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Navigating Fertility Choices and Reproductive Autonomy: A Qualitative Study of Women in Orangi Town, Karachi

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Abstract

Inhabitants of slum areas are substantial part of the urban population, but still they are excluded from demographic surveys and their data is unavailable in official statistics. Huge number of people lives in slum areas in Pakistan, and Orangi Town is one among Karachi's densely populated area which lacks in empirical evidence on fertility behaviours of residents and town's fertility patterns. This study explores not only the fertility patterns but also their perceptions, family planning, experiences, and reproductive goals. Qualitative research method is adopted in this study in which the term household is referred as people who share the same kitchen. Using purposive sampling technique women were selected from households and semi-structured interviews were conducted to collect data for deeper insight. According to the findings the fertility decisions are influenced and shaped by socio-economic factors. Son preference influences women's reproductive intentions, whereas family size, childbearing decisions affects economic conditions within the household. The study also identifies differences between actual and desired fertility and examines contraceptive prevalence and barriers to family planning. These findings provide evidence to highlight the issues related to reproductive health interventions, policies of urban planning and social development on Karachi's population growth in informal settlements.

Keywords: Fertility, Contraceptive Use, Qualitative Research, Urban Slums, Socio-Economic Determinants.

Introduction

Women's reproductive decision-making and choices of having children and deciding family size not only impacts their lives but also leave marks on their families, and communal socio-economic development. Fertility choices are linked directly to women's empowerment, health care, education, employment, and poverty (Bashir & Guzzo, 2021). Investigation and discussion on female's reproductive choices not only revolve around statistics and demography patterns, but also plays a vital role in existing experiences and perceptions of women. Particularly, the issue of decision-making about childbearing, contraception, and family planning deserves further elaboration, as a woman's expressed preference regarding her ideal family size does not always translate into action due to

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lack of means and/or autonomy. High fertility continues to be a major development challenge in many countries of the Global South (Faour, 1989), where the fertility rates are affected by such factors as gender, culture, religion, economic situation in the country, and household structure (Ali, 1985). Pakistan represents a good example of a developing country facing challenges associated with high fertility rates. Pakistan continues to face relatively high rates of fertility in comparison to other countries in the region. According to the United Nations Data Portal (2022), there are more than 6.6 million births in Pakistan annually, the General Fertility Rate being 100.7 births per 1,000 women and the Crude Birth Rate standing at 29.7. These statistics do not account for the processes underlying the reproductive choices of individual women (UN DESA, 2024).

Previous research has identified a range of social and economic factors associated with fertility behaviour in Pakistan and other developing contexts. These include women's age, level of education, employment, religion, age at marriage, household wealth, and son preference (Hakim & Mahmood, 1994). Such factors can influence the timing of marriage, the number of children women have the spacing of births, and access to and use of contraception (Qureshi & Adamchak, 1996). However, fertility decisions are rarely determined by a single factor. They are often produced through interactions between individual preferences and household expectations. For instance, a woman may prefer to have small family size, but she may experience pressure from her family, husband or even society (Folbre, 1983). Similarly desire for a son may drive some couples to continue childbearing, even after reaching their preferred family size (Mannan, 1988 & Chaudhuri, 2012). Therefore, it is necessary to understand the fertility requirement in the context of power relations, social expectations, so that couple can make right reproductive decisions (Rele & Kanitkar, 1976). Therefore, it becomes more pertinent to focus on women's particular situation living in low status settlements. Generally people living in such informal settlements suffer from poverty, lack of infrastructure and insecurity, lack of public services and scarcity of resources. Under such socio-economic circumstances women's reproductive health care options may be marginalized (Hakim & Mahmood, 1994).

