



# LONGITUDINAL PANEL STUDY IN BALOCHISTAN USING PERFORMANCE MONITORING FOR ACTION (PMA) FRAMEWORK

PHASE-II, 2024





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### **PHASE-II, 2024**

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Islamabad



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## LIST OF ACRONYMS

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ANC	Antenatal Care
BHU	Basic Health Unit
CCI	Council of Common Interest
cLMIS	contraceptive Logistics Management Information System
CMWs	Community Midwives
CPR	Contraceptive Prevalence Rate
DHIS	District Health Information System
DoH	Department of Health
DPM	Data Processing Manager
EAs	Enumeration Areas
EC	Emergency Contraception
FP	Family Planning
FWC	Family Welfare Centre
GoB	Government of Balochistan
IUCDs	Intra Uterine Contraceptive Devices
LHWs	Lady Health Workers
LHVs	Lady Health Visitors
mCPR	modern Contraceptive Prevalence Rate
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal, And Child Health
MSU	Mobile Service Unit
NGO	Non -Governmental Organization
NIPST&R	National Institute for Population Studies, Training & Research
OE	Office Editor
PBS	Pakistan Bureau of Statistics
PMA	Performance Monitoring for Action
PNC	Postnatal Care
PWD	Population Welfare Department
PDHS	Pakistan Demographic and Health Survey
RH	Reproductive Health
RHC	Rural Health Center
RTIs	Regional Training Institutes
SBA	Skilled Birth Attendant
SDPs	Service Delivery Points
SDGs	Sustainable Development Goals
UNFPA	United Nations Population Fund



## PREFACE

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With its unique demographic and geographic landscape, Balochistan requires tailored, data-driven approaches to meet its family planning and reproductive health goals. At the national level, Pakistan remains committed to reducing its total fertility rate (TFR) to 2.1 births per woman and increasing the contraceptive prevalence rate (CPR) to 60 percent by 2030. In line with this vision, the Government of Balochistan has set its own target of achieving a 46 percent CPR by 2030—an ambitious goal that depends on strong partnerships, locally grounded interventions, and sustained provincial ownership.

The National Institute of Population Studies, Training & Research (NIPST&R), under the Ministry of National Health Services, Regulations & Coordination, continues to support this agenda through the Performance Monitoring for Action (PMA) project. Building on the previous phase of PMA Balochistan, the Phase-II (2024) survey collected data from women aged 15–49 to provide timely, high-quality insights on contraceptive use, service readiness, and client experiences—enabling stakeholders to monitor progress and adapt strategies accordingly.

We hope the findings serve as a practical resource for Programme Managers, policymakers, and civil society to strengthen services and address gaps. In particular, we acknowledge the collaboration of the Population Welfare Department Balochistan and the Health Department Balochistan, whose coordination and support were essential to the success of this round.

I would like to commend the leadership of Ms. Rabia Zafar, Director, NIPST&R, for managing the survey from design through completion with diligence and clarity. Her focused oversight helped ensure both operational efficiency and analytical integrity.

We are also grateful to Dr. Tauseef Ahmed, PMA Advisor, for his expert guidance throughout the project. His continued mentorship and technical input have played a critical role in enhancing the quality, relevance, and credibility of this work.

We extend sincere thanks to the United Nations Population Fund (UNFPA) for its ongoing partnership. Special appreciation goes to Dr. Luay Shabaneh, UNFPA Country Representative, for his leadership; Mr. Muqaddar Shah for his technical support and layout design; and Ms. Farah Ashraf, Technical Specialist, for her close coordination and input throughout the process.

Finally, we thank the Pakistan Bureau of Statistics (PBS) for their support in sampling and weighting, and the Technical Advisory Committee for their valuable feedback and sectoral insights.



(Samina A. Hasan)  
Executive Director



## ACKNOWLEDGEMENTS

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The PMA Balochistan Phase-II (2024) survey represents another important milestone in the National Institute of Population Studies, Training & Research (NIPST&R)'s mission to generate actionable, high-quality data that informs Pakistan's reproductive health and family planning efforts. Reliable evidence is essential for designing responsive programmes, and this survey offers critical insights into the availability, accessibility, and quality of services across Balochistan.

On behalf of the Institute, I express my sincere appreciation to Mrs. Samina A. Hasan, Executive Director, for her continued guidance and unwavering support throughout this survey cycle. Her leadership helped maintain the pace, direction, and integrity of this effort from start to completion.

I also acknowledge the contributions of Mr. Ali Raza, Data Processing Manager, whose supervision ensured robust handling of data systems and analysis, and Ms. Rizwana Timsal, Fellow, who played a key role in training and field coordination. Special thanks to Mr. Qamar Munir, Programmer, for his technical support in system development and IT troubleshooting.

Our research and field teams deserve heartfelt recognition, especially Ms. Sarma Saeed (Associate Fellow), Syed Talha Ali (Research Associate), Dr. Mohsin Kiani and Dr. Amna Noor Asim (Researchers)—each of whom provided valuable input across planning, supervision, and reporting. We are also grateful to Mr. Muhammad Arif (Accounts Officer) and Mr. Asif Amin Khan (PS to Executive Director) for their effective handling of financial and administrative logistics.

At the operational level, Mr. Qamer Ur Rasool, Data Entry Operator, contributed diligently to data entry and quality checks. Appreciation is also extended to Mr. Mustafa Ali Khan, Office Coordinator, for ensuring smooth coordination across teams, and to the Office Editors for their meticulous review of the report and supporting materials.

Finally, we recognize the collaborative environment that enabled this work to succeed—from institutional leadership to field execution—and we thank all those who contributed their time, skills, and commitment to the completion of this important survey round.

We hope the findings and datasets generated through this exercise will be widely used by policymakers, planners, researchers, development partners, and NGOs. The insights are expected to support the design and monitoring of family planning strategies—especially those promoting accessible, affordable, and community-based services that reach underserved populations.

  
(Rabia Zafar)  
Director



## EXECUTIVE SUMMARY

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The Government of Balochistan made several commitments over the years as part of national endeavour to address the rising population growth rate by strengthening family planning activities among key stakeholders. The Government evolved necessary policies and strategies to create an enabling environment, strengthen institutions, and improve the coverage and access of the services to enhance family planning performance and progress. Additionally, the government has emphasized the need to move forward with functional integration and prioritize strategies to increase access and coverage to address the growing number of new users, while also enhancing resources to overcome regional inequities.

To support the measurement of progress on the commitments, the National Institute of Population Studies, Training & Research (NIPST&R), Islamabad established a Longitudinal Panel Study using Performance Monitoring for Action (PMA) framework. This framework provides an annual stream of information on critical family planning and maternal health indicators using representative household sample across the province. This approach has an advantage over the Pakistan Demographic Health Surveys (PDHS), which are typically conducted every five years to show impact. The PMA framework provides process-level field evidence needed to bring programme improvements, addressing policy commitments to enhancing access to services, improving service quality, and strengthening the enabling environment.

The Phase II of Longitudinal Panel Survey in Balochistan (2024), using the Performance Monitoring for Action (PMA) Framework, collects provincial-level data from 46 clusters selected from 7 districts across the province. The survey involves a representative sample of 1,759 households, interviewing 1,978 currently married women aged 15 to 49 years within these households, and assessing 115 selected health facilities. Additionally, the survey includes interviews with currently married women and gathers data from Department of Health (DoH) and Population Welfare Department (PWD) facilities, as well as private facilities providing family planning services in the selected clusters. Information was also collected from 1,053 clients/patients exiting various selected health facilities located within 5-10 kilometers of the selected clusters.

### **Key Findings:**

#### **Currently Married Women on Family Planning and Maternal Health:**

- The contraceptive prevalence rate in Balochistan is recorded at 27 percent in Phase II while it was estimated to be 23.2 percent in 2023.
- The modern contraceptive prevalence rate stands at 17 percent in Phase II while it was 14.8 percent in baseline survey in 2023. The percentage of women reporting use of traditional methods is 10 percent in 2024 which was recorded as 8 percent in baseline survey.
- The source of modern contraceptive methods is predominantly private health facilities, serving 53 percent of women in 2024.

- An analysis of contraceptive prevalence by program interventions reveals that interaction with Lady Health Workers (LHWs) reflects a negative impact on modern contraceptive prevalence rate (mCPR), implying low CPR among women who reported interaction with LHWs. The modern contraceptive prevalence rate (mCPR) among women who interacted with Lady Health Workers (LHWs) is 10 percent, compared to 18 percent among those who did not have such interactions.
- The first-ever used of any contraceptive method among women is estimated to be 36 percent for Phase II while it was 32 percent (in baseline) indicating approximately 9 percent women discontinuing over the years, as the current users of any methods are 27 percent.
- Percent women reporting their first method used reflects condoms (9%), injectables (5.7%), and pills (5.2%) higher than all other methods. Implants are reported by a very small percent of women as their first method (0.4%), followed by IUCDs (1.1%).
- The survey reveals only 2.6 percent of all women report experiencing unintended pregnancy in their lifetime. Desire to have large families in conservative society underlies such a logic.
- Three main reasons noted in the survey results for discontinuation of contraceptives including women wanted to become pregnant (60%), fear of side effect (3.8%), and health concerns (11%). On the whole, more than two-thirds of all women (69%) give fertility related reasons while only 22 percent refer to contraceptive related reasons.
- Unmet need for contraception is estimated to be 32.6 percent. Among them 28.9 percent women show an unmet need for spacing and 3.6 percent of women for limiting birth.
- Birth spacing appears to be the key intent behind current use of contraception while birth limiting is practiced by relatively lower proportion of users. Women age less than 35 focus on birth spacing for use of contraception and a small percent of women in older ages (beyond age 34) report use of contraception for limiting births.
- Survey reveals that most maternal health indicators reflect good progress as more than 72 percent of women in Balochistan reported antenatal care received while those who delivered within the facility by skilled health staff are more than 75 percent.

### **Family Planning and MCH Service Delivery Points**

- Three modern methods (pills, injectables and condoms) are universally available at facilities of Health, PWD and private sector. Provision of IUCDs and emergency contraception available in more than fifty percent of facilities across the province. Availability of tubal ligation and implants need attention.
- A large number of surveyed facilities both public and private have trained staff for preparing to supplies IUCD and implants (insertion and removal). Overall 58 percent of DOH facilities (35 in number), 87 percent of PWD facilities (13 in number), and 53 percent of private facilities (21 facilities) report prepared to serve IUCDs.
- As compared to 2023 survey, surveyed Health Dept. facilities show a reasonable number have adequate stocks of oral pills, IUCDs and injectables but a fair proportion of facilities

show stock outs of condoms, IUCDs, Injectables, pills, and implants for quite some time. On the other hand, PWD facilities too show stock outs in some facilities but the number of stock out days are much fewer than DoH facilities.

- In the survey, 115 facilities covered and they provide FP services to 68,673 clients (in three months of 2024). Twenty one percent of these clients are served by private facilities as per records made available to survey teams. It is interesting to note that almost three quarters (73%) of all clients are registered and served by Dept of Health facilities over the three months period.
- Facility registers reveal a total of almost 122 thousand MCH visits recorded over the three months in the 115 facilities. In addition, almost 182 thousand visits were recorded for general ailment and health issues during these months. A small percent of all maternal health visits are recorded by private facilities. The data reflects a huge potential for FP integration with MCH services. Private sector served 19 percent patients for general ailments and therefore plays an important role in health sector.
- Three fourth of all facilities (public and private), provide FP counselling after delivery.
- Percent distribution of prescribed methods by place of residence also interesting to note. Exiting clients told that Injectables are prescribed relatively higher to rural women while oral pills equally to both rural and urban women exiting facilities
- Results based on client exit data show that a fairly large percent of clients report counselling on birth spacing done by staff of public and private facilities while contraception and side effects of methods are given little lower attention in counseling.
- Survey found that more than 90 percent of clients acknowledged to have been explained how the method works, similarly around 90 percent clients reported to be told about the side effects, and also told what to do in case of problems faced by them, and when to return to the facility for seeking queries or resupplies.



Balochistan, in line with national commitment towards Sustainable Development Goals (SDGs) and FP2030, has resolved to achieve a higher level of contraceptive prevalence through increased investment to enhance coverage and availability of FP, increase the number of users and enhance resources to address regional inequities. Balochistan pledged to achieve CPR 36 percent and 46 percent by 2025 & 2030 by lowering the unmet need for contraception by two-thirds by 2030 and raising the total users. Under FP2030 Commitments, the government expressed the need to move forward with functional integration and prioritizing strategies to enhance access and coverage to address the growing number of new users, besides enhancing resources to overcome regional inequities. Fulfilling these commitments requires a comprehensive and detailed plan that translates Population Policy into people-focused programs for the spread of information, and services that are easily accessible to the people within their communities, especially to the rural poor and dwellers of urban slums in an environment of trust and care. The Balochistan Population Policy 2015 postured family planning as an important intervention to save lives and protect the wellbeing of mothers and children and envisioned to increase Contraceptive Prevalence Rate (CPR) from 19.5 percent in 2012-13 to 32 percent by 2020 and to raise modern CPR from 14 percent in 2012-13 to 28 percent by 2020. The CPR is recorded at 19.8 percent (PDHS 2017-18<sup>1</sup>) as against 19.5% in 2012-13, the lowest compared to other provinces. Access to FP information, commodities, and services and counselling were highlighted as a basic right for every woman and individual in the community to enable them to exploit their full potential. The Balochistan Population Policy 2015 emphasizes an active pursuit of a birth spacing strategy to achieve long-term fertility goals. It envisions close collaboration with the private sector and civil society in its implementation, and in such a way that conforms to the national development priorities and commitments. The public sector (Population Welfare and Department of Health) has a large network of facilities that provide FP services. These public facilities provided contraceptives to 48 percent of users, whereas 52 percent of users accessed contraceptives through private sector outlets (as per the results of the PMA Phase-1 survey 2023).

Task sharing strategy was endorsed in 2022 to enhance access to all methods, including new methods/ range of methods across all clients, especially in remote and rural areas. Under the strategy, LHVs/FWWs are to be trained to carry out specific FP tasks that are being looked after by medical doctors at the public facilities. Furthermore, LHWs are to be trained to administer first contraceptive injection to married women of reproductive age (MWRA); which at present they can only administer second injections onwards. Activities include ‘building skills of LHVs at DHQ/THQ and RHC levels and imparting skills and competencies to LHVs in IUCD and implant insertion) in selected facilities, DHQ, THQ, RHCs, and BHUs (under PPHI) and FTOs posted at MSUs.

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<sup>1</sup> National Institute of Population Studies and ICF: Pakistan Demographic and Health Survey Key Indicators 2017-18. Islamabad: August 2018.

Strategies include lowering the unmet need for contraception by two-thirds by 2030 and raising the total users. Moving forward with functional integration and prioritizing strategies to address growing number of new users are government's vision to move forward.

The slow increase in contraceptive use over a decade against the expectation of a rise in CPR is a serious challenge as it counters the plans and strategies set for lowering fertility. The slow progression persists in the presence of commitment to enhance CPR and lower fertility. The presence of high unmet need for contraception, high unintended pregnancies, high missed opportunities for family planning, etc., consistently points towards the need to improve the situation by regular review programme activities. Prior studies of family planning programmes note four areas as critical for achievement of FP goals that are set under FP2030 Commitments: Access, Equity, Quality and Choice, contraceptive security, and coverage. These areas have challenges and need regular critical assessments to help understand the ways to ensure best practices are implemented.

The existing challenges vary from low uptake of family planning, poor quality of services and counselling, stock outs of contraceptives, weak communication of service providers with clients, low knowledge of effective methods reflecting poor choice, poor availability of contraceptives in remote facilities and areas, and large unserved areas.

### **1.1 Introduction to Performance Monitoring for Action Framework**

Performance monitoring is a function that is performed by planners and implementers at different levels of organization, including assessment of outcomes, process and efficiency of activities, including quality and knowledge valuation. The current status of family planning in Sindh seeks attention to performance monitoring to help managers evolve strategies for programme improvements. Though the public sector spearheads family planning activities but the scope of performance monitoring is much wider today due to active role of private sector in dispensing FP across the province. For effective family planning decision making, this exercise provides information on outcome indicators (based on user's perspective), facility service data, and client satisfaction information.

The PMA framework is multifaceted as it gathers information at household level; from women in households to assess use of contraceptives; family planning service delivery points serving local women; and women clients exiting facilities after receiving services. The framework allows tracking of users both as a cross-section and as a panel over time to see their behavioural and attitudinal changes, and willingness to use contraception and access facilities, preparedness and availability and choices at facilities, measures taken to address missed opportunities, and to maintain stocks of all needed commodities, and finally assess quality of service using responses of women exiting health facilities. Furthermore, PMA results have an edge over the routine service statistics because of their roots in the beneficiaries and greater reliability towards decision making to address emerging needs, besides eliminating exaggerated service statistics by linking field data with users' responses. The uniqueness of PMA is the frequent availability of data to see progress and steer programme activities. The second Phase of this PMA exercise in the province, undertaken during 2024, provides good trend data to track the trend of several key reproductive health indicators. The exercise is different from Pakistan

Demographic Health Survey due to its research design and sample selection process thus results are not comparable.

The framework provides a unique design that links users to FP service delivery points nearest to their community. The survey provides information about women's access to contraceptive methods in both public and private facilities and how that affects their method choice options. The quality of services has remained central to contraceptive uptake and sustaining CPR. This exercise tries to assess quality of services from users' and service providers' perspective, but also assesses knowledge about FP among service providers across sectors to relate it to service delivery standards. The survey framework focuses on current users (their most recent visit), discontinued users for reasons, and women with unmet need, identifying access and quality barriers, service accessibility, and service quality and integration (where provided).

The survey also introduces new tools to measure family planning access, equity, quality and choice (e.g., whether contraceptive users obtained the method of their choice, decision-making on choice of current method, payment for contraceptives and services, and availability of integrated health services). The survey framework concentrates on three main groups: current users at their most recent visit, discontinued users and their reasons for discontinuation, and women with Unmet Need. It aims to identify barriers related to access and quality, assess service accessibility, and evaluate service quality and integration where available.

What impact do we expect from such an effort to make? This information covers a wide range of aspects of the program, including CPR, unintended pregnancies, reasons for non-use, and feedback on service quality. It also encompasses the service delivery environment, considering factors like stock outs and provider knowledge, along with client perspectives and feedback on their interactions. This comprehensive guidance can assist in developing corrective program measures and utilizing evidence for advocacy where necessary to support the program. New strategies, including enhancing coverage, improving quality of services, building partnerships with private sector, building efficient procurement and supply systems, and of course strengthening the monitoring system, are expected outcomes. Ownership of the government of the exercise results is vital to bring necessary improvements and to align with the FP/RH goals. The support by UNFPA to address this critical research gap lays the basis of long-term improvements in the FP enabling environment in Khyber Pakhtunkhwa.

The slow increase in contraceptive use over a decade against the expectation of a rise in CPR is a serious challenge as it counters the plans and strategies set for lowering fertility. The slow progression persists in the presence of commitment to enhance CPR and to lower fertility. The presence of unmet need for contraception, unintended pregnancies, high missed opportunities for family planning etc., consistently points towards the need to improve the situation by regular review programme activities. Prior studies of family planning programmes note four areas as critical for achievement of FP goals that are set under FP2030 Commitments: Access, Equity, Quality and Choice, contraceptive security, and coverage. These areas have challenges and need regular critical assessments to help understand the ways to ensure best practices are implemented.

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Ownership of the government of the exercise results is critical to bring necessary improvements and to align with the FP/RH goals. The support by UNFPA to address this critical research gap lays the basis of long-term improvements in the FP enabling environment in Balochistan.

## **1.2 Objectives of the Study**

The longitudinal Panel Study aims to produce reliable estimates for family planning and reproductive health on a regular basis. The following are the objectives:

1. To generate reliable point estimates of key indicators that provide evidence to family planning Programme managers in Balochistan for improvements and track programme performance
2. To analyze contraceptive dynamics and causal factors to identify areas needing attention for remedial initiatives
3. To monitor core indicators over time as a guide and advise on performance monitoring and improve systems to meet FP2030 Commitments, including enhancing access and quality of services
4. To assess feedback on:
  - Policy Commitments on strategies to lower unmet need for contraception, improve service quality and ensure easy access to family planning services and facilities
  - Service integration at the facility level for enabling the environment to boost FP and MCH services to address missed opportunities and enhance modern CPR

## **1.3 Survey Methodology**

### **Sample Design and Size**

The Panel Study focused on exercise to collect province-level data using a representative sample of households and women in selected clusters. The design involves (i) interviewing a sample of currently married females aged 15 to 49 years in selected households; and (ii) identifying a sample of facilities that provide family planning services including public sector (Health and Population Welfare facilities), and outlets of private sector serving the selected communities/clusters. The currently married female respondents are asked questions about their use and experiences of family planning, reproduction, and fertility preferences.

### **1.4 Sample Selection**

#### Target Clusters / Areas and Households

The Phase-II of the Balochistan Panel Study 2024 household selection used a two-stage cluster design. Forty-eight (46) enumeration areas (EA) were drawn from the Pakistan Maternal Mortality Survey (PMMS) 2019 master sampling frame, of which 23 clusters each from urban and rural areas. Following the general sampling rule laid down by PMA 2020, 42 households from urban and 35 from rural are selected. The survey aimed for a sample size of 1828 households. Data collection of this Phase was conducted in June to August 2024.

In Phase-II, five (5) health service delivery points (SDPs) were visited that lie within 5 kilometers of each selected EA. These SDPs were obtained from the community that served FP-RH to the selected EAs at all three levels. The SDP sample design is linked to the household survey design. SDP sample size is determined by two factors: the number of EAs selected for the population-based survey, and the family planning service system in Balochistan. The public sector system included facilities of the DoH (that include District Hospital, Rural Health Centres, Basic Health Units, and MCH Centres), and of the Population Welfare Department (Reproductive Health Service Centres and Family Welfare Centres). Three public sector facilities were selected from the available with 5 kilometres of the EA. Two non-public SDPs were selected, which are run by non-government organizations (NGOs), private formal health facilities, such as hospitals and clinics, and non-formal health facilities, such as pharmacies and drug shops. The survey aimed for a sample of 230 SDPs, but survey teams could find and reach out to only 115 facilities even at more than 10 kilometers away from the cluster. Data gathering of SDPs focused on type of FP services, stocks, skills of service providers, quality of service aspects, and knowledge of service providers regarding FP. The SDP survey monitors service availability and quality, understands attributes for the availability and readiness, and explores the association of these SDP results with individual behaviors in the cluster, by linking data from both the SDP and household surveys.

Ten (10) client exit interviews are included for each SDP to cover ample information from users who visited SDPs for family planning and MCH services. The client exit surveys provide data to understand service provision (i.e., the process dimension of quality) and perceived quality among FP and RH service users.

Survey follows a Three-Stage Sample Selection Design:

- (i) random selection of districts from each division of Balochistan, covering all ecological zones
- (ii) random selection of 46 enumeration areas (clusters) from all districts (able below); and random selection of 23 households from urban and 23 from rural clusters. The exercise produces province-level estimates of key indicators.

**Table 1.1: Sample Selection – Clusters by Districts of Balochistan**

Divisions	Districts	Clusters		
		Urban	Rural	Total
KALAT	Khuzdar	6	3	9
	Mastung	2	2	4
MEKRAN	Kech	5	4	9
NASIRABAD	Kachhi	3	1	4
QUETTA	Quetta	3	9	12
SIBI	Sibi	2	2	4
ZHOB	Zhob	2	2	4
<b>Total</b>		<b>23</b>	<b>23</b>	<b>46</b>

The survey includes a sample size that allows for calculating province-level estimates for all indicators, including computing the modern contraceptive prevalence rate (mCPR) with a margin of error of  $\pm 5$  percentage points. Sample weights were estimated by the Pakistan Bureau of Statistics (PBS), based on non-response at the cluster, household, and individual

level and were applied to the women dataset for analysis. The study selected 1,759 households, of which all were successfully contacted. A total of 1,978 eligible women participated in the interviews.

