2006

Baseline household survey: Sukkur district

Pakistan Initiative for Mothers and Newborns (PAIMAN)

Baseline Household Survey

Sukkur

DISTRICT

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Population Council

PAIMAN
Pakistan Initiative for Mothers and Newborns

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(PAIMAN)

Sukkur

Baseline Household Survey

Population Council

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Contents

List of Tables

List of Figures

Acknowledgments

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Chapter 1

Introduction

Background

The Pakistan Initiative for Mothers and Newborns (PAIMAN) is a five-year project funded by the United States Agency for International Development (USAID). PAIMAN is committed to assisting the Government of Pakistan (GoP) in the implementation of the full spectrum of interventions necessary to address maternal and neonatal health (MNH) issues.

The consortium is led by John Snow Incorporated (JSI), with partners from Pakistani and international organizations including Aga Khan University, Contech, Greenstar Social Marketing, Johns Hopkins University Center for Communication Program (JHU), PAVHNA, Population Council and Save the Children USA.

USAID has provided a grant to implement PAIMAN in 10 districts of Pakistan's four provinces. These districts are: Rawalpindi, Jhelum, Khanewal, and DG Khan in Punjab; Dadu and Sukkur in Sindh; Jafarabad and Lasbela in Balochistan; and Upper Dir and Bunner in the North West Frontier Province. The goal of the project is to reduce maternal, newborn and child mortality in Pakistan. The project is based on the "Pathway to Care and Survival" framework. The five major strategic objectives are to:

1) Increase awareness and promote positive maternal and neonatal health behaviors
2) Increase access (including essential obstetric care) to and community involvement in maternal and child health services, while ensuring that services are successfully delivered through health and ancillary health services
3) Improve service quality in both the public and private sectors, particularly related to the management of obstetrical complications
4) Increase the capacity of Maternal and Newborn Health (MNH) managers and care providers
5) Improve the management and integration of services at all levels

The PAIMAN Project will promote skilled attendants as the long-term goal for all deliveries in Pakistan, while acknowledging that maternal and neonatal health outcomes are influenced by factors other than health care. The PAIMAN Project calls for a multi-pronged and integrated strategic approach combining individual health care with public health and community-based interventions.

To ensure that the success of PAIMAN is properly ascertained, and that the appropriate lessons are learned, PAIMAN has developed a Monitoring and Evaluation Plan. Included in this plan is the

establishment of baseline measures for a set of indicators which will be used to evaluate the success of the project. This baseline report explores the level of knowledge of, as well as the attitudes and behaviors towards maternal and newborn health in the Sukkur district. The specific objectives of the baseline survey were as follows:

Objectives

- To measure the Intermediate Result 7 indicators necessary as part of PAIMAN's obligation to USAID.
- To measure PAIMAN indicators for which household survey data are appropriate for measurement, and for which sample sizes are feasible.
- To obtain information on maternal and neonatal health along with related issues, which may be of use to district Departments of Health for health management purposes.
- To obtain information needed for the detailed design of the PAIMAN project and, in particular, behavior change communication, public/private partnerships, and health systems strengthening.

Methodology

Study Population

PAIMAN is primarily a district-level project, intended to improve the health of all pregnant women, women with neonatal children, as well as all neonates of the district over the course of the project. To this end, the study covers community residents – notably mothers and prospective mothers – in order to understand and measure general knowledge and practice in relation to pregnancy, delivery, obstetric and neonatal emergencies etc.

Hence, the study population for the baseline includes all currently married women of reproductive age (15-49 years) living in the selected districts. More specifically, it includes women who have experienced a pregnancy during the last three years.

Sample Design

The sampling design adopted for the survey is a stratified, systematic sample of households. The universe consists of all urban and rural areas of the district. The number of blocks selected in urban areas, along with the number of villages selected in rural areas, are presented in table 1.1. The selection procedure is described below:

Table 1.1 Number of blocks/villages and households selected for the sample population

Area	Number of Sample Blocks/Villages	Number of Households Selected
Urban	20	480
Rural	20	480
Total	40	960

Urban Sample

Keeping in view the heterogeneity of the city of Sukkur, the sampling procedure was carried out to capture the full range of the socio-economic conditions of the urban population. For this purpose, we utilized the literacy rate which was obtained from the 1998 Population Census as an indicator of the socio-economic status of each of the Census Enumeration Circles.

The "Enumeration Circle" was the smallest unit available in the 1998 Population District Census Reports as demarcated by the Population Census organizations. The required numbers of enumeration blocks were selected with probability proportional to size. The maps of these circles were obtained from the Population Census Organization.

The areas were already divided into blocks of approximately 250-300 households depending on the number of households in each circle. Later, blocks were randomly selected with probability proportional to size from the list of total blocks in that circle. The listing of each block was then updated by the enumeration teams before selecting the sampled households. A fixed number of 24 households have been drawn from each sample enumeration block by using systematic random technique.

Rural Sample

The 1998 Population Census list of villages was used as the sampling frame for the selection of the rural sample. Villages in rural areas have been treated as primary sampling units (PSU). Sample PSUs have been selected with probability proportional to size (number of households). Households within the sample PSUs were considered secondary sampling units. The enumeration teams then updated the listing of each village before selecting the sampled households. A fixed number of 24 households have been drawn from each sample enumeration village by the systematic random technique.

Questionnaire Design

The questionnaire has been developed by the Population Council based on a combination of current general Demographic and Health Survey methodologies and the questionnaire developed by the Population Council for the Safe Motherhood Applied Research and Training (SMART) Project. The questionnaires contain data sufficient to estimate all PAIMAN indicators.

