10

Gilgit Baltistan

Demographic and Health Survey 2008

National Institute of Population Studies
Government of Pakistan
Islamabad

GILGIT BALTISTAN

DEMOGRAPHIC AND HEALTH SURVEY (2008)

NATIONAL INSTITUTE OF POPULATION STUDIES (NIPS)
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Table of Contents

List of Tables

List of Figures

Foreword

An important function of the National Institute of Population Studies (NIPS) is to provide research based input to the policy makers and planners for improving the reproductive health and family planning programmes. In pursuance of this, NIPS undertook a household survey namely Gilgit and Baltistan Demographic and Health Survey (GBDHS) during 2008. This household survey was carried out on the pattern of Pakistan Demographic and Health Survey (PDHS) 2006-07. The main objective of the survey is to provide reliable information on population, family planning, maternal and child health, reproductive health, nutrition, and knowledge about AIDS and Tuberculosis. A sample of 1,120 households, covering geographic boundaries of Gilgit and Baltistan was selected with the help of Federal Bureau of Statistics and information was collected through interviews of ever married women residing in the households.

This report is based on the data collected from the sampled areas and weighted estimates of various indicators are present in different chapters. It is the collective effort of members of core team of the project which is highly appreciated. I hope that the data and analysis presented in this report would help program managers and policy makers in effective planning and formulation of future strategies for improving the reproductive health status of people of Gilgit and Baltistan.

All those organizations and individuals who provided valuable help in smooth implementation of the survey deserve appreciation. In particular, I acknowledge with gratitude, the administrative and logistic support provided by the Project Directorate of Population Welfare, Gilgit and Baltistan which enabled NIPS to carry out the survey.

Dr. Firdous Ashiq Awan, Feral Minister for Population Welfare, deserves special thanks for her all out support and guidance. Mr. Nayyar Agha, Federal Secretary, Ministry of Population Welfare, as always, has been the driving force, by continuously monitoring the progress of the study.

My special appreciation to the courageous female interviewers and team supervisors of GBDHS, who collected the data with great effort and dedication, despite un-friendly terrain and resistance/ opposition from the local community.

Mr. Iqbal Ahmad, Director NIPS, who was the Project Director, deserved my special commendation for undertaking the survey, till his retirement from Government service. Mr.

Mehboob Sultan, former Director (R&S) was of a great help during the launch of the project and also provided technical input during the entire course of the survey. Mr. Amanullah Bhatti current Director (R&S) deserves special thanks for his continuous and untiring supervision. Mr. Mubashir Ali Syed, Former Principal Investigator PDHS, has provided professional input during the questionnaire preparation, training of survey staff and editing of this report which is highly appreciated. In the end I acknowledge the efforts of Mr. Zafar Zahir, Principal Investigator, Mr. Ali Anwar Buriro, Deputy Principal Investigator and Mr. Badar ud Din Tanweer, Coordinator of the project. Mr. Faateh ud din Ahmad, Programmer and his staff worked really hard in processing the data and generating tables for this report, therefore, deserve a special mention. The support and efforts of all other staff involved in the project are duly acknowledged. I would also like to acknowledge the guidance and leadership provided by Mrs. Sarod Lashari and Mr. Muhammad Ali Afridi (former Executive Directors).

I hope that, this report will be useful for the planners, managers and researchers as well as by all others involved in any capacity with the programme of reproductive health and family planning in Pakistan.

Dr. Sajid Ahmad
Executive Director

December, 2009

Acknowledgement

The Gilgit and Baltistan Demographic and Health Survey (GBDHS) was undertaken by National Institute of Population Studies (NIPS) during 2008-09 and completed in several stages and number of organizations and individuals provided assistance during its implementation. First of all, I would like to thank the field staff of the survey, particularly; the female interviewers who conducted interviews of married women belonging to different types of background, and at times had to amicably handle difficult situations. The team supervisors have put their best effort to manage the data collection process within given timeframe. I acknowledge the cooperation extended by our worthy respondents who shared their views on personal matters such as reproductive health and family planning.

The survey could not be implemented without the support rendered by the officers and staff of Project Directorate of Population Welfare, Gilgit and Baltistan. In particular, Mr. Ikramullah Baig, Project Director, has taken keen interest for undertaking this survey and provided valuable guidance during various stages of implementation. The Federal Bureau of Statistics, designed the sample for this survey and the staff of its Gilgit office provided assistance during the process of household listing in the selected clusters, their technical support is fully acknowledged.

I am grateful to the Ministry of Population Welfare (MPW) for providing administrative and financial support during the implementation of this survey. My special thanks to Mr. Nayyar Agha, the Federal Secretary, Mo PW who has extended his encouragement to the members of the core team for completing a difficult task. I also thank the senior officers of M/o Population Welfare for their support.

I am grateful to Mrs. Sarod Lashari and Mr. Muhammad Ali Afridi, Former Executive Directors of NIPS for their support in executing the project. Dr. Sajid Ahmad, Executive Director, NIPS enthusiastically helped in data analysis as well as in report writing and provided valuable comments on the draft of the report. I am grateful for his guidance and encouragement.

My special acknowledgments to Mr. Mubashir Ali Syed, Ex- Principal Investigator, Pakistan Demographic and Health Survey for providing technical guidance at each stage of the survey, particularly for questionnaire designing and training of survey staff. He has given valuable comments on the earlier draft of this report which is highly appreciated.

The support and advice rendered by Mr. Mehboob Sultan and Mr. Iqbal Ahmad, Ex-Directors, NIPS during the initial stages of this survey are gratefully acknowledged. Mr. Amanullah Bhatti, Director (Research and Survey), NIPS, has contributed in writing this report and provided support at various stages. I am grateful to Mr. Ali Anwar Buriro, Deputy Principal Investigator and Mr. Badar ud Din Tanweer, Coordinator for providing assistance during the completion of the project. Mr. Faateh ud din Ahmad, Programmer, NIPS has cheerfully done a marvelous job in handling a very large data set of the survey and generated valuable tables for this report. Mr. Faateh has also provided professional support to the Principal Investigator at various stages of this project which is fully acknowledged. I appreciate the hard work done by Mr. Zahid Zaman, Mr. Shoaib Khan Lodhi, Mr. Muhammad Ismail, Mr. Dilnawaz and Mr. Takasar Amin, of computer section for data processing. I am grateful to all officers and staff of Administration and Finance sections of NIPS for efficiently managed the project and ensure availability of funds.

Last but not the least I am grateful to all the authors and co-authors who have written different chapters of this report with their professional commitment and dedications.

Zafar Zahir
Principal Investigator

December, 2009

Executive Summary

One of the main functions of National Institute of Population Studies (NIPS) is to generate quality information through sample surveys and in-depth research studies so as to provide guidelines to policy makers and programme managers for right policy formulation, effective strategies and programmes. In the absence of a good and reliable data on demographic and health indicators for Gilgit and Baltistan, a need was felt by different stakeholders, to persuade NIPS to undertake a household survey on the pattern of Pakistan Demographic and Health Survey (PDHS) 2006-07.

Therefore, Gilgit and Baltistan DHS was undertaken during 2008 to collect information for addressing the monitoring and evaluation needs of population welfare and reproductive health programmes and to provide programme managers and policy makers with the information that they need to effectively plan and implement future interventions. This survey has been designed on the lines of PDHS carried out by NIPS in four provinces of Pakistan during 2006-07.

The sample for the GBDHS 2008 was scientifically designed and drawn by Federal Bureau of Statistics. It is a stratified, two-stage, weighted sample of households based on the up-dated 1998 population census frame. The total sample comprised of 54 clusters (1,120 households) and spread over all the districts of Gilgit and Baltistan.

The GBDHS 2008 reveals very useful data on various indicators based on the information related to demographic, family planning and health of mother and child. A reader of this report can benefit from a detailed analysis of data which is presented in different chapters.

The age structure of the household population is typical of a society with a youthful population. Gilgit and Baltistan show a pyramidal age structure due to a large number of children in less than 15 years of age. Fifty-two percent of the population is in the age group 15-64 years and less than 4 percent are over 65.

About half of the total female population falls into the reproductive age group (15-49 years). The fact that this segment has been increasing over the last two decades has an impact, because they are in the childbearing years and hence can contribute to overall population growth.

Education is an important factor influencing an individual's attitude and approach on various aspects of life. A large majority of ever-married women in Gilgit and Baltistan (77 percent)

have no education. However, it is encouraging to note that a large proportion of women (39 percent) are currently working for gainful employment.

Fertility is one of the three principal components of population dynamics, the others being mortality and migration (UN, 1973). In view of the fast growing population, the government has been trying since 1960s, to reduce fertility rate through the implementation of its population policies. Total Fertility Rate (TFR) in Gilgit and Baltistan is 4.6 children per woman for the 3 years period preceding the survey. Fertility in rural areas is higher (5.1 children per woman) as compared to urban areas (3.8 children per woman). Women's education brings about the most conspicuous differentials in fertility. The Children Ever Born (CEB) is almost 3 children less among women with higher education than among uneducated women.

The Population Welfare Programme has been able to create universal awareness about family planning methods among married women but the contraceptive prevalence rate is quite low. The challenge is to ensure continuous use by current users and increase existing CPR by meeting the unmet need for family planning services along with sustaining the demand of family planning services by new entrants in the reproductive age group.

In Gilgit and Baltistan, more than one fourth of currently married women (29 percent) are using a method of family planning, with 27 percent using a modern contraceptive method. Use of any method is highest (48 percent) among women with higher level of education and lowest (25 percent) among women with middle level of education.

Among the current users of modern methods, 71 percent rely on public sector institutions while 15 percent of women use the private medical sector. In the public sector, the most important sources of family planning services (28 percent of users) are government hospitals and Reproductive Health Service Centers (RHSC). Family Welfare Centres (FWCs) are the main source of service delivery under the Ministry of Population Welfare, but only 23 percent of women visit FWCs to obtain methods. Lady Health Workers are also an important source (11 percent of all users of modern methods) at grass root level.

It is very important that, a pregnant woman should have regular checkups by a health professional during pregnancy. A qualified person would monitor the health of a mother and the growth of child in her womb. It is observed that about 61 percent of the women have received prenatal care from a skilled health professional. It is encouraging to note

that a majority of these women have contacted a doctor for antenatal checkup, followed by a nurse/mid wife/LHV.

Place of delivery is vitally important for the health of mothers and the newborns. In 2008 GBDHS, data indicates that the home based deliveries are very high (61 percent). This practice is more common amongst older age women and those, who have more than 4 children; among uneducated and, those women who belong to poor households.

The postnatal checkup is highly recommended, as a large proportion of maternal and neo-natal deaths occur during the first 24 hours after delivery. The data shows that majority of women (74 percent) did not have a checkup after their last delivery.

WHO recommended guidelines for child immunization are implemented in Pakistan under expanded programme of immunization (EPI). It is discouraging to note that complete vaccination was given to 34 percent of the children age 12-23 months.

Data of 2008 GBDHS reveals that the prevalence of all types of diarrhea was 22 percent among children under five years of age during two weeks preceding the survey. Furthermore, about three in five children (57 percent) who are suffering from diarrhea have been taken to a health facility/ provider for treatment.

UNICEF and WHO recommend that children be exclusively breastfed during the first six months of life and that children be given solid or semisolid complementary food in addition to continued breastfeeding after six months. Overall only 16 percent of children under 3 years of age are found to be exclusively breastfed. Children of young mothers and children living in rural areas are more likely to have exclusive breastfeeding.

In Gilgit and Baltistan, every eighth woman (12.9 percent) reported that she has heard of AIDS. The data indicates that most of women age 15-49, lack accurate knowledge about various modes of AIDS virus transmission. Only six percent of women know that AIDS cannot be transmitted by mosquito bites. Four percent women correctly believe that a person cannot become infected by sharing food with a person who has AIDS. Only 10 percent of women know that HIV can be transmitted from mother to child during pregnancy (MTCT).

1 INTRODUCTION

Zafar Zahir

1.1 Background

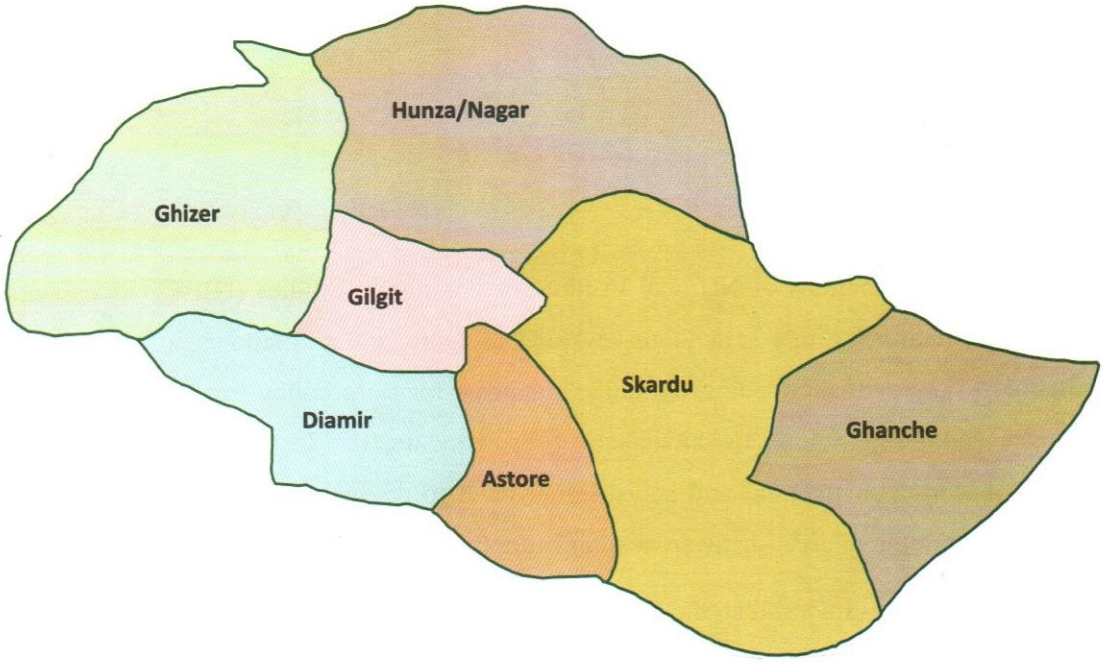
One of the main functions of National Institute of Population Studies (NIPS) is to generate quality information through sample surveys and in-depth research studies so as to provide guidelines to policy makers and programme managers for right policy formulation, effective strategies and programmes. In pursuance of its mandate, the Institute has undertaken a number of studies at national and sub-national level to evaluate the impact of Population Welfare programme in creating awareness and adoption of family planning methods.

NIPS in 2006-07 has undertaken the Pakistan Demographic and Health Survey (PDHS). The PDHS was a national level sample survey designed to provide information on population, family planning, maternal and child health, child survival, AIDS, reproductive health, and nutrition in Pakistan. This survey did not cover the geographical areas of Federally Administrative Tribal Area (FATA) and Federally Administrative Northern Area (FANA) now renamed as Gilgit and Baltistan. In the absence of good and reliable data on demographic and health indicators, a need was felt by different stakeholders in particular by the project directorate of population welfare, Gilgit and Baltistan, to perused NIPS to undertake a household survey on the pattern of Pakistan DHS.

1.2 Geography of Gilgit and Baltistan.

According to population census 1998, the population of FANA (now Gilgit and Baltistan) was 883,799 persons and an area of 72,520 Sq. Km. Geographically, this area lies amidst the towering mountains of Karakoram (K2 peak), Hindu Kush, Himalayas and Pamir with an altitude between 3,000-28,250 ft. above sea level. The population of Gilgit and Baltistan is scattered in small settlements all over the hilly terrain which is difficult to approach and consumes long hours to reach the target population during any data collection process. Gilgit and Skardu are the main cities in Gilgit and Baltistan.

Map of Gilgit and Baltistan



1.3 Objectives of Gilgit and Baltistan DHS

The Gilgit and Baltistan DHS 2008 was undertaken to collect information in order to address the monitoring and evaluation needs of population welfare and reproductive health programmes and to provide program managers and policy makers with the information that they need to effectively plan and implement future interventions. This survey has been designed on the lines of Pakistan Demographic and Health Survey carried out by NIPS in four provinces of Pakistan during 2006-07.

More specifically, the objectives of the GBDHS 2008 were to collect high-quality data relating to:

1. Household and woman characteristics;
2. Fertility levels and preferences;
3. Family planning knowledge and use;
4. Child mortality;
5. Health and nutrition of mother and children;
6. Unmet need for family planning; and
7. Knowledge about HIV/AIDS.

A related objective is to produce the research findings in a timely manner and ensure that the data is disseminated so as to be useful for programme managers and policy-makers in government and non-governmental organizations (Annexure - 1 for the list of indicators). The data will also facilitate the managers to measure the improvements male in the socio-economic and demographic indicators.

1.4 Project Team and Responsibilities

The GBDHS 2008 was implemented by the National Institute for Population Studies (NIPS). The Executive Director, NIPS has been responsible for overall management of the survey. To implement the survey, a Core Team was constituted under the Project Director, who was assisted by the Principal Investigator, Deputy Principal Investigator, Computer Programmer, Field Coordinator and others (Annexure - 2).

A Technical Advisory Committee comprising of technical experts from different organizations was formulated to discuss the project methodology and the contents of questionnaires used for data collection (Annex- III). The core team members have over-seen the day-to-day operations; recruitment and training of field staff; supervision of field and office operations; and data processing. NIPS staff has been involved in analysis and report writing of the survey. The Administration and Accounts sections of NIPS were responsible for administering project funds and keeping an account of these funds.

1.5 Collaboration with other Organizations

The institute sought the cooperation from various organizations working at federal level and also in Gilgit and Baltistan Areas so as to implement the project in a well-organized manner. The regional office of the Directorate of Population Welfare, Gilgit were taken on board. The office was a focal point during training of interviewers and supervisor and field operation. In this regards, Mr. Akramullah Baig, Project Director (PWD-GB), provided consultative support during the planning stage and logistic support for the implementation of the project. The District Coordination Officers (DCO) were contacted for providing security of the team members while traveling in remote areas of Gilgit & Baltistan.

The Federal Bureau of Statistics (FBS) was approached to provide a representative sample of Gilgit and Baltistan, the list of the clusters or primary sampling units (PSUs) and total households in each PSU. The local offices of the organization have extended assistance to NIPS survey teams in locating the sampled cluster and the households during data collection process.

2 METHODOLOGY

Zafar Zahir and Faateh ud din Ahmad

2.1 Sample Design

For this study, a household sample survey was carried out to collect information in the light of survey objectives. Therefore, the entire geographical boundaries of the Gilgit and Baltistan constituted the universe of the survey and a representative sample of 1,120 households was selected. The Federal Bureau of Statistics (FBS) has been approached to bear the responsibility for designing the survey methodology and selecting a representative sample of households so as to estimate the main indicators of the study. The local office of FBS in Gilgit provided help for listing operation in each cluster. The process of selecting a PSU, households and the eligible respondents is explained in the following passages.

(i) Selection of Primary Sampling Units (PSU)

The sample for the GBDHS 2008 was a stratified, two-stage, weighted sample of households based on the 1998 population census frame. The total sample comprised of 54 clusters (1,120 households) spread over all the districts of Gilgit and Baltistan and is presented in Table 2.1.

The sample is designed in a way to allow separate estimates for the Northern Areas as a whole and also for urban and rural areas separately. The sample also produced interviews with more than 1,100 ever-married women of reproductive age (15-49) residing in the sampled households.

(ii) Selection of Secondary Sampling Units (SSU) Households

To get a representative sample of rural and urban population, 22 households were selected from a rural cluster and 18 households from the urban cluster. A household was taken as a secondary sampling unit for the survey and all ever married women aged 15-49 years residing in it were interviewed to get relevant information.

NIPS undertook fresh listing of all households inhabited in each selected clusters (PSUs) with the assistance of FBS staff. Thereafter, a sample of households was drawn by using the systematic sampling technique with a random start. In order to accomplish this task, the supervisor of each survey team was trained to prepare a complete list of selected households i.e. 22 and 18 in each rural and urban cluster respectively. The process of household listing

and selection of sample has been completed well before starting the data collection for the survey.

Table 2.1: Sample of the survey

Distribution of Sample Clusters and Households by Districts, Gilgit and Baltistan, 2008

S. No.	District	Number of clusters (PSUs)		
		Rural	Urban	Total
1.	Skardu	9 (198)	4 (72)	13 (270)
2.	Ghanche	4 (88)	3 (54)	7 (142)
3.	Gilgit	8 (176)	5 (90)	13 (266)
4.	Ghizer	6 (132)	2 (36)	8 (168)
5.	Diamir	7 (154)	3 (54)	10 (208)
6.	Astor	3 (66)	--	3 (66)
7.	Hunza / Nagar	--	--	--
	Total	37 (814)	17 (306)	54 (1,120)

Note: Figures in parenthesis are the number of households (HH)

2.2 Questionnaires for Survey

In order to meet survey objectives, two questionnaires were prepared viz. (i) Household Questionnaire, and (ii) Woman Questionnaire for ever-married women age 15-49. These instruments were based on the questionnaires developed for latest DHS questionnaires (PDHS 2006-07). During the adaptation of these questionnaires, inputs were sought from a variety of experts engaged in the field of fertility, family planning and reproductive health. NIPS hosted a number of consultative meetings during the questionnaire design process. The household questionnaire identifies the eligible woman for interview and also broadly classify the respondents by socio-economic status. Using this data on housing characteristics, availability of durable goods, etc., it was possible to develop 'wealth' index as a background characteristic.

The questionnaires were initially prepared in English language and most of the PDHS questions were copied as it is. Then it is translated into Urdu language for easy understanding among the interviewers and respondents. The translated questionnaires were pre-tested to detect any possible problems in the translations or flow of the questionnaire, as well as to gauge the length of time required for interviews. The pretest also provided valuable experience for the survey organizers about questionnaire design, training mechanisms, and fieldwork logistics (Annexure- 3).

2.3 Recruitment of Project Staff

Six survey teams of field personnel were recruited for completing the data collection process. Each team was comprised of a supervisor (team leader-male), three female interviewers, and a driver for the vehicle. The supervisor was responsible for over all management of field activities such as establishing a close contact with NIPS office; preparing the household listing and sample selection; lodging and boarding of team members in a suitable accommodation; arrangement of transport; ensuring the quality of data; organizing questionnaires in a sequence after interview and dispatching them to NIPS office, and other related activities.

The female interviewer was responsible for conducting the interview first for household questionnaire and then with all of the eligible women in a sampled household assigned to her by the team supervisor. Before leaving the house, she has ensured that the interview is completed and all relevant answers were properly recorded on the questionnaire. She has also edited the questionnaire after completing the day work and then handed over it to the team supervisor for further action. She has to extend cooperation to other team members to complete the field work according to schedule prepared by the supervisor.

The driver of the vehicle, an important member of the team; was responsible for maintaining the vehicle in working condition and ensuring availability of sufficient fuel during the field visits. He was supposed to help the supervisor in locating the cluster and establishing rapport with the local community. He was helpful in providing security to the female team members.

2.4 Training of Field Staff

All the members of field teams have participated in a three-week training program devoted to various aspects of the survey. The main city of Gilgit was selected as the training venue and a local hotel to accommodate all trainees. The resource persons and trainers were drawn from NIPS and experts from other line departments organizations. The training program included a detailed description of the questionnaires; interviewing techniques; how to complete the questionnaire; and lectures on fertility, reproduction, and family planning. Training sessions consist of classroom lectures, mock interviews and practice interviews in the field. Each interviewer has completed at least five interviews during the training period. Finally, the team supervisors were trained on how to manage the field activities, to assign the task to interviewers in the field, and to edit the completed questionnaires.

2.5 Data Collection

2.5.1 Field work

The data collection process was carried out in two stages; firstly the household listing was completed in each cluster (PSU) by official of FBS. At the time of main survey, FBS officer who has conducted listing operation accompanied the team members for the identification of the geographic boundaries of urban clusters. The rural clusters were located by the team members themselves. After arriving in a cluster, the supervisor used to draw a representative sample of households from the listed households by using systematic sampling with a random start technique.

In the second stage, female interviewers used to conduct interview first for household questionnaire and then with the eligible women identified in the household questionnaire. After completing the interview, female interviewers used to go through the filled-in questionnaire for completeness before leaving the household. In the evening, every interviewer has edited the filled-in questionnaires before handing them over to supervisor. The supervisor has also checked the questionnaires before he dispatches them to NIPS office. For completing the data collection procedure, each team were assigned 8-10 clusters keeping in view the geographic location of the cluster and the language spoken by the people of the area.

2.5.2 Duration of field work

The procedure of households listing was completed between 10-15 days before starting the actual field work. And the field work for collecting information from the respondent through household survey was completed during May-June 2008.

2.6 Monitoring and Supervision of Field Work

To ensure the quality of data, a close communication was maintained at all times between the central office of NIPS and field personnel during fieldwork. NIPS also placed two field coordinators at Gilgit whose job was to monitor field activities and provide help and guidance to the team members as and when required.

Quality Control Measures

Primarily the supervisor of a team has been responsible to ensure good quality of data through proper field work; efficient team building; and regular editing of questionnaire and verify the responses by re-visit to the household.

As mentioned earlier, the NIPS also established a field office manned with two field coordinators in Gilgit to monitor the data collection process according to laid down methodology and to supervise the field staff by checking their performance, provide guidance and, on the job training. They also kept a close communication between NIPS office and all the team supervisors during the field operation.

In addition, NIPS project staff has also monitored the data collection process and visited each of the field teams at least twice a month during the fieldwork. During each visit to a team, the NIPS researchers accompanied by a female editor has spot-checked the data collection activities of the team. This include visiting a few households in a recently completed cluster and completing parts of the household questionnaire, which subsequently checked against the answers recorded in the original questionnaire for the household. Periodic review sessions were held with the interviewing teams. These review sessions were designed to identify and correct errors detected in the fieldwork.

Finally, NIPS computer programmer has set-up the data management system at NIPS. He has regularly run a set of field check tables from the computerized data at NIPS during fieldwork. Problems that appear from review of these tables were discussed with the relevant teams so that mistakes/ errors are not repeated.

2.7 Data Processing and Analysis

After checking and correction in the field, all questionnaires were sent to the NIPS office in Islamabad for logging in and supplementary checking prior to data entry. Data from the questionnaires were entered onto microcomputers by a team of data entry operators. The Incharge computer section of NIPS has developed the software programs for data entry, editing and tabulation for the survey report. He has also imparted training to data processing staff. At NIPS, 4 computers were allocated for data processing. Efforts were made to match the pace of data processing operation with the data collection and delivery of completed questionnaires. Data editing included, range checks, structure and a selected set of checks for internal consistency.

2.8 Response rate

Table 2.2 presents household and eligible women response rate for the survey. A total of 1120 households were selected for the sample of which 1086 were occupied at the time of the field survey. The main reasons for the difference is that some of the dwelling units that were occupied during the household listing operation were either vacant or the entire members of

the household were away for an extended period at the time of interviewing of the occupied households, 1071 (99 percent) were successfully interviewed.

In the 1071 household interviews, a total of 1279 ever-married women age 15-49 were identified of whom 1197 were successfully interviewed, yielding a response rate of 94 percent. The main reason for non-response among eligible women was the failure to find them at home despite repeated visits to the household.

The response rate for household was higher in rural than urban areas while a reverse pattern observed for the response rate of eligible women.

Table 2.2: Results of the household and individual interviews

Number of households, number of interviews, response rates Number of eligible women, number of eligible women interviewed, women response rate and over all women response rates according to residence (un weighted) GBDHS-2008

Result	Urban	Rural	All Areas
Sample households	302	818	1120
Occupied households	285	801	1086
Interviewed households	277	794	1071
Household response rate	97.2	99.1	98.6
Eligible women	306	973	1279
Interviewed women	294	903	1197
Women response rate	96.1	92.8	93.6
Overall women response rate (women response / household response)	93.4	92.0	92.3

HOUSEHOLD POPULATION AND HOUSING CHARACTERISTICS

3

Badar ud Din Tanweer

In this chapter we discuss about the information regarding socio-economic characteristics of households and respondents. These characteristics are age, sex, marital status, place of residence, and educational status. The chapter also provides information on household facilities and household characteristics, such as source of drinking water, electricity, sanitation facilities, housing construction materials, possession of durable goods, and ownership of a homestead. The information collected about the characteristics of the households and respondents is important for understanding and for interpretation of the findings of the survey. The information is also useful in identifying the major factors that determine or influence the basic demographic indicators of the population.

The Gilgit and Baltistan, Demographic and Health Survey, 2008 (GBDHS-2008) collected information from all usual residents of a sampled household. A household was defined as "a person or group of related and unrelated persons who live together in the same dwelling unit(s) or in connected premises, who acknowledge one adult member as head of the household, and who have common arrangements for cooking and eating".

In this chapter data on the age, sex, and education of household members is based on information collected in the household questionnaire. The data is also collected on current school attendance, orphan-hood, and housing characteristics. These indicators are representative of Gilgit and Baltistan with urban-rural differentials.

3.1 Household Population by Age and Sex

Age and sex are most important demographic variables in research and are the key correlates of various demographic indicators such as mortality, fertility and reproductive health. In general, age and sex are useful in the analysis of all forms of data obtained in surveys.

The distribution of the household population in Gilgit and Baltistan is shown in Table 3.1 by five-year age groups, urban-rural residence and sex. The total population counted in the survey was 8,970, with males are slightly outnumbering females. Eighty six percent population reside in rural areas while 14 percent in urban areas. The overall sex ration is 103

males for 100 females. This sex ratio is slightly higher than the sex ratio estimated in 2006-07 PDHS but lower than the national sex ratio estimated in various household surveys.

The age structure of the household population is typical of a society with a youthful population. The sex and age distribution of the population is shown in the population pyramid (Figure 3.1.). Gilgit and Baltistan has a pyramidal age structure due to the large number of children in less than 15 years of age. It is evident that the pyramid is broad-based but slightly narrower at the lowest base (age group 0-4 years), a pattern that typically describes a high fertility but with a recent declining trend. Nevertheless, this decline could also be partially attributed to under enumeration of children under age 5. Children under 15 years of age account for 44 percent of the population in Northern Areas, a feature of population with high fertility levels. Fifty-two percent of the population are in the age group 15-64 years and less than 4 percent are over 65.

Figure 3.1: Population Pyramid

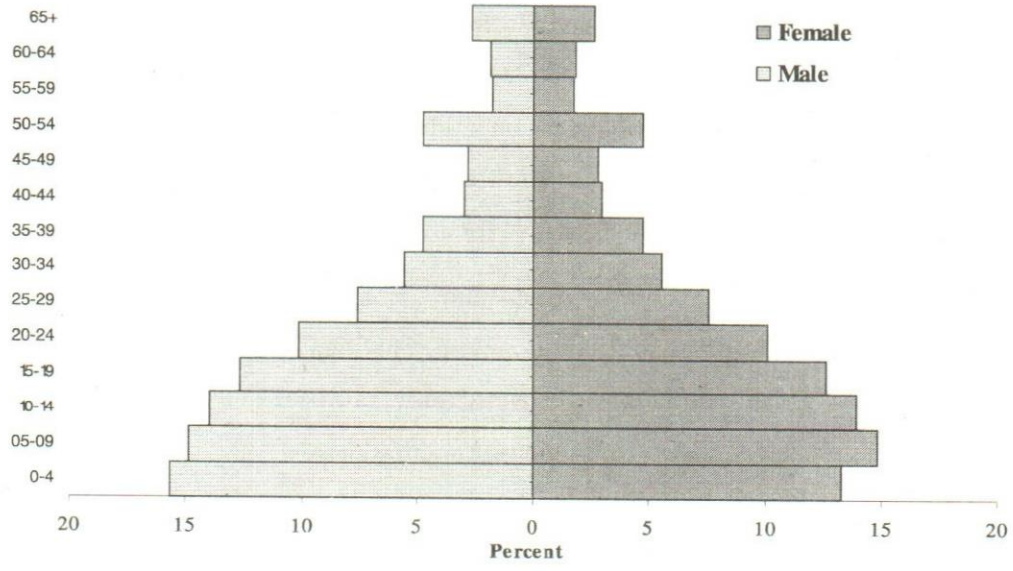


Table 3.1: Household population by age, sex, and residence

Percent distribution of household population by five-year age groups, according to sex and residence, GBDHS-2008

Age group	Residence						All Areas		
	Urban			Rural					
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	13.4	12.7	13.1	16.0	13.4	14.7	15.6	13.3	14.5
5-9	14.5	12.4	13.6	16.4	15.2	15.8	16.1	14.8	15.5
10-14	14.2	14.9	14.5	14.8	13.8	14.3	14.7	13.9	14.3
15-19	12.8	13.7	13.2	11.2	12.4	11.8	11.5	12.6	12.0
20-24	6.6	9.2	7.8	6.5	10.3	8.4	6.5	10.1	8.3
25-29	7.5	6.2	6.9	6.5	7.8	7.2	6.7	7.6	7.1
30-34	4.9	6.3	5.6	4.5	5.5	5.0	4.5	5.6	5.1
35-39	4.3	5.5	4.9	4.0	4.7	4.4	4.1	4.8	4.4
40-44	3.7	3.4	3.6	3.7	3.0	3.4	3.7	3.0	3.4
45-49	3.5	3.2	3.3	2.7	2.8	2.7	2.8	2.8	2.8
50-54	3.5	4.9	4.1	3.1	4.8	4.0	3.2	4.8	4.0
55-59	1.3	1.8	1.5	2.3	1.9	2.1	2.1	1.8	2.0
60-64	4.6	1.3	3.2	3.7	2.0	2.8	3.8	1.9	2.9
65 and more	5.2	4.2	4.7	4.7	2.4	3.6	4.8	2.7	3.7
Total Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total Number	663	582	1245	3880	3845	7725	4543	4427	8970

The overall sex ratio results of Gilgit and Baltistan survey indicate 103 males per 100 females, an implausibly high ratio that is most probably due to a tendency of underreporting the presence of women. The sex ratio is higher in urban areas (114 males per 100 females) than in rural areas (101 males per 100 females) shown in (Table 3.2). The sex ratio varies by age group, being over 100 in the younger and older age groups and under 100 at ages 15-39. The lower sex ratios in the prime working ages (20-39) may be due to the fact that men may have migrated to other parts of country or overseas in search of jobs.

About half of the total female population falls into the reproductive age group (15-49 years). The fact that this segment has been increasing over the last two decades has an impact, because they are in the childbearing years and hence can contribute to overall population growth.

Table 3.2 Sex ratios by age

Sex ratios for the household population by five-years age groups, PRHFPS 2000-01 and GBDHS-2008

Age group	Sex ratio[1]
0-4	120
5-9	112
10-14	108
15-19	96
20-24	66
25-29	90
30-34	83
35-39	86
40-44	126
45-49	102
50-54	68
55-59	117
60-64	202
65 and over	183
Total	103

[1] Sex ratio = (males/females)*100

3.2 Household Composition

The household is considered to be the basic social and economic unit of society. Changes at the household level, therefore, have repercussions at the aggregate level of a country as a whole. Such changes also have an impact on the distribution of goods and services and on the planning and requirements of community institutions, schools, housing, and health infrastructure (Ekouevi et al., 1991).

In this survey the Table 3.3 indicates the distribution of households by sex of the head of the household and by number of household members in urban and rural areas. Households in Gilgit and Baltistan are predominantly male-headed, with 93 percent of households being headed by a male and only 7 percent being headed by a female. The proportion of female-headed households is slightly greater in urban areas (8 percent) as compared to rural areas (6 percent). This could be attributed to out-migration of the male population from urban areas to out side Gilgit and Baltistan for employment purposes. Female headship of households is of concern to policymakers, particularly those dealing with poverty issues, as normally it is financially difficult for a woman to manage a household alone (Osaki, 1991).

Table-3.3: Household Composition

Percent distribution of all households by sex of head of household and household size, and mean size of household, according to residence, GBDHS-2008

	Residence		
	Urban	**Rural**	**Total**
Household headship			
Male	91.7	93.8	93.5
Female	8.3	6.2	6.5
Total	100.0	100.0	100.0
Number of usual members			
1	3.1	0.8	1.1
2	3.4	3.5	3.5
3	5.1	2.5	2.8
4	7.0	5.6	5.8
5	10.7	8.5	8.8
6	11.7	11.9	11.8
7	10.9	13.4	13.1
8	11.6	12.5	12.4
9 +	36.4	41.3	40.6
Total	100.0	100.0	100.0
Number of households	149	922	1071
Average household size	8.3	8.4	8.4

Households in Gilgit and Baltistan tend to be large because of the predominance of the extended and joint family system. Economic pressure can also force middle- and lower-income families to live with their parents and other relatives because they cannot afford to build or rent separate dwellings. The Gilgit and Baltistan data show that the average

household size is 8.4 persons (Table 3.3). The household size is slightly smaller in urban areas (8.3 persons) than in rural areas (8.4 persons). In other words, mean number of person per household is approximately the same in urban and rural areas.

More than half of households (53.0 percent) consist of 8 and more members and 33.7 percent household have 5 to 7 members and only 13.3 percent have less than 5 household members (Table 3.3.)

3.3 Education of the Household Population

Education is one of the major social factors that influence a person's behaviour and attitude. In general, women having higher level of education are better aware of the use of health facilities, family planning methods, and healthcare of her children. Children generally enter primary school at age 5; this level comprises classes 1 through 5. Middle school is of classes 6 through 8; secondary school is of classes 9 and 10, higher secondary and above, is of classes 11 and more.

3.3.1 Educational Attainment of Household Population

The percent distribution of educational attainment of female and male household population by background characteristics is presented in Table 3.4 and 3.5. According to the survey results female in Gilgit and Baltistan have low educational level as compared to males. The Table 3.4 shows that over all 63 percent females have no education. Comparatively, the proportion of male population with no education is much less (39 percent). Nineteen percent of females and 27 percent of males have attended primary school, 9 percent of females and 14 percent of males attended middle school, and 6 percent of females and 13 percent of males have acquired more than secondary education. Only 3 percent of females and 8 percent of males have attended higher than secondary education. The gender differentials in education could be attributed to cultural norms and the social constraints faced by women in Gilgit and Baltistan.

The survey results show that there has been a marked improvement in the educational attainment of both women and men when looked across through the age groups. For example, the proportion of women with no education has declined significantly from 100 percent among women age 65 and over to 33 percent among women age 10-14. A similar pattern is noticeable among men, with the proportion of men with no education declining from 78 percent among those ages 65 and over to just 16 percent among those age 10-14. This implies that the young population is more inclined to attend schools as compared to older generation.

Table 3.4: Educational attainment of the female household population

Percent distribution of the female population age five and over by highest level of schooling attended according to background characteristics, GBDHS-2008

Characteristics		No Education	Primary	Middle	Secondary	Higher Sec. +	Total	
							Percent	Number
Urban	**Age**							
	05-09	54.7	45.3	--	--	--	100.0	72
	10-14	11.3	61.5	25.5	1.7	--	100.0	86
	15-19	11.1	16.5	33.1	32.4	6.9	100.0	80
	20-24	30.2	9.1	23.3	22.8	14.3	100.0	54
	25-29	37.8	14.8	9.3	17.4	20.7	100.0	36
	30-34	55.4	10.3	7.9	14.5	12.0	100.0	37
	35-39	62.1	11.4	7.9	7.8	10.8	100.0	32
	40-44	82.2	6.9	--	3.2	7.7	100.0	20
	45-49	98.9	1.1	--	--	--	100.0	18
	50-54	92.6	2.0	0.7	0.7	4.0	100.0	28
	55-59	100.0	--	--	--	--	100.0	10
	60-64	100.0	--	--	--	--	100.0	9
	65 and more	100.0	--	--	--	--	100.0	24
	Total	46.0	23.4	13.8	10.7	6.2	100.0	508
Rural	05-09	67.5	31.8	0.7	0.9	-	100.0	584
	10-14	36.7	49.5	13.0	14.8	3.6	100.0	531
	15-19	43.2	14.8	23.5	15.1	9.3	100.0	478
	20-24	56.2	6.5	13.0	11.6	5.7	100.0	395
	25-29	67.1	7.3	8.2	4.2	4.7	100.0	302
	30-34	80.2	5.8	5.1	1.1	3.5	100.0	210
	35-39	81.5	11.3	2.6	--	1.0	100.0	182
	40-44	95.8	3.2	-	0.9	--	100.0	115
	45-49	93.9	3.5	1.6	0.4	--	100.0	105
	50-54	98.2	1.4	--	--	--	100.0	186
	55-59	100.0	--	--	--	--	100.0	71
	60-64	98.6	--	1.4	--	--	100.0	76
	65 and more	100.0	--	-	--	--	100.0	94
	Total	65.1	18.3	8.4	5.5	2.7	100.0	3329
Total	05-09	66.1	33.3	0.6	--	--	100.0	656
	10-14	33.1	51.2	14.7	1.0	--	100.0	617
	15-19	38.6	15.0	24.9	17.3	4.1	100.0	557
	20-24	53.1	6.8	14.2	16.0	9.9	100.0	449
	25-29	64.0	8.1	8.3	12.2	7.3	100.0	338
	30-34	76.5	6.4	5.5	5.7	5.7	100.0	247
	35-39	78.6	11.3	3.4	2.1	4.6	100.0	214
	40-44	93.7	3.8	-	0.5	2.0	100.0	135
	45-49	94.7	3.1	1.4	0.8	-	100.0	124
	50-54	97.5	1.4	0.1	0.5	0.5	100.0	214
	55-59	100.0	--	--	--	--	100.0	82
	60-64	98.8	--	1.2	--	--	100.0	85
	65 and more	100.0	--	--	--	--	100.0	118
	Total	62.6	19.0	9.1	6.2	3.1	100.0	3837

Primary=Class 1-5; Middle= Class 6-8; Secondary=Class 9-10; Higher=Class 11 or more;

The proportion of respondents with no education is higher among the rural population than the urban population. As 65 percent of females in rural areas have no education compared with 46 percent of females in urban areas. A similar pattern is envisaged for male population. For example, in rural areas 40 percent of males have no education as against 28 percent of those in urban areas. The urban-rural difference in educational attainment is undoubtedly due to a lack of educational facilities or inaccessibility to educational institutions in rural areas.

Table 3.5: Educational attainment of the male household population

Percent distribution of the male population age five and over by highest level of schooling attended according to background characteristics, GBDHS-2008

Characteristics		No Education	Primary	Middle	Secondary	Higher Sec. +	Total	
							Percent	Number
Urban area	**Age**							
	05-09	58.4	40.4	1.3	--	--	100.0	96
	10-14	4.1	67.7	24.9	3.4	--	100.0	94
	15-19	4.9	17.6	35.5	35.5	6.5	100.0	085
	20-24	6.6	12.4	21.5	27.7	31.7	100.0	44
	25-29	17.3	3.5	19.7	29.6	29.9	100.0	49
	30-34	20.5	2.4	12.4	32.1	32.5	100.0	33
	35-39	23.4	10.5	14.7	12.5	39.0	100.0	28
	40-44	33.1	24.9	7.8	11.3	22.9	100.0	25
	45-49	29.3	21.7	12.1	5.9	31.0	100.0	23
	50-54	45.4	18.1	1.8	14.6	20.0	100.0	23
	55-59	37.2	12.2	18.7	22.0	9.9	100.0	8
	60-64	60.2	13.7	6.3	8.0	11.7	100.0	30
	65 and more	73.3	9.8	6.0	8.5	2.4	100.0	35
	Total	28.1	26.6	16.2	15.5	13.7	100.0	574
Rural area	05-09	55.0	45.0	--	--	--	100.0	635
	10-14	17.9	61.7	19.3	1.1	--	100.0	573
	15-19	17.6	14.4	39.3	25.4	3.3	100.0	426
	20-24	29.3	8.2	13.9	30.9	17.8	100.0	253
	25-29	29.1	11.6	13.1	31.0	15.2	100.0	254
	30-34	38.8	11.8	15.4	16.3	17.8	100.0	173
	35-39	38.7	5.7	12.1	23.3	20.2	100.0	156
	40-44	48.2	10.7	9.5	13.1	18.5	100.0	145
	45-49	57.8	15.8	12.1	74.1	7.2	100.0	103
	50-54	61.6	14.9	6.1	9.6	7.7	100.0	122
	55-59	58.0	18.7	9.0	7.5	6.7	100.0	87
	60-64	81.5	9.7	4.4	2.8	1.6	100.0	142
	65 and more	78.8	12.9	2.7	2.9	2.7	100.0	181
	Total	40.4	27.1	13.8	12.0	6.7	100.0	3281
All areas	05-09	55.5	44.4	0.2	--	--	100.0	732
	10-14	15.9	62.5	20.1	1.4	--	100.0	667
	15-19	15.5	14.9	38.7	27.0	3.8	100.0	521
	20-24	25.9	8.8	15.0	30.4	19.9	100.0	297
	25-29	27.2	10.3	14.2	30.8	17.6	100.0	303
	30-34	35.9	10.3	15.0	18.8	20.1	100.0	206
	35-39	36.3	6.5	12.5	21.7	23.1	100.0	185
	40-44	46.0	12.8	9.2	12.8	19.2	100.0	170
	45-49	52.6	16.9	12.1	6.9	11.6	100.0	126
	50-54	59.1	15.4	5.4	10.4	9.7	100.0	145
	55-59	56.2	18.1	9.9	8.8	7.0	100.0	96
	60-64	77.7	10.4	4.8	3.7	3.4	100.0	172
	65 and more	77.9	12.4	3.2	36.8	2.7	100.0	216
	Total	38.6	27.1	14.1	12.5	7.7	100.0	3835

Primary=Class 1-5; Middle= Class 6-8; Secondary=Class 9-10; Higher=Class 11 or more;

3.4 Housing Characteristics

The availability and accessibility of basic household facilities are important in assessing the general welfare and socio-economic condition of physical characteristics of the population. For GBDHS-2008, respondents were asked about drinking water and household sanitation facilities. This included the questions on the source of drinking water, time taken to travel to

the nearest source of water, the person who usually collects drinking water, and questions on types of sanitation facilities.

The information on drinking water is presented in Table 3.6. The majority of households (61 percent) in Gilgit and Baltistan have access to source of drinking water within the dwelling/yard/plot, which is higher in urban areas than rural areas (78.6 and 57.7 percent respectively). The most commonly used method is piped water directly into the house/plot or public tap/standpipe. The second popular method for the provision of drinking water is the tanker. Over all, 14 percent of households use that means. But there is a wide gap in rural (16 percent) and urban households (4 percent). Table 3.6 also indicates that 3 percent of households use drinking water provided by cart with small tank. A small proportion of rural households (2.8 percent) used rainwater for drinking purpose

Table 3.6: Household drinking water

Percent distribution of households and population by source and time to collect drinking water; and percentage of households and the population according to residence, GBDHS-2008

Characteristics	Households			Population		
	Urban	Rural	Total	Urban	Rural	Total
Source of drinking water						
Piped into dwelling	65.6	30.4	35.3	64.8	29.7	34.6
Piped into yard/plot	13.0	27.3	25.3	14.6	18.5	26.6
Piped public tap / standpipe	13.0	16.8	16.3	11.6	15.7	15.1
Tube well or borehole	0.4	0.2	0.2	0.3	0.2	0.2
Hand pump	-	0.1	0.1	--	0.1	0.1
Covered well	1.5	0.7	0.8	0.9	0.6	0.6
Un-covered well	-	1.2	1.0	--	1.9	1.7
Spring protected	0.4	0.9	0.9	0.4	0.7	0.7
River / Pond / lake / Dam	-	0.4	0.4	--	0.7	0.6
Rain water	-	2.8	2.4	--	3.0	2.6
Cart with small tank	2.3	2.8	2.7	2.8	2.9	2.9
Water tanker truck	3.8	16.1	14.4	4.6	15.7	14.2
Boiled water	--	0.3	0.3	--	0.3	0.2
Time to obtain drinking water (round trip)						
Water on premises	78.6	57.8	60.7	79.5	58.4	61.3
Less than 30 minutes	16.4	31.7	29.6	15.5	30.9	28.7
30 minutes or longer	5.0	9.0	8.4	5.0	9.2	8.6
Don't know / missing	--	1.5	1.3	--	1.6	1.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number	149	922	1071	1245	7726	8971

As more than six in ten households reported having water on their premises. Households not having access on their premises were asked for the time taken to collect drinking water. About 30 percent of all households take less than 30 minutes to fetch drinking water, while 8 percent take 30 minutes or longer to get water for drinking purpose.