In low-income households, poverty can increase women's economic independence, which can marginalize their decision-making and negotiation on family matters, especially for married women (Teo, 1991), whereas, at the same time women for being passive recipient of socio-economic limitations, might develop preferences and strategies to deal with such circumstances (Phan, 2013). If we take a close look of women's reproductive experiences and preferences, we may perhaps dig deeper into reproductive decisions rather than just focusing on demographic data. Family size may indicate women's reproductive preferences, and women may have their own perceptions and ideas regarding ideal family size, but on the contrary actual family size differs from their ideal family size preferences (Rele & Kanitkar, 1976). This difference has many aspects for

example, unexpected or unplanned pregnancies, lack of access or low access to contraceptives, son preference, motherhood expectations and failure of contraceptives (Mannan, 1988). It has been examined that women's reproductive choices are drawn from cultural values and norms in connection to motherhood and marriage, and the potential gap between reproductive choices of women and its outcomes is analyzed by actual fertility rates and women's family size desire and preferences. Motherhood is considered as completion of womanhood in many societies and it also plays a vital role in enhancing women's social status and femininity. This concept exerts social pressure on women to bear a child soon after their marriage (Meyers, 2001). A woman who bears a son gains social status and her place in a family improve (Nosaka, 2000). Sometimes social standards and expectations even influence women's own preferences of reproductive-decisions. In other words, we can say that for women, fertility is not a personal choice and can be influenced by the network of relationships, socio-cultural norms and values, economic realities, and unequal gender dynamics within the domestic domain. These factors are undoubtedly important, but in Pakistan, only population size and demographic goals are discussed. Demographic data focuses on development growth, and fertility is obscured behind statistical data, and personal and human experiences are considered a secondary issue (Sathar, 1984). Since statistical data is objective, it does not reveal whether the pregnancy was intentional or desired by a woman, whether she had access to contraceptives, or whether they were restricted.

A woman's desire is totally neglected; she does not have any decisive authority in family planning or in shaping her reproductive life (Frank & McNicoll, 1987). Statistical data can provide us with figures of family size (how many), but it rarely offers the facts about why and how it is felt, or her feelings and decision-making about her reproductive life (Frank & McNicoll, 1987). To understand the demographic trend and the shaping pattern, we must first understand the day-to-day routines of women's lives at the household level. This study focuses on women's experiences living in low-status settlements regarding marriage and family dynamics, fertility and family planning, along with management of contraceptives in the context of household relationships. This study directly focuses on women's voices and their experiences rather than fertility patterns and women's preferences. As a researcher, I have attempted to investigate how women perceive their reproductive choices, how they compromise childbearing decisions, and to what extent women feel that they can practice their control and autonomy regarding family planning, family size, and contraceptives. This study highlights that reproductive decisions are shaped by various factors like gender dynamics, family relations, cultural values and norms, and poverty. The main emphasis of this study is on exploring the gap in the literature about women's experiences linked with reproductive life. Eventually, this article provides a wider view on reproductive rights, gender inequality, and reproductive autonomy by diverting attention from fertility as a population growth concern to fertility as a socio-cultural and personal process (Hagen et al., 1999).

Limitations

Many practical limitations were faced by the researcher and these limitations were considered during data interpretation. It could be more appropriate to adopt random sampling method but due to limited household access and limited data of Orangi Town population it was not feasible, therefore the researcher built contacts to relevant organizations to obtain the current data, but even that was not much of a help. The study relied on convenience sampling. As the data is not random, it was not possible to use inferential statistical techniques like regression analysis because the required assumptions would not have been met. This restricts causal inferences and generalization of the results. The topic of this research is viewed as a sensitive and, in some ways, taboo topic in the social environment of Orangi Town. Hence, some women did not respond openly to some topics. This may have impacted the depth or accuracy of some of the responses, and the potential for a social desirability bias cannot be totally discounted.

The results of this study cannot be generalized to all the people residing in Orangi Town due to the sampling techniques and the small number of respondents. That is if we have data available of the entire population, even then it is not easy due to the community size and logistics. Regardless of lack of data sources, this study has attempted to cover fertility trends, decision-making in low-income and upper class communities. Another issue faced by the researcher was the unavailability of male family members, which restricted from interviewing them. These situation barriers in data collection regarding men's decision making power and issues linked with fertility. In places like Orangi Town and other informal settlements lack of male inclusion in data collection is a significant gap and not just men, other family members are also involved in reproductive decision-making.

Review of the Literature

Fertility is deeply associated with social life; it builds a family, community and whole structure of a society. Concept of fertility has different patterns in different cultures, social classes, region wise, and also religiously. Literature review of this study is classified into three main themes: changing patterns of fertility, socio-economic fertility determinants, and governance of reproductive behaviour. These themes helped in understanding the existed data, research gaps, and arguments in context of fertility.