Information on the following is included in the questionnaire

- Household information
- Socio-economic status of women
- Fertility, pregnancy history and reproductive intentions
- Attitude towards, as well as knowledge and practice of contraceptive methods
- Attitude towards pregnancy, delivery, and the postpartum period
- Current birth preparedness/complications readiness (BP/CR) and knowledge of newborn care
- Current birth practices
- Health seeking behaviors
- Future BP/CR intentions

- Personal beliefs regarding pregnancy, delivery and the postpartum period
- Common perceptions pertaining to women who are pregnant, delivering or in their postpartum period
- Facilities regarding BP/CR available in the community
- Factors that facilitate or hinder behaviors related to BP/CR
- Media habits

Pre-testing of Questionnaire

The questionnaire was reviewed by the PAIMAN's M&E thematic group as well as by other interested stakeholders and were pre-tested in non-PAIMAN districts. The main objective of pre-testing was to examine the suitability and effectiveness of questions in eliciting adequate responses, and to find out if there were any linguistic problems faced either by interviewers or by respondents.

Finally, the pre-testing also helped determine the approximate time required to complete a questionnaire. The pre-tests were carried out by the Population Council's female staff members, who recorded their experiences with regard to each question. These records were then used to revise and finalize the questionnaire.

Hiring of Interviewers and Supervisors

Since the respondents in the baseline were to be MWRA and married men, it was decided that female interviewers would be used to interview women and male interviewers for men. Based on the constitution of each team, the required number of female interviewers were hired by the National Institute of Population Studies (NIPS) according to its own internal procedures.

Training of Interviewers and Supervisors

The quality of training received by interviewers is reflected in the quality of data they record. In order to ensure that the training provided for interviewers was of a high and uniform quality, and that interviewers understood the definitions and concepts behind the language of the questions, training was conducted by the Population Council in collaboration with NIPS. The training took place in Islamabad over a two week period, and interviewers were trained regarding survey procedures. During the training, interviewers visited 3-4 households to conduct practice interviews.

It was very important for the interviewers to thoroughly understand the methodology and statistical importance of the sampled households. Training regarding the importance of the criterion for the selection of primary sampling units, mapping and listing procedure, sample selection, field operation procedures, as well as the selection of the particular households and respondents was also provided by experts.

Data Entry and Edit Procedures

Data processing was started from the field level with the checking of the questionnaires. Each team leader completed on-the-spot checks and preliminary editing of questionnaires during the enumeration period. Editing instructions were provided to the team leaders, and emphasis was laid on the importance of completing each questionnaire, correctly identifying each eligible respondent, and the completeness of household composition.

Quality Assurance

To ensure the quality of the data, Population Council staff monitored the fieldwork accompanying the field teams. While supervising the fieldwork, the Population Council supervisory staff was also available to provide on-the-spot guidance to interviewers in the event that any part of the questionnaire was unclear to them. This ensured the completeness and accuracy of each questionnaire.

Chapter 2

Socioeconomic and Demographic Characteristics

This chapter presents the demographic and socioeconomic characteristics of the population in the survey households of Sukkur. Information was collected on some demographic and socioeconomic characteristics such as the condition of the households, including the source of drinking water, sanitation facilities, building materials, and possession of household durable goods. This information on the characteristics of the households is essential for the interpretation of survey findings. The definition of the household used for the baseline survey was "a person or a group of persons, related or unrelated, who live together in the same dwelling unit and share a common source of food".

Urban/Rural sample women

Table 2.1 shows the number of households selected in both urban and rural areas of Sukkur, as well as the interview completion status. A total sample of 960 households was selected from Sukkur; this number included 480 households in rural areas, along with 480 blocks in urban Sukkur.

Table 2.1 indicates a slightly higher interview completion rate in rural areas as opposed to urban areas. The incompleteness of some interviews may be due to lack of knowledge on the part of respondents, or perhaps due to the fact that women were not willing or permitted to share sensitive information with interviewers. The refusal rate was about the same in both rural and urban areas.

Table 2.1: Interview completion status

Result	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Completed	97.7	469	95.8	460	96.8	929
Incomplete	0.8	4	2.3	11	1.6	15
Refused	1.5	7	1.7	8	1.6	15
Others			0.2	1	0.1	1
Total	100.0	480	100.0	480	100.0	960

Languages Spoken

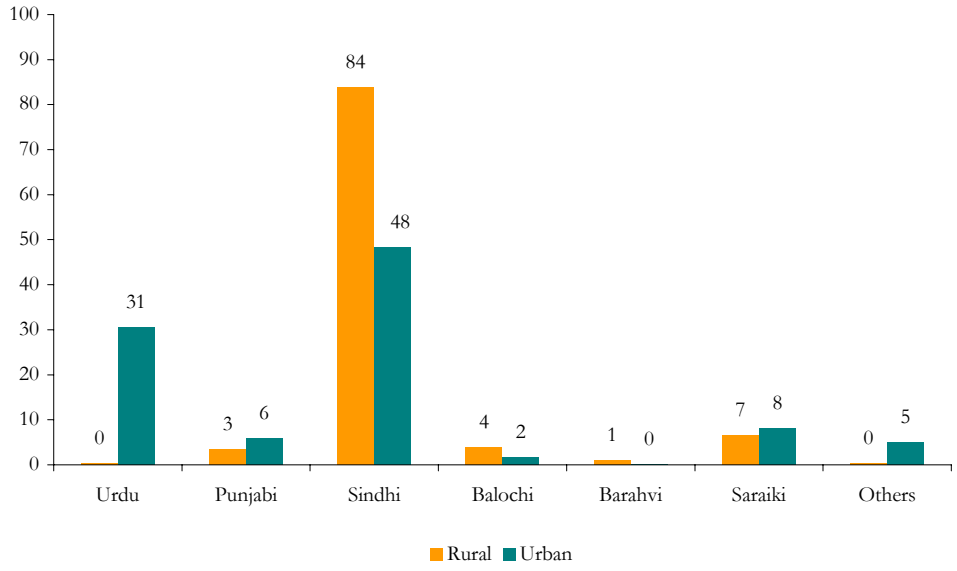
Respondents were asked to indicate which language they spoke within their households, and the answers were recorded. The results are depicted in table 2.2 below. An overall picture of the ethnic and linguistic makeup of the district becomes clear by determining the languages spoken in the households.