**Table 1.2: Survey Coverage**

<b>Number of Households, Women, Facilities and Clients</b>	<b>Phase-II, 2024</b>
Number of households contacted	1,759
Number of eligible women interviewed	1,978
Number of facilities visited for interview	115
Number of client exit interviews held	1,053

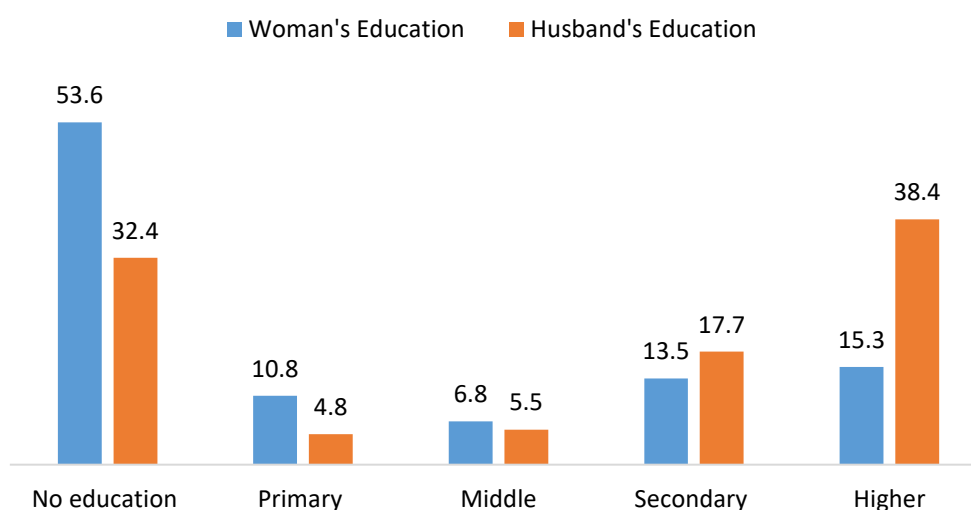
In this phase, 753 households (43%) were replaced for various reasons including: Not found/migrated - 38% or No eligible women in household – 0.5%, or Refused – 3.8%, and Others – 0.3%. A total of 1007 households were same that were interviewed in the previous survey.

On average, 1.12 women were interviewed per contacted household. Rural women interviewed accounted for 71 percent of all women contacted. This report summarizes cross-sectional data collected from the households of EAs, service delivery points that were reached out in this Phase of the survey, summarizing readiness to provide FP services and reproductive health services, and clients exiting facilities reflecting their experiences regarding services.

## 2.1 Profile of the Woman Respondents

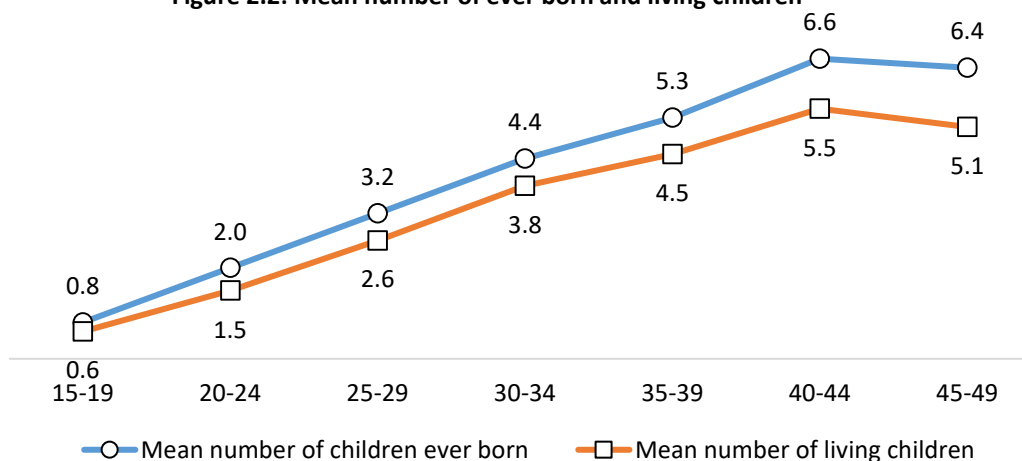
Inequity in educational attainment exists among husbands and wives in Balochistan. Among currently married women, the majority (54 percent) have no formal education, compared to only 32 percent of husbands without education (Figure 2.1). Furthermore, more than half of all husbands are reported to have completed Secondary or higher education, as against only 29 percent of currently married women completing secondary or higher education.

**Figure 2.1: Educational attainment of woman and her husband**



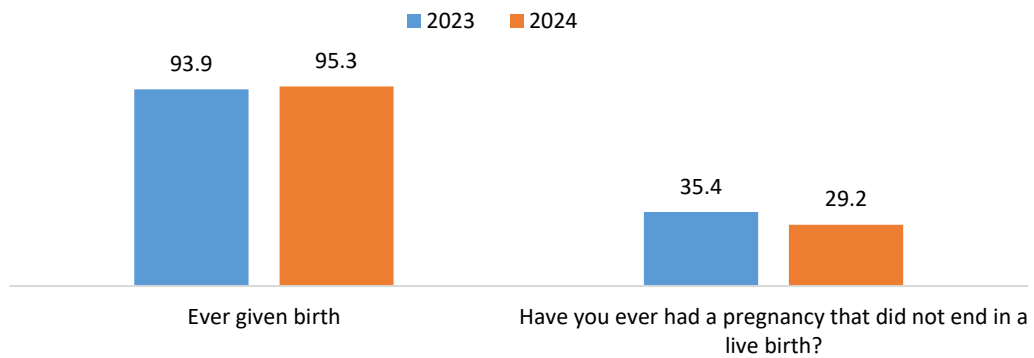
The survey asked women about the number of children they have ever given birth to and the number of children currently living (Figure 2.2). Women aged 15-19 have the lowest number, with an average of 0.8 children ever born and 0.6 living children. In contrast, women aged 40-44 had the highest numbers, with 6.6 children ever born and 5.5 living children. Notably, there is a slight decline in both the mean number of children ever born and the mean number of living children among women aged 45-49. The gap between these two figures indicates the loss of children among women.

**Figure 2.2: Mean number of ever born and living children**



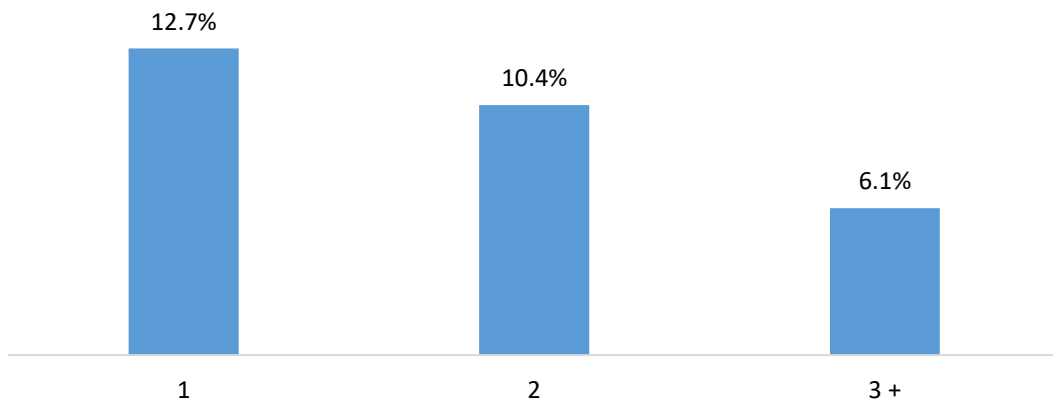
Pregnancy loss is a serious maternal health issue in all provinces of Pakistan. The percentage of women who have ever given birth increased slightly from 93.9 percent in 2023 to 95.3 percent in 2024. However, percent women reporting pregnancy loss or stillbirth declined from 35.4 percent in 2023 to 29.2 percent in 2024, reflecting an improvement in the quality of life of women. On average, a woman in Balochistan experiences more than 1.8 pregnancy losses over her lifetime, which is quite high.

**Figure 2.3 Trend of percent women who ever gave birth and those who experienced pregnancy loss or still birth**



Survey 2024 reveals a high percentage of women (12.7%) experiencing a pregnancy loss (Figure 2.4) in their lifetime. One in ten women (10.4 percent) reported experiencing two pregnancy losses and 6 percent experienced three and more pregnancy losses.

**Figure 2.4: Percent of women reporting number of pregnancies that did not end in a live birth**



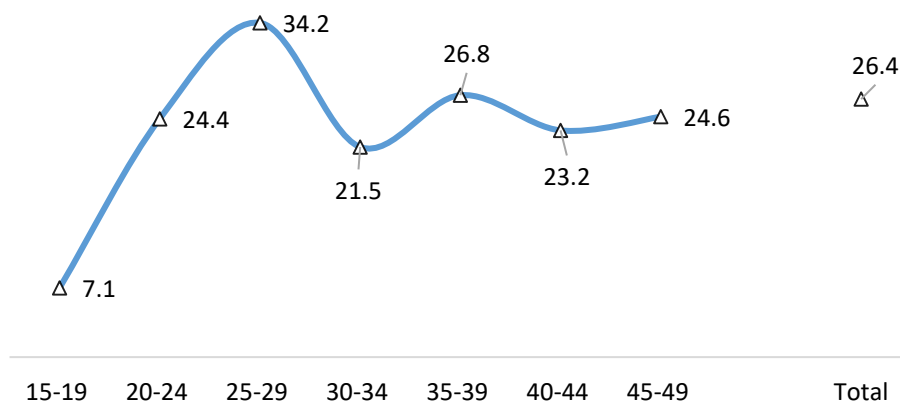
## WOMEN’S KNOWLEDGE AND CONTRACEPTIVE USE 3

This section explores various aspects of family planning, including knowledge, usage, and sources of contraceptive methods, as well as informed choice and the rates and reasons for discontinuing contraceptive use. It also addresses the need for family planning, the extent to which demand is met, post-pregnancy counselling, and whether non-users are engaging with service providers in the community or at facilities. The use of contraceptive methods enables women to prevent unintended or untimely pregnancies, reducing the risk of unsafe abortions. Additionally, contraceptives support birth spacing, which has significant health benefits for both mothers and infants.

### 3.1 Knowledge of Family Planning Methods

An important indicator of family planning relates to women’s knowledge of family planning concepts and methods before a woman’s marriage. Knowledge of contraceptives before marriage peaks among women aged 25-29 (34.2%) and is lowest among younger women of 15 to 19 years (7.1%). All the other age groups had similar knowledge of FP methods before marriage (ranging between 21% and 24%) (Figure 3.1). Younger women are better educated and therefore more informed than older women.

**Figure 3.1: Percentage of women who heard of any method before marriage**

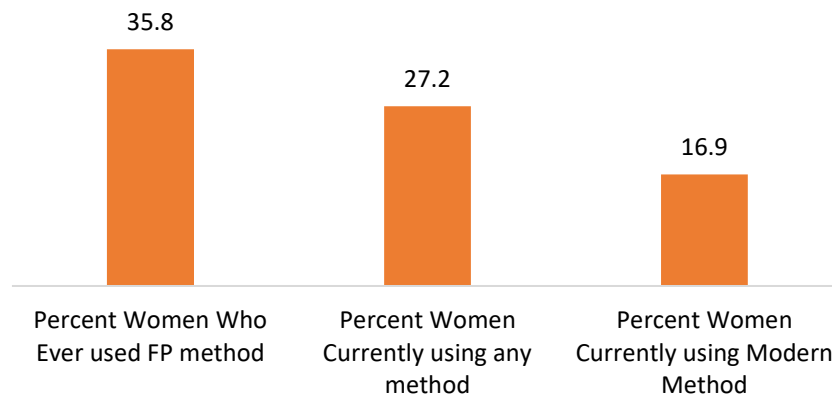


### 3.2 Use of Family Planning Methods

All eligible women were asked about their use of contraceptive methods since marriage for birth spacing or limiting. The proportion of women who have ever used a contraceptive method stood at 35.8 percent (Figure 3.2). Among all women, more than a quarter (27%) reported being current users of

any contraceptive method of FP, while only 17 percent of women reported using a modern method. The gap between the user of any method and any modern method indicates the use of traditional methods and of

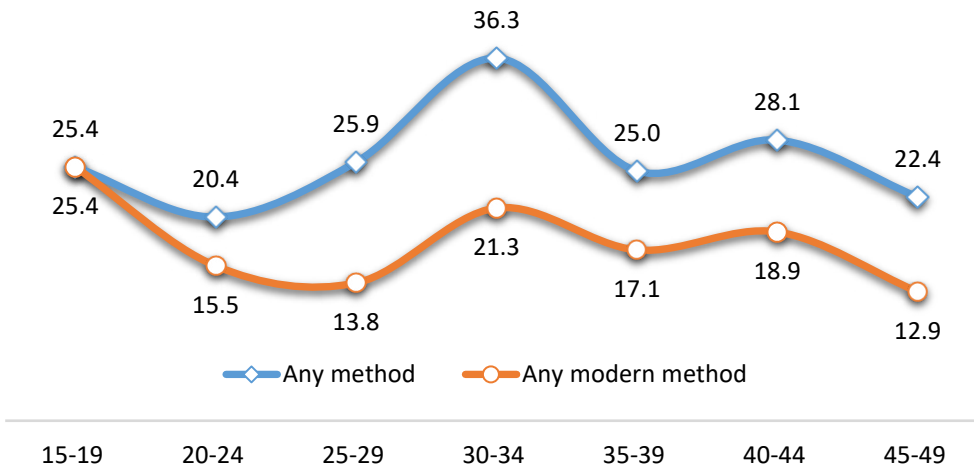
**Figure 3.2: Percent women reporting contraceptive use - ever and current use**



course, the need for interventions designed to encourage women to adopt modern methods of contraception. Use of any family planning method has risen from 23 percent (Phase I 2023 survey) to 27 percent (Phase II 2025 survey). On the contrary, comparison of two surveys reveals a slight decline in use of modern methods (from 17 percent in 2023 to 14.8 percent in 2024). This analysis implies a slight increase in the use of traditional methods by women, on the other hand, discontinuation of use as reflected by the difference between ever use and current use of any method reflects 9 percent of women who dropped out. This behaviour not only adds to unmet needs but also to the risk of unintended pregnancies.

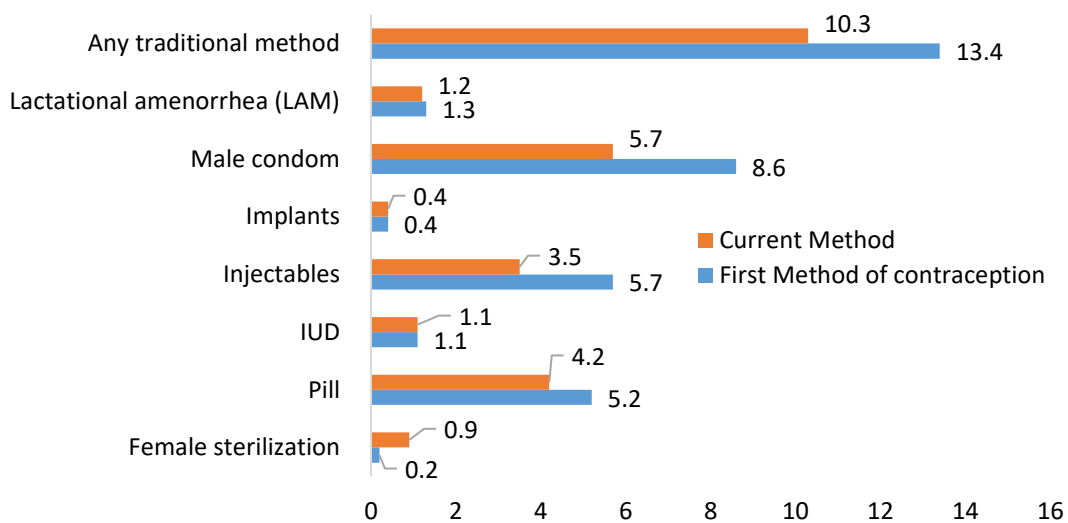
Variation in use of family planning is expected as women follow their reproductive health needs, from high demand for fertility towards high demand to limit or space births over the life cycle. Examining contraceptive use by women's age shows a rapid rise of any contraceptive method from young ages (15-19) to a maximum of 36 percent at age 30-34. By age 30, most women have completed their fertility and prefer to limit births. Survey reveals that women increasingly depend on traditional methods (from ages 25 onwards) while use of modern methods remains relatively low (between 14 percent and 19 percent). This low use may reflect poor access and low knowledge regarding contraceptive methods among women beyond age 30.

**Figure 3.3: Percentage of women by current use of contraceptive method**



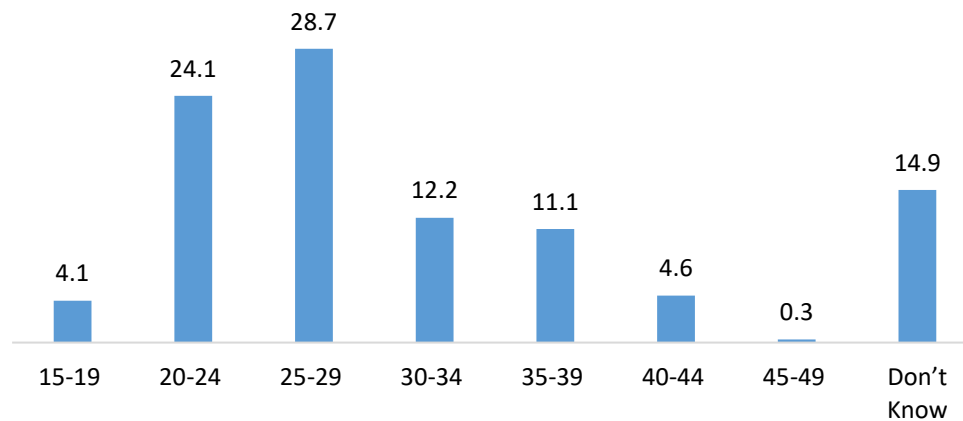
Contraceptive mix is an important area of interest in PMA surveys. The survey enquired regarding the first contraceptive method ever used and current method in use (if any). A fair percentage of women (13 percent) reported use of traditional methods as their first method which is currently being used by 10 percent of women and remains the most popular and common method in use (Figure 3.4). Traditional methods are well known for their ineffectiveness towards birth spacing or limiting but women use it due to lack of access to or lack of knowledge of modern methods. From among the modern methods, condoms are popular as the first method and also in current use but by fewer women (8.6 percent vs 5.7 percent). Condoms may still be quite popular but remain as an inefficient method to give necessary protection against unintended pregnancies. A reasonable percentage of women reported injectables and pills as their first method but due to experiencing side effects and poor knowledge to manage side effects, women dropped out using these methods. Three methods are least common in Balochistan: female sterilization (0.9%) and IUD (1.1%) and implants least popular current method (0.4%).

**Figure 3.4: Changes in contraceptive method use - first and current method**



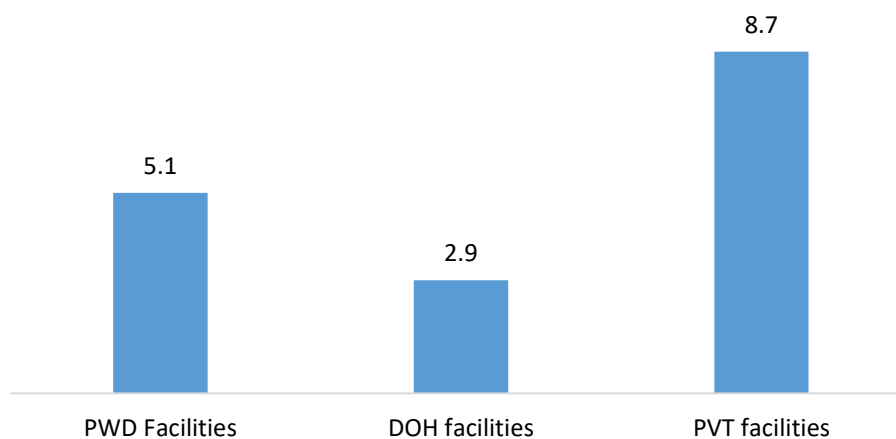
More than half (53%) of women started to use their first method while they were between the ages of 20-29 (Figure 3.5). Late starters (use of first method beyond age 30) are few (26%) and could be due to lack of access or poor knowledge as where to acquire the same. Around 15 percent of women said they couldn't recall the age at which they first used a contraceptive method.

**Figure 3.5: Percent distribution of respondent age when first used contraceptive method to avoid pregnancy**



Access to modern methods is another area of interest in the survey. Survey reveals that the highest percentage of women (8.7%) report having accessed FP method from a private facility (Figure 3.6). PWD facilities were the second most common source of contraceptive methods (by 5 percent of women), while DOH facilities were the least popular source of contraceptives (less than 3 percent). The importance of private sector facilities cannot be denied, especially when the public sector faces tremendous financial and logistics problems to ensure full access to contraceptive commodities across Balochistan.

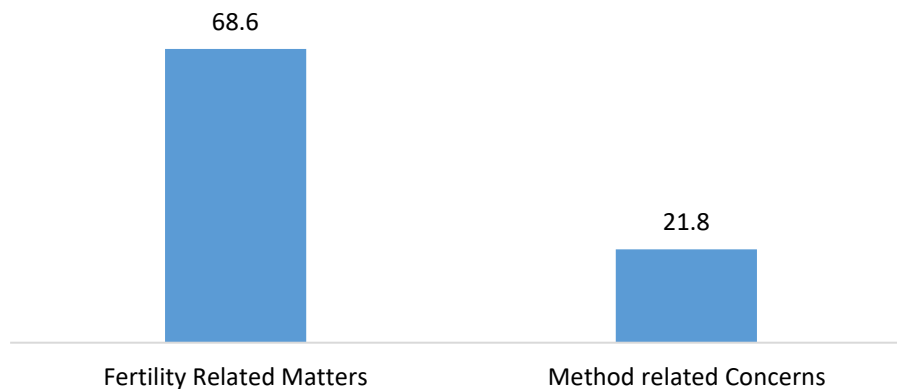
**Figure 3.6: Percent of women reporting most recent source of FP services**



Discontinuation of contraceptive methods is a serious issue for women who need protection against unintended pregnancies and desire to space or limit births. The survey enquired from

women the reasons for their discontinuation which are lumped to evolve two broad categories – method-specific reasons of fertility-related reasons. Surveys finds quite a high percentage (69%) in favour of fertility-related reasons to discontinue, implying high demand for additional children (Figure 3.7). However, when it comes to method-related discontinuation, women are less likely to discontinue (22%) (Figure 3.7). Lack of necessary information regarding side effects, fear of side effects and how to manage side effects are major reasons for method-specific reasons for discontinuation.

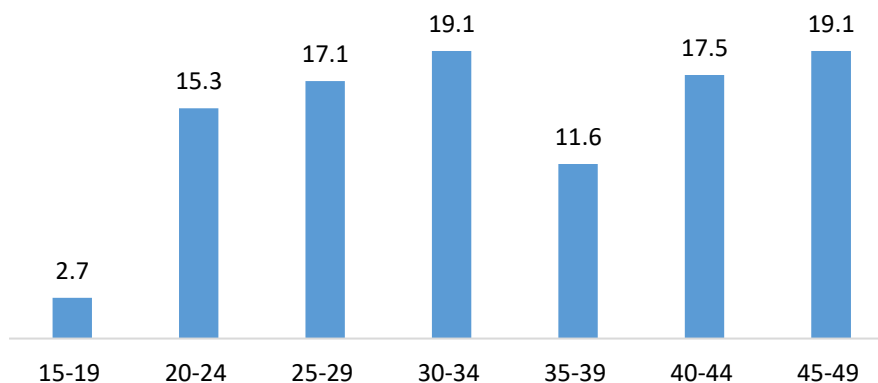
**Figure 3.7: Reasons for contraceptive discontinuation**



### 3.3 Interaction with Health Facility Staff

Women were asked about the visit by Lady Health Workers to their homes to provide family planning and maternal health information and services. Survey results show that less than 19 percent of currently married women reported visits by LHWs between ages of 20 and 29 years (Figure 3.8). The percentage of LHW visits is quite low for ages less than 20 implying newlywed women are scarcely visited by LHWs. Low percent reporting by women of LHW visits to their homes reflects poor performance which surely needs to be addressed by the Department of Health to ensure LHWs attend to women to encourage them to use contraception for birth spacing. The LHWs programme has a rural focus which is reflected by a much higher percentage of rural women reporting visits by LHWs than their urban counterparts.