The sanitation facilities available to a household have direct implications on the hygienic and health status of household members. Absence of sanitary disposal of waste exposes people to risk of acquiring infections and other diseases. Table 3.8 presents information on household sanitation facilities by type of toilet/latrine.

A large number of households in Gilgit and Baltistan (49 percent) have flush to sewer system or to septic tanks. That means overall, about half of household use improved toilets that are not shared with other households. Of these households, a majority uses flush to septic tank. A flush to septic tank is used by majority (56 percent) in urban areas, while this toilet system is also the most used in rural areas. In Gilgit and Baltistan, 11 percent households do not have any toilet facility, a statistics that is considerably higher among rural households (12 percent) than urban households (2 percent). The situation of toilet facilities is much better in Gilgit and Baltistan than in Pakistan where 30 percent of households have no facility at all. A very small proportion of households has ventilated improved pit (VIP) toilet facility (2 percent). The ventilated improved pit (VIP) toilet facility is mostly used in rural areas (3 percent) (Table 3.7).

Table 3.7: Household sanitation facilities

Percent distribution of households and population by type of toilet/latrine facilities, according to residence, GBDHS-2008

Type of toilet/latrine facilities	Households			Population		
	Urban	Rural	Total	Urban	Rural	Total
FLUSH OR PURE FLUSH TOILET						
Flush to sewer system	10.4	12.1	11.9	11.4	11.6	11.6
Flush to septic tank	54.6	33.1	36.1	55.5	33.7	36.7
Flush to somewhere else	0.3	0.4	0.4	0.1	0.4	0.4
Flush don't know where	0.3	0.2	0.2	0.1	0.2	0.2
PIT LATRINE						
Pit latrine (VIP)	0.5	2.5	2.2	0.3	2.0	1.8
Pit latrine with slab	-	2.9	2.5	-	2.3	2.0
Pit latrine without slab/open pit	3.8	6.7	6.3	4.2	6.9	6.5
Bucket toilet	-	0.7	0.6	-	0.7	0.6
No facility/bush/field	2.3	12.2	10.8	1.6	11.7	10.3
Others	27.8	29.0	28.8	26.7	30.4	29.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number	149	921	1070	1245	7713	8958

Information on housing characteristics such as availability of electricity; housing structure, type of material used in the floors, roof, and walls; number of rooms used for sleeping; type of fuel used for cooking; is shown in Table 3.8. Overall 92 percent of households in Northern Areas have electricity, with a visible difference by place of residence Hundred percent urban household as compared to 91 percent rural households have access to electricity. Survey

results indicate that a small number of households (8 percent) have pacca structure and more than half of households (58 percent) have Katcha structure. Thirty four percent of households have semi-pacca structure.

The GBDHS indicates that the material used for roof in most of the housing units (94 percent) was found to be very rudimentary such as thatch, bamboo mud and wood. However, the situation in urban area is slightly better as more solid material is used to construct the roof of the houses when compared with rural areas.

Table 3.8: Household characteristics

Percent distribution of households and population by housing characteristics as well as using fuel for cooking, according to residence, GBDHS-2008

Household characteristics	Households			Population		
	Urban	Rural	Total	Urban	Rural	Total
Electricity						
Yes	100.0	90.6	91.6	100.0	90.2	91.5
No	--	9.4	8.4	--	9.8	8.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
Housing structure						
Kacha	31.9	61.7	57.5	29.8	60.9	56.6
Semi-pacca	44.9	32.2	34.0	49.1	32.5	34.8
Pacca	22.8	5.9	8.3	20.9	6.3	8.4
Flat	0.4	0.2	0.2	0.1	0.3	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Main roof material						
Thatch / Bamboo / Wood / Mud	72.3	97.2	93.7	69.5	97.3	93.5
Cardboard / plastic	3.8	0.1	0.6	2.7	0.1	0.4
Iron sheets / asbestos	8.0	1.4	2.3	8.8	1.3	2.3
T-iron wood / brick	4.6	0.3	0.9	4.7	0.3	0.9
Reinforced brick cement / RCC	11.4	0.6	2.1	14.3	0.7	2.6
Other	--	0.5	0.4	--	0.3	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Main walls material						
Mud / stones	50.5	62.2	60.6	50.7	60.8	59.4
Bamboo / sticks / Mud	5.7	12.5	11.5	5.9	13.0	12.0
Unbaked bricks / mud	5.0	1.9	2.3	4.6	1.9	2.3
Plywood sheets	0.3	0.1	0.2	0.1	0.1	0.1
Stone bricks	8.8	8.1	8.2	8.5	7.9	8.0
Backed bricks	1.9	1.1	1.2	1.6	1.5	1.5
Cement blocks / cement	27.8	8.6	11.3	28.6	9.2	11.9
Other	--	5.5	4.7	--	5.6	4.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
Rooms used for sleeping						
One	22.1	23.6	23.4	13.4	16.5	16.0
Two	38.5	40.6	40.3	31.4	38.2	37.3
Three or more	39.4	35.8	36.3	55.2	45.3	46.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
Cooking fuel						
Electricity	2.3	--	0.3	2.0	--	0.3
Cylinder gas	30.0	3.4	7.1	27.2	3.2	6.5
Bio-gas	1.2	0.1	0.3	1.2	0.1	0.3
Kerosene oil	--	0.2	0.2	--	0.2	0.2
Wood	64.0	93.7	89.6	66.9	94.9	91.0
Straw / shrubs / grass	1.0	0.3	0.4	0.7	0.3	0.3
Cow dung	1.5	1.8	1.7	2.0	1.1	1.2
Other	--	0.5	0.4	--	0.3	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of households	149	922	1071	1245	7726	8971

In Gilgit and Baltistan, more than six in ten households have used mud/stones for the construction of the main walls of the dwelling. As expected, the proportion of such dwellings was higher (62 percent) in rural than urban areas (51 percent). Furthermore, one in eight households used bamboo/sticks/mud for the main walls material. Almost a similar proportion of households have made main wall with cement blocks/cement. One out of thirteen households has used stone blocks for the construction of the main walls of the dwelling (Table 3.8).

Data were also collected on the number of sleeping rooms per household. Forty percent of households have two rooms for sleeping. Whereas 36 percent have three or more rooms. There are no major variations in the number of rooms used for sleeping by urban-rural residence.

A very high proportion of households (90 percent) use wood for cooking. Rural households are much more likely (94 percent) to use wood for cooking than urban households (64 percent). The use of cylinder gas is the second most common fuel used primarily in urban area. It is to be noted that a majority of households use solid fuel, like wood, cow dung, straw/shrubs/grass etc, for cooking. This generates smoke which is hazardous for health of the population.

3.5 Household Possessions

Information on ownership of household durable goods and other possessions is presented in Table 3.9. The ownership of household effects and means of transportation is indicative of a household's social and economic well-being. The survey results indicate that more than half (56 percent) of all households has a radio. The possession of radio in urban area is slightly more than in rural areas. Possession of television is three times more in urban than rural areas. One out of four (24 percent) households have a television, more than one third have a telephone/mobile (36 percent), and a small proportion of households have refrigerator (6 percent). Furthermore, 43 percent of households own a sewing machine, 14 percent own a washing machine, 16 percent households have camera, 10 percent households have personal computer, 3 percent have water pump and 2 percent households have room cooler/air conditioner. Generally, the households in rural areas are much less likely to possess items like televisions, telephones, refrigerators, sewing and washing machines, or water pumps than urban households.

Generally, the people of Gilgit and Baltistan are not very likely to own a means of transport. In rural areas commonly used mode of transport is animal drawn cart. This mode of transport is used by 31 percent of rural households. Overall, 6 percent households own a bicycle while 5 percent households own a motorcycle or scooter. Urban households are much more likely than rural households to own a motorcycle or a scooter.

Table 3.9: Household durable goods

Percent distribution of households and population possessing various household accessories, according to residence, GBDHS-2008

Possession	Households			Population		
	Urban	Rural	Total	Urban	Rural	Total
Radio	58.4	56.0	56.3	60.8	58.5	58.8
Television	55.8	18.3	23.5	55.9	21.1	25.9
Refrigerator	21.9	3.4	6.0	27.4	4.4	7.6
Mobile telephone or land line telephone	75.2	29.8	36.1	80.2	33.4	39.9
Room cooler, air conditioner	11.8	0.8	2.3	19.3	0.7	3.3
Washing machine	37.2	9.8	13.6	41.2	11.2	15.4
Water pump	6.0	1.9	2.5	10.2	2.1	3.3
Bed	50.7	33.6	36.0	53.5	35.3	37.8
Chairs	38.3	14.6	17.9	41.4	15.5	19.1
Almirah / cabinet	72.9	50.4	53.5	76.5	52.1	55.4
Clock	86.9	68.5	71.1	88.6	70.9	73.3
Sofa	23.0	8.6	10.6	28.2	9.1	11.7
Sewing machine	66.7	39.5	43.3	75.2	43.4	47.8
Camera	32.4	13.0	15.7	38.3	14.4	17.7
Personal computer	26.2	7.1	9.8	30.9	8.3	11.4
Watch	84.7	85.4	85.3	88.5	88.1	88.2
Bicycle	7.5	6.1	6.3	7.2	6.9	7.0
Motorcycle / Motor scoter	11.6	4.4	5.4	14.2	5.2	6.4
Animal drawn cart	9.8	30.6	27.7	11.2	34.5	31.3
Car or truck, tractor						
Number of households	149	922	1071	1245	7726	8971

3.6 Socioeconomic Status Index

One of the background characteristics used throughout this report is an index of socio-economic status. The index used here was recently developed and tested in a large number of countries in relation to inequalities in household income, use of health services, and health outcomes (Rutstein et al., 2000). It is an indicator of the level of wealth that is consistent with expenditure and income measures (Rutstein, 1999). The economic index was constructed using household asset data including ownership of a number of consumer items ranging from

a television to a bicycle or car, as well as dwelling characteristics, such as source of drinking water, sanitation facilities, and type of material used for flooring.

Each asset was assigned a weight (factor score) generated through principal components analysis, and the resulting asset scores were standardized in relation to a normal distribution with a mean of zero and standard deviation of one (Gwatkin et al., 2000). Each household was then assigned a score for each asset, and the scores were summed for each household; individuals were ranked according to the score of the household in which they resided. The sample was then divided into quintiles from one (lowest) to five (highest). A single asset index was developed for the whole sample; separate indices were not prepared for urban and rural populations. This wealth quintile index is used in this report for analysing the socio-economic status of household members.

Table 3.10 presents data on wealth quintiles by region of residence. Twenty four percent of the population in Gilgit and Baltistan fall in second quintile. While equal proportion is found in first third and fourth wealth quintiles. While 15 percent of the population lies in the richest wealth quintile. The distribution of wealth quintile varies significantly by urban and rural residence. Forty two percent of the population in urban areas is in the richest wealth quintile in contrast to 11 percent of the rural population. On the other hand, 22 percent of the rural population fall in the lowest quintile compared with only 4 percent of the urban population.

Table 3.10: Wealth quintiles

Percent distribution of population by wealth quintiles, according to residence, GBDHS-2008

Residence	Wealth Quintiles						
	Lowest	Second	Middle	Fourth	Highest	Total	Number
Urban	4.2	8.0	20.4	25.2	42.3	100.0	149
Rural	22.3	26.8	20.8	19.1	11.0	100.0	922
Total	19.8	24.2	20.7	20.0	15.3	100.0	1071

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4 CHARACTERISTICS OF RESPONDENTS

Badar ud Din Tanweer

This chapter provides information on demographic and socio-economic indicators of ever-married women age 15-49 interviewed in GBDHS-2008. Information on basic characteristics such as age, level of education, marital status, native language, and wealth status was collected. Literacy status was also examined, and detailed information was collected on employment status, occupation, and earnings. Such background information is important for better understanding the social and demographic findings presented in this report. Understanding how women's education and employment are related to reproductive attitudes and behaviors can be helpful in promoting change, especially in patriarchal societies like Gilgit and Baltistan where the status of women is generally low. Curtailing the population growth is not only affected by the direct means of fertility management (family planning, age at marriage, duration of breastfeeding, abortion), but also indirectly by motivation to control fertility, which includes many factors. Central among these factors are reduced mortality, education (particularly of women), economic development (particularly poverty reduction), and the general status of women (Ministry of Population Welfare, 2002).

4.1 Characteristics of Survey Respondents

Table 4.1 provides information on the background characteristics of ever-married women age 15-49 who were interviewed. This table is important for providing background of the woman for interpreting findings presented in later part of this report.

The age-wise distribution of ever married women indicates that the proportion of women increases sharply from 5 percent in the age group (15-19) to 21 percent in the 25-29 age group, 17 percent for age group 35-39 and falls steadily thereafter to 10 percent for the 45-49 age group. Over six in ten (63 percent) women are under age 35.

The majority of surveyed women (96 percent) are currently married, 3 percent are widowed, 1 percent of the women are divorced and a very small percentage of women (0.3 percent) are recorded as separated (Table 4.1).

Place of residence is another characteristic that determines access to services and exposure to information pertaining to reproductive health and other aspects of life. Fourteen percent of

ever-married women age 15-49 in Gilgit and Baltistan reside in urban areas, while 86 percent reside in rural areas.

Education is an important factor influencing an individual's attitude and approach on various aspects of life. A large majority of ever-married women in Gilgit and Baltistan (77 percent) have no education while among the women who have attained education, the proportion do not vary much among various levels of education [primary (6 percent), middle (6 percent), secondary, (7 percent) and above secondary (5 percent)].

Wealth and work status are important characteristics that shed light on the economic status of women in the society. Surveyed women are distributed in five wealth quintiles. According to Table 4.1 about 18 percent of women lie in poorest and richest wealth quintile. Surveyed women are almost equally distributed among 2nd, 3rd and, 4th quintile. The data on work status of women reveals that six in ten women have not been working at the time of survey. It is encouraging to note that a large proportion of women (39 percent) were currently working for gainful employment.

Table 4.1: Background characteristics of respondents

Percent distribution of ever-married women age 15-49 by selected background characteristics, GBDHS 2008

Background characteristic	Weighted percent	Number of women	
		Weighted	Un-weighted
Age			
15-19	4.7	57	58
20-24	19.1	229	222
25-29	20.5	246	240
30-34	18.7	224	228
35-39	16.6	199	202
40-44	10.6	127	131
45-49	9.7	117	116
Marital status			
Married	95.8	1147	11491
Divorced	1.1	13	11
Separated	0.3	3	4
Widowed	2.8	34	33
Residence			
Urban	13.7	164	294
Rural	86.3	1033	903
Education			
No education	76.5	916	866
Primary (1-5)	6.2	74	83
Middle (6-8)	5.8	70	82
Secondary (9-10)	6.7	80	92
Higher (11 +)	4.8	57	74
Wealth quintile			
Lowest	18.0	216	180
Second	22.2	266	233
Middle	21.1	253	249
Fourth	20.9	250	256
Highest	17.7	212	279
Work status[1]			
Currently working	39.2	470	456
Not working	60.8	727	741
Total 15-49	100.0	1197	1197

Note: Education categories refer to the highest level of education attended, whether or not that level was completed.
Categories are mutually exclusive.

4.2 Educational Attainment and Literacy

Education is a basic indicator to play an important role in a country's development and progress and can be a good investment for improving the quality of life of the people and for human development in general. National development programmes can be successfully accomplished if the population of the country is educated and adequately provided with knowledge and skills. Islam places great emphasis on acquiring education. Generally, education provides people with new ideas and increases their potential to learn, to respond to new opportunities, to adjust to social and cultural changes occurring around the world, and to participate in the socio-cultural and political activities in the country. Education also can redirect the attitudes and behaviors of the population towards improvement in the quality of life. Furthermore, education helps to overcome poverty, increase income, improve health and nutrition, and bring a change towards small family size norms. Therefore, its relationship to population growth cannot be underestimated.

Table 4.2 shows variations in the level of education among ever-married women, according to background characteristics. Overall, 77 percent of women in Northern Areas have no education at all, 6 percent have attended primary school only, and same proportion of women have reached middle school, while 7 percent have some secondary education (Class 9-10) and 5 percent have reached Class 11 or higher. As expected, women in the 45-49 year age group are most likely to have no education and their proportion is 96 percent. Comparatively 60 percent of the women age 15-19 have no education. Slightly higher proportions of ever-married women in other age groups are uneducated.

As expected, the proportion of uneducated women is much lower in the urban areas than in the rural areas (60 and 79 percent, respectively), while among educated women the proportion of urban women is higher in all levels of education. A clear inverse relationship exists between women's education and wealth quintile. For example, ever-married women in the lowest quintile are over two times more likely to be uneducated (97 percent) than those in the highest quintile (42 percent). Moreover, nearly one-third women (34 percent) in the highest wealth quintile have attained secondary or higher education.

When looking at the relationship between education and working status of women. As expected, ever-married women who are currently working are less likely to be uneducated than those who are not working.

Table 4.2: Educational attainment

Percent distribution of ever-married women age 15-49 by highest level of schooling attended or completed, according to background characteristics, GBDHS 2008

Background characteristic	Education					Total	Number of women
	No education	Primary (1-5)	Middle (6-8)	Secondary (9-10)	Higher (11+)		
Age							
15-19	59.5	13.0	13.8	8.0	5.8	100.0	57
20-24	66.4	3.5	10.4	11.8	8.0	100.0	229
25-29	68.8	6.7	6.7	13.1	4.7	100.0	246
30-34	76.7	7.1	4.9	5.4	5.9	100.0	224
35-39	81.2	8.8	4.1	2.0	4.0	100.0	199
40-44	91.9	4.7	0.4	0.5	2.5	100.0	127
45-49	95.9	2.4	1.7			100.0	117
Residence							
Urban	60.1	8.6	10.3	12.2	8.8	100.0	164
Rural	79.1	5.8	5.1	5.8	4.2	100.0	1033
Wealth quintile							
Lowest	96.8	2.0	0.7	0.5		100.0	216
Second	92.6	3.7	2.2	0.8	0.7	100.0	266
Middle	81.2	6.2	4.9	5.1	2.7	100.0	253
Fourth	66.2	7.4	9.7	11.1	5.6	100.0	250
Highest	42.1	12.1	12.1	17.1	16.4	100.0	212
Work status							
Currently working	74.2	5.1	6.3	7.1	7.3	100.0	470
Not working	78.0	6.9	5.5	6.4	3.2	100.0	727
Total	76.5	6.2	5.8	6.7	7.8	100.0	1197

Literacy is widely acknowledged as benefiting the individual and the society and is associated with a number of positive outcomes for health and nutrition. In the GBDHS-2008, literacy means the respondent's ability to read with understanding all or part of a sentence. Only those who had never been to school and those whose highest grade at school was Class 1-8 were asked to read a sentence in the language they were most likely able to read; those who have attained secondary school or above were assumed to be literate. Table 4.3 presents the percent distribution of ever-married women age 15-49 by level of schooling and level of literacy, according to background characteristics.

There is only one-fourth (23 percent) of ever-married women age 15-49 in Gilgit and Baltistan are literate. The level of literacy consistently decreases from 37 percent among women age 15-19 to 20 percent among those of age 35-39 and thereafter decreases substantially to 2 percent among women age 45-49. Urban women are much more likely to be literate than rural women (39 and 20 percent respectively). There is also a marked difference in literacy levels by women's wealth status, ranging from a low of 2 percent among women

in the lowest wealth quintile to a high of 57 percent among women in the highest wealth quintile. By work status, women who are currently working are more likely to be literate (25 percent) than those who are not working (22 percent).

Table 4.3: Literacy

Percent distribution of ever-married women age 15-49 by level of schooling attended and level of literacy, and percentage literate, according to background characteristics, GBDHS 2008

Background characteristic	Class 9 or higher	No schooling or primary or middle school					
		Can read	Cannot read	Missing	Total	Percentage literate[1]	Number
Age							
15-19	13.8	23.5	62.7		100.0	37.3	57
20-24	19.8	13.0	66.7	0.5	100.0	32.8	229
25-29	17.8	13.4	68.8		100.0	31.2	246
30-34	11.2	10.5	77.7	0.6	100.0	21.7	224
35-39	6.0	13.8	80.2		100.0	19.8	199
40-44	3.0	6.0	91.0		100.0	9.0	127
45-49	0.0	2.0	97.0	1.0	100.0	2.0	117
Residence							
Urban	21.0	18.2	60.8		100.0	39.2	164
Rural	10.0	10.4	79.3	0.3	100.0	20.4	1033
Wealth quintile							
Lowest	0.5	1.5	98.0		100.0	2.0	216
Second	1.5	7.5	91.0		100.0	9.0	266
Middle	7.7	9.2	82.6	0.5	100.0	16.9	253
Fourth	16.7	16.4	66.9		100.0	33.1	250
Highest	33.6	23.2	42.1	1.1	100.0	56.8	212
Work status							
Currently working	14.4	10.7	74.6	0.3	100.0	25.1	470
Not working	9.6	11.9	78.2	0.3	100.0	21.5	727
Total	11.5	11.4	76.8	0.3	100.0	22.9	1197

4.3 Employment

4.3.1 Employment Status

Participation in the labour force not only gives women an opportunity to earn income, but also exposes them to the outside world and to authority structures and networks other than kin-based ones (Dixon-Muller, 1993). The empowering effects of employment are dependant on factors such as type of occupation, the continuity of employment, and the type of income. It is generally accepted that women who have a regular job, who earn money, and who perceive that their contribution is a substantial part of total household earnings are more likely to be empowered than other women (Yousef, 1982; Mahmud and Johnston, 1994).

The respondents of Gilgit and Baltistan were asked a number of questions regarding their employment status, including whether they were working in the seven days preceding the

survey. At the time of the survey, only about 39 percent of ever-married women were currently working. An overwhelming majority of women (61 percent) had not worked in the preceding seven days.

The women in the age groups 25-29, 30-34 and 35-39 are more likely (between 41-44 percent) to be currently working than those in other age groups. On the other hand, in the age group 40-44, most women (72 percent) are found to be currently not working. The divorced, widowed, and separated women are slightly less currently employed when compared with those who are currently married (38 and 39 percent respectively). This pattern is just the opposite what is envisaged in 2006-07 PDHS. The proportion of working women increases with the increase in the number of children. In Gilgit and Baltistan, many women take up jobs because of financial constraints, which generally increase as family size increases.

There are notable variations in the proportion of women currently employed by urban and rural residence. Rural women are more likely to be currently employed than urban women (41 percent and 28 percent, respectively). Current employment and education have an interesting relationship (Figure 4.1 and Table 4.4). The highest proportions of currently employed women are among those with education secondary and above (60 percent) and those having education up-to secondary (42 percent), while the lowest proportion is among women with education up-to primary (32 percent). By wealth quintile women's employment does not show any consistent pattern. Further more it may be noted that an over whelming majority of working women in Gilgit and Baltistan are either working for family members or are self employed. Only 6 percent work for some one else.

Table-4.4: Employment status

Percent distribution of ever-married women age 15-49 by employment status, according to background characteristics, GBDHS-2008

Background characteristics	Currently working	Not currently working	Number	Work for family or for someone else: For family member	For someone else	Self-employed	Number of working women
Age							
15-19	29.7	70.3	57	81.5	8.4	10.0	17
20-24	38.6	61.4	229	83.7	4.8	11.5	88
25-29	42.1	57.9	246	78.2	6.2	15.6	103
30-34	43.7	56.3	224	78.1	10.8	11.1	98
35-39	41.5	58.5	199	88.2	3.7	8.1	82
40-44	28.3	71.7	127	86.9	0.0	13.1	36
45-49	38.5	61.5	117	83.7	6.2	10.2	45
Marital status							
Married	39.3	60.7	1147	82.0	6.2	11.8	450
Divorced/ separated/ widowed	38.1	61.9	50	87.6	3.3	9.0	19
Number of living children							
0	36.0	64.0	138	84.2	2.2	13.6	50
1-2	39.1	60.9	279	83.7	3.4	12.9	109
3-4	39.7	60.3	341	75.5	7.6	16.9	135
5 +	40.0	60.0	439	86.0	7.6	6.3	175
Residence							
Urban	27.6	72.4	164	77.3	3.6	19.1	45
Rural	41.1	58.9	1033	82.8	6.4	10.8	424
Education							
No education	38.1	61.9	916	84.4	6.9	8.7	349
Primary	32.1	67.9	74	82.2	-	17.8	24
Middle	42.4	57.6	70	84.0	2.1	13.9	30
Secondary	41.8	58.2	80	70.8	9.6	19.5	33
Higher	59.6	40.4	57	70.6	3.0	26.5	34
Wealth quintile							
Lowest	35.4	64.6	216	90.5	5.4	4.1	76
Second	39.6	60.4	266	82.6	10.7	6.7	105
Middle	35.6	54.4	253	82.6	5.5	11.9	115
Fourth	38.0	62.0	250	81.7	3.4	14.9	95
Highest	36.5	63.5	212	73.8	4.8	21.4	77
Total	39.2	60.8	1197	82.3	6.1	11.6	470

4.3.2 Occupation

Respondents, who were currently employed were further asked to specify their occupation. Table 4.5 shows the distribution of employed ever-married women by occupation, according to background characteristics. There are large numbers of women (60 percent) found to be housewife and 30 percent of working women are engaged in agricultural occupation with the next most common occupation. The women working as professional/technical and production workers are 4 percent each while only 1 percent of employed women work in domestic service and other professions.

An examination of women's occupation by background characteristics suggests that the proportion of working women with jobs in sales and services, skilled manual labour, and agriculture is higher among currently married women than among those who are divorced,

separated, or widowed. Residence has a strong relationship with the type of occupation. As expected, the largest urban-rural differentials are found among women working in the agricultural sector; 54 percent of women in rural areas work in agriculture compared with only 6.7 percent in urban areas. Nearly half (41.1 percent) of working women residing in rural areas are employed in sales and services compared with women residing in urban areas 27.6 percent.

The relationship between education and type of occupation is especially strong. The proportion of employed women who work in agriculture decreases significantly with education, from 33.1 percent among ever-married women with no education to virtually 9.3 percent among those with higher education. The opposite reaction is found for women who work in professional, technical, or managerial fields (45.5 percent) women with education secondary and above work in such jobs compared with less than 1 percent of women with no education. The table 4.5 shows that majority of ever-married working women as housewife in urban areas (71.5 percent) as compared to rural areas (58.4 percent).

Table 4.5 also shows that majority of ever married women with 3-4 children are working in agriculture (28.4 percent). An overwhelming majority of working women (35 percent) in the lowest wealth quintile are engaged in the agricultural sector compared with only 13 percent of women in the highest wealth quintile with same profession. On the other hand, the proportion of women working in professional/technical service and production worker increases with wealth quintile in table 4.5.

Table 4.5: Occupation

Percent distribution of ever-married women age 15-49 employed in the 12 months preceding the survey, by occupation, according to background characteristics, GBDHS 2008

Background characteristic	Professional /technical	Service	Agriculture	Production	Other	Housewife	Percent	Women
Age								
15-19	3.8	0.0	24.6	2.2	0.0	69.3	100.0	57
20-24	2.8	0.5	27.6	6.0	1.7	61.4	100.0	229
25-29	5.2	0.2	30.5	5.8	0.9	57.4	100.0	246
30-34	5.5	2.3	31.6	5.1	0.7	54.8	100.0	224
35-39	5.6	1.5	31.9	2.8	0.0	58.2	100.0	199
40-44	3.1	0.3	22.5	1.4	0.9	71.7	100.0	127
45-49	2.3	0.8	33.9	1.0	1.2	60.7	100.0	117
Marital status								
Married	4.3	0.7	30.0	4.1	0.7	60.2	100.0	1147
Divorced/separated/ widowed	2.7	6.2	21.5	5.4	4.0	60.2	100.0	50
Number of living children								
0	2.1	--	25.9	7.2	0.9	64.0	100.0	138
1-2	5.0	0.7	26.7	5.7	1.8	60.1	100.0	279
3-4	5.7	1.6	28.4	4.2	0.5	59.7	100.0	341
5+	3.4	0.8	33.6	2.1	0.6	59.6	100.0	439
Residence								
Urban	6.7	2.3	14.3	4.8	0.4	60.7	100.0	164
Rural	3.9	0.7	32.0	4.0	0.9	58.4	100.0	1033
Education								
No education	0.7	0.7	33.1	2.9	1.0	61.6	100.0	916
Primary	3.5	--	24.6	4.0	--	67.9	100.0	74
Middle	3.9	1.6	20.0	17.7	--	56.8	100.0	70
Secondary	16.6	--	16.7	8.5	--	58.2	100.0	80
Higher	45.5	6.1	9.3	0.8	2.7	35.6	100.0	57
Wealth quintile								
Lowest	0.0	0.0	34.8	0.6	0.0	64.6	100.0	216
Second	1.6	0.6	34.3	2.6	1.3	59.7	100.0	266
Middle	1.2	1.0	39.1	4.1	0.5	54.1	100.0	253
Fourth	5.9	1.4	24.6	5.9	0.8	61.4	100.0	250
Highest	13.8	1.6	12.9	7.7	1.8	62.2	100.0	212
Work status								
Working	10.6	1.9	75.1	10.5	1.9	0.0	100.0	470
Not working	0.2	0.3	0.2	0.0	0.2	99.1	100.0	727
Total	4.3	0.9	29.6	4.1	0.9	60.2	100.0	1197

4.3.3 Type of Earnings

Table 4.6 shows the percent distribution of ever-married, currently employed women by type of earnings (cash or non cash), according to type of employment (agricultural or non-agricultural). Overall, 48 percent of currently employed women receive money for their work. The proportion of women who receive money for their work is much higher in the nonagricultural than in the agricultural sector (69 percent and 41 percent, respectively).

Table 4.6: Type of earning

Percent distribution of ever-married women age 15-49 currently employed, by type of earnings, according to type of employment (agricultural or non-agricultural), GBDHS-2008

Type of earnings	Agricultural Work	Non- agricultural Work	Total
Received money	41.1	68.8	48.0
Don't received money	58.9	31.2	52.0
Total	100.0	100.0	100.0
Number of women currently employed	352	117	470

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3. Yousaf, N.H. 1982. The Interrelationship between the division of Labour in the household, women's role and their compact on fertility. In Women's roles and population trends in the third world, ed. R. Anker, M. Buvinic, and N.H. Yousaf. London: Groom Helon.

5 FERTILITY

Ali Anwar Buriro

Fertility is one of the three principal components of population dynamics, the others being mortality and migration (UN, 1973). In view of the fast growing population, the government has been trying since 1960s, to reduce fertility rate through the implementation of its population policies. However, the fertility transition in this country has started from only about two decades back. The fertility levels that remained more or less constant at 6 children per woman through 1960's to the mid 1980's were started to decline to 5.4 children in the late 1980's (Feeney and Alam, 2003; NIPS/IRD Macro, 1992). The recent PDHS (2006-07) was another effort to observe the pace of fertility transition in Pakistan.

Gilgit and Baltistan Demographic and Health survey is the first such effort that has provided the information regarding fertility in northern regions of Pakistan. A major objective of the Gilgit and Baltistan Demographic and Health survey is to analyse fertility levels and examine differentials in fertility by selected background characteristics of ever-married women (Place of Residence, educational level and Wealth quintile), lifetime fertility (Children Ever-Born and Living) teenage pregnancy, and motherhood.

The fertility data was collected by asking all ever-married women of reproductive age (15-49 years) to provide complete birth history of their last three children born alive: those who were currently living with them, living away from them and those who had died. The information was also collected about: name, sex, date of birth, survival status, current age (if alive), and age at death (if dead) of the last 3 children born alive.

Moreover, readers may note that unlike previous conventional practice of recording births in the birth history in chronological order, in this survey we have reversed the order and recorded the last birth first followed by birth in the preceding years. This was done assuming a better reporting of recent births which in turn brings about a good estimate of current fertility that is based on the births in 3 years preceding the survey. Also during training, efforts were made to impress upon the interviewers about the importance of collecting information of all ever born children. It is important to mention here that the birth history approach has some limitations that might distort fertility levels and patterns. For example;

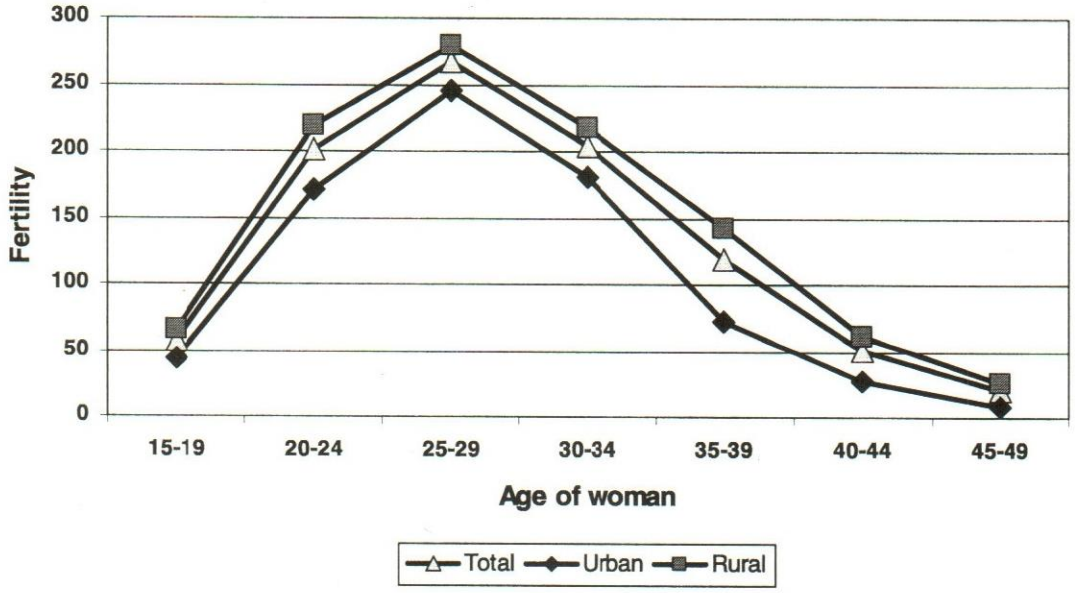
women may include relatives' children as their own or omit children who died in young age (UN, 1983). The results of GBDHS (2008) should be read with this forewarning in mind.

5.1 Current Fertility

Total Fertility Rate (TFR) is defined as the average number of children a woman would have if she went through her entire reproductive period (15-49) reproducing at the prevailing Age Specific Fertility Rates (ASFRs). The Age Specific Fertility Rates calculated by dividing the number of births to women in specific age group by the number of women lived years during a given period (Figure 5.1).

Table (5.1) indicates that Total Fertility Rate (TFR) in Gilgit and Baltistan is 4.6 children per woman for the 3 years period preceding the survey. Fertility in rural areas is higher (5.1 children per woman) as compared to urban areas (3.8 children per woman) (Figure 5.2). A pattern that is evident at every age group. A relatively lower fertility among urban women could be associated to the factors like better access to family planning and health facilities, better education, economic status, and prevalence of late female marriages.

Figure 5.1: Age-specific Fertility Rates



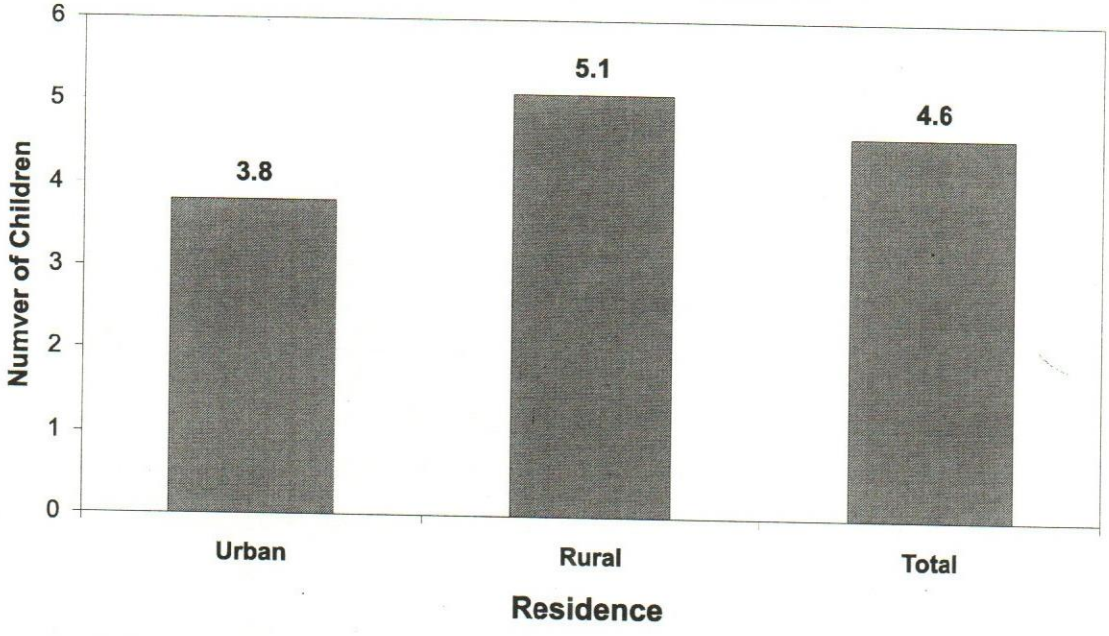
The fertility is highest in age group 25-29. This pattern is also evident in both urban and rural areas. Fertility decreases rapidly after age groups 35-39.

Table 5.1: Fertility

Age Specific Fertility Rates (ASFR) and Total Fertility Rate (TFR) For three years preceding the survey by residence, GBDHS (2008)

Age group	Urban	Rural	Total
15-19	44.5	66.2	58.2
20-24	171.7	219.2	201.1
25-29	245.7	279.5	267.1
30-34	181.1	218.2	204.7
35-39	73.2	143.1	119.4
40-44	27.4	61.7	50.2
45-49	8.0	26.3	20.6
TFR	**3.8**	**5.1**	**4.6**

Figure 5.2: Total Fertility Rates by Residence



A table (5.2) shows currently pregnant women and means number of children ever born by background characteristics. Data shows that 12 percent women's were pregnant at the time of survey. Although, this estimate is much higher than what is estimated (8 percent) in 2006 PDHS, yet it is likely that even this proportion is under estimated as women in their early stages of pregnancy may be unaware or uncertain that they are pregnant. Some may even refuse to declare that they are pregnant. The differentials in pregnancy levels by urban-rural residence are generally consistent with the pattern depicted in urban and rural TFR. Just as pregnancy levels, mean number of children ever born are also observed to follow a similar pattern across urban and rural areas.

The current pregnancy levels by women's education show unexpected pattern. The pregnancy levels are lower for women with "no education" or "up to primary" level of education. Whereas a consistently decreasing pattern is found for both pregnancy levels and mean children ever born with wealth quintile.

Table 5.2: Cumulative Fertility by Background Characteristics

Percentage of all women age 15-49 currently pregnant, and mean number of children ever born to all women age 40-49 years, by background characteristics, GBDHS (2008)

Background characteristics		Percentage of currently pregnant women age 15-49	Mean number of Children Ever-Born to women age 40-49	Number of Women
Place of residence	Urban	10.1	6.7	170
	Rural	12.7	7.1	1112
Level of education	None	11.8	7.1	973
	Upto Primary	6.7	7.3	79
	Middle	18.1	6.9	80
	Secondary	18.7	5.0	85
	Higher	11.9	4.2	64
Wealth quintile	Poorest	10.2	5.8	236
	Second	18.2	8.3	281
	Middle	12.7	7.7	269
	Fourth	10.7	6.9	266
	Richest	9.0	6.1	229
Total		12.4	7.0	1281

5.2 Children Ever Born and Children Surviving

The number of children ever born and the mean number of living children is presented in table 5.3 for all women and currently married women age 15-49 years. The estimates for all women are based on the assumption that all births occur within marriage. About 96 percent of women age 15-19 have never given birth. However, this proportion declines rapidly to about 13 percent for women age 30-34 years and only nearly 10 percent women at the end of their reproductive age remain childless. Comparatively only 4 percent Pakistani women remained childless at the end of their reproductive age (Ali and Buriro, 2008) indicating that either a higher proportion of Gilgit and Baltistan women than their counter parts in Pakistan remain unmarried or there is high infertility among Gilgit and Baltistan women. This is an area that requires an investigation. Childlessness is also high among currently married women of Gilgit and Baltistan.

Table 5.3: Children ever born and living

Percent Distribution of All Women according to Number of Children Ever-Born & Mean Number of Children Ever-Born and Living by Age group, GBDHS (2008)

Age group	Number of children ever born											Total	Number Of women	Mean Number Of Children Ever Born	Mean Number Of Living children	% women (15-49) currently pregnant
	0	1	2	3	4	5	6	7	8	9	10+					
All Women																
15-19	95.8	3.2	0.9	0.2	--	--	--	--	--	--	--	100	568	0.06	0.06	2.29
20-24	61.7	14.2	12.4	7.6	2.5	0.9	-	0.2	0.2	0.2	--	100	436	0.89	.82	13.53
25-29	33.1	11.2	13.1	16.7	12.5	7.3	3.0	2.1	0.9	--	--	100	329	2.35	2.11	9.42
30-34	12.9	4.3	5.9	12.9	18.8	17.2	11.7	10.2	4.3	1.2	0.8	100	256	4.27	3.74	11.72
35-39	8.7	2.3	1.8	6.4	17.9	14.2	15.1	15.1	3.7	8.3	6.4	100	218	5.64	4.95	6.42
40-44	9.9	1.4	1.4	2.1	9.9	7.8	12.8	15.6	11.3	9.2	18.4	100	141	6.99	5.72	2.84
45-49	9.8	-	0.8	2.4	3.3	6.5	12.2	10.6	13.0	14.6	26.8	100	123	7.60	6.48	3.25
Total	48.3	6.5	6.0	6.9	7.6	5.9	5.1	4.9	2.7	2.6	3.6	100	2,071	2.63	2.28	7.48
Currently Married Women																
15-19	59.1	28.6	10.5	1.9	--	--	--	--	--	--	--	100	55	0.6	0.5	22.0
20-24	25.2	26.9	23.4	15.4	4.9	2.3	--	0.5	0.6	0.7	--	100	225	1.7	1.5	26.4
25-29	6.6	14.2	17.9	23.2	17.7	11.1	5.4	2.5	1.4	--	--	100	238	3.1	2.8	13.4
30-34	1.5	3.5	6.0	12.7	20.1	20.4	13.2	12.8	6.6	1.8	1.4	100	217	4.9	4.3	14.1
35-39	2.0	2.0	1.6	5.0	16.6	15.5	16.2	17.5	4.7	10.3	8.6	100	187	6.1	5.3	7.7
40-44	1.1	1.0	--	1.6	9.1	6.6	15.0	17.7	13.5	12.6	22.0	100	114	7.5	6.2	4.2
45-49	4.4	--	0.9	2.4	2.9	5.1	12.4	10.5	13.3	17.2	30.9	100	110	8.0	6.9	4.6
Total	10.3	10.7	10.3	11.5	12.3	10.3	9.0	8.6	5.1	5.1	6.8	100	1,147	4.4	3.9	13.8

The same pattern is replicated for currently married women with the difference that the proportion of women age 15-19, who have not borne a child, reduced to 59 percent. Furthermore, currently married women age 45-49 have, on average, borne 4.4 children each. The difference in childbearing between all women and currently married women can be explained by the presence of many unmarried young and widowed, divorced, and separated women in the "all women" category. As expected, women above 40 years have much higher parities with considerable proportions having 10 or more births by the closing stages of their childbearing years.

On the whole the mean number of children ever-born and mean number of living-children increases with rising age of women, thus presupposing negligible or no recall lapse, which heightens confidence in the reported birth history.

5.3 Teenage Fertility

An examination of teenage fertility is important for various reasons. Firstly, children born to very young mothers are normally prone to higher danger of sickness and death. Secondly, teenage mothers are more likely to experience complications during pregnancy and are less likely prepared to deal with them. It often leads to maternal death. Moreover, early entry into reproductive process denies them the opportunity to pursue educational goals. This in turn reduces their prospects for better careers and lowers their status in society.

Table 5.4 shows the percentage of women age 15-19 who were mothers or were pregnant with their first child at the time of the GBDHS (2008) by selected background characteristics. Data shows no consistent pattern by the selected characteristics of women. Such a pattern may be attributed to small number of cases in each category of selected background characteristics.

Table 5.4: Teenage Pregnancy and Motherhood

Percentage of women age 15-19 who have had a live birth or who are pregnant with their first child by background characteristics, GBDHS (2008)

Background characteristics		Percentage Who are			Total	Number of women
		Mothers	Pregnant With First Child	No Child		
Age	15	24.1	19.6	56.4	100.0	6
	16	46.9	--	53.1	100.0	7
	17	22.1	16.3	61.7	100.0	6
	18	12.1	7.7	80.2	100.0	19
	19	54.0	12.3	33.6	100.0	26
Place of residence	Urban	56.1	10.0	34.0	100.0	8
	Rural	32.3	10.7	57.0	100.0	56
Level of education	None	35.8	11.6	52.6	100.0	37
	Upto Primary	34.4	6.6	59.1	100.0	9
	Middle	51.8	11.0	37.2	100.0	8
	Secondary	27.0	--	73.0	100.0	6
	Higher	18.6	21.9	59.5	100.0	5
Wealth quintile	Poorest	51.2	18.3	30.5	100.0	12
	Second	42.8	7.7	49.5	100.0	12
	Middle	27.1	15.6	57.3	100.0	15
	Fourth	30.1	--	69.9	100.0	12
	Richest	29.1	10.4	60.6	100.0	14
Total		35.4	10.6	54.0	100.0	64

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6 FAMILY PLANNING

Amanullah Bhatti and Rabia Zafar

The Population Welfare Programme has been able to create universal awareness about family planning methods among married couples but the contraceptive prevalence rate is quite low (30 percent) in Pakistan. The challenge is to ensure continuous use by current users and increase existing CPR by meeting the unmet need for family planning services along with sustaining the demand of family planning services by new entrants in the reproductive age group.

The strategy of the National Policy on Population is aimed at reducing the high unmet need for family planning services by bringing family planning services into the fold of health outlets, developing greater partnerships between various arms of the public sector and enhancing the public-private sector partnerships. The reduction in the gap between the demand and supply of family planning services will be the first thrust of this policy. (Ministry of Population Welfare, 2002)

This chapter focuses on Gilgit and Baltistan and appraises the knowledge of various contraceptive methods and discusses current prevalence and the timing for its adoption. Special attention is on the source of contraception, reasons of nonuse and intention to use contraceptive methods in the future. The chapter also contains information on exposure to family planning messages through the media and relationship between clients and family planning service providers. These topics are of practical use to policy and program administrators in formulating effective family planning strategies.

6.1 Knowledge of Contraceptive Methods

Knowledge about contraceptive methods is an important prerequisite for adopting family planning. The ability to spontaneously name or recognize a family planning method when it is described is a simple test of a respondent's knowledge but not necessarily an indication of the extent of his/her knowledge. Information on knowledge of contraception was collected by first asking an ever married woman to name ways or methods by which a couple can delay or avoid pregnancy. If the respondent failed to mention a particular method spontaneously, the interviewer described the method and asked whether the respondent recognized it. The survey

collected information on eight modern family planning methods, female and male sterilization, the pill, the IUD, injectables, implants, male condoms and emergency contraception and two traditional methods, rhythm method and withdrawal. Folk methods could be mentioned spontaneously by respondents.

In Table 6.1, information about knowledge of contraceptive methods is presented for all ever and currently married women by specific methods. Findings from the 2008 GBDHS show that knowledge of at least one modern method of family planning in Gilgit and Baltistan is almost universal (above 90 percent) among married women. The most widely known modern contraceptive methods among currently married women are pills (86 percent), Injectables (85 percent), IUD (80 percent). Seventy percent of currently married women age 15-49 knew of female sterilization, about sixty percent women have heard of male sterilization, more than half of women (53 percent) have knowledge about condoms and 13 percent of women have heard of emergency contraception. Comparatively a small proportion of married women have knowledge about traditional methods such as rhythm and withdrawal. Only thirty-three percent currently married women have heard of the rhythm method and withdrawal is mentioned by 28 percent of women. The mean number of methods known to an ever -married woman as well as currently married woman is five.