Table 2.2: Language spoken in the households

Language	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Urdu	0.4	2	30.7	141	15.4	143
Punjabi	3.4	16	5.9	27	4.6	43
Sindhi	83.8	393	48.3	222	66.2	615
Pushto			0.2	1	0.1	1
Hindko	0.4	2			0.2	2
Balochi	3.8	18	1.7	8	2.8	26
Barahvi	1.1	5	0.2	1	0.6	6
Saraiki	6.6	31	8.0	37	7.3	68
Others	0.4	2	5.0	23	2.7	25
Total	100.0	469	100.0	460	100.0	929

Sindhi is the most widely spoken language overall, followed by Urdu due to the vast settlement of Urdu-speakers in urban Sindh. Saraiki is also spoken in some parts of Sukkur. It is clear that Pushto and Hindko are very rarely spoken in Sukkur.

Figure 2.1: Languages spoken



A slightly more in-depth analysis reveals that that while Sindhi is widely spoken in both rural and urban areas, this is not the case for Urdu. Almost all Urdu speakers reside in urban areas, and only a negligible percent (0.4%) of rural respondents speak Urdu. However, the fact that Urdu and Sindhi are both spoken in urban Sukkur indicates that this region is more linguistically and ethnically diverse, whereas rural areas are more homogenous. This would necessitate the employment of different strategies in rural and urban areas when it comes to spreading the message of maternal and newborn health.

Population Composition

Table 2.3 shows the women in the baseline survey with regard to age and sex composition. Age and sex are important demographic variables and are the primary basis of demographic analysis. They are also important variables in the study of reproductive health, mortality and fertility.

In the district of Sukkur, the age-sex distribution indicates that almost 44 percent of the women are currently under the age of fifteen; this is due to persistently high fertility rates in the recent past. The male population of the district appears to be slightly higher than the female population resulting in a sex ratio of 107 males for every 100 females.

Table 2.3: Age-sex distribution of population

Age Group	Males		Females		Both sexes	
	Number	Percent	Number	Percent	Number	Percent
Less than 5	654	15.1	597	14.7	1,251	14.9
5-9	710	16.4	621	15.3	1,331	15.9
10-14	526	12.1	574	14.1	1,100	13.1
15-19	488	11.3	498	12.3	986	11.8
20-24	399	9.2	406	10.0	805	9.6
25-29	354	8.2	295	7.3	649	7.7
30-34	244	5.6	223	5.5	467	5.6
35-39	210	4.8	208	5.1	418	5.0
40-44	170	3.9	150	3.7	320	3.8
45-49	126	2.9	103	2.5	229	2.7
50-54	136	3.1	152	3.7	288	3.4
55-59	79	1.8	73	1.8	152	1.8
60-64	92	2.1	66	1.6	158	1.9
65 and older	142	3.3	92	2.3	234	2.8
Total	4,330	100.0	4,058	100.0	8,388	100.0

Marital Status

The survey collected information on the marital status of all the household members over 15 years of age. In the district of Sukkur, the percentage of married women between the ages of 15 and 19 is considerably higher than the percentage of married men within the same age group (18.5 percent versus 6.4 percent respectively). Table 2.4 clearly shows that women tend to get married earlier than men. However, the results also demonstrate a delay in age at marriage for women, which is an improvement in the status of women compared to the 1998 Population Census. Also, a greater percentage of women show signs of early widowhood compared to men. This trend has not changed since the 1998 census.

Table 2.4: Household population by age (15 years and above), sex and marital status

Age Group	Males			Females		
	Never married	Currently married	Widow/ Divorced	Never married	Currently married	Widow/ Divorced
PAIMAN Baseline Survey						
15-19	93.2	6.4	0.0	80.7	18.5	0.6
20-24	68.2	31.6	0.0	41.1	57.9	0.7
25-29	36.4	61.9	1.1	9.8	88.8	1.4
30-34	16.0	82.4	1.6	4.5	91.9	3.6
35-39	3.3	95.2	1.4	1.9	94.2	3.8
40-44	3.5	95.9	0.6	1.3	92.0	6.7
45-49	1.6	90.5	7.1	0.0	82.5	17.5
50-54	0.	97.8	2.2	0.7	88.2	11.2
55-59	0.0	93.7	6.3	0.0	76.7	23.3
60-64	1.1	88.0	9.8	1.5	51.5	45.5
65 and older	1.4	73.2	25.4	1.1	29.3	69.6
Total	44.1	52.9	2.7	36.5	56.3	7
Population Census 1998						
15 -- 19	88.4	11.2	0.4	66.7	32.7	0.6
20 -- 24	58.7	40.6	0.7	30.1	69.0	0.9
25 -- 29	30.6	68.2	1.2	13.2	85.2	1.5
30 -- 34	14.8	83.6	1.6	7.4	89.7	2.9
35 -- 39	8.7	89.3	2.0	4.3	90.6	5.0
40 -- 44	6.5	90.1	3.4	3.4	88.6	8.1
45 -- 49	4.5	91.0	4.5	2.7	83.3	14.0
50 -- 54	4.6	89.1	6.3	3.5	74.4	22.0
55 -- 59	3.5	87.1	9.4	3.1	67.0	29.8
60 -- 64	4.7	83.1	12.2	6.2	52.7	41.1
65 and Older	6.3	72.7	21.0	7.3	36.2	56.5
Total	34.0	62.7	3.3	22.3	68.9	8.8

Education Attainment

Substantial disparity exists between the genders in the district of Sukkur, and it is further exacerbated by a lack of women's education. The level of education attained by females in the district of Sukkur is consistently lower than the level of education obtained by males for each age group as shown in Table 2.5. The percentage of women who received no schooling whatsoever is also higher than the number of men. The percentage of women over 65 years of age who never received any schooling stands at nearly 97 percent while the figure is 54 percent for men of the same age group.