Changing Patterns of Fertility

There has been a radical transformation in fertility levels in many parts of the world during the last few decades. Births are becoming fewer and later, or are increasingly a matter of choice depending on circumstances (Strulik & Vollmer, 2015). All changes are not uniform

and rapidly declining fertility rates are seen in some countries and high fertility rates in others. Within countries, there are varying rates of fertility decline. This is important to recognize because it provides insights into the processes which underlie changes in reproductive behaviour over time as a result of social, economic and cultural factors.

Previous research on population growth referred to the second half of the 20th century as a turning point for the world's fertility (McNicoll, 1992). In the developing world, the fertility rate per woman has fallen from approximately six children in the 1960s to approximately four in the late 1980s. This overall picture conceals significant regional variations, however, as East and Southeast Asia saw a dramatic drop; Sub-Saharan Africa and portions of South Asia trailed, said McNicoll. These structural differences influence fertility and marriage patterns and can be used to explain differences in them, such as unequal social structure that affects access to education and resources, economic systems that influence household income and financial security, and cultural orientations which refer to social norms and gender roles that shape behaviour around marriage and childbearing (Fent et al., 2013). He argues that population pressure is not the only factor behind the fall in fertility. It reflects the more profound changes in gender relations, education and the role of the state in reproduction (McNicoll, 1992).

The same has been found in later studies on the different ways in which fertility decline occurred in Latin American countries, despite the fact that they implemented similar policy frameworks. In some instances, fertility decline was less related to economic growth, while in others, family planning programs and urbanization became more important. Contrary to the prevailing modernization theory, fertility declines tend to precede economic development. This implies that the decline in fertility is not necessarily a consequence of industrialization or increasing incomes. Additionally, family values, availability of contraceptives, and social aspirations influences it (McNicoll, 1992 & Miah, 1992; Tsui, 2001). Bashir and Guzzo propose one of the theories for fertility decline as a change in the inter-generational transfers of wealth and obligation (Bashir & Guzzo, 2021). In the process of modernization of society, the trend of giving financial and emotional assistance changes within the family, where the flow of support shifts between parents and children (Rammohan, 2004). This wealth flow theory can be used to explain the negative correlation between education and urbanization and fertility – it is more expensive to raise children in the city. The same trend is evident in studies that distinguish between the immediate and ultimate factors influencing fertility (Mohanty et al., 2016). Proximate factors like age at marriage, contraceptive use, and breastfeeding practice affect current fertility, and distal factors like literacy, infant mortality, and gender norms affect the choices people have. Over time, these distal factors tend to mutually reinforce each other. More education leads to a later marriage age, fewer children, and more investment in the education of those children, creating a further decline in fertility in the next generation.

Figure 5(b): Change in TFR and change in female literacy during in districts of India



Figure 1: Change in TFR and change in female literacy during 1991 and 2011 in districts of India (Mohanty et al., 2016).

Mohanty et al. (2016) presented the data shown in Figure 1, which plots the change in TFR (TFR 2011 – TFR 1991) against changes in distal determinants such as female literacy. This indicates that fertility reduction is associated with changes in distal determinants. As fertility has declined, population growth continues because so many young adults of today are entering the reproductive age with a completely changed mindset, a more modern one, as explained by Rammohan (2004). These studies show that fertility change is not just about the number of births. It's also the result of cultural change in attitudes towards family, womanhood, and future objectives and aspirations. Thus, the demographic transition is not only the diffusion of contraceptive technology, but also the change in values, the shift from a collective to individual life, and the shift from many children to quality of life.

Factors Influencing Fertility and Structural Inequality

One can have personal choices and desires but they are not always dependent of the factors like health, qualification, income, structure of the family, gender roles, control over assets and religion. Above all, these determinants shape the fertility decisions of people within the age bracket of reproduction. Other than these factors some non-economic factors also influence their impact like cultural aspect, family and social pressure, future resolutions directly impacts fertility rates.