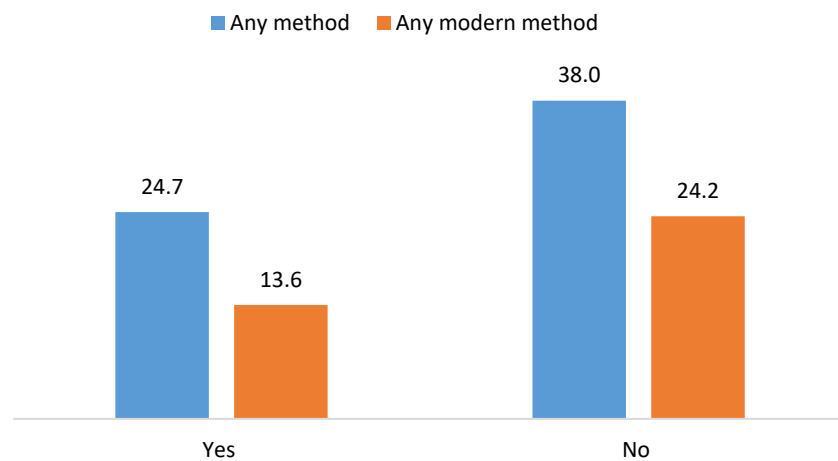
**Figure 3.8: Percent distribution of women who visit by LHW and to health facility in last 12 months**



An analysis of contraceptive prevalence by program interventions reveals that interaction with Lady Health Workers (LHWs) reflects a negative impact on modern contraceptive prevalence rate (mCPR), implying low CPR among women who reported interaction with LHWs. The modern contraceptive prevalence rate (mCPR) among women who interacted with Lady Health Workers (LHWs) is 10 percent, compared to 18 percent among those who did not have such interactions.

Further analysis to see whether visit of LHW to women's homes has any effect on the first use of contraception reveals that the reported use of first any contraceptive method as well as any modern method is higher for women who were not

**Figure 3.9: Percent distribution of women by first used contraceptive method and LHW visit to talk about FP in previous 12 months**

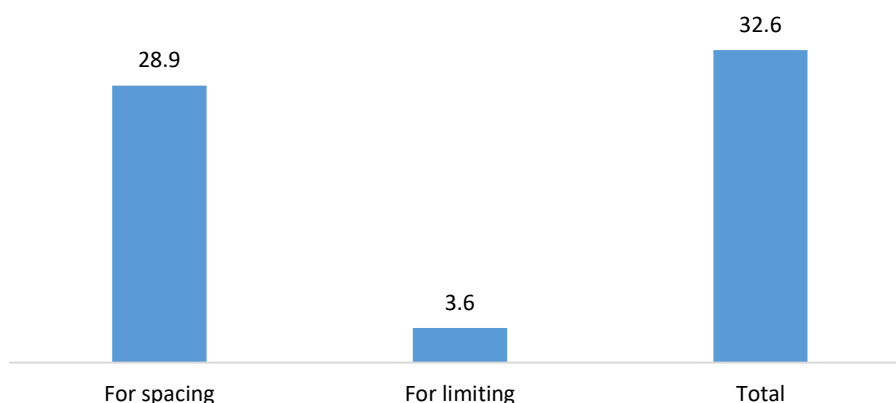


visited by a LHW in the last 12 months (Figure 3.9). The results are quite opposite to what the LHW Programme is supposed and designed to achieve. Only a quarter of women (24.7 percent) reported a visit by a LHW (in the last 12 months) and were using any contraceptive method, this percentage was much higher, i.e. 38 percent for women who were not visited by a LHW. A similar pattern is observed in the case of modern methods of contraception.

### 3.4 Purpose of Use and Unmet Need for Family Planning

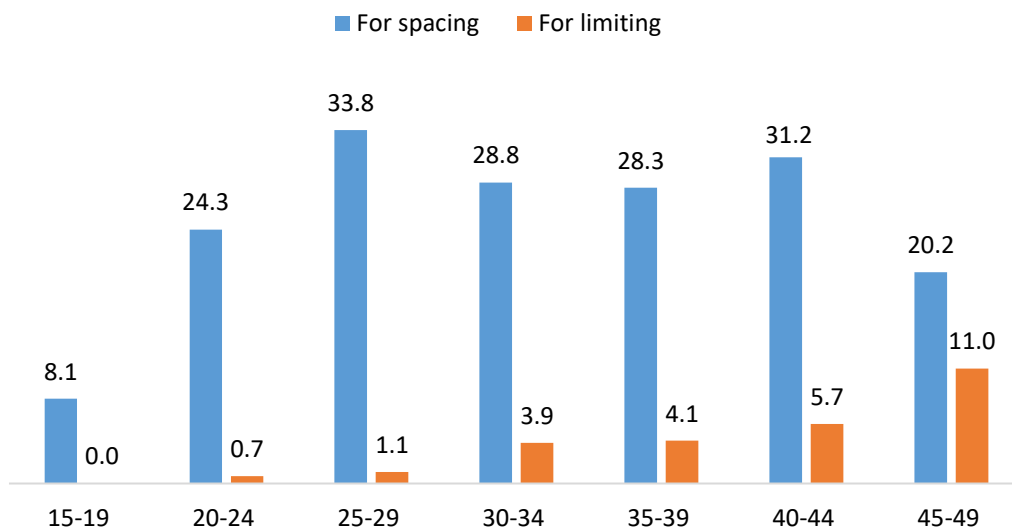
The unmet need which reflects fecund women desiring to space or limit births but not using any family planning method to achieve their desired objective. Survey reveals a very high percentage of women indicated an unmet need for FP - 32.6 percent (Figure 3.10). Among these women, 28.9 percent expressed need for birth spacing while only 3.6 percent has an unmet need for limiting future births.

**Figure 3.10: Percentage of women with unmet need for family planning**



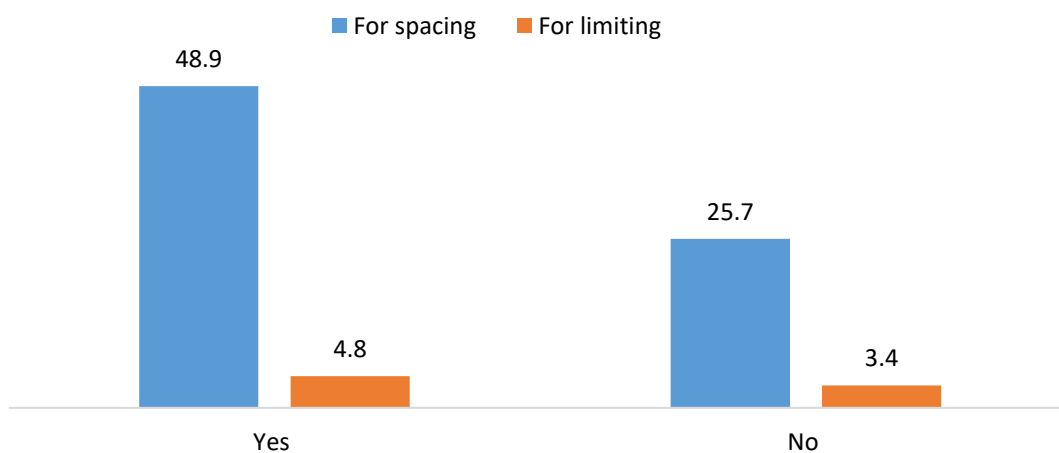
The unmet need for birth spacing was highest (33.8%) in the age group 25 to 29 years, followed by women aged 40 to 44 years (31.2%). Women in the youngest age group had the lowest unmet need for birth spacing. The unmet need for limiting births shows an increasing pattern i.e. as the women age, the unmet need for limiting births also increases, as shown in Figure 3.11.

**Figure 3.11: Percentage of women with unmet need for family planning by age**



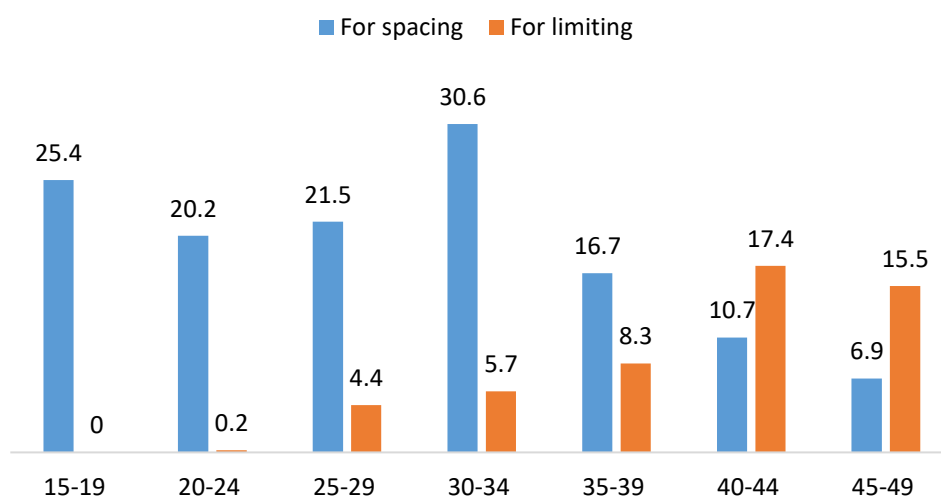
Analysis was done to see if women who visited a health facility in the previous 12 months and talked to health staff, what women's unmet need indicated. Survey reveals that only 16 percent of women who visited a health facility talked about family planning. Women who were advised by the health staff indicated much higher unmet need for birth spacing, almost half of them (49%) and less than 5 percent had unmet need for limiting future births (Figure 3.12). Women who didn't talk to facility staff reflect much lower unmet need for birth spacing (25.7 percent). Analysis reveals that women talking to health staff does make a difference in terms of their unmet needs, especially for birth spacing purposes.

**Figure 3.12: Percentage of women with unmet need for family planning whom any staff member at health facility speak about FP method**



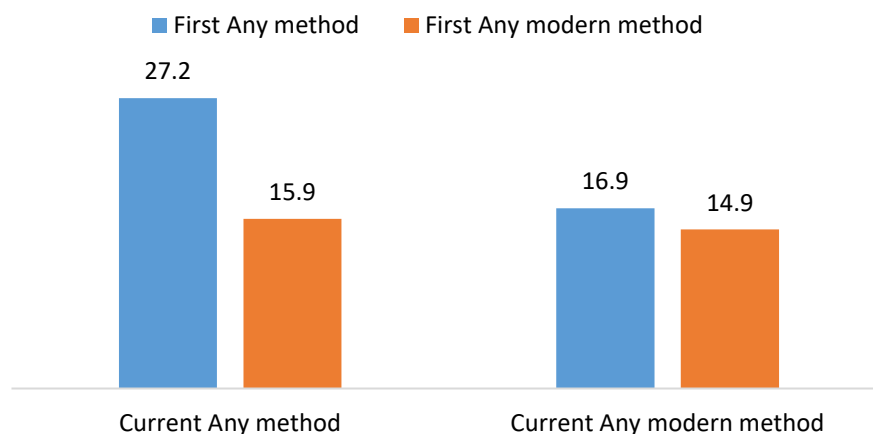
Birth spacing is been a key strategy to lower overall fertility rates. This aspect is assessed by asking women regarding the purpose of contraceptive use and also estimating unmet need for family planning. Among the currently married women who are using FP methods to space or limit future births a clear pattern is observed (Figure 3.13) i.e. younger women of age less than 30 prefer using contraception for birth spacing, and as women progress in age, the use of FP for limiting birth also increases. The highest proportion of women using FP methods for birth spacing is in the age group 30 to 34 years (30.6%), followed by women 15 to 19 years old (25.4%). Women aged 45 to 49 years reported the least use of FP for birth spacing (6.9%). This is a good finding that program managers need to utilize to ensure access to contraception for birth spacing.

**Figure 3.13: Percentage of women by purpose of family planning by age**



Among women who are currently using any contraception, 27.2 percent of them are using the same method they started first time (Figure 3.14) while only 15.9 percent opted for modern methods of contraception as the first FP they ever used. On the other hand, among women currently using modern methods there is hardly any difference between their first time use of any FP methods (16.9 percent) and those modern methods of contraception as their first method (14.9 percent).

**Figure 3.14: Percent distribution of women current contraceptive method by first contraceptive method used**



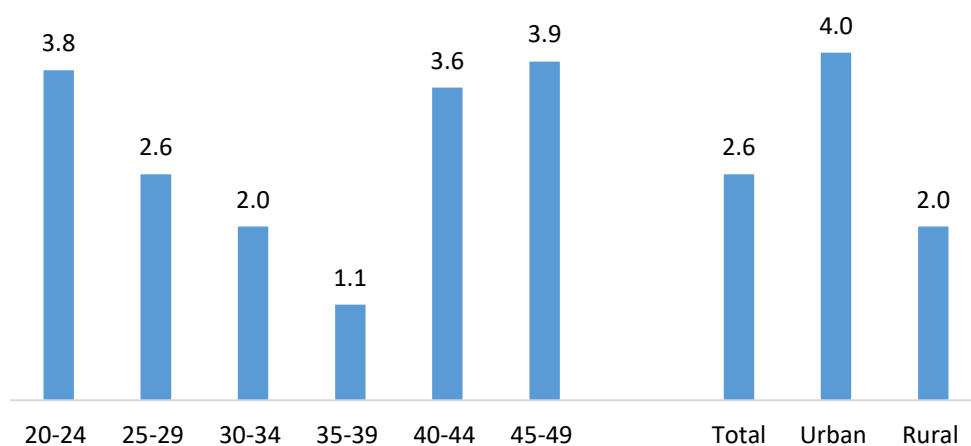
### 3.5 Maternal Health Indicators

Healthcare services during pregnancy, childbirth, and the postpartum period are crucial for ensuring the survival and well-being of both mother and infant. In April 2005, Pakistan introduced a comprehensive National Maternal, Neonatal, and Child Health (MNCH) Strategic Framework, followed by the launch of the National MNCH Programme in 2007 to accelerate progress toward achieving MDGs 4 and 5. This framework outlines the vision and guidelines for developing MNCH interventions. Key focus areas include promoting institutional deliveries, skilled birth attendance, and expanding primary healthcare services through Community Midwives (CMWs) and Lady Health Workers (LHWs), especially in rural areas via home visits. CMWs provide skilled birth attendance and antenatal care (ANC) at the community level, while LHWs directly contribute to improving maternal and child health by promoting personal hygiene, increasing contraceptive use, administering antenatal care, providing iron and folic acid supplements during pregnancy, monitoring child growth, and offering vaccination counseling for mothers and children.

Several maternal health indicators are measured in the PMA 2024 to observe maternal health status in 2024. Women were asked about their unintended pregnancy, ANC, skilled birth attendance, place of delivery and post-natal checkup.

Balochistan has a conservative traditional culture where all pregnancies are wanted and very few are stated as unintended. A very small percentage of women (2.6%) reported an unintended pregnancy in the previous five years, most of which are reported by urban women (Figure 3.15). Survey shows a relatively high percentage of women who are in younger ages (less than 25) and those who are above age 40. Older age groups, i.e. 40 to 49 years, report the highest percentage of unintended pregnancy. Women reporting unintended pregnancies reflect non-use or use of less effective contraceptive methods and clearly reflecting the need for programmatic initiatives to reach out to meet their reproductive health needs.

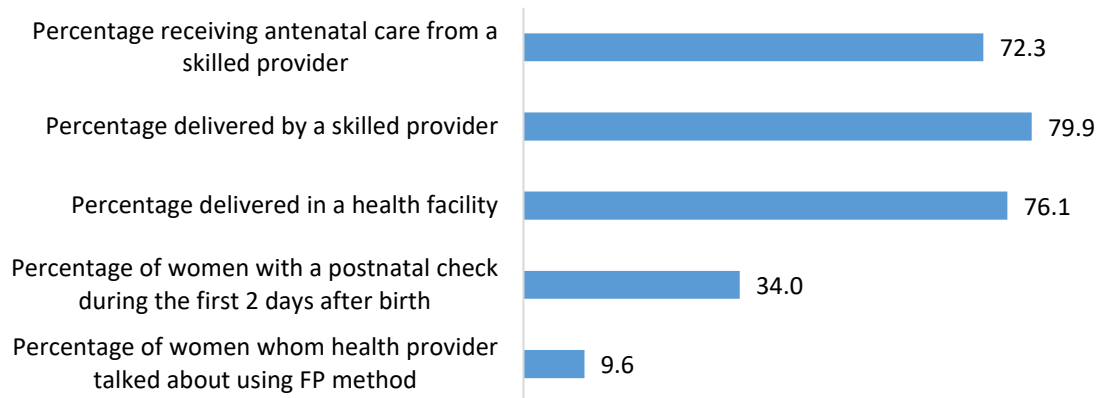
**Figure 3.15: Percentage of of women who experienced an unintended pregnancy by age groups and place of residence**



More specifically, maternal health indicators including ANC, delivery by a skilled person, and postnatal care were inquired in detail. Survey reveals three-quarters or more women received

antenatal care by a skilled person, were delivered by a skilled staff, and delivered at a skilled facility (Figure 3.16). Only a third of women (34%) reported receiving postnatal checkups for their last delivery. A smaller percentage (10%) reported getting a postnatal check-up during the first two days after birth. However, a very small number reported that health providers talked to them about FP.

**Figure 3.16: Percent distribution of women who had a most current birth in preceding the survey by receiving ANC, delivery by skilled provider and PNC by birth attendant**



Mental health is a critical aspect of overall well-being, and its importance cannot be overstated, especially for married women in Balochistan, where cultural, social, and economic factors often aggravate mental health challenges. Mental health is integral to physical health, emotional stability, and social functioning. Poor mental health can lead to chronic physical conditions, reduced productivity, and impaired relationships. Mental health problems can lead to social isolation, stigma, and discrimination, further worsening the individual's condition. Poor maternal mental health can negatively impact children's development, leading to long-term consequences for future generations.

Married women in Balochistan often face societal expectations related to marriage, childbearing, and household responsibilities, which can lead to stress, anxiety, and depression. Many women in Balochistan have limited decision-making power, which can contribute to feelings of helplessness and low self-esteem. High rates of domestic violence in the region can lead to trauma, anxiety, and depression among married women. Issues like unintended pregnancies, lack of access to family planning, and postpartum depression can significantly impact mental health. Stigma surrounding mental health prevents many women from seeking help, while limited access to mental health services further compounds the problem.

To assess symptoms of anxiety, the Mental Health Module includes the Generalized Anxiety Disorder 7 scale (GAD-7), a series of seven items designed to measure the main feature of anxiety: persistent and impairing worry. The GAD-7 captures characteristics of three other common anxiety disorders: panic disorder, social anxiety disorder, and posttraumatic stress disorder. Anxiety is a feeling of worry, nervousness, or unease about something with an uncertain outcome. It becomes a mental health disorder when it is excessive, persistent, and interferes with daily functioning. Furthermore, to assess symptoms of depression, the module includes nine items from the Patient Health Questionnaire, or PHQ-9. Stress is often inferred from symptoms like trouble relaxing, feeling nervous, or worrying too much. The questions in the PHQ-9 are based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for diagnosis of depression. Both scales focus on symptoms experienced in the 2 weeks preceding the survey. Severity of symptoms for both tools is depicted using a Likert scale in which scores of 0, 1, 2, and 3 are assigned to the response categories "not at all" (never), "several days" (rarely), "more than half the days" (often), and "nearly every day" (always), respectively. A total score is generated by adding together the scores of individual items. One of the key elements in implementing the Mental Health Module was the effort to use a set of translated questionnaires for the GAD-7 and PHQ-9 in the local languages.

**Table 4.1: Symptoms of anxiety**

Percent distributions of women age 15-49 by frequency of symptoms of anxiety in the 2 weeks preceding the survey, according to specific symptoms included in the Generalized Anxiety Disorder 7 (GAD-7) scale

Symptom of anxiety	Never	Rarely	Often	Always	Refuse	Don't Know	Total	Number of women
Feeling nervous, anxious or on edge	29.4	50.3	12.1	5.2	2.1	0.9	100.0	1,968
Not being able to stop or control worrying	36.4	38.8	19.3	2.5	2.4	0.6	100.0	1,968
Worrying too much about different things	23.7	36.0	27.7	9.6	2.2	0.7	100.0	1,968
Trouble relaxing	39.8	31.2	16.2	8.2	2.7	1.9	100.0	1,968
Being so restless that it is hard to sit still	46.3	30.9	14.2	3.8	2.9	1.9	100.0	1,968
Becoming easily annoyed or irritable	27.0	35.0	22.9	11.0	2.6	1.5	100.0	1,968
Feeling afraid as if something awful might happen	38.3	31.8	17.7	8.1	2.5	1.6	100.0	1,968

The distribution of responses to each item in the GAD-7<sup>2</sup> is given in Table 4.1: (a) feeling nervous, anxious, or on edge; (b) not being able to stop or control worrying; (c) worrying too much about different things; (d) trouble relaxing; (e) being so restless that it is hard to sit still; (f) becoming easily annoyed or irritable; and (g) feeling afraid as if something awful might happen.

**Prevalence of anxiety symptoms:** A significant proportion of women reported experiencing anxiety symptoms often or always: (i) "Worrying too much about different things" (37.3% combined often/always); (ii) "Becoming easily annoyed or irritable" (33.9% combined often/always); and (iii) "Not being able to stop or control worrying" (21.8% combined often/always). These findings suggest that anxiety is a notable mental health concern among women in this population.

**Protective factors:** The relatively low prevalence of symptoms like "Being so restless that it is hard to sit still" and "Feeling afraid as if something awful might happen" suggests that some women may have coping mechanisms or social support systems in place. In conservative or patriarchal settings, women may face stressors such as limited autonomy, domestic responsibilities, or gender-based violence, contributing to anxiety. Furthermore, limited access to mental health care may prevent women from seeking help.

#### 4.1 Severity of Symptoms of Anxiety

The percent distribution of women aged 15–49 by their Generalized Anxiety Disorder 7 (GAD-7) scores presented in Table 4.2 gives a measure of the severity of anxiety symptoms and it shows the percentage of women with symptoms of anxiety (GAD-7 score  $\geq 6$ ) across various background characteristics.

General observation regarding Anxiety Severity which is reflected by the percentage with

<sup>2</sup> GAD-7 scores range from a minimum of 0 to a maximum of 21. Higher scores are associated with more severe symptoms of anxiety.

Symptoms of Anxiety (GAD-7  $\geq 6$ ) shows that 55.7% of women interviewed in Balochistan have symptoms of anxiety. Women with GAD-7 score distribution of 15–21 (severe anxiety) are 4.5 percent. Little more than half of all women (51.2%) have symptoms of anxiety (GAD-7  $\geq 6$ ), indicating a significant mental health burden. The survey data reveals that anxiety is a significant mental health concern among women in Balochistan.

