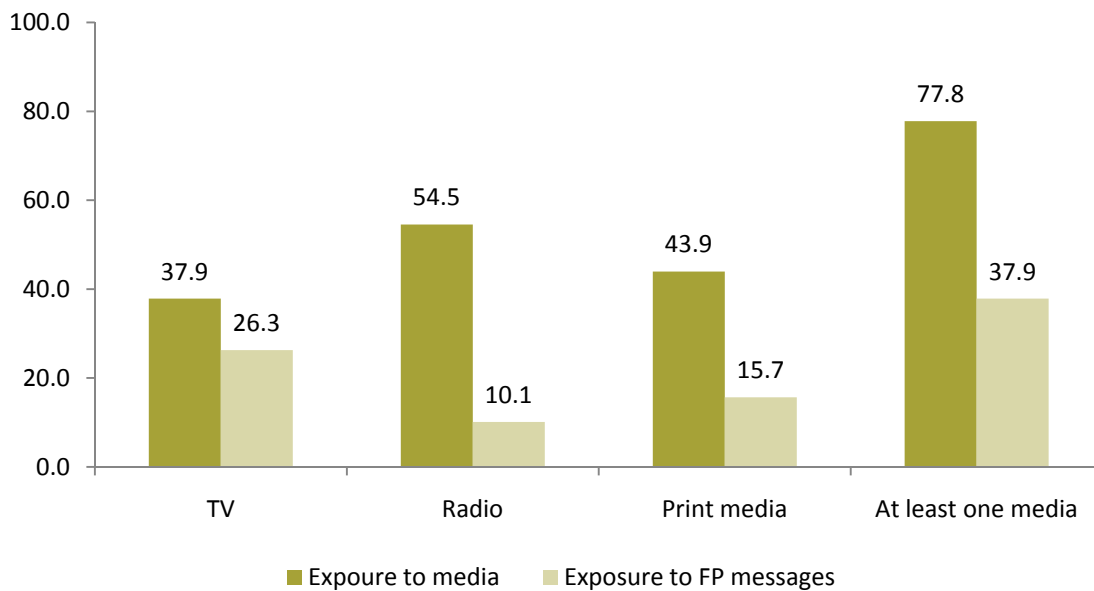
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