Economic Determinants of Fertility

Economy is an important factor in fertility trends, particularly in rural and low-income areas where household labor is essential for survival. In this context, children are an

economic asset and social insurance (Denton, 1979). Karamat Ali studied agricultural economies, and his findings showed a close relationship between fertility and production patterns and labour. With the increase in productivity per worker following mechanization or modernization, fertility decreases as fewer workers are required on the farm, there is less necessity for raising children as farm labour, and the cost of raising children increases (Ali, 1985). However, in the case of increased productivity per unit of land, fertility may increase because a greater workforce will be required to operate the land and child labour can contribute to household incomes. Similarly, a study on determinants of fertility in Swaziland (Warren et al., 1992) applied Bongaarts' proximate determinants framework to demonstrate the effects of social and economic institutions on reproductive behaviour. The higher fertility levels among rural women were linked to several factors, including early sexual activity, low contraceptive use, and traditional marriage practices. These patterns were most common among rural women with low education who were primarily engaged in farming. In contrast, urban women had lower fertility due to education and access to family planning.

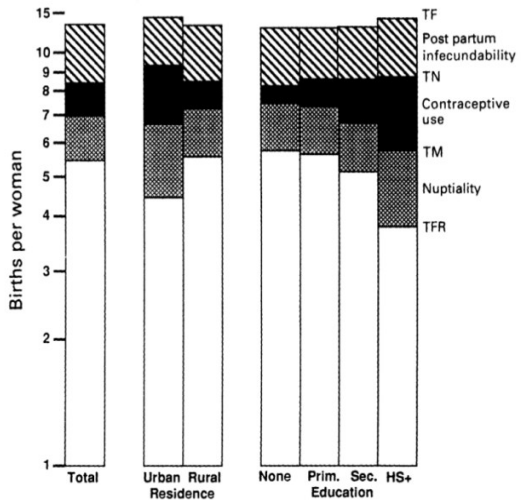


Figure 2. Changes in measures of fertility-inhibiting effects of proximate determinant variables by residence and education, Swaziland 1988. TF, total fecundity rate; TN, total national marital fertility rate; TM, total marital fertility rate; TFR, total fertility rate.

Figure 2: Illustrates how fertility varies by education and residence due to different fertility-influencing factors (Warren et al., 1992).

A similar trend was observed in Pakistan and India, with economic and regional differences influencing fertility. In Pakistan, high fertility is prevalent in the rural areas where agriculture is still labour-intensive, and women's labour is not common outside the household (Whittington & Stapleton, 1995). Fertility rates are lower in urban and more industrialized areas, suggesting access to reproductive services, education, and work

opportunities (Aziz & Ali, 1994). In India, the decline of agriculture and the rise of non-farm jobs and education are associated with falling fertility, but these impacts vary by state as a result of variations in social development and gender attitudes (Mohanty et al., 2016; Jain, 1985). A further study of Sub-Saharan Africa also suggested that economic modernization, migration and urban working contributed to postponing marriage and decreasing fertility. Women became increasingly part of the wage labour force, increasing their economic independence and reducing the need for large families. These results indicate that fertility transitions typically take place after economic shifts, and that the magnitude and direction of this shift is dependent on structural differences—primarily in terms of access to education, land and work across regions (Bongaarts et al., 1984). Economic inequality sustains fertility gaps. High fertility acts as a response to lack of welfare protection and insecurity for poorer families. In such cases, children provide labour, old-age care and social protection. Thus, although economic growth is associated with falling fertility, the most deprived people are associated with higher fertility, underpinned by deep-rooted inequality and weak welfare systems (Chung, 1990).

Non-Economic Factors Affecting the Birth Rate

In addition to economic systems, other social, cultural and demographic factors, such as education, gender attitudes, health status and infant mortality, play a significant role in determining fertility. Many of these factors intersect with economic factors, which can increase or decrease their effects. One of the most constant and powerful factors associated with declining fertility in studies is education, particularly for women. The effect of women's levels of education on their fertility has been a consistent and reliable research finding. As Wusu summarizes educated women are more likely to delay marriage, have more knowledge about and use of family planning, and want fewer children. They also tend to invest more in their health and their children's health and consider large families as contradictory to their social and economic aspirations (Wusu, 2012). In the countries of sub-Saharan Africa, data indicate that low female literacy is associated with high fertility despite the overall social change. For instance, in Nigeria, female literacy has genuinely improved, with the female-to-male literacy ratio rising from 76.8% in 1990 to 95.7% in 2007, yet fertility remains high. This indicates that the impact of education upon fertility is not only quantitative, but also qualitative, which is related to the quality of education, employment, and gender norms (Wusu, 2012).