**Table 4.2: Severity of symptoms of anxiety**

Percent distribution of women age 15–49 by their Generalized Anxiety Disorder 7 (GAD-7) score and percentage with symptoms of anxiety, according to background characteristics

Background characteristic	GAD-7 Score				Total	Percentage with symptoms of anxiety <sup>5</sup>	Number of women
	0-5	6-14	15-21				
<b>Respondent Age</b>							
15-19	62.0	38.0	0.0	100.0	38.0	20	
20-24	51.6	47.7	0.7	100.0	48.4	233	
25-29	46.8	48.6	4.5	100.0	53.2	509	
30-34	48.7	47.5	3.8	100.0	51.3	395	
35-39	43.2	53.1	3.7	100.0	56.8	357	
40-44	36.2	55.2	8.6	100.0	63.8	300	
45-49	29.3	63.5	7.2	100.0	70.7	155	
<b>Number of living children</b>							
0	55.1	43.6	1.3	100.0	44.9	93	
1-2	47.1	48.1	4.8	100.0	52.9	593	
3-4	46.7	50.1	3.2	100.0	53.3	669	
5+	37.3	56.5	6.2	100.0	62.7	613	
<b>Region</b>							
Urban	44.4	51.0	4.6	100.0	55.6	573	
Rural	44.2	51.3	4.5	100.0	55.8	1,396	
<b>Respondent's Education</b>							
No education	45.9	49.0	5.2	100.0	54.1	1,056	
Primary <sup>1</sup>	49.1	48.7	2.2	100.0	50.9	213	
Middle <sup>2</sup>	35.1	54.1	10.8	100.0	64.9	134	
Secondary <sup>3</sup>	47.3	51.2	1.5	100.0	52.7	265	
Higher <sup>4</sup>	36.7	59.3	3.9	100.0	63.3	301	
<b>Employment status</b>							
Currently employed	35.8	56.5	7.7	100.0	64.2	225	
Not currently employed	45.4	50.5	4.1	100.0	54.6	1,744	
<b>Any spousal violence (physical or sexual or emotional) in last 12 months</b>							
Yes	32.5	63.1	4.4	100.0	67.5	668	
No	49.4	47.2	3.4	100.0	50.6	825	
Privacy not obtained/Women not selected	52.0	41.2	6.8	100.0	48.0	476	
<b>Any spousal violence (physical or sexual or emotional) ever</b>							
Yes	33.1	62.1	4.7	100.0	66.9	744	
No	50.4	46.6	3.0	100.0	49.6	749	
Privacy not obtained/Women not selected	52.0	41.2	6.8	100.0	48.0	476	
<b>Wealth Index</b>							
Lowest	38.4	57.6	4.0	100.0	61.6	413	
Second	32.7	61.5	5.8	100.0	67.3	395	
Middle	49.4	44.0	6.6	100.0	50.6	364	
Fourth	56.4	42.3	1.4	100.0	43.6	391	
Highest	45.3	49.6	5.1	100.0	54.7	406	
<b>Total</b>	<b>44.3</b>	<b>51.2</b>	<b>4.5</b>	<b>100.0</b>	<b>55.7</b>	<b>1,968</b>	

<sup>1</sup> Primary refers to classes 1-5 <sup>2</sup> Middle refers to classes 6-8 <sup>3</sup> Secondary refers to classes 9-10 <sup>4</sup> Higher refers to class 11 and above

<sup>5</sup> Respondents with a GAD-7 score of 6 or higher

## 4.2 Patterns by Background Characteristics

Age-specific pattern: Percentage of women with symptoms of anxiety the highest prevalence is in the 45–49 age group (70.7%) and the lowest prevalence was in the 15–19 age group (38.0%). Older women (35 and above) have higher percentages of mild to moderate anxiety (GAD-7 6–14) while younger women (15–19) have higher percentages of minimal or no anxiety (GAD-7 0–5). Older women (e.g., 30 and above) are more likely to experience anxiety, possibly due to increased responsibilities (e.g., childcare, financial stress).

Number of living children: Women with high parity (5+) have the highest prevalence of anxiety symptoms (62.7%) as against low parity women (with 1–2 children) who have the lowest prevalence of anxiety symptoms (44.9%). Women with three or more children show a high prevalence of anxiety, likely due to the physical, emotional, and financial strain of raising a large family.

Education level: Women with middle education had the highest prevalence of anxiety symptoms (64.9%), which reflects the protective role of education in mental health. Women with higher levels of education also reflect a high prevalence of anxiety (64%).

Employment status: Currently employed women have higher prevalence of anxiety symptoms (64%) relative to unemployed women (55%). Employed women had higher anxiety rates, possibly due to workplace stress or the dual burden of work and household responsibilities.

Anxiety and spousal violence (Last 12 months): Women who experienced any form of spousal violence in the last 12 months have significantly higher anxiety symptoms (67.5%) compared to those who did not (50%). The proportion of women with moderate (GAD-7: 6–14) or severe anxiety (GAD-7: 15–21) is much higher among those who faced violence (63.1% + 4.4%) than those who did not (47.2% + 3.2%). The results suggest a strong association between spousal violence and anxiety symptoms, reinforcing the mental health burden of husbands' violence.

Anxiety and spousal violence (Ever experienced): The pattern is similar when considering lifetime exposure to violence. Women who have ever experienced spousal violence report anxiety symptoms at a higher rate (67%) compared to those who never experienced it (50%). The severity of symptoms remains notably higher among those who faced violence, with nearly 62% falling in the moderate anxiety category. The results suggest that even past exposure to violence has long-term mental health consequences.

## 4.3 Symptoms of Depression

The elements covered in the Patient Health Questionnaire (PHQ-9)<sup>3</sup> include: (a) little interest or pleasure in doing things; (b) feeling down, depressed, or hopeless; (c) trouble falling asleep or staying asleep or sleeping too much; (d) feeling tired or having little energy; (e) poor appetite or overeating; (f) feeling bad about yourself or that you are a failure or have let yourself or your family down; (g) trouble concentrating on things such as reading the newspaper or watching

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<sup>3</sup> PHQ-9 scores range from a minimum of 0 to a maximum of 27. Higher scores are associated with more severe symptoms of depression. A PHQ-9 score of 0–4 is considered minimal symptoms or no symptoms, while a score of 5–9 is considered mild, 10–14 is considered moderate, 15–19 is considered moderately severe, and 20–27 is considered severe.

television; (h) moving or speaking so slowly that other people could have noticed or the opposite (being so fidgety or restless that you have been moving around a lot more than usual); and (i) thoughts that you would be better off dead or of hurting yourself in some way. The PHQ-9 is a reliable and valid measure of depression severity. The PHQ-9 is a widely used tool to assess depression severity, and the symptoms listed in Table 4.3 are key indicators of depressive disorders. Detailed distribution of each element of PHQ-9 can be seen in Table 4.3.

Overall prevalence of depression symptoms: Three elements are noted as the most common symptoms. (i) "Feeling tired or having little energy" (26.8% often, 18.5% always); (ii) "Trouble falling asleep, staying asleep, or sleeping too much" (25.4% often, 11.3% always); and (iii) "Feeling down, depressed, or hopeless" (23.5% often, 6% always).

High prevalence of depression symptoms: A significant proportion of women reported experiencing depression symptoms often or always: "Feeling tired or having little energy" (45.3% combined often/ always); and "Feeling down, depressed, or hopeless" (29.5% combined often/always); and "Trouble sleeping" (36.7% combined often/always). These findings suggest that depression is a notable mental health concern among women in Balochistan.

**Table 4.3: Symptoms of depression**

Percent distributions of women age 15-49 by frequency of symptoms of depression in the 2 weeks preceding the survey, according to specific symptoms included in the Patient Health Questionnaire (PHQ-9)

Background characteristic	Never	Rarely	Often	Always	Refuse	Don't Know	Total	Number of women
<b>Symptoms of depression</b>								
Little interest or pleasure in doing things	32.9	41.4	17.2	4.8	2.6	1.1	100.0	1,968
Feeling down, depressed or hopeless	31.7	35.5	23.5	6.0	2.6	0.7	100.0	1,968
Trouble falling asleep, staying asleep, or sleeping too much	20.9	39.0	25.4	11.3	2.7	0.8	100.0	1,968
Feeling tired or having little energy	13.4	37.7	26.8	18.5	2.7	0.9	100.0	1,968
Poor appetite or overeating	30.5	38.8	19.1	7.5	3.1	1.0	100.0	1,968
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	75.4	11.2	5.6	1.3	4.3	2.2	100.0	1,968
Trouble concentrating on things, such as reading the newspaper or watching television	62.6	20.0	7.8	1.1	4.0	4.5	100.0	1,968
Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	61.4	23.1	7.3	1.5	3.6	3.1	100.0	1,968
Thoughts that you would be better off dead or of hurting yourself in some way	75.4	12.1	4.1	1.7	3.8	2.9	100.0	1,968

Following key symptoms are noted based on results: (i) Fatigue and Low Energy is the most commonly reported symptom, indicating that many women may be experiencing physical and emotional exhaustion; (ii) Sleep Disturbances implies trouble sleeping is a significant issue, which can aggravate other depression symptoms; and (iii) Low Self-Esteem and Suicidal Thoughts are less common, these symptoms are critical to address due to their severe implications.

Little more than a quarter of women (26.7%) in Balochistan show symptoms of depression

(PHQ-9 score  $\geq 10$ ), while 22.3% experience moderate depression, 3.8% have moderately severe depression, and 0.7% suffer from severe depression. These results indicate that depression is an important mental health issue among women in Balochistan, likely exacerbated by social, economic, and gender-based challenges (Table 4.4).

**Table 4.4: Severity of symptoms of depression**  
Percent distribution of women age 15-49 by their Patient Health Questionnaire (PHQ-9) score and percentage with symptoms of depression, according to background characteristics

Background characteristic	PHQ-9 Score						Percentage with symptoms of depression <sup>5</sup>	Number of women
	0-4	5-9	10-14	15-19	20-27	Total		
<b>Respondent Age</b>								
15-19	72.3	22.0	5.7	0.0	0.0	100.0	5.7	20
20-24	37.4	37.5	22.5	0.9	1.6	100.0	25.0	233
25-29	32.6	42.4	20.6	3.5	0.9	100.0	25.0	509
30-34	32.1	41.5	21.4	5.0	0.0	100.0	26.4	395
35-39	25.1	48.0	24.1	2.8	0.0	100.0	26.9	357
40-44	23.7	41.7	25.6	7.3	1.6	100.0	34.5	300
45-49	27.6	49.4	20.7	2.3	0.0	100.0	23.0	155
<b>Number of living children</b>								
0	32.7	28.6	28.7	1.9	8.2	100.0	38.7	93
1-2	33.4	42.4	19.9	4.2	0.1	100.0	24.2	593
3-4	32.7	41.0	22.2	4.0	0.0	100.0	26.3	669
5+	24.5	47.6	23.5	3.5	0.8	100.0	27.9	613
<b>Region</b>								
Urban	30.9	36.7	27.8	4.5	0.1	100.0	32.4	573
Rural	30.1	45.5	20.0	3.5	0.9	100.0	24.4	1,396
<b>Respondent's Education</b>								
No education	31.9	44.3	19.3	4.0	0.5	100.0	23.8	1,056
Primary <sup>1</sup>	26.4	46.1	24.8	2.7	0.0	100.0	27.5	213
Middle <sup>2</sup>	25.4	42.7	28.8	3.2	0.0	100.0	32.0	134
Secondary <sup>3</sup>	34.5	39.8	19.3	4.9	1.4	100.0	25.7	265
Higher <sup>4</sup>	26.4	38.5	30.5	3.2	1.4	100.0	35.1	301
<b>Employment status</b>								
Currently employed	27.3	36.9	29.1	6.5	0.2	100.0	35.8	225
Not currently employed	30.8	43.7	21.4	3.5	0.7	100.0	25.6	1,744
<b>Any spousal violence (physical or sexual or emotional) in last 12 months</b>								
Yes	16.1	50.3	26.4	6.5	0.7	100.0	33.6	668
No	36.0	40.5	20.0	2.4	1.1	100.0	23.5	825
Privacy not obtained/ Women not selected	40.6	36.7	20.2	2.5	0.0	100.0	22.7	476
<b>Any spousal violence (physical or sexual or emotional) ever</b>								
Yes	16.6	49.7	26.5	6.1	1.1	100.0	33.7	744
No	37.5	40.1	19.3	2.4	0.6	100.0	22.4	749
Privacy not obtained/ Women not selected	40.6	36.7	20.2	2.5	0.0	100.0	22.7	476
<b>Wealth Index</b>								
Lowest	22.4	39.4	33.7	4.5	0.1	100.0	38.2	413
Second	32.0	37.1	24.0	6.8	0.1	100.0	30.9	395
Middle	26.6	52.8	18.3	1.0	1.3	100.0	20.6	364
Fourth	33.9	45.7	15.6	3.8	1.0	100.0	20.4	391
Highest	36.8	40.7	18.8	2.7	0.9	100.0	22.5	406
<b>Total</b>	<b>30.4</b>	<b>42.9</b>	<b>22.3</b>	<b>3.8</b>	<b>0.7</b>	<b>100.0</b>	<b>26.7</b>	<b>1,968</b>

<sup>1</sup> Respondents with a GAD-7 score of 6 or higher <sup>2</sup> Respondents with a PHQ-9 score of 10 or higher

#### 4.4 Patterns by Background Characteristics

Age-specific pattern: The percentage with Symptoms of Depression shows that the highest prevalence is in the age group 40–44 (34.5%) and the lowest prevalence is in the 15–19 age group (5.7%), possibly due to fewer responsibilities or stronger family support.

Number of living children: With respect to this background indicator, analysis shows that women with no children have the highest prevalence of depression symptoms (38.7%) while women with 1–2 children have the lowest prevalence of depression symptoms (24.2%). Women with no children have the highest prevalence of depression, likely due to the family pressure and emotional strain of bearing a child.

Education level: Analysis of data from Balochistan shows that women with higher education attainment have the highest prevalence of depression symptoms (35.1%) while women with no education show the lowest prevalence rates (23.8%).

Spousal violence and depression: Women who experienced spousal violence in the last 12 months have significantly higher rates of depression (33.6%) compared to those who did not (23.5%). A quarter of all abused women (26 percent) have moderate depression (PHQ-9: 10-14), while 6.5% have moderately severe depression (15-19), and 0.7% experience severe depression (20-27). Interestingly to note, women with no recent experience of spousal violence report much lower levels of depression, with only 20.0% in the moderate category and 2.4% in the moderately severe category.

Lifetime experience of spousal violence and depression: Around a third of all women (33.7%) who have ever experienced spousal violence show symptoms of depression, compared to only 22.4% of women who have never faced violence. Furthermore, 26.5% of survivors have moderate depression (PHQ-9: 10-14), while 6.1% have moderately severe depression (15-19), and 1.1% suffer from severe depression (20-27). The results confirm that even past experiences of spousal violence contribute to long-term mental health struggles.

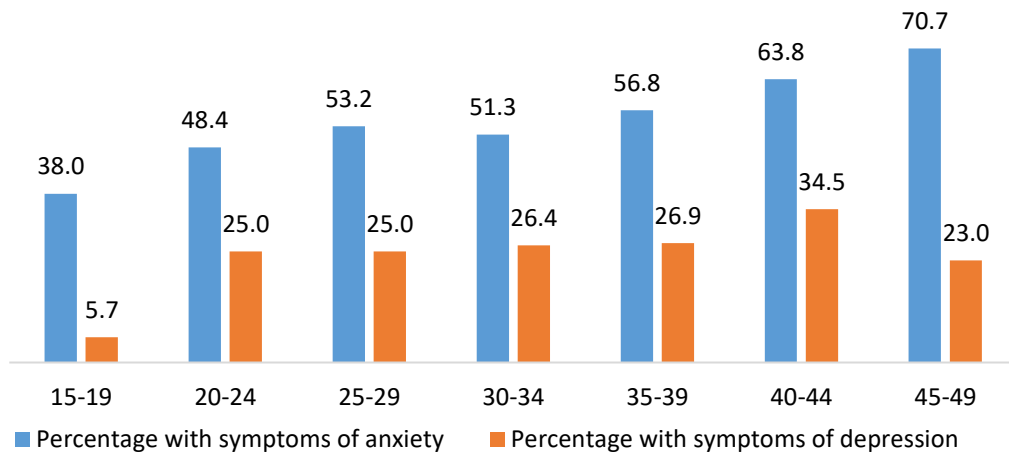
The analysis reveals that depression is a significant mental health concern among married women in Balochistan, particularly among older women, those with no children, and those with higher education.

Prevalence of anxiety and depression:

- Anxiety: More than half of women (53%) reported symptoms of anxiety, with the highest prevalence in the 25-29 and 40–49 age groups (Figure 4.1).
- Depression: More than a quarter of women reported symptoms of depression (with around a quarter or more in each age group from 20-24 to 40-44), and the highest prevalence in the 40–44 age group.

Lower prevalence of anxiety and depression is reflected among younger women (15–19) while higher prevalence of anxiety and depression is observed among older women (20–49). Younger women may benefit from stronger family support systems, while some women may develop coping mechanisms over time, explaining the slight decline in depression prevalence in the 45–49 age group.

**Figure 4.1: Percentages of women with symptoms of anxiety and depression by age group**



#### **4.5 Treatment for Symptoms of Anxiety and Depression**

Regardless of their scores on the GAD-7 or PHQ-9, all respondents were asked (a) if a health care provider had ever told them that they had anxiety or depression, (b) if they had taken medicine in the 2 weeks before the survey that was prescribed by a health care provider for anxiety or depression, or (c) if they had received counseling for their mental health condition in the 2 weeks before the survey.

Close to 13 percent of women age 15–49 ever told by a health care provider that they had anxiety, and 13% of women were ever told by a health care provider that they had depression (Table 4.5). Close to 11 percent of women reported taking medicine prescribed by a health care provider for depression or anxiety in the past 2 weeks. The results indicate significant gaps in diagnosis and treatment.

**Table 4.5: Treatment for symptoms of anxiety or depression**

Percentage of women age 15-49 who have ever been told by a health care provider that they have anxiety or depression, percentage who took medicine prescribed by a health care provider for anxiety or depression in the 2 weeks preceding the survey, according to background characteristics

<b>Background characteristic</b>	<b>Ever told had anxiety</b>	<b>Ever told had depression</b>	<b>Ever told had anxiety or depression</b>	<b>Ever told had anxiety and depression</b>	<b>Took medicine prescribed by a health care provider for anxiety or depression in past 2 weeks</b>	<b>Number of women</b>
<b>Respondent Age</b>						
15-19	0.0	0.0	0.0	0.0	0.0	20
20-24	11.6	11.8	13.3	10.1	9.3	233
25-29	9.4	9.5	12.4	6.6	8.1	509
30-34	10.7	10.2	12.7	8.2	7.3	395
35-39	13.1	14.3	17.5	9.9	9.0	357
40-44	17.5	18.8	20.3	16.0	17.9	300
45-49	26.1	22.1	28.4	19.7	22.6	155
<b>Number of living children</b>						
0	12.8	14.3	14.3	12.8	11.4	93
1-2	11.2	13.5	14.8	9.9	9.8	593
3-4	11.6	9.3	13.8	7.0	7.8	669
5+	16.5	16.7	19.2	14.1	14.9	613
<b>Region</b>						
Urban	10.5	8.9	14.3	5.0	5.6	573
Rural	14.1	14.9	16.4	12.5	12.9	1,396
<b>Respondent's Education</b>						
No education	13.3	13.5	15.6	11.1	11.1	1,056
Primary <sup>1</sup>	11.4	12.3	15.0	8.7	11.5	213
Middle <sup>2</sup>	13.1	14.1	14.1	13.1	12.7	134
Secondary <sup>3</sup>	6.0	5.3	9.0	2.3	4.0	265
Higher <sup>4</sup>	19.8	18.9	23.9	14.7	14.3	301
<b>Employment status</b>						
Currently employed	12.7	12.6	13.9	11.4	9.9	225
Not currently employed	13.1	13.2	16.1	10.2	10.9	1,744
<b>GAD-7 Score</b>						
0-5	6.8	4.5	8.3	3.0	2.8	871
6+	18.0	20.0	21.8	16.2	17.1	1,097
<b>PHQ-9 Score</b>						
0-9	10.5	9.1	12.3	7.2	7.2	1,442
10+	20.1	24.2	25.4	19.0	20.6	526
<b>Any spousal violence (physical or sexual or emotional) in last 12 months</b>						
Yes	17.9	21.0	24.5	14.5	17.3	668
No	10.6	9.0	11.7	7.9	7.2	825
Privacy not obtained/Women not selected	10.5	9.1	10.9	8.8	8.0	476
<b>Any spousal violence (physical or sexual or emotional) ever</b>						
Yes	19.0	21.4	25.2	15.1	18.0	744
No	8.9	7.4	9.7	6.6	5.4	749
Privacy not obtained/Women not selected	10.5	9.1	10.9	8.8	8.0	476
<b>Wealth Index</b>						
Lowest	19.2	18.0	22.9	14.3	16.3	413
Second	15.9	17.5	21.3	12.1	14.6	395
Middle	14.1	13.8	15.9	12.0	12.4	364
Fourth	9.3	9.0	10.7	7.7	6.9	391
Highest	6.7	7.2	8.1	5.8	3.8	406
<b>Total</b>	<b>13.1</b>	<b>13.1</b>	<b>15.8</b>	<b>10.4</b>	<b>10.8</b>	<b>1,968</b>

<sup>1</sup> Primary refers to classes 1-5 <sup>2</sup> Middle refers to classes 6-8 <sup>3</sup> Secondary refers to classes 9-10 <sup>4</sup> Higher refers to class 11 and above

#### 4.6 Patterns by Background Characteristics

**Number of living children:** Women with 5+ children are more likely to take prescribed medicine (15%) compared to those with fewer (1-2) children (9.8%).

**Education level:** Women with higher education are more likely to take prescribed medicine (14.3%) compared to those with no education (11%).

Severity of symptoms of anxiety (GAD-7 Score): Women with higher anxiety scores (6+) were more likely to be told they had anxiety (18%) and to take prescribed medicine (17%). Regarding severity of Depression (PHQ-9 Score), women with higher depression scores (10+) were more likely to be told they had depression (20%) and to take prescribed medicine (21%). Women with higher anxiety or depression scores are more likely to be diagnosed and treated, indicating that severe symptoms may drive healthcare utilization.

Women with symptoms of anxiety (GAD-7 score 6+) or depression (PHQ-9 score 10+) are far more likely to be diagnosed with mental health conditions. Twenty-two percent of those with anxiety symptoms were told they had anxiety or depression, while 25% of those with depression symptoms were told they had anxiety or depression. However, even among symptomatic women, a significant proportion remains undiagnosed.

Spousal violence and mental health treatment: Women who have experienced spousal violence (physical, sexual, or emotional) are more likely to be diagnosed with anxiety or depression. More than 24 percent of women who have experienced spousal violence were told they had anxiety or depression, compared to 12% of women who did not experience. However, only 17% of abused women took medication, despite twice as many having been diagnosed.

#### **4.7 Care Seeking for Symptoms of Anxiety and Depression**

Respondents who said that they had experienced any symptoms of anxiety or depression during the 2 weeks before the survey, regardless of frequency (i.e., respondents with a score of 1 or higher on either the GAD-7 or PHQ-9), were asked if they had ever sought help and the type of provider from whom they sought help.

Close to 19 percent of women who experienced any symptoms of anxiety or depression in the 2 weeks preceding the survey sought help (Table 4.6). Among those who sought help, almost 70 percent of women sought help from a health care provider while 30% sought help from other sources (e.g., traditional healers, religious leaders, family members). The results indicate the existence of barriers to accessing mental health care.