Table 6.1: Knowledge of contraceptive methods

Percentage of ever-married and currently married women age 15-49 who knows any contraceptive method, by specific method, Gilgit and Baltistan 2008

Method	Ever married	Currently married
Any method	90.8	91.7
Any modern method	90.7	91.5
Female sterilization	69.4	70.1
Male sterilization	59.4	59.8
Pills	85.4	86.4
IUD	79.0	80.0
Injectables	84.3	85.3
Implants	17.4	17.4
Condom	52.0	52.8
Emergency contraception	12.8	13.1
Any traditional method	38.1	39.0
Rhythm methods	32.0	32.7
Withdrawal	26.9	27.7
Mean number of methods known by women age 15-49	5.2	5.3
Number of women	1,197	1,147

Table 6.2 shows currently married women age15-49 who have heard at least one contraceptive method and at least one modern method according to selected background characteristics. There is no visible difference between knowledge about a modern method and any method. By age groups, the contraceptive knowledge is somewhat low among women of age groups 15-24 and 40-44. The women in these two age groups are more likely to be indifferent about knowledge of a contraceptive method. The women in age groups 20-24 are newly weds and are in the early stages of family formation, On the other hand, older women have completed their family size and hence these women are not as interested in knowing about contraceptive methods as their counterparts in other age groups.

Difference in the level of knowledge between urban and rural areas is quite visible. The level of contraceptive knowledge increases with education and wealth status of women.

Table 6.2: Knowledge of contraceptive methods by background characteristics

Percentage of currently married women age 15-49 who have heard of at least one contraceptive method and who have heard of at least one modern method, by background characteristics, Gilgit and Baltistan

Background Characteristics		Heard of any method	Heard of any modern method	Number of Women
Age	15-19	86.9	86.9	55
	20-24	88.5	87.9	225
	25-29	94.4	94.4	238
	30-34	93.7	93.7	217
	35-39	93.9	93.9	187
	40-44	88.4	88.4	114
	45-49	90.2	90.2	110
Residence	Urban	95.1	95.1	159
	Rural	91.1	91.0	988
Education	None	90.5	90.3	871
	Upto Primary	94.4	94.4	70
	Middle	95.4	95.4	68
	Secondary	93.8	93.8	80
	Higher	98.9	98.9	57
Wealth quintiles	Poorest	86.6	86.6	200
	Second	87.6	87.6	258
	Middle	92.7	92.7	244
	Fourth	94.1	94.1	240
	Richest	97.6	96.9	206
Total 15-49		91.7	91.5	1,147

6.2 Ever Use of Contraception

Data on ever use of contraception has special significance because it provides an evaluation of family planning programs for promoting the use of family planning methods among couples. Ever use refers to use of a method at any time, with no distinction between past and present use. In the 2008 GBDHS, ever-married women who had heard of a method of family planning were asked if they had ever used a contraceptive method.

Table 6.3 shows the percentage of ever and currently married women who have ever used specific methods of family planning by age of women. Forty-seven percent of currently married women have ever used a method of contraception, and 45 percent have used a modern method while only 10 percent have used traditional method. Among currently married women, one in five has ever used pill and injection and 17 percent have used IUD, making the three methods, the most commonly used modern methods. One in ten currently married women have used condoms. Six percent of currently married women reported the use of rhythm followed by withdrawal (5 percent) and female sterilization (5 percent) and less than one percent reported about emergency contraception, male sterilization and implant.

As expected, ever use of any contraceptive method rises steadily with age, from 19 percent among currently married women age 15-19 to 63 percent among women age 40-44, and then falling slightly among those age 45-49. Ever use of any modern method by age follows a similar pattern. Female sterilization is more likely to have been used by older women, while use of pills is more popular among women in their thirty's. IUD, and injectables are common among 25 and older currently married women. The use of rhythm is most common among women age 30-34 whereas, maximum use of withdrawal has been reported by women in the age group 40-44 years.

Table 6.3: Ever use of contraception

Percentage of ever-married and currently married women age 15-49 who have ever used any contraceptive method, by method, according to age, Gilgit and Baltistan 2008

Age group	Any method	Any modern method	Female sterili-zation	Male sterili-zation	Pills	IUD	Injection	Implants	Condom	Any traditional method	Rhythm	Withdrawal	Emergency contracep-tion	Number of women
EVER-MARRIED WOMEN														
15-19	18.9	12.7	.0	.0	5.8	4.4	4.4	.0	5.6	8.0	5.9	2.2	.0	57
20-24	29.1	25.7	.0	.0	13.0	5.2	10.1	.0	7.1	7.7	4.5	4.9	.0	229
25-29	43.5	42.5	.5	.5	21.2	14.1	19.8	.0	10.4	9.6	5.9	3.6	1.1	246
30-34	48.9	48.0	3.8	.0	27.0	20.0	21.0	.7	12.0	11.2	7.8	4.5	1.6	224
35-39	56.9	56.0	6.7	.8	25.3	23.5	29.9	.0	12.9	10.3	7.3	6.6	.7	199
40-44	58.8	58.6	15.6	2.1	19.6	23.2	24.8	.9	7.2	11.1	3.6	9.0	.4	127
45-49	55.8	55.4	12.0	1.3	23.0	19.5	20.0	.0	5.9	6.4	3.0	4.2	.0	117
Total	45.6	44.1	4.7	.6	20.7	16.1	19.7	.2	9.5	9.4	5.7	5.1	.7	1197
CURRENTLY-MARRIED WOMEN														
15-19	19.4	13.0	.0	.0	6.0	4.5	4.5	.0	5.7	8.2	6.0	2.2	.0	55
20-24	29.6	26.1	.0	.0	13.2	5.2	10.3	.0	7.2	7.8	4.6	5.0	.0	225
25-29	44.4	43.4	.5	.5	21.6	14.4	20.2	.0	10.5	9.7	6.1	3.7	1.0	238
30-34	49.3	48.3	3.9	.0	26.9	20.1	21.7	.7	12.2	11.6	8.0	4.6	1.7	217
35-39	60.1	59.1	7.1	.9	26.6	24.9	31.7	.0	13.7	10.9	7.7	7.0	.7	187
40-44	62.9	62.7	17.3	1.2	20.5	25.8	26.6	1.0	8.0	12.3	4.0	10.0	.5	114
45-49	57.1	56.7	12.8	1.4	23.8	20.8	20.5	.0	5.5	6.0	2.4	4.5	.0	110
Total	46.8	45.2	5.0	.5	21.1	16.7	20.3	.2	9.7	9.7	5.9	5.3	.7	1147

6.3 Current Use of Contraception

Current use of contraception is defined as the proportion of women who reported the use of a family planning method at the time of interview. The level of current use usually calculated among currently married women, is the most widely used and valuable measure of the success of family planning program. Table 6.4 and figure 6.1 show the percent distribution of currently married women who are currently using specific family planning methods by age.

Figure 6.1: Current Use of Contraceptives

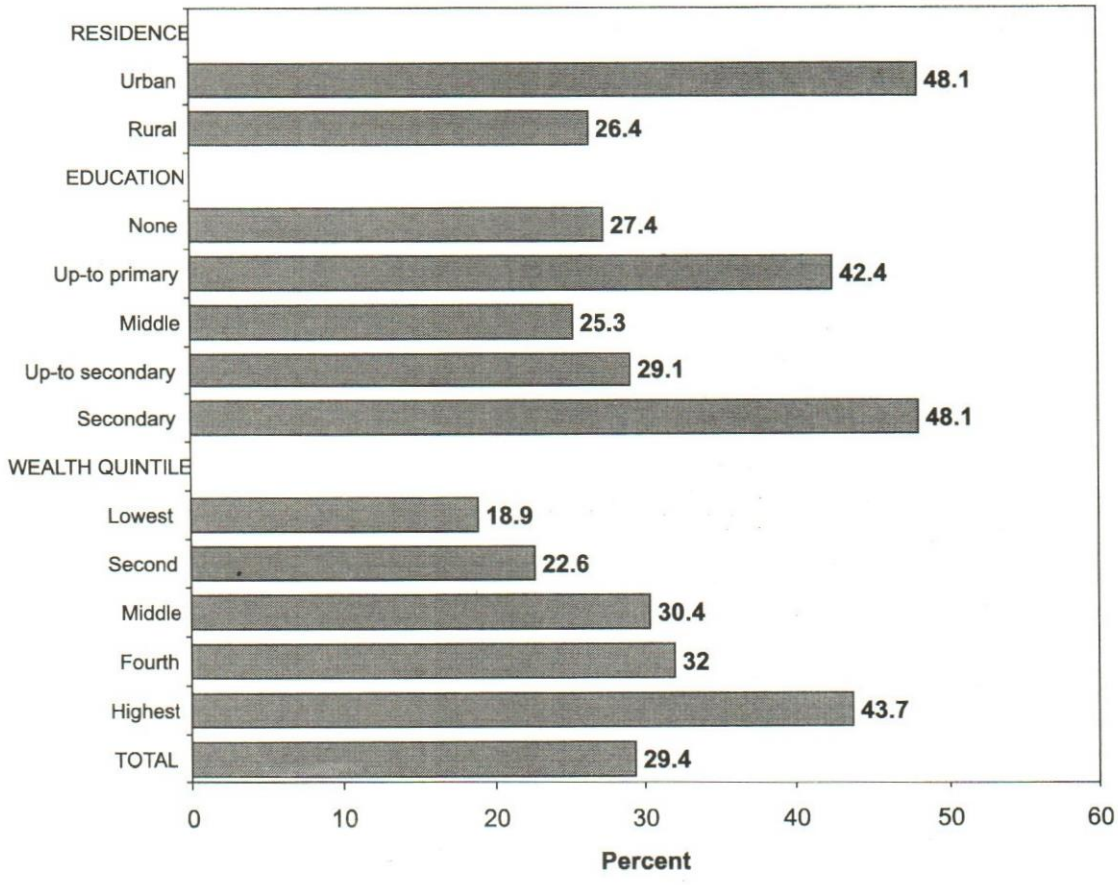


Table 6.4: Current use of contraception

Percent distribution of currently married women age 15-49 by contraceptive method currently used, according to age, Gilgit and Baltistan.2008

Age group	Any method	Any modern method	Any traditional method	Female Sterili-zation	Male Sterili-zation	Pill	IUD	Injections	Implants	Condom	Rhythm	Withdrawal	Other	Not currently using	Total	Number of women
15-19	10.1	6.0	4.1				2.8	1.3		1.9	4.1			89.9	100.0	55
20-24	15.6	12.0	3.6			2.3	4.2	3.3		2.1	1.2	2.4		84.4	100.0	225
25-29	20.8	20.6	.7	.5		4.4	6.6	7.1	.3	1.7		.7		78.6	100.0	238
30-34	32.0	30.1	1.9	3.9		6.0	9.9	8.6		1.7	.6	1.3		68.0	100.0	217
35-39	40.8	38.5	2.3	7.1	.9	6.5	7.4	14.1		2.6	.9	.6	.8	59.2	100.0	187
40-44	48.9	45.7	3.2	16.8	1.2	5.7	12.6	6.2	.7	2.5	.3	2.9		51.1	100.0	114
45-49	40.6	38.3	2.3	12.8	1.4	7.5	10.3	6.4			.4	1.2	.7	59.4	100.0	110
Total	29.4	27.1	2.3	4.9	.4	4.8	7.6	7.3	.1	1.8	.8	1.4	.2	70.5	100.0	1147

Table 6.4 shows that more than one forth of currently married women (29 percent) are using a method of family planning, with 27 percent using a modern contraceptive method.

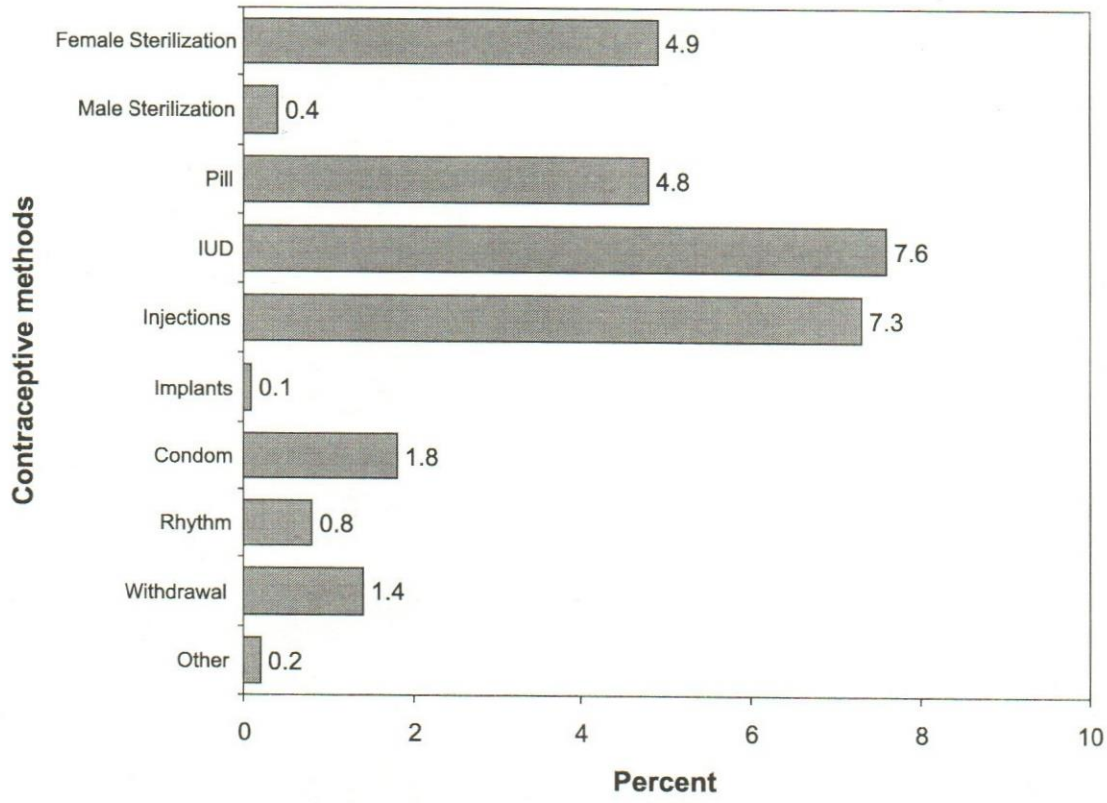
Contraceptive use varies by age. Use is lower among younger women (because they are in the early stage of family building) and among older women (some of whom are no longer fecund) than among those at intermediate ages. For example, current use of a modern contraceptive method rises from 6 percent among women age 15-19, to 46 percent among age 40-44 and then drops sharply to 38 percent at age 45-49. Most women who are sterilized are older than 40 years, while injectables are popular among women age 35-39. The use of IUD method is popular among women in age group 40 – 49.

6.4 Current use of contraception by background characteristics

The study of differentials in current use of contraception is important because it helps to identify subgroups of the population that need to be targeted for provision of family planning services. Table 6.5 and figure 6.2 presents the percent distribution of currently married women by their current use of family planning methods, according to background characteristics. This table provides a comparison of levels of current contraceptive use among major population groups.

Substantial differences in the use of contraceptive methods among subgroups of currently married women can be seen in Table 6.5 Women in urban areas are more likely to use a family planning method than rural women. Besides other factors, this could be partly attributed to wider availability and easy access to methods in urban areas. The contraceptive prevalence rate for modern methods is 45 percent in urban areas, compared with only 24 percent in rural areas.

Figure 6.2: Contraceptive use by Background Characteristics



The impact of education on contraceptive use is mixed. However, the educated women are more likely to use contraceptive methods than the women with no education. Use of any method is highest (48 percent) among women with higher level of education and lowest (25 percent) among women with middle level of education. Over one-fourth (27 percent) of the women with no education are currently using any method. In general, women do not begin to use contraception until they have had at least one child, after which use increases rapidly with the increases in number of children.

It is expected that women who are working would be more likely to use contraceptives than those who are not working. In congruence to this premise, the data in Table 6.5 show that contraceptive use among currently working married women is slightly higher (31 percent) than those who have never worked (29 percent)

Contraceptive use increases as wealth status improve. The contraceptive prevalence rate increases from 19 percent of currently married women in the poorest quintile to 44 percent of those in the richest quintile.

Table 6.5: Current use of contraception by background characteristics

Percent distribution of currently married women age 15-49 by contraceptive method currently used, according to background characteristics GBDHS 2008

Background characteristics		Any method	Any modern method	Any traditional method	Female Sterili-zation	Male Sterili-zation	Pill	IUD	Injections	Implants	Condom	Rhythm	Withdrawal	Other	Not currently using	Total	Number of women
Level of education	Urban	48.1	45.0	3.1	10.6		10.2	12.3	8.0		3.9	1.0	2.1		51.9	100.0	159
	Rural	26.4	24.3	2.2	4.0	.5	4.0	6.9	7.3	.2	1.5	.7	1.3	.2	73.5	100.0	988
	None	27.4	25.7	1.7	5.3	.4	4.4	7.6	6.8	.2	1.0	.5	1.0	.3	72.6	100.0	871
	Upto Primary	42.4	40.0	2.4	3.3		7.4	10.7	14.7		3.8	.8	1.6		57.6	100.0	70
	Middle	25.3	22.8	2.5	3.5		3.5	6.5	6.1		3.3	.9	1.5		74.7	100.0	68
	Secondary	29.1	30.7	.0	2.6		10.4	7.7	6.7		3.3				69.3	100.0	80
	Higher	48.1	33.8	14.3	5.5	1.9	2.5	6.5	9.1		8.3	5.9	8.4		51.9	100.0	57
Number of living children	0	.0	.0	.0											100.0	100.0	126
	1-2	18.5	14.9	3.6	.4		3.6	5.2	4.4		1.4	1.9	1.7		81.5	100.0	265
	3-4	37.4	35.5	2.3	5.8		7.9	8.7	9.4	.2	3.4	.8	1.5		62.2	100.0	328
	5+	38.5	36.3	2.3	8.5	1.1	4.7	10.6	9.7	.2	1.5	.2	1.5	.5	61.5	100.0	428
Work status	Working	30.6	28.3	2.3	4.1	.4	4.3	8.8	8.6	.4	1.8	.9	1.3	.2	69.4	100.0	450
	Not working	28.5	26.4	2.3	5.5	.4	5.2	6.9	6.6		1.9	.7	1.4	.2	71.3	100.0	696
Wealth quintiles	Poorest	18.9	17.5	1.4	2.4		1.7	7.3	5.4		.6	.8	.6		81.1	100.0	200
	Second	22.6	22.0	.6	5.9		3.8	6.2	5.7	.3	.1		.6		77.4	100.0	258
	Middle	30.4	28.8	1.5	2.9	.6	7.4	8.2	8.6	.3	.9	.7	.8		69.6	100.0	244
	Fourth	32.0	29.2	3.3	5.7	.9	3.6	8.7	7.1		3.2	.6	2.4	.3	67.5	100.0	240
	Richest	43.7	38.5	5.2	7.6	.5	7.7	7.9	10.1		4.7	1.9	2.6	.8	56.3	100.0	206
Total 15-49		29.4	27.1	2.3	4.9	.4	4.8	7.6	7.3	.1	1.8	.8	1.4	.2	70.5	100.0	1147

6.5 Source of Contraception

Table 6.6 on source of supply for contraception is intended to document the main sources of contraception as reported by users of different modern methods of contraception. Such information is important for program managers in designing and formulating policies for the provision of contraceptive methods. All current users of modern contraceptive methods were asked the most recent source of supply of their method. To improve the accuracy of source reporting, interviewers were instructed to note the full name of the source or facility. Supervisors were instructed to verify the name and type of source.

Table 6.6 shows that 71 percent of modern method users rely on public sector institutions while 15 percent of women use the private medical sector and 4 percent use other sources. In the public sector, the most important sources of family planning services (28 percent of users) are government hospitals and Reproductive Health Service Centres (RHSC). Family Welfare Centres (FWCs) are the main source of service delivery under the Ministry of Population Welfare. A large proportion of users (23 percent of women) visit FWCs to obtain methods. Lady Health Workers are also an important source (11 percent of all users of modern methods) at grass root level. Only 5 percent of users rely on rural health or maternal and child health (MCH) centers. Only three percent obtain modern method from Village Based Family Planning Workers (VBFPWs). The main contributors in the private medical sector are nongovernmental organization (NGO), such as key clinics (7.5 percent), and green star (1.9 percent). Three percent of modern method users obtain their methods from shops other than pharmacies or chemists.

Table 6.6: Source of modern contraception methods

Percent distribution of users of modern contraceptive methods age 15-49 by most recent source of method, according to method, GBDHS 2008

Source	Female sterilization	Pills	IUD	Injectables	Condoms	Total
Public sector	75.0	71.5	67.9	70.2	74.4	70.6
NGO sector	15.5	1.7	11.5	14.2	2.7	11.1
Private sector	9.5	12.7	20.6	13.4	12.9	14.6
Other sources		14.1		2.1	10.1	3.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
Public sector						
Govt hospital/RHSC	**69.6**	**11.3**	**18.6**	**25.2**		**27.7**
Rural Health center/MCH	4.4	4.2	6.2	6.0		4.9
Family welfare centre		15.8	39.7	30.0	16.6	23.3
Mobile service camp			1.5			.4
Village Based Family Planning Worker		10.0	.5	1.0	7.8	2.7
Lady health worker		30.1	1.5	8.2	50.0	11.4
Other public	1.0					.2
Private Sector						
NGO sector						
Green star Clinic	2.0	1.1	3.5	1.3		1.9
Key clinic	1.4	3.8	10.2	11.5	5.2	7.5
Other Doctors	2.5		4.2			1.7
Pharmacy/Drug store		7.8			7.7	1.9
TBA/Dai			1.3			.4
Other private medical	3.5		1.4	.7		1.2
Other Sources						
Shop (other than drug store)		12.9		1.5	10.1	3.4
OTHER		1.1		.7		.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	56	56	88	84	21	311

6.6 Future Use of Contraception

An important indicator of change in demand for family planning is the future intentions of non users. Currently married women who were not using contraception at the time of the survey were asked about their intention to use family planning in the future. The results indicate that about 45 percent of women reported that they intend to use a family planning method in the future, and about the same proportion of women do not intend to use a method in the future while 8 percent are unsure of their future intention (Table 6.7). The proportion of women who intend to use family planning differs by their number of living children. The proportion of women intending to use family planning peaks at 55 percent with one child, declines to 42 percent among women having 4 or more children. Such women should be

approached by the family planning services providers so as to increase the CPR in short period of time.

Table 6.7: Future use of contraception

Percent distribution of currently married women age 15-49 who are not using a contraceptive method by intention to use in the future, according to province and number of living children, GBDHS 2008

Intention	Number of living children					Total
	0	1	2	3	4+	
Intend to use	30.5	55.1	52.4	53.9	42.1	44.9
Unsure	18.2	9.0	11.7	6.5	4.2	8.3
Does not intend to use	45.8	34.5	32.7	36.5	52.5	44.5
Missing	5.5	1.4	3.2	3.1	1.2	2.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	126	116	99	98	370	810

6.7 Exposure to Family Planning Messages

The electronic media such as radio and television are important for communicating messages about family planning. Information on the level of exposure to such media is important for program managers and planners to effectively approach the subgroups for information, education and communication IEC campaigns. To assess the extent, which media serve as a source of family planning messages, respondents were asked if they had heard or seen a message about family planning on radio, television, in the print media (newspaper/magazine, poster, leaflets/brochures) in the months preceding the survey shown in Table 6.8. In Gilgit and Baltistan, a relatively common media source is the radio (18.2 percent). Television is mostly found in urban areas (33.5 percent), while the print media are accessed mostly by the educated women.

The medium of radio is a more likely source of family planning message for women age 25 – 39 and television is more likely source among young women age (15 – 29). The print media is more likely source for the women age 15 – 24.

Not surprisingly, women residing in urban areas are more likely to have been exposed to family planning messages in any media, except radio, which is the prime source in rural areas. Exposure to family planning messages through various channels of media, especially through television, increases with the level of education and with wealth status.

Table 6.8: Exposure to family planning messages

Percentage of currently married women age 15-49 who heard or saw a family planning message on the radio or television in the month preceding the survey, according to background characteristics, GBDHS 2008

Background characteristics		On Radio	On Television	In Newspaper or Magazine	In Poster	In Leaflets or Brochures	Others	None	Number
Age of respondent	15-19	12.5	18.9	10.2	7.3	3.9	.6	76.0	55
	20-24	17.7	21.1	8.5	6.7	5.4	5.0	65.0	225
	25-29	22.5	19.2	5.0	4.2	1.9	6.2	63.7	238
	30-34	18.1	18.8	5.6	3.1	2.1	9.8	64.9	217
	35-39	21.7	13.6	5.4	3.2	1.9	4.4	68.8	187
	40-44	13.5	13.6	3.0	1.6	1.6	7.0	70.5	114
	45-49	12.1	9.9	--	--	--	4.2	77.8	110
Place of Residence	Urban	16.6	33.5	7.4	4.4	3.9	8.5	56.1	159
	Rural	18.5	14.5	5.1	3.7	2.3	5.6	69.5	988
Level of education	None	13.8	9.0	.4	.2		5.1	76.4	871
	Upto Primary	24.8	30.4	4.9	3.3	1.8	11.4	48.2	70
	Middle	36.3	39.7	17.2	8.9	7.3	11.7	44.9	68
	Secondary	31.0	44.4	20.8	17.5	11.0	2.1	38.6	80
	Higher	37.4	60.2	47.4	34.4	24.2	11.3	24.9	57
Wealth quintiles	Poorest	6.3	.4	--	--	--	3.1	90.6	200
	Second	15.4	5.1	1.1	.4	.5	4.0	76.7	258
	Middle	17.7	11.0	3.9	2.5	.8	4.5	72.9	244
	Fourth	26.3	25.1	4.9	4.1	3.6	7.5	52.8	240
	Richest	24.5	46.4	18.6	12.8	8.2	11.1	45.0	206
Total		18.2	17.1	5.4	3.8	2.5	6.0	67.6	1147

6.8 Contact of Nonusers with Family Planning Providers

When family planning providers visit women or when women visit health facilities, family planning fieldworkers and health providers are expected to discuss family planning issues, contraceptive options available, and motivate nonusers to adopt a method of family planning. To get insight into the level of contact between nonusers and health workers, women were asked if a family planning fieldworker or Lady Health Worker had visited them during the 12 months preceding the survey and discussed family planning and other issues with them.

Table 6.9 shows that more than one-third (38 percent) of nonusers have been reached by workers. Twenty five percent nonusers have reported to have discussion with family planning or health workers on children's health, 22 percent reported a discussion on family planning and only 12 percent reported to have discussed other health issues. Differentials by background characteristics show that non-user women living in rural areas, women with no education, the ones with high parity (5 or more children) and women in poorest wealth quintile are less likely than other non users to have been visited by a field worker or a Lady Health Worker (LHW) in the 12 months before the survey. This is an important finding for

managers of the health and family planning program who should take a notice of the affairs of their field staff working at grass root level. The above stated segment of society requires much more attention of health and family planning workers than others.

Table 6.9: Contact of non users with family planning providers

Among currently married women age 15-49 who are not using contraceptives, the percentage who were visited in the 12 months preceding the survey by a fieldworker or Lady Health Worker (LHW) who discussed family planning, and the percentage who were visited and discussed health issues. GBDHS 2008

Background characteristics		Women who were visited by field worker/LHW	Discussion with				Number of women not using contraception
			Family planning	Respondent's health	Children's health	Other health	
Place of Residence	Urban	48.7	28.2	18.9	33.2	5.2	82
	Rural	36.3	21.4	18.1	24.1	12.6	728
Level of education	None	32.3	16.9	13.5	20.6	8.2	632
	Upto Primary	58.3	40.7	38.0	41.6	26.0	41
	Middle	63.2	41.5	33.4	47.1	27.6	51
	Secondary	43.5	33.3	21.4	27.3	14.1	57
	Higher	66.2	53.2	56.6	53.4	39.9	30
Number of living children	0	34.6	15.9	12.0	22.5	7.6	126
	1-2	46.1	26.6	21.4	31.1	14.5	216
	3-4	39.4	27.0	22.3	26.3	13.6	206
	5+	30.6	17.5	15.2	20.1	10.4	263
Wealth quintiles	Poorest	18.0	5.0	4.5	6.9	2.2	162
	Second	31.5	18.0	13.2	18.2	8.7	199
	Middle	42.9	24.2	17.9	28.5	12.7	170
	Fourth	46.9	32.6	24.9	36.4	18.3	163
	Richest	54.4	35.1	36.6	40.9	20.7	116
Total 15-49		37.6	22.1	18.1	25.0	11.9	810

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7

OTHER DETERMINANTS OF FERTILITY

Ali Anwar Buriro

Levels and trends of fertility are influenced by the several factors i.e. socio-economic, demographic, physiological and ecological. Different studies show that level of fertility can be explained by a number of key proximate determinants that describe the risk of becoming pregnant. These determinants are marriage, postpartum amenorrhea, abstinence from sexual relations and onset of menopause. This chapter addresses these fertility determinants. In Pakistani society, usually, sexual activities take place within marriage. Thus marriage signals the onset of a woman's exposure to the risk of childbearing, and the onset of menopause marks the end of a woman's reproductive life. Hence, a study of proximate determinants becomes important for understanding fertility dimensions.

7.1 Marital status

As marriage is considered a social and religious obligation, its incidence is universal in Pakistan. The length of time, women are exposed to the risk of child bearing affects the number of children women potentially can bear. Thus increase in marriage age can play a vital role in reducing fertility levels, as it reduces the period of exposure to child bearing.

In Gilgit and Baltistan marriage defines the onset of the socially acceptable time for childbearing. Women who marry early will have, on average, a longer period of exposure to pregnancy that often leads to a higher number of children ever born. The minimum legal age at marriage is 18 years for males and 16 years for females. There are two terms important in this regard: Nikah and Rukhsati. Nikah means that a girl is legally married, but she may or may not have yet started living with her husband. Rukhsati is the ceremony when the bride goes to her husband's house and thereafter husband and wife start living together. Women are considered to be exposed to the risk of pregnancy only after Rukhsati. Interviewers were instructed to probe to differentiate between Nikah and Rukhsati. In the following discussion marriage refers to Rukhsati rather than Nikah

Table 7.1 presents the distribution of all women of reproductive age by marital status. The category "married" in this table refers to those who are currently married while those who are

divorced, separated or widowed be referred to as formerly married. The currently married and formerly married combined gives the proportion of ever married.

Table 7.1: Current marital status

Percent distribution of all women age 15-49 by current marital status, according to age GBDHS, 2008

Age groups	Never married	Married	Divorced	Separated	Total	All areas
15 - 19	89.0	11.0	-	-	100.0	557
20 - 24	43.6	55.5	0.2	0.7	100.0	449
25 - 29	19.2	78.6	1.2	1.0	100.0	338
30 - 34	5.7	91.0	0.9	2.4	100.0	247
35 - 39	1.9	94.2	2.9	1.0	100.0	214
40 - 44	0.4	91.5	6.1	2.0	100.0	135
45 - 49	2.0	91.5	5.7	0.8	100.0	124
Total 15-49	37.7	60.0	1.4	0.9	100.0	2064

Table 7.1 shows that about 38 percent women of childbearing age are never married; 60 percent are currently married and the remaining women are divorced or separated. It is encouraging to note that a high proportion of never married women (89 percent) are in age group 15-19 indicating practice of delays in marriage. The small proportion of women (2 percent) who have never been married age 45-49 indicates that marriage is a universal phenomenon in Gilgit and Baltistan. Divorce and separation are uncommon in Gilgit and Baltistan (2 percent).

7.2 Staying elsewhere

The staying elsewhere can reduce the risk of becoming pregnant which ultimately affects the fertility of a woman. The results shows that majority (81 percent) of husbands have been living somewhere else in the Gilgit and Baltistan. It may be due to the fact that geographically, the area of Gilgit and Baltistan is mountainous with less opportunities of employment. Thus, most of the husbands work out of their own region. The GBDHS data indicates that a higher proportion (86 percent) of urban women have reported that their husbands are living elsewhere as compared to their rural counterparts who reported that 81 percent of their husbands are living elsewhere. Similarly, uneducated women are more likely living without the company their husbands as compared to educated women. The findings of the survey also show that the phenomenon of husband staying elsewhere is more prominent among poorest and poorer classes of Gilgit and Baltistan society (Table 7.2).

Table 7.2 Cohabitation and Polygyny

Percentage of currently married women age 15-49 whose husbands are staying else where according to background characteristics, GBDHS, 2008

Background characteristics		Percentage staying elsewhere	Total
Age of respondent	15-19	82.3	57
	20-24	72.6	229
	25-29	78.4	246
	30-34	84.6	224
	35-39	83.4	199
	40-44	84.3	127
	45-49	90.1	117
Place of Residence	Urban	86.1	164
	Rural	80.5	1033
Level of education	None	84.0	916
	Upto Primary	77.7	74
	Middle	70.7	70
	Secondary	73.0	80
	Higher	66.0	57
Wealth quintiles	Poorest	85.4	216
	Poorer	85.3	266
	Middle	78.6	253
	Richer	76.9	250
	Richest	80.1	212
Total		81.2	1,197

7.3 Marriage between relatives

One of the significant aspects of marriage patterns in Gilgit and Baltistan is that a majority of the marriages (52 percent) takes place within relatives (Table 7.3). Comparatively, marriage within relatives is more widely prevalent (67 Percent) in Pakistan (PDHS- 2006-07).

Table 7.3: Marriage between relatives

Percent Distribution of ever-married women by their Relationship with husbands, according to background characteristics, GBDHS, 2008

Background characteristics		Cousin on father's side	Cousin on mother's side	Second cousin	Other relationship	No relation	Percent	Total (N)
Age of respondent	15-19	15.8	10.6	12.1	5.4	56.2	100.0	57
	20-24	19.8	15.0	6.7	9.6	48.8	100.0	229
	25-29	20.6	17.1	7.1	7.7	47.5	100.0	246
	30-34	25.9	14.2	5.0	5.4	49.4	100.0	224
	35-39	19.4	25.0	5.3	6.5	3.7	100.0	199
	40-44	17.4	16.2	9.4	10.7	46.3	100.0	127
	45-49	19.4	14.1	12.3	8.2	45.9	100.0	117
Age at marriage	Less than 15	25.6	16.5	6.9	5.8	45.2	100.0	267
	15 - 19	20.8	15.9	9.1	8.4	45.8	100.0	649
	20-24	15.9	18.2	3.9	8.1	53.9	100.0	225
	25-29	15.7	26.3	1.6	5.2	51.2	100.0	44
	30 and More	-	10.7	9.1	9.1	71.1	100.0	11
Place of Residence	Urban	18.2	16.9	3.0	8.9	53.0	100.0	164
	Rural	20.9	16.8	8.0	7.5	46.8	100.0	1033
Level of education	None	21.2	15.6	7.4	7.7	48.1	100.0	916
	Upto Primary	12.8	32.0	3.6	5.9	45.6	100.0	74
	Middle	22.6	18.2	9.1	8.6	41.5	100.0	70
	Secondary	15.7	14.1	3.7	6.9	59.5	100.0	80
	Higher	24.5	17.4	14.5	9.4	34.2	100.0	57
Wealth quintiles	Poorest	21.0	18.1	8.7	4.1	48.0	100.0	216
	Poorer	23.5	18.7	9.8	5.4	42.5	100.0	266
	Middle	17.5	14.1	5.8	12.8	49.9	100.0	253
	Richer	20.4	12.8	4.8	9.1	52.9	100.0	250
	Richest	20.3	20.9	7.6	6.5	44.7	100.0	212
Total		20.6	16.8	7.3	7.7	47.6	100.0	1,197

Of the total marriages, 45 percent are consanguineous unions between first and second cousins. First cousin marriages occur more frequently on father's side (21 percent) rather than mother's side (17 percent).

The incidence of consanguineous marriage is higher among middle age (30-39) women, those married late at the age of 25-29 years, women residing in the rural areas and those living in households belong to poorer quintile. As such education depicts a mixed pattern.

7.4 Median age at first marriage

Table 7.4 indicates the median age at first marriage for women 25-49 by background characteristics and results shows that urban women tend to marry about one year later than their rural counterparts. The level of education of a woman increases the age at marriage. The difference in age at marriage between uneducated women and those with higher level of education is 4 years. However, the difference in median age at marriage by wealth quintile is not large.

Table 7.4: Median age at first marriage

Median age at first marriage among women 25-49 by five-year age group according to background characteristics, GBDHS 2008

Background characteristics		25-29	30-34	35-39	40-44	45-49	25-49
Place of Residence	Urban	18.0	17.0	17.5	17.7	16.2	17.3
	Rural	16.7	15.2	15.7	15.3	15.6	15.9
Level of education	None	16.2	15.0	15.5	15.3	15.9	15.5
	Upto Primary	17.6	17.1	16.3	15.9	15.7	16.3
	Middle	16.7	17.9	17.8	21.9	21.7	17.7
	Secondary	19.7	17.7	16.9	26.1	-	19.1
	Higher	20.5	19.5	19.0	20.5	-	19.4
Wealth quintiles	Poorest	17.1	15.0	15.0	15.0	14.9	15.6
	Poorer	16.8	15.0	15.0	15.7	14.6	15.3
	Middle	18.0	15.0	15.3	16.5	17.3	16.0
	Richer	15.9	16.4	16.4	14.8	15.1	16.0
	Richest	17.8	17.1	17.0	15.8	16.1	17.0
Total		16.9	15.6	16.0	15.4	15.9	16.0

7.5 Menopause

While the start of infecundity is difficult to determine for an individual woman, there are ways of estimating it for a given population. One indicator of infecundity is the onset of menopause. The menopausal women in this survey are defined as the ones who are not pregnant and not postpartum amenorrhoeic whose last menstrual period occurred six or more months preceding the survey.

Generally, prevalence of menopausal period increases in women with their age. Table 7.5 depicts that in Gilgit and Baltistan, the percentage varies in all age groups. Nevertheless, as expected, the proportion of menopausal women is height in 45-49 age group. The results

show that the prevalence of menopausal women is higher (11 percent) in rural as compared to urban areas (9 percent) of Gilgit and Baltistan.

Table 7.5: Menopause

Percentage of ever-married women age 30-49 who are Menopausal, by Age GBDHS, 2008

Current age	Urban area		Rural area		Total	
	Percentage menopausal	Number of women	Percentage menopausal	Number of women	Percentage menopausal	Number of women
30-34	8.4	33	9.1	191	9.0	224
35-39	9.9	30	13.6	169	13.0	199
40-41	1.5	15	6.7	78	5.9	93
42-43	20.1	5	10.7	24	12.3	29
44-45	20.9	12	7.6	52	10.1	63
46-47	0.0	5	21.3	17	16.7	21
48-49	0.0	2	17.3	35	16.3	37
Total	9.2	101	10.9	565	10.7	666

Another important factor affecting the level of fertility is abortion and other pregnancy " wastage" such as miscarriage and stillbirths. Although it is extremely difficult to get accurate information about the level of induced abortion, the GBDHS (2008) included several questions about pregnancies that did not end in a live birth. Table 7.6 shows that more than 23 percent of ever-married women reported that they had a miscarriage in the five years before the survey. In 2006-07 PDHS, 8 percent of ever married woman reported a miscarriage. In view of a very high proportion of Gilgit and Baltistan, women undergoing miscarriage, a separate study should be done to investigate the reasons for such a high number of miscarriages and subsequently measures should be adopted to mitigate women's sufferings on account of miscarriages. Only 3 percent had a abortion and about 4 percent had a still birth.

The level of miscarriage is higher in urban (26 percent) compared to rural areas (22 percent). The percentage of miscarriage is highest among older women (31 percent), those who have acquired education (30 percent) and among richest women (26 percent).

Table 7.6: Pregnancy terminations

Among ever-married women, the Percentage who had a miscarriage, abortion and/or still births, According to Background characteristics, GBDHS, 2008

Background characteristics		Percentage who had miscarriage	Percentage who had abortion	Percentage who had still births	Number of women
Current age	15-19	7.7	0.0	0.0	57
	20-24	17.4	2.2	1.6	229
	25-29	16.8	1.8	2.0	246
	30-34	23.0	3.4	7.2	224
	35-39	30.5	1.4	6.2	199
	40-44	31.4	4.8	5.3	127
	45-49	28.4	4.5	2.5	117
Place of residence	Urban	25.7	7.6	5.6	164
	Rural	22.1	1.8	3.6	1,033
Level of education	None	22.7	2.6	4.1	916
	Upto Primary	29.6	0.0	4.2	74
	Middle	19.4	5.6	2.7	70
	Secondary	18.4	1.7	3.1	80
	Higher	21.0	4.0	3.0	57
Wealth quintiles	Poorest	19.5	1.5	4.6	216
	Poorer	22.3	3.9	3.4	266
	Middle	24.1	2.0	2.9	253
	Richer	21.4	2.6	5.4	250
	Richest	25.8	2.9	3.2	212
Total		22.6	2.6	3.9	1,197

8 FERTILITY PREFERENCES

Ali Anwar Buriro

The study of fertility desires in a population is important for estimating potential unmet need for family planning and to predict future fertility. The policy makers in the Ministry of Population Welfare are particularly interested in knowing about future reproductive preferences, so as to determine the demand for family planning. The chapter presents the fertility intentions and family size norms prevailing among Gilgit and Baltistan women. The chapter also looks at the level of unwanted and mistimed pregnancies.

To know the childbearing desires various questions were asked to GBDHS respondents. The first question asked was whether the respondent 'wants to have additional children in future'. In the response to this question several, additional questions were asked. It may be necessary to mention here that a woman's fertility preference may not necessarily predict her reproductive behaviour.

8.1 Desire for More Children

Fertility preferences relating to future childbearing is a major indicator of future fertility, however, sterilized women and those who stated that they are infecund, have no impact on the future fertility as their potential contribution towards fertility has been ceased.

The data on future childbearing also provide information on the potential need of couple for contraceptive services for spacing and limiting births. The currently married, non-sterilized and not pregnant women were asked: "Would you like to have (a/another) child, or would you prefer not to have any (more) children?" If the response was 'yes' then they were asked: "How long would you like to wait from now before the birth of (a/another) child?" For currently married, non-sterilized, pregnant women, the questions were phrased differently: "After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?" In case of 'yes', reply they were asked, "After the birth of the child you are expecting now, how long would you like to wait before the birth of another child?" Responses to these questions are presented in Table (8.1).

Table 8.1 and figure 8.1 show that about 46 percent currently married women age 15-49 either do not want another child at any time in the future or are sterilized. About 48 percent

women expressed the desire that they need another child soon or two or more years later. Only a small proportion of women (3 percent) were undecided about their future childbearing.

Figure 8.1: Fertility Preference of Currently Married Women Age 15-49

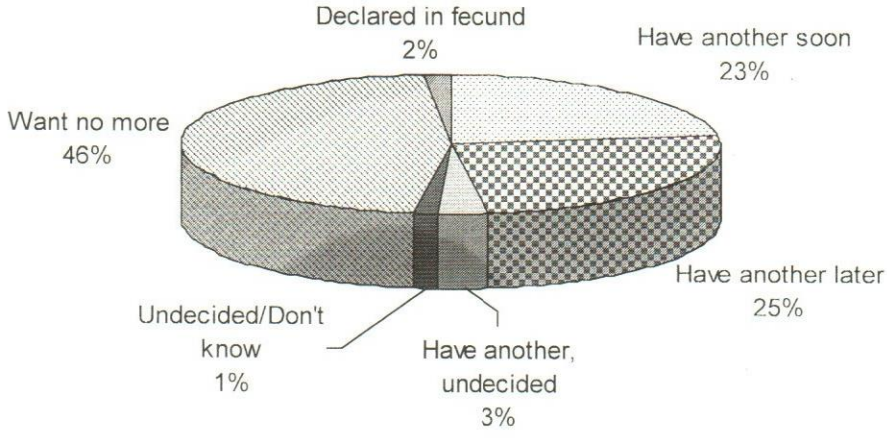

Table 8.1: Fertility preferences by number of living children

Percent distribution of currently married women age 15-49 by desire for children, according to number of living children GBDHS 2008

Desire for Children		Number of Living Children (Including Current Pregnancy)								Total
		0	1	2	3	4	5	6	7+	
Have another soon		68.3	33.4	29.3	18.2	16.4	14.5	10.4	12.2	22.8
Have another later		15.2	54.2	47.4	41.6	13.7	12.5	6.2	10.9	25.1
Have another, undecided		5.7	5.3	2.5	2.6	1.6	-	5.3	2.4	2.9
Undecided/Don't know		1.6	2.7	1.0	1.1	3.8	-	-	-	1.3
Want no more		1.6	3.1	16.2	30.6	57.7	67.1	63.1	64.0	40.9
Sterilized		-	-	.6	4.3	6.9	5.9	13.0	9.3	5.3
Declared in fecund		7.6	1.3	2.9	1.4	-	-	2.0	1.1	1.7
Total	Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Number	90	129	151	150	182	135	110	200	1147

The desire for terminating childbearing is associated with the number of children a woman already has. The desire to bring an end to childbearing (including those women who are sterilized) increases with the number of living children reaching 35 percent among women with 3 children and 76 percent among those with 6 or more children.

Table 8.2 and figure 8.2 show currently married women who want no more children (including those who are satisfied) by the number of children and background characteristics. There are slightly more urban women than rural women who want to terminate childbearing (48 percent and 46 percent respectively). In comparison, the data from four provinces of Pakistan show more women (57 percent urban and 49 percent rural) who wanted to terminate childbearing (Ali and Faateh, 2008). The Table 8.2 also shows that at 6+ children, more urban women (83 percent) than rural women (75 percent) wanted to cease childbearing.

By education of women, a mixed pattern is exhibited where women with primary or less education have the highest desire (52 percent) to cease childbearing. Similarly, the highest proportions (54 percent) of women who do not want another child are found among women who belong to highest wealth quintile.

Figure 8.2: Desire to Limit Childbearing among Currently Married Women by Number of Living Children

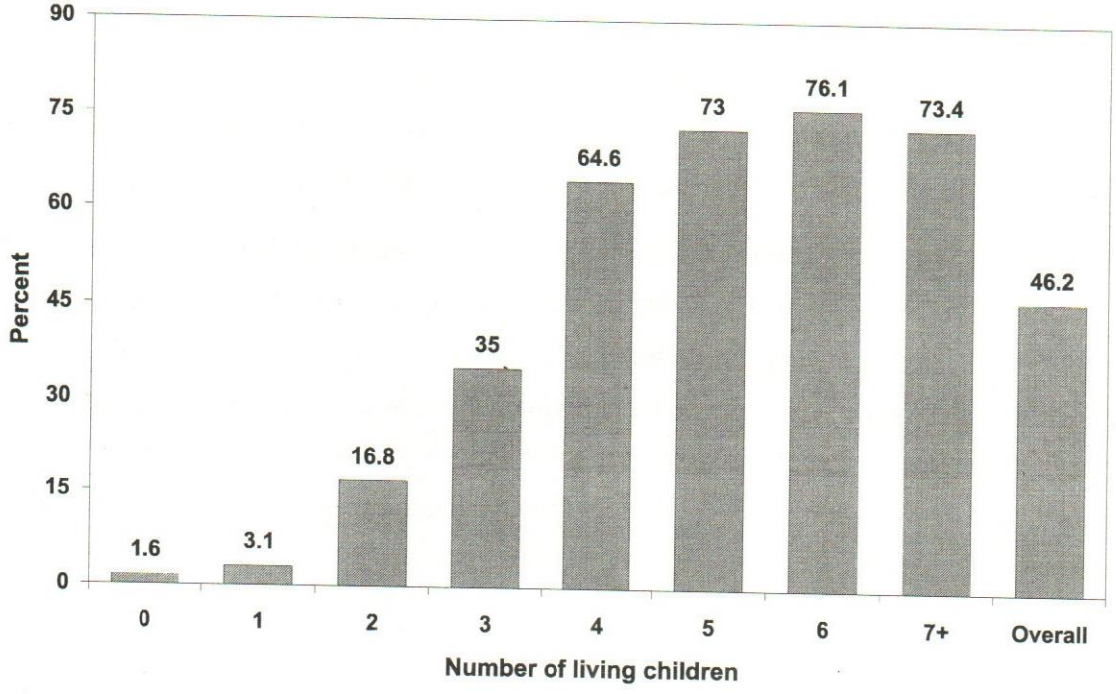

Table 8.2: Desire to limit childbearing

Percentage of currently married women age 15-49 want no more children, by number of living children (including current pregnancy) according to background characteristics GBDHS 2008

Background characteristics		Number of living children (including current pregnancy)								Total
		0	1	2	3	4	5	6	7+	
Place of residence	Urban	0.0	8.6	15.5	34.5	65.4	75.3	83.3	70.8	47.9
	Rural	1.8	2.2	17.1	35.1	64.4	72.7	74.5	73.6	45.9
Level of education	None	2.3	0.6	14.9	24.7	60.5	72.5	73.7	71.4	47.6
	Upto primary	0.0	6.5	12.0	47.6	77.0	68.4	100.0	91.8	51.8
	Middle	0.0	7.4	23.6	64.5	94.2	94.6	100.0	100.0	45.2
	Secondary	0.0	2.2	29.7	60.6	54.1	70.8	100.0	100.0	31.3
	Higher	0.0	9.3	12.0	50.7	88.4	100.0	74.7	100.0	39.8
Wealth quintiles	Poorest	0.0	0.0	4.2	23.2	58.2	58.2	73.8	59.7	40.1
	Second	7.6	0.0	9.9	30.9	49.6	74.2	81.0	64.0	45.5
	Middle	0.0	1.3	29.1	26.8	60.6	83.3	63.2	80.5	46.2
	Fourth	0.0	5.4	12.3	32.8	75.0	64.1	84.3	82.6	45.0
	Richest	0.0	6.6	24.9	54.9	76.6	89.6	84.7	89.1	54.3
Total		1.6	3.1	16.8	35.0	64.6	73.0	76.1	73.4	46.2

Fertility preferences are affected not only by the number of living children, but also by the sex composition of the children a couple has. In a country like Pakistan were son preference is strong (Ali, 1989; Bhatti , 1996 and Westoff and Bankole, 1995).