Table 2.5: Household population by age (10 years and above), sex and educational level

Age Group	No Schooling	1-5 Years	6-10 Years	11 or more	Total
Males					
10-14	30.8	48.5	20.7	0.0	526
15-19	24.8	21.1	39.3	14.8	488
20-24	19.3	16.0	34.1	30.6	399
25-29	26.8	16.7	22.6	33.9	354
30-34	25.8	19.3	21.3	33.6	244
35-39	31.0	21.0	19.5	28.6	210
40-44	37.1	22.4	19.4	21.2	170
45-49	34.9	23.0	17.5	24.6	126
50-54	41.9	27.9	13.2	16.9	136
55-59	36.7	32.9	11.4	19.0	79
60-64	50.0	29.3	12.0	8.7	92
65 and older	53.5	28.9	12.0	5.6	142
Total	32.8	22.1	16.6	28.4	4330
Female					
10-14	47.4	37.3	15.3	0.0	574
15-19	50.6	15.9	26.5	7.0	498
20-24	50.2	13.1	18.0	18.7	406
25-29	63.4	9.8	10.2	16.6	295
30-34	66.8	12.1	13.9	7.2	223
35-39	75.0	10.6	8.7	5.8	208
40-44	78.0	10.0	8.0	4.0	150
45-49	85.4	4.9	6.8	2.9	103
50-54	80.3	11.2	7.2	1.3	152
55-59	89.0	6.8	4.1	0.0	73
60-64	92.4	6.1	1.5	0.0	66
65 and older	96.7	1.1	2.2	0.0	92
Total	55.4	14.9	10.1	19.6	4058

Housing Characteristics

Source of Drinking Water

In order to obtain a clear understanding of the living conditions of the women interviewed, it is necessary to record the source of drinking water available to respondents and their families. The source of drinking water has a close bearing on a household's socio-economic status, and conclusions regarding the level of hygiene of a household can also be determined.

Table 2.6 outlines the types of water sources available to the residents of urban and rural Sukkur. In rural areas, less than 7 percent of the respondents have access to a government supply of tap water inside their homes. Even in urban Sukkur, the percentage of people who had the same privilege stands at only 52 percent. While the quality of the water available through government supply of tap water is questionable, it can be assumed that this is the cleanest and safest option available. Approximately 5 percent of both urban and rural respondents have access to a communal water source. Motorized hand pumps inside the home are by far the most cited sources of water in rural Sukkur, followed by motorized hand pumps outside the home. Finally, rivers/streams/canals are the main source of water for almost 4 percent of the rural respondents.

Table 2.6: Main source of drinking water

Source	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Govt. supply (tap water inside)	6.6	31	52.2	240	29.2	271
Govt. supply (communal)	5.1	24	5.0	23	5.1	47
Motorized/hand pump (inside)	71.2	334	39.6	182	55.5	516
Motorized/hand pump (outside)	10.4	49	2.2	10	6.4	59
Well (inside)	0.2	1			0.1	1
Well (outside)	0.9	4			0.4	4
Tube-well	0.6	3			0.3	3
River/canal/stream	3.8	18	0.2	1	2.0	19
Others	1.1	5	0.9	4	1.0	9
Total	100.0	469	100.0	460	100.0	929

As mentioned above, closed water sources (including tap water) are the safest option for drinking water. While water-based diseases may be spread through closed water sources, the chances are much higher when the water source is open, such as a well or river or canal. Motorized hand pumps may draw water from these open sources and may therefore put the health of an expectant mother or a newborn baby at risk.

Toilet Facilities

Along with the source of drinking water, toilet facilities are a major indicator of a household's socio-economic status, and therefore the level of hygiene, sanitation and comfort available to an expectant or new mother and her newborn children. Similar to the source of drinking water, households with open-concept toilet facilities or no toilet facilities altogether are at a higher risk when it comes to the spread of diseases, than households with closed flush systems.

In rural Sukkur, less than 10 percent of the respondents have access to a flush to sewerage system and about 14 percent have access to a flush connected to a septic tank. However, almost half of the rural respondents in Sukkur (48 percent) have no access to any toilet facilities, and are forced to use fields. In fact, over 5 percent of the women interviewed in urban Sukkur indicated the same thing. Pit latrines, along with flush connected to an open drain are the most widely used toilet facilities in the households surveyed (26.5 percent and 26.7 percent respectively) in urban households.

According to the data in table 2.7, a large proportion of the households of Sukkur use fields as a toilet facility, followed by a large portion that have access only to pit latrines and flush systems connected to open drains. Since the three most cited toilet facilities are all open drain systems, it can be concluded that the level of hygiene and sanitation in Sukkur is on average quite low.

Table 2.7: Type of toilet facility used by household members

Toilet facility	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Flush to sewerage	9.4	44	21.5	99	15.4	143
Flush connected to septic tank	13.9	65	18.0	83	15.9	148
Flush connected to open drain	7.0	33	26.7	123	16.8	156
Raised latrine	6.0	28	0.4	2	3.2	30
Pit latrine	9.6	45	26.5	122	18.0	167
In fields	48.2	226	5.4	25	27.0	251
Others	6.0	28	1.3	6	3.7	34
Total	100.0	469	100.0	460	100.0	929

Fuel Used for Cooking

Fossil fuel is hazardous for health and is an important source of environmental pollution. The fuel a household uses for cooking purposes is yet another indicator of the socio-economic status of that household. In rural Sukkur, 99.6 percent of the respondents use firewood for cooking. In urban Sukkur however, over 80 percent of the respondents use natural gas, while 17 percent use firewood for cooking purposes.