**Table 4.6: Care seeking and providers**

Among women with any symptoms of anxiety or depression in the 2 weeks preceding the survey, percentage who have ever sought help, and among those who sought help, type of provider from whom the help was sought, according to, background characteristics

Background characteristic	Among women with any symptoms of anxiety or depression in the 2 weeks preceding the survey <sup>5</sup>		Among those who sought help by type of provider		Number of women
	Ever sought help	Number of women	Health care provider	Other <sup>6</sup>	
<b>Respondent Age</b>					
15-19	0.0	19	-	-	0
20-24	16.0	213	74.1	25.9	34
25-29	14.5	459	70.3	29.7	67
30-34	16.3	368	55.1	44.9	60
35-39	21.2	330	57.3	42.7	70
40-44	22.2	278	86.7	13.3	62
45-49	36.1	139	84.5	15.5	50
<b>Number of living children</b>					
0	14.1	91	76.9	23.1	13
1-2	19.1	533	64.1	35.9	102
3-4	16.2	613	64.8	35.2	99
5+	22.5	570	79.1	20.9	128
<b>Region</b>					
Urban	17.4	507	49.7	50.3	88
Rural	19.6	1,299	77.6	22.4	254
<b>Respondent's Education</b>					
No education	17.3	976	71.0	29.0	168
Primary <sup>1</sup>	21.9	198	69.0	31.0	43
Middle <sup>2</sup>	23.9	122	74.5	25.5	29
Secondary <sup>3</sup>	10.3	233	58.8	41.2	24
Higher <sup>4</sup>	27.9	278	71.8	28.2	78
<b>Employment status</b>					
Currently employed	19.3	205	56.2	43.8	39
Not currently employed	18.9	1,602	72.2	27.8	303
<b>GAD-7 Score</b>					
0-5	8.1	710	52.5	47.5	57
6+	26.0	1,097	74.0	26.0	285
<b>PHQ-9 Score</b>					
0-9	14.8	1,281	70.6	29.4	189
10+	29.1	526	70.1	29.9	153
<b>Any spousal violence (physical or sexual or emotional) in last 12 months</b>					
Yes	26.9	648	71.9	28.1	174
No	13.5	769	73.7	26.3	104
Privacy not obtained/Women not selected	16.5	390	61.0	39.0	64
<b>Any spousal violence (physical or sexual or emotional) ever</b>					
Yes	27.3	722	74.1	25.9	197
No	11.6	695	68.8	31.2	81
Privacy not obtained/Women not selected	16.5	390	61.0	39.0	64
<b>Wealth Index</b>					
Lowest	31.0	390	72.0	28.0	121
Second	26.4	367	61.8	38.2	97
Middle	16.7	347	76.3	23.7	58
Fourth	9.4	364	83.8	16.2	34
Highest	9.5	338	65.3	34.7	32
<b>Total</b>	<b>19.0</b>	<b>1,807</b>	<b>70.4</b>	<b>29.6</b>	<b>342</b>

<sup>1</sup> Primary refers to classes 1-5 <sup>2</sup> Middle refers to classes 6-8 <sup>3</sup> Secondary refers to classes 9-10 <sup>4</sup> Higher refers to class 11 and above  
<sup>5</sup> Includes respondents who said that they experienced any symptom of anxiety or depression during the 2 weeks before the survey, regardless of frequency (i.e., respondents with a score of 1 or higher on either the GAD-7 or PHQ-9)

<sup>6</sup> It includes social service organization, social worker, community health worker/fieldworker, religious leader, current/former spouse/partner, other family member, friend, neighbor, and Other

## 4.8 Patterns by Background Characteristics

**Age-specific trends:** The highest percentage of women who ever seek help is in the 45–49 age

group (36%) while the lowest percentage is in the 25–29 age group (14.5%). Older women (e.g., 40–44) are more likely to use healthcare providers, possibly due to better access to education or healthcare services while older women (40–44) are more likely to seek help possibly due to greater awareness of mental health issues or accumulated stressors.

Type of provider: Older women (e.g., 40–49) are more likely to seek help from healthcare providers (87%) while middle-aged women (e.g., 30–39) are more likely to seek help from healthcare providers (45%).

Number of living children: Women with 1 to four children are more likely to seek help (35–36%) compared to those with 5+ children.

Education level: Women with higher education are more likely to seek help (28%), while those with no education are least likely (17%) to do so. Women with middle education are also more likely to seek help from healthcare providers (75%) compared to those with higher education (72%).

Employment status and help-seeking behavior: Employed women have same likelihood to seek help (19%) as unemployed women (19%). Employed women are less likely to seek help from a healthcare provider (56%). Instead, 72% of unemployed women report relying on formal sources of support.

Severity of symptoms: Women with higher anxiety GAD-7 scores (6+) are more likely to seek help (26%) compared to those with lower scores (8%). Women with higher depression PHQ-9 scores (10+) are more likely to seek help (29%) indicating that severe symptoms may drive help-seeking behavior as compared to those with lower scores (15%).

Help-seeking by anxiety and depression scores: Women with higher anxiety or depression symptoms are much more likely to seek help than those with minimal symptoms. Only 8% of women with mild anxiety sought help, compared to 26% of those with moderate to severe anxiety. Similarly, help-seeking jumps from 15% (minimal depression) to 29% (moderate to severe depression).

Among those who sought help, two-thirds consulted a non-healthcare provider. Women with severe depression (70%) sought help from a healthcare provider, while the rest relied on non-medical sources (family, religious leaders, social workers, etc.). For women with mild symptoms, reliance on informal support systems is lower (only 30% consulted a healthcare provider).

Impact of spousal violence on help-seeking: Women who have experienced spousal violence (physical, sexual, or emotional) are relatively more likely to seek help. More than a quarter of all women who experienced spousal violence in the last 12 months (27%) sought help, compared to only 12% of those who had not. However, 72% of women who experienced spousal violence sought help consulted a healthcare provider.

Women who experienced spousal violence seek help more frequently, many rely on non-medical sources such as family, religious leaders, or community support. This highlights the need for better integration of mental health services within GBV response programs to ensure that survivors receive professional psychological care.

Gender-based violence, particularly against women, is acknowledged worldwide as a violation of basic human rights. The United Nations defines gender-based violence as any act of violence that results in physical, sexual, or psychological harm or suffering to women, girls, men, and boys, as well as threats of such acts, coercion, or the arbitrary deprivation of liberty. There is substantial research that has determined the serious health burden and demographic consequences of domestic violence (United Nations 2006). This chapter focuses on spousal violence, a widely prevalent form of gender based domestic violence.

The Balochistan Domestic Violence (Prevention and Protection) Bill 2014 was approved by the Provincial Assembly of Balochistan on February 1, 2014, to establish measures for safeguarding individuals from domestic violence and to affirm the fundamental rights of both women and men to personal dignity. Subsequently, the Balochistan Provincial Assembly enacted the Balochistan Protection of Women against Violence Act, 2016. This legislation is designed to shield women from workplace harassment and applies throughout the entire province, with the exception of the Provincially Administered Tribal Areas. The act requires the formation of Inquiry Committees within organizations to handle harassment complaints. Comparable laws have also been enacted in other provinces.

### 5.1 Measurement of Violence

In the 2024 PMA Balochistan, a total of 1493 women were successfully interviewed with the domestic violence module. Information was obtained from currently-married women on their experience of violence committed by their current husbands. More specifically, violence committed by the current husband was measured by asking all women if their husbands ever did the following to them:

Physical spousal violence: push you, shake you, or throw something at you; slap you; twist your arm or pull your hair; punch you with his fist or with something that could hurt you; kick you, drag you, or beat you up; try to choke you or burn you on purpose; or threaten or attack you with a knife, gun, or any other weapon

Sexual spousal violence: physically force you to have sexual intercourse with him even when you did not want to, physically force you to perform any other sexual acts you did not want to, or force you with threats or in any other way to perform sexual acts you did not want to

Emotional spousal violence: say or do something to humiliate you in front of others, threaten to hurt or harm you or someone close to you, or insult you or make you feel bad about yourself

In addition, information was obtained about physical violence committed by anyone during pregnancy. Also, information was gathered on experiences of physical violence committed by women on their husbands when they were not hurting; kicking, dragging, or beating them up.

### 5.2 Ethical Considerations in the PMA 2024

Recognizing the challenges in collecting data on violence, the interviewers in the survey were given special training. The training focused on how to ask sensitive questions, ensure privacy,

and build rapport between interviewer and respondent. Rapport with the interviewer, confidentiality, and privacy are all keys to building respondents' confidence so that they can safely share their experiences with the interviewer. Also, placement of the violence questions at the end of the questionnaire provided time for the interviewer to develop a certain degree of intimacy that should have further encouraged respondents to share their experiences of violence, if any. In addition, the following protections were built into the survey in keeping with the World Health Organization's ethical and safety recommendations for research on domestic violence (WHO, 2001):

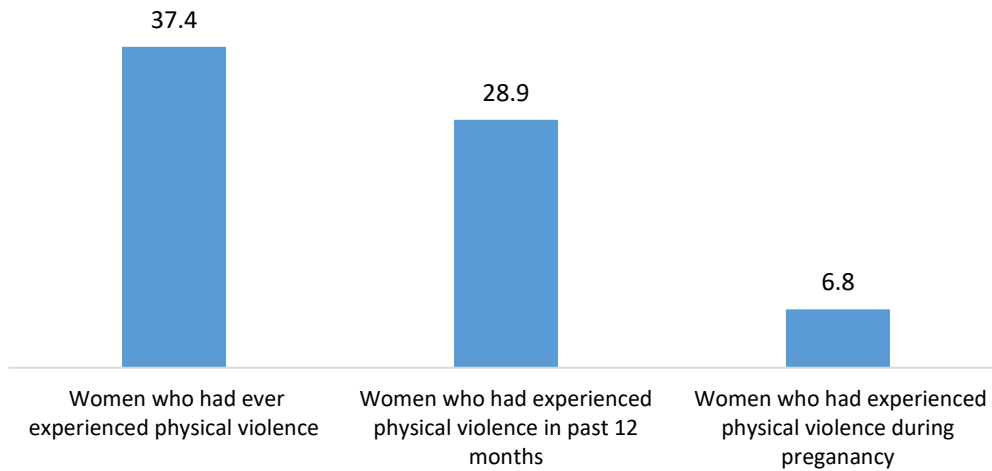
1. Only one woman per household was administered the questions on violence to maintain confidentiality. In the selected household one female respondent was randomly selected to be administered the questions on domestic violence. The random selection of one woman was done through a simple selection procedure based on the Kish grid, which was built into the Household Questionnaire (Kish, 1965).
2. As a means of obtaining additional consent beyond the initial consent provided at the start of the interview, the respondent was informed that the questions could be sensitive and was reassured regarding the confidentiality of her responses.
3. The violence module was implemented only if privacy could be obtained. The interviewers were instructed to skip the module, thank the respondent, and end the interview if they could not maintain privacy.

### **5.3 Physical Spousal Violence**

This section presents data on the experience of physical violence among currently married women of reproductive age. The percentage of women who have experienced any physical spousal violence during their lifetime and in the 12 months preceding the survey is discussed by background characteristics of women i.e. age, number of living children, place of residence, women's and husband's education, employment and wealth status.

Figure 5.1 shows that 37.4 percent of women said that they had experienced physical spousal violence in during their lifetime. Moreover, 28.9 percent reported the experience of physical spousal violence in the twelve months preceding the survey. When asked about the experience of physical spousal violence during pregnancy 6.8 percent of women said that they had experienced it.

**Figure 5.1: Women's experience of spousal physical violence**



The survey results reveal that women aged 45-49 years most frequently (37.6%) reported the experience of spousal physical violence. Followed by women aged 40-44 years (33.4%) and women aged 25-29 years (29.6%). Women in the youngest age group i.e. 15-19 years, reported the lowest percentage of physical violence (7%). Figure 5.2 indicates that women in the older age groups are more frequently victims of spousal physical violence.

**Figure 5.2: Percentage of women who have experienced spousal physical violence by age**

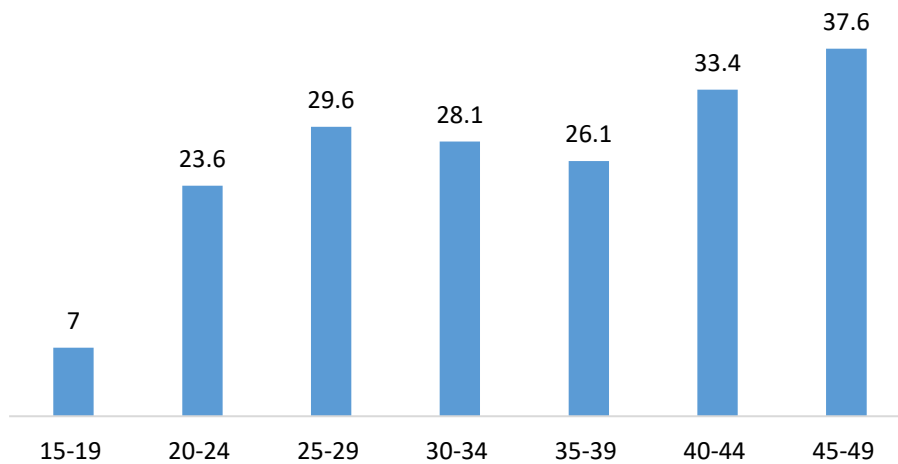
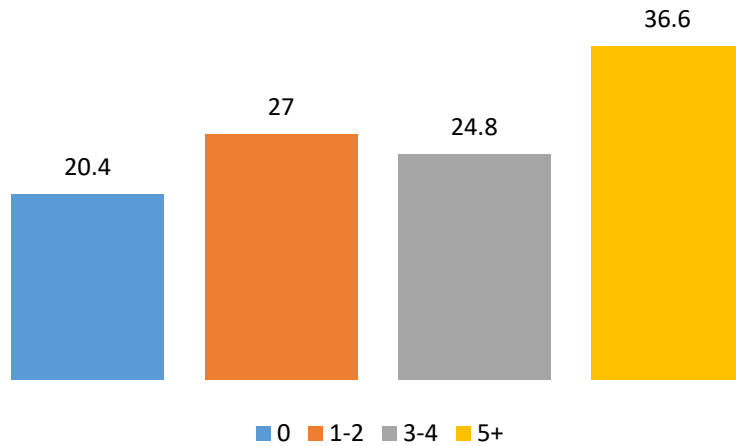


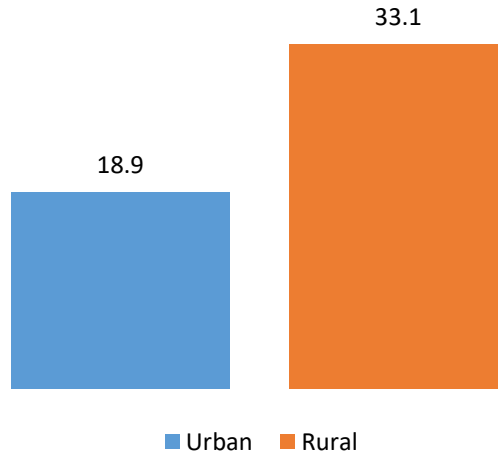
Figure 5.3 shows a trend whereby the experience of physical spousal violence increases with the increase in number of living children, indicating a link between number of living children and the experience of physical violence. Women with no children report the lowest rates of physical violence (20.4%), while women with five or more children have the highest incidence at 36.6 percent.

**Figure 5.3: Percentage of women who have experienced spousal physical violence by number of living children**



According to Figure 5.4 urban women reported lower rates of physical spousal violence than rural women, with 18.9 percent of urban women experiencing physical violence compared to 33.1 percent of rural women in the 12 months preceding the survey. It shows that urban women are significantly less likely to experience physical spousal violence when compared to their rural counterparts.

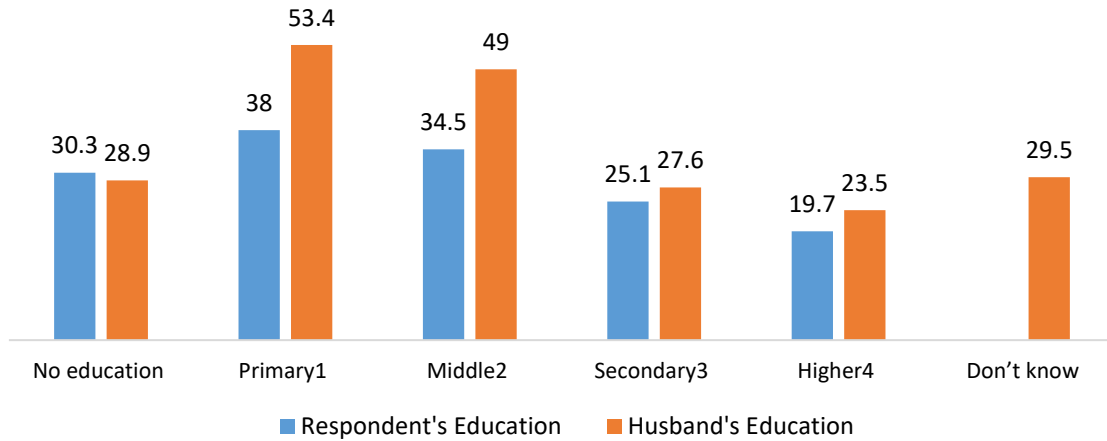
**Figure 5.4: Percentage of women who have experienced physical violence by residence**



Results reveal that physical spousal violence decreased with the increase in educational attainment of women and their husbands. Women with primary level education (38%) reported the highest rates of experiencing violence, followed by women with middle education (34.5%) and no education (30.3%), while those with higher education reported the lowest rates (23.7%).

Husband's education level also influenced the prevalence of physical violence. Women whose husbands had primary and middle-level education reported the highest incidence of violence (53.4% and 49% respectively). Whereas, women whose husbands had higher education reported the lowest percentage of violence (23.5%).

**Figure 5.5: Percentage of women who experienced spousal physical violence by women and husband's education**



Employment status also plays a role in the experience of physical spousal violence and being employed. Figure 5.6 shows that employed women (35.4%) have more commonly experienced physical violence compared to unemployed women (28%).

**Figure 5.6: Percentage of women who have experienced spousal physical violence by employment status**

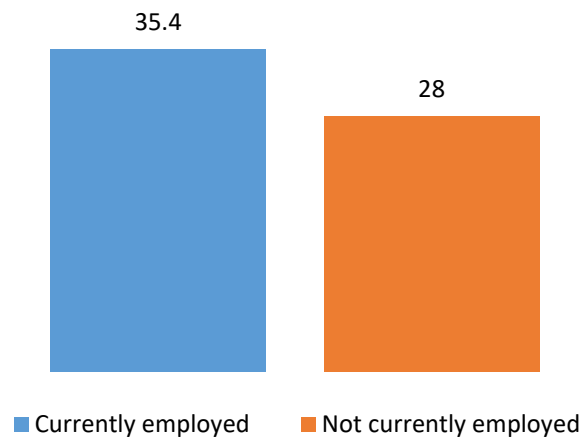
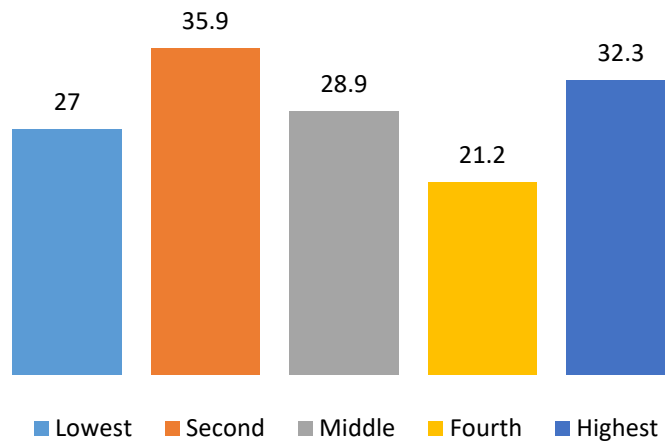


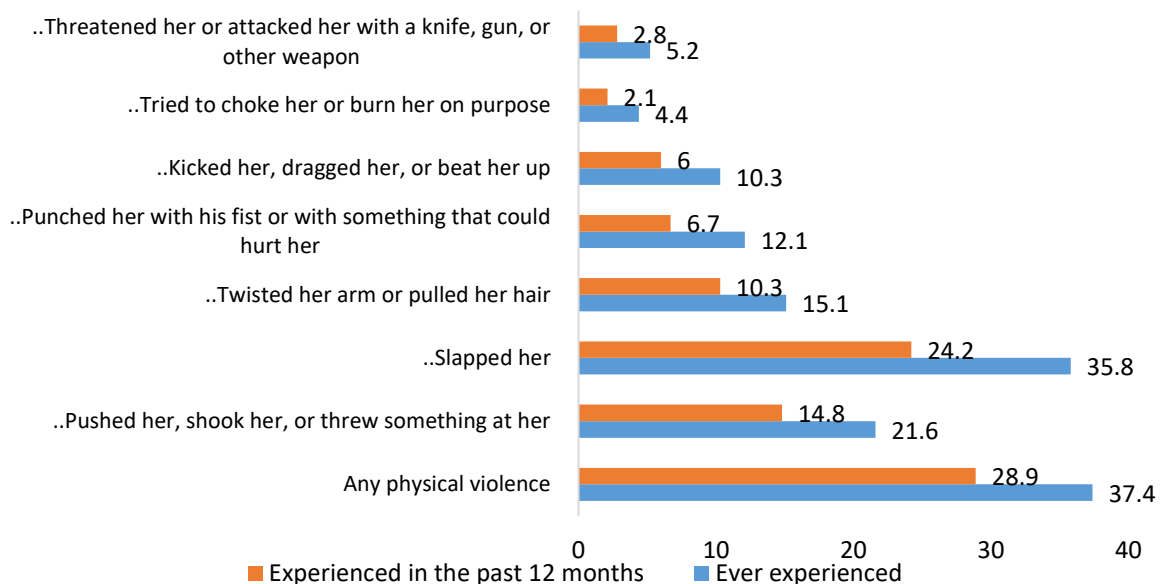
Figure 5.7 shows that wealth is an important factor in the experience of physical violence. The highest percentage of women who experienced physical violence was in the second wealth quintile (35.9%), followed by those in the highest wealth quintile (32.3%). Women in the fourth wealth quintile reported the least frequent experience of physical violence (21.2%).

**Figure 5.7: Percentage of women who have experienced physical violence by wealth quintiles**



Women were also asked about the various forms of physical violence that they had experienced. Figure 5.8 reveals that slapping was the most common form of violence (35.8%) followed by being pushed, shook or thrown something at (21.6%) and twisting arm and pulling hair (15.1%). Threatening or attacking with a knife or a gun and trying to choke or burn on purpose were the least reported forms of violence (5.2% and 4.4%, respectively).