Fertility preferences are influenced by such perceptions. Gilgit and Baltistan being a territory of Pakistan is no exception. The table 8.3 shows almost a clear positive relationship between number of living sons and the desire for no more children among women of Gilgit and Baltistan. For example women with four children, all of these being sons, 79 percent wanted no more children as against zero percent women with no son. With the presence of one son in a family of four children, the proportion of those who do not want another child increases to 56 percent.

Table 8.3: Desire to limit childbearing by sex of living children

Percentage of currently married, non pregnant woman age 15-49 who want no more children, by number of living children and sons, GBDHS 2008

Background characteristics		Percentage who want no more children/are sterilized	Number of women
No Children		1.6	126
One Child	No Sons	4.7	51
	One Son	8.6	78
Two Children	No Sons	7.2	25
	One Son	17.1	76
	Two Sons	27.6	35
Three Children	No Sons	10.8	17
	One Son	26.8	39
	Two Sons	53.5	54
	Three Sons	28.0	38
Four Children	No Sons	0.0	6
	One Son	56.1	29
	Two Sons	72.1	74
	Three Sons	75.2	60
	Four Sons	78.5	11
Five Children	No Sons	52.6	3
	Less than Two Son	60.3	32
	Two or Three Sons	81.7	203
	Four or More Sons	69.7	190
Total		46.2	1,147

8.2 Need for Family Planning

To define the size of the potential demand for contraception and to identify women who are in need of contraceptive services is one of the major concerns of Population Welfare programme. Table 8.4 presents estimates of unmet need[1] met need for family planning services and total demand for family planning in Gilgit and Baltistan according to background characteristics. By definition "Unmet need refers to women whose last birth or current pregnancy was mistimed or unwanted or who are not currently using family planning methods but do not want another child soon". Menopausal and in fecund women are excluded from the unmet need category. Women with a "met need for family planning includes women who are currently using family planning methods". The "total demand for family planning is represented by the sum of unmet need and met need.

Table 8.4 presents information for currently married women on unmet need, met need, and total demand for family planning according to whether the need or demand is for spacing or

limiting births. According [1]to Table 8.4, the total unmet need is 38 percent; there is a greater need for limiting births than for spacing future births (22 percent and 16 percent, respectively). The total met need for family planning (i.e., current use) is 29 percent of currently married women, among these; a large majority is using contraceptive methods because they do not want more children.

An expected, unmet need for spacing is higher among younger women, while unmet need for limiting is higher among older women. Across various age groups unmet need is highest (41 percent) among younger (15-19 years) women. The middle passed women in Gilgit and Baltistan exhibited the highest (52 percent) unmet need women living in rural areas tend to have greater unmet need (39 percent) than women in urban (29 percent). Unmet need is also higher among women in the second and third wealth quintile.

By district, Ghanche has the highest level (43 percent) of unmet need followed by Baltistan (40 percent) and Hunza Nagar (37 percent). In Ghizer unmet need is lowest (33 percent), and

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[1] Unmet need for spacing: Includes women who are fecund and not using family planning and who say they want to wait two or more years for their next birth, or who say they are unsure whether they want another child, or who want another child but are unsure when to have the child. In addition, unmet need for spacing includes pregnant women whose current pregnancy was mistimed, or whose current pregnancy was unwanted but who now say they want more children. Unmet need for spacing also includes amenorrheic women whose last birth was mistimed, or whose last birth was unwanted but who now say they want more children.

Unmet need for limiting: Includes women who are fecund and not using family planning and who say they do not want another child. In addition, unmet need for limiting includes pregnant women whose current pregnancy was unwanted but who now say they do not want more children or who are undecided whether they want another child. Unmet need for limiting also includes amenorrheic women whose last birth was unwanted but who now say they do not want more children or who are undecided whether they want another child. 2 Using for spacing is defined as women who are using some method of family planning and say they want to have another child or are undecided whether to have another. Using for limiting is defined as women who are using and who want no more children. Note that the specific methods used are not taken into account here.

met need is highest (49 percent). It may be deducted that an improved situation in Ghizer could partially be due to the availability of better family planning services there.

Overall, the total demand for family planning comprises 67 percent of currently married women. Of this demand, 44 percent of the demand for contraception is satisfied. The percentage of demand satisfied for family planning ranges from 20 percent at age 15-19 to 65 percent for those who have attained Secondary+ educational level. In views of higher unmet need, it is imperative that urgent consideration of policymakers is required to reduce unmet need by converting it into met need.

Table 8.4: Need and demand for family planning among currently married women

Percentage of currently married women age 15-49 with unmet need, percentage with met need, the total demand for family planning and percentage of total demand for contraception that is satisfied, by background characteristics

Background Characteristics		Met need			Unmet need			Total Demand			Percentage of demand satisfied	Number
		Limiting	Spacing	Total	Limiting	Spacing	Total	Limiting	Spacing	Total		
District	Gilgit	26.7	10.0	36.7	15.2	21.7	36.9	41.9	31.7	73.6	49.9	102
	Baltistan	22.0	6.6	28.6	18.6	21.0	39.6	40.6	27.6	68.2	41.9	311
	Daimir	10.3	1.7	12.1	24.9	10.7	35.6	35.3	12.4	47.7	25.4	238
	Ghizer	33.8	15.3	49.1	17.2	15.6	32.9	51.1	30.9	82.0	59.9	155
	Ghanche	14.2	13.2	27.4	18.4	25.0	43.4	32.6	38.2	70.8	38.7	144
	Astor	9.7	4.0	13.7	31.5	4.0	35.5	41.3	8.0	49.3	27.8	66
	Hunza/Nagar	38.3	6.4	44.7	30.3	6.8	37.2	68.6	13.3	81.9	54.6	130
Residence	Urban	32.3	15.8	48.1	12.6	16.7	29.3	44.9	32.5	77.4	62.1	159
	Rural	20.0	6.4	26.5	22.9	16.0	38.9	43.0	22.5	65.4	40.5	988
Age of respondent	15-19	1.9	8.2	10.1	4.8	35.9	40.6	6.6	44.1	50.7	19.9	55
	20-24	1.1	14.5	15.6	7.3	29.7	36.9	8.4	44.2	52.6	29.7	225
	25-29	10.2	11.2	21.4	16.6	20.8	37.5	26.8	32.0	58.8	36.4	238
	30-34	24.8	7.1	32.0	22.5	14.5	37.0	47.4	21.6	69.0	46.4	217
	35-39	37.4	3.5	40.8	29.7	7.2	36.9	67.1	10.6	77.7	52.5	187
	40-44	48.4	.5	48.9	37.8	1.9	39.7	86.3	2.4	88.6	55.2	114
	45-49	38.6	2.0	40.6	36.5	1.4	38.0	75.1	3.5	78.6	51.7	110
Level of education	None	21.8	5.6	27.4	23.0	14.5	37.5	44.8	20.1	64.9	42.2	871
	Upto Primary	29.9	12.5	42.4	21.0	19.0	40.1	51.0	31.5	82.5	51.4	70
	Middle	19.8	5.5	25.3	20.4	31.6	52.0	40.2	37.1	77.3	32.7	68
	Secondary	12.2	18.5	30.7	15.6	16.9	32.5	27.8	35.4	63.2	48.6	80
	Higher	26.8	21.3	48.1	8.0	18.2	26.2	34.8	39.5	74.3	64.7	57
Wealth quintiles	Poorest	15.8	3.1	18.9	23.6	13.2	36.9	39.4	16.4	55.8	33.9	200
	Second	16.5	6.1	22.6	25.0	15.7	40.7	41.6	21.8	63.4	35.6	258
	Middle	23.1	7.3	30.4	19.1	21.3	40.4	42.2	28.5	70.7	43.0	244
	Fourth	23.0	9.5	32.5	18.5	14.8	33.2	41.5	24.3	65.8	49.4	240
	Richest	30.9	12.8	43.7	21.3	14.9	36.2	52.2	27.7	79.9	54.7	206
All		21.7	7.7	29.4	21.5	16.1	37.6	43.2	23.9	67.1	44.0	1147

Note: The sample of GBDHS is representative at Gilgit and Baltistan level. The readers are cautioned about the interpretation of the results at district level.

8.3 Ideal Number of Children

As mentioned earlier fertility preferences are influenced by the number of children a woman already has. In this survey, another measure of fertility preference that is less influenced by the existing number of children is estimated based on ideal number of children. The question about ideal family size required a woman to respond to a question on the number of children she would choose to have in her whole life regardless of the number (if any) that she had already borne.

The data in Table 8.5 may be divided into three categories. The first category is of women who have attained their ideal family size, i.e., women whose ideal number of children is exactly the same as their number of living children. The second category of women are those whose surviving children have exceeded their ideal family size, and the third category consists of women who have not yet achieved their ideal family size.

Table 8.5 shows the distribution of respondents by ideal number of children according to actual number of living children. It shows that 47 percent ever-married women with four living children consider the ideal family size to be four children. But many women in Gilgit and Baltistan have had more children than they prefer. Over all, a preference of a 2-child family size is stated by just 4 percent women and another 13 percent consider 3-children as their ideal family size. The mean ideal number of children is 5 in Gilgit and Baltistan for both ever and currently married women. The data indicates a strong association between the ideal number of children and the actual number of living children. The mean ideal number of children increases from 4.1 children for women who have 1 child to 6.7, children for those who have seven or more children. This pattern clearly indicates rationalization of the existing number of living children.

This situation requires attention of family planning programme personnel in Gilgit and Baltistan. The revamping of the program activities will reduce fertility rate that in turn may affect negatively to the ideal number of children.

Figure 8.3: Mean Ideal Number of Children, by Background Characteristics

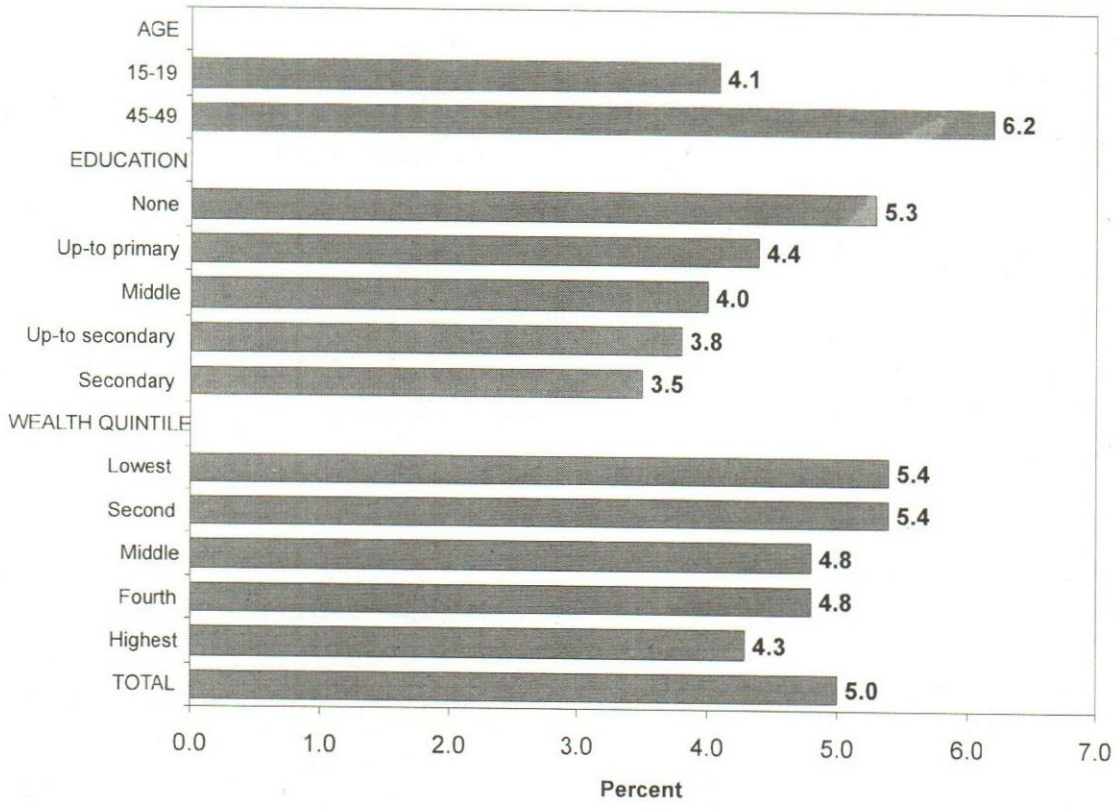

Table 8.5: Ideal number of children

Percent distribution of ever-married women age 15-49 by ideal number of children, GBDHS 2008

Ideal Number of Children		Number of Living Children								Total
		0	1	2	3	4	5	6	7+	
0		1.6	0.8	-	-	-	-	1.9	3.0	.9
1		1.6	-	-	1.1	-	-	-	.8	.5
2		5.3	8.3	9.5	5.2	3.1	-	1.7	1.1	4.2
3		17.4	27.8	17.6	18.5	10.1	5.7	4.0	2.5	12.7
4		22.3	30.3	36.2	31.6	46.6	20.9	16.8	6.5	26.6
5		12.5	10.7	8.0	19.4	9.8	34.8	7.8	11.4	14.1
6 +		22.5	15.3	19.7	17.9	17.6	22.0	52.8	53.3	27.7
Other		16.8	6.8	9.0	6.4	12.7	16.5	15.0	21.5	13.4
Percent		100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total Number		138	139	140	153	188	135	107	197	1197
Ever-married women	Mean	4.5	4.1	4.2	4.6	4.6	5.2	5.6	6.7	5.0
	Number	115	130	127	143	164	113	91	154	1037
Currently married women	Mean	4.6	4.1	4.3	4.7	4.6	5.1	5.6	6.7	5.0
	Number	105	120	123	139	161	108	89	151	997

Table 8.6 and figure 8.3 present the mean ideal number of children for ever-married women by selected background characteristics. The mean ideal number of children generally increases with age, from 4.1 children for younger age (15-19) to 6.2 among the oldest women (45-49). Interestingly, urban-rural residence does not show large differentials, mean ideal number of children is estimated as 5 for rural women compared with 4.9 children for urban women. A considerable differential is found by education of women. The ideal family size decreases from 5.3 children for women with no education to 3.5 children for women who have acquired higher secondary or more education. In other words attainment of higher education brings about a reduction of about 2 children in the ideal family size. The inverse relationship is also found between ideal family size and wealth quintile. But the differentials are not as large as are found between women's education and ideal family size.

Table 8.6: Mean ideal number of children

Mean ideal number of children for ever married women age 15-49 by background characteristics, Gilgit and Baltistan, 2008

Background characteristics		Mean	Number of women
Age of respondent	15-19	4.1	44
	20-24	4.5	211
	25-29	4.6	223
	30-34	5.0	194
	35-39	5.2	165
	40-44	5.3	104
	45-49	6.2	96
Place of Residence	Urban	4.9	153
	Rural	5.0	884
Level of education	None	5.3	773
	Upto Primary	4.4	64
	Middle	4.0	66
	Secondary	3.8	79
	Higher	3.5	56
Wealth quintiles	Poorest	5.4	179
	Second	5.4	220
	Middle	4.8	218
	Fourth	4.8	233
	Richest	4.3	186
Total		5.0	1,037

8.4 Couple's Agreement on Family Size

The decisions about childbearing are usually made by couples and not by the women herself. In a patriarchal society like the one of Gilgit and Baltistan, couples agreement on family size has very important implications.

Table 8.7 shows that, 43 percent husband and wife wanted the same number of children in Gilgit and Baltistan. However, over on-fourth of women reported that their husband, want more children than they do, while only 6 percent said that their husbands want fewer children than they do. About one-fourth of women reported that they do not know about their husband's ideal number of children.

Table 8.7: Couple's agreement on family size

Percent distribution of currently married, non sterilized women by wealth they think their want the some number of children as they want according to women's ideal number of children, Gilgit Baltistan, 2008

Wife desired family size	Husband's desire for children				Total	
	Both want same	Husband's wants more	Husband's want's fewer	Don't Know	Percent	Number
Upto 2	53.3	20.7	5.1	20.9	100.0	60
3	69.5	18.4	3.7	8.4	100.0	136
4	55.6	23.4	5.6	15.4	100.0	295
5	44.3	21.9	7.2	26.6	100.0	160
6 +	30.8	32.8	4.5	31.9	100.0	293
Other	6.7	49.4	8.1	35.7	100.0	141
Total	42.5	28.3	5.6	23.6	100.0	1,086

8.5 Wanted and Unwanted Fertility

Unwanted fertility can be derived from Gilgit and Baltistan Demographic and Health Survey (2008) data where women were asked question about the prior planning of births. In other words, whether a birth was planned (wanted then), mistimed (wanted later), or not wanted at all.

Table 8.8 shows the percent distribution of births in the five years preceding the survey by planning status of the birth. Overall, 30 percent of births in the five-year period preceding the survey were not wanted at the time of conception, 18 percent wanted later and, 12 percent not wanted at all.

The proportion of births that are mistimed or not wanted at all at the time of conception increases sharply with birth order ranging from 21 percent at first birth to 36 percent at six and higher births. The planning status of births does not portray a consistent increasing

pattern with age and educational level of mother. But in general, older women as well as educated women reported a higher proportion of children that are unplanned, be they mistimed or not wanted at all. The unplanned pregnancies also increase with wealth quintile. In other words, planned pregnancies decreases with the increase in wealth. Generally, it is observed that poor women are mostly uneducated, non user of contraceptive methods, fatalist, contended by nature and accept a conception as Allah's will. Nevertheless, this phenomenon requires further investigations.

Table 8.8: Fertility planning status

Percent distribution of births to women age 15-49 in the five years preceding the survey (Including current pregnancies) by status of birth according to birth order and background characteristics, GBDHS 2008

Background characteristics		Planning status of last pregnancy			Total	
		Wanted then	Wanted later	Wanted no more	Percent	Number
Age of respondent	15-19	71.2	28.8	-	100.0	23
	20-24	72.8	22.3	4.9	100.0	163
	25-29	76.4	18.7	4.9	100.0	210
	30-34	67.5	16.3	16.2	100.0	170
	35-39	66.1	17.8	16.1	100.0	122
	40-44	60.7	5.3	34.0	100.0	48
	45-49	63.8	12.5	23.7	100.0	37
Birth Order	1	79.2	18.3	2.5	100.0	112
	2 - 3	74.0	21.7	4.3	100.0	219
	4 - 5	69.4	16.7	13.9	100.0	202
	6 +	63.6	15.4	20.9	100.0	239
Place of Residence	Urban	70.0	17.5	12.5	100.0	101
	Rural	70.4	18.0	11.6	100.0	671
Level of education	None	73.3	15.4	11.2	100.0	581
	Upto Primary	62.6	18.4	19.0	100.0	47
	Middle	64.9	18.9	16.2	100.0	51
	Secondary	61.6	28.5	9.9	100.0	55
	Higher	54.0	39.6	6.4	100.0	38
Wealth quintiles	Poorest	75.5	11.5	13.0	100.0	139
	Second	72.2	19.4	8.5	100.0	178
	Middle	70.9	16.0	13.1	100.0	168
	Fourth	68.2	18.3	13.6	100.0	160
	Richest	64.1	25.2	10.7	100.0	126
Total		70.3	17.9	11.7	100.0	772

Reference:

1. Ali, Syed Mubashir 1989. "Does Son Preference Matter". Journal of Biosocial Science, Vol 21 (4).

2. Ali, Syed Mubashir and Faateh ud Din in "Pakistan Demographic and Health Survey; 2006-07 *Chapter-7 Fertility Preference*" 2008. NIPS, Islamabad/ Macro International Inc.

3. Hakim, Abdul and Mansoor ul Hasan Bhatti 1998. "Pakistan Fertility and Family Planning Survey 1996-97; *a chapter Family Size Preference*", NIPS, Islamabad.

9

REPRODUCTIVE HEALTH

Zafar Zahir

One of the objectives of the GBDHS was to provide information on the health-seeking behaviour of ever-married women, particularly during the motherhood process. This chapter focuses on the women's medical histories; the various types of symptoms/diseases they may have experienced during their pregnancies; and the types of medical help they may have had during the antenatal, the delivery and the post-partum periods.

9.1 Prenatal Care

It is very important that a pregnant woman should have regular checkups by a health professional during pregnancy. A qualified person would monitor the health of a mother and the growth of child in her womb. In 2008 GBDHS data was collected on the type of health professional who carried out the checkup during pregnancy for the last birth. It is observed that about 61 percent of the women who had a birth in the five years preceding the survey have received prenatal care from a skilled health professional. It is encouraging to note that a majority of these women have contacted a doctor for antenatal care checkup, followed by a nurse/mid wife/LHV. Only 3 percent of mothers have received pre-natal care from a traditional birth attendant (dai) (Table 9.1).

The data also indicate that women who belong to middle age group; women who were pregnant with first child; those with higher level of education; and the ones residing in richest households are more likely to receive prenatal care from a skilled health professional (Figure 9.1).

Figure 9.1: Antenatal Care by Background of Woman

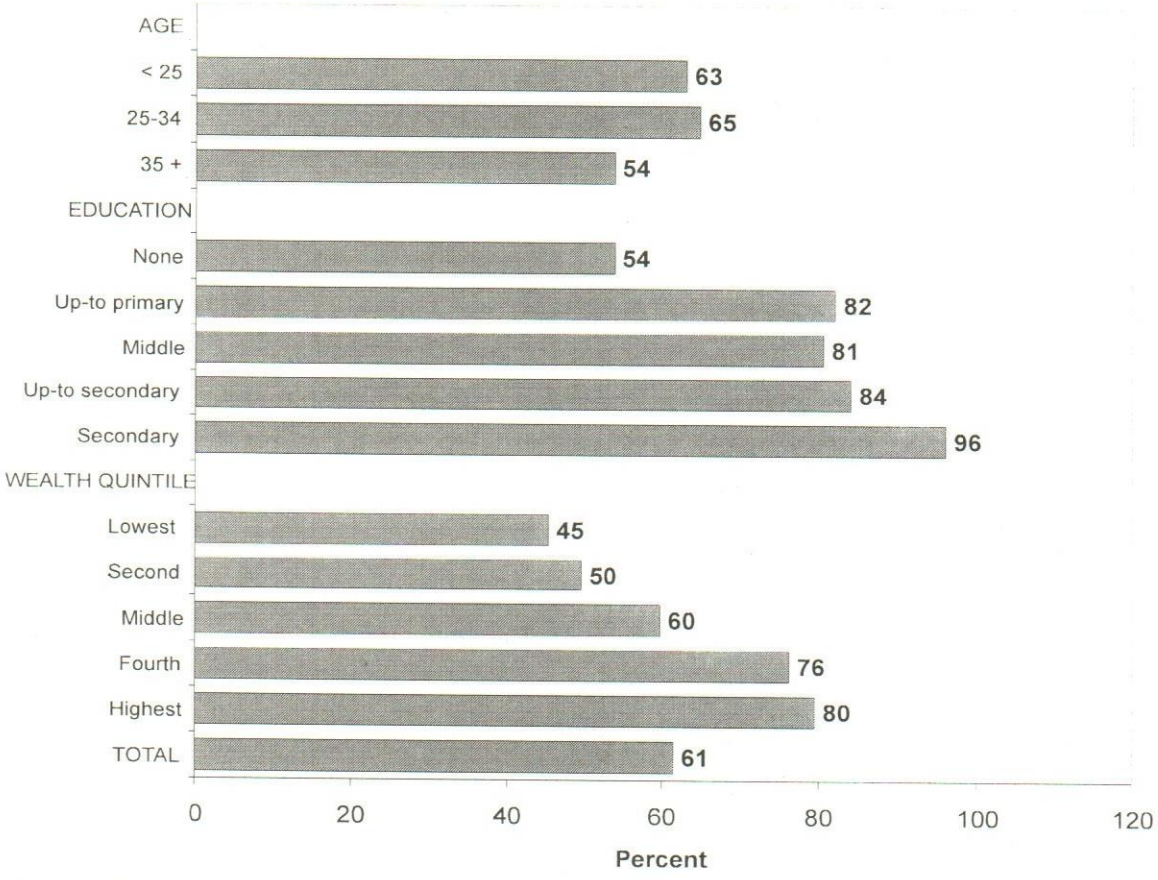

Table 9.1: Prenatal care

Percent Distribution of women age 15-49 who had a ANC visits for last live birth according to background characteristics, GBDHS 2008

Background characteristics		Person who assisted in antenatal check-ups							Total	Percentage receiving antenatal from skilled providers	Total
		Doctor	Nurse/Mid wife/LHV	Dai-TBA	Lady Health Worker	Hakim	Dispenser/ Compounder	No one			
Age of mother	< 25	41.6	21.4	4.3			.6	32.1	100.0	63.0	
	25-34	45.2	19.5	1.4	.3	.3	.8	32.5	100.0	64.7	381
	35 +	39.3	14.5	4.1	.5	1.1	.1	40.4	100.0	53.8	209
Birth Order	1	50.5	24.0	2.2				23.3	100.0	74.6	113
	2 - 3	43.5	21.6	3.8	.6		.7	29.7	100.0	65.2	219
	4 - 5	45.0	18.4	1.4			.6	34.6	100.0	63.4	202
	6 +	36.5	13.5	3.6	.4	1.4	.6	44.0	100.0	50.0	241
Level of education	None	37.3	16.3	2.9	.4	.6	.6	41.9	100.0	53.7	584
	Upto Primary	43.0	39.0				2.2	15.7	100.0	82.1	47
	Middle	63.7	16.8	4.2				15.2	100.0	80.5	51
	Secondary	63.1	20.9	5.6				10.3	100.0	84.0	55
	Higher	68.4	27.6					4.0	100.0	96.0	38
Wealth quintiles	Poorest	28.6	16.6	2.6	.9			51.2	100.0	45.3	142
	Second	33.4	16.1	5.0		1.3		44.3	100.0	49.5	178
	Middle	40.2	19.5	2.7	.6	.7		36.3	100.0	59.7	168
	Fourth	53.8	22.4	3.1			2.2	18.5	100.0	76.2	160
	Richest	61.2	18.3				.6	19.9	100.0	79.5	127
Total		42.8	18.6	2.9	.3	.4	.6	34.5	100.0	61.4	775

9.1.1 Number and Timing of Prenatal Visits

The number of ANC visits in an important indicator of safe motherhood and WHO recommends that at least four visits should be made during a pregnancy. The data in Table 9.2 indicate that only 22 percent of women had four or more ANC visits during her last pregnancy. The data also shows that the rural women are less likely to have ANC visit as compared to women residing in urban areas.

Information was also collected on the timing of the first ANC visit. The data shows that a quarter of the women have had their first ANC visit during first three months of pregnancy. A little more than a quarter of the women had their first ANC visit as late as six or more months of pregnancy. This state of affair indicates an indifferent behaviour of the concerned people on such an important and risk prone matter of human life.

Table 9.2: Number of prenatal care visits and timing of first visit

Percent distribution of women age 15-49 who had a live birth in the five years preceding the survey by number of pre-natal care visits for the most recent live birth and by the timing of the first visit among women with pre-natal care, median month pregnant at first visit according to residence: GBDHS 2008

Number of timing of prenatal care visits		Urban	Rural	Total
Number of prenatal care visits	None	18.3	36.9	34.5
	1	12.8	19.8	18.9
	2-3	32.1	22.9	24.1
	4+	36.2	20.4	22.4
	Don't know/missing	0.6		0.1
	Total	100	100	100
Number of months pregnant at time of first prenatal care visit	No prenatal care	18.3	37.5	34.9
	< 4	34.6	24.2	25.6
	4-5	18.0	11.5	12.4
	6-7	19.1	16.1	16.5
	8+	9.2	10.3	10.1
	Don't know/missing	.9	.4	.5
	Total	100	100	100
Median months pregnant at first antenatal visit for those with pre-natal care		4.0	5.0	5.0
Number of women with prenatal care		83	425	508

9.1.2 Components of Prenatal Care

It is highly recommended that a pregnant woman should take iron tablets and calcium during pregnancy to protect her from anemia and for child growth. The data reveals that only 39 percent of women had taken iron tablets during her last pregnancy and 36 percent of woman had taken calcium (Table 9.3). The proportion of such women who have taken both iron and calcium tablets is relatively more among urban women (51 percent for both iron and calcium. as compared to their rural counterparts (37 & 33 percent) respectively. The young women;

who are pregnant with first child; highly educated and; the ones belong to richest wealth quintiles are more likely to take these supplements.

The women were also asked about the type of examination they had during the last ANC visit (Table 9.3). The table indicates that majority of women (79 percent) had blood pressure checkup. Over half were weighed (53 percent) and an equal number of women gave urine for laboratory test and an ultra sound examination performed. The blood examination was performed for only 46 percent of women who received pre-natal care.

By background characteristic, age of women and birth order do not exhibit any clear pattern for women receiving antenatal care. Never the less, education of women and wealth quintile shows quite a strong relationship with various elements of antenatal care. For example, a very high proportion of women (83 percent and more) with higher education, were weighed, their blood pressure measured, urine and blood samples were taken and ultra sound examination was done. Comparatively, one fourth of uneducated women were weighed, one-third gave blood or urine samples and a little more than half were examined for ultra sound. Like wise, by wealth quintile, pre-natal care also depicts a pattern more or less similar to women's education.

9.1.3 Reasons of Not Receiving Prenatal Checkups

Information was also collected on the reasons of not receiving antenatal care from the health professional for their most recent birth and presented in Table 9.4. The main reason reported by almost half of the women (48 percent) is that the mothers did not feel it necessary to have ANC visit during her last pregnancy. Access to health facility was the second most cited reason given by more than 33 percent of the women. The women also mentioned cultural barrier to ANC visits. Thirteen percent of women did not go for ANC visits as they do not want to see a male doctor during her ANC checkup. The high cost of ANC visits was also mentioned by about one-fifth of the women as a reason of not receiving ANC.

The reason "Did not feel it necessary to receive antenatal care" is mostly cited by young mothers age <25 and, those who were at birth order one. Unlike expectation, the proportion of women who cited the above stated reason was high among urban women and women living in richest households. Interestingly, for the reason "Cost too much" an opposite pattern than what is envisaged above, is observed.

In view of the finding of Table 9.4, it is important that policies be framed and remedial measures are adopted so that all women in Gilgit and Baltistan receive pre-natal care during pregnancy.

Table 9.3: Components of prenatal care

Among women age 15-49 with a live birth in the five years preceding the survey, the percentage who took iron tablets or syrup and calcium tablets during the pregnancy of the most recent child, and among women receiving prenatal care (ANC) for the most recent live birth in the five years preceding the survey, the percentage receiving specific prenatal services, according to background characteristics, GBDHS 2008

Background characteristics		Women with a live birth in the last 5-yrs, the percentage		Number of women with birth in last 5-yrs	Women who received prenatal care for birth in the last 5yrs					Number of women with prenatal care
		Percentage who took Iron tablets	Percentage who took Calcium		Weight	Blood pressure	Urine	Blood	U/S exam	
Age of mother	< 25	50.0	37.7	185	53.8	74.8	47.8	45.0	53.8	126
	25-34	36.9	36.5	381	56.0	77.7	53.8	48.0	56.0	258
	35 +	31.5	31.8	209	46.2	84.0	55.2	44.7	46.2	124
Birth Order	1	51.7	44.8	113	59.0	78.6	53.1	52.0	59.0	87
	2 – 3	43.1	37.4	219	54.4	77.5	51.9	45.2	54.4	154
	4 – 5	37.9	36.4	202	56.4	79.9	54.6	44.6	56.4	132
	6 +	28.9	28.7	241	44.3	78.4	51.3	46.1	44.3	135
Place of Residence	Urban	51.3	51.4	102	57.2	81.9	50.2	49.6	57.2	83
	Rural	36.6	33.1	673	52.2	77.9	53.1	45.8	52.2	425
Level of education	None	30.9	27.8	584	45.4	73.9	47.2	37.5	45.4	339
	Upto Primary	59.1	47.5	47	63.1	84.2	63.7	68.8	63.1	40
	Middle	52.3	52.0	51	55.8	74.8	52.6	52.4	55.8	43
	Secondary	65.9	67.0	55	72.3	93.2	56.0	57.4	72.3	49
	Higher	73.2	72.0	38	83.3	100.0	87.6	83.3	83.3	36
Wealth quintiles	Poorest	21.2	16.9	142	38.9	65.1	40.0	32.7	38.9	69
	Second	30.0	23.9	178	42.1	70.3	41.8	40.7	42.1	99
	Middle	42.3	37.3	168	53.1	77.2	60.5	51.9	53.1	107
	Fourth	41.8	43.2	160	58.8	84.9	57.6	47.2	58.8	131
	Richest	60.9	60.5	127	65.7	88.9	57.3	54.6	65.7	102
Total		38.6	35.5	775	53.0	78.5	52.7	46.4	53.0	508

Table 9.4: Reasons of not getting prenatal care

Among women age 15-49 with a live birth in the five years preceding the survey who did not see anyone for prenatal care for their most recent birth, percentage who cite specific reasons for not getting prenatal care, according to background characteristics, GBDHS 2008

Background characteristics		Not necessary	Cost too much	Too far	No transport	No one to go with	Service not good	No time to go	Don't know where to go	Did not want to see a male doctor	Long waiting time	Not allowed to go	Others	Number of women
Age of mother	< 25	53.9	13.5	36.1	6.2	2.8	2.1	11.8		6.1		7.2	2.0	59
	25-34	45.5	17.7	34.0	11.4	1.5	3.7	11.2	1.3	13.8	3.5	6.2	1.0	124
	35 +	48.1	26.8	30.3	8.4	1.7	3.5	7.4		16.1	1.7	6.0		84
Birth Order	1	55.4	4.4	18.1	7.7	6.2		17.4		17.1			4.5	26
	2 – 3	56.9	15.4	44.6	6.0		7.3	8.6		4.0	1.7	5.8		65
	4 – 5	47.5	12.5	22.9	13.7	4.7	.7	7.8	1.5	15.0	1.3	5.4	1.8	70
	6 +	41.6	30.7	37.0	8.8	.0	3.3	10.9	.5	15.8	3.5	8.9	.0	106
Place of Residence	Urban	67.3		4.7	2.7	3.1	9.1	8.8	3.1			31.2		19
	Rural	46.8	21.1	35.4	9.8	1.8	2.8	10.3	.4	13.8	2.3	4.5	1.0	249
Level of education	None	48.5	20.2	35.7	9.4	2.0	3.6	9.3	.7	13.0	2.4	5.5	.5	245
	Upto Primary	36.4	30.0	11.0	25.8					16.1		17.5		7
	Middle	29.6	11.1	11.1				28.6		15.9		15.5	15.3	8
	Secondary	64.2						35.8						6
	Higher	100.0						.0				63.6		2
Wealth quintiles	Poorest	42.1	30.2	39.8	16.4		3.4	3.4	1.4	6.1	1.3	5.2		73
	Second	35.3	26.9	39.0	3.8	3.9	1.3	16.7		19.4	3.4	5.1	1.5	79
	Middle	56.3	10.5	36.7	16.3		4.7	11.0		13.7	3.6	4.8		61
	Fourth	60.5	10.0	22.2		4.3	4.0	9.1	1.9	16.9		8.5		30
	Richest	72.0		1.5		2.3	4.8	8.1		4.9		14.9	4.9	25
Total		48.2	19.6	33.3	9.3	1.8	3.3	10.2	.6	12.8	2.2	6.3	.9	267

9.1.4 Tetanus Toxoid Vaccinations

The health professionals recommend that the child and mother could be protected from tetanus - one of major killer diseases among neo-natal babies - if the mother receives at least two tetanus toxoid injections during her pregnancy. Table 9.5 shows that only 28 percent of women had received two or more injection of tetanus toxoid during their last pregnancy. Furthermore, this vaccination was received more by relatively younger expectant mothers, and those who were pregnant with first child; residing in urban areas, with education at secondary level; and belong to richest wealth quintile. Clearly a solution must be found to make all pregnant women aware of the importance of TT immunization and bring services closer to them so that precious lives are saved.

Table 9.5: Tetanus toxoid injections

Among mothers age 15-49 with a live birth in the five years preceding the survey the percentage receiving two or more tetanus toxoid injections (TT) during the pregnancy for the last live birth according to background characteristics, GBDHS 2008

Background characteristics		%age receiving two+ injections during last pregnancy	Number of women with birth in last 5-yrs
Age of mother	< 25	33.3	185
	25-34	26.0	381
	35 +	26.6	209
Birth Order	1	42.0	113
	2 - 3	30.0	219
	4 - 5	25.5	202
	6 +	21.3	241
Place of Residence	Urban	38.2	102
	Rural	26.3	673
Level of education	None	22.3	584
	Upto Primary	28.1	47
	Middle	43.6	51
	Secondary	56.5	55
	Higher	51.3	38
Wealth quintiles	Poorest	17.9	142
	Second	17.9	178
	Middle	25.2	168
	Fourth	34.2	160
	Richest	48.8	127
Total		27.9	775

9.1.5 Complications during Pregnancy

In 2008 GBDHS, women were asked about the complication they had during last pregnancy and the data is presented in table 9.6. The most common complications mentioned by women were Epigastric pains (45 percent) and severe headaches (44 percent). The other complications were blurred vision (32 percent), swelling of face (20 percent) and swelling of hands (18 percent).

Although there are large variations of these complications by background characteristics of the women yet no consistent pattern emerged by the characteristics of the women.

Table 9.6: Pregnancy complications

Among women age 15-49 who had a live birth in the five years preceding the survey, the percentage who had specific problems during the pregnancy live birth, according to background characteristics GBDHS 2008

Background characteristics		Severe headaches	Blurred vision	Swelling of hands	Swelling of face	Vaginal bleeding/spotting	Fits or convulsion	Epigastric pains	Number of women with birth in last 5-years
Age of mother	< 25	43.3	27.8	10.6	15.9	5.5	8.6	41.6	185
	25-34	42.0	33.7	16.6	18.2	5.9	7.4	45.4	381
	35 +	47.2	33.2	25.8	25.8	4.9	8.0	45.9	209
Birth Order	1	19.2	26.3	4.4	8.6	4.7	4.7	25.8	113
	2 - 3	40.4	22.4	13.7	12.8	5.1	6.5	42.9	219
	4 - 5	48.4	33.0	14.0	17.8	1.3	7.5	42.7	202
	6 +	49.3	39.2	27.1	29.0	8.6	9.7	51.8	241
Place of Residence	Urban	70.2	10.4	13.9	22.4	1.3	11.0	65.4	102
	Rural	42.0	33.8	18.5	19.9	5.8	7.6	43.2	673
Level of education	None	44.5	34.5	18.5	20.2	5.5	7.0	44.1	584
	Upto Primary	32.5	11.0	19.1	33.9	.0	19.1	25.8	47
	Middle	48.8	11.1	11.1	11.1	15.9	31.4	57.4	51
	Secondary	37.0	.0	15.8	15.8	.0	.0	72.8	55
	Higher	.0	.0	.0	.0	.0	.0	63.6	38
Wealth quintiles	Poorest	47.7	39.9	15.1	15.2	8.3	6.0	40.0	142
	Second	52.5	34.4	28.1	26.8	5.5	7.5	55.4	178
	Middle	37.3	31.7	16.4	23.8	5.0	5.2	34.4	168
	Fourth	34.4	32.0	14.2	14.2	.0	11.0	34.4	160
	Richest	33.5	4.8	4.9	11.2	4.9	17.0	61.6	127
Total		43.9	32.2	18.2	20.1	5.5	7.9	44.7	775

9.2 Delivery Care

The safety of a newborn baby and the mother is significantly related to the competency of the person who is attending the delivery. It is recommended to deliver a birth at a health facility so as to minimize the risk factors of child and maternal mortality.

9.2.1 Place of Delivery

Place of delivery is vitally important for the health of mothers and the newborns. Unfortunately, in Pakistan the majority of deliveries take place at home, where aseptic conditions may not be optimal.

In 2008 GBDHS, data indicates that the home based deliveries are very high (61 percent). This practice is more common amongst older age women and those, who have more than 4 children; among uneducated and, those belong to poor wealth quintile (Table 9.7).

The breakdowns of the births (39 percent) that take place in a health facility, 21 percent takes place in a public sector health facility and 18 percent in a privately run health facility. The young age women (<25 years) those who are at lower birth order; have attained higher secondary education and; the ones living in households belonging to richest wealth quintile are more likely to deliver at a health facility (Figure 9.2).

Figure 9.2: Place of delivery and Background Characteristics

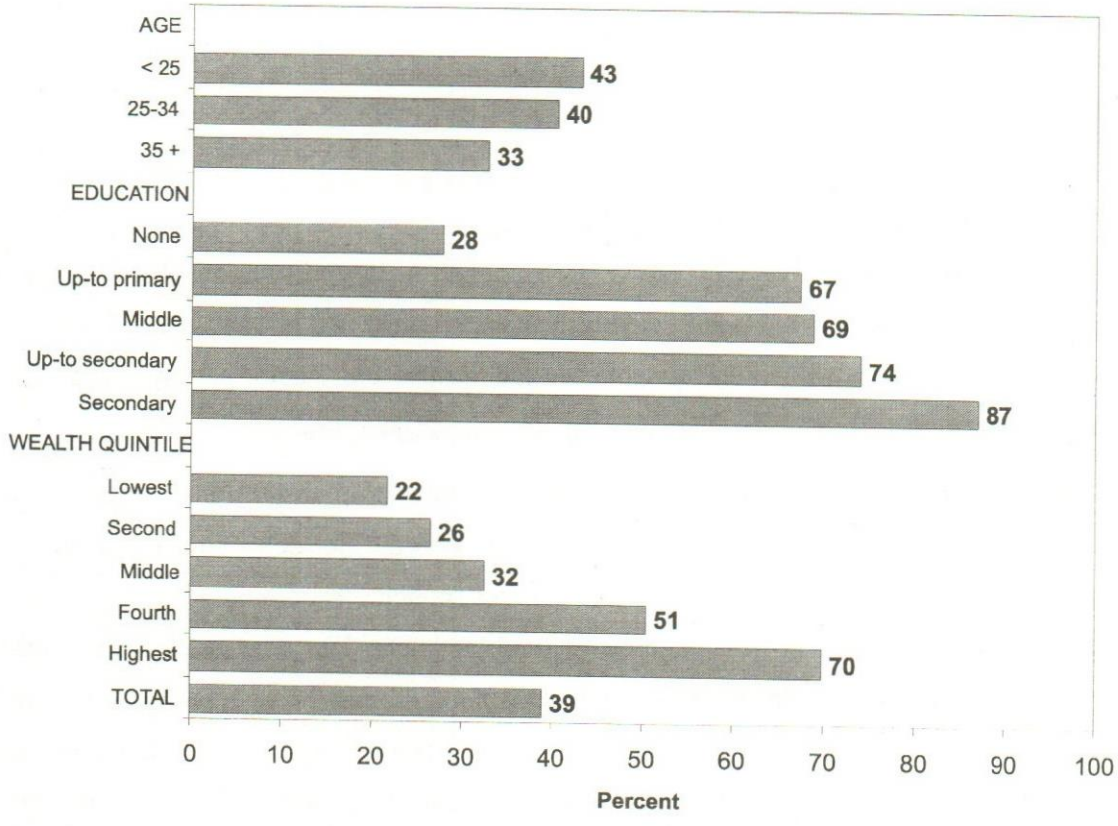

Table 9.7: Place of delivery

Percent distribution of live births in the five years preceding the survey by place of delivery and percentage delivered in a health facility according to background characteristics, GBDHS 2008

Background characteristics		Place of delivery					Total	Percentage delivered in a health facility	Number of Births
		Public health facility	Private health facility	Home	Others	Missing			
	< 25	24.0	19.0	56.9	.1		100.0	43.0	
	25-34	20.6	19.7	59.0	.3	.4	100.0	40.3	381
	35 +	18.1	14.7	66.5		.8	100.0	32.7	209
Birth Order	1	30.3	27.1	41.4	.2	1.0	100.0	57.4	113
	2 - 3	21.4	20.5	57.6	.5		100.0	41.9	219
	4 - 5	16.3	20.4	63.1		.2	100.0	36.7	202
	6 +	19.3	10.0	69.9		.7	100.0	29.4	241
Level of education	None	16.8	10.7	71.9		.6	100.0	27.6	584
	Upto Primary	26.4	41.0	30.1	2.5		100.0	67.3	47
	Middle	31.4	37.5	31.1			100.0	68.9	51
	Secondary	41.3	32.7	25.7	.4		100.0	74.0	55
	Higher	29.3	57.7	13.0			100.0	87.0	38
Wealth quintiles	Poorest	14.8	6.8	76.7		1.7	100.0	21.6	142
	Second	14.4	11.9	73.0	.7		100.0	26.3	178
	Middle	14.7	17.7	67.3		.3	100.0	32.4	168
	Fourth	23.2	27.3	49.5			100.0	50.5	160
	Richest	41.0	28.7	29.8	.2	.3	100.0	69.8	127
Total		20.7	18.2	60.5	.2	.4	100.0	38.9	775

9.2.2 Reasons for Not Delivering at a Facility

Women who did not deliver their last birth in a health facility were asked about the reasons why they did not deliver in a health facility. The data is presented in Table 9.8. It is noted that over one-third of the women have mentioned the health facility is too far away and there is lack of transport facility.

The second most cited reason is that "it is not necessary to give birth in a health facility". This reason is given by one-fourth of the women who did not deliver their last birth in a health facility. The policy makers while framing policies should target these hard-core women so that a change be brought in their attitude and behaviour. The reasons like "Cost too much"; "health facility remain closed" and ; "it is not customary to give birth in a facility" is reported by around one-fifth of women. And seven percent women also mentioned non-availability of a female health professional as one of the reasons. The above mentioned

common reasons are reported mostly by older than younger women; women with higher birth order; uneducated; and the ones in first and second wealth quintile.

Table 9.8: Reasons of not delivering in a facility

Among women who had a live birth in the five years preceding the survey and who did not deliver the most recent birth in a health facility, percentage citing specific reasons for not delivering in a facility according to background characteristics, GBDHS 2008

Background characteristics		Cost too much	Facility not open	Too far/no transp-ortation	Facility/ poor quality service	No female provider at health facility	Did not allow	Not nece-ssary	Not custo-mary	No time/ baby came too fast	Others	Number of women
Age of mother	< 25	17.3	8.7	42.3	.0	10.0	7.0	21.5	14.3	18.1	2.3	106
	25-34	20.5	19.9	33.0	1.6	5.3	5.8	23.6	26.4	9.8	2.0	226
	35 +	26.8	28.9	31.8	2.0	7.8	13.4	28.1	12.3	7.3	.8	139
Birth Order	1	18.5	6.2	23.9	.0	6.2	.0	33.8	29.9	11.5	6.2	47
	2 - 3	19.4	14.6	44.2	2.3	5.8	8.7	11.4	20.3	20.9	.0	127
	4 - 5	10.8	13.3	27.4	3.0	9.1	9.5	40.7	17.7	4.2	4.5	128
	6 +	31.0	31.0	35.4	.0	6.9	9.1	20.5	17.8	8.6	.0	168
Place of Residence	Urban	14.3	3.6	3.6	4.2	.0	53.7	25.8	4.2	33.9	4.2	44
	Rural	22.2	21.1	36.6	1.2	7.5	5.6	24.4	20.4	9.5	1.5	426
Level of education	None	23.2	20.9	35.9	1.5	7.2	8.5	24.9	21.0	8.6	1.0	420
	Upto Primary	11.0	.0	25.8	.0	.0	17.5	47.9	.0	16.1	7.6	15
	Middle	.0	.0	18.1	.0	25.0	.0	.0	.0	57.0	25.0	16
	Secondary	.0	39.8	19.1	.0	.0	.0	.0	.0	41.1	.0	14
	Higher	.0	.0	.0	.0	.0	.0	.0	.0	100.0	.0	5
Wealth quintiles	Poorest	21.5	21.1	37.4	2.0	.0	10.2	30.8	13.8	5.7	.0	109
	Second	26.9	39.1	31.3	.0	12.1	6.4	12.3	31.3	11.3	1.6	131
	Middle	25.4	.9	51.4	.0	9.8	.7	29.2	16.3	13.2	.0	113
	Fourth	11.6	11.4	21.6	5.0	8.6	19.4	28.2	17.9	7.4	3.4	79
	Richest	2.5	13.6	.0	3.8	.0	18.6	31.7	.0	28.3	12.0	38
Total		21.7	20.1	34.7	1.4	7.1	8.4	24.5	19.4	10.9	1.7	470

9.2.3 Use of Home Delivery Kits

In 2008 GBDHS, all women who delivered a baby at home were further probed and information regarding use of "safe delivery kit" was asked from the women and the data is presented in Table 9.9.