Table 2.8: Main type of fuel used for cooking

Type of fuel	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Fire wood	99.6	467	17.4	80	58.9	547
Kerosene oil			0.2	1	0.1	1
Gas cylinder	0.2	1	1.1	5	0.6	6
Natural gas (Sui gas)			80.9	372	40.0	372
Dung dry			0.2	1	0.1	1
Charcoal / coal	0.2	1	0.2	1	0.2	2
Total	100.0	469	100.0	460	100.0	929

Materials used for the Roof

The materials used for the roof and walls of a household are major indicators of the socio-economic status of that household, as well as the living standards of the people residing there. The more secure the materials, the higher the level of comfort and living standard for residents, and the lower the risk of disease and infection.

According to figure 2.2, a majority of the households (69 percent) in urban Sukkur have roofs made from girder and T-iron. In rural Sukkur, nearly half the respondents (49.7 percent) use wood/bamboo and mud to construct roofs for their homes, whereas the other half (48 percent) utilize girder and T-iron for the same purpose. Only 10 percent of the respondents of urban Sukkur have concrete roofs, while the percentage that enjoys the same privilege in rural Sukkur is negligible, sitting at only 0.9 percent.

Figure 2.2: Material used for construction of roof

Number of Rooms for Sleeping

The number of separate rooms available for sleeping in each household is an important indicator of sanitation and hygiene levels. Overcrowding in households may lead to the spread of infections and diseases, which puts the lives of expectant/young mothers and their newborn children at risk. Table 2.9 below indicates the number of rooms available to the women of urban and rural Sukkur.

In rural Sukkur, 46 percent of the respondents indicated that they only have one room available for sleeping in their household. More than one third (34 percent) stated that they had two rooms that were used for sleeping purposes. In urban Sukkur, the figures were not much better. More than one-quarter (27 percent) of the women indicated that they have one room, which household members use for the purpose of sleeping. More than 43 percent of the urban women indicated that they have access to only two rooms for the same purpose. The percentage of households that had three or more rooms was quite low in both urban and rural Sukkur (16.5 percent and 13 percent respectively).

Table 2.9: Number of rooms used for sleeping by place of residence

Number of rooms	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
0			0.2	1	0.1	1
1	46.1	216	26.7	123	36.5	339
2	34.1	160	43.5	200	38.8	360
3	13.0	61	16.5	76	14.7	137
4	3.4	16	8.9	41	6.1	57
5+	3.4	16	4.1	19	3.8	35
Total	100.0	469	100.0	460	100.0	929

Therefore, this data appears to indicate that most households in Sukkur are overcrowded and do not have adequate space for family members. Findings show that in urban Sukkur there is an average of 4.5 persons to one room, compared to an average of 5.8 persons per room in rural Sukkur. It also indicates that the average socio-economic level of Sukkur is quite low as even urban respondents, whoare usually better off than their rural counterparts, endure similar conditions.

Conditions such as the ones in Sukkur are not at all conducive to maternal and newborn health, and may jeopardize the lives of infants due to the potential for disease.

Household possessions

Household possessions are perhaps one of the most effective ways of determining socio-economic success in a household. Often, it is easier to obtain information on household possessions rather than asking for details about the household income, which respondents may be less willing to provide for various reasons.

In rural Sukkur, the electric fan is the most widely owned household possession with 81 percent in rural and 99.6 percent households in urban Sukkur having access to electric fans. For mid-range possessions such as electric irons, sewing machines, clocks, radios etc. and high-range possessions such as televisions, air conditioners, refrigerators etc. urban Sukkur scores much higher than rural Sukkur. However, even in the urban areas, the percentage of people who have access to these possessions in their households is not extremely high, with more than 54 percent of the population owning refrigerators, 57 percent owning telephones and 16 and 13 percent respectively owning air coolers and air conditioners. In both urban and rural Sukkur, only 3 percent of the population owns cars.

However, according to the data presented in table 2.10, 45 percent of the population in rural Sukkur owns some agricultural land. This is indicative of the main source of livelihood for a large portion of the respondents in rural Sukkur (28 percent). In urban areas however, only 6 percent of the population owns some agricultural land, indicating that most of the population is employed through means other than agriculture.

Table 2.10: Ownership of household commodities/ land by place of residence

Household items	Rural	Urban	Total	
			Percent	Number
Electric iron	50.7	90.9	70.6	656
Electric fan	81.0	99.6	90.2	838
Sewing machine	45.4	83.7	64.4	598
Radio or cassette player	40.7	65.4	53.0	492
Chair/table	19.2	62.2	40.5	376
Television	38.4	80.0	59.0	548
Telephone	17.7	57.0	37.1	345
Watch/clock	56.5	86.7	71.5	664
VCR/VCP/VCD/CD player	9.6	23.5	16.5	153
Refrigerator/Deep freezer	17.3	54.6	35.7	332
Air cooler	2.1	16.3	9.1	85
Air conditioner	1.7	13.5	7.5	70
Computer	1.7	11.3	6.5	60
Bicycle	30.7	18.9	24.9	231
Motorcycle	16.8	28.0	22.4	208
Car/jeep	3.2	3.3	3.2	30
Tractor/truck	4.7	0.4	2.6	24
HH Owned any agriculture land	45.4	6.1	25.9	241
Agriculture land major source of livelihood	28.4	3.5	16.0	149

Ownership of the House

Table 2.11 presents information regarding the percentage of respondents that live in their own homes. More than 96 percent of the rural population in Sukkur lives in homes that they own. The figure is slightly lower for urban Sukkur, where 80 percent of the population owns the home in which they live. Less than 19 percent of the urban population indicated that they rent their accommodations, whereas only 1.1 percent of the rural population claimed to do the same thing.