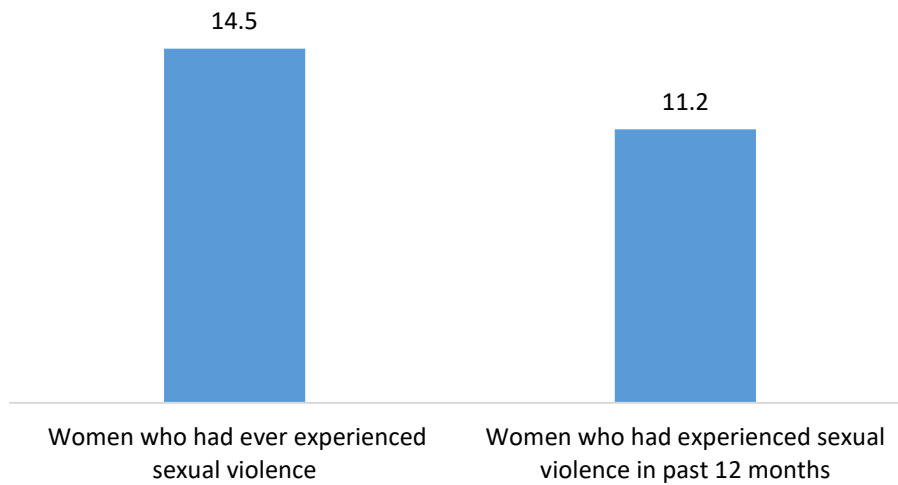
**Figure 5.8: Percentage of women who have experienced various forms of physical violence**



#### 5.4 Spousal Sexual Violence

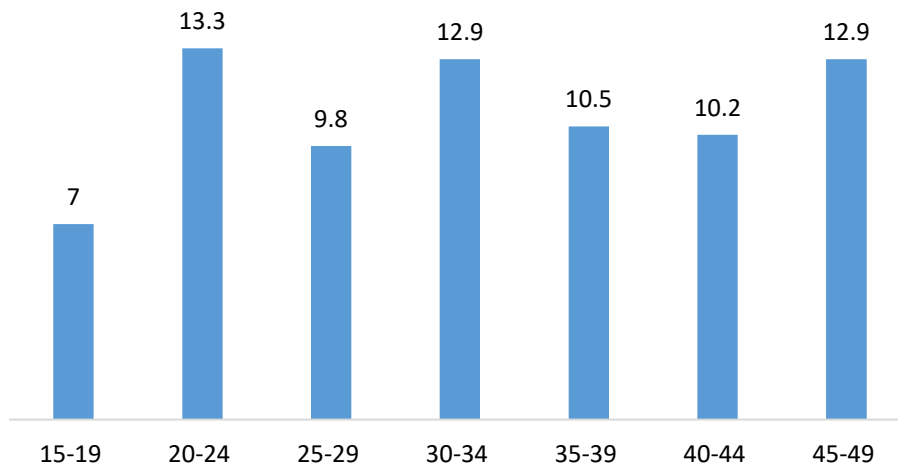
Women were asked about their experience of sexual spousal violence; the findings of the survey are reported by the background characteristics of women in this section. Figure 5.9 shows that 14.5 percent of women respondents said that they had experienced sexual spousal violence during their lifetime. Moreover, 11.2 percent reported the experience of sexual spousal violence in the twelve months preceding the survey.

**Figure 5.9: Women's experience of sexual spousal violence**



Women in the 20-24 years age group reported the highest percentage of spousal sexual violence (13.3%), followed by women aged 30-35 years (12.9%) and 45-49 years (12.9%). Women in their teens (i.e. 15-19 years old) reported the least percentage of spousal sexual violence (7%).

**Figure 5.10: Percentage of women who have experienced sexual spousal violence by age**



The experience of spousal sexual violence does not vary drastically with the number of living children. However, those with no living children reported the least percent of sexual spousal violence (9.6%) and those with 3 to 4 living children reported the highest percentage (12.6%).

**Figure 5.11: Percentage of women who have experienced sexual spousal violence by number of living children**

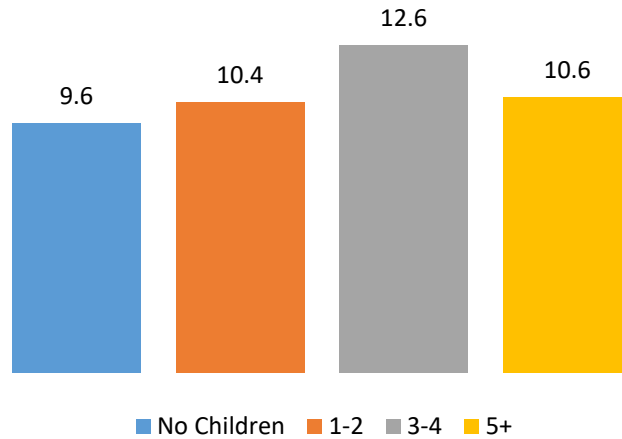


Figure 5.12 shows that urban women reported a lower percentage (9.1%) of spousal sexual violence than rural women (12.1%).

**Figure 5.12: Percentage of women who have experienced spousal sexual violence by residence**

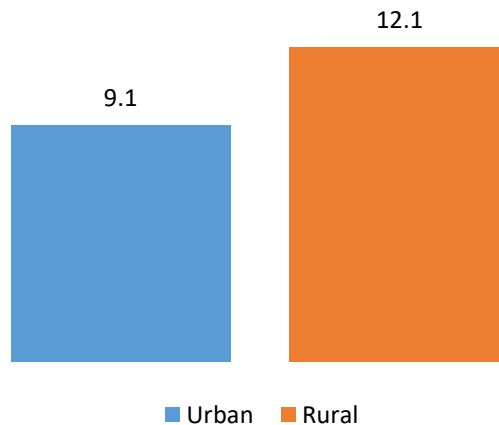
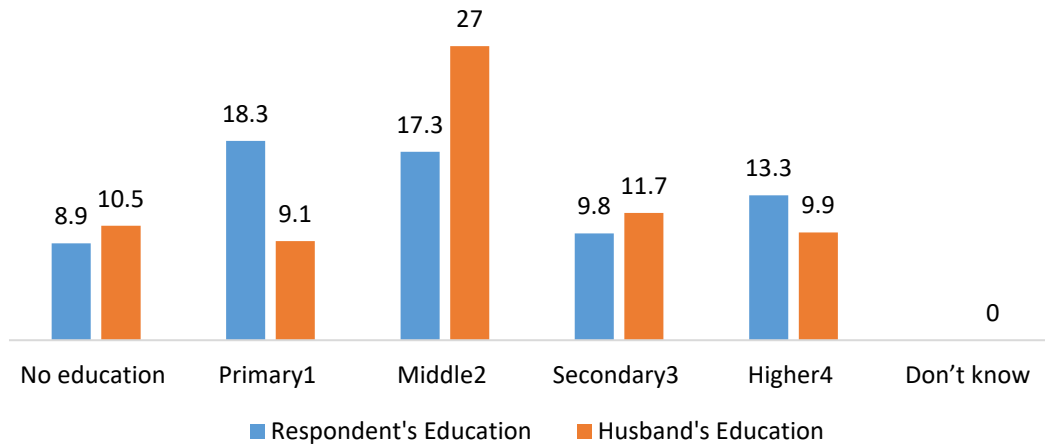


Figure 5.13 shows that women who had primary education reported the highest percentage of spousal sexual violence (18.3%), followed by women who received middle education (17.3%). Women with no education reported lowest percentage of spousal sexual violence (8.9%). When looking at women's husband education it is evident that the highest percentage of spousal sexual violence is committed by those who received middle education (27%). For all other levels of education, the level of sexual spousal violence ranged between 9 to 10 percent and did not vary significantly.

**Figure 5.13: percentage of women who experienced spousal sexual violence by women and husband's education**



Women who are currently employed reported higher percentage of the experience of spousal sexual violence (19.3%) than those who are currently unemployed (10.1%).

**Figure 5.14: Percentage of women who have experienced spousal sexual violence by employment status**

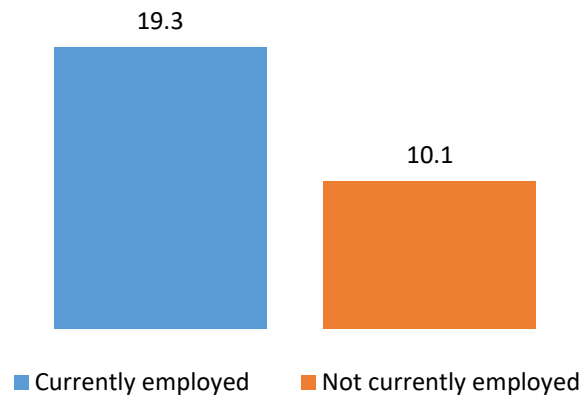
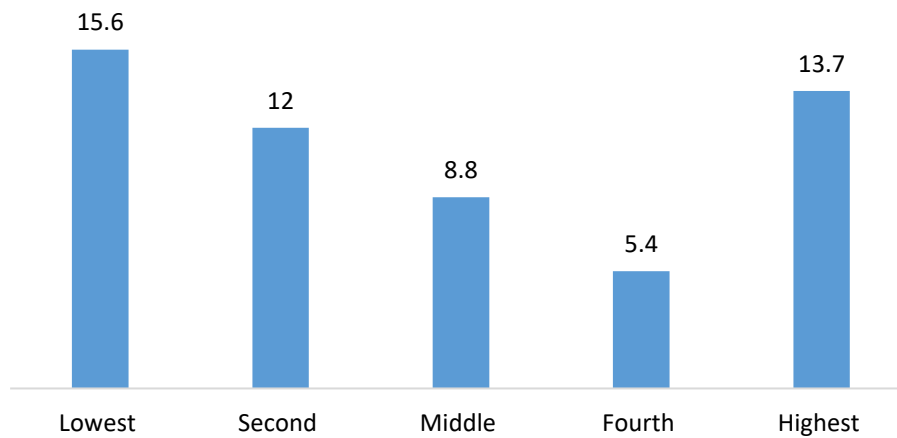


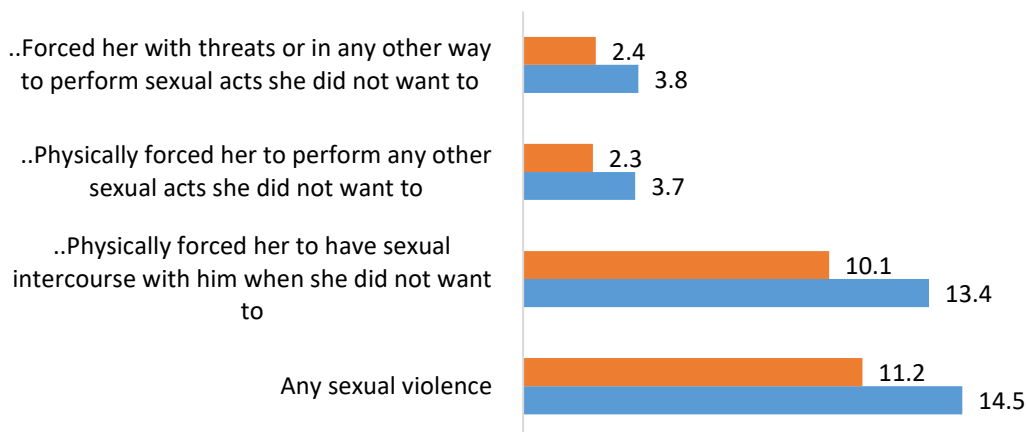
Figure 5.15 shows a declining trend in the experience of sexual spousal violence as the wealth status of women enhances. Women in the lowest wealth quintile reported 15.6 percent incidence of sexual spousal violence in contrast to those in the fourth wealth quintile who only reported a 5.4 incidence. However, this trend is reversed for the highest wealth quintile where 13.7% women reported experiencing sexual spousal violence.

**Figure 5.15: Percentage of women who have experienced spousal sexual violence by wealth index**



The most common form of spousal sexual violence was ‘physically forced her to have sexual intercourse with him when she did not want to’, followed by ‘physically forced her to perform any other sexual acts she did not want to’. The least common form of spousal sexual violence was ‘forced her with threats or in any other way to perform sexual acts she did not want to’, i.e., only 3.8%.

**Figure 5.16: Percentage of women who have experienced various forms of spousal sexual violence**



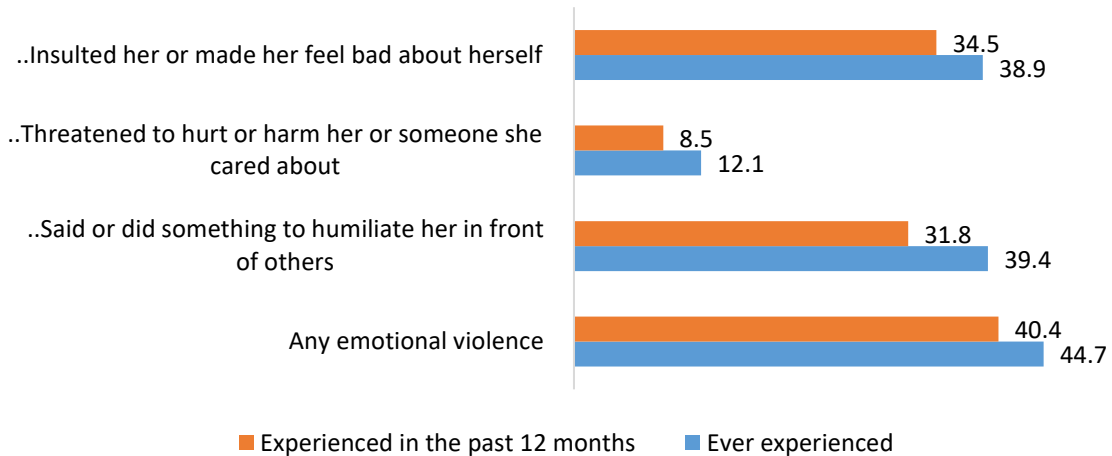
## 5.5 Experience of Emotional Spousal Violence

This section presents data on the experience of emotional violence among currently married women of reproductive age. The percentage of women who have experienced any emotional spousal violence during their lifetime and in the 12 months preceding the survey is displayed here. Figure 5.17 shows that 44.7 percent of women respondents said that they had experienced emotional spousal violence during their lifetime. Moreover, 40.4 percent reported the experience of emotional spousal violence in the twelve months preceding the survey.

Among the various forms of emotional spousal violence, the most commonly reported was ‘insulted her or made her feel bad about herself’ which was reported by 38.9 percent of women.

The least reported was ‘threatened to hurt or harm her or someone she cared about’, reported by only 12.1% women.

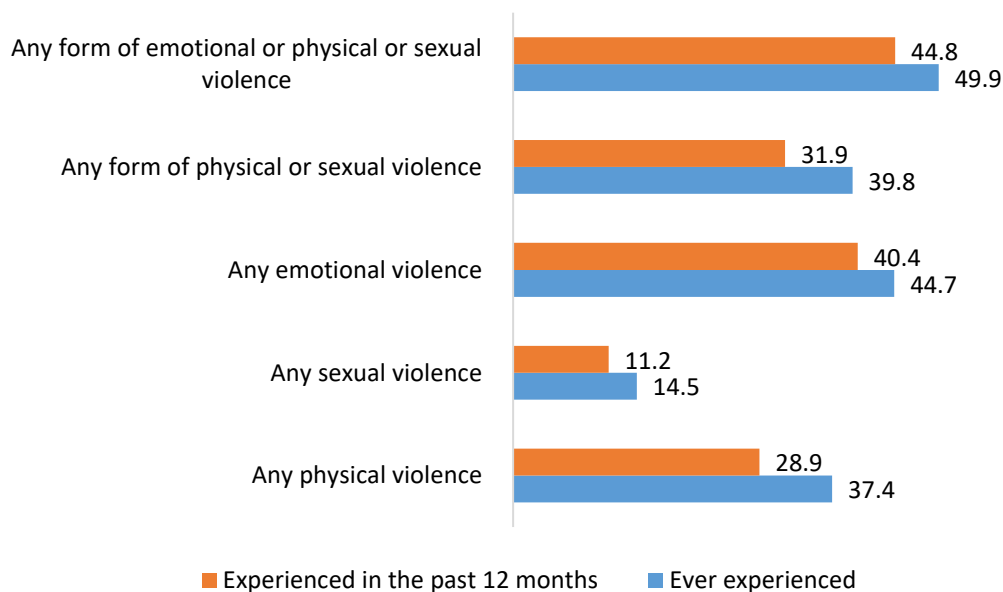
**Figure 5.17: Percentage of women who have experienced various forms of emotional spousal violence**



## 5.6 Experience of Spousal Violence

Emotional violence was the most common form of spousal violence, where 44.7% of all participants reported experiencing it and 40.4% reported experiencing emotional violence in the 12 months preceding the survey. Physical violence was reported by 37.4% women. Sexual violence was the least common form of violence at only 14.5%. Figure 5.18 shows that half of the women (49.9%) reported that they experienced some kind of physical, sexual, or emotional violence and 39.8% reported experiencing either physical or sexual violence.

**Figure 5.18: Percentage of women who have experienced various forms of spousal violence**





Under the FP2030 commitments, achieving ‘universal access to safe and quality reproductive health care and family planning services with increased and widely accessible method choices’ is endorsed by the government of Balochistan. In this regard, strengthening of Population Departments’ coordination with the Department of Health to expand FP services including post-pregnancy family planning services, to minimize missed opportunities; and endorsement of Task Shifting and Task Sharing strategies and competency-based training of paramedics and doctors in implant insertion and systematic procurement have been significant steps forward. Strong ownership of the Department of Health is recognized as a means for universal access.

### 6.1 Structure of Family Planning Availability System

Family planning is provided both by the public and private sectors across the province of Balochistan. Outlets of PWD including Reproductive Health Service Centres (hospital based facilities) and Family Welfare Centers (facilities located at community level serving FP and basic MCH services), and facilities of Health Dept. including teaching and civil hospitals, secondary healthcare and primary health care unit (District hospitals, RHCs, BHUs, and MCH Centres) are mandated to provide family planning services and commodities to clients who visit and seek the services from the facilities. Lady Health Workers (community-based health workers) are an essential part of the primary healthcare system, providing FP counseling and services as part of the MCH package served to women and children of the communities they are assigned, mostly in rural areas. Private sector and NGOs outlets also provide family planning services within their health facilities. The private sector encompasses private clinics, hospitals, maternity homes and MCH facilities and drug stores mostly in urban localities. Population Welfare has a limited infrastructure while Dept. of Health has a wider infrastructure across the province where family planning services are provided. The public sector dispenses FP commodities free of cost or a nominal charge while the private sector charges for commodities and services depending on the commodities purchased. The private sector also charges a service fee for the commodities. The analysis in this section maintains the distinction of the three entities to see their contribution and delivery of FP services.

A total of 115 public and private facilities were visited in the survey by the enumerators in 46 clusters across the province. These facilities were identified by the women respondents where they normally visit to obtain services for their family health and family planning needs. The aim of maintaining the same facilities over all phases of the survey was to see if any substantive changes have been made in the facilities especially in improving availability and quality of service that leads to ‘choice’.

A comprehensive insight into the distribution of service delivery points, categorized into public and private facilities, shows that public facilities constitute the majority, comprising 65 percent of the total service delivery points surveyed. Among these, the most covered are Rural Health Centres and Basic Health Units (34%) and MCH Centres and Public Dispensaries (8%) followed by Family Welfare Centers, constituting 13 percent of all public facilities - Table 6.1. On the other hand, private facilities accounted for 35 percent of the total service delivery points.

Notable categories within private facilities included: Big and Small Hospitals (15%), doctors' Clinics (3%), and nurses and midwives clinics (8%).

**Table 6.1: Percent distribution of service delivery points by type of facility**

<b>Public Facilities</b>		<b>Private Facilities</b>	
	<b>Percent</b>		<b>Percent</b>
	<b>65</b>		<b>35</b>
District Headquarters/Civil Hospital	9	Teaching Hospital	3
Tehsil Headquarters	1	Big hospital (4+ beds)	12
Rural Health Centre	7	Small Hospital (less than 4 beds)	3
Basic Health Unit	27	Doctors Clinic (male/female)	3
Public Dispensary	4	Nurse/LHV Clinic	4
Maternal and Child Health Care Center	4	Midwife Clinic	4
Family Welfare Centre	13	Maternity Home	2
		Private Dispensary	3
		Other	1
<b>Number of Facilities 115</b>			

Available staff at the facility who serve family planning were the key respondents for the questionnaire. Table 6.2 shows the key staff who responded and facilitated the survey in public and private sector facilities. Respondents are asked questions about the general infrastructure, services available, resources, and systems at the facility, including staff pattern, basic amenities, management information systems, and performance monitoring by tracking records. A glance at the respondents' shows that almost all PWD facilities staff are FWWs or FWAs, while more than half of the Health facility staff are LHV/FHT, and nurse/midwife (Table 6.2). Nearly half of private sector facility respondents are Gynecologists, specialists or doctors.

**Table 6.2: Percent distribution of respondents of FP service delivery points questionnaire**

<b>Designation of respondent</b>	<b>DOH</b>	<b>PWD</b>	<b>Private Facility</b>
Qualified Gynecologist	0	0	18
Qualified Specialist	2	0	5
Doctor	13	7	30
Nurse/Midwife	17	0	23
LHV/FHT	55	7	18
FWW/FWC	7	73	5
FWA	2	13	0
Other	5	0	3
<b>Gender of respondent</b>			
Male	5	0	10
Female	95	100	90

Among the Department of Health (60), Population Welfare (15), and Private facilities (40) family planning services/ products are offered by a large percentage of them. Nine out of ten of all Dept of Health facilities (91 percent) offer services for 6 days a week while 7 percent offer these services throughout the week (Table 6.3). On the other hand, 100% of Population Welfare facilities provide services 6 days a week. Amongst the private facilities, more than half (54 percent) offer services throughout the week and 43 percent offer services for six days a week.

**Table 6.3: Percent distribution of family planning service availability**

Characteristic	DOH	PWD	Public Facility	Private Facility
<b>Offering family planning services/products</b>				
Yes	90	100	92	93
Number of Facilities	<b>60</b>	<b>15</b>	<b>75</b>	<b>40</b>
<b>Family planning services offered in the number of days in a week</b>				
	DOH	PWD	Public Facility	Private Facility
<=5	2	0	1	3
6	91	80	88	43
7	7	20	10	54
<b>Number of facilities that offer family planning services</b>	<b>54</b>	<b>15</b>	<b>69</b>	<b>37</b>

## 6.2 Availability of Family Planning Services

All facilities visited in Balochistan were asked about the availability of contraceptive services. Three contraceptive methods are universally available in all facilities: condoms, injectables, and oral pills (Table 6.4). Availability of condoms was a problem during 2023 which has been taken care and all facilities report availability. Provision of tubal ligation and vasectomy remains limited to a few public facilities across the province. Female sterilization is available in 30% private facilities and 13 % of DoH facilities. Emergency contraceptive pills, though not recognized as a contraceptive method, are essentially available at almost two-thirds of facilities of PWD and DoH and private facilities. Availability of implants is reported to be available in a fair proportion across all facilities, especially public and fewer private facilities. IUDs are available in almost all PWD facilities and half of DoH and private facilities. The overall availability appears to be good and reflects availability of various methods to enhance choice and accessibility.

**Table 6.4: Percentage of family planning methods provided to clients**

Characteristic	DOH	PWD	Private Facility
Female sterilization	13	0	30
Male sterilization	3	0	5
IUD	58	87	53
Injectables	88	100	90
Implants	47	53	30
Pills	85	100	88
condoms	80	100	75
Emergency contraception	60	67	65
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>40</b>

Facility readiness to serve family planning is an important area of enquiry and asked about a number of aspects at each facility. The results of the survey show that all public and private facilities are adequately ready with running water, equipment needed to service, examination table, visual and auditory privacy, examination table, and essential chemicals for disinfection and good quality service (Table 6.5). The survey results show the percentage availability of various items necessary for preparedness in examination rooms and adjacent areas across

different types of health facilities. Overall, the information below reflects a comprehensive overview of the availability of essential items in examination rooms and adjacent areas across different types of health facilities, highlighting variations in availability among different facilities.

**Table 6.5: Percentage availability of a separate room for examination and items in the examination and adjacent room**

Items necessary for Preparedness	DOH	PWD	Public Facilities	Private Facilities
Separate room examination	98	100	98	86
Running water (piped)	78	80	79	90
Other running water (bucket with tap or pour pitcher)	82	100	85	80
Available from other sources	87	93	88	83
Hand-washing soap	82	100	85	95
Hand drying towels	73	93	77	93
Waste basket with lid	67	93	72	78
Sharps container	88	93	89	83
Disposable latex gloves	87	93	88	98
Disinfectant	85	93	87	90
Disposable needles and syringes	92	100	93	95
Auditory privacy	90	100	92	95
Visual privacy	95	100	96	95
Examination table	95	100	96	88
Client educational materials on FP	77	93	80	80
Examination lamp on stand (Proper light arrangement)	97	100	97	95
Syringe cutter	87	93	88	80
Chlorine solution	78	93	81	83
Boiler/Sterilizer	83	93	85	80
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>40</b>

### 6.3 Preparedness for IUDs and Implants Service

The survey focused on evaluating the readiness of facilities to provide key contraceptives, particularly Intrauterine Devices (IUDs) and Implants. Public and private facilities offering family planning services were visited for this purpose, aiming to assess staff training and service quality preparedness. Staff members were questioned regarding their training in IUD and Implant insertion and removal. The findings, as depicted in tables below (Table 4.6), indicate that almost all facilities that indicated serving do have trained personnel for IUD and Implant procedures. Overall, it is evident that 58 percent of DOH facilities (35 in number), 87 percent of PWD facilities (13 in number), and 53 percent of private facilities (21 facilities) reported being prepared to serve IUCDs (Table 6.6).