The other important non-economic factor that Ali includes is the infant mortality rate (IMR). High infant mortality generally stimulates fertility because families aim to have more children to ensure that a certain number survive, which is referred to as the replacement effect or hoarding effect, however, when access to health care, sanitation, and nutrition increases, fertility tends to decrease. This is because of the role played by health infrastructure and child survival rates in bridging social development and fertility

outcomes. Fertility patterns are also influenced by population density and social structures. In rural areas, limited land and high density can result in a shortage of resources for households, and sometimes postpone marriage or reduce the size of the family (Ali, 1985). However, in other parts of the world, cultural concerns such as their wish to keep families alive and to preserve their social status ensure high birth rates despite economic and/or spatial constraints (Demeny, 1986). The outcome of these studies demonstrates that fertility is the combined effect of economic systems and social relationships. Economic change, education, and healthcare can reduce fertility—however, they do so through entrenched social norms and structural inequalities (Sobotka et al., 2017). Fertility can, therefore, not be regarded as a separate demographic development; it is influenced by overlapping economic, social and cultural systems that shape the options available for reproduction in unequal societies.

Research Methodology

Background

Fertility trends in Pakistan, especially in urban settings are changing, but are uneven due to the class system. Like many densely populated cities, Karachi also portrays acute diversion of fertility trends. Karachi being metropolitan city accommodates both formal and informal settlements, where access to health care services, housing, education and job opportunities are getting scarce (Ali, 1985). These disparities become decisive factors for the families to make fertility choices, family planning and future planning. Orangi town is one such informal settlement in South Asia. Inhabitants of this settlement face problems in accessing health care services, family planning and affordability of better living. Cultural practices do play very important role in shaping institution of marriage, ideal family size, and women's reproductive role (Bashir & Guzzo, 2021). This clearly demonstrates that fertility behaviours can be truly understood by examining demography of Orangi Town in combination of other factors as well. We need to understand that peoples 'choices are based on socio-economic structural context. This study is important for two main reasons: first is why fertility declines and is uneven in Pakistan even in the presence of information system on family planning. Secondly, it covers many other factors like governance, poverty, and gender relations which were not captured in reproductive decision-making and policy dialogues (Hyatt & Milne, 1991). This research seeks to demonstrate how fertility patterns relate to individual goals and to broader inequalities in the city, through the case study of Orangi Town.

Research Questions

Practice of child marriage, unequal gender relations and restricted access to reproductive health care influence fertility behaviour in Pakistan (Ahmed, 1969). This intensity increases in urban slums, where women's lives and choices are shaped by poverty,

density and poor public services. National surveys provide general information on the level of fertility in the country, but provide little information on the factors affecting women in low-income settlements when deciding on childbearing, ideal family size, and contraceptive use. Women's fertility is a key determinant of their life chances, autonomy, and health, but women's voices remain underrepresented in policy debates.

General Research Question

What are the perceptions, experiences, and negotiations of the women residents of Orangi Town in relation to fertility, ideal family size, and use of contraceptives in their families and marriages?

The Semi-structured interviews were conducted in Orangi Town, Karachi, from October 2025 to February 2026. Orangi Town is one of the largest low-income urban slums in Karachi, characterized by high density of population, diverse household composition, and weak health and social service provision. Its socio-economic and cultural heterogeneity, together with the difficulties of urban life, makes it an appropriate place to examine fertility trends and their determinants. Convenience and snowball sampling techniques were used because of the population size of Orangi Town and the absence of any reliable census data at the household level recently. Five localities were selected based on accessibility and community networks. To mitigate selection bias at the household level, one woman of reproductive age (15-49 years) was randomly selected from each selected household to participate, following DHS standards. Households consisted of people who normally reside in the same household and eat from the same source of food. A total of 13 semi-structured interviews were conducted. The study was done by the researcher alone, and all the data were collected by the researcher in person. The participants were told the purpose and importance of the study, and verbal informed consent was secured prior to participation. The participants were guaranteed confidentiality and that their answers would only be used for academic research.