Table 2.11: Status of house by place of residence

Status	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Owner occupied	96.6	453	80.0	368	88.4	821
Rented	1.1	5	18.9	87	9.9	92
Rent free	2.3	11	1.1	5	1.7	16
Total	100.0	469	100.0	460	100.0	929

Chapter 3

Background Characteristics of Married Women of Reproductive Age

Information on the basic background characteristics of the respondents is essential for the interpretation of results presented in the report. This chapter describes the basic background characteristics including age, marital status, educational level, and residential characteristics of the respondents. It also describes detailed information on respondents' and their husbands' educational status, literacy, and exposure to mass media. As only married women of 15-49 years of age were interviewed, in this chapter we will only focus on the characteristics of these women in Sukkur.

Women's Characteristics

Age Distribution of Married Women

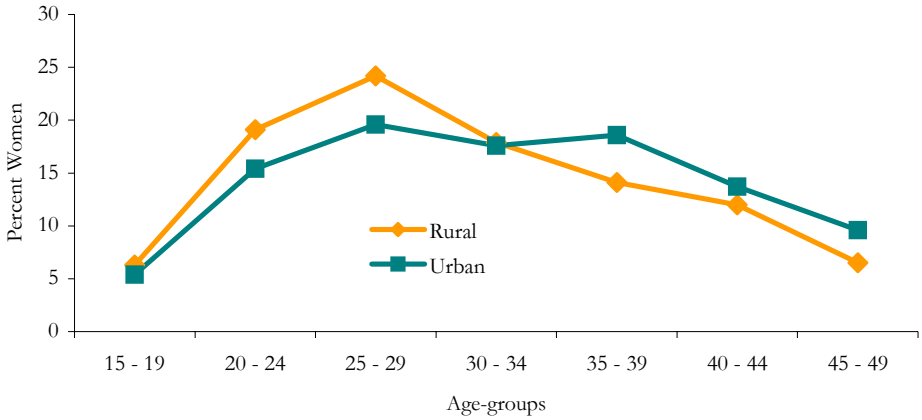
This section of the survey explores the age of respondents at the time of marriage. According to table 3.1, the married women in rural Sukkur are on average younger than the married women in urban Sukkur. As well, in rural Sukkur more than 23 percent of the women interviewed indicated that they were married before the age of 15, while 17 percent of the females in urban Sukkur were married before reaching that age.

Table 3.1: Current age and age at marriage by place of residence

Age		Rural		Urban		Total	
		Percent	Number	Percent	Number	Percent	Number
Age of respondent	15 - 19	6.3	32	5.4	22	5.9	54
	20 - 24	19.1	97	15.4	63	17.4	160
	25 - 29	24.2	123	19.6	80	22.1	203
	30 - 34	17.9	91	17.6	72	17.8	163
	35 - 39	14.1	72	18.6	76	16.1	148
	40 - 44	12.0	61	13.7	56	12.8	117
	45 - 49	6.5	33	9.6	39	7.9	72
Age at marriage	< 15	23.2	118	17.4	71	20.6	189
	15 - 19	56.6	288	55.1	225	55.9	513
	20 - 24	17.1	87	22.8	93	19.6	180
	25 +	3.1	16	4.7	19	3.8	35

Figure 3.1 is a visual depiction of the age distribution of women in urban and rural Sukkur. Women in rural areas appear to marry earlier than women in urban areas. The younger a woman is at the age of marriage, the less education she is likely to have obtained.

Figure 3.1: Age distribution by place of residence



Education/Literacy level

The education and literacy level of a woman is a good indicator of her place and status in society. Women who have been married at a young age and have not been given the chance to obtain an education may not be valued as much as women who are encouraged to obtain an education prior to marriage. It is presumed that the higher her level of education, the more say a woman has in decisions regarding health and healthcare. Young married women without extensive education are left in the care of others such as their husbands, in-laws or family members, who may not let them make important decisions for themselves. It is important that women be educated so that they are able to make their own decisions regarding safe birth practices, complication readiness, antenatal care and neonatal care.

According to table 3.2, nearly 87 percent of the women interviewed in rural Sukkur indicated that they received no education at all, followed by about 7 percent who indicated that they obtained a primary level education. Only 2 percent of the rural women of the district completed studies higher than the secondary level.

In urban Sukkur, the figures were slightly different. While almost 53 percent of the women indicated that they received no education whatsoever, 15 percent had been schooled up to primary school, 12.7 percent up to secondary school, and 13 percent completed studies past secondary school. As a result, exactly 50 percent of the respondents in urban Sukkur are literate, while the remaining 50 percent are illiterate. In rural Sukkur however, the portion of illiterate women stands at 86.4 percent, while only 13.6 percent are literate.

Table 3.2: Background profile by place of residence

Background profile		Rural		Urban		Total	
		Percent	Number	Percent	Number	Percent	Number
Level of education	No education	86.8	442	52.7	215	71.6	657
	Up to primary	7.3	37	15.4	63	10.9	100
	Up to middle	2.4	12	6.1	25	4.0	37
	Up to secondary	1.4	7	12.7	52	6.4	59
	Secondary +	2.2	11	13.0	53	7.0	64
Respondent's literacy	Literate	13.6	69	50.0	204	29.8	273
	Illiterate	86.4	440	50.0	204	70.2	644
Husband's Level of education	No education	40.9	208	23.8	97	33.3	305
	Up to primary	25.5	130	17.9	73	22.1	203
	Up to middle	3.3	17	8.1	33	5.5	50
	Up to secondary	13.4	68	15.2	62	14.2	130
	Secondary +	16.7	85	34.6	141	24.6	226
	Don't know	0.2	1	0.5	2	0.3	3
Husband's literacy	Literate	59.1	301	75.7	309	66.5	610
	Illiterate	40.9	208	24.3	99	33.5	307

While more than 86 percent of the women in rural Sukkur received no schooling whatsoever, the rest of the women indicated that they did receive some form/level of education. In urban Sukkur 24 percent of men were not educated at all. The rate of literacy is 59 percent in rural areas, and nearly 76 percent in urban centers.