IUD insertion emerges as a prominent contraceptive method offered by many health facilities, both public and private. Facilities offering IUD services were surveyed regarding the availability and functionality of various items required for the procedure. Except autoclave availability and functionality in some DoH and PWD facilities (83% and 77%), all other necessary items were reported to be available and operational in a vast majority of facilities, indicating well-preparedness and adequate equipment for IUD services across different facility types. IUCD service availability has improved in 2023 in facilities of Health and PWD.

**Table 6.6: Percentage of family planning facilities have trained personnel and supplies to insert and remove IUDs**

Facility has trained personnel able to insert or remove IUDs	DOH	PWD	Private Facility
Yes	100	100	100
No	0	0	0
<b>Facility have the supplies needed to insert and/or remove IUDs:</b>			
Sponge holding forceps	97	100	100
Vaginal speculum	100	100	100
Tenaculum	100	100	95
Uterine sound	100	100	95
Examination table/ couch	100	92	95
Examination lamp on stand	91	92	95
Adult weighing scale	91	92	100
Stethoscope	100	100	100
BP apparatus	100	100	100
Kidney tray	100	100	100
Scissors straight	100	100	100
Bowls	100	100	100
Pair of gloves	89	92	95
Disposable syringes 5cc, 3cc, 2cc	100	92	95
Sterilizer	94	100	95
Autoclave	83	77	81
Disinfection solution: (Dettol, Savlon, iodine)	89	100	100
Chlorine Solution	83	100	95
Container for chlorine solution	77	100	95
<b>Number of facilities that provide IUDs</b>	<b>35</b>	<b>13</b>	<b>21</b>

Facilities are also enquired concerning provision of implant contraceptive and facility readiness with essential supplies and equipment for aseptic implant insertion/removal. The staff reported that almost a half of Health facilities (47 percent of 60 facilities) and less than a third of private visited facilities (30% of 40 facilities) serve implants and have necessary items for implant provision (Table 6.7). Only 8 of 15 PWD facilities acknowledged the provision of implants services. All required items are reported to be available and functional in a vast majority of facilities, demonstrating preparedness and adequate equipment for implant services across selected facility types. In general, fewer PWD facilities are prepared to offer implants than claimed above to serve these to clients. Overall, KP reflects a negligible implants coverage/provision of implants in various facilities.

**Table 6.7: Percent distribution of family planning facilities that have trained personnel who can insert or remove the implants and availability of supplies/items to handle it**

Facility have trained personnel able to insert and remove implants	DOH	PWD	Private Facility
Yes	100	100	100
<b>Facility has the following supplies/items to handle implants</b>			
Marking pen	96	100	100
Tape measure (Plastic ruler preferred)	93	88	100
Alcohol pads	93	100	100
5 ml syringe 2% lidocaine with Epi + 0.5 ml	93	88	100
8.4% Sodium Bicarbonate	75	88	100
18 g to draw up medication	75	88	92
25g 1-1/2 needle to attach syringe	82	88	92
Non-sterile 4 x 4's	68	100	92
A + D ointment	89	88	100
1 or 2 inch gauze roll for pressure	93	100	100
Tape	96	100	100
Bandage Scissors	100	100	100
Benzoin, Sterile-strips, Ethyl Chloride	79	100	100
Clean Gloves	89	100	100
Antiseptic	93	100	100
Sterile Gauze Pad or Cotton Wool	100	100	100
Local Anaesthetic	93	100	100
Sealed Implant Pack	86	100	100
Surgical Blade	93	100	100
Mosquito forceps (Straight or Curved)	86	100	100
<b>Number of facilities that provides Implants method</b>	<b>28</b>	<b>8</b>	<b>12</b>

#### 6.4 Quality of Services

Effective communication between service providers and family planning (FP) clients plays a crucial role in ensuring continued use and satisfaction among clients. Counselling, as highlighted by previous research, is an essential aspect requiring persistence and comprehensiveness to encourage clients to adopt contraception for the long term. During the survey, facility staff were asked about FP counselling, specifically focusing on informing clients about the benefits and side effects of various methods. According to the facility staff, the benefits of all methods are communicated to clients, and some are emphasized more than others as per the needs of the client. However, modern methods such as IUCD, injectables, Pills, Condoms, and ECP receive greater attention from the DOH and PWD facilities compared to private sector facilities. Permanent methods and implants are not given due attention in communicating benefits. Table 6.8 reveals that DOH and PWD health facilities exhibit a relatively higher level of emphasis on communicating benefits relative to private sector facilities.

**Table 6.8: Percent distribution of service providers gives information on the benefits of specific methods**

<b>Contraceptive Methods</b>	<b>DOH</b>	<b>PWD</b>	<b>Private Facility</b>
Female sterilization	62	65	52
Male sterilization	52	57	41
IUD	90	95	87
Injectables	97	98	98
Implant	72	65	60
Pills	98	98	99
Condoms	97	92	90
Emergency contraception	80	95	72
Standard days method	69	86	66
Lactational amenorrhea method	90	98	84
Rhythm method	90	98	86
Withdrawal	92	98	86
Other method	10	13	8
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>40</b>

Staff across all types of facilities also provide necessary information on the side effects of various modern and traditional FP methods to clients. According to the survey results, DOH and PWD health facilities staff place a notably greater emphasis on communicating the side effects of FP methods compared to private sector facilities (Table 6.9). Male and female sterilization are given low attention followed by implants.

**Table 6.9: Percent distribution of service providers gives information on side effects of methods**

<b>Contraceptive Methods</b>	<b>DOH</b>	<b>PWD</b>	<b>Private Facilities</b>
Female sterilization	55	40	75
Male sterilization	37	40	53
IUD	82	93	85
Injectables	88	100	90
Implant	78	87	63
Pills	88	100	90
Condoms	88	100	88
Emergency contraception	78	93	85
Standard days method	60	87	63
Lactational amenorrhea method	80	100	80
Rhythm method	80	100	80
Withdrawal	80	100	85
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>40</b>

## 6.5 Charges Made on FP Commodities and Services

A dedicated segment was incorporated in the survey to assess the pricing of contraceptives by different private facilities. Service providers were requested to disclose their approach to charging for commodities. DOH and PWD facilities uniformly offer FP commodities and services either free of charge or at nominal rates. Private sector facilities indicated that a significant proportion levies charges for commodities and services to maintain their business

operations. The percentage of private facilities offering contraceptives for a fee and the average charges imposed on clients for each contraceptive method is illustrated in Table 6.10.

- The 2024 survey indicates that among the visited facilities, neither DOH nor PWDs offer both male and female sterilization services. Similarly, public sector facilities do not charge for any method.
- Survey reveals more than a quarter (28 percent) of private health facilities provide female sterilization services (tubal ligation), with an average cost of Rs 2,500. Furthermore, a small number of private facilities offer vasectomy, and their average charges are Rs 8000.
- The 2024 survey reveals that DOH and PWDs offer injectables free of charge, whereas 83 percent of private health facilities provide injectables, averaging a cost of Rs 348, which was Rs 296 in the 2023 facility survey.
- Among the long-acting contraceptives, implants provided by private facilities are the most costly item, priced at more than Rs. 3,150 and offered by a handful of facilities (7 out of 40 private facilities). The charges were around Rs 2000 in 2023 survey. Furthermore, almost half (48 percent of 40 private facilities) make IUCD available and their charges are on average Rs. 1,566 which were more than Rs. 1300 per unit in 2023. IUCD is comparatively less expensive than implants from private providers.
- The survey indicates oral pills and condoms, made available by private sector are notably lower priced than other commodities.

**Table 6.10: Percent distribution of private facilities offering various methods and average charges levied on clients**

Contraceptive Methods	Private Facilities	
	2023	2024
<b>Female sterilization</b>	21	28
Average Charges (Rs)	3,350	2,509
<b>Male sterilization</b>	2	3
Average Charges (Rs)	- -	8000
<b>IUD</b>	42	48
Average Charges (Rs)	1,314	1566
<b>Injectables</b>	73	83
Average Charges (Rs)	296	348
<b>Implants</b>	31	28
Average Charges (Rs)	1,973	3145
<b>Oral Pills</b>	79	75
Average Charges (Rs)	307	174
<b>Condom</b>	50	60
Average Charges (Rs)	118	118
<b>Emergency contraception</b>	31	50
Average Charges (Rs)	191	155
<b>Number of Facilities</b>	<b>48</b>	<b>40</b>

## 6.6 Availability of Contraceptive Stocks

Availability of FP commodities is the backbone of FP delivery mechanism. All facilities visited during the survey were asked about the stocks of each contraceptive method and the period of stock outs where these were not available. The stocks register was used to record information of various key contraceptives at the facility. Table 6.11 below captures percent of facilities that reported availability of specific commodity, percent of facilities that experienced stock out which were asked for the period of stock outs of that commodity. As compared to 2023 survey report, Health Dept. facilities show a reasonable number have adequate stocks of oral pills, IUCDs and injectables but a fair proportion of facilities show stock outs of condoms, IUCDs, Injectables, pills, and implants for quite some time. On the other hand, PWD facilities too show stock outs in some facilities but the number of stock out days are much lower than DoH facilities. What is noteworthy is that average number of stock out days of DoH facilities is much longer now than previous year survey esp for condoms, implants and injectables. Contrary to previous year, implants are reported stock-out in fewer health facilities and average stock out days of more than a year (567 days). The majority of PWD facilities show improved stocks availability (condoms and Implants) (Table 6.11) and only a few facilities reflect stock out and fewer average stock out days. A small percentage of private sector facilities show stock outs of various contraceptives (condoms, pills, injectables, IUCDs and emergency pills) for a shorter duration than previous year. IUCD and Implants are available in a small percent of public and private facilities but lack of stocks in some facilities for several months needs attention for improved availability to enhance accessibility.

**Table 6.11: Percentage of facilities with adequate stocks of contraceptives and other facilities with stock outs by average number of stock outs days**

Condoms	DOH		PWD		Private Facility	
	Available	Not Available	Available	Not Available	Available	Not Available
Percent of Facilities	50	28	67	33	65	10
Stock out days (average)	727		126		38	
<b>Pills (Cycles)</b>						
Percent of Facilities	43	40	13	87	80	8
Stock out days (average)	421		50		81	
<b>IUD (units)</b>						
Percent of Facilities	40	17	33	53	48	5
Stock out days (average)	319		90		75	
<b>Injection (Vials)</b>						
Percent of Facilities	67	18	93	7	85	3
Stock out days (average)	1606		360		30	
<b>Implants</b>						
Percent of Facilities	25	17	20	27	28	3
Stock out days (average)	567		113		20	
<b>Emergency Pills</b>						
Percent of Facilities	22	37	40	27	65	0
Stock out days (average)	379		308		00	
<b>Number of Facilities</b>	<b>60</b>		<b>15</b>		<b>40</b>	

## 6.7 Human Resource Development for Family Planning

Proficient and skilled service providers are core to ensuring the quality of service delivery. The survey asked several questions regarding human development to staff dispensing family planning services in the facility. The idea is to assess their technical knowledge and how they use their knowledge in service delivery. Staff were asked about the types of training in family planning they received them in the previous three years. Survey revealed that 53 percent of staff of DoH facilities, 80 percent of PWD (total 15 facilities), and 40 percent of staff of private sector facilities (total 40) received training in the past three years (Table 6.12). Main training for PWD staff focused on IUCD and PPIUCD insertion and removal (67 and 58%) followed by FP technology-related training. However, the Health Department staff received training in Family planning (contraceptive technology) and IUCD insertion and removal, FP counselling related training, distantly followed by Implant insertion/ removal. Fewer staff received training in Minilap and infection prevention management, which needs to be enhanced for all staff.

**Table 6.12: Percentage of staff reporting receiving type of training**

Type of training received on family planning/ contraceptive	DoH	PWD	Private Facility
Family planning (contraceptive technology)	88	50	69
IUCD insertion/removal	78	67	69
Contraceptive logistics management	56	25	50
Family planning counseling	50	33	56
Client Centered Family Planning	47	17	44
Clients rights	34	25	75
Minilap/ Vasectomy	19	0	38
Implant insertion/ removal	66	42	63
PPIUCD insertion/removal	56	58	50
Infection prevention management	34	8	38
<b>Number of respondents who attend training</b>	<b>32</b>	<b>12</b>	<b>16</b>

## 6.8 Opinions Regarding Service Improvement

Provision and access to family planning services have been persistent issues over the years. All facility-based service providers were asked what they felt was essential to help boost delivery of FP services. A wide variety of responses were recorded across type of facilities and spelled out in Table 6.13. More the half of DoH staff pointed availability of contraceptives commodities (75%), provision of general medicines (65%) and training for management of side effects (62%). The PWD staff also opined need for provision of counseling to community level, provision of free contraceptives (47%) and free camps (47%) as important areas. For private sector staff provision of provision of free contraceptives (75%) and availability of contraceptives commodities (63%) are key areas (Table 6.13). These are good field-level suggestions to enhance access and availability of family planning services at the grassroots.

**Table 6.13: Percentage of requirements identified by staff to promote family planning**

Requirements identified by staff	DoH	PWD	Public Facility	Private Facility
Training to provide and serve the methods	57	40	53	48
Training for management of side effects	62	33	56	53
Availability of contraceptive commodities	75	33	67	63
Provide counseling to community level	37	53	40	33
Clarify doubts about religious aspects	27	20	25	30
Provide contraceptives free of cost	65	47	61	75
Provide general medicines	58	27	52	45
More staff needed	53	13	45	40
Free camps	55	47	53	58
Ultrasound machine and delivery kit should be provided	42	40	41	33
Clients should be supported financially	27	20	25	55
Transport for field visits	30	33	31	25
Staff for community mobilization	22	7	19	18
Others	7	13	8	5
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>40</b>

### 6.9 Suggestions Regarding Service Quality Improvement

Service providers were asked to identify key areas they deemed essential to discuss with potential family planning clients. Health, PWD, and private sector providers highlighted several crucial areas, including the advantages and disadvantages of various methods, instructions on how to use the method, clarification on how the method works to address any misinformation, the duration of use, and potential side effects (Table 6.14). However, there was a notable variance in prioritization among Health staff regarding how the method works, management of side effects, and follow-up procedures. To ensure quality counseling, it is imperative that all these aspects are comprehensively covered and uniformly discussed with clients using standardized protocols. Encouragingly, there was a consensus among respondents across Health, PWD, and private sector providers on many aspects of counseling, indicating a degree of uniformity in practice. Management of side effects needs to be given higher attention to minimize discontinuation and continued usage of contraception.

**Table 6.14: Percentage of topics/areas of counselling given to FP clients**

Areas of Counselling	DOH	PWD	Public Facility	Private Facility
Advantages and disadvantages of the method	90	93	91	73
How the method works	82	80	81	70
How to use the method	83	73	81	85
How often to use the method	72	60	69	75
Duration of use	73	80	75	63
Effectiveness level	68	73	69	75
Possible side effects	65	67	65	68
Management of side effects	38	40	39	50
Return for follow up	70	93	75	58
Refer, if method not available	43	53	45	45
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>40</b>

### 6.10 Assessment of Service Provider’s Technical Knowledge

To evaluate the technical knowledge of service providers, facility staff providing family planning were presented eight specific questions covering various aspects of family planning, contraceptive technology, health conditions for contraception use, and technical issues related to different contraceptive methods. Multiple-choice responses were provided, aiming to seek the correct answer from FP service providers. The table below details the questions and the percentage of facility-based care providers who provided the correct answer (along with the correct answer).

Overall, PWD staff demonstrated relatively better knowledge of some technical aspects of contraceptives as compared to staff from other entities, correctly responding to three questions with 60 percent or over accuracy (Table 6.15). On the other hand, DOH and private facility staff also achieved a 60 percent accuracy rate in two technical areas. For more specific inquiries concerning topics such as miscarriage, Norigest usage, oral pills, IUCD side effects, and emergency pills, the proportion of correct responses varied across staff entities, indicating the need for knowledge enhancement and refresher training among staff. The higher percentage of responses from Health Department staff exhibits better pre-service training in maternal health issues, particularly related to miscarriage, postpartum care, and delivery. Responses from private facilities reflect an urgent need for refresher training for all. Questions with less than a 60 percent response rate warrant immediate attention and staff refresher training. Utilizing e-learning technology could be beneficial in addressing knowledge gaps among facility staff.

**Table 6.15: Percentage of corrected responses to specific technical questions about contraceptive methods and family planning/ birth spacing**

Responses to Technical Questions and Correct Answers	DOH	PWD	Public Facility	Private Facility
Period of spacing between birth of a baby and becoming pregnant again (At least 24 months)	58	33	53	48
How long should women wait after a miscarriage before becoming pregnant again (After 6 months)	60	60	60	50
Norigest injection to have continuous protection against pregnancy (8 weeks)	35	20	32	50
Indications when oral pills can be provided (Women aged over 35 years who smoke)	23	20	23	33
Who cannot have IUCD (Post abortion clients who have purulent discharge)	75	73	75	50
What is true about emergency contraception (EC Pills) (All of answers)	53	67	56	40
Side effects of IUCD (All of the above )	37	47	39	45
Replace IUCD after how long (After 12 Years)	32	53	36	13
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>40</b>

### 6.11 Assessing Knowledge of FP Providers regarding Family Planning Methods and Services

FP service providers across all facilities were surveyed using 14 statements to assess their understanding of various aspects related to contraceptive methods and family planning/birth spacing. The table below (Table 6.16) illustrates the percentage of service delivery staff who provided correct responses to these statements. The questions covered a range of topics, including the decision-making process for providing contraceptive methods, handling of medical equipment, and guidelines for different contraceptive methods. Responses were

categorized by the type of healthcare facility, including DoH, PWD, and private facilities. Some questions were intentionally posed in a tricky format to gauge clarity of understanding among the staff, while others focused on recent advancements in infection prevention and other preventive measures. The aim was not only to evaluate their technical knowledge but also their perceptions based on their training and experience. Overall, the questions addressed quality-of-service aspects crucial for building confidence in contraception among clients.

Technical knowledge about disposable syringes, age selection of women for tubal ligation, oral pills, IUCDs, and Depo-Provera appears to be low among several service providers based on the questions asked. The low percentage of correct responses across all sectors is a concern and highlights the urgent need for refresher training for all service providers. Enhancing competencies through refresher training for FP staff across all sectors is essential to improve the quality of service delivery.

**Table 6.16: Percentage of service delivery staff understanding correctly to specifics about contraceptive methods and family planning/birth spacing**

Questions (with Correct Responses)	DoH	PWD	Public Facility	Private Facility
The doctor should decide provision of contraceptive of method to a client as per his/her own best judgment (False)	83	87	84	78
It is important to discuss misconceptions and rumors about Family Planning methods with the client (True)	88	100	91	95
Always bend the needle of a disposable syringe after use to make sure it cannot be reused (False)	10	0	8	8
Decontamination of the needle and syringe must be done before destroying it in destruclick (False)	60	67	61	50
The strength of chlorine solution is 0.1% for effective decontamination (False)	52	40	49	38
If a client is on injection depo -provera, she comes one week later than the schedule time; she can be given a second injection (True)	65	67	65	75
Oral pills can be given to nulliparous women (True)	30	53	35	25
A woman who is breastfeeding a baby can take progestin-only pills after 6 weeks of delivery (True)	72	80	73	75
A progestin-only pills can be used for emergency contraception after unprotected sex (True)	53	60	55	63
A woman should stop using depo –provera (3 months injection) if she has no menstrual bleeding for a long time (amenorrhea) (False)	40	40	40	45
Sterilization should be offered only to woman who have had a certain number of children or who have reached a certain age (False)	27	40	29	40
A woman who has never had a baby can use an IUCD (True)	22	7	19	30
A woman with diabetes can be given/insert an IUCD (True)	32	27	31	43
Withdrawal method is highly effective and practical among teenagers (False)	32	33	32	28
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>40</b>

## 6.12 Facility Level Performance Assessment

Survey examined and recorded two important pieces of information from facilities' based Client and Service Registers - the number of clients served and total commodities dispensed by various facilities from June to August 2024. The Table 6.17 gives an interesting distribution

of clients for three months and facilities by Departments. Facilities register clients with the purpose of their visit and record commodities dispensed to them.

The three-month record of clients shows a mixed trend (some increase and others decline) in general clientele during June to August 2024 at Health and PWD facilities. Dept of Health clientele for IUDs, injectables and oral pills reflects a much higher clientele than PWD facilities and a gradual increasing pattern over three months. For injectables, the increasing trend of clientele over three months is noted (Table 6.17). Oral pill clients are provided with at least one cycle (for a month) but more than one is also feasible to minimize client's follow up visits. The trend for condom clientele for public facilities as noted in Table 6.17 reflects a positive situation as over three months of 2024 esp for DoH facilities while PWD hardly dispensed condoms to clients which is a popular contraceptive method. DoH facilities reflect a reasonable number of clients for condoms but an increasing trend over three months. Male sterilization has limited facilities and services so we notice no cases in each month for all facilities. Implant clients show a slow decline among DoH facilities over three months while only a handful of PWD clients were served with implants. Emergency Contraceptive (EC) Pills are the lowest item dispensed also to fewer clients by private sector facilities.

It is interesting to note that number of clients and number of commodities served by public sector for IUCDs, implants, and injectables are very well aligned (quite similar) reflecting accuracy in recording of commodity dispensation. Oral pills and condoms are two commodities that are dispensed more than one per client for longer term usage. Condoms distribution data appears not correct for PWD facilities, especially in June 2024 and for other months too.

Closer analysis of Table 6.17 reveals total number of IUCD clients and number of IUCD dispensed are consistent over three months for each type of facility. Injectables clients do also match with the number of injectables dispensed. What catches eyes is the difference between PWD and DoH facilities number of clients and number of commodities (condoms) dispensed. The dispensation is many times higher than the number of clients registered by the DoH facilities. Condoms are normally dispensed 6 or more items per client on client's visit. Pills and condoms are provided free of charge but number of items given to clients does not show any uniformity across Depts.

A quick review of three month record shows that number of clients served declined from 21,249 (in June 2024) to 23,150 (in July 2024) to 24,274 (in August 2024). A total of 68,673 family planning clients were served by 115 public and private facilities. Twenty-one percent of these clients are served by private facilities as per records made available to survey teams. It is interesting to note that almost three-quarters (73%) of all clients are registered and served by Dept of Health facilities over the three months. The proactive pursuit of FP agenda by Health facilities is a positive aspect of enhancing access and availability of contraception to women.