It is alarming to note that a very high proportion of women (83 percent) have mentioned that a un-boiled thread was used to tie the umbilical cord, which exposed the child to infections. This practice is found more in rural than urban areas.

The use of new razor blade - a highly recommended method - to cut the umbilical cord, was used for over half (54 percent) of the home based deliveries. It is pathetic to note that the use of scissors (21 percent) and a knife (15 percent) was also quite common for this purpose. Use of scissors is more common in urban areas, while knife in rural areas.

Table 9.9: Use of home delivery kits

Among women who had a live birth in the five years preceding the survey and whose last live birth was not delivered in a health facility, percentage who used a safe delivery kit for the last live birth and percent distribution by what was used to tie the cord and utensil used to cut the cord by urban-rural areas, GBDHS, 2008

Percentage using a safe delivery kit		Urban	Rural	Total
Used to TIE the umbilical cord	Unboiled thread	77.9	83.7	83.1
	Boiled thread	13.7	10.5	10.8
	Washed clamps	4.6	1.3	1.6
	Unwashed clamps	.4	.3	.3
	Hair	1.2	3.0	2.9
	Other	2.2	1.2	1.3
	Total	100.0	100.0	100.0
Used to cut the umbilical cord	New razor blade	52.8	53.8	53.7
	Old razor blade	10.0	7.9	8.1
	Scissors	32.2	19.4	20.7
	Knife	4.0	16.6	15.4
	Toka, chopper	.5	2.0	1.9
	Other	.4	.3	.3
	Total	100.0	100.0	100.0
Total	Number of women	44	426	470

9.3 Postnatal Care

9.3.1 Timing of First Postnatal Checkups

The postnatal checkup in highly recommended as a large proportion of maternal and neo-natal deaths occurs during the 24 hours after delivery. As such at least two post natal check ups in 6 weeks following delivery are considered vital for monitoring complications arising from the delivery. In order to assess the post natal care utilization in 2008 GBDHS, women were asked whether they had postnatal checkup after the delivery of their most recent birth in the five years preceding the survey. The data shows that majority of women (74 percent) did not have checkup after their last delivery. Only one-fifth of the women have had checkups with in four hours after the delivery. The mother's in the age group 15-24 years; those who had first child; women with secondary and higher level education and the ones belong to

richest wealth quintile are more likely to have received postnatal care within four hours of delivery.

Table 9.10: Timing of first postnatal checkup

Among women age 15-49 giving birth in the five years preceding the survey, the percent distribution of the mothers first postnatal check up for the last live birth by time after delivery, according to background characteristics, GBDSH, 2008

Background characteristics		Timing after delivery of mother's first postnatal checkup						Total	Number of women
		Less than 4-hrs	4-23 hours	2 days	3-41 days	Don't know/ missing	No checkup		
Age of mother	< 25	23.6	2.9	1.8	.8	.9	70.1	100.0	185
	25-34	19.6	2.4	1.8	1.6	2.4	72.0	100.0	381
	35 +	15.6	.6	2.2	.7	1.2	79.6	100.0	209
Birth Order	1	31.7	2.8	2.8	.7	2.0	60.0	100.0	113
	2 – 3	20.8	4.7	2.3	1.2	1.0	70.0	100.0	219
	4 – 5	19.9	.6	1.6	1.3	2.0	74.6	100.0	202
	6 +	12.2	.5	1.5	1.2	2.1	82.5	100.0	241
Level of education	None	13.7	1.5	1.3	.6	2.0	80.9	100.0	584
	Upto Primary	34.2	.4	6.8	4.9	1.2	52.4	100.0	47
	Middle	34.1	4.8	3.0	3.8		54.2	100.0	51
	Secondary	39.5	1.5	.9		2.0	56.1	100.0	55
	Higher	41.3	9.7	6.0	3.5		39.6	100.0	38
Wealth quintiles	Poorest	12.5	1.1	.5		2.5	83.3	100.0	142
	Second	12.4	1.9	1.8	.5	2.6	80.9	100.0	178
	Middle	20.8	1.6	.8	1.3	.3	75.2	100.0	168
	Fourth	24.6	2.7	1.4	.2	1.0	70.1	100.0	160
	Richest	29.2	3.2	5.9	4.4	2.5	54.8	100.0	127
Total		19.5	2.1	1.9	1.2	1.7	73.6	100.0	775

9.3.2 Type of Provider of First Postnatal Check-ups

Data was also collected on the type of service provider for postnatal care and presented in table 9.11 and figure 9.3. As mentioned earlier, a large proportion of women did not receive the postnatal checkup (74 percent). Nineteen percent of the women had consulted a health professional (doctor/nurse/LHV). Dai, a traditional birth attendant was the second most person (7 percent) consulted by the mothers after delivery of their most recent birth in the five years preceding the survey.

Young mothers (age<25); mothers of first order births, mothers with higher education; and those from the wealthiest households are more likely to have received postnatal care from a skilled health provider.

Figure 9.3: Services Provider for Post-natal Check-up by Background Characteristics

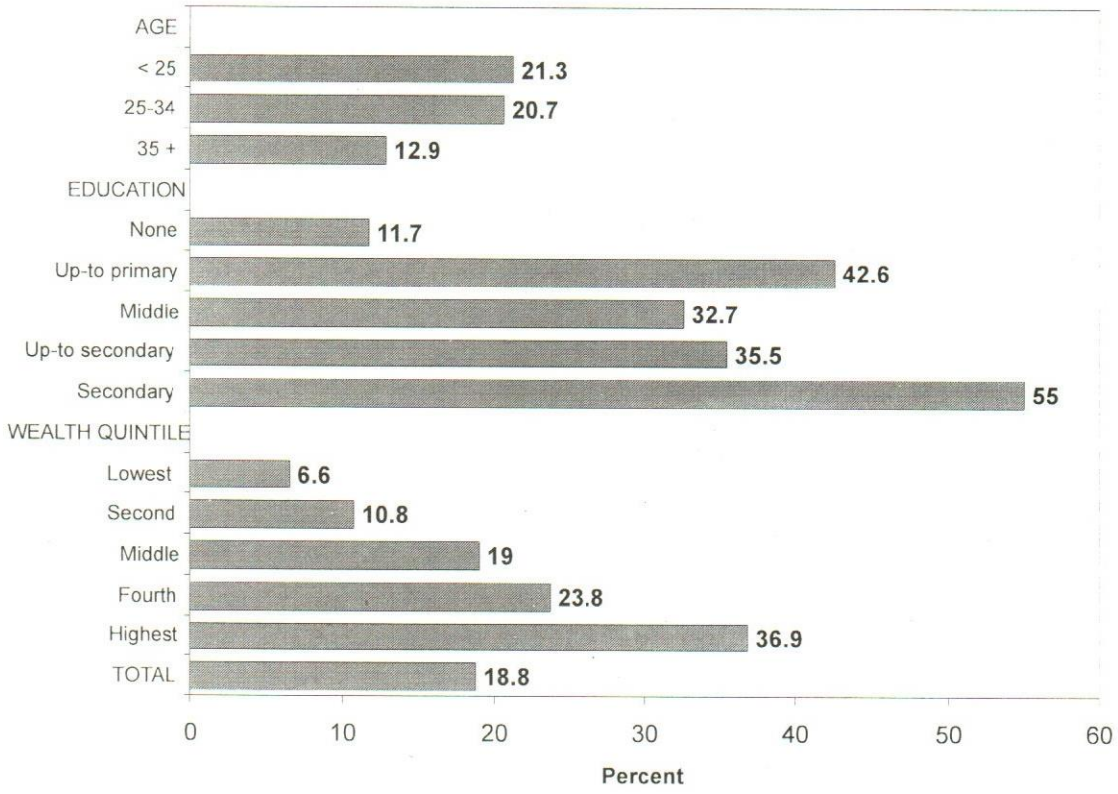

Table 9.11: Type of provider of first postnatal checkup

Among women age 15-49 giving birth in the five years preceding the survey, the percent distribution by type of provider of the last live birth, according to background characteristics, GBDHS, 2008

Background characteristics		Type of health provider of mother's first postnatal checkup					Total	Number of women
		Doctor/Nurse/LHV	Dai/TBA	LHW/ dispensor/ compounder / other	Don't know/ missing	No checkup		
Age of mother	< 25	21.3	7.9	.8		70.1	100.0	185
	25-34	20.7	6.2	.6	.4	72.0	100.0	381
	35 +	12.9	6.0	.7	.8	79.6	100.0	209
Birth Order	1	27.5	11.0	.6	1.0	60.0	100.0	113
	2 - 3	23.2	6.5	.4		70.0	100.0	219
	4 - 5	18.6	5.6	.9	.2	74.6	100.0	202
	6 +	10.7	5.3	.7	.7	82.5	100.0	241
Level of education	None	11.7	6.1	.8	.6	80.9	100.0	584
	Upto Primary	42.6	4.9			52.4	100.0	47
	Middle	32.7	11.9	1.2		54.2	100.0	51
	Secondary	35.5	8.4			56.1	100.0	55
	Higher	55.0	5.5			39.6	100.0	38
Wealth quintiles	Poorest	6.6	8.4		1.7	83.3	100.0	142
	Second	10.8	7.4	.9		80.9	100.0	178
	Middle	19.0	5.2	.3	.3	75.2	100.0	168
	Fourth	23.8	5.5	.6		70.1	100.0	160
	Richest	36.9	6.5	1.5	.3	54.8	100.0	127
Total		**18.8**	**6.6**	**.6**	**.4**	**73.6**	**100.0**	**775**

10 CHILD HEALTH

Zafar Zahir

The importance of child health cannot be overstated as children are affected the most by diseases because of their weak and immature immune system. The parents belonging to poor socio-economic stratum are likely to have children with low weight and small size at birth, making them even more vulnerable to health hazards. In the back drop at these facts, the study of child health becomes ever more momentous.

10.1 Size of Child at Birth

In the 2008 GBDHS women were asked to mention the size of their last child at the time of birth and data is presented in Table 10.1 it is observed that a baby of an average size is reported by 28 percent of the women followed by "larger than average size" (24 percent); "smaller than average size" (18 percent) and "very small size" by 16 percent of women. The births of "very small size" babies are at a greater risk of morbidity and mortality than other sized new born.

The babies of very small size at birth were born to mothers who are relatively young; mothers at first birth order; the ones residing in rural areas; and those who belong to poorest wealth quintile.

Table 10.1: Child's size at birth

Percent distributions of all live births in the five years preceding the survey by mother's estimate of baby's size at birth according to background characteristics, GBDHS, 2008

Background characteristics		Size of child at birth						Total	Number of children
		Very large	Larger than average	Average	Smaller than average	Very small	Don't know		
Age of mother	< 25	11.3	27.4	25.3	15.4	19.3	1.3	100.0	185
	25-34	14.2	23.2	26.2	20.7	14.0	1.7	100.0	381
	35 +	13.3	22.7	31.9	16.0	16.0	--	100.0	209
Birth Order	1	10.0	26.7	22.5	20.9	18.9	1.0	100.0	113
	2 - 3	9.6	25.6	26.7	18.2	17.5	2.3	100.0	219
	4 - 5	13.7	20.2	27.6	19.4	17.7	1.3	100.0	202
	6 +	17.8	24.6	30.6	15.8	11.1	--	100.0	241
Place of Residence	Urban	14.3	27.2	30.5	17.1	10.8	--	100.0	102
	Rural	13.1	23.6	27.1	18.3	16.6	1.3	100.0	673
Level of education	None	14.5	22.7	25.9	19.5	15.8	1.5	100.0	584
	Upto Primary	13.9	27.9	30.6	10.2	17.3	--	100.0	47
	Middle	6.6	34.3	37.8	9.0	12.3	--	100.0	51
	Secondary	8.3	23.3	33.6	17.8	17.1	--	100.0	55
	Higher	9.6	27.6	25.0	20.2	17.6	--	100.0	38
Wealth quintiles	Poorest	13.3	18.8	21.2	22.2	22.6	1.9	100.0	142
	Second	14.7	28.2	22.5	20.0	14.1	0.7	100.0	178
	Middle	14.1	24.4	30.7	15.2	14.2	1.4	100.0	168
	Fourth	10.3	18.9	33.6	17.6	17.9	1.7	100.0	160
	Richest	14.2	30.1	29.6	15.7	10.4	--	100.0	127
Total		**13.3**	**24.1**	**27.5**	**18.2**	**15.8**	**1.2**	**100.0**	**775**

10.2 Child Immunization

WHO recommended guideline for child immunization is implemented in Pakistan under expanded programme on immunization (EPI). It is recommended that all children receive a BCG vaccination against tuberculosis, three doses of DPT vaccine for the prevention of diphtheria, pertussis (whooping cough), and tetanus; three doses of polio vaccine; and a vaccination against measles during the first year of child's life.

10.2.1 Vaccination Coverage

In the 2008 GBFHS, information on vaccination coverage is recorded from the immunization cards and in case of unavailability of the card, mothers were asked to recall whether the child had received BCG, Polio, DPT (including the number of doses for Polio and DPT) and measles vaccinations. Table 10.2 shows that complete vaccination was given to 34 percent of

the children age 12-23 months. The main source of information is the mother of the child through memory recall (21 percent) as compared to vaccination card (13 percent).

A breakdown of the immunization by various antigens indicates that a large majority of the children have been given polio 1 (88 percent) followed by polio 2 (86 percent) and polio 3 (75 percent), however, the proportion is very low (46 percent) for polio 0 which is given within the first week of child's life. The coverage for other vaccines is BCG (67 percent); DPT (60 percent); DPT2 (51 percent); DPT3 (44 percent); and Measles (51 percent).

Table 10.2: Vaccinations by source of information

Percentage of children age 12-23 months who received specific vaccine at any time before the survey by source of information (vaccination card or mother's report, GBDHS 2008

Source of Information		BCG	DPT 1	DPT 2	DPT-3	Polio 0	Polio 1	Polio 2	Polio 3	Measles	All vacci-nation	No vacci-nation	Number of chil-dren
Vaccinated at any time before survey	Vaccination card	20.1	20.1	18.6	18.2	18.5	19.2	18.6	18.1	14.5	13.2	--	46
	Mother's report	46.6	39.7	32.6	25.5	27.1	69.2	67.7	56.8	36.5	21.2	10.2	184
Either source		66.7	59.7	51.2	43.7	45.6	88.4	86.3	74.9	51.0	34.4	10.2	230

10.2.2 Differentials in Vaccination Coverage

The data presented in table 10.3 and figure 10.1 indicate the coverage of vaccination according to the background characteristics of the mother. The children of mothers in age group 25-34 years are more likely than those in other age groups have received complete doses of basic vaccinations. Likewise, children of mothers at birth order 2-3; children of mothers residing in urban areas, children of mothers with middle education and, those residing in richest quintile households are more likely than others to have received complete immunization. A large differential among children who are fully vaccinated are found by wealth quintile. For example, children whose, mothers are in the poorer (2^{nd}) wealth quintile are far less likely to be fully immunized than the children of the ones in the richest (5^{th}) wealth quintile (26 percent and 51 percent respectively).

Figure 10.1: Percentage of Children 12-23 months who are Fully Immunized by Background Characteristics

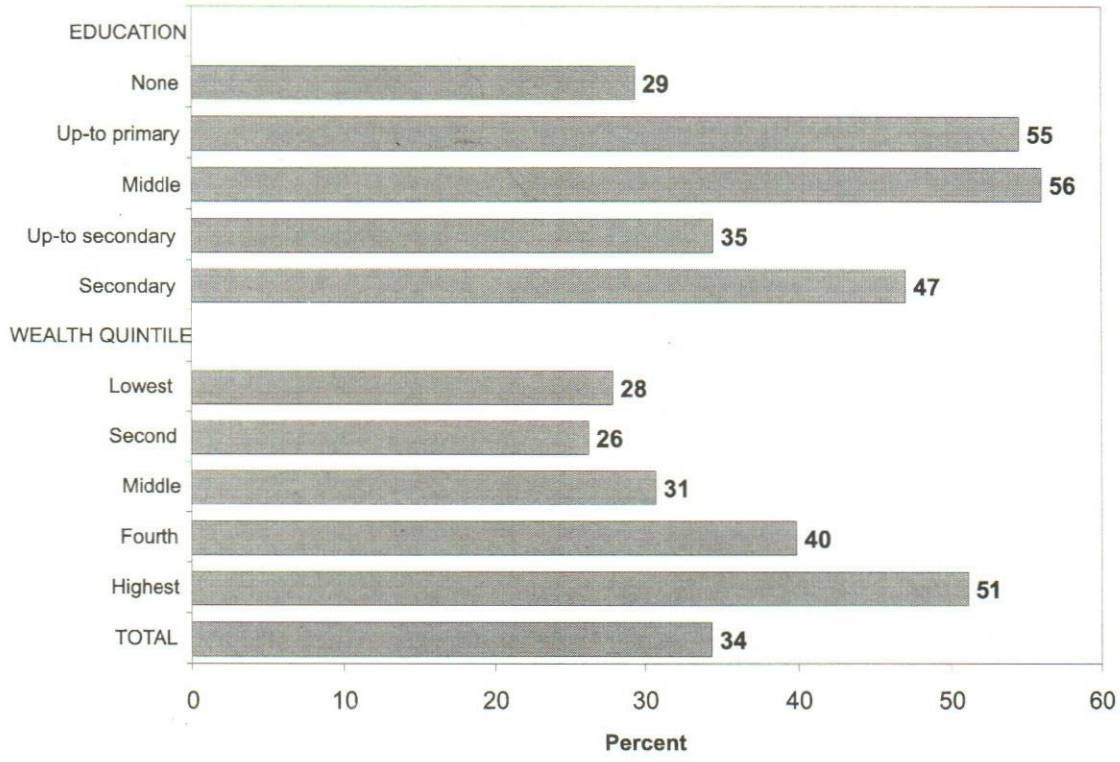

Table 10.3: Vaccinations by background characteristics

Percentage of children age 12-23 months who received specific vaccine at any time before the survey by background characteristics, GBDHS 2008

Background characteristics		BCG	DPT 1	DPT 2	DPT-3	Pollo 0	Pollo 1	Pollo 2	Pollo 3	Measles	All vacci-nation	No vacci-nation	Number of children
Age of mother	< 25	67.6	55.7	50.1	40.0	43.3	87.4	87.4	70.6	50.1	30.7	10.8	68
	25-34	68.4	62.2	50.6	46.8	49.2	90.7	86.3	75.4	52.5	37.2	7.4	106
	35 +	62.3	59.9	53.7	42.3	41.6	85.1	85.1	79.3	49.4	33.7	14.9	56
Birth Order	1	75.9	68.5	62.0	54.6	56.4	86.0	86.0	65.8	62.1	37.8	13.5	38
	2 - 3	76.9	66.5	57.3	50.6	47.0	96.3	94.4	82.8	61.6	43.7	2.1	68
	4 - 5	66.7	62.4	55.0	44.3	41.2	85.7	79.6	74.2	46.5	34.0	14.3	56
	6 +	51.2	45.6	35.8	30.0	41.8	84.0	84.0	72.8	37.9	23.5	13.0	67
Residence	Urban	84.3	74.3	67.1	52.8	57.4	93.3	93.3	82.6	70.3	48.5	6.1	31
	Rural	64.0	57.5	48.7	42.3	43.8	87.6	85.2	73.7	48.0	32.3	10.8	199
Level of education	None	57.4	50.4	44.3	36.6	41.2	87.2	85.2	71.9	42.7	29.3	12.8	168
	Upto Primary	94.8	91.2	84.4	61.2	60.9	93.2	93.2	89.6	81.5	54.6	--	16
	Middle	98.2	79.7	79.7	76.7	49.7	100.0	100.0	91.2	77.5	56.0	--	19
	Secondary	91.9	91.9	51.4	51.4	62.0	79.2	79.2	75.9	62.2	34.5	8.1	18
	Highly	72.7	72.7	59.1	59.1	59.1	94.0	80.4	68.5	72.7	47.1	6.0	10
Wealth quintiles	Poorest	51.5	44.3	35.8	27.9	39.0	87.0	84.9	73.4	39.0	27.9	13.0	44
	Second	50.5	41.7	36.0	31.2	35.6	88.6	88.6	68.1	40.6	26.2	11.4	57
	Middle	66.5	60.5	52.7	40.5	49.0	82.6	82.6	73.2	47.2	30.7	17.4	46
	Fourth	79.6	72.2	63.9	54.7	45.6	92.8	89.9	82.9	67.1	39.9	4.6	40
	Richest	92.1	87.1	74.1	70.1	62.2	91.4	85.3	79.9	66.5	51.1	3.4	42
Total		66.7	59.7	51.2	43.7	45.6	88.4	86.3	74.9	51.0	34.4	10.2	230

10.3 Child Mortality

In the absence of complete birth history in the GBDHS we have estimated child mortality by using indirect technique developed by. Brass and Trussell (Manual X: Indirect Techniques of Demographic estimation – Chapter 3: Estimation of Child Mortality from information on children ever born and children surviving). It is a well known technique and provides robust estimates of childhood mortality by sex.

This technique take into account the information about children ever born, children surviving, children dead and number of women in reproductive age by 5 years age group i.e. women between 15 to 49. It may be noted that in GBDHS, the above required information is gathered from more than 2000 women age 15-49. These women reported nearly 5200 children ever born and more than 650 deaths. According to indirect estimation, the child mortality for both sexes is 92 per thousand live births. A considerable variation has been found by sex, as male child mortality is higher (96 per thousands live births) than female child mortality (88 per thousand live births). It may be noted that these lifetime probabilities refer to 2.5 years before the survey.

10.4 Childhood Diseases

In 2008 GBDHS information was collected from the mothers of children who got ill with the symptoms of acute respiratory infections (ARI), fever, and diarrhea in the two weeks before the survey. Information was also collected whether ill children received treatment or not.

10.4.1 Prevalence and Treatment of ARI

Table 10.4. Shows that the prevalence of ARI is low (9 percent) among children under five years of age. As ARI is observed to be more prevalent in winter than summer seasons, the incidence of ARI in this survey may portray a subdued picture of ARI prevalence. The 2008 GBDHS was carried out in summer. By background characteristic, children of young mothers (age <25); children whose another's are at birth order 4-5, children of mothers residing in rural areas, and children belonging to households in poorest wealth quintile are more likely got ill with ARI than children of mothers in other categories. By education of mothers, the children of mothers with higher education are found to be comparatively more ill with ARI. This unexpected finding could only be attributed to better reporting due to better understanding of the symptoms of ARI among highly educated mother. The treatment seeking for ARI shows that about eighty percent of the children have been provided the

treatment from a health facility or by a health provider. Mothers of age 25-34 are more likely than younger or older mothers to seek treatment for their children.

Table 10.4: Prevalence and treatment of symptoms of ARI

Among children under age five, the percentage who had symptoms of acute respiratory infection (ARI) in the two weeks preceding the survey, among the children with symptoms of ARI, percentage who received specific treatment, according to background characteristics, GBDHS, 2008

Background characteristics		Children under age five		Children under age five with symptoms of ARI	
		Percentage with symptoms of ARI	Number of children	Percentage for whom treatment was sought from a health facility or provider	Number of children with ARI
	< 25	11.3	185	59.6	21
	25-34	8.9	381	93.6	34
	35 +	8.2	209	76.6	17
Birth Order	1	10.2	113	58.5	12
	2 - 3	8.8	219	86.9	19
	4 - 5	12.3	202	86.8	25
	6 +	6.7	241	75.3	16
Residence	Urban	6.6	102	100.0	7
	Rural	9.7	673	77.6	65
Level of education	None	9.7	584	82.9	57
	Upto Primary	7.9	47	34.6	4
	Middle	2.3	51	0.0	1
	Secondary	10.3	55	100.0	6
	Higher	11.9	38	72.3	4
Wealth quintiles	Poorest	9.9	142	67.0	14
	Second	9.2	178	83.2	16
	Middle	4.1	168	100.0	7
	Fourth	14.5	160	79.5	23
	Richest	8.9	127	78.2	11
Total		9.3	775	79.7	72

Note: Because of small member of cases, some of the findings are not interpreted

10.4.2 Prevalence and Treatment of Fever

Data relating to prevalence of fever and treatment sought from a health facility or a health provider is presented in Table 10.5.

It is noted that the prevalence of fever was high as 37 percent of the children have suffered from fever during two weeks preceding the survey. Relatively more of the children suffering from fever belong to young mothers (age<25), the children of mothers at 1st birth order, those residing in rural areas and children of mothers belonging to fourth wealth quintile (rich households).

Furthermore, it was found that for seventy percent of the ill children the treatment was sought from a health facility or from a health provider. For these children the treatment seeking was relatively better among mothers aged 25-34; the ones at first birth order, those residing in

urban areas; mothers with secondary level education and those who belong to richest wealth quintile.

Table 10.5: Prevalence and treatment of fever

Among Children under age five, the percentage who had a fever in the two weeks preceding the survey, and among children with fever, the Percentage of children for whom treatment was sought from a health facility or provider by background characteristics GBDHS 2008

Background characteristics		Children under age five		Children under age five with fever	
		Percentage with Fever	Number of children	Percentage for whom treatment was sought from a health facility or provider	Number of children with fever
Age of mother	< 25	40.0	185	69.8	74
	25-34	36.4	381	73.0	139
	35 +	34.7	209	62.8	72
Birth Order	1	41.1	113	81.8	47
	2 - 3	35.5	219	75.0	78
	4 - 5	37.3	202	65.3	75
	6 +	35.5	241	61.7	85
Residence	Urban	33.3	102	84.3	34
	Rural	37.3	673	67.6	251
Level of education	None	35.3	584	70.3	206
	Upto Primary	37.3	47	51.5	18
	Middle	50.5	51	64.5	26
	Secondary	39.8	55	79.3	22
	Higher	37.2	38	76.5	14
Wealth quintiles	Poorest	30.7	142	74.1	43
	Second	38.3	178	59.7	68
	Middle	34.0	168	66.7	57
	Fourth	43.0	160	74.9	69
	Richest	37.6	127	75.3	48
Total		36.8	775	69.6	285

10.4.3 Prevalence of Diarrhea

Data of 2008 GBDHS reveal that the prevalence of all types of diarrhea was 22 percent among children age under five year during two weeks preceding the survey. Moreover, the diarrhea with blood was reported for only 3 percent of children. The incidence of diarrhea is higher among children belonging to mothers of young age; among female children; children of mothers at birth order one; children of mother with secondary education and those belonging to poorest wealth quintile.

Table 10.6: Prevalence of diarrhea

Percentage of children under age five who had diarrhea in the two weeks preceding the survey, by background characteristics, GBDHS 2008

Background characteristics		Diarrhea in the two weeks preceeding the survey		
		All Diarrhea	Diarrhea with Blood	Number of children
Age of mother	< 25	30.7	3.6	185
	25-34	19.9	2.7	381
	35 +	19.2	2.0	209
Sex of child	Male	21.6	2.5	449
	Female	23.2	3.1	326
Birth Order	1	25.1	3.7	113
	2 – 3	24.7	2.5	219
	4 – 5	24.3	2.3	202
	6 +	17.2	2.9	241
Residence	Urban	20.7	1.4	102
	Rural	22.5	2.9	673
Level of education	None	22.4	3.2	584
	Upto Primary	21.0	3.0	47
	Middle	18.1	0.7	51
	Secondary	28.1	1.8	55
	Higher	20.5	0.0	38
Wealth quintiles	Poorest	23.4	3.4	142
	Second	19.6	2.9	178
	Middle	21.6	3.2	168
	Fourth	25.3	3.6	160
	Richest	22.1	0.0	127
Total		22.3	2.7	775

10.4.4 Treatment of Diarrhea

In case of children suffering from diarrhea, it is highly recommended that the treatment should be sought from a health professional and oral rehydration therapy (ORT) should be given at the earliest.

The data from the 2008 GBDHS indicate that about three in five children suffering from diarrhea (57 percent) have been taken to a health facility or provider for treatment. Better treatment seeking practice for children suffering from diarrhea is observed among mothers of age group 25-34; among mothers at birth order 2-3, those mothers who are urban residents; those who have acquired middle level education, and mothers who are residing in households belonging to poorest wealth quintile (Table 10.7)

Table 10.7: Diarrhea treatment

Among children under age five who had diarrhea in the two weeks, preceding the survey, the percentage who were taken for treatment to a health provider, percentage given oral dehydration therapy (ORT), the percentage given increased fluids the percentage given ORT or increased fluids, and the percentage who were given other treatment by background characteristics, GBDHS, 2008

Background characteristics	Percentage of children with diarrhea taken to health provider	Oral rehydration therapy (ORT)					Other treatments					Number of children with Diarrhea
		ORS packets or pre-packaged liquid	Recommended home fluid (RHF)	Either ORS or RHF	Increased fluids	Either ORS or increased fluid	Pills/syrup	Injection	IV drip	Home remedy/others	No treatment	
Age of mother												
< 25	57.0	61.6	13.5	62.6	18.7	67.4	38.9	.0	4.3	15.0	41.8	57
25-34	61.6	65.0	6.7	65.5	21.6	68.6	45.0	1.5	3.6	5.1	44.8	76
35 +	49.3	67.2	9.1	69.8	3.5	70.7	46.4	.0	.0	3.5	50.0	40
Sex of child												
Male	56.2	66.9	6.8	67.5	12.2	68.8	51.3	1.1	5.0	5.3	37.3	97
Female	58.5	61.0	12.9	63.0	22.0	68.6	33.2	.0	.5	11.4	54.9	76
Type of diarrhea												
Non-bloody	55.3	62.1	9.8	63.5	16.6	67.0	40.9	.7	3.2	9.1	46.1	152
Bloody	71.2	80.4	7.2	80.4	15.5	80.4	60.8	.0	1.7	.0	37.5	21
Birth Order												
1	52.3	68.4	16.0	70.4	17.6	69.1	57.3	.0	.0	11.0	31.7	28
2 - 3	67.9	70.4	12.4	71.2	17.0	73.3	38.2	2.0	4.5	16.2	39.0	54
4 - 5	58.6	58.7	5.8	58.7	16.8	65.2	42.0	.0	1.4	2.9	53.7	49
6 +	45.1	60.4	5.4	62.9	14.6	66.5	42.2	.0	4.9	1.2	51.6	42
Residence												
Urban	72.3	81.7	4.7	86.4	16.4	82.6	46.2	.0	.0	12.1	41.7	21
Rural	55.2	61.9	10.1	62.6	16.5	66.7	43.0	.7	3.4	7.4	45.5	152
Level of education	60.1	61.5	8.0	62.7	14.7	66.1	42.7	.8	4.0	5.9	46.6	131
None												
Upto Primary	22.1	54.4	13.1	54.4	34.3	67.5	59.9	.0	.0	23.7	16.4	10
Middle	71.1	87.3	17.1	87.3	10.4	87.3	37.5	.0	.0	12.7	49.7	9
Secondary	56.0	77.2	12.8	79.8	20.7	77.2	52.1	.0	.0	15.0	32.8	15
Higher	40.0	72.9	14.2	72.9	23.0	75.4	23.3	.0	.0	2.5	74.2	8
Wealth quintiles												
Poorest	63.0	63.0	3.2	63.0	16.8	71.4	29.0	.0	7.2	8.7	55.1	33
Second	38.7	36.2	13.5	39.2	7.5	41.3	61.4	.0	.0	.0	38.6	35
Middle	62.5	69.1	6.1	69.1	11.3	73.0	42.4	3.0	3.3	8.3	43.0	36
Fourth	67.3	80.7	9.6	81.7	23.0	80.7	44.7	.0	3.9	12.1	39.3	40
Richest	52.2	71.2	15.9	73.2	24.6	76.5	37.2	.0	.0	10.8	52.0	28
Total	57.2	64.4	9.5	65.5	16.5	68.7	43.4	.6	3.0	8.0	45.0	173

The children should also be given the treatment with oral rehydration solution (ORS) so as to avoid dehydration caused by diarrhea. The same data reveals that two-third of the children (66 percent) suffering from diarrhea were provided either ORS treatment or recommended home made fluid (RHF).

The data shows interesting results of treatment seeking behaviour of mothers with various background characteristics. The old age (35+ years) mothers are found to be more conscious of providing ORT to their children suffering from diarrhea. As expected, mothers residing in urban areas, those with educational level of middle and above; and the ones belonging to rich households(fourth quintile) are more likely to provide ORT than mothers belonging to other categories of background characteristics.

10.4.5 Feeding Practices during Diarrhea

It is highly recommended that children who have suffered with diarrhea should be given liquid and solid food in more amount than normal quantity. The data on feeding practice during diarrhea is presented in Table 10.8. it is observed that a low proportion of children (only 17 percent) were given more than the normal quantity of liquid. On the other hand, forty one percent of children were given liquid in less than normal quantity.

A similar pattern is observed in case of feeding for solid food to the children during illness with diarrhea. For example, 27 percent of children were given somewhat less than normal diet and, a visible proportion of children (12 percent) have not been given any food during diarrhea. Giving less than normal liquid and food to children suffering from diarrhea is an extremely dangerous practice that should be eliminated by campaigning through electronic and print media as well as by using the service of Lady Health Workers.

The above mentioned analysis of child health data clearly indicate some gaps in EPI coverage, treatment seeking behavior of mothers for children's illnesses due to ARI, fever and diarrhea. Therefore, the programme managers of health department should give attention to these issues in order to reduce morbidity and mortality among children.

Table 10.8: Feeding practices during diarrhea

Percent distribution of children under age five who had diarrhea in the two weeks preceding the survey by amount of liquids and food offered compared with normal practice, the percentage of children given increased fluids and continued feeding during the diarrhea episode and the percentage of children given ORT or increased fluids and continued feeding during the episode of diarrhea, by background characteristics, GBDHS, 2008

Background characteristics	Amount of liquids offered							Amount of food offered							Number of children with diarrhea
	Much less	Somewhat less	About the same	More	Nothing to drink	Don't know	Total	Much less	Somewhat less	About the same	More	Never gave food	Don't know	Total	
Age of mother															
< 25	18.3	23.2	26.5	18.7	12.6	.6	100.0	21.4	22.9	32.7	10.3	12.3	.6	100.0	57
25-34	14.0	21.3	36.7	21.6	3.5	2.8	100.0	20.0	23.5	35.1	10.7	9.1	1.6	100.0	76
35 +	10.4	39.2	30.7	3.5	16.2		100.0	13.0	37.2	26.0	5.3	18.5		100.0	40
Birth Order															
1	9.6	29.9	31.9	17.6	11.0		100.0	18.5	30.4	38.6	3.3	9.3		100.0	28
2 - 3	21.4	21.2	26.1	17.0	12.4	1.8	100.0	27.4	20.1	23.5	10.9	18.2		100.0	54
4 - 5	8.2	16.4	47.0	16.8	10.8	.7	100.0	12.4	18.8	45.1	9.6	13.5	.7	100.0	49
6 +	16.7	41.1	21.8	14.6	2.9	2.9	100.0	15.6	41.2	23.9	11.1	5.4	2.9	100.0	42
Residence															
Urban	23.7	24.6	35.4	16.4			100.0	24.0	24.8	41.4	9.7			100.0	21
Rural	13.3	26.3	31.5	16.5	10.7	1.7	100.0	18.1	26.7	30.9	9.2	14.0	1.0	100.0	152
Level of education															
None	15.4	29.3	28.4	14.7	11.0	1.2	100.0	18.0	27.0	28.3	10.8	14.8	1.2	100.0	131
Upto Primary	5.7		59.9	34.3			100.0	31.9	14.3	35.0	8.2	10.7		100.0	10
Middle	12.5	20.5	36.0	10.4	20.6		100.0	12.5	25.0	62.5				100.0	9
Secondary	15.2	15.8	41.9	20.7		6.3	100.0	23.7	27.2	42.8		6.3		100.0	15
Higher	14.2	31.7	31.0	23.0			100.0	14.2	34.2	37.0	14.6			100.0	8
Wealth quintiles															
Poorest	17.6	36.5	12.6	16.8	16.5		100.0	22.0	39.1	21.7	5.1	12.1		100.0	33
Second	10.8	35.5	31.2	7.5	11.6	3.4	100.0	8.5	38.1	34.6	3.8	11.6	3.4	100.0	35
Middle	13.3	29.6	26.8	11.3	15.4	3.6	100.0	26.0	18.5	24.1	15.1	15.2	1.0	100.0	36
Fourth	12.7	16.1	45.3	23.0	2.9		100.0	14.9	21.6	37.9	12.9	12.9		100.0	40
Richest	20.2	11.9	43.3	24.6			100.0	24.4	14.4	43.9	8.3	9.0		100.0	28
Total	14.6	26.1	32.0	16.5	9.4	1.5	100.0	18.8	26.5	32.2	9.3	12.3	.9	100.0	173

11 NUTRITION

Amanullah Bhatti and Rabia Zafar

Nutrition is the intake of food, considered in relation to the body's dietary needs. Good nutrition – an adequate, well balanced diet combined with regular physical activity – is a cornerstone of good health. Poor nutrition can lead to reduced immunity, increased susceptibility to disease, impaired physical and mental development, and reduced productivity. This chapter reviews the nutritional status of children and women in Gilgit and Baltistan. The specific issues discussed are infant and young child feeding practices, including breastfeeding, other liquids and feeding with solid/semi-solid foods; micronutrient intake among children and women.

11.1 Breastfeeding and Supplementation

According to WHO, nutrition and nurturing during the first three years are both crucial for lifelong health and well-being. In infancy, no gift is more precious than breastfeeding; yet barely one in three infants is exclusively breastfed during the first four months of life.

Faulty feeding practices begin with giving any other nourishment but breast milk before complementary feeding is nutritionally required – or with substituting entirely for breast milk, which places babies at risk of illness, even death. When complementary feeding begins, uninformed decisions can also interfere with good nutrition in terms of which foods are given, how much and how often and whether breastfeeding continues, as it should. Nutritionally inadequate or contaminated food and starting complementary feeding too early or too late are major causes of malnutrition in infants and young children.

11.1.1 Initiation of Breastfeeding

Early initiation of breastfeeding is encouraged for a number of reasons. Mothers benefit from early suckling because it stimulates breast milk production and facilitates the release of oxytocin, which helps the contraction of the uterus and reduces postpartum blood loss. The first breast milk contains colostrums, which is highly nutritious and has antibodies that protect the newborn from diseases. Early initiation of breastfeeding also fosters bonding between mother and child.

Table 11.1 shows the percentage of children born in the five years before the survey by breastfeeding status and the timing of initial breastfeeding, by background characteristics. Breastfeeding is nearly universal in Gilgit and Baltistan, with 98 percent of the last child born in the five years preceding the survey having been breastfed at some time. The percentage of children ever breastfed does not vary much by background characteristics.

Nearly two in three children are breastfed within one hour of birth (60 percent) and 95 Percent within one day of birth. High proportion of children (90 percent) is given colostrums that is a form of milk produced soon after the birth and has high nutrients and antibodies. Nineteen percent of children are given a pre-lacteal feed, that is, something other than breast milk during the first three days of life.

The practice of giving colostrums to new born children is highest among residents of rural areas. Mother's education is positively associated with the practice of giving colostrums to the children while the wealth quintile is inversely associated. The children in the poorest wealth quintile are most likely to be given colostrums.

The proportion of children who started breastfeeding within one-hour of birth increases with age of mothers whereas proportion who started breastfeeding within 1 day of birth and those who were given colostrums do not show perceptible variation by the age of mother. Children living in the urban areas are more likely to be breastfed within one day of birth and received prelactal feed, compared with children living in the rural settings of Gilgit and Baltistan.

Women who have completed their secondary or higher level of education are slightly more likely to initiate breastfeeding within one hour and one day of birth than women with lower levels of education. Differences in early breastfeeding by wealth quintile are not very large except for children in the highest wealth quintile who are more likely to be breastfed within an hour of birth.

Table 11.1 Initial breastfeeding

Percentage of children born in the five years preceding the survey who were ever breasted, and for the last children born in the five years preceding the survey ever breasted, the percentage who started breastfeeding within one hour or within one day of birth, Percentage who received a prenatal feed, Percentage who were given colostrums, by background characteristics GBDHS-2008

Background characteristics	Percentage ever breastfed	Number of children	Percentage who started breastfeeding within 1-hr of birth	Percentage who started breastfeeding within 1-day of birth	Percentage who were given colostrums	Percentage who received a prelacteal feed	Number of last-born children ever breastfed
Age of mother							
< 25	98.5	185	56.8	95.5	89.7	21.7	182
25-34	98.4	381	59.7	94.5	90.6	15.3	375
35 +	96.9	209	63.1	94.3	90.4	22.2	202
Place of Residence							
Urban	97.0	102	60.0	96.8	86.6	27.1	99
Rural	98.2	673	59.9	94.3	90.9	17.4	661
Level of education							
None	98.2	584	59.4	94.9	89.0	18.2	573
Upto Primary	100.0	47	55.4	89.5	93.8	24.1	47
Middle	100.0	51	66.4	93.4	97.2	21.2	51
Secondary	94.1	55	57.2	96.1	92.5	14.2	52
Higher	97.1	38	69.0	97.0	94.1	22.3	36
Wealth quintiles							
Poorest	98.3	142	53.9	95.0	93.6	15.1	139
Second	99.8	178	64.4	97.5	91.0	16.5	178
Middle	97.3	168	52.5	90.3	88.4	15.4	164
Fourth	97.7	160	57.1	96.8	86.5	21.0	156
Richest	96.7	127	74.0	93.3	92.9	27.4	123
Total 15 – 49	98.1	775	59.9	94.7	90.3	18.7	760

11.1.2 Breastfeeding status

UNICEF and WHO recommend that children be exclusively breastfed during the first six months of life and that children be given solid or semisolid complementary food in addition to continued breastfeeding after six months.

Table 11.2 (a) presents the percentage of the children under 3 years who are exclusively breastfed, received other liquids, complimentary foods and who use bottle with nipple. Overall only 16 percent of children under 3 year of age are found to be exclusively breastfed but this proportion varies with mothers age, urban-rural residence, education and wealth quintile. Children of young mothers and children living in rural areas are more likely to have exclusive breastfeeding.

Table 11.2 (a) shows that exclusive breastfeeding is highest among mothers with no education while exclusive breastfeeding exhibits an inverse association with wealth quintile. Among children under 3 years, 17 percent are being fed with other milk and 27 percent with complimentary food. Complimentary food is more likely to be given by older mothers and those who belong to richest wealth quintile.

Table 11.2 (a) also shows that overall, bottle feeding is not much common among children under 3 years of age (15 percent). Use of nipple is higher among children of middle aged (25–34 years), mother's children living in urban areas, mothers with higher than secondary education and those living in households belonging to richest wealth quintile.

Information on breastfeeding and supplementation was obtained in the 2008 GBDHS by asking mothers about the current breastfeeding status of all children under three years of age and for the youngest child born in the three years before the survey and living with the mother and the status of food (liquids or solids) given to the child, the day before the survey by age of child in months.

Table 11.2 (b) presents the above stated information by age of child in months. Contrary to WHO's recommendations, only a little more than one third (37 percent) of children under 6 months are exclusively breastfed in Gilgit and Baltistan.

Table 11.2 (b) also shows that the highest proportion of exclusively breastfed children (25 percent) in the age bracket of 2-3 months, 8 percent consumed plain water, and 9 percent consumed other milk in addition to breast milk. The proportion of children exclusively breastfed decreases substantially after 3 months of age. At 6 months of age, solid and mushy foods are introduced to the children.

Bottle-feeding is usually associated with increased risk of illness, especially diarrheal diseases, because of improper sterilization of Bottle and Nipple. Table 11.2 (b) shows that nearly 12 percent of children under six months are fed on bottles with nipple.

Table 11.2 (a) Breastfeeding status

Percent distribution of most recent births under three years who are living with their mother by breastfeeding status and the percentage currently breastfeeding and the percentage of all children under three years using a bottle with nipple, according to background characteristics, GBDHS-2008

	Status of Breastfeeding practice										
Background characteristics	**Exclusively breastfeeding**	**With Plain water**	**With non milk liquid juices**	**Other milk**	**Complementary foods**	**Not currently breastfed**	**Not ever breastfed**	**Total**	**Percentage currently breastfeeding**	**Percentage using a bottle with nipple**	**Number of women**
Age											
< 25	21.7	8.6	1.9	9.9	23.9	29.7	4.2	100.0	66.1	10.4	168
25-34	12.7	7.3	3.2	20.3	27.1	25.0	4.5	100.0	70.5	18.5	299
35 +	16.0	10.5	2.3	17.1	31.3	18.0	4.8	100.0	77.2	14.9	141
Place of Residence											
Urban	8.2	6.7	4.8	19.3	28.0	30.0	2.9	100.0	67.1	25.6	79
Rural	17.1	8.6	2.3	16.3	27.0	23.9	4.7	100.0	71.4	13.9	529
Level of education											
None	18.6	8.1	2.2	18.3	23.4	24.7	4.6	100.0	70.7	11.9	448
Upto Primary	6.4	4.7	6.5	8.3	39.0	29.3	5.7	100.0	65.0	24.4	37
Middle	7.4	12.0	1.3	12.8	36.6	29.8		100.0	70.2	15.3	45
Secondary	9.5	11.5	6.5	9.8	36.8	19.4	6.5	100.0	74.1	23.9	48
Higher	10.9	6.7		19.5	38.4	19.1	5.5	100.0	75.5	43.3	30
Wealth quintiles											
Poorest	23.3	8.8	1.2	17.0	25.6	21.0	3.2	100.0	75.8	15.5	104
Second	20.9	8.6	1.0	15.9	18.7	31.6	3.3	100.0	65.1	11.5	140
Middle	19.6	10.6	4.5	19.6	18.3	19.2	8.2	100.0	72.6	11.3	134
Fourth	6.9	5.8	3.8	17.2	34.5	27.6	4.3	100.0	68.1	13.8	128
Richest	8.2	8.1	2.5	13.0	42.8	22.4	2.9	100.0	74.7	28.0	102
Total	16.0	8.4	2.6	16.7	27.2	24.7	4.5	100.0	70.8	15.4	608

Table 11.2(b) Breastfeeding status by age

Percent distribution of most recent births under three years who are living with their mother by breastfeeding status and the percentage currently breastfeeding and the percentage of all children under three years using a bottle with nipple, according to age in months, GBDHS-2008

Age (In months)	Status of Breastfeeding practice							Total	Percentage currently breastfeeding	Percentage using a bottle with nipple	Number of women
	Exclusively breastfeeding	With Plain water	With non milk liquid juices	Other milk	Complementary foods	Not currently breastfed	Not ever breastfed				
00 - 01	65.4	3.5		10.9	11.5	7.4	1.3	100.0	91.3	15.6	33
02 - 03	75.1	7.6		8.8	3.2		5.3	100.0	94.7	7.6	43
04 - 05	36.8	11.9	2.3	33.6	3.2	8.7	3.5	100.0	87.8	13.9	62
06 - 08	10.9	7.8	3.2	20.1	44.2	11.8	1.9	100.0	86.3	31.5	42
09 - 11	10.1	19.7	2.7	16.8	29.2	8.9	12.8	100.0	78.4	21.9	47
12 - 17	5.8	13.1	4.1	24.3	40.0	9.0	3.7	100.0	87.3	19.9	168
18 - 23	2.4	7.8	3.4	4.9	45.3	35.3	.9	100.0	63.8	17.3	62
24 - 35	.4		1.9	8.7	20.1	63.1	5.8	100.0	31.1	6.0	153
00 - 03	70.9	5.8		9.7	6.8	3.2	3.6	100.0	93.2	11.1	75
00 - 05	55.5	8.6	1.0	20.5	5.2	5.7	3.5	100.0	90.8	12.4	137
06 - 09	10.5	15.7	2.3	18.6	36.7	12.6	3.6	100.0	83.7	28.0	58
12 - 15	11.6	11.6	5.4	20.2	40.4	5.9	4.9	100.0	89.2	24.5	83
12 - 23	4.8	11.7	3.9	19.1	41.4	16.1	3.0	100.0	80.9	19.2	230
20 - 23	3.9			6.6	50.3	37.7	1.5	100.0	60.8	28.5	38
06 - 23	6.4	12.3	3.7	18.9	40.0	14.4	4.3	100.0	81.3	21.2	319
Total	16.0	8.4	2.6	16.7	27.2	24.7	4.5	100.0	70.8	15.4	608

11.1.3 Complementary Feeding

WHO recommends introduction of solid food to infants around the age of 6 months as at that age breast milk by itself is no longer sufficient to maintain a child's optimal growth. Table 11.3 shows information on the types of food given to the youngest child under three years of age living with the mother and consumed specific type of liquid or solid in the day or night proceeding the day of interview, according to their breastfeeding status and age.