The vast disparity which can be noted between the levels of education obtained by men and women, is most shocking when comparing the literacy rates of women in rural areas and men in urban areas. The literacy rate for rural women is 13.6 percent while the literacy rate for urban men sits at 75.7 percent. Gender inequality may be cited as a reason for such disparity in literacy levels.

It is very important to gather information regarding the literacy level of a target audience in a given area, as health communicators are then able to adjust their campaigns accordingly. As well, it has also been shown that the mortality rates among children with mothers who have six or more years of education are considerably lower than the mortality rates among children with uneducated mothers (Martin, 1983). Educated women are more likely to recognize signs of illness in their children, actively seek assistance from a doctor, and finally administer the treatment in the manner required. As well, educated women are more likely to return to a doctor in the event that the treatment administered fails to take effect. Therefore, the proactive nature of educated women in regards to the health of their children lowers the mortality rates of infants and young children (Caldwell, 1986).

Similarly, the level of education of fathers also affects the mortality rates amongst children. This is measured more on a socio-economic level, as typically the more education the father of a child has, the higher his socio-economic status and standard of living. However, the effect an educated father has on the mortality rates of children is lower than the effect an educated mother has in Pakistan (Mahmood, 1992).

Children Ever Born and Living

Table 3.3 presents the distribution of married women by the number of children ever born (CEB). This table also shows the mean number of children ever born and the mean number of living children for each five-year age group. It is observed that on average in Sukkur; there are 4.3 children ever born and 3.8 surviving children.

Table 3.3: Percentage distribution of married women by number of children ever born, mean number of children ever born, living children and age group

Age	Number of Children Ever Born					No. of	Mean No. of Children	
Group	0	1-2	3-4	More than 4	Total	Women	Ever born	Living
15 - 19	42.6	53.7	1.9	1.9	100	54	0.8	0.7
20 - 24	20.6	49.4	25	5	100	160	1.8	1.7
25 - 29	10.3	28.1	35	26.6	100	203	3.2	2.7
30 - 34	4.9	16.6	27	51.5	100	163	4.6	4.2
35 - 39	2	6.1	17.6	74.3	100	148	6.2	5.5
40 - 44	2.6	4.3	6.8	86.3	100	117	6.9	6.1
45 - 49	2.8	4.2	11.1	81.9	100	72	7	6.2
Total	10.1	22.8	21.6	45.5	100	917	4.3	3.8

Preceding Birth Interval

The length of the preceding birth interval is very important as it directly affects the health and mortality of both mother and child. A mother with repeated pregnancies, especially at short intervals, does not have sufficient time for recovery both physically and nutritionally and is therefore more likely to have pregnancy losses and babies of a lower birth weight. Table 3.4 shows that almost 19.7 percent of the last births occurred at an interval of less than 19 months, 18.5 percent had an interval of 19-24 months, while 26.4 percent of the births had an interval of 25-36 months. About 36 percent of the respondents indicated that they had an interval of over 36 months between their last two births.

Table 3.4: Percentage distribution of married women by length of preceding birth interval

Length of Preceding Birth Interval	Number	Percent
Less than 12 Months	20	4.4
13-18 Months	70	15.3
19-24 Months	85	18.5
25-36 Months	121	26.4
More than 36 Months	163	35.5
Total	459	100

Access to Information

In the baseline survey, respondents were asked several questions regarding access and exposure to television, radio and newspapers. One of the main objectives of the baseline was to determine the knowledge of married women on different maternal and newborn health issues and the source of that knowledge. This information is useful in determining which media channels should be employed in the dissemination of maternal and newborn health information to target audiences. Moreover it is important to measure the likelihood of reaching target audiences as well as to determine which media channels are most effective when it comes to reaching that target audience.

Access to Media (Television, Radio and Newspaper)

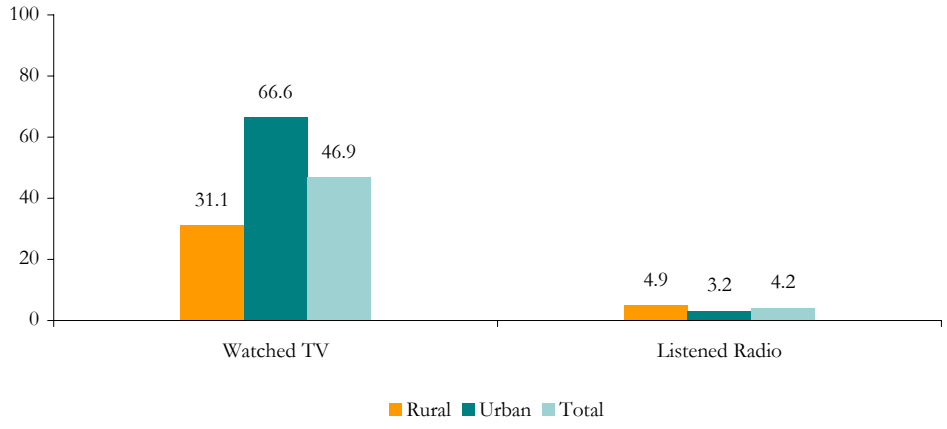
Mass media is regularly used to campaign on various issues, including those relating to the health of mothers and newborns. However, according to the data obtained for this portion of the survey, television has become the most popular source of information in recent decades.

Television

Figure 3.2 is a visual depiction of the percentage of respondents who watch television and listen to the radio. In rural areas of Sukkur, less than one third (31 percent) of the respondents indicated that they watch television, whereas in urban areas it was almost two-thirds (66.6 percent). This difference may be due to the socioeconomic disparities between urban and rural Sukkur. In general, urban inhabitants are better off socio-economically than their rural counterparts.