The qualitative stage was completed by reviewing secondary literature to obtain a contextual background and conducting semi-structured interviews with women of reproductive age. The interviews were held in the home of the interviewees, and this provided a detailed understanding of the interviewees' experience and perspective. These discussions included questions on issues like reproductive intentions, family planning practices, decision-making processes, and social expectations around fertility. The participants agreed to the audio recording of all the interviews, which were then transcribed verbatim. The transcripts were then subjected to thematic analysis, where patterns and themes were revealed to explore the effect of individual, family, and societal factors on fertility behaviour. The qualitative dimension was launched to understand the

social and cultural processes that underlie the observed trends in fertility, and to complement and explain the quantitative results. The study was approved by the ethics review committee of Habib University, Karachi.

Research Findings

Qualitative Findings

The qualitative interviews conducted in Orangi Town offer an in-depth understanding of the factors shaping fertility behaviour, contraceptive use, and reproductive decision-making among women in the community. The results indicate that reproductive decisions are made within a complex matrix of social, cultural, economic and health determinants, of which women have limited control over their body and future.

Marriage Patterns and Early Childbearing

One thing that was found throughout the interviews was that marriage decisions were very much a family affair and not of the women. Most respondents said that their marriage was arranged by their parents; several of the women were married between the ages of 14 and 18. While many people said they would like the age at which people can marry to be some years older, typically 25 years or older, early marriage was still widespread because of the social norms and family pressure.

> *"Meri shaadi 18 saal mai hogayee thi kyunki mere walid bemar hogaye thay." [I got married at the age of 18 because my father got sick.]*

This early marriage often resulted in early and multiple pregnancies, a greater number of children born during the reproductive period, and poor birth interval.

The Gap between Ideal and Actual Family Size and Fertility Preferences

In response to the question about the ideal size of the family, many women said that they would like to have 3-5 children, including both boys and girls. In reality, though, family sizes were often larger than desired. The main reasons for this difference between ideal and actual fertility were the lack of reproductive autonomy and the significant role played by husbands, in-laws, and community beliefs. There was general agreement that the size of a woman's family is up to God's will, and this diminished the perceived value of family planning, even for families with financial constraints or health challenges.

"Bacha apna rizq khud lekar araha hai hum usko nahi khila sakte. Saas nay bola bacha band karake shohar ka rizq khatam kar rahi ho."

[Children bring their own sustenance; you cannot provide for them yourself. By using contraceptives, you are stopping your partner's share of sustenance.]

The Role of Husbands and In-Laws

Husbands' and in-laws' influences were highlighted as one of the major factors influencing fertility outcomes, especially mothers-in-law. Numerous women said they needed their husband's consent to use any type of contraceptive. In some instances, husbands wanted to have more children, and in-laws had a positive attitude about having more babies until a son was born.

"Meri saas nay mujhay ghar se nikaldia boli k bacha kyu band karaya. Mera shohar bhi bohot ghussa kia k goli kyu rakhwayee bazu mai."

[My mother-in-law kicked me out of the house and said, 'Why did you stop having a baby?' My husband got angry and asked why I secretly got the implant.]

Some of the women did not say anything about it to avoid any trouble within the house, and others said they used contraceptive devices privately, without their husbands' knowledge. These accounts suggest a basic lack of women's autonomy in reproductive decision-making.

"Humaray mohallay mai ek aurat thi woh humko leke gaee jab humara beta 1 mahinay ka hoa. Woh humko boli injection laganay ko k kitna bacha paida karogi. Doctor ne shohar ka CNIC mangi tou woh to mana kar di; to hum nay copy chori kar k 3 mahinay wala injection lagwana shuroo kardia"

[There was a woman in our neighborhood who took me along when my son was one month old. She told me to get the injection, saying, 'How many children will you keep having?' The doctor asked for my husband's CNIC, but he refused, so I secretly took a copy and started getting the three-month contraceptive injection.]