Consumption of infant formula or other milk, liquids and any mushy or solid food increases gradually by age. Overall, one forth (23 percent) of breastfed children in the age bracket 6-23 months receive infant formula or other milk. Unexpectedly, among non breastfed children this proportion is about two times lower (12 percent). Only five percent of breastfeeding children as against less than one percent of non breastfeeding children age 6-23 months are given other liquids besides infant formula or other milk. By age 6-8 months, more than half of breastfed children and about two third of non breastfed children have started receiving mushy or solid food. At higher ages a mixed pattern is indicated for both breastfed and non breastfed children.

Table 11.3 Foods and liquids consumed by children

Among the most recently born living children under three years of age who are living with the mother, percentage who consumed specific type of liquid or food in the day or night preceding the interview, according to breastfeeding status and age GBDHS -2008

Age (In months)	Infant formula/other milk	Other liquid	Any mushy or solid food	Number of children
Breastfeeding Children				
00 – 01	11.9	.0	12.6	30
02 – 03	9.3	.0	3.3	40
04 – 05	38.3	2.6	3.6	54
06 – 08	23.3	3.7	51.3	36
09 – 11	21.4	3.4	37.2	36
12 – 17	27.8	4.7	45.8	147
18 – 23	7.8	5.4	71.0	39
24 – 35	27.9	6.3	64.6	47
00 – 03	10.4	.0	7.3	70
00 – 05	22.6	1.1	5.7	124
06 – 09	22.2	2.8	43.8	49
12 – 15	22.6	6.0	45.3	74
12 – 23	23.5	4.9	51.2	186
20 – 23	10.9	.0	82.7	23
06 – 23	23.2	4.5	49.2	259
Total	23.5	3.7	38.4	431
Non-Breastfeeding Children				
00 – 01	.0	.0	85.2	3
02 – 03	.0	.0	.0	2
04 – 05	15.7	.0	55.6	8
06 – 08	22.4	.0	63.6	6
09 – 11	.0	.0	55.1	10
12 – 17	13.3	.0	49.9	21
18 – 23	12.1	1.9	83.5	22
24 – 35	10.6	3.9	75.8	105
00 – 03	.0	.0	47.3	5
00 – 05	9.4	.0	52.2	13
06 – 09	13.7	.0	63.9	9
12 – 15	27.8	.0	39.9	9
12 – 23	12.6	1.0	67.1	44
20 – 23	18.3	2.8	74.9	15
06 – 23	11.5	.7	64.7	60
Total	10.8	2.6	70.4	177

Note: Readers are cautioned that because of a small number of non-breastfed children of the results for some of the categories may not reflect the true picture.

11.2 Micronutrient Intake

Micronutrients are vitamins and minerals that are needed by the body in very small amounts but are essential for the body to maintain its normal functions. Without them, the body cannot function optimally and different health problems occur. As they cannot be synthesized in the

body, they must be provided by the diet. If these micronutrients are missing during phase of rapid growth, the development of basic biological function like intellect, and even life itself can be threatened. That is why young children and pregnant women are often among the risk groups for micronutrients deficiencies.

11.2.1 Micronutrient Intake among Children

Micronutrient deficiency has serious consequences for childhood morbidity and mortality. Children can receive micronutrients from foods, fortified foods, and direct supplementation. Vitamin A is an essential micronutrient for the immune system. Severe vitamin A deficiency can cause eye damage. It can also increase the severity of infections such as measles and diarrheal diseases in children and can slow recovery from illness.

Table 11.4 shows that 40 percent of children age 6-59 months received a vitamin A supplement. It is encouraging to observe that this proportion does not vary substantially by background characteristics. For example, there is hardly any male-female difference in the consumption of vitamin A supplements (40 and 41 percent, respectively) consumption of vitamin A increases from 49 % among children age 6-8 months to 53 % among children age 18-23 months and decreases to 39 % among children age 48-59 months. Children who are breastfed are slightly less likely (38 percent) to receive vitamin A supplements compared with their no breastfed counterparts (42 percent). Children of mother age 25 and higher than younger mothers are less likely to receive Vitamin A. Also children residing in rural areas, children of uneducated mothers, and children in the poorest wealth quintiles are less likely than others to receive vitamin A supplements.

Table 11.4: Micronutrient intake among Children

Among all children 6-59 months, percentage who were given vitamin A supplements in the six months preceding the survey, by background characteristics GBDHS -2008

Background characteristics	Percentage given Vitamin-A supplements	Number of children
Age (in months)		
06 – 08	48.4	42
09 – 11	33.0	47
12 – 17	33.3	168
18 – 23	52.9	62
24 – 35	39.1	153
36 – 47	46.9	99
48 – 59	38.7	68
Sex of child		
Male	39.6	377
Female	41.1	261
Breastfeeding practices		
Currently breastfeeding	38.4	319
Not breastfeeding	42.1	319
Age of mother		
< 25	43.4	144
25-34	39.4	314
35 +	39.1	181
Place of Residence		
Urban	44.9	87
Rural	39.5	551
Level of education		
None	35.4	475
Upto Primary	46.8	41
Middle	59.4	44
Secondary	53.5	46
Higher	58.4	32
Wealth quintiles		
Poorest	27.9	110
Second	29.8	147
Middle	33.2	135
Fourth	56.9	138
Richest	54.6	108
Total 15 – 49	40.2	638

11.2.2 Micronutrient Intake among Women

A mother's nutritional status during pregnancy is important both for the child's intrauterine development and for protection against maternal morbidity and mortality. Night blindness is an indicator of severe vitamin A deficiency, and pregnant women are especially prone to suffer from it. This section discusses women's micronutrient intake status, in terms of supplementation.

Table 11.5 presents the percentage of women with a birth in the five years preceding the survey who received a vitamin A dose in the first two months after birth, who took iron tablets or syrup or calcium tablets during pregnancy, and who suffered from night blindness during the pregnancy of last birth. Over all, 17 percent received a vitamin A dose, but this varies substantially with area of residence, educational attainment, and wealth quintile. Women in age group 25-34 are more likely to receive vitamin A than women in other age groups.

Women in urban areas are more likely (31 percent) to receive vitamin A supplements than those in rural areas (15 percent). With regard to educational level, women with no education (13 percent) are least likely to receive vitamin A doses. The data shows that at least 31 percent of women with secondary or higher education have received a vitamin A dose. Vitamin A supplementation is strongly associated with household wealth, rising from 8 percent of the poorest mothers to 35 percent of the richest mothers.

Vitamin A deficiency causes eye disorders ranging from night blindness to permanent blindness during pregnancy to which pregnant women are especially prone. One fifth of the women (20 percent) with a recent birth reported having had night blindness during their last pregnancy. Night blindness is higher among older (age 35+) women, women residing in the rural areas of Gilgit and Baltistan. Night blindness is also found to be inversely related to education of women and wealth quintile. These segments of women require immediate attention of the health planners for remedial action.

As shown in Table 11.5, the intake of iron tablets or syrup during pregnancy is low as well. Overall, two third of women (62 percent) do not take iron tablets or syrup during pregnancy. Intake varies considerably by area of residence. Sixty-four percent of women in rural areas, compared with 49 percent of women in urban areas, do not take any iron supplements during pregnancy.

Mother's education and wealth index show more or less an inverse relationship with the likelihood of not taking iron supplements during pregnancy. By education, 69 percent of uneducated women, compared with only 27 percent of those with secondary and higher education, reported that they did not take iron tablets or syrup during their last pregnancy. The proportion of poorest women who did not take iron tablets or syrup is higher (79 percent) compared to wealthiest women (39 percent). Women who took iron supplements during pregnancy, many took them for 90 and more days.

A similar pattern is observed for the proportion of women who took calcium tablets during pregnancy. About two third (65 percent) of women reported that they had not taken any calcium supplements during the pregnancy leading to their most recent birth. Women who took calcium tablets during their pregnancy of last birth are mostly took them for less than 60 days (19 percent).

Table 11.5 Micronutrient intake among Women

Among all women with a child born in the five years preceding the survey, percentage who received vitamin dose in the first two months after the birth of last child, percentage who suffered from night blindness during the pregnancy of the last born child, and the percentage who took iron tablets or syrup during pregnancy of last birth and the percentage of women who took calcium tablets during pregnancy of last birth, by background characteristics GBDHS -2008

Background characteristics	Percentage who received Vitamin-A	Night blindness reported	Number of days women took iron tablets or syrup during pregnancy of last birth					Number of days women took calcium tablets pregnancy of last birth					Total	Number of children
			None	< 60	60 - 89	90 +	Don't know	None	< 60	60 - 89	90 +	Don't know		
Age														
< 25	15.2	13.1	50.0	21.2	7.4	20.9	.5	62.3	23.9	6.1	7.7		100.0	185
25-34	19.2	21.0	63.5	14.2	6.2	15.6	.5	63.5	17.1	5.0	12.8	1.6	100.0	381
35 +	14.8	22.8	68.5	12.4	5.5	13.3	.4	68.2	16.5	5.0	8.7	1.6	100.0	209
Place of Residence														
Urban	31.4	11.0	48.7	19.7	7.7	23.9		48.6	25.9	5.6	19.9		100.0	102
Rural	14.9	20.9	63.6	14.7	6.1	15.1	.5	66.9	17.5	5.2	9.0	1.4	100.0	673
Level of education														
None	13.1	21.5	69.1	13.2	5.7	11.5	.5	72.2	15.7	4.3	6.5	1.3	100.0	584
Upto Primary	31.4	18.1	40.9	27.0	8.2	23.9		52.5	20.2	6.1	21.2		100.0	47
Middle	20.3	7.2	47.7	14.4	8.0	28.1	1.7	48.0	20.0	6.7	21.0	4.2	100.0	51
Secondary	34.8	14.2	36.7	24.9	7.0	31.4		33.0	38.6	13.8	14.5		100.0	55
Higher	30.6	15.8	26.8	21.3	10.6	41.4		28.0	30.2	4.0	37.7		100.0	38
Wealth quintiles														
Poorest	7.7	24.1	78.8	12.5	3.7	4.5	.6	83.1	11.8	1.0	2.9	1.2	100.0	142
Second	11.7	28.2	70.0	16.0	5.9	7.5	.5	76.1	13.3	5.1	4.2	1.3	100.0	178
Middle	14.8	17.0	57.7	12.9	5.3	23.5	.5	62.7	19.3	6.7	9.4	2.0	100.0	168
Fourth	19.4	14.8	59.1	13.9	9.8	17.3		56.8	22.6	7.3	12.5	.8	100.0	160
Richest	35.1	11.9	39.1	23.0	6.7	30.6	.7	39.5	27.5	5.7	26.6	.7	100.0	127
Total	17.1	19.6	61.6	15.4	6.3	16.2	.5	64.5	18.6	5.3	10.5	1.2	100.0	775

KNOWLEDGE OF HIV/AIDS AND TUBERCULOSIS

12

Faateh ud din Ahmad and Badar ud Din Tanweer

Acquired immune deficiency syndrome (AIDS) is caused by a human immunodeficiency virus (HIV) that weakens the immune system, making the body susceptible to and unable to recover from other diseases. It was first recognized internationally in 1981. HIV/AIDS is a pandemic with cases reported from every country. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that approximately 33 million people worldwide were living with HIV in 2007. An estimated 2 million lost their lives to AIDS (UNAIDS, 2008).

Pakistan is a signatory to the Millennium Development Goals (MDGs). The goal 6 states that Pakistan will "Halt and begin to reverse the spread of HIV/AIDS" by the year 2015.The primary objective of this programme is to seek not only a halt but reversal of HIV/AIDS spread. The project seeks to contain the epidemic among the most at risk group where it has established, and prevent it from establishing among the bridge groups and the general population. Presently National AIDS Control Programme (NACP) and its provincial counterparts (Provincial AIDS Control Programs in Punjab, Sindh, Balochistan, NWFP and AJK) are implementing the interventions throughout the country.

The first case of HIV in Pakistan was diagnosed in 1987. However, the infection remains unnoticed for many year, most infected individuals are unaware that they are infected. There have been various efforts by both government and non-government organizations to prevent HIV transmission, including public health education through the media. Particularly, information, education and communication (IEC) efforts are directed at increasing awareness of these issues. The findings of the Gilgit and Baltistan Demographic and Health Survey (GBDHS) will be helpful in shaping these initiatives in the Gilgit and Baltistan.

This chapter presents findings about current levels of knowledge (general and specific) on AIDS related issues, such as the proportion who have ever heard about AIDS, methods of preventing AIDS, misconceptions about AIDS, and knowledge of other AIDS-related issues.

12.1 Knowledge of AIDS

To collect information about the level of HIV/AIDS knowledge, GBDHS respondents were asked a general question about whether they have ever heard about the AIDS illness. All those who responded in the affirmative were asked additional questions about various ways to spread and prevention of AIDS including whether it is possible to reduce the chance of getting the AIDS virus by using a condom at every sexual intercourse. To get an assessment of the level of possible misconceptions, respondents were also asked whether they think it is possible a person can get AIDS from mosquito bites, sharing food with a person who has AIDS, or through witchcraft or supernatural means.

Figure 12.1 and Table 12.1 shows the percentage of ever-married women who have heard of AIDS by background characteristics. In Gilgit and Baltistan, every eighth woman (12.9 percent) reported that they have heard of AIDS. Knowledge of AIDS varies considerably by background characteristics.

Figure 12.1: Percentage of Ever-married women who have heard about AIDS by Background Characteristics

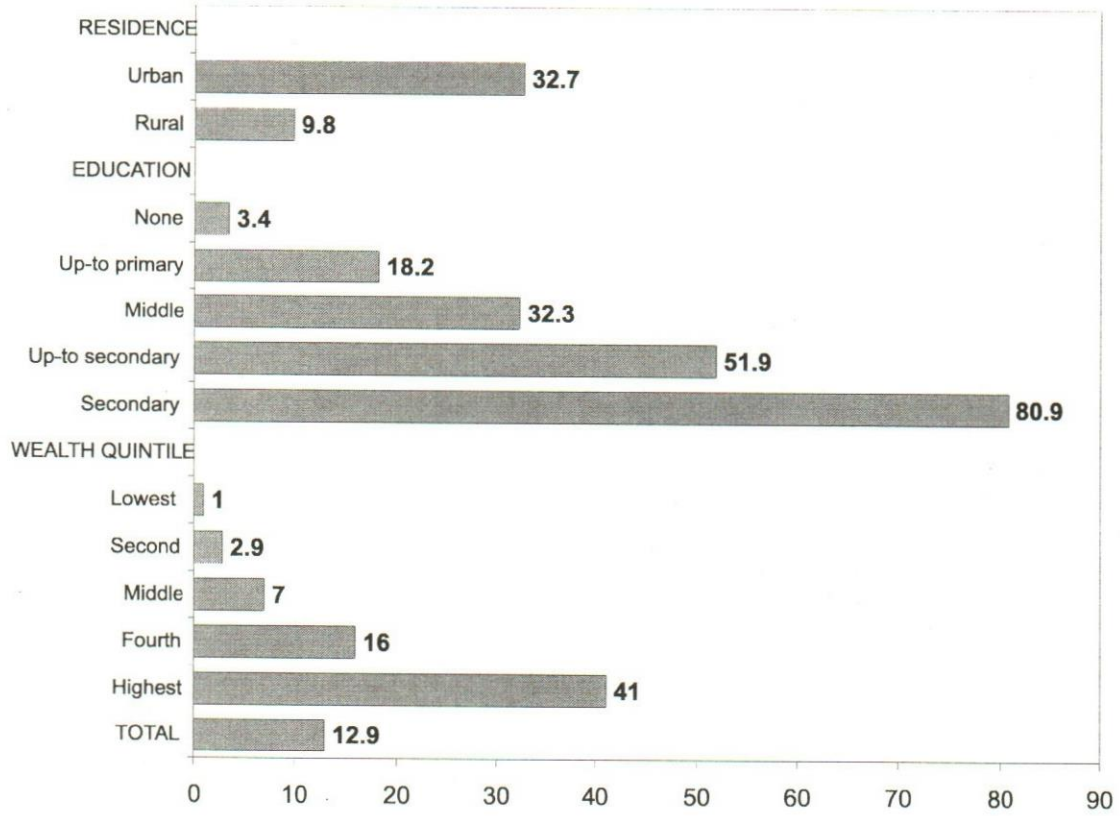

Table 12.1: Knowledge of AIDS

Percentage of ever-married women age 15-49 who have heard of AIDS by background characteristics, GBDHS-2008

Background Characteristics	Has heard of AIDS	Number of women
Age		
<25	14.4	285
25-34	15.2	469
35 +	9.6	442
Residence		
Urban	32.7	164
Rural	9.8	1033
Level of education		
None	3.4	916
Up-to primary	18.2	74
Middle	32.3	70
Secondary	51.9	80
Higher	80.9	57
Wealth quintile		
Lowest	1.0	216
Second	2.9	266
Middle	7.0	253
Fourth	16.0	250
Highest	41.0	212
Total 15-49	**12.9**	**1197**

The level of awareness of AIDS is relatively higher (15 percent) among women age 25-34 (15 percent), while ever-married women age >35 years, have the lowest level of awareness (10 percent) about AIDS. One in ten, respondents living in rural areas have heard about AIDS. Whereas, one-third of all urban respondents have heard about AIDS.

Education and wealth quintile are strongly associated with AIDS awareness. More than 80 percent of women, with more than secondary education, have heard about AIDS as compared to only three percent women with no education. In the highest wealth quintile two in 5 women (41 percent) have heard about the AIDS. In contrast, from among the women living in the poorest households, just one percent have heard about the AIDS illness.

12.2 Knowledge of ways to prevent HIV/AIDS

To ascertain the knowledge about prevention of HIV/AIDS, respondents were asked specific question about whether it is possible to reduce the chances of getting the AIDS virus by using a condom at every sexual encounter. Only two percent of women age 15-49 years replied in affirmative. This shows ineffectiveness of the programme efforts in creating awareness about

prevention of HIV/AIDS virus in Gilgit and Baltistan. Among these two percent women younger ones were relatively more knowledgeable about prevention of AIDS virus by using condoms at every sexual encounter than women in older age groups. As expected urban women are more knowledgeable about specific method of prevention than their rural counterparts.

Table 12.2 Knowledge of HIV/AIDS prevention methods

Percentage of ever-married women age 15-49 who, in response to prompted questions, say that people can reduce the risk of getting the AIDS virus by using condoms every time they have sexual intercourse, by background characteristics, GBDHS-2008

Background Characteristics	Percentage who say HIV can be prevented by	
	Using Condom	Number of women
Age		
<25	2.2	285
25-34	1.8	569
35 +	1.4	442
Residence		
Urban	3.4	164
Rural	1.5	1033
Level of education		
None	0.5	916
Up-to primary	3.8	74
Middle	5.7	70
Secondary	8.3	80
Higher	5.0	57
Wealth quintile		
Lowest	0.0	216
Second	0.4	266
Middle	1.2	253
Fourth	3.8	250
Highest	3.6	212
Total 15-49	1.8	1197

AIDS awareness is found to be increasing with women's education upto secondary level. Similarly, by wealth quintile, AIDS awareness also exhibited an increasing trend upto fourth quintile.

12.3 Comprehensive knowledge of HIV/AIDS transmission

The 2008 GBDHS also includes questions to assess the prevalence of common misconceptions about AIDS and HIV transmission. Respondents were asked whether they think it is possible that a person can get HIV/AIDS from mosquito bites, by supernatural means like witchcraft, or by sharing food with a person who has AIDS.

The data presented in Tables 12.3 indicate that most of women age 15-49, lack accurate knowledge about the ways in which the AIDS virus can and cannot be transmitted. Only six percent of women know that AIDS cannot be transmitted by mosquito bites. Two percent correctly believe that a person cannot get the AIDS virus by supernatural means. Four percent women correctly believe that a person cannot become infected by sharing food with a person who has AIDS. By background characteristics, women in age group 25-34; those living in urban areas; the ones with higher education and; the women living in the richest households are more likely to have correct knowledge about transmissions of HIV/AIDS virus.

Table 12.3 also provides an assessment of the level of comprehensive knowledge of HIV/AIDS prevention and transmission. Comprehensive knowledge of HIV/AIDS is comprised of the following information: (1) Knowing that using condom at every sexual contact is essential, and (2) Rejecting the two common local misconceptions - that HIV/AIDS can be transmitted through mosquito bites and by sharing food. Table 12.3 reveals that the percentage of ever-married women with comprehensive knowledge of AIDS is negligible (0.4 percent).

Table 12.3: Comprehensive knowledge about AIDS

Percentage of women age 15-49 who say that a healthy-looking person can have the AIDS virus and who, in response to prompted questions, correctly reject local misconceptions about AIDS transmission or prevention, and the percentage with a comprehensive knowledge about AIDS, by background characteristics, GBDHS-2008

Background Characteristics	Percentage of women who say that			Percentage with a comprehensive knowledge about AIDS	Do you know any person having AIDS or died from AIDS	Number of women
	AIDS cannot be transmitted by mosquito bite	A person cannot become infected by sharing food with a person who has AIDS	AIDS cannot be transmitted by supernatural means			
Age						
<25	4.1	2.9	3.2	0.0	0.4	285
25-34	7.7	4.8	3.0	0.9	1.8	469
35 +	4.3	3.4	0.9	0.1	0.5	442
Residence						
Urban	15.3	15.3	4.7	0.8	1.4	164
Rural	4.1	2.5	1.9	0.3	0.9	1033
Level of education						
None	1.2	0.9	0.8	0.2	0.1	916
Up-to primary	7.0	1.3	3.3	0.0	1.3	74
Middle	6.1	5.7	2.0	0.0	4.4	70
Secondary	24.7	11.2	11.1	2.0	1.0	80
Higher	45.8	41.3	13.2	2.6	9.6	57
Wealth quintile						
Lowest	0.6	0.0	0.0	0.0	0.6	216
Second	1.4	0.7	0.7	0.0	0.0	266
Middle	3.7	1.5	3.4	0.4	0.0	253
Fourth	4.8	3.8	2.9	0.6	1.7	250
Highest	19.0	14.4	4.6	1.0	2.9	212
Total 15-49	5.6	3.8	2.3	0.4	1.0	1197

12.4 Knowledge of mother-to-child transmission

An important route of transmission of HIV in the general population is mother-to-child transmission (MTCT). The government of Pakistan has recently launched a programme to reduce this route of transmission.

In 2008 GBDHS, women were asked whether they know that the AIDS virus can be transmitted from mother to child during pregnancy, during delivery, and through breastfeeding. The Table 12.4 indicates that 10 percent knows that HIV can be transmitted from mother to child during pregnancy (MTCT) and nine percent knows that the virus can be transmitted during delivery as well as by breastfeeding.

Knowledge of HIV transmission during pregnancy and through delivery and breastfeeding is positively associated with a woman's education. Six in ten women with higher educational level are aware of HIV transmission during pregnancy and through delivery, whereas, half of these women knew that the HIV virus can be transmitted from mother to child by breastfeeding. Similarly, awareness about transmission of HIV/AIDS through the three above stated routes increase with wealth quintile. Urban women are also more likely to know the transmission route than women living in rural areas. As expected olds women (age 35+) are less likely to know HIV/AIDS virus transmission route.

Table 12.4 Knowledge of prevention of mother-to-child transmission of HIV

Percentage of ever-married women who know that HIV can be transmitted from mother to child during pregnancy, at delivery, and by breastfeeding,, by background characteristics, GBDHS-2008

	Percentage of women who know that AIDS can be transmitted			Number of women
	During pregnancy	During delivery	By breastfeeding	
Age				
<25	11.4	10.5	12.1	285
25-34	11.3	11.3	10.8	469
35 +	6.9	6.0	5.9	442
Marital Status				
Married	10.0	9.5	9.6	1147
Divorced	1.9	1.9	2.7	50
Residence				
Urban	24.0	20.9	21.3	164
Rural	7.4	7.3	7.4	1033
Level of education				
None	2.7	2.2	2.4	916
Up-to primary	10.6	8.5	10.4	74
Middle	20.8	20.9	24.5	70
Secondary	41.7	41.7	44.4	80
Higher	61.8	60.8	50.3	27
Wealth quintile				
Lowest	0.5	0.5	1.0	216
Second	1.7	2.0	2.6	266
Middle	5.5	4.7	5.6	253
Fourth	10.7	10.5	11.2	250
Highest	32.9	30.7	28.3	212
Total 15-49	9.7	9.1	9.1	1197

12.5 Knowledge of tuberculosis

The 2008 GBDHS collected data on women's knowledge and attitudes concerning tuberculosis (TB). The respondents were asked "Have you ever heard of an illness called tuberculosis". All those who had the knowledge about TB were asked additional questions like whether or not they know that TB spread through air by coughing, and that TB can be

cured, and the last question was that has she ever been told by a doctor or nurse that she has TB.

Figure 12.2 and Table 12.5 show that seventy two percent of ever-married women in Gilgit and Baltistan have heard about TB. By background characteristics, women who live in rural areas, those who have higher education and, the ones belonging to the highest wealth quintile are most likely to have heard about TB than their counterparts in other categories.

Figure 12.2: Percentage of Ever-married women who have heard about TB by Background Characteristics

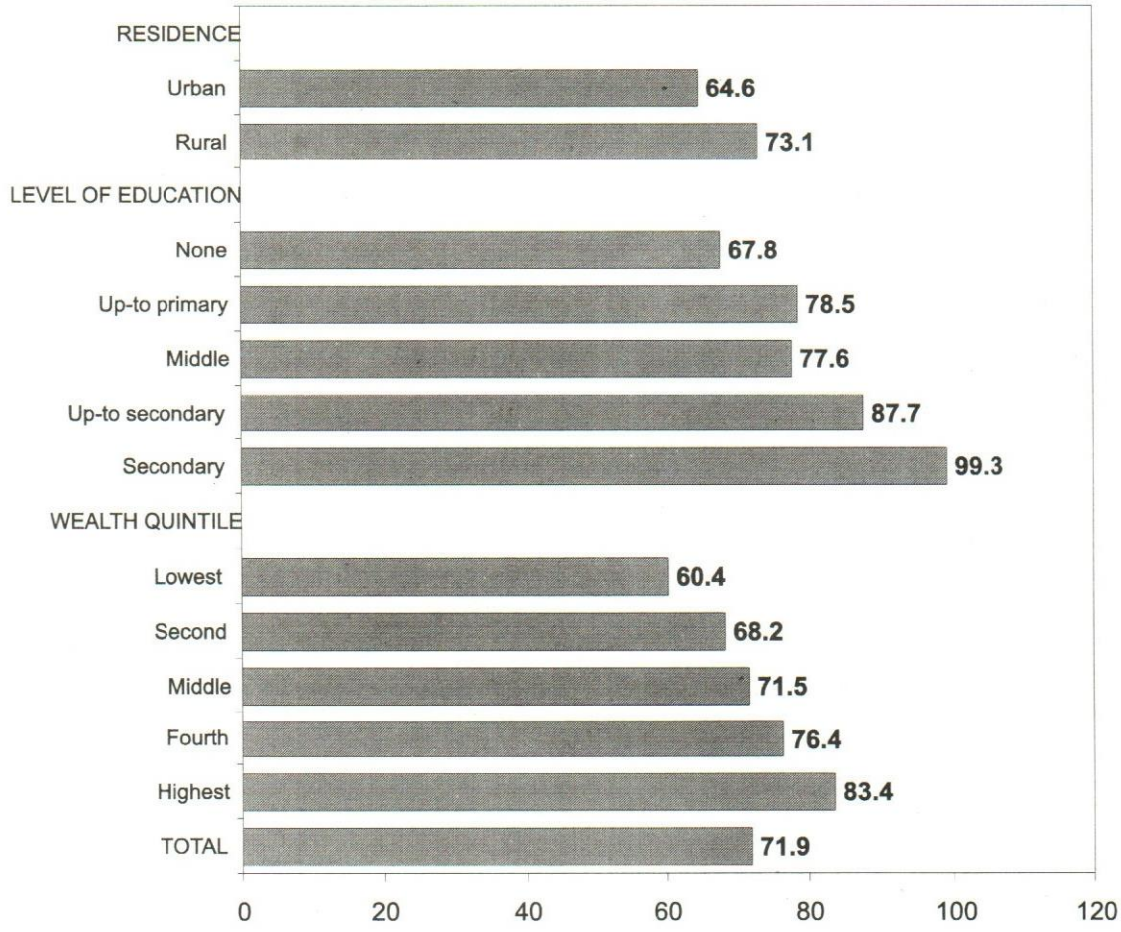

Table 12.5: Knowledge of tuberculosis

Percentage of ever-married women age 15-49 who have heard of tuberculoses by background characteristics, GBDHS-2008

Background Characteristics	Has heard of TB	Number of women
Age		
<25	70.4	285
25-34	74.0	469
35 +	70.7	442
Residence		
Urban	64.6	164
Rural	73.1	1033
Level of education		
None	67.8	916
Up-to primary	78.5	74
Middle	77.6	70
Secondary	87.7	80
Higher	99.3	57
Wealth quintile		
Lowest	60.4	216
Second	68.2	266
Middle	71.5	253
Fourth	76.4	250
Highest	83.4	212
Total 15-49	**71.9**	**1197**

12.6 Comprehensive knowledge of tuberculosis transmission

The table 12.6 elaborates comprehensive knowledge about TB. It shows that 9 percent of ever-married women reported that TB can be transmitted through sexual contact. Almost half of women (48 percent) also reported TB can spread through air when coughing and sneezing. Over half (54 percent) ever-married women reported that TB can spread by sharing food with person who is suffering form TB illness. Interestingly, the misconception is highest among urban women, those with higher education and the ones living in households belonging to highest wealth quintile. Table also depicts the misconception about the spread of TB disease. Only three percent of ever-married women have the misconception that TB can be transmitted by mosquito bites.

Moreover, two-third ever-married women (66 percent) know that TB is curable. The Table 12.6 shows that a negligible proportion of ever-married women age 15-49 have accurate

knowledge that the TB cannot be transmitted by mosquito bites and have no other misconceptions (1.1 percent).

Table 12.6: Comprehensive knowledge about tuberculoses

Among women age 15-49 who have heard of tuberculoses the percentage who know that TB spread through the air by coughing, who believed that TB can be cured, and the percentage with a comprehensive knowledge about TB, by background characteristics, GBDHS-2008

Background Characteristics	Percentage with a comprehensive knowledge about TB	Percentage who say that a person can become infected				TB can be cured	Number of women
		Through air when coughing and sneezing	A person can become infected by sharing food with a person who has TB	Through sexual contact	Through mosquito bites		
Age							
<25	2.2	46.4	49.0	9.4	3.6	66.3	285
25-34	0.1	49.5	58.8	10.1	2.3	68.4	469
35 +	1.2	47.2	53.2	8.6	3.7	64.5	442
Residence							
Urban	0.3	43.9	54.3	11.7	9.8	62.6	164
Rural	1.3	48.6	54.4	9.0	2.1	67.1	1033
Level of education							
None	1.3	42.3	48.6	7.7	2.4	62.1	916
Up-to primary	0.0	59.3	65.6	18.8	2.2	75.5	74
Middle	1.2	56.9	62.9	10.8	5.8	74.9	70
Secondary	0.7	71.5	75.2	17.5	6.6	82.7	80
Higher	0.0	79.2	93.2	10.9	7.5	90.6	57
Wealth quintile							
Lowest	2.1	35.2	37.5	4.8	0.6	57.2	216
Second	1.3	41.6	50.5	10.4	2.8	62.3	266
Middle	1.0	45.8	53.0	6.4	3.0	64.0	253
Fourth	1.2	51.8	57.3	9.4	2.2	72.2	250
Highest	0.0	66.8	74.8	16.2	7.3	77.1	212
Total 15-49	1.1	47.9	54.4	9.4	3.1	66.4	1197

References:

1. UNAIDS, 2008

Annexure

Annuxure-1

List of indicators

- **Fertility and reproduction**
  - age-specific and total fertility rates;
  - fertility preferences (percent who want no more, ideal number of children);
  - level of unwanted and mistimed births;
- **Family Planning**
  - knowledge of contraceptive methods, contraceptive prevalence rate;
  - reasons for non-use;
  - unmet need for family planning services;
  - exposure to family planning messages in the media;
  - median age at first marriage and first birth;
- **Mother and Child Health**
  - prenatal, delivery and postnatal care;
  - child vaccination;
  - child mortality
- **Knowledge about Health Issues (TB, HIV/AIDS)**
  - awareness of HIV mode of transmission;
  - knowledge of tuberculosis and means of transmission;
- **Others**
  - Housing structure;
  - source of household drinking water and type of toilet facility;
  - Possession of durable items by the household members; and etc.
  - Measurement of Household socio-economic status (wealth index).

Annuxure-2

List of Project Staff

S.No.	Name/ designation	
Core Staff		
1.	Dr. Sajid Ahmad	Executive Director
2.	Mr. Iqbal Ahmad	Project Director/ Director (HRD
3.	Mr. Amanullah Bhatti	Director (R&S)/ Secretary (F&M)
4.	Mr. Zafar Zahir	Principal Investigator/ Associate Fellow
5.	Mr. Ali Anwar Buriro	Deputy Principal Investigator/ Associate Fellow
6.	Mr. Faateh ud din Ahmad	Computer Programmer
7.	Mr. Hafeez Khokar	Account Office (NIPS)
8.	Mr. Badar ud din Tanweer	Field Coordinator
Data Entry Operators		
1.	Muhammad Ismail	
2	Takasar Amin	
3	Dilnawaz	
Field Staff		
Team 1:		Gilgit
1	Munir Ahmad	Supervisor
2	Memoona	Interviewer
3	Shahina Bano	Interviewer
4	Chera Pari	Interviewer
Team 2:		Skardu
5	Ashraf Hussain	Supervisor
6	Shakila Batool	Interviewer
7	Nazira	Interviewer
8	Shahida Batool	Interviewer
Team 3:		Diamer/ Astore
9	Munir Ahmad	Supervisor
10	Adeeba Batool	
11	Shabana Begum	Interviewer
12	Rehana Begum	

Team 4:		Ghizer
13	Sher Bahadar Khan	Supervisor
14	Almeen Sajjad	Interviewer
15	Naheeda Bibi	Interviewer
16	Amar Begum	Interviewer
Team 5:		Ghanchi
17	Khalid ur Rehman	Supervisor
18	Sumaira Sulaiman	Interviewer
19	Fiza Bano	Interviewer
20	Bano Abbas	Interviewer
Team 6:		Hunza/Nagar
21	Ehsan Ali	Supervisor
22	Yasmeen	Interviewer
23	Tasleem	Interviewer
24	Hasina Bano	Interviewer

Annexure-3

Questionnaires

NATIONAL INSTITUTE OF POPULATION STUDIES

NORTHERN AREAS DEMOGRAPHIC AND HEALTH SURVEY 2008

HOUSEHOLD QUESTIONNAIRE

IDENTIFICATION

DISTRICT (GILGIT=1; BALTISTAN=2; DIAMIR=3; GHIZER=4; GHANCHE=5; ASTOR=6; HUNZA/NAGAR=7)	.....
AREA (URBAN=1; RURAL=2)	.....
TEHSIL _____	.....
CLUSTER NUMBER	.....
HOUSEHOLD NUMBER	.....
NAME OF HOUSEHOLD HEAD _____	

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY / MONTH / YEAR (2 0 0 8)
INTERVIEWER'S NAME	_____	_____	_____	INT. NUMBER
RESULT*	_____	_____	_____	RESULT
NEXT VISIT: DATE TIME	_____ _____	_____ _____		TOTAL NUMBER OF VISITS

*RESULT CODES:

1 COMPLETED
2 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME
3 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME
4 POSTPONED
5 REFUSED
6 DWELLING VACANT OR ADDRESS NOT A DWELLING
7 DWELLING DESTROYED
8 DWELLING NOT FOUND
9 OTHER _____ (SPECIFY)

TOTAL PERSONS IN HOUSEHOLD

TOTAL ELIGIBLE WOMEN

LINE NO. OF RESPONDENT

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME _____	NAME _____		
DATE _____	DATE _____		

السلام علیکم!

میرا نام ---------- ہے۔ اور میں (NIPS, Islamabad) میں کام کرتی ہوں۔ ہم صحت کے مختلف مسائل سے متعلق نادرن ایریا میں سروے کر رہے ہیں۔ اگر آپ اِس سروے میں شریک ہو کر ہماری مدد کریں گے تو ہم آپ کے بڑے شکر گزار ہوں گے۔ اِس سروے میں سب سے پہلے ہم آپ کے کنبے کے بارے میں چند ایک سوال پوچھتے ہیں۔ ہم آپ کو یقین دلاتے ہیں کہ آپ کے جوابات صیغۂ راز میں رہیں گے۔ اِس سروے میں آپ کی شرکت کلی طور پر رضا کارانہ ہے۔ اگر آپ کسی سوال کا جواب نہیں دینا چاہتے تو آپ مجھے بتا دیں، میں آپ سے اگلا سوال پوچھ لوں گی۔ آپ یہ انٹرویو کسی وقت بھی ختم کر سکتی ہیں لیکن ہم اُمید کرتے ہیں کہ آپ اِس سروے میں شریک ہوں گے کیونکہ آپ کے خیالات اِس وقت ہمارے لیے بڑی اہمیت کے حامل ہیں۔ اَب کیا آپ اِس سروے کے بارے میں مجھ سے کچھ پوچھنا پسند کریں گی؟ کیا میں اَب آپ کا انٹرویو لینا شروع کروں؟

Signature of interviewer: _____ Date: تاریخ _____

RESPONDENT AGREES TO BE INTERVIEWED ..... 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED .... 2→ END

HOUSEHOLD SCHEDULE

Now we would like some information about the people who usually live in your household.

اَب ہم آپ سے اُن لوگوں کے بارے میں معلومات لینا چاہیں گے جو عام طور پر آپ کے گھرانے میں رہتے ہیں

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	AGE	AGE 12 OR OLDER	IF AGE 5 YEARS OR OLDER			ELIGIBILITY
						EDUCATION			
	Please give me the names of the persons who usually live in your household, starting with the head of the household. برائے مہربانی آپ مجھے ان افراد کے نام بتائیں جو عام طور پر آپ کے گھرانے میں رہتے ہیں گھرانے کے سربراہ سے شروع کریں۔ AFTER LISTING NAMES, RELATIONSHIP AND SEX FOR EACH PERSON, ASK Qs. 2A-2B TO BE SURE THAT THE LISTING IS COMPLETE. THEN ASK QUESTIONS IN COLUMNS 5-9 FOR EACH PERSON.	What is the relationship of (NAME) to the head of the household? گھرانے کے سربراہ سے (نام) کا کیا رشتہ ہے؟ (SEE CODES) (BELOW)	Is (NAME) male or female? (نام) مرد ہے یا عورت ہے؟	How old is (NAME)? (نام) کی کیا عمر ہے؟ IF LESS THAN 1 YEAR, WRITE '00'. IF AGE 96 YEARS OR MORE, WRITE '96'.	MARITAL STATUS What is (NAME'S) current marital status? (نام) کی موجودہ ازدواجی حیثیت کیا ہے؟ (SEE CODES) (BELOW)	Has (NAME) ever attended school? کیا (نام) نے کبھی سکول میں پڑھا ہے/تھا؟	What is the highest class of school (NAME) completed? (نام) نے آخری جماعت کون سی پاس کی؟ (SEE CODES) BELOW)	IF AGE LESS THAN 25 YRS Is (NAME) still in school?	CIRCLE LINE NUMBER OF ALL **WOMEN** AGE 15-49 WHO ARE MARRIED, WIDOWED OR DIVORCED OR SEPARATED
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
			M F	IN YEARS	M W D/S N	YES NO	CLASS	YES NO	
01			1 2		1 2 3 4	1 2 → GO TO 10		1 2	01
02			1 2		1 2 3 4	1 2 → GO TO 10		1 2	02
03			1 2		1 2 3 4	1 2 → GO TO 10		1 2	03
04			1 2		1 2 3 4	1 2 → GO TO 10		1 2	04
05			1 2		1 2 3 4	1 2 → GO TO 10		1 2	05
06			1 2		1 2 3 4	1 2 → GO TO 10		1 2	06
07			1 2		1 2 3 4	1 2 → GO TO 10		1 2	07
08			1 2		1 2 3 4	1 2 → GO TO 10		1 2	08
09			1 2		1 2 3 4	1 2 → GO TO 10		1 2	09
10			1 2		1 2 3 4	1 2 → GO TO 10		1 2	10

CODES FOR Q. 3
RELATIONSHIP TO HEAD OF HOUSEHOLD:
01 = HEAD
02 = WIFE OR HUSBAND
03 = SON OR DAUGHTER
04 = SON-IN-LAW OR DAUGHTER-IN-LAW
05 = GRANDCHILD
06 = PARENT
07 = PARENT-IN-LAW
08 = BROTHER OR SISTER
09 =BROTHER/SISTER IN LAW
10 = NIECE/NEPHEW
11 = GRAND PARENTS
12 =AUNTS/UNCLE
13 = OTHER RELATIVE
14 = ADOPTED/FOSTER/STEPCHILD
15 = NOT RELATED
16= DOMESTIC SERVANT
98 = DON'T KNOW

CODES FOR Q. 6
MARITAL STATUS
1 = MARRIED
2 = WIDOWED
3 = DIVORCED/SEPARATED
4 = NEVER MARRIED

CODES FOR Q. 8
EDUCATION CLASS:
00 = LESS THAN 1 YEAR COMPLETED
01 = CLASS 1;
02 = CLASS 2
. . .
10 = MATRIC, CLASS 10
11 = CLASS 11
. . . .
16 = MASTER'S DEGREE OR MBBS, PhD, MPHIL, BSc (4 YEARS)
98 = DON'T KNOW

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	AGE	AGE 12 OR OLDER	IF AGE 5 YEARS OR OLDER			ELIGIBILITY
						EDUCATION			
	Please give me the names of the persons who usually live in your household, starting with the head of the household. برائے مہربانی آپ مجھے ان افراد کے نام بتائیں جو عام طور پر آپ کے گھرانے میں رہتے ہیں گھرانے کے سربراہ سے شروع کریں۔ AFTER LISTING NAMES, RELATIONSHIP AND SEX FOR EACH PERSON, ASK Qs. 2A-2B TO BE SURE THAT THE LISTING IS COMPLETE. THEN ASK QUESTIONS IN COLUMNS 5-9 FOR EACH PERSON.	What is the relationship of (NAME) to the head of the household? گھرانے کے سربراہ سے (نام) کا کیا رشتہ ہے؟ **(SEE CODES) (BELOW)**	Is (NAME) male or female? (نام) مرد ہے یا عورت ہے؟	How old is (NAME)? (نام) کی کیا عمر ہے؟ IF LESS THAN 1 YEAR, WRITE '00'. IF AGE 96 YEARS OR MORE, WRITE '96'.	MARITAL STATUS What is (NAME'S) current marital status? (نام) کی موجودہ ازدواجی حیثیت کیا ہے؟ **(SEE CODES) (BELOW)**	Has (NAME) ever attended school? کیا (نام) نے کبھی سکول میں پڑھا ہے/تھا؟	What is the highest class of school (NAME) completed? (نام) نے آخری جماعت کون سی پاس کی؟ **(SEE CODES) BELOW)**	IF AGE LESS THAN 25 YRS Is (NAME) still in school?	CIRCLE LINE NUMBER OF ALL **WOMEN** AGE 15-49 WHO ARE MARRIED, WIDOWED OR DIVORCED OR SEPARATED
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
11			M F 1 2	IN YEARS	M W D/S N 1 2 3 4	YES NO 1 2 GO TO 10	CLASS	YES NO 1 2	11
12			1 2		1 2 3 4	1 2 GO TO 10		1 2	12
13			1 2		1 2 3 4	1 2 GO TO 10		1 2	13
14			1 2		1 2 3 4	1 2 GO TO 10		1 2	14
15			1 2		1 2 3 4	1 2 GO TO 10		1 2	15
16			1 2		1 2 3 4	1 2 GO TO 10		1 2	16
17			1 2		1 2 3 4	1 2 GO TO 10		1 2	17
18			1 2		1 2 3 4	1 2 GO TO 10		1 2	18
19			1 2		1 2 3 4	1 2 GO TO 10		1 2	19
20			1 2		1 2 3 4	1 2 GO TO 10		1 2	20

TICK HERE IF CONTINUATION SHEET USED ☐

Just to make sure that I have a complete household listing:

اس امر کا یقین کرلیں کہ میں نے گھرانے کا مکمل اندراج کرلیا ہے۔

2A) Are there any other persons such as small children or infants that we have not listed?

☐ NO

کیا ایسے دیگر افراد جیسے چھوٹے اور شیر خوار بچے ہیں جن کا ہم نے اندراج نہ کیا ہو؟

2B) Are there any other people who may not be members of your family, such as domestic servants, lodgers or friends who usually live here?