**Table 6.17: Percent distribution of total number of family planning clients according to type of facility**

Contraceptive Method	June-24			July-24			Aug-24		
	DOH	PWD	Public Facility	DOH	PWD	Public Facility	DOH	PWD	Public Facility
Female sterilization	18	0	18	16	0	16	28	0	28
Male sterilization	0	0	0	-	-	-	-	-	-
IUD	288	74	362	195	65	260	268	37	305
Injectables	2,955	505	3,460	3,971	483	4,454	6,056	578	6,634
Implant	166	14	180	152	59	211	106	13	119
Pills	3,969	292	4,261	5,268	348	5,616	5,608	200	5,808
Condoms	3,809	475	4,284	6,599	514	7,113	6,866	520	7,386
Emergency contraception	1,259	8	1,267	1,239	4	1,243	817	12	829
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>60</b>	<b>15</b>	<b>75</b>

Contraceptive Method	Total Products/Services dispensed			Total Products/Services dispensed			Total Products/Services dispensed		
	DOH	PWD	Public Facility	DOH	PWD	Public Facility	DOH	PWD	Public Facility
Female sterilization	20	0	20	16	0	16	28	0	28
Male sterilization	-	-	-	-	-	-	-	-	-
IUD	288	74	362	195	61	256	268	30	298
Injectables	2,952	508	3,460	3,974	473	4,447	6,032	696	6,728
Implant	166	14	180	152	56	208	106	13	119
Pills	4,070	330	4,400	5,350	378	5,728	5,791	227	6,018
Condoms	11,253	10,534	21,787	14,704	6,058	20,762	17,233	6,979	24,212
Emergency contraception	1,260	8	1,268	1,230	109	1,339	821	119	940
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>60</b>	<b>15</b>	<b>75</b>

### 6.13 Integration of Family Planning with Maternal Health Services

An important area of interest to enhance access to family planning is integration of FP in maternal health services especially by Department of Health and private sector facilities. The facility survey enquired this in particular from all outlets as to what extent this is being practiced. The reason behind that is to assess the scope that FP services could be enhanced by women visiting facility for their maternal health needs.

The percentage of facilities that offer maternal health services besides FP services categorized by the Department of Health (DOH), Population Welfare Dept. (PWD), and private facilities are presented in Table 6.18. For instance, under the "Antenatal care service" characteristic, 92% of DOH facilities, 100% of PWD facilities, and 98% of private facilities provided antenatal care services. Similarly, "delivery service," is provided by 75% of DOH facilities, 6% of PWD facilities, and 95% of private facilities offered delivery services. Only a few PWD facilities offer safe delivery services. All facilities also claimed to provide FP counseling and services at each of these maternal health stages. Overall, the table provides insights into the availability of various healthcare services beyond family planning across different types of health facilities.

**Table 6.18: Percentage of health facilities which provide maternal health services other than FP**

Maternal Health Indicators	DOH	PWD	Private Facility
Antenatal care service	92	100	98
Delivery service	75	60	95
Postnatal care service	87	93	95
Post-abortion/Miscarriage service	77	80	85
General Ailment service	100	100	90
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>40</b>

A large proportion of DoH and Population Welfare facilities acknowledged providing needed counseling to women visiting facilities for ANC/PNC and during post-abortion care. The areas of counseling include healthy timings and spacing of pregnancies, exclusive breastfeeding, long-acting methods, and where to obtain the method of choice. Detail is provided in Tables 6.19 and 6.20.

**Table 6.19: Percentage of health facilities that discussed the services with women after delivery or during first postnatal visit**

Matters discussed with Women on Postnatal Visit	DOH	PWD	Private Facility
Return to fertility Healthy timing and spacing of pregnancies services	95	100	95
Immediate and exclusive breastfeeding services	96	100	92
Family planning methods available while breastfeeding services	87	100	90
Lactational Amenorrhea Method and to use transition to other methods services	87	100	82
Long-acting method options-LAM services	91	100	87
Woman offered a method of family planning during the postnatal visit	78	87	64
<b>Number of facilities which provide ANC/ delivery care/ postnatal care</b>	<b>55</b>	<b>15</b>	<b>39</b>

The survey revealed that most of the public facilities and private facilities discussed the services with women after delivery or during their first postnatal visit and the post abortion visits (Table 6.20).

**Table 6.20: Percentage of health facilities that discussed the services with women during post-abortion visits**

Areas discussed with post-abortion patients	DOH	PWD	Private Facility
Post-abortion/ Miscarriage maternal health	98	92	91
Return to fertility Healthy timing and spacing of pregnancies	93	100	97
Long-acting method options-LAM	91	100	88
FP methods for birth spacing	93	100	94
Women offered a method of family planning during the post-abortion visit	74	75	71
Given information on where they can obtain contraception elsewhere	98	100	88
<b>Number of facilities that provide post abortion/ miscarriage services</b>	<b>46</b>	<b>12</b>	<b>34</b>

Facilities were asked to share their MCH service records and patients' attendance for the three months prior to the survey (June – August 2024). The idea was to assess the functional integration of FP with various MCH services. Registers reveal a total of almost 122 thousand MCH visits recorded over the three months in the 115 facilities (Table 6.21). In addition, almost 182 thousand visits were recorded for general ailments and health issues during these months. Less than three percent of all maternal health visits are recorded by private facilities for ante-natal care, 4 percent for delivery and 9 percent for post-natal care. All these maternal health visits reflect tremendous potential for FP counseling and PNC patients for post-pregnancy FP. Of the total maternal health visits, 4 percent are recorded by private sector facilities. The private sector served 19 percent of patients for general ailments and therefore plays an important role in health sector and their involvement in integrating family planning in MCH is critical and essential to move forward in the sector. Currently neither public nor private facilities maintain any record of integration of services.

**Table 6.21: Average and total number of patients recorded in the three months, according to type of facility**

Health Services	June-24			July-24			Aug-24			
	DoH	PWD	Private Facility	DoH	PWD	Private Facility	DoH	PWD	Private Facility	
Antenatal Care	539	11	432	419	15	337	42			
Delivery	354	7	306	305	7	265	54			
Postnatal Care	107	9	87	67	9	55	27			
General Ailment	749	52	617	1,055	105	875	921			
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>40</b>	<b>60</b>	<b>15</b>	<b>75</b>

**Total number of patients recorded in the month according to type of facility**

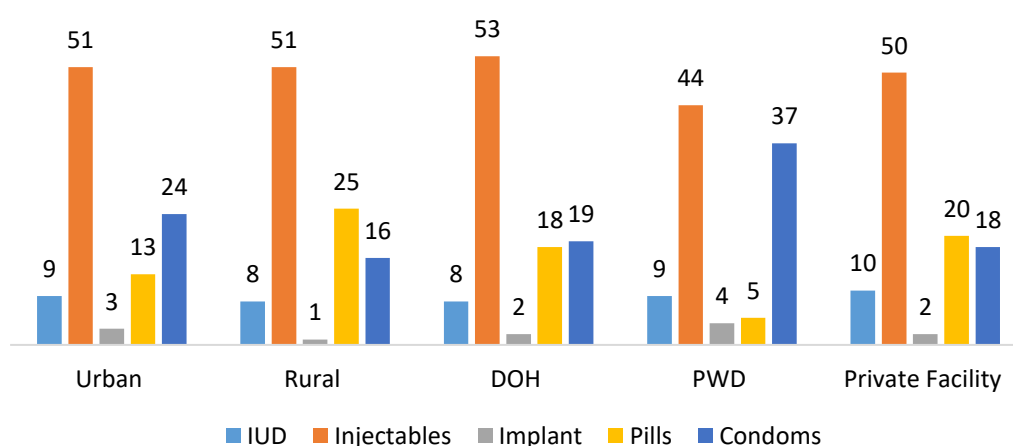
Health Services	June-24			July-24			Aug-24			
	DoH	PWD	Private Facility	DoH	PWD	Private Facility	DoH	PWD	Private Facility	
Antenatal Care	23,197	121	23,318	18,015	161	18,176	543			
Delivery	13,436	41	13,477	11,601	43	11,644	703			
Postnatal Care	4,514	102	4,616	2,808	104	2,912	293			
General Ailment	35,196	573	35,769	49,594	1,157	50,751	12,894			
<b>Number of Facilities</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>60</b>	<b>15</b>	<b>75</b>	<b>40</b>	<b>60</b>	<b>15</b>	<b>75</b>

Interviewing women exiting health facilities adds to the uniqueness of the survey to learn directly from them their experience of service quality and what they received. This segment is the only section where respondents are not the same as were in the household/woman section and the Facility interviews. The survey focuses on family planning, and the tool also seeks information from them regarding family planning services and experiences of counselling, and affordability. Ten exit interviews were performed with the women in each facility to seek their feedback and level of satisfaction with FP/MCH services received/ provided at the facility. A total of 1,053 women clients were interviewed, of whom 72 percent are from urban facilities. Overall, almost 32 percent were family planning clients (1053 cases), 16 percent came for ANC and 41 percent visited for general health issues. Furthermore, almost two-thirds (64%) of clients are from public sector facilities and the remaining 36 percent from private sector facilities.

## 7.1 Method Prescribed or Given on the Visit

The exiting family planning clients were asked about the method prescribed or given to them. The client survey reveals that three methods stand out –Injectables (51%), Pills (16%) and Condoms (22%). Injectables are prescribed highly by DoH and private facilities and relatively lower by the PWD facilities (Figure 7.1). On the contrary, condoms are noted to be highly prescribed by PWD facilities (37%) and lower by DoH and Private facilities. Oral pills are the third popular method that is prescribed quite low by PWD facilities and relatively higher by private and DoH facilities.

**Figure 7.1: Percent distribution of family planning method prescribed or given by facility type provider**



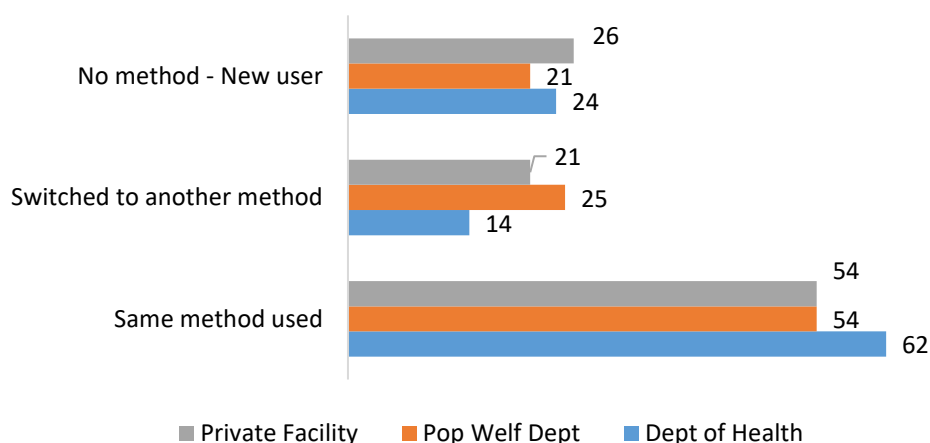
The percent distribution of prescribed methods by place of residence is also interesting to note. Injectables are prescribed relatively higher to rural women while oral pills are equally prescribed to both rural and urban women exiting facilities (Table 7.1).

**Table 7.1: Percent distribution of family planning method prescribed or given by place of residence**

Place of Residence	IUD	Injectables	Pills	Condoms
Urban	17	30	31	18
Rural	15	36	31	15

The clients exiting the facilities are asked about the kind of method they received from the facility. The survey reveals that a large percentage of clients are given the same method on their current visit to the facility and is above 54 percent for each type of facility and highest by DoH facilities (Figure 7.2). Furthermore, analysis reveals that a quarter (24%) of PWD clients and private facility clients report being a new user, which is a good reflection of women adopting contraception. Switching methods is a good option for women who experience any problem with its use. PWD and private facility exit clients are relatively higher than DoH clients (Figure 7.2). Need for improved counseling is noted here esp when a large segment of clients visit private sector where counseling for family planning is rather weak.

**Figure 7.2: Percent distribution of family planning method prescribed or given by provider by user type**



## 7.2 Charges Paid by Clients

Accessing FP services may be hindered by various factors, one of which is the affordability of these services. Exiting clients from facilities were enquired about the charges they paid for the contraceptive method and services in their visit to the facility. Clients exiting public sector facilities are expected not to report any charges for the contraceptives and services received by them. Method-wise charges paid by the private sector clients reflect price differential of various contraceptive methods (Table 7.2). Private sector clients bear additional cost of service charge made by the facilities, which may make the total cost of contraceptive higher. Women continue use the private sector services, as they can afford these services.

Interesting to note a few matters that emerge from the information revealed by the client's survey (Table 7.2). First, a few public sector (esp DoH facilities) are charging for commodities and services beyond their required mandate/rate (free commodities). Second, private sector charge are quite high, yet women take their services and commodities regularly. Third, clients report that DoH facilities charge quite high for three methods: IUCDs, pills, and injectables relative to PWD facilities where charges are nominal.

**Table 7.2: Average charges for method and services of FP methods according to type of facilities**

		Private Facility	DOH	PWD	Private Facility	DOH	PWD
		Method Price/ Charges			Service Charges		
IUD	Percent Charged	25			31	5	
	Average Charges (Rs)	700			500	200	
Depo-Provera injection	Percent Charged	73	32	12	46	2	
	Average Charges (Rs)	279	206	153	262	50	
Pills	Percent Charged	63			14	3	
	Average Charges (Rs)	250			350	50	
Condoms	Percent Charged	53			20		
	Average Charges (Rs)	150			300		

### 7.3 Maternal Health and Integration of Services - Quality of Counselling Services

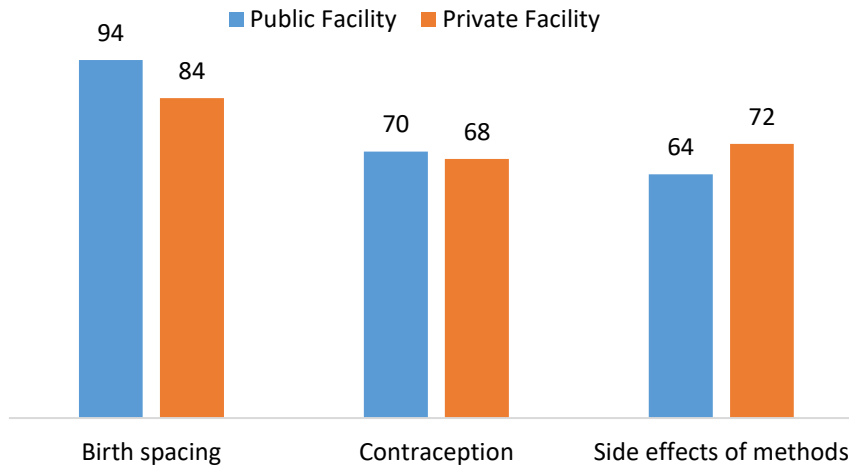
Integration of family planning with MCH services is an important area covered in the survey. Women were asked whether counseling was done or not on important matters during ANC visits. Client's responses by place of residence reflect relatively higher percentages of rural facilities providing counseling on all aspects than urban facilities (early initiation of breastfeeding, exclusive breastfeeding, balanced diet, and birth spacing (Table 7.3). Client's survey reveals clients visiting private facilities get a better opportunity of counseling while PWD, and Health facilities need to do extra effort and counseling regarding all four areas of counseling (Table 7.3).

**Table 7.3: Percentage responses on four aspects of quality of services of antenatal care**

	Early initiation of breastfeeding	Exclusive breastfeeding	Balanced diet during pregnancy	Birth spacing	No of Cases
<b>Residence</b>					
Urban	74	72	75	62	109
Rural	79	80	80	71	56
<b>Type of Health Facility</b>					
DOH	68	69	73	60	78
PWD	71	64	71	50	14
Private Facility	85	84	82	74	73

Another important area of integration of services is the post-natal visit by women to care providers. Three questions were posed to assess the status of integration of women exiting various health facilities. The questions related to counseling regarding birth spacing, contraceptive methods and side effects of various methods. Results show that a fairly large percentage of clients report counselling on birth spacing is done by staff of public and private facilities while contraception and side effects of methods are given little attention in counseling (Figure 7.3). Interestingly, the survey reflects hardly any difference between urban and rural facilities in all these areas. Overall results point out gaps to fully integrate FP in MCH services and the need to give greater focus and supervision for the purpose.

**Figure 7.3: Percent distribution of quality of service indicators of postnatal care**



#### 7.4 Quality of Family Planning Service

Effective counselling is essential to ensure good understanding among women regarding contraceptive choice and selection of right method to address women’s birth spacing needs. Several questions were posed to women exiting facilities after their ANC visit to assess the comprehensiveness of family planning counselling. The areas included: Whether they were explained how to use the method; possible side effects of various methods; what to do if you have problems; When to return for follow-up; contraceptive methods other than the method you were given or prescribed; family planning method preference; and she could switch to a different method in the future.

A closer look at clients’ feedback by facilities departments (Health, Population Welfare or Private Sector) reveals that three areas are universally covered by staff to counsel women visiting for ANC. Several aspects were asked separately. It is heartening to know that rural women get the same level of counseling as urban women (Table 7.4). When asked about counseling regarding ‘when to return for follow-up’ staff of all entities (DoH, PWD and private facilities) counseled equally to all clients. Advising women when to return for follow-up is essential for continuous use without any interruptions.

Survey found that more than 90 percent of clients acknowledged to have been explained how the method works, similarly around 90 percent clients reported to be told about the side effects, and also told what to do in case of problems faced by them, and when to return to the facility for seeking queries or resupplies (Table 7.4). An important area relates to switching methods for continuity in use, which appears to be discussed lowest with clients by all service providers especially by PWD staff.

**Table 7.4: Percent distribution of quality of services of family planning methods during ANC visit**

<b>Areas of Counseling</b>	<b>DOH</b>	<b>PWD</b>	<b>Private Facility</b>	<b>Urban</b>	<b>Rural</b>
Explain how to use the method	90	95	98	92	94
Possible side effects	88	91	90	89	91
What to do if you have problems	91	95	85	92	85
When to return for follow-up	91	88	85	88	88
Contraceptive methods other than the method you were given or prescribed	78	84	88	85	79
Family planning method preference	79	85	88	80	100
You could switch to a different method in the future	52	50	56	50	62
<b>Number of clients, prescribed or given family planning method</b>	<b>77</b>	<b>22</b>	<b>41</b>	<b>106</b>	<b>34</b>



### 8.1 Main Conclusions

1. The PMA framework-based data gathering is a unique opportunity to analyze the existing family planning situation from various angles and is cost and time-efficient. It is a tool for programme managers for informed decision making with provincial level representative estimates of actionable indicators.
2. The exercise provides valuable information on several indicators and their use for policy reforms and improving programme components is critical to assess desired progress.
3. Two clear messages are visible from the exercise: (i) changes in CPR in Balochistan are currently driven by modern methods which need acknowledgement for recent programme efforts; and (ii) private sector has played an active role as a source to access and provide modern contraceptives. The public sector role (two key players) is supportive in enhancing access to modern methods.
4. Condom use is the most popular method followed by oral pills and injectables while traditional methods are being adopted in increasing proportions even as a first method. Condoms and traditional methods have little effect on birth spacing or limiting and on fertility decline.
5. Survey reveals more rural women (18%) have had interaction with LHWs than urban women (13%). Looking at the CPR, LHWs appear not to have played an effective role in promoting modern methods among rural women. CPR is 29 percent among women who didn't interact with LHWs against 21 percent among women who met LHW in the previous 12 months.
6. Women's interaction with health staff and discussion regarding FP is noted to give a boost to the percentage of women using modern contraception (21 percent who met health staff as against 16 percent who did not meet). More than half of women (54%) reported visiting a health facility for personal or child health matters in Balochistan. Among these 26 percent reported that facility staff talked to them regarding FP.
7. Unmet need is quite high in Balochistan as revealed by the survey (33 percent of women). Higher unmet need among rural (34%) than urban women (28%) is based on their desire for spacing births. Unmet need is quite high among women who had interaction with LHWs (44%) and also those who met health staff in their last visit to facility (54%). It reflects the need and efforts in rural areas to give accurate information to rural women who in return desire to space future births relative to their urban counterparts.
8. More 85 percent of women either do not intend or do not know whether they intend to use contraception in the future. Only 14 percent of women who are not using any method intend to use it any time in the future to avoid getting pregnant. For an effective FP programme, a strong social mobilization and an effective communication strategy with face-to-face meetings is the needed of time.
9. Only less than 3 percent of women reported having experienced an unintended pregnancy in their lifetime. Relatively high unintended pregnancies between ages 20 and 29 are a serious concern reflecting an urgent need to meet contraception needs. Furthermore, urban women have higher unintended pregnancies (4.0 percent of women relative to 2.0 percent of rural women) that can be related to increased use of traditional methods.

10. The number of clients and number of commodities served by public sector for IUCDs, and injectables are very well aligned (quite similar) reflecting accuracy in recording of commodity dispensation. The monthly average FP client attendance at Health facilities reflects good utilization of facilities for family planning and reasonable dispensation of contraceptives by DoH facilities reflects good stock situation.
11. All DoH facilities reflect and inform about integration of FP counselling and services at all maternal health stages. This integration needs a thorough review at all facilities in light of the results of client exit interviews. All gaps in FP counselling to women during ANC, PNC and general ailment visits needs to be addressed effectively to encourage women to use modern methods.
12. Technical knowledge pertaining to disposable syringes, age selection of women for tubal ligation, oral pills, IUCDs, and Depo-Provera appears to be low among several service providers. Areas with less than a 60 percent response rate warrant immediate attention and staff refresher training in all entities. Refresher training for DoH staff in various aspects of contraceptive methods (IUCD, and Norigest), contraceptive technology and counseling is needed. E-learning technology may be employed to reach out to facility staff in remote areas to address staff's knowledge gaps.

## 8.2 Key Recommendations

1. Enhancing access, coverage, quality of service and contraceptive security are critical to fulfill FP2030 prime commitments. Making family planning counselling and services universally available at all public sector health facilities and private sector health facilities, especially where deliveries and PNC services are available is important. Promote post-pregnancy family planning services. Strong support and ownership by Department of Health is fully recognized as means for universal access.
2. For accelerated programme social mobilization and community level counseling are essential. Adequate preparation is critical to overhaul demand creation and communication strategy and components. All community-based service providers (LHWs and CMWs) and facility-based care providers (FWWs and LHVs) should give greater attention to counseling and must receive refresher training to focus on newly-wed, younger couples, low parity women and promote IUDs and implants. Furthermore, male mobilizers posted in rural communities must proactively pursue social mobilization role to educate men to make informed choices for birth spacing and use of long acting reversible methods. Myths and misinformation among men needs to be addressed.
3. Inequity in access remains a management barrier across the province. Proactively reaching out the vulnerable, poorest of the poor and marginalized population through its infrastructure should be a key priority of the public sector. Link family planning activities with the Social Safety Net Programme (such as providing vouchers to poor women) and introduce innovative schemes for adoption of FP services and institutionalized birth delivery. Use of mobile service units and local health facilities with trained staff must be engaged to reach out the poor communities for better access to services. Home delivery services of contraceptives must be tested and scaled up by the private sector entities.
4. Top priority needs to be given to fully equip designated health facilities in rural communities with trained staff in implant insertion with due provision of implant supplies to address unmet need and unintended pregnancies.

5. Boosting integration of family planning counseling and services: With a very large base of women visiting health facilities for their health needs (ante natal care, delivery and post-natal care) complete plan of action for functional integration of FP in all health protocols needs to be developed to ensure family planning services are delivered at ANC, delivery or postnatal stages including counseling regarding birth spacing and contraception services.
6. Proper implementation of Life Skills Education and Planned Parenthood programmes should be carried forward to boost not only demand but better understanding of contraceptive methods.
7. In order to achieve programme objectives and accelerate the FP Programme, competent and motivated human resources are of crucial importance. E-learning technology developed and successfully tested in recent years has become very convenient to use. This technical advancement must be brought under use to meet the human development needs across all sectors especially for those working in remote facilities.
8. Stock-outs of contraceptives at private facilities is a serious concern. Such stock outs are a barrier to easy access and a cause of unintended pregnancies. Long-term Joint assessment and procurement plan for all stakeholders is highly recommended to overcome the supply-related problem. A dynamic logistics system must be in place to minimize chances of clients returning without a method and face increased risk of unintended pregnancies. The procurement plans for the upcoming years should specifically include the acquisition of implants. Additionally, ensuring long-term financing is crucial to guarantee contraceptive security.