Contraceptive Use: Patterns, Barriers, and Discontinuation

The general level of contraceptive use among the respondents was low and irregular. Many women said they had never used any method of contraception, for various reasons including that it was not needed, that it was unhealthy, or that it was not allowed because of religion. The most frequently mentioned contraceptive methods among those who used contraceptives included condoms, pills, injections, and intrauterine devices.

> *"Mai nay ek dafa lagwaya tha injection woh 3 mahinay wala lekin uska reaction hoa aur itna khoon nikla mera periods mai k main martay martay bachi. Iske baad husband nay mana kardia ab bas hum condom istemal kartay hain."*
>
> *[I got the three-month injection once, but I had a reaction to it and bled so heavily during my period that I almost died. After that, my husband refused, and now we only use condoms.]*

Many women reported negative side effects, including weakness, heavy bleeding, or breathing difficulties, and discontinuation was common. The most popular method was condoms, and injections and intrauterine devices were often considered to be fearful or suspicious. Consistent and continued use was hindered by a lack of support from husbands.

> *"Humaray ilaqay mai ek aurat nay challa rakhwaya tou jab rakhwao tou uska doori latakta hai. Uss aurat nay beydehani mai woh doori khench di aur uske andar se woh bahar agaya. Uski tou ussi waqt maut hogayee. Iske baad hum nay tauba kari ab ye istamal nahi karna hai. Woh tou mar gayee ab uske bachay reh gaye peechay."*
>
> *[In our area, a woman had an IUD inserted. It has a string that hangs down after insertion. She accidentally pulled on that string, and it came out from inside her. She died at that very moment. After that, we swore never to use it. She died, and her children were left behind.]*

Religious and Cultural Influences on Family Planning

Religious and cultural attitudes were the main contributors to attitudes towards fertility and contraception. Many of the participants shared a perspective that it could be sinful to prevent a child from being conceived, and that God provides for every child. These beliefs lessened the overall acceptability of family planning and strengthened the notion that there should be no interference with fertility.

> *"Bachay tou Allah ki den hai hum beech mai akar kyu gunnah samaitay?"*
>
> *[Children are a gift from God; why should we interfere and take on sin?]*

Meanwhile, there were some women who were cognizant of the value of birth spacing for health, but said that they could not do so because of religious beliefs and external social pressure. This was a recurring theme throughout the interviews, as many participants reported feeling aware of the issue but not practicing it.

Economic Considerations

Economic considerations also influenced fertility decisions, but usually in conjunction with religious belief. Some women factored the burden of children, their schooling, and daily expenses when they were considering the number of children they wished for. But the assumption that God would take care of children often trumped financial considerations, and the idea that economic pressure would not always lead to lower fertility did not always hold true.

> *"Mere susral walay tou pressure daltay thay k aur bachay karo lekin mujhay unke mustaqbil ka bhi tou sochna hai. Mere shohar ki mehdood amdani hai ussi mai bacho ko acha khilana hai, parhana hai aur pehnana hai."*
>
> *[My in-laws used to pressure me to have more children, but I also have to think about their future. My husband has a limited income, and within that we have to feed, educate, and clothe the children well.]*

Education and Its Influence on Fertility Behaviour

Respondents had a broad view that education was an important influence on fertility behaviour. Some women think that educated women have fewer children as they have more awareness and understanding of health and family planning services. But, based on the interviews, it was clear that education alone did not mean reproductive autonomy because even educated women had to deal with family pressure and entrenched social norms.

> *"Ab ek aurat parhi likhi hai tou woh tou kum bachay chahegi. Ek tou uski shaadi late hogi aur agar woh khud parhi hai tou bacho ko bhi parhana chahay gi. Acha hai na kum bachay ziada behtar parh saken ge."*

> *[An educated woman will prefer to have fewer children. She will usually marry late, and if she is educated herself, she would also like to educate her children. This is a good thing, as fewer children means they can have better education opportunities.]*

Overall, the qualitative analysis revealed that fertility behaviour in Orangi Town is influenced by a complex and deeply-rooted interplay of social and religious norms, economic factors, and gender factors. Even though women in this community know how important family planning and birth spacing are, their ability to change is always restricted by external pressure, lack of decision-making power, and structural constraints in accessing health care.