☐ NO

کیا ایسے دیگر لوگ ہیں جو آپ کے خاندان کے ارکان نہ ہوں جیسے گھریلو ملازم، کرایہ دار اور دوست احباب جو عام طور پر آپ کے پاس رہتے ہوں؟

IF NO MORE MEMBERS, GO TO 11

HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
11	What is the main source of drinking water for members of your household?	**PIPED WATER** PIPED INTO DWELLING ..... 01 PIPED TO YARD/PLOT ..... 02 PUBLIC TAP ..... 03 TUBE WELL OR BOREHOLE ..... 04 HAND PUMP ..... 05 **WELL IN RESIDENCE/YARD/PLOT** COVERED WELL ..... 06 UNCOVERED WELL ..... 07 **PUBLIC WELL** COVERED WELL ..... 08 UNCOVERED WELL ..... 09 **SURFACE WATER** SPRING ..... 10 RIVER/STREAM ..... 11 POND/LAKE ..... 12 DAM ..... 13 RAIN WATER ..... 14 **CART WITH SMALL TANK** ..... 15 **WATER TANKER TRUCK** ..... 16 **BOTTLED WATER** ..... 17 OTHER _____ 96 (SPECIFY)	→ 13
12	How long does it take to go there, get water, and come back? وہاں تک جانے، پانی لینے اور واپس آنے میں کتنا وقت لگتا ہے؟	MINUTES ..... [ ][ ][ ] ON PREMISES ..... 995 DON'T KNOW 998	
13	How many rooms in this household are used for sleeping? اس گھرانے میں سونے	TOTAL ROOMS ..... [ ][ ] USED FOR SLEEPING ..... [ ][ ]	
14	What kind of toilet facility do members of your household usually use? آپ کے کنبے کے افراد عام طور پر رفع حاجت/پاخانے کے لیے کس قسم کی سہولت کا استعمال کرتے ہیں؟	**FLUSH OR POUR FLUSH TOILET** FLUSH TO SEWER SYSTEM ... 01 FLUSH TO SEPTIC TANK ..... 02 FLUSH TO SOMEWHERE ELSE ... 03 FLUSH, DON'T KNOW WHERE ... 04 **PIT LATRINE** VENTILATED IMPROVED PIT LATRINE (VIP) ..... 05 PIT LATRINE WITH SLAB ..... 06 PIT LATRINE WITHOUT SLAB/ OPEN PIT ..... 07 BUCKET TOILET ..... 08 NO FACILITY/BUSH/FIELD ..... 09 OTHER _____ 96 (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
15	Does your household have: کیا آپ کے گھر میں یہ چیزیں موجود ہیں؟	YES NO	
	Electricity? بجلی	ELECTRICITY 1 2	
	Radio? ریڈیو	RADIO 1 2	
	Television? ٹیلی ویژن	TELEVISION 1 2	
	Refrigerator? ریفریجریٹر	REFRIGERATOR 1 2	
	Mobile telephone or land line telephone? موبائل فون یا لائن فون	ANY TELEPHONE 1 2	
	Room cooler, air conditioner? روم کولر ایئر کنڈیشنر	ROOM COOLER, AIR COND. . 1 2	
	Washing machine? واشنگ مشین	WASHING MACHINE 1 2	
	Water pump? واٹر پمپ	WATER PUMP 1 2	
	Bed? پلنگ	BED 1 2	
	Chairs? کرسیاں	CHAIRS 1 2	
	Almirah / cabinet? الماری	ALMIRAH/CABINET 1 2	
	Clock? گھڑی	CLOCK 1 2	
	Sofa? صوفہ	SOFA 1 2	
	Sewing machine? سلائی مشین	SEWING MACHINE 1 2	
	Camera? کیمرہ	CAMERA 1 2	
	Personal computer? کمپیوٹر	PERSONAL COMPUTER ... 1 2	
16	Does any member of this household own: کیا گھرانے کے کسی فرد کے پاس یہ چیزیں ہیں؟	YES NO	
	A watch? گھڑی	WATCH 1 2	
	A bicycle? سائیکل	BICYCLE 1 2	
	A motorcycle or motor scooter? موٹر سائیکل یا سکوٹر	MOTORCYCLE/SCOOTER ... 1 2	
	An animal-drawn cart? ریڑھا یا چھکڑا جسے کوئی جانور چلائے	ANIMAL-DRAWN CART 1 2	
	A car or truck or Tractor? کار یا ٹرک یا ٹریکٹر	CAR/TRUCK 1 2	
17	Is this house rented, rent-free, mortgaged, or or owned by a member of the household? کیا یہ گھر کرائے کا ہے، بغیر کرائے کا ہے، رہن رکھا گیا ہے یا گھرانے کے کسی فرد کی ملکیت ہے؟	RENTED ..... 1 RENT-FREE ..... 2 MORTGAGED ..... 3 OWNED ..... 4 OTHER 6	
18	Main source of energy for cooking? آپ کا گھرانہ کھانا پکانے کے لیے زیادہ تر کون سا ایندھن استعمال کرتا ہے؟	ELECTRICITY ..... 01 CYLINDER GAS ..... 02 BIOGAS ..... 03 KEROSENE ..... 04 WOOD ..... 05 STRAW/SHRUBS/GRASS ..... 06 COW DUNG ..... 07 OTHER _____ 96 (SPECIFY)	
19	HOUSING STRUCTURE: **[RECORD OBSERVATION]**	KATCHA ..... 1 SEMI-PACCA ..... 2 PACCA ..... 3 FLAT ..... 4 CONSTRUCTED HOUSE/BUNGALOW 5 OTHER _____ 6 (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
20	MAIN MATERIAL OF THE ROOF: چھت کا خاص میٹریل کیا ہے؟ **RECORD OBSERVATION**	**NATURAL ROOFING** THATCH / BAMBOO / WOOD /MUD 1 **RUDIMENTARY ROOFING** CARDBOARD / PLASTIC ..... 2 **FINISHED ROOFING** IRON SHEETS / ASBESTOS ... 3 T-IRON / WOOD / BRICK ..... 4 REINFORCED BRICK CEMENT/RCC 5 OTHER _____ 6 (SPECIFY)	
21	MAIN MATERIAL OF THE WALLS: دیواروں کا خاص میٹریل کیا ہے؟ **RECORD OBSERVATION**	**NATURAL WALLS** MUD / STONES ..... 01 BAMBOO / STICKS / MUD ..... 02 **RUDIMENTARY WALLS** UNBAKED BRICKS / MUD ..... 03 PLYWOOD SHEETS ..... 04 CARTON / PLASTIC ..... 05 **FINISHED WALLS** STONE BLOCKS ..... 06 BAKED BRICKS ..... 07 CEMENT BLOCKS/ CEMENT ... 08 TENT/ CLOTH ..... 09 OTHER _____ 96 (SPECIFY)	

NATIONAL INSTITUTE OF POPULATION STUDIES

NORTHERN AREAS DEMOGRAPHIC AND HEALTH SURVEY 2008

EVER-MARRIED WOMAN'S QUESTIONNAIRE

IDENTIFICATION

DISTRICT (GILGIT=1; BALTISTAN=2; DIAMIR=3; GHIZER=4; GHANCHE=5 ASTOR=6; HUNZA/NAGAR=7)	.....
AREA (URBAN=1; RURAL=2)	.....
TEHSIL _____	.....
CLUSTER NUMBER	.....
HOUSEHOLD NUMBER	.....
NAME OF HOUSEHOLD HEAD _____	
NAME AND LINE NUMBER OF WOMAN _____	.....

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY / MONTH / YEAR (2008)
INTERVIEWER'S NAME	_____	_____	_____	INT. NUMBER
RESULT*	_____	_____	_____	RESULT
NEXT VISIT: DATE / TIME	_____ / _____	_____ / _____		TOTAL NUMBER OF VISITS

*RESULT CODES:

1	COMPLETED	4	REFUSED		
2	NOT AT HOME	5	PARTLY COMPLETED	7	OTHER _____ (SPECIFY)
3	POSTPONED	6	INCAPACITATED		

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY
NAME _____	NAME _____		
DATE _____	DATE _____		

تعارف اور رائے السلام علیکم!

میرا نام ---------- ہے۔ اور میں (NIPS, Islamabad) میں کام کرتی ہوں۔ ہم صحت کے مختلف مسائل سے متعلق نادرن ایریا میں سروے کر رہے ہیں۔ اگر آپ اِس سروے میں شریک ہو کر ہماری مدد کریں گے تو ہم آپ کے بڑے شکر گزار ہوں گے۔ اِس سروے میں سب سے پہلے ہم آپ کے کنبے کے بارے میں چند ایک سوال پوچھتے ہیں۔ ہم آپ کو یقین دلاتے ہیں کہ آپ کے جوابات صیغۂ راز میں رہیں گے۔ اِس سروے میں آپ کی شرکت کلی طور پر رضا کارانہ ہے۔ اگر آپ کسی سوال کا جواب نہیں دینا چاہتے تو آپ مجھے بتا دیں، میں آپ سے اگلا سوال پوچھ لوں گی۔ آپ یہ انٹرویو کسی وقت بھی ختم کر سکتی ہیں لیکن ہم اُمید کرتے ہیں کہ آپ اِس سروے میں شریک ہوں گے کیونکہ آپ کے خیالات اِس وقت ہمارے لیے بڑی اہمیت کے حامل ہیں۔ اَب کیا آپ اِس سروے کے بارے میں مجھ سے کچھ پوچھنا پسند کریں گی؟ کیا میں اَب آپ کا انٹرویو لینا شروع کروں؟

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED ..... 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED .... 2 → END

SECTION 1. RESPONDENT'S BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	**RECORD THE TIME.**	HOUR ..... [ ][ ] MINUTES ..... [ ][ ]	
102	In what month and year were you born? آپ کس مہینے اور سال میں پیدا ہوئیں؟	MONTH ..... [ ][ ] DON'T KNOW MONTH ..... 98 YEAR ..... [ ][ ][ ][ ] DON'T KNOW YEAR 9998	
103	How old are you? آپ کی عمر کیا ہے؟ **COMPARE AND CORRECT 102 AND/OR 103 IF INCONSISTENT**	AGE IN COMPLETED YEARS [ ][ ]	
104	What is your current marital status? Are you married, Godforbid widowed, divorced, or separated? آپ کی موجودہ ازدواجی حیثیت کیا ہے؟ کیا آپ شادی شدہ خدانخواستہ بیوہ، طلاق یافتہ یا آپ کی علیحدگی تو نہیں ہو چکی؟	MARRIED ..... 1 WIDOWED ..... 2 DIVORCED ..... 3 SEPARATED ..... 4 NEVER MARRIED 5	→ 106 → END
105	Is your husband usually living with you now or is he staying elsewhere? کیا آج کل آپ کے شوہر آپ کے ساتھ رہتے ہیں یا وہ کہیں اور رہ رہے ہیں؟	LIVING WITH HER ..... 1 STAYING ELSEWHERE 2	
106	Is/was there a blood relationship between you and your husband? کیا آپ اور آپ کے شوہر کے درمیان خون کا کوئی رشتہ ہے/تھا؟	YES ..... 1 NO 2	→ 108
107	What type of relationship (is/was) it? وہ کیا رشتہ ہے/تھا؟	FIRST COUSIN ON FATHER'S SIDE . 1 FIRST COUSIN ON MOTHER'S SIDE . 2 SECOND COUSIN ..... 3 OTHER RELATIONSHIP 6	
108	In what month and year did you start living with your husband? آپ نے اپنے شوہر کے ساتھ کس مہینے اور سال سے رہنا شروع کیا	MONTH ..... [ ][ ] DON'T KNOW MONTH ..... 98 YEAR ..... [ ][ ][ ][ ] DON'T KNOW YEAR 9998	→ 110
109	How old were you when you first started living with him? جب آپ نے اس کے ساتھ رہنا شروع کیا تھا تو آپ کی عمر کیا تھی؟	AGE ..... [ ][ ]	
110	Have you ever attended school? کیا آپ نے کبھی سکول میں پڑھا ہے؟	YES ..... 1 NO 2	→ 113
111	What is the highest class you passed ? آپ نے آخری کون سی جماعت پاس کی ہے؟ **WRITE '00' IF LESS THAN CLASS ONE;** **WRITE '16' = IF MA, MPHIL, PHD, MBBS, BSC/4YEARS**	CLASS ..... [ ][ ]	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
112	**CHECK 111** CLASS 00 - 08 ↓ CLASS 09 OR HIGHER → 114		
113	Can you read and write a simple letter with understanding? کیا آپ ایک سادہ خط، سمجھ بوجھ کے ساتھ پڑھ اور لکھ سکتی ہیں؟	YES ..... 1 NO 2	
114	How old is/was your husband? آپ کے شوہر کی کتنی عمر ہے؟	AGE IN COMPLETED YEARS ☐☐	
115	Did your (last) husband ever attend school? کیا آپ کے (پچھلے) شوہر نے کبھی سکول میں تعلیم حاصل کی تھی؟	YES ..... 1 NO ..... 2 → 118	
116	What was the highest class he passed? انھوں نے آخری کون سی جماعت پاس کی تھی؟ **WRITE '00' IF LESS THAN CLASS ONE;** **WRITE '16' = IF MA,MPHIL,PHD, MBBS, BSC(4 YEARS)**	CLASS ..... ☐☐ DON'T KNOW 98	
117	**CHECK 116** CLASS 00 - 08 ↓ CLASS 09 OR HIGHER → 119		
118	Can (could) <u>your husband</u> read and write a simple letter with understanding? کیا آپکے شوہر پوری سمجھ بوجھ کے ساتھ ایک سادہ خط پڑھ اور لکھ سکتے ہیں؟	YES ..... 1 NO 2	
119	How often do you listen to radio in a week? آپ ہفتہ میں کتنے دن ریڈیو سنتی ہیں؟	DAILY ..... 1 ATLEAST ONCE A WEEK ..... 2 ONCE IN A WHILE ..... 3 NEVER 4	
120	How often do you watch television in a week? آپ ہفتہ میں کتنے دن ٹی وی دیکھتی ہیں؟	DAILY ..... 1 ATLEAST ONCE A WEEK ..... 2 ONCE IN A WHILE ..... 3 NEVER 4	
121	What is your mother tongue? آپ کی مادری زبان کیا ہے؟	URDU ..... 01 PUNJABI ..... 02 PUSHTO ..... 03 SINDHI ..... 04 HINDKO ..... 05 ENGLISH ..... 06 KASHMIR ..... 07 SHINA ..... 08 BRUSHASKI ..... 09 WAKHI ..... 10 KHWAR ..... 11 BALTI ..... 12 PAHARI ..... 13 OTHER _____ 96	

SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	Now I would like to ask about all the births you have had during your life. Have you ever given live birth? اَب میں اُن تمام بچوں کے بارے میں پوچھنا چاہوں گی جن کو آپ نے اپنی تمام زندگی میں جنم دیا۔ کیا آپ نے کبھی کسی زندہ بچے کو جنم دیا ہے؟	YES ..... 1 NO ..... 2 → 206	
202	Do you have any sons or daughters to whom you have given birth who are now living with you? کیا آپ کے ایسے کوئی بیٹے اور بیٹیاں ہیں جن کو آپ نے جنم دیا ہو اور وہ اَب آپ کے ساتھ رہتے ہوں؟	YES ..... 1 NO ..... 2 → 204	
203	How many sons live with you? آپ کے ساتھ کتنے بیٹے رہتے ہیں؟ And how many daughters live with you? **IF NONE, RECORD '00'.** آپ کے ساتھ کتنی بیٹیاں رہتی ہیں؟	SONS AT HOME ..... ☐☐ DAUGHTERS AT HOME ..... ☐☐	
204	Do you have any sons or daughters to whom you have given birth who are alive but do not live with you? کیا آپ کے ایسے کوئی بیٹے اور بیٹیاں ہیں جن کو آپ نے جنم دیا ہو اور وہ حیات بھی ہوں لیکن آپ کے ساتھ نہ رہتے ہوں؟	YES ..... 1 NO ..... 2 → 206	
205	How many sons are alive but do not live with you? کتنے بیٹے حیات ہیں جو آپ کے ساتھ نہیں رہتے؟ And how many daughters are alive but do not live with you? **IF NONE, RECORD '00'.** کتنی بیٹیاں حیات ہیں جو آپ کے ساتھ نہیں رہتیں؟	SONS ELSEWHERE ..... ☐☐ DAUGHTERS ELSEWHERE . ☐☐	
206	Have you ever given birth to a boy or girl who was born alive but later died? کیا آپ نے کبھی ایسے لڑکے یا لڑکی کو جنم دیا ہے جو زندہ پیدا ہوا/ ہوئی لیکن بعد میں فوت ہو گیا/ ہو گئی ہو؟ **IF NO, PROBE:** Any baby who cried or showed signs of life but did not survive? کیا کوئی ایسا بچہ/ بچی جو پیدا ہونے کے بعد رویا/ روئی ہو یا زندگی کی کوئی علامت ظاہر کی ہو لیکن زندہ نہ بچ سکا/ سکی ہو؟	YES ..... 1 NO ..... 2 → 208	
207	How many boys have died? آپ کے کتنے لڑکے فوت ہوئے؟ And how many girls have died? اور کتنی لڑکیاں فوت ہوئیں؟ **IF NONE, RECORD '00'.**	BOYS DEAD ..... ☐☐ GIRLS DEAD ..... ☐☐	
208	SUM ANSWERS TO 203, 205, 207. **ENTER TOTAL. IF NONE, RECORD '00'.**	TOTAL ..... ☐☐	
209	**CHECK 208:** Just to make sure that I have this right: you have had in TOTAL _____ births during your life. Is that correct? یقین دہانی کیلئے مجھے بتایئے کیا میں صحیح سمجھی ہوں کہ آپ نے اپنی زندگی میں کل ____ بچے پیدا کئے ہیں۔ کیا یہ تعداد درست ہے؟ YES ☐ NO ☐ → PROBE AND CORRECT 201-208 AS NECESSARY.		
210	**CHECK 208:** ONE OR MORE BIRTHS ☐ NO BIRTHS ☐ → 226		

211 Now I would like to talk to you about your last three live births, whether still alive or not, starting with the last birth.
اب میں آپ کے آخری تین پیدا ہونے والے بچوں کے ناموں کو لکھنا چاہوں گی۔ چاہے وہ زندہ ہیں یا نہیں۔ سب سے آخری بچے/بچی کے نام سے شروع کریں۔

RECORD NAMES OF THE BIRTHS IN 212. RECORD TWINS AND TRIPLETS ON SEPARATE LINES.

212	213	214	215	216	217	218	219	220	221	222
What name was given to your last (next-to-last) baby? آپ کے آخری یا اس سے پہلے والے بچوں کے نام کیا ہیں؟ (NAME)	Were any of these births twins? کیا یہ جڑواں بچے تھے؟	Is (NAME) a boy or a girl? کیا (نام) لڑکا ہے یا لڑکی؟	In what month and year was (NAME) born? (نام) کس مہینے اور سال میں پیدا ہوا تھا/ہوئی تھی؟ **PROBE:** What is his/her birthday? **RECORD MONTHS** 1 THROUGH 12 **OR SEASONS** WINTER = 21 SPRING = 22 SUMMER = 23 MONSOON = 24 AUTUMN = 25 DON'T KNOW = 98	Is (NAME) still alive? کیا (نام) زندہ ہے؟	**IF ALIVE:** How old is (NAME)? (نام) کی کیا عمر ہے؟ **WRITE AGE IN COMPLETED YEARS. WRITE '00' IF UNDER 1**	**IF ALIVE:** Is (NAME) living with you? کیا (نام) آپ کے ساتھ رہتا/رہتی ہے؟	**IF ALIVE:** RECORD HOUSEHOLD LINE NUMBER OF CHILD (RECORD '00' IF CHILD NOT LISTED IN HOUSEHOLD).	**IF DEAD:** How old was (NAME) when he/she died? وفات کے وقت (نام) کی عمر کیا تھی؟ **IF '1 YR', PROBE:** How many months old was (NAME)? **RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS.**	**IF DEAD:** Where did (NAME) die? (نام) کہاں فوت ہوا/ہوئی؟	Were there any other livebirths between (NAME) and (NAME OF PREVIOUS BIRTH), including any children who died after birth?* (نام) اور (اس سے پہلے بچے کا نام) کی پیدائش کے درمیان کیا کوئی اور زندہ بچہ یا بچی پیدا ہوئے تھے ان میں وہ بچہ یا بچی بھی شامل ہیں جو پیدائش کے بعد انتقال کر گئے ہوں؟
01	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/SEASON ☐☐ YEAR ☐☐☐☐ DON'T KNOW 9998	YES . . 1 NO . . . 2 → 220	AGE IN YEARS ☐☐	YES . . . . 1 NO 2	LINE NUMBER ☐☐ (GO TO 222)	DAYS . . . 1 ☐☐ MONTHS 2 ☐☐ YEARS . . 3 ☐☐	HOME 1 HOSP 2 OTHER 6	YES . . . . 1 ADD BIRTH NO . . . . . 2 NEXT BIRTH
02	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/SEASON ☐☐ YEAR ☐☐☐☐ DON'T KNOW 9998	YES . . 1 NO . . . 2 → 220	AGE IN YEARS ☐☐	YES . . . . 1 NO 2	LINE NUMBER ☐☐ (GO TO 222)	DAYS . . . 1 ☐☐ MONTHS 2 ☐☐ YEARS . . 3 ☐☐	HOME 1 HOSP 2 OTHER 6	YES . . . . 1 ADD BIRTH NO . . . . . 2 NEXT BIRTH
03	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/SEASON ☐☐ YEAR ☐☐☐☐ DON'T KNOW 9998	YES . . 1 NO . . . 2 → 220	AGE IN YEARS ☐☐	YES . . . . 1 NO 2	LINE NUMBER ☐☐ (GO TO 222)	DAYS . . . 1 ☐☐ MONTHS 2 ☐☐ YEARS . . 3 ☐☐	HOME 1 HOSP 2 OTHER 6	YES . . . . 1 ADD BIRTH NO . . . . . 2 NEXT BIRTH
04	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/SEASON ☐☐ YEAR ☐☐☐☐ DON'T KNOW 9998	YES . . 1 NO . . . 2 → 220	AGE IN YEARS ☐☐	YES . . . . 1 NO 2	LINE NUMBER ☐☐ (GO TO 222)	DAYS . . . 1 ☐☐ MONTHS 2 ☐☐ YEARS . . 3 ☐☐	HOME 1 HOSP 2 OTHER 6	YES . . . . 1 ADD BIRTH NO . . . . . 2 NEXT BIRTH
05	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/SEASON ☐☐ YEAR ☐☐☐☐ DON'T KNOW 9998	YES . . 1 NO . . . 2 → 220	AGE IN YEARS ☐☐	YES . . . . 1 NO 2	LINE NUMBER ☐☐ (GO TO 222)	DAYS . . . 1 ☐☐ MONTHS 2 ☐☐ YEARS . . 3 ☐☐	HOME 1 HOSP 2 OTHER 6	YES . . . . 1 ADD BIRTH NO . . . . . 2 NEXT BIRTH

* IN CASE OF WOMEN WHO HAVE GIVEN BIRTH TO ONE OR TWO CHILDREN ONLY ; ASK FOR FIRST BIRTH "WERE THERE ANY OTHER LIVE BIRTHS BETWEEN (NAME) AND YOUR (FIRST) MARRIAGE? PLEASE ADD BIRTH(s) IN TABLE.

223 Have you had any live births since the birth of (NAME OF LAST BIRTH)?
کیا (آخری بچے کا نام) کی پیدائش کے بعد آپ کے گھر کوئی زندہ بچہ یا بچی پیدا ہوا تھا/ہوئی تھی؟ اگر جواب ہاں میں ہے تو جدول میں پیدائش لکھیں

IF YES, WRITE BIRTH(S) IN TABLE

Yes 1
No 2

224
CHECK: 215 FOR EACH BIRTH : MONTH AND YEAR OF BIRTH ARE RECORDED. ☐
CHECK: 217 FOR EACH LIVING CHILD: CURRENT AGE IS RECORDED. . . . . ☐
CHECK: 220 FOR EACH DEAD CHILD: AGE AT DEATH IS RECORDED. . . . . ☐
CHECK: 220 FOR AGE AT DEATH 12 MONTHS OR 1 YEAR: PROBE TO DETERMINE EXACT NUMBER OF MONTHS. . . . . ☐

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
225	Are/were any of your children suffering mental or physical disability at birth? کیا آپکی اولاد میں سے کوئی خدانخواستہ پیدائشی طور پر ذہنی یا جسمانی معذور ہے یا تھا؟	YES ..... 1 NO 2	
226	Are you pregnant now? کیا آپ آج کل حاملہ ہیں؟	YES ..... 1 NO ..... 2 UNSURE 8	→ 229
227	How many months pregnant are you? آپ کتنے ماہ سے حاملہ ہیں؟	MONTHS	
228	At the time you became pregnant did you want to become pregnant then, did you want to wait until later, or did you not want to have any (more) children at all? جب آپ حاملہ ہوئیں، کیا اُس وقت آپ حمل چاہتی تھیں یا چاہتی تھیں کہ کچھ وقت کے بعد ہوتا یا آپ کو (اور) بچوں کی بلکل کوئی خواہش نہیں تھی؟	THEN ..... 1 LATER ..... 2 NOT AT ALL 3	
229	Have you ever had a pregnancy that miscarried, was aborted, or ended in a stillbirth? کیا آپ کا حمل کبھی ضائع ہوا یا آپ نے حمل کبھی گروایا یا آپ کو کبھی مردہ بچے کی پیدائش ہوئی؟	YES ..... 1 NO 2	→ 231
230	How many pregnancies have you had that did not result in a live birth. How many of these pregnancies were miscarried, aborted or ended in a still birth? آپ کو کتنے ایسے حمل ہوئے جن سے کسی زندہ بچے کی پیدائش نہ ہوئی ہو؟ ان میں سے کتنے حمل ضائع ہوئے، کتنے حمل گروائے یا کتنے بچے مردہ پیدا ہوئے؟ **IF 7 OR MORE, RECORD '7'.**	NUMBER OF MISCARRIAGES ... NUMBER OF ABORTIONS ..... NUMBER OF STILLBIRTHS	
231	When did your last menstrual period start? آپ کو آخری ماہواری کب شروع ہوئی تھی؟ _____ (DATE, IF GIVEN) **IF LESS THAN A WEEK, RECORD DAYS, IF ONE WEEK AND LESS THAN ONE MONTH RECORD WEEKS. IF ONE MONTHA AND LESS THAN A YEAR RECORD MONTHS, IF YEAR OR MORE RECORD YEARS.**	DAYS AGO ..... 1 WEEKS AGO ..... 2 MONTHS AGO ..... 3 YEARS AGO ..... 4 IN MENOPAUSE/ HAS HAD HYSTERECTOMY ... 994 BEFORE LAST BIRTH ..... 995 NEVER MENSTRUATED 996	

SECTION 3. PREGNANCY, LABOUR/DELIVERY AND POSTNATAL CARE

301	**CHECK 208:** ONE OR MORE LIVE BIRTHS ☐ ↓ NO LIVE BIRTH ☐ → 501	
302	**ENTER IN THE BIRTH NUMBER, NAME, AND SURVIVAL STATUS OF LAST BIRTH** Now I would like to ask you some questions about the health of your Last child born since January 2003. اَب میں آپ کے آخری بچے کے بارے میں کچھ پوچھنا چاہوں گی۔	
303	BIRTH NUMBER FROM 212	LAST BIRTH BIRTH NO. ☐☐
304	FROM 212 AND 216	NAME LIVING ☐ ↓ DEAD ☐ ↓
305	At the time you became pregnant with (NAME), did you want to become pregnant then, did you want to wait until later, or did you not want to have any (more) children at all? جب (م) آپ کے پیٹ میں تھا/ تھی تو کیا آپ اُس وقت حمل چاہتی تھیں۔ پھر یہ چاہتی تھیں کہ یہ حمل کچھ عرصہ بعد ہو۔ آپ کو (اور) بچوں کی بالکل خواہش نہیں تھیں؟	THEN ..... 1 (SKIP TO 307)← LATER ..... 2 NOT AT ALL ..... 3 (SKIP TO 307)←
306	How much longer would you have liked to wait? آپ کتنا عرصہ اور انتظار کرنا چاہتی تھیں؟	MONTHS ..1 ☐☐ YEARS ..2 ☐☐ DON'T KNOW ... 998
307	Did you see anyone for antenatal care for this pregnancy? کیا آپ حمل کے دوران چیک اپ کے لیے کسی کے پاس گئی تھیں؟ **IF YES:** Whom did you see? کس کے پاس گئی تھیں؟ Anyone else? کسی اور کے پاس بھی گئی تھیں؟ **PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD THE ALL MENTIONED.**	**HEALTH PERSON** DOCTOR ..... A NURSE/MIDWIFE/ LHV ..... B **OTHER PERSON** DAI-TBA ..... C LADY H. WORKER D HOMEOPATH .... E HAKIM ..... F DISPENSER / COMPOUNDER .. G OTHER _____ X (SPECIFY) NO ONE ..... Y (SKIP TO 313)←

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
308	Where did you receive antenatal care for this pregnancy? آپ نے اپنے حمل کے دوران چیک اپ کہاں کروا۔ تھا؟ Anywhere else? کسی اور جگہ سے بھی چیک اپ کروا۔ تھا؟ **FOR ANY HOSPITAL, HEALTH CENTRE, OR CLINIC, WRITE THE NAME OF THE PLACE.** _____ (NAME OF PLACE(S) **PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.**	**HOME** YOUR HOME .... A OTHER HOME.... B **PUBLIC SECTOR** GOVT. HOSPITA .. C RHC/MCH ..... D BHU/FWC ..... E OTHER PUBLIC _____ F (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/ CLINIC..... H PVT. DOCTOR .. I HOMEOPATH .. J DISPENSER / COMPOUNDER .. K OTHER PRIVATE MED. _____ L **(SPECIFY)** HAKIM ..... M OTHER_____ X (SPECIFY)
309	The first time you went for antenatal care did you go because you had a problem or did you go just for a check-up? جب آپ پہلی ۔ را پنے حمل کا چیک اپ کروا نے گئی تھیں تو کیا آپ کو کوئی مسئلہ در پیش تھا۔ پھر آپ صرف اپنا چیک اپ کرانے گئی تھیں؟	FOR PROBLEM ..... 1 FOR CHECK-UP ONL\ 2
310	How many months pregnant were you when you first received antenatal care for this pregnancy? جب آپ نے اپنا اس حمل کا چیک اپ کروا۔ تو اُس وقت آپ کو کتنے ماہ کا حمل تھا؟	MONTHS . . . ☐☐ DON'T KNOW 98
311	How many times did you receive antenatal care during this pregnancy? اس حمل کے دوران آپ نے کتنی ۔ ر اپنا چیک اپ کروا۔ تھا؟	NUMBER OF TIMES .. ☐☐ DON'T KNOW 98
312	As part of your antenatal care during this pregnancy, were any of the following measures taken at least once? اِس حمل کے دوران آپ کے چیک اپ کے وقت کم از کم ایک ۔ ر: Were you weighed? کیا آپ کا وزن کیا گیا تھا؟ Was your blood pressure measured? کیا آپ کا بلڈ پریشر دیکھا گیا تھا؟ Did you get a urine test? کیا آپ نے پیشاب کا ٹیسٹ کروا۔ تھا؟ Did you get a blood test? کیا آپ نے خون کا ٹیسٹ کروا۔ تھا؟ Did you have an ultra sound exam? کیا آپ نے اپنا الٹرا ساؤنڈ کروا۔ تھا؟	**YES NO** WEIGHT ... 1 2 B.PRESSURE 1 2 URINE ..... 1 2 BLOOD ... 1 2 U/S EXAM . 1 2 (SKIP TO 314)

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
313	Why didn't you see anyone for an antenatal check-up? آپ اپنے حمل کا چیک اپ کروانے کے لیے کسی کے پاس کیوں نہیں گئی تھیں؟ **CIRCLE CODES ALL MENTIONED.**	NOT NECESSARY .... A COSTS TOO MUCH .. B TOO FAR ..... C NO TRANSPORT .. .. D NO ONE TO GO WITH E SERVICE NOT GOOD F NO TIME TO GO .. .. G DID NOT KNOW WHERE TO GO .. H DID NOT WANT TO SEE A MALE DOCTOR .. I LONG WAITING TIME J NOT ALLOWED TO GO. K OTHER _____ X
314	Do you know your blood group? کیا آپ کو اپنا بلڈ گروپ معلوم ہے؟	YES ..... 1 NO 2
315	When you were pregnant with (NAME), did anyone talk to you about how to have a safe delivery? I mean things like using a safe delivery kit or a a clean blade to cut the baby's cord or asking the person who helps you to wash their hands? جب آپ (نام) سے حاملہ تھیں تو کسی نے آپ کو یہ مشورہ دیا تھا کہ کس طرح محفوظ زچگی ہوسکتی ہے جیسے زچگی کے لیے صاف کٹ کا استعمال، ڈوکا ٹنے کے لیے صاف بلیڈ کا استعمال، زچگی کروانے والی خاتون کو ہاتھ دھونے کا کہنا؟	YES ..... 1 NO ..... 2 DON'T KNOW 8
316	During this pregnancy, were you given an injection in the buttocks or your arm to prevent the baby from getting tetanus, that is, convulsions after birth? بچے کو تشنج سے محفوظ رکھنے کے لیے اس حمل کے دوران آپ کو، زو، کو لہے میں ٹیکہ لگایا گیا تھا؟	YES ..... 1 NO ..... 2 (SKIP TO 318) ← DON'T KNOW 8
317	During this pregnancy, how many times did you get this tetanus injection? اس حمل کے دوران کتنی بار آپ کو تشنج سے بچاؤ کا ٹیکہ لگایا گیا تھا؟	TIMES ..... ☐ DON'T KNOW 8
317A	Before this pregnancy, how many years ago did you receive that tetanus injection? اس حمل سے پہلے آپ نے تشنج سے بچاؤ کیلئے ٹیکہ کتنے سال پہلے لگوایا تھا؟	YEARS AGO .... ☐☐
318	During this pregnancy, were you given or did you buy any iron tablets or iron syrup? اس حمل کے دوران کیا آپ کو فولاد کی گولیاں، شربت دیا گیا تھا، آپ نے انھیں خود خریدا تھا؟ **SHOW TABLETS/SYRUP.**	YES ..... 1 NO ..... 2 (SKIP TO 320) ← DON'T KNOW 8
319	During the whole pregnancy, for how many days did you take the tablets or syrup? حمل کے تمام عرصہ کے دوران آپ نے کتنے دن گولیاں، شربت استعمال کیا تھا؟ **IF ANSWER NOT NUMERIC, ASK FOR APPROXIMATE NUMBER.**	DAYS .. ☐☐☐ DIDN'T TAKE ... 997 DON'T KNOW ... 998
320	During this pregnancy, were you given or did you take calcium tablets? اس حمل کے دوران کیا آپ کو کیلشیم کی گولیاں دی گئیں، آپ نے انہیں خریدا تھا؟	YES ..... 1 NO ..... 2 (SKIP TO 322) ← DON'T KNOW 8

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
321	During the whole pregnancy for how many days did you take the tablets? حمل کے تمام عرصہ کے دوران آپ نے کتنے دِن گولیوں کا استعمال کیا تھا؟	DAYS .. ☐☐☐ DIDN'T TAKE ... 997 DON'T KNOW ... 998
322	During this pregnancy, did you have difficulty with your vision during daylight? اس حمل کے دوران کیا آپ کو دن کے وقت دیکھنے میں کوئی مسئلہ درپیش آیا تھا؟	YES ..... 1 NO ..... 2 DON'T KNOW 8
323	During this pregnancy, did you suffer from night blindness *[Punjabi=andirata]* اس حمل کے دوران کیا آپ کو رات کے وقت دیکھنے میں کوئی مشکل پیش آئی یعنی (اندھرا-) ہوا؟	YES ..... 1 NO ..... 2 DON'T KNOW 8
324	When you were pregnant with (NAME), did you have any of the following problems?: جب آپ کے پیٹ میں (نام) تھا/تھی تو کیا آپ کو کوئی بھی مسئلہ درپیش تھا یعنی:	YES NO Severe headaches? شدید سر کا درد ہوا؟ ..... 1 2 Blurred vision? دھندلا نظر آیا؟ ..... 1 2 Swelling of your hands? ہاتھوں پر سوجن یا ورم ہوا؟ ..... 1 2 Swelling of your face? چہرہ پر سوجن یا ورم ہوا؟ ..... 1 2 Vaginal bleeding /spoting شرمگاہ سے خون آیا یا خون کے دھبے لگے؟ ..... 1 2 Fits or convulsions? جھٹکے یا دورے پڑے؟ ..... 1 2 Epigastric pains? معدے کے اوپر والے حصے میں درد ہوا؟ 1 2
325	**CHECK 324:**	ANY YES ☐ ALL NO ☐ (SKIP TO 331)
326	Were any of these problems so severe that you were afraid you might die? کیا ان مسائل میں سے کوئی مسئلہ اتنا شدید تھا جس کی وجہ سے آپ کو یہ خوف ہوا ہو کے آپ فوت ہو جائیں گی؟	YES ..... 1 NO ..... 2 DO NOT REMEMBER 8

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
327	Did you seek advice or treatment for the problem(s)? کیا آپ نے ان تکالیف کے حل کے لیے علاج مشورہ کیا تھا؟ **IF YES:** Whom did you see? آپ کس کے پاس گئی تھیں؟ Anyone else? اس کے علاوہ کسی اور کے پاس بھی گئی تھیں؟ **PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD ALL MENTIONED.**	**HEALTH PERSON** DOCTOR ..... A NURSE/MIDWIFE/ LHV ..... B **OTHER PERSON** DAI-TBA ..... C LADY H. WORKER D HOMEOPATH .... E HAKIM ..... F DISPENSER / COMPOUNDER .... G OTHER _____ X (SPECIFY) NO ONE ..... Y (SKIP TO 330)
328	Where did you seek treatment for the problem(s)? آپ نے ان تکالیف کا علاج کہاں سے کروایا تھا؟ Anywhere else? کسی اور جگہ سے بھی علاج کروایا تھا؟ **PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.**	**HOME** YOUR HOME .... A OTHER HOME .... B **PUBLIC SECTOR** GOVT. HOSPITAL C RHC/MCH ..... D BHU/FWC ..... E OTHER PUBLIC _____ F (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/ CLINIC ..... H PVT. DOCTOR .... I HOMEOPATH .... J DISPENSER / COMPOUNDER .... K HAKIM ..... L OTHER PRIVATE MED. _____ M (SPECIFY) OTHER _____ X (SPECIFY)
329	How long after you first started having the (first) problem did you seek advice or treatment? ان تکالیف کے شروع ہونے کے کتنے عرصہ بعد آپ نے ان کے بارے میں مشورہ لیا تھا علاج کروایا تھا؟ **IF LESS THAN ONE DAY, RECORD HOURS IF LESS THAN ONE WEEK, RECORD DAYS. IF MORE THAN ONE WEEK, RECORD WEEKS.**	HOURS .. ..1 ☐☐ DAYS ... ..2 ☐☐ WEEKS .. ..3 ☐☐ DON'T REMEMBER ... 998 (SKIP TO 331)

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
330	Why didn't you see anyone for the problem(s)? ان تکالیف کے علاج کے لیے آپ کسی کے پاس کیوں نہیں گئی تھیں؟ **RECORD ALL MENTIONED.**	NOT NECESSARY .... A COSTS TOO MUCH .. B TOO FAR ..... C NO TRANSPORT .. .. D NO ONE TO GO WITH E SERVICE NOT GOOD F NO TIME TO GO .. .. G DID NOT KNOW WHERE TO GO .. H DID NOT WANT TO SEE A MALE DOCTOR I LONG WAITING TIME J NOT ALLOWED TO GO. ..... K OTHER _____ X (SPECIFY)
331	When (NAME) was born, was he/she very large, larger than average, average, smaller than average, or very small? جب (م) پیدا ہوا/ ہوئی تو کیا یہ بہت بڑا تھا/ تھی، اوسط سے بڑا تھا/ تھی اوسط درجے کا تھا/ تھی اوسط سے چھوٹا تھا/ تھی۔ بہت چھوٹا تھا/ تھی؟	VERY LARGE ..... 1 LARGER THAN AVERAGE ..... 2 AVERAGE ..... 3 SMALLER THAN AVERAGE ..... 4 VERY SMALL ..... 5 DON'T KNOW 8
332	Who assisted with the delivery of (NAME)? (م) کی پیدائش میں کس نے مدد کی تھی؟ Anyone else? اس کے علاوہ کوئی اور تھا؟ **PROBE FOR THE TYPE OF PERSON AND RECORD ALL MENTIONED.** **IF RESPONDENT SAYS NO ONE ASSISTED, ASK IF ANY ADULTS WERE PRESENT AT THE DELIVERY.**	**HEALTH PERSON** DOCTOR ..... A NURSE/MIDWIFE/ LHV ..... B **OTHER PERSON** DAI-TBA ..... C LADY H. WORKER D HOMEOPATH .... E HAKIM ..... F RELATIVE/FRIEND (NOT A DAI) .... G OTHER _____ X (SPECIFY) NO ONE ..... Y
333	Where did you give birth to (NAME)? (م) کہاں پیدا ہوا تھا/ ہوئی تھی۔ **IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE.** _____ (NAME OF PLACE	**HOME** YOUR HOME .... 11 (SKIP TO 338) ← OTHER HOME .... 12 **PUBLIC SECTOR** GOVT. HOSPITAL 13 RHC/MCH ..... 14 OTHER PUBLIC _____ 15 (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/ CLINIC ..... 16 OTHER PRIVATE MED. _____ 17 (SPECIFY) OTHER _____ 96 (SPECIFY) (SKIP TO 338) ←

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
334	Before you were discharged after (NAME) was born, did any health personnel check on your health? (۰م) کی پیدائش کے بعد اور ہسپتال سے جانے سے پہلے کیا کسی صحت کے عملے نے آپ کی صحت کا چیک اپ کیا تھا؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 337)
335	How many hours, days or weeks after delivery did the first check take place? زچگی کے کتنے گھنٹے، دن۔ ہفتوں بعد آپ کا پہلا چیک اپ ہوا تھا؟ **IF LESS THAN ONE DAY, RECORD HOURS.** **IF LESS THAN ONE WEEK, RECORD DAYS.** **IF MORE THAN ONE WEEK, RECORD WEEKS.**	HOURS 1 DAYS 2 WEEKS 3 DON'T KNOW . . . 998
336	Who checked on your health at that time? اُس وقت آپ کی صحت کا چیک اپ کس نے کیا تھا؟ **PROBE FOR MOST QUALIFIED PERSON.**	**HEALTH PERSONNEL** DOCTOR . . . . . 11 NURSE/MIDWIFE LHV . . . . . 12 **OTHER PERSON** DAI- TBA . . . . . 13 LADY H.WORKER 14 HOMEOPATH . . . . 15 HAKIM . . . . . 16 OTHER _____ 96 (SPECIFY) (SKIP TO 351)
337	After you were discharged, did any health care provider or a traditional birth attendant check on your health? ہسپتال سے فارغ ہونے کے بعد کیا کسی طبی عملے۔ لیڈی دائی نے آپ کا چیک اپ کیا تھا؟	YES . . . . . 1 (SKIP TO 344) NO . . . . . 2 (SKIP TO 351)
338	Why didn't you deliver in a health facility? آپ نے کسی ہسپتال۔ کلینک وغیرہ میں بچے کو جنم کیوں نہیں دیا؟ **PROBE:** Any other reason? کوئی اور وجہ؟ **RECORD ALL MENTIONED.**	COST TOO MUCH . . A FACILITY NOT OPEN . B TOO FAR/ NO TRANS-PORTATION ..... C DON'T TRUST FACILITY/POOR QUALITY SERVICE D NO FEMALE PROVID-ER AT FACILITY . . E HUSBAND/FAMILY DID NOT ALLOW . . F NOT NECESSARY . . G NOT CUSTOMARY . . H NO TIME/ BABY CAME TOO FAS' .. I OTHER _____ X (SPECIFY)
339	Was a safe delivery kit used during this delivery? کیا اس زچگی کے لیے ایک محفوظ کٹ استعمال کی گئی تھی؟	YES . . . . . 1 NO . . . . . 2 DOES NOT KNOW 8

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
340	What was used to TIE the umbilical cord? ناڑ(ن ل) باندھنے کے لیے کیا چیز استعمال کی گئی؟	UNBOILED THREAD 1 BOILED THREAD .... 2 WASHED CLAMPS .... 3 UNWASHED CLAMPS 4 HAIR ..... 5 OTHER _____ 6
341	What was used to CUT the umbilical cord? ناڑ(ن ل) کاٹنے کے لیے کیا چیز استعمال کی گئی؟	NEW RAZOR BLADE 1 OLD RAZOR BLADE 2 SCISSORS ..... 3 KNIFE ..... 4 TOKA, CHOPPER .... 5 OTHER _____ 6
342	Was the instrument boiled before using or not boiled? اس اوزار کو استعمال سے پہلے اُبالا گیا تھا۔ نہیں اُبالا گیا تھا؟	BOILED ..... 1 NOT BOILED ..... 2 DON'T KNOW 8
343	After (NAME) was born, did any health care provider or a traditional birth attendant check on your health? (ن م) کی پیدائش کے بعد کیا کسی طبی عملے یا روایتی دائی نے آپ کی صحت کا چیک اپ کیا تھا؟	YES ..... 1 NO ..... 2 (SKIP TO 347)
344	How many hours, days or weeks after delivery did the first check take place? زچگی سے کتنے گھنٹے، دن، ہفتوں بعد آپ کا پہلا چیک اپ ہوا تھا؟ **IF LESS THAN 1 DAY, RECORD HOURS. IF LESS THAN 1 WEEK, RECORD DAYS; IF ONE WEEK OR MORE, RECORD WEEKS.**	HOURS ... 1 DAYS ... 2 WEEKS ... 3 DON'T KNOW ... 998
345	Who checked on your health at that time? اُس وقت آپ کا چیک اپ کس نے کیا تھا؟ **PROBE FOR MOST QUALIFIED PERSON.**	**HEALTH PERSONNEL** DOCTOR ..... 11 NURSE/MIDWIFE LHV ..... 12 **OTHER PERSON** DAI- TBA ..... 13 LADY H.WORKER 14 HOMEOPATH .... 15 HAKIM ..... 16 DISPENSER / COMPOUNDER .. 17 OTHER _____ 96 (SPECIFY)

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
346	Where did this first check take place? سب سے پہلا چیک اپ کہاں ہوا تھا؟ **IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, RECORD THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE.** _____ (NAME OF PLACES)	**HOME** YOUR HOME .... 11 OTHER HOME .... 12 **PUBLIC SECTOR** GOVT. HOSPITAL .. 13 RHC/MCH ..... 14 BHU/FWC ..... 15 OTHER PUBLIC _____ 16 (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/ CLINIC ..... 17 OTHER PRIVATE MED. _____ 18 (SPECIFY) OTHER _____ 96 (SPECIFY)
347	In the two months after (NAME) was born, did any health care provider or dai or a LHW or hakim check on his/her health? (نام) کی پیدائش کے دو مہینے تک کیا کسی عملہ صحت، دوائی، لیڈی ہیلتھ ورکر۔ حکیم نے بچہ / بچی کی صحت کیا چیک اپ کیا تھا؟	YES ..... 1 NO ..... 2 (SKIP TO 351) ← DON'T KNOW 8
348	How many hours, days or weeks after the birth of (NAME) did the first check take place? کتنے گھنٹے، دن۔ ہفتوں بعد (نام) کا پہلا چیک اپ ہوا تھا؟ **IF LESS THAN ONE DAY, RECORD HOURS. IF LESS THAN ONE WEEK, RECORD DAYS. IF ONE WEEK OR MORE, RECORD WEEKS.**	HOURS .. 1 ☐☐ DAYS .. 2 ☐☐ WEEKS .. 3 ☐☐ DON'T KNOW ... 998
349	Who checked on (NAME)'s health at that time? اس وقت (نام) کی صحت کا چیک اپ کس نے کیا تھا؟ **PROBE FOR MOST QUALIFIED PERSON.**	**HEALTH PERSONNEL** DOCTOR ..... 11 NURSE/MIDWIFE LHV ..... 12 **OTHER PERSON** DAI- TBA ..... 13 LADY H.WORKER 14 HOMEOPATH .... 15 HAKIM ..... 16 OTHER _____ 96 (SPECIFY)
350	Where did this first check of (NAME) take place? (نام) کا سب سے پہلا چیک اپ کہاں ہوا تھا؟ **IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, RECORD THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE.** _____ (NAME OF PLACE)	**HOME** YOUR HOME .... 11 OTHER HOME .... 12 **PUBLIC SECTOR** GOVT. HOSPITAL 13 RHC/MCH ..... 14 BHU/FWC ..... .15 OTHER PUBLIC _____ 16 (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/ CLINIC ..... 17 OTHER PRIVATE MED. _____ 18 (SPECIFY) OTHER _____ 96 (SPECIFY)

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
351	In the first two months after delivery, did you receive a vitamin A dose like this? زچگی کے پہلے دو ماہ میں کیا آپ نے وٹامن اے **SHOW AMPULES/CAPSULE/SYRUP.** کے اس طرح کے کیپسول (دوائی) لیے تھے؟	YES . . . . . 1 NO 2
352	Has your menstrual period returned since the birth of (NAME)? کیا (م۔) کی پیدائش کے بعد آپ کو دوبارہ ماہواری آنا شروع ہوئی؟	YES . . . . . 1 (SKIP TO 354) NO 2
353	For how many months after the birth of (NAME) did you not have a period? (م۔) کی پیدائش کے کتنے مہینے بعد تک آپ کو ماہواری نہیں آئی؟	MONTHS . . . ☐☐ DON'T KNOW 98
354	Did you ever breastfeed (NAME)? کیا (م۔) کو آپ نے کبھی اپنا دودھ پلایا تھا؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 362)
355	How long after birth did you first put (NAME) to the breast? (م۔) کی پیدائش کے کتنی دیر بعد آپ نے پہلی بار اُسے اپنا دودھ پلایا تھا؟ **IF LESS THAN 1 HOUR, RECORD '00' HOURS.** **IF LESS THAN 23 HOURS, RECORD HOURS.** **OTHERWISE, RECORD DAYS.**	IMMEDIATELY . . . 000 HOURS 1 ☐☐ DAYS 2 ☐☐
356	Did you give the (NAME) the thick milk (colostrum) that comes first or did you discard it? کیا آپ نے (م۔) کو وہ گاڑھا دودھ جو سب سے پہلے نکلتا ہے پلایا تھا یا آپ نے اُسے ضائع کر دیا تھا؟	GAVE COLOSTRUM 1 DISCARDED IT . . . . 2 DO NOT REMEMBER 8
357	In the first three days after delivery, was (NAME) given anything to drink other than breast milk? پیدائش کے بعد پہلے 3 دنوں میں (م۔) کو ماں کے دودھ کے علاوہ کچھ اور پینے کو دیا تھا؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 359)
358	What was (NAME) given to drink? (م۔) کو پینے کے لیے کیا دیا تھا؟ Anything else? اِس کے علاوہ کچھ اور چیز دی تھی؟ **RECORD ALL LIQUIDS MENTIONED.**	MILK (OTHER THAN BREAST MILK) . . A PLAIN WATER . . . . B HONEY OR SUGAR WATER . . . . . C GHEE, BUTTER . . . . D FRUIT JUIC . . . . . E INFANT FORMULA . . F GHUTEE . . . . . G GREEN TEA . . . . . H OTHER _____ X (SPECIFY)
359	**CHECK 303:** IS CHILD LIVING?	LIVING ☐ DEAD ☐ (SKIP TO 361)
360	Are you still breastfeeding (NAME)? کیا آپ اَب بھی (م۔) کو اپنا دودھ پلا رہی ہیں؟	YES . . . . . 1 (SKIP TO 362) NO 2
361	For how many months did you breastfeed (NAME)? آپ نے کتنے مہینے (م۔) کو اپنا دودھ پلایا تھا؟ **IF LESS THAN ONE MONTH, RECORD '00'**	MONTHS . . . ☐☐ DON'T KNOW . . . 98

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
362	**CHECK 303:** IS CHILD LIVING?	LIVING ☐ → DEAD ☐ → (SKIP TO 401)
363	Yesterday or last night, did (NAME) drink or eat: پچھلے 24 گھنٹوں میں (نام) نے کیا:	YES NO DK
	Plain water? سادہ پانی پیا؟	WATER .. 1 2 8
	Baby formula or other milk? بچوں کا ڈبے والا دودھ۔ کوئی اور دودھ پیا؟	MILK ... 1 2 8
	Juice, soda, tea, rice water? جوس، سوڈا، چائے، چاولوں کی پیچ (پانی) پی؟	JUICE/SODA 1 2 8
	Any mushy or solid food? کوئی مسلی ہوئی۔ ٹھوس غذا کھائی؟	FOOD ... 1 2 8
364	Did (NAME) drink anything from a bottle with a nipple yesterday or last night? کیا (نام) نے کل دن۔ پچھلی رات نپل والی بوتل سے کچھ پیا تھا؟	YES ..... 1 NO ..... 2 DON'T KNOW 8

SECTION 4. CHILD VACCINATION, HEALTH AND NUTRITION

401	**CHECK 208:** ONE OR MORE LIVE BIRTHS ☐	NO LIVE BIRTH ☐→ 501
401A	ENTER IN THE BIRTH NUMBER, NAME, AND SURVIVAL STATUS FOR LAST LIVE BIRTH .	
402	BIRTH NUMBER FROM 212	LAST BIRTH BIRTH NO ..... ☐☐
403	FROM 212 AND 216	NAME _____ LIVING ☐ DEAD ☐
404	Do you have a card where (NAME'S) vaccinations are written down? کیا آپ کے پاس کوئی ایسا کارڈ ہے جس میں (نام) کو لگائے گئے حفاظتی ٹیکوں کا اندراج ہو؟ **IF YES:** May I see it please? کیا میں اسے دیکھ سکتی ہوں؟	YES, SEEN ..... 1 YES, NOT SEEN ..... 2 (SKIP TO 407) ← NO CARD 3

405 (1) COPY DATE OF BIRTH IF GIVEN. IF NOT ON CARD, LEAVE IT BLANK.

(2) COPY VACCINATION DATE FOR EACH VACCINE FROM THE CARD.

(3) WRITE '44' IN 'DAY' COLUMN IF CARD SHOWS THAT A VACCINATION WAS GIVEN, BUT NO DATE IS RECORDED.

	LAST BIRTH DAY	MONTH	YEAR
BIRTH			
BCG			
POLIO 0 (POLIO GIVEN AT BIRTH)			
POLIO 1			
POLIO 2			
POLIO 3			
DPT 1			
DPT 2			
DPT 3			
HBV 1			
HBV 2			
HBV 3			
MEASLES			

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
406	Has (NAME) received any vaccinations that are not recorded on this card including vaccinations received in national immunization day campaign **RECORD 'YES' ONLY IF RESPONDENT MENTIONS BCG, POLIO 0-3, DPT 1-3, HBV 1-3 , OR MEASLES VACCINES.** کیا (۔م) کو کوئی ایسا حفاظتی ٹیکہ لگوا۔ گیا ہے۔ قطرے پلائے گئے جس کا اس کارڈ پر اندراج نہیں کیا گیا ہو۔ اس میں حفاظتی ٹیکوں ۔ قطرے پلانے کی قومی مہم میں لگائے گئے ٹیکے۔ قطرے بھی شامل ہیں۔	YES . . . . . 1 (PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 405) (SKIP TO 409) NO . . . . . 2 (SKIP TO 409) DON'T KNOW 8
407	Did (NAME) ever receive any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunisation campaign? کیا (۔م) نے بیماریوں سے بچاؤ کے لیے کبھی کوئی حفاظتی ٹیکہ لگوا۔۔ قطرے پیئے اس میں حفاظتی ٹیکوں کی قومی مہم میں لگائے گئے ٹیکے۔ قطرے بھی شامل ہیں؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 410) DON'T KNOW 8
408	Please tell me if (NAME) received any of the following vaccinations: اگر (۔م) نے ان میں سے کوئی ٹیکے لگوائے۔ قطرے پیئے ہوں تو مہربانی فرما کر مجھے بتائیں کہ کیا:	
408A	A BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar? ٹی بی سے بچاؤ کے لیے بی سی جی کا ٹیکہ لگوا۔ تھا جس سے ۔ زد ۔کو لہے میں لگوانے سے عام طور پر ایک نشان پڑ جا۔ ہے	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
408B	Polio vaccine, that is, drops in the mouth? کیا پولیو کی دوا کے قطرے پلائے گئے تھے؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 408E) DON'T KNOW 8
408C	Was the first time polio drops were received in the first 2 weeks after birth or later? کیا پہلی ۔ پولیو کے قطرے پیدائش کے بعد پہلے دو ہفتوں میں پلائے گئے ۔ دو ہفتوں کے بعد؟	FIRST 2 WEEKS . . . . . 1 LATER 2
408D	How many times was the polio vaccine received? پولیو کی دوا کے قطرے کتنی ۔ ر پلائے گئے تھے؟ **IF 7 OR MORE TIMES RECORD 7**	NUMBER OF TIMES . . . . . ☐
408E	A DPT vaccination, that is, an injection given in the thigh or buttocks,(sometimes at the same time as polio drops)? کیا ڈی پی ٹی کا ٹیکہ لگوا۔ تھا جو ران ۔ کو لہے میں لگا۔ جا۔ ہے (بعض اوقات اُسی وقت پولیو سے بچاؤ کے قطرے بھی پلا دیئے جاتے ہیں)؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 408G) DON'T KNOW 8
408F	How many times was a DPT vaccination received? ڈی پی ٹی DPT کا حفاظتی ٹیکہ کتنی ۔ ر لگا۔ گیا تھا؟	NUMBER OF TIMES . . . . . ☐
408G	A hepatitus HBV vaccination, that is an injection given in the thigh or buttocks, sometimes at the same time as polio drops? کالا یرقان (ہیپاٹائٹس)، ایچ بی وی HBV کے بچاؤ کے لیے کیا ران ۔ کولہوں میں ٹیکہ لگا۔ گیا تھا۔ بعض اوقات اُسی وقت پولیو سے بچاؤ کے قطرے بھی پلا دیئے جاتے ہیں؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 408I) DON'T KNOW 8
408H	How many times was an HBV vaccination received? ایچ بی وی HBV یعنی کالا یرقان سے بچاؤ کا حفاظتی ٹیکہ کتنی ۔ ر لگا۔ گیا تھا؟	NUMBER OF TIMES . . . . . ☐

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
408I	An injection to prevent measles? کیا خسرہ سے بچاؤ کے لیے ٹیکہ لگوا گیا تھا؟	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
409	Did (NAME) ever receive a polio vaccine (drops in the mouth) during a national immunisation day campaign? کیا (م ۰) نے کبھی پولیو سے بچاؤ کی قومی مہم کے دوران پولیو کی دوا کے قطرے (جو منہ میں ڈالے جاتے ہیں) لیے تھے؟ **IF YES, CHECK 405OR 408D IS 1 OR MORE.**	YES . . . . . 1 NO 2
410	Has (NAME) ever received a vitamin A dose like this? کیا (م ۰) نے کبھی وٹامن اے کے اس طرح کے کیپسول کھائے ہیں؟ **SHOW VIT.A CAPSULES.**	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
411	Has (NAME) had diarrhea in the last 2 weeks? کیا (م ۰) کو پچھلے 2 ہفتوں میں دست آئے تھے؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 423) ← DON'T KNOW 8
412	Was there any blood in the stools? کیا پخانے کے ساتھ خون آیا تھا؟	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
413	Has (NAME) had diarrhea in the last 24 hours ? کیا (م ۰) کو پچھلے 24 گھنٹوں میں دست آئے؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 415) ← DON'T KNOW 8
414	How many times did (NAME) pass stool in the last 24 hours ? (م ۰) کو پچھلے 24 گھنٹوں میں کتنی دفعہ دست آئے؟	NUMBER OF STOOLS .. ☐☐
415	Now I would like to know how much (NAME) was given to drink during the diarrhea. اب میں جاننا چاہوں گی کہ دستوں کے دوران (م ۰) کو پینے کے لیے کتنا کچھ دیا گیا تھا؟ Was he/she given less than usual to drink, about the same amount, or more than usual to drink? کیا (م ۰) کو عام دنوں کے مقابلے میں پینے کے لیے کم دیا گیا تھا، وہی مقدار دی گئی تھی یا عام دنوں سے بھی زیادہ دیا گیا تھا؟ **IF LESS, PROBE:** Was he/she given much less than usual to drink or somewhat less? کیا اُسے عام دنوں کے مقابلے میں پینے کے لیے بہت کم دیا گیا تھا یا تھوڑا سا کم دیا گیا تھا؟	MUCH LESS . . . . . 1 SOMEWHAT LESS . 2 ABOUT THE SAME . 3 MORE . . . . . 4 NOTHING TO DRINK .. 5 DON'T KNOW 8

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
416	When (NAME) had diarrhea, was he/she given less than usual to eat, about the same amount, more than usual, or nothing to eat? جب (۰ م) کو دست آئے تھے تو کیا اُسے عام دنوں کے مقابلے میں کھانے کے لیے کم دیا گیا تھا، وہی مقدار دی گئی تھی، زیادہ دی گئی تھی۔ پھر کھانے کے لیے کچھ بھی نہیں دیا گیا تھا؟ **IF LESS, PROBE:** Was he/she given much less than usual to eat or somewhat less? کیا اُسے عام دنوں کے مقابلے میں کھانے کو بہت کم دیا گیا تھا۔ تھوڑا سا کم دیا گیا تھا؟	MUCH LESS ..... 1 SOMEWHAT LESS . 2 ABOUT THE SAME . 3 MORE ..... 4 STOPPED FOOI... . 5 NEVER GAVE FOOD 6 DON'T KNOW 8
417	Did you seek advice or treatment for the diarrhea from any source? کیا آپ نے کسی سے دست کے بارے میں مشورہ لیا تھا۔ علاج کرایا تھا؟	YES ..... 1 NO ..... 2 (SKIP TO 420)
418	Where did you seek advice or treatment? آپ نے کہاں سے مشورہ لیا تھا۔ علاج کرایا تھا؟ Anywhere else? اس کے علاوہ کسی اور جگہ سے؟ **FOR ANY HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE.** _____ (NAME OF PLACE-S) **PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.**	**PUBLIC SECTOR** GOVT. HOSPITAL A RHC/MCH ..... B BHU/FWC ..... C LADY H.WORKER D OTHER PUBLIC _____ E (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/ CLINIC ..... F CHEMIST ..... G PVT. DOCTOI..... H HOMEOPATH ..... I DISPENSER / COMPOUNDER . . J OTHER PRIVATE MED. _____ K (SPECIFY) **OTHER SOURCE** SHOP ..... L HAKIM ..... M DAI, TBA ..... N OTHER _____ X (SPECIFY)
419	How many days after the illness began did you first seek advice or treatment for (NAME)? بیماری شروع ہونے کے کتنے دن بعد آپ نے (۰ م) کے لئے پہلی بار علاج۔ مشورہ کیا تھا؟ **IF THE SAME DAY RECORD '00'**	DAYS ..... ☐☐

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
420	Was he/she given any of the following to drink at any time since he/she started having the diarrhea: دست شروع ہونے کے بعد کیا کسی وقت (م·) کو پینے کے لیے:	
420A	A fluid made from a special packet called ORS or Nimkol? ایک خصوصی پیکٹ سے تیار کردہ محلول دیا گیا تھا یعنی نمکول۔ ORS؟	YES NO DK FLUID FROM ORS PKT . 1 2 8
420B	A drink made at home with sugar, salt and water? چینی۔نمک اور پانی سے گھر میں تیار کردہ محلول دیا گیا تھا؟	HOMEMADE FLUID . . . 1 2 8
421	Was anything (else) given to treat the diarrhea? کیا دست کے علاج کے لیے کوئی (اور) چیز دی گئی تھی؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 423) ◄ DON'T KNOW 8
422	What (else) was given to treat the diarrhea? دست کے علاج کے لیے (اور) کیا کچھ دیا گیا تھا؟ Anything else? اس کے علاوہ کچھ اور؟ **RECORD ALL TREATMENTS GIVEN.**	PILLS/SYRUP . . . . . A INJECTION . . . . . B I V DRIP . . . . . C HOME REMEDY/ HERBAL MEDICINE / ISPAGHOL . . . . . D OTHER _____ X (SPECIFY)
423	Has (NAME) been ill with a fever at any time in the last 2 weeks? کیا (م·) کو پچھلے 2 ہفتوں میں کسی وقت بخار ہوا تھا؟	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8
424	Has (NAME) had an illness with a cough at any time in the last 2 weeks? کیا (م·) کو پچھلے دو ہفتوں میں کسی وقت کھانسی کے ساتھ طبیعت خراب ہوئی تھی؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 427) ◄ DON'T KNOW 8
425	When (NAME) had an illness with a cough, did he/she breathe faster than usual with short, rapid breaths or have difficulty breathing? جب (م·) کو کھانسی تھی تو کیا وہ عام دنوں کے مقابلے میں تیز تیز سانس لیتا تھا/لیتی تھی۔ سانس لینے میں مشکل آئی تھی؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 428) ◄ DON'T KNOW 8
426	Were these breathing symptoms due to a problem in the chest or to a blocked or runny nose? کیا سانس کی یہ علامات سینے میں تکلیف کی وجہ سے۔ ناک کے بند۔ بہنے کی وجہ سے ہوئی تھیں؟	CHEST ONLY . . . . . 1 NOSE ONLY . . . . . 2 BOTH . . . . . 3 OTHER _____ 6 (SPECIFY) DON'T KNOW . . . . . 8 (SKIP TO 428) ◄

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____
427	**CHECK 423:** HAD FEVER YES ☐ ↓ NO/DK ☐ → **501**	
428	Did you seek advice or treatment for the illness from any source? کیا آپ نے کسی سے اِس بیماری کے رے میں مشورہ لیا۔ علاج کرا۔ تھا؟	YES . . . . . 1 NO . . . . . 2 (SKIP TO 501)←
429	Where did you seek advice or treatment? آپ نے کہاں سے مشورہ لیا۔ علاج کرا۔ تھا؟ Anywhere else? اِس کے علاوہ کسی اور جگہ سے؟ FOR ANY HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE(S) **PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.**	**PUBLIC SECTOR** GOVT. HOSPITAL A RHC/MCH . . . . . B BHU/FWC . . . . . C LADY H.WORKER D OTHER PUBLIC _____ E (SPECIFY) **PRIVATE MED. SECTOR** PVT. HOSPITAL/ CLINIC . . . . . F PHARMACY . . . . . G PVT. DOCTOR . . . . . H HOMEOPATH . . . . . I DISPENSER / COMPOUNDER .. J OTHER PRIVATE MED. _____ K (SPECIFY) **OTHER SOURCE** SHOP . . . . . L HAKIM . . . . . M DAI, TBA . . . . . N OTHER _____ X (SPECIFY)
430	How many days after the illness began did you first seek advice or treatment for (NAME)? بیماری شروع ہونے کے کتنے دن بعد آپ نے (۰م) کے لیے پہلی۔ رعلاج ومشورہ لیا تھا؟ **IF THE SAME DAY, RECORD '00'.**	DAYS . . . . ☐☐

SECTION 5. CONTRACEPTION

501	Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy. اب میں خاندانی منصوبہ بندی کے بارے میں بات کرنا چاہوں گی۔ یعنی حمل میں تاخیر کرنے یا اس سے بچنے کے مختلف طریقے یا ذرائع جنہیں میاں بیوی استعمال کر سکتے ہیں۔ Which ways or methods have you heard about? آپ نے کن طریقوں یا ذرائع کے بارے میں سنا ہے؟ **FOR METHODS NOT MENTIONED SPONTANEOUSLY, ASK:** Have you ever heard of (METHOD)? کیا آپ نے کبھی Method کے بارے میں سنا ہے؟ CIRCLE CODE 1 IN 501 FOR EACH METHOD MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN COLUMN 501, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE 2 IF METHOD IS RECOGNIZED, AND CODE 3 IF NOT RECOGNIZED. THEN, FOR EACH METHOD WITH CODE 1 & 2 CIRCLED IN 501, ASK 502.		502 Have you ever used (METHOD)? کیا آپ نے کبھی Method استعمال کیا ہے؟
01	**FEMALE STERILISATION** Women can have an operation to avoid having any more pregnancies. عورت کی نس بندی عورتیں مزید بچوں کی پیدائش سے بچنے کے لیے آپریشن کرا سکتی ہیں۔	YES/SPON . . . . . 1 YES/PROBED . . . . 2 NO 3	Have you ever had an operation to avoid having any more pregnancies? کیا آپ نے کوئی آپریشن کرایا ہے۔ کہ کوئی حمل نہ ہو؟ YES . . . . . 1 NO 2
02	**MALE STERILISATION** Men can have an operation to avoid having any more pregnancies. مردوں کی نس بندی مرد مزید بچوں کی پیدائش سے بچنے کے لیے آپریشن کرا سکتے ہیں۔	YES/SPON . . . . . 1 YES/PROBED . . . . 2 NO 3	Has your husband ever had an operation to avoid having any more pregnancies? کیا آپ کے خاوند نے کوئی آپریشن کرایا ہے۔ کہ کوئی حمل نہ ہو؟ YES . . . . . 1 NO 2
03	**PILL** Women can take a pill every day to avoid becoming pregnant. گولیاں عورتیں حمل سے بچنے کے لیے ایک گولی روزانہ کھا سکتی ہیں۔	YES/SPON . . . . . 1 YES/PROBED . . . . 2 NO 3	YES . . . . . 1 NO 2
04	**IUD** Women can have a loop or coil placed inside them by a doctor or a trained health worker. چھلا عورتیں کسی ڈاکٹر تربیت یافتہ ہیلتھ ورکر سے اپنے اندر ایک چھلا رکھوا سکتی ہیں۔	YES/SPON . . . . . 1 YES/PROBED . . . . 2 NO 3	YES . . . . . 1 NO 2
05	**INJECTABLES** Women can have an injection by a health provider that stops them from becoming pregnant for one or more months. انجکشن عورتیں کسی ڈاکٹر تربیت یافتہ ہیلتھ ورکر سے انجکشن لگوا سکتی ہیں جس سے وہ ایک یا اس سے زائد ماہ تک حاملہ نہیں ہو سکتیں۔	YES/SPON . . . . . 1 YES/PROBED . . . . 2 NO 3	YES . . . . . 1 NO 2
06	**IMPLANTS** Women can have several small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years. راڈ عورتیں کسی ڈاکٹر سے اپنے بازو کے اوپر کے حصے میں چھوٹے چھوٹے راڈ رکھوا سکتی ہیں جس سے وہ ایک یا اس سے زائد سال تک حاملہ نہیں ہوتیں	YES/SPON . . . . . 1 YES/PROBED . . . . 2 NO 3	YES . . . . . 1 NO 2
07	**CONDOM** Men can put a rubber sheath on their organ before sexual intercourse. کنڈوم مرد مباشرت یعنی میاں بیوی کے ملاپ سے پہلے ربڑ کا خول یعنی کنڈوم استعمال کر سکتے ہیں۔	YES/SPON . . . . . 1 YES/PROBED . . . . 2 NO 3	YES . . . . . 1 NO 2

08	**RHYTHM METHOD** Every month that a woman is sexually active she can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant. وقتی پرہیز کا طریقہ ہر ماہ اُن دِنوں میں جب عورت کے حاملہ ہونے کے امکانات زیادہ ہوتے ہیں، مباشرت یعنی میاں بیوی کے ملاپ سے پرہیز کر کے حاملہ ہونے سے بچا جا سکتا ہے۔	YES/SPON . . . . . 1 YES/PROBED . . . . 2 NO 3	YES . . . . . 1 NO 2
09	**WITHDRAWAL, AZAL** Men can be careful and pull out before ejaculation. عزل/اَزاج مرد احتیاط کر سکتے ہیں اور اخراج سے پہلے جدا ہو سکتے ہیں۔	YES/SPON . . . . . 1 YES/PROBED . . . . 2 NO 3	YES . . . . . 1 NO 2
10	**EMERGENCY CONTRACEPTION** Women can take pills up to five days after sexual intercourse to avoid becoming pregnant. ہنگامی مانع حمل طریقے مباشرت یعنی میاں بیوی کے ملاپ کے بعد حمل سے بچنے کے لیے خواتین 5 دن تک مانع حمل گولیاں کھا سکتی ہیں۔	YES/SPON . . . . . 1 YES/PROBED . . . . 2 NO 3	YES . . . . . 1 NO 2
11	Have you heard of any other ways or methods that women or men can use to avoid pregnancy? کیا آپ نے کسی اور طریقے ذریعے کے بارے میں سنا ہے جسے عورتیں مرد استعمال کر کے حمل سے بچ سکتے ہیں؟	YES/SPON . . . . . 1 YES/PROBED . . . . 2 (SPECIFY) (SPECIFY) NO 3	YES . . . . . 1 NO . . . . . 2 YES . . . . . 1 NO 2

503	**CHECK 502:** NOT A SINGLE "YES" (NEVER USED) ↓ AT LEAST ONE "YES" (EVER USED) →		506
504	Have you ever used anything or tried in any way to delay or avoid getting pregnant? کیا آپ نے کبھی کوئی چیز استعمال کی کوئی طریقہ آزمایا ہے کہ حمل میں خیر یا اس سے بچا جا سکے؟	YES . . . . . 1 NO 2	→ 515
505	What have you used or done? آپ نے کون سی چیز طریقہ استعمال کیا؟ **CORRECT 502 AND 503 (AND 501 IF NECESSARY).**		
506	**CHECK 104:** CURRENTLY MARRIED ↓ WIDOWED, DIVORCED OR SEPARATED →		516
507	**CHECK 502 (01):** WOMAN NOT STERILISED ↓ WOMAN STERILISED →		510
508	**CHECK 226:** NOT PREGNANT OR UNSURE ↓ PREGNANT →		516
509	Are you currently doing something or using any method to delay or avoid getting pregnant? آپ آج کل حمل میں خیر اس سے بچاؤ کے لیے کچھ کر رہی ہیں کوئی طریقہ استعمال کر رہی ہیں؟	YES . . . . . 1 NO 2	→ 513

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
510	Which method are you using? آپ کون سا طریقہ استعمال کر رہی ہیں؟	FEMALE STERILISATION ..... 01 MALE STERILISATION ..... 02 PILL ..... 03 IUD ..... 04 INJECTABLES ..... 05 IMPLANTS ..... 06 CONDOM ..... 07 RHYTHM ..... 08 WITHDRAWAL ..... 09 OTHER _____ 96 (SPECIFY)	
511	Where did you obtain (CURRENT METHOD) the last time? آخری مرتبہ آپ نے (موجودہ طریقہ) کہاں سے حاصل کیا تھا؟ IF STERILISED: Where did the sterilisation take place? نس بندی کہاں کی گئی تھی؟ IF SOURCE IS HOSPITAL, HEALTH CENTER, OR FWC, WRITE THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. _____ (NAME OF PLACE)	PUBLIC SECTOR RHSC/ GOVT. HOSPITAL ..... 01 GOVERNMENT HEALTH CENTRE, MCH BHU/RHC ..... 02 FAMILY WELFARE CENTR ..... 03 MOBILE SERVICE CAMP ..... 04 VILLAGE BAESD FAMILY PLANNING WORKER ..... 05 LADY HEALTH WORKER ..... 06 OTHER GOVT. _____ 07 (SPECIFY) NGO SECTOR ..... 08 PRIVATE SECTOR GREEN STAR CLINIC 09 KEY CLINIC ..... 10 OTHER DOCTORS ..... 11 PHARMACY/DRUG STORE ..... 12 HAKIM ..... 13 HOMOEOPATH ..... 14 TBA/DAI ..... 15 OTHER _____ 16 (SPECIFY) OTHER SOURCE SHOP (OTHER THAN DRUG STORE) ..... 17 FRIEND/RELATIVE ..... 18 OTHER _____ 19 (SPECIFY) NOT APPLICABLE 20	
512	Since what month and year have you been using (CURRENT METHOD) without stopping? آپ کس مہینے اور سال سے (موجودہ طریقہ) مسلسل استعمال کر رہی ہیں؟ IF STERILISED: In what month and year was the sterilisation performed? کس مہینہ اور سال میں نس بندی کا آپریشن ہوا؟ PROBE: For how long have you been using (CURRENT METHOD) now without stopping? آپ کتنے عرصہ سے (موجودہ طریقہ) مسلسل استعمال کر رہی ہیں؟	MONTH ..... ☐☐ YEAR ..... ☐☐☐☐	→ 515
513	You did use contraceptive in the past, why did you stop using them? آپ نے ماضی میں خاندانی منصوبہ بندی کے طریقے استعمال کئے آپ نے ان کا استعمال کیوں ترک کر دیا؟	INFREQUENT SEX/HUSBAND WENT AWAY ..... 01 BECAME PREGNANT WHILE USING 02 WANTED TO BECOME PREGNANT ... 03 HUSBAND DISAPPROVED ..... 04 HEALTH CONCERNS ..... 05 SIDE EFFECT ..... 06 LACK OF ACCESS/TOO FAR ..... 07 COST TOO MUCH ..... 08 INCONVENIENT TO USE ..... 09 MENOPAUSE ..... 10 MARITAL DIFFICULTIES/PROBLEMS 11 OTHERS _____ 96 DON'T KNOW 98	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
514	Why are you not currently using contraceptives? آپ آجکل خاندانی منصوبہ بندی کا کوئی طریقہ کیوں استعمال نہیں کر رہی ہیں؟	PREGNANT ..... 01 WANT TO BECOME PREGNAN ..... 02 HUSBAND AWAY ..... 03 HUSBAND DISAPPROVES ..... 04 INCONVENEINT TO USI ..... 05 HEALTH PROBLEM/CONCERN ..... 06 SIDE EFFECT ..... 07 COST TOO MUCH ..... 08 MENOPAUSE ..... 09 MARITAL DISRRUPTION/PROBLE ... 10 HARD TO GET PREGNAN ..... 11 NATURAL SPACING ..... 12 OTHERS _____ 96 DON'T KNOW 98	→ 516
515	What is the main reason you never used a method? اِس کی سب سے بڑی وجہ کیا ہے کہ آپ نے خاندانی منصوبہ بندی کا طریقہ کبھی بھی استعمال نہیں کیا؟	AFRAID OF SIDE EFFECT ..... 01 RELIGIOUS REASONS ..... 02 DON'T WANT OR SHY TO GO TO FP CLINIC ..... 03 FP FACILITY NOT AVAILABLE ..... 04 FATALISTIC ..... 05 COST TOO MUCH ..... 06 HUSBAND/OTHER OPPOSE ..... 07 CANT GET PREGNANT ..... 08 HAVE NO CHILDREN/NEWLY MARRIE 09 HAVE NOT YET HAD DESIRED NUMBER OF CHILDREN ..... 10 NATURAL SPACING ..... 11 BREAST FEEDING ..... 12 OTHERS _____ 96 DON'T KNOW 98	
516	In the last 12 months, were you visited by a fieldworker or a Lady Health Worker who talked to you about family planning? پچھلے ۱۲ مہینوں میں کیا آپ کو کوئی فیلڈ ورکر / لیڈی ہیلتھ ورکر ملنے آئی ہے جس نے آپ کو خاندانی منصوبہ بندی کے بارے میں بتایا ہو؟	YES ..... 1 NO 2	→ 519
517	How many visits did she pay in the last 12 months? پچھلے ۱۲ ماہ کے دوران اُس نے کتنی مرتبہ آپکے گھر آپ سے ملاقات کی؟	NUMBER OF VISITS ..... ☐☐	
518	On the last visit, what did she discuss? **CIRCLE ALL MENTIONED.** پچھلی ملاقات کے دوران اُس نے کن موضوعات پر بات چیت کی؟	YES NO FAMILY PLANNING ..... 1 2 RESPONDENT'S HEALTH ..... 1 2 CHILDREN HEALTH ..... 1 2 OTHER HEALTH 1 2	
519	Have you visited a health/FP facility for any reason in the last 12 months? کیا آپ پچھلے ۱۲ ماہ کے دوران کسی وجہ سے صحت / خاندانی منصوبہ بندی کے مرکز گئیں؟	YES ..... 1 NO 2	→ 601
520	Did you visit the health/FP facility alone or someone accompanied you? کیا آپ صحت / خاندانی منصوبہ بندی کے مرکز تنہا گئیں / کسی کو ساتھ لے کر گئیں؟	ACCOMPANY ..... 1 ALONE 2	
521	On the last occasion what was the main reason that you attended that health/FP facility? پچھلی مرتبہ جب آپ صحت / خاندانی منصوبہ بندی کے مرکز گئیں تو وہاں جانے کی خاص وجہ کیا تھی؟	CHILD ILL ..... 01 RESPONDENT ILL ..... 02 OTHER FAMILY MEMBER ILL ..... 03 ANTE-NATAL/POST-NATAL CHECK-UP ..... 04 IMMUNIZATION ..... 05 FAMILY PLANNING ..... 06 OTHER _____ 96 (SPECIFY)	

SECTION 6. FERTILITY PREFERENCES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	**CHECK 104:** CURRENTLY MARRIED ☐ ↓ WIDOWED, DIVORCED, SEPARATED ☐		→ 610
602	**CHECK 510:** NEITHER STERILISED ☐ ↓ HE OR SHE STERILISED ☐		→ 610
603	**CHECK 227:** NOT PREGNANT OR UNSURE ☐ ↓ PREGNANT ☐ ↓ Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children? اَب میں آپ سے مستقبل کے رے میں کچھ سوالات پوچھنا چاہوں گی۔ کیا آپ چاہیں گی کہ آپ کے ہاں (ایک اور) بچہ ہو یا آپ اس بات کو ترجیح دیں گی کہ (اور) بچے نہ ہوں؟ Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children? اب میں آپ سے مستقبل کے بارے میں کچھ سوالات پوچھنا چاہوں گی آپ اس ہونے والے بچے کی پیدائش کے بعد چاہیں گی کہ آپ کے ہاں ایک اور بچہ پیدا ہو۔ اس بات کو ترجیح دیں گی کہ اَب اور بچے نہ ہوں؟	HAVE (A/ANOTHER) CHILD ..... 1 NO MORE/NONE ..... 2 → 605 SAYS SHE CAN'T GET PREGNANT .. 3 → 610 UNDECIDED/DON'T KNOW AND PREGNANT ..... 4 → 605 UNDECIDED/DON'T KNOW AND NOT PREGNANT ..... 5 → 605	
604	**CHECK 227:** NOT PREGNANT OR UNSURE ☐ ↓ PREGNANT ☐ ↓ How long would you like to wait from now before the birth of (a/another) child? آپ اَب سے اگلے بچے کی پیدائش تک کتنا عرصہ انتظار کرنا پسند کریں گی؟ After the birth of the child you are expecting now, how long would you like to wait before the birth of another child? آپ ہونے والے بچے کی پیدائش کے بعد اگلے بچے کی پیدائش تک کتنا عرصہ انتظار کرنا پسند کریں گی؟	MONTHS ..... 1 ☐☐ YEARS ..... 2 SOON/NOW ..... 993 SAYS SHE CAN'T GET PREGNAN .. 994 → 610 OTHER _____ 996 (SPECIFY) DON'T KNOW 998	
605	**CHECK 226:** NOT PREGNANT OR UNSURE ☐ ↓ PREGNANT ☐		→ 607
606	**CHECK 509:** NOT ASKED ☐ ↓ NO, NOT CURRENTLY USING ☐ ↓ YES, CURRENTLY USING ☐		→ 610
607	Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future? کیا آپ سمجھتی ہیں کہ آپ مستقبل میں کسی بھی وقت حمل سے بچاؤ۔ اس میں۔ خیر کرنے کے لیے کوئی بھی طریقہ استعمال کریں گی؟	YES ..... 1 → 609 NO ..... 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
608	What is the main reason that you think you will not use a contraceptive method at any time in the future? آپ مستقبل میں کسی بھی وقت حمل سے بچاؤ کا طریقہ استعمال کرنے کا ارادہ نہیں رکھتیں۔ آپ کے نزدیک اس کی سب سے اہم وجہ کیا ہے؟	**FERTILITY-RELATED REASONS** INFREQUENT SEX ..... 01 MENOPAUSAL/HYSTERECTOMY . 02 SUBFECUND/INFECUND 03 WANTS(MORE) CHILDREN 04 **OPPOSITION TO USE** RESPONDENT OPPOSE ..... 05 HUSBAND OPPOSED ..... 06 OTHERS OPPOSED ..... 07 RELIGION PROHIBITION ..... 08 **LACK OF KNOWLEDGE** KNOWS NO METHOD ..... 09 KNOWS NO SOURCE ..... 10 **METHOD-RELATED REASONS** HEALTH CONCERNS ..... 11 FEAR OF SIDE EFFECTS ..... 12 LACK OF ACCESS/TOO FAR ..... 13 COSTS TOO MUCH ..... 14 INCONVENIENT TO USE ..... 15 INTERFERES WITH BODY'S NORMAL PROCESSES ..... 16 **OTHER** _____ 96 DON'T KNOW 98	→ 610
609	Which method would you perfer to use? آپ کون سا طریقہ استعمال کرنے کو ترجیح دیں گی؟	PILLS ..... 01 IUD ..... 02 INJECTABLES ..... 03 IMPLANTS ..... 04 CONDOM ..... 05 FEMALE STERILIZATION ..... 06 MALE STERILIZATION ..... 07 PERIODIC ADSTINENCE ..... 08 WITHDRAWAL ..... 09 OTHER _____ 96 UNSURE/DI 98	
610	**CHECK 216:** HAS LIVING CHILDREN ☐ → If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life, how many would that be? آپ ماضی پر نگاہ ڈالیں جب آپ کے ہاں کوئی بچہ نہیں تھا اور سوچیں اگر آپ کو اپنی پوری زندگی کے لیے بچوں کی کل تعداد کا انتخاب کرنے کا اختیار ہو- تو آپ کتنے بچے چاہتیں؟ NO LIVING CHILDREN ☐ → If you could choose exactly the number of children to have in your whole life, how many would that be? اگر آپ کو اپنی پوری زندگی کے لیے بچوں کی کل تعداد کا انتخاب کرنے کا اختیار ہو تو آپ کتنے بچے چاہیں گی؟ **PROBE FOR A NUMERIC RESPONSE.**	NONE ..... 00 → 612 NUMBER ..... ☐☐ OTHER _____ 96 → 612 (SPECIFY)	
611	How many of these children would you like to be boys, how many would you like to be girls and for how many would the sex not matter? آپ کیا چاہیں گی کہ ان میں سے کتنے لڑکے ہوں اور کتنی لڑکیاں ہوں اور کتنے بچے چاہے وہ لڑکے ہوں۔ لڑکیاں؟	BOYS GIRLS EITHER NUMBER ☐☐ ☐☐ ☐☐ OTHER _____ 96 (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
612	In last few months have you heard/read about family planning on/in: کیا آپ نے پچھلے ایک ماہ کے دوران خاندانی منصوبہ بندی کے بارے میں سنا؟	Yes No ON RADIO . . . . . 1 2 ON TELEVISION . . . . . 1 2 IN NEWSPAPER OR MAGAZINE . 1 2 IN POSTER . . . . . 1 2 IN LEAFLETS OR BROCHURES . . 1 2 OTHERS _____ 1 2 (SPECIFY)	
613	In the last one month have you discussed family planning with your friends, neighbours or relatives? کیا آپ نے پچھلے ایک ماہ کے دوران اپنے دوستوں، پڑوسیوں یا رشتہ داروں سے کبھی خاندانی منصوبہ بندی کے متعلق بات چیت کی ہے؟	YES . . . . . 1 NO . . . . . 2 → 615	
614	With whom? [RECORD ALL MENTIONED] کس سے بات چیت کی؟	Yes No HUSBAND . . . . . 1 2 MOTHER . . . . . 1 2 FATHER . . . . . 1 2 SISTER(s) . . . . . 1 2 BROTHER(s) . . . . . 1 2 DAUGHTER . . . . . 1 2 MOTHER-IN-LAW . . . . . 1 2 FRIENDS/NEIGHBOURS/ OTHER RELATIVES . . . . . 1 2 OTHER _____ 1 2 (SPECIFY)	
615	**CHECK 104:** CURRENTLY MARRIED ☐ WIDOWED, DIVORCED, SEPARATED ☐ → 701		
616	Have you talked to your husband about family planning in the past year? If "YES" once or twice or more often? کیا آپ نے گذشتہ ایک سال کے دوران اپنے شوہر سے خاندانی منصوبہ بندی کے متعلق بات چیت کی ہے؟ اگر ہاں تو ایک دفعہ، دو دفعہ یا اکثر و بیشتر؟	NEVER IN PAST YEAR . . . . . 1 ONCE OR TWICE . . . . . 2 MORE OFTEN 3	
617	Now I want to ask you about your husband's views on family planning. Do you think that your husband approves or disapproves of couples using a method to aviod pregnancy? اب میں آپ سے آپ کے شوہر کے خاندانی منصوبہ بندی کے متعلق خیالات کے بارے میں جاننا چاہوں گی۔ کیا آپ کے شوہر حمل روکنے کیلئے میاں بیوی کے خاندانی منصوبہ بندی کے طریقے اپنانے کو اچھا سمجھتے ہیں یا بُرا؟	APPROVES . . . . . 1 DISAPPROVES . . . . . 2 DK 3	
618	Do you think your husband wants the same number of children that you want, or does he want more or fewer than you want? آپ کا کیا خیال ہے کہ آپ کے شوہر بھی اُتنے ہی بچے چاہتے ہیں جتنے آپ چاہتی ہیں، وہ آپ کی خواہش سے زیادہ بچے چاہتے ہیں، کم بچے چاہتے ہیں؟	SAME CHILDREN . . . . . 1 MORE CHILDREN . . . . . 2 FEWER CHILDREN . . . . . 3 DK 8	
619	Does your husband want to have another child? کیا آپکے شوہر مزید بچے کی خواہش رکھتے ہیں؟	YES . . . . . 1 NO 2	

SECTION 7. SOCIO-ECONOMIC AND HEALTH RELATED INFORMATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	**CHECK 104:** CURRENTLY MARRIED ↓ / NOT CURRENTLY MARRIED →		705
702	**CHECK 701:** What is your husband's occupation? آپ کے شوہر کا کیا پیشہ ہے؟ That is, what kind of work does he mainly do? وہ زیادہ تر کس قسم کا کام کرتے ہیں؟	_____ _____ _____	
703	**CHECK 702:** HUSBAND WORKS IN AGRICULTURE ↓ / DOES NOT WORK IN AGRICULTURE →		705
704	Does your husband work mainly on his own land or family land or does he rent land or does he work on someone else's land? کیا آپکے شوہر زیادہ تر اپنی اپنے خاندان کی زمین پر کام کرتے ہیں، انہوں نے زمین کرائے پر لے رکھی ہے کسی اور کی زمین پر کام کرتے ہیں؟	HIS/FAMILY LAND ..... 1 RENTED LAND ..... 2 SOMEONE ELSE'S LAN 3	
705	As you know, aside from your own work, some women take up jobs for which they are paid in cash or kind. Others sell things, have a small business or work on the family farm or in the family business. In the last seven days, have you done any of these things or any other work? جیسا کہ آپ جانتی ہیں کہ گھریلو کام کاج کے علاوہ کچھ عورتیں کام کرتی ہیں اور انھیں معاوضہ نقد رقم بعض کی صورت میں ادا کیا جاتا ہے۔ بعض عورتیں اشیاء فروخت کرتی ہیں، چھوٹا موٹا کاروبار کرتی ہیں، اپنے خاندان کے کھیت پر کام کرتی ہیں اُن کے کاروبار میں ہاتھ بٹاتی ہیں۔ پچھلے 7 دنوں میں آپ نے ان میں سے کوئی کام کیا ہے کوئی دوسرا کام کیا ہے؟	YES ..... 1 NO 2	→ 707
706	Although you did not work in the last seven days, do you have any job or business from which you were absent for leave, illness, vacation, maternity leave or any other such reason? اگرچہ آپ نے پچھلے 7 دنوں میں کوئی کام نہیں کیا ہے لیکن کیا آپ ایسا کوئی کام کاروبار کرتی ہیں جہاں سے آپ رخصت، بیماری، چھٹیوں، زچگی کی رخصت کسی اور وجہ سے غیر حاضر ہوں؟	YES ..... 1 NO 2	→ 712
707	What is your occupation, that is, what kind of work do you mainly do? آپ کا پیشہ کیا ہے (تھا) یعنی آپ زیادہ تر کس قسم کا کام کرتی ہیں (تھیں)؟	_____ _____ _____	
708	In your current work, do you work for a member of your family, for someone else, or are you self-employed? آپکے موجودہ کام میں کیا آپ اپنے خاندان کے کسی مرد کیلئے کام کر رہی ہیں کسی اور کیلئے کام کرتی ہیں، یہ کام آپ کا اپنا ہے؟	FOR FAMILY MEMBER ..... 1 FOR SOMEONE ELSE ..... 2 SELF-EMPLOYED 3	
709	Do you receive money for the work you do? جو کام آپ کرتی ہیں، کیا آپکو اُس کام کے پیسے ملتے ہیں؟	YES ..... 1 NO 2	→ 711
710	Do you keep all the money, some or none of the money especially at your disposal? کیا آپ تمام رقم اس کا کچھ حصہ خاص طور پر اپنے استعمال کے لئے رکھتی ہیں کچھ بھی نہیں رکھتیں؟	KEEP ALL THE MONEY ..... 1 KEEP SOME MONEY ..... 2 DOES NOT KEEP ANY MONEY 3	
711	Do you do this work at home or away from home? آپ یہ کام گھر پر کرتی ہیں گھر سے دور کرتی ہیں؟	HOME ..... 1 AWAY 2	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
712	We are interested in knowing about property that belongs only to you. Do you own: **[READ OUT]** ہم آپکی اپنی جائیداد کے بارے میں جاننا چاہتے ہیں کیا آپکے اپنے نام پر کوئی زرعی زمین، کمرشل پلاٹ، زمین، مکان، کوئی کاروبار ہے؟	**Yes No** AGRICULTURE LAND ..... 1 2 COMMERICAL LAND/PLOT .... 1 2 A HOUSE ..... 1 2 A BUSINESS 1 2	
713	**CHECK 711:** ATLEAST ONE "YES" ☐ ↓ NOT A SINGLE "YES" ☐ → 715		
714	Who gets the income of this property/Business? اس جائیداد، کاروبار کی آمدنی کون لیتا ہے؟	RESPONDENT ..... 1 HUSBAND/SON ..... 2 BOTH ..... 3 ELSE ..... 4 NO INCOME 5	
715	If you need to go to a health clinic or hospital, could you go by yourself or would you need to be accompanied by someone else? اگر آپ کو صحت کے مرکز، ہسپتال جانا پڑے تو کیا آپ اکیلی جا سکتی ہیں، کسی کو ساتھ لے جانا پڑے گا؟	SELF ..... 1 ACCOMPANIED BY SOMEONE ELSE 2 DEPEND ..... 3 DON'T KNOW 8	
716	How far is the nearest health facility from your house? نزدیک ترین صحت کا مرکز آپکے گھر سے کتنی دور ہے؟	DISTANCE (IN KM) ..... ☐☐☐	

SECTION 8. HIV/AIDS AND TUBERCULUSIS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	Now I would like to talk about something else. Have you ever heard of an illness called AIDS? کیا آپ نے ایڈز کی بیماری کے بارے میں کبھی کچھ سنا ہے؟	YES . . . . . 1 NO 2	→ 808
802	Can people get the AIDS virus from mosquito bites? کیا لوگوں کو مچھر کے کاٹنے سے ایڈز کا مرض ہوسکتا ہے؟	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
803	Can people get the AIDS virus by sharing food with a person who has AIDS? کیا ایڈز کے مریض کے ساتھ کھانا کھانے سے ایڈز کی بیماری لگ سکتی ہے؟	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
804	Can people get the AIDS virus because of witchcraft or other supernatural means? کیا لوگوں کو سحر، جادو دیگر مافوق الفطرت چیزوں سے ایڈز کا مرض لگ سکتا ہے؟	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
805	Can people reduce their chance of getting the AIDS virus by using a condom every time they have sex? کیا لوگ مباشرت یعنی میاں بیوی کے ملاپ کے وقت ہر بار کنڈوم استعمال کر کے ایڈز کے مرض لگنے کے امکانات کم کر سکتے ہیں؟	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
806	Do you know someone personally who has the virus that causes AIDS or someone who died from AIDS? کیا آپ ذاتی طور پر کسی ایسے شخص کو جانتے ہیں جو ایڈز کے مرض میں مبتلا ہو۔ کوئی ایسا شخص جو ایڈز سے ہلاک ہوگیا ہو؟	KNEW A PERSON HAVING AIDS . . . . 1 KNEW A PERSON DIED FROM AIDS . 2 NO . . . . . 3 DON'T KNOW 8	
807	Can the virus that causes AIDS be transmitted from a mother to a child: کیا ایڈز کا مرض ایک ماں سے بچے میں منتقل ہوسکتا ہے:	YES NO DK	
	During pregnancy? حمل کے دوران؟	DURING PREGNANCY? .. 1 2 8	
	During delivery? زچگی کے دوران؟	DURING DELIVERY? 1 2 8	
	By breastfeeding? ماں کا دودھ پلانے سے؟	BY BREASTFEEDING 1 2 8	
808	Have you ever heard of an illness called tuberculosis or TB? کیا آپ نے تپ دق۔ ٹی بی کی بیماری کے بارے میں کبھی سنا ہے؟	YES . . . . . 1 NO 2	→ END INTERVIEW
809	How does tuberculosis spread from one person to another? تپ دق ایک شخص سے دوسرے شخص میں کس طرح پھیلتی ہے؟ **PROBE:** Any other ways? اس کے علاوہ کسی اور طریقے سے؟ **RECORD ALL MENTIONED.**	THROUGH THE AIR WHEN COUGHING OR SNEEZING . . . . . A BY SHARING UTENSILS . . . . . B BY TOUCHING A PERSON WITH TE . C THROUGH SHARING FOOD . . . . . D THROUGH SEXUAL CONTACT . . . . . E THROUGH MOSQUITO BITE . . . . . F OTHER _____ X (SPECIFY) DON'T KNOW . . . . . Z	
810	Can tuberculosis be cured? کیا تپ دق کا علاج ہوسکتا ہے؟	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 812

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
811	What is the duration of treatment of TB now a days? آج کل تپ دق کا علاج کتنے عرصہ میں ہو جا- ہے؟ **IF MORE THAN 7 MONTHS, RECORD 7**	MONTHS . . . . . ☐ DON'T KNOW 8	
812	Have you ever been told by a doctor or nurse or LHV that God forbid you have/had tuberculosis? کیا کسی ڈاکٹر، نرس۔ LHV نے آپ کو کبھی بتا۔ کہ آپ کو خدانخواستہ تپ دق ہے/ تھی؟	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ END INTERVIEW
813	Do you get treatment for TB from any health personal? کیا آپ کسی بھی طبی ماہر سے تپ دق کا علاج کروا رہی ہیں؟	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
814	RECORD THE TIME.	HOUR . . . . . ☐☐ MINUTES . . . . . ☐☐	

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF SUPERVISOR: _____ DATE: _____

EDITOR'S OBSERVATIONS

NAME OF EDITOR: _____ DATE: _____