Discussion

The results of the qualitative interviews all indicate a similar answer: the fertility outcome is not only an individual choice, but rather is more strongly influenced by social norms, intra-household power relations, and structural constraints. The results give important context as to these patterns. Early marriage became a central issue affecting fertility behaviour, and many women got married in the mid to late teens. This early marriage also prolongs the reproductive life and makes it more probable to have more children in the future. Though respondents stated a preference for late marriage and smaller families, but this does not actually happen in practice, largely as a result of a strong influence of family and social expectations.

One of the key findings from the interviews was the difference between the desired and actual family size. Many women expressed a desire for three to five children, but often this was not the case. This difference restricted reproductive freedom, in which women do not make their own decisions on childbearing. Instead, it is husbands and in-laws who take the steering role, and sometimes urge childbearing. The role of mothers-in-law in particular, both positively and negatively, was mentioned on numerous occasions, particularly with regard to the pressure to have more children or to keep bearing children until a son is produced. There was limited and inconsistent use of contraceptives in the sample. Some women were familiar with contraceptive techniques, but many women discontinued contraception for side effects, fear, or for other reasons. Misconceptions and negative experiences are commonly expressed in the community, and they are also discouraged to use. The need for the husband's consent and fear of conflict in the household were major barriers to women's access to adoption or family planning methods.

Reproductive behaviour was also influenced by religious/cultural beliefs. Many were of the opinion that children are the will of God and that there is a moral problem in limiting

births. These beliefs diminish the perceived need to use contraceptives and reduce the influence of economic factors, even in the face of economic constraints. Consequently, fertility choices are not necessarily in line with economic means or health choices. The importance of education and economic considerations is more complex. Respondents recognized that education can increase awareness of family planning and reduce fertility preferences, but it does not necessarily mean increased decision-making power. Likewise, some women talked about financial factors in deciding about the number of children to have, but economic factors on their own were not enough to limit the birth rate when there was strong social and cultural pressure.

Overall, the discussion suggests that individual-level factors are not sufficient to explain the fertility behaviour in Orangi Town. Rather, it is a product of the effects of early marriage, gendered power dynamics, son preference, religious beliefs, and restricted access to health care. The findings indicate that besides improving access to services, social and cultural structures, still it limits women's reproductive autonomy need to be tackled in order to enhance their reproductive outcomes in this context.

Conclusion

Fertility behaviour, contraceptive use, and reproductive decision-making of women in Orangi Town, Karachi were explored using qualitative interviews. This methodology offers a coherent picture of reproductive health in one of Karachi's largest informal urban settlements. The data behind the figures is the voice of the women involved. The women in this study had good awareness of the importance of birth spacing and had definite preferences regarding family size. But their autonomy in making choices was always constrained by their husbands' and in-laws' expectations, strong religious views over childbearing, fear and misconceptions about contraceptive methods, and poor access to reliable and trusted health services (Folbre, 1983). Collectively, these results indicate that the high fertility rate in Orangi Town is not merely a result of preference, but is a product of a complex system of structural and social restrictions on women's reproductive choice that are meaningful and ongoing.

Interventions are needed to overcome these constraints that depend on more than the provision of information or services. What is needed is methods that are based on the reality of women's lives in this community, that take religion and household norms seriously, and that speak in a language and register those women in this community to be recognized and trusted. This study has its limitations. The sampling method used in this study is non-random, and the number of samples is small, so the results of this study cannot be generalized outside the study group. The lack of male perspectives in the study is another observation that was noted, as there is an important role of the husband and male

family members in reproductive decision-making. These are significant limitations, and they indicate a clear need for a greater and more extensive research program in this field.

However, the present investigation is a real contribution. It provides a contextually rich account of fertility and family planning amongst a large population of low-income, undervalued and underserved people. It is hoped that the findings will provide a valuable basis for the future and will also help improve the effectiveness of family planning programmes in Orangi Town, and urban settlements similar to it in Pakistan, in terms of equity and community responsiveness.

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