Since access to television is synonymous with access to information, women in urban areas have more access to information through television. As a result, they are able to make informed decisions, based on the knowledge made available to them through this medium. The majority of women in rural areas may not be afforded this privilege.

Figure 3.2: Percentage of women who watch TV or listen radio by place of residence



In fact, in table 3.5, respondents who indicated that they watch television were asked to state where they usually watch TV. In rural Sukkur, almost 87 percent of those who watch television indicated that they watch it at home, while about 11 percent stated that they watch TV at a relative's house.

Table 3.5: Place where usually watch TV by place of residence

Place	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
At home	86.9	172	98.3	283	93.6	455
At relative's house	11.1	22	1.4	4	5.3	26
At neighbor's house	2.0	4	0.3	1	1.0	5
Total	100.0	198	100.0	288	100.0	486

Finally, respondents were asked how often they watch television. By determining the frequency of women's access to television, it is possible to gauge the potential success of television campaigns and health messages promoting safe motherhood. For example, if most people with access to a television watch TV only rarely, the chances of their seeing an advertisement for a health campaign are very small. However, if most of the respondents indicate that they watch television on a daily basis, it is easier for health programs and campaigns to reach their target audience through television. In Sukkur, almost 64 percent of the rural women that have access to a television indicated that they watch it almost on a daily basis. Table 3.6 shows that more than 78 percent indicated that they watch television on a daily basis in urban areas. However, in both urban and rural Sukkur, the proportion of respondents who indicated that they rarely watch television was quite high. In rural Sukkur, almost 34 percent of the married women that has access to a television rarely watch TV, while in urban Sukkur, 20 percent of the respondents made the same claim.

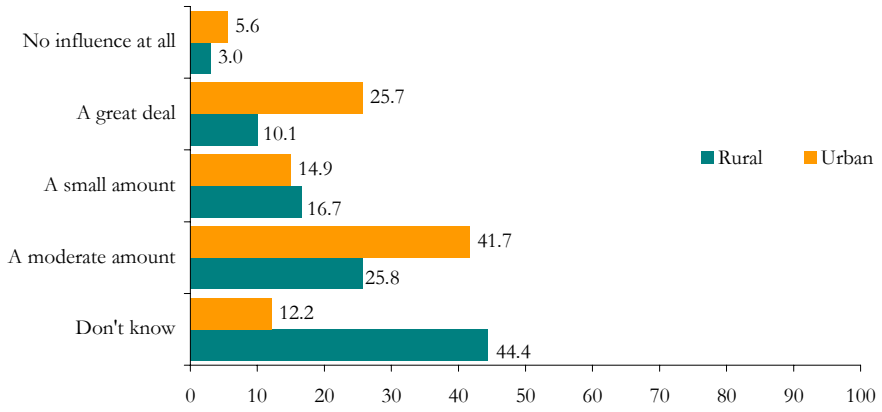
This would mean that while a large portion of the married women can be reached or targeted via television, there is still a considerable portion of the women that cannot be reached through this medium.

Table 3.6: Frequency of watching television by place of residence

Frequency	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Almost daily	63.6	126	78.5	226	72.4	352
At least once a week	0.5	1	1.4	4	1.0	5
At least once a month	1.5	3			0.6	3
Rarely	33.8	67	20.1	58	25.7	125
Others	0.5	1			0.2	1
Total	100.0	198	100.0	288	100.0	486

When asked if TV programs have an influence on health behaviors, the answers received were very interesting. A quarter (25.7 percent) of the urban women in Sukkur indicated that television has "a great deal" of influence on people's health behaviors. A very large percentage of the urban women (41.7 percent) believe that TV has "a moderate amount" of influence, while 5.6 percent of the women stated that it has "no influence at all". About 12 percent of the urban women of Sukkur did not know if television had any impact on health behaviors.

Figure 3.3: Influence of TV programs on health behaviors of people by place of residence



In rural Sukkur, the picture is slightly different. Only 10 percent of the women indicated that television has a great deal of influence on people's behaviors. However, more than one-fourth (25.8 percent) of the rural women believe that television has "a moderate amount" of influence on health behaviors, and almost 17 percent stated that it has "a small amount" of influence. Finally, over 44 percent were unsure if television had any influence on the health behaviors of people. This may be indicative of the lack of education in rural areas.

Radio

Much like television, radio is a tool through which messages may be relayed to a relatively large audience. However, after an analysis of figure 3.2 (also shown in the section examining access to television), it becomes clear that radio is not a very widely used media channel. One major reason for this may be the rising popularity of television in the developing world where more and more television sets are being sold and more women have access to them. Therefore, it can be suggested that radio is not the most effective means of communicating information about health and neonatal care to the majority of married women.

As seen in figure 3.2, just less than 5 percent of the women in rural areas indicated that they listen to the radio, whereas the figure was even lower for urban areas, sitting at 3.2 percent.

As shown in table 3.7, of the women who do listen to the radio, less than half (45.5 percent) the respondents in rural areas indicated that they listened on a daily basis. Less than half (47 percent) of the women made the same claim in urban Sukkur. These figures, coupled with the fact that less than 5 percent of the total women actually listen to the radio makes it even more evident that radio is not an effective means of communication. Furthermore, approximately 50 percent of the women in both urban and rural areas clearly indicated that they rarely listen to the radio (table 3.7).

Table 3.7: Frequency of listening radio by place of residence

Frequency	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Almost daily	45.5	30	46.7	14	45.8	44
At least once a week	1.5	1	3.3	1	2.1	2
Rarely	51.5	34	50.0	15	51.0	49
Others	1.5	1			1.0	1
Total	100.0	66	100.0	30	100.0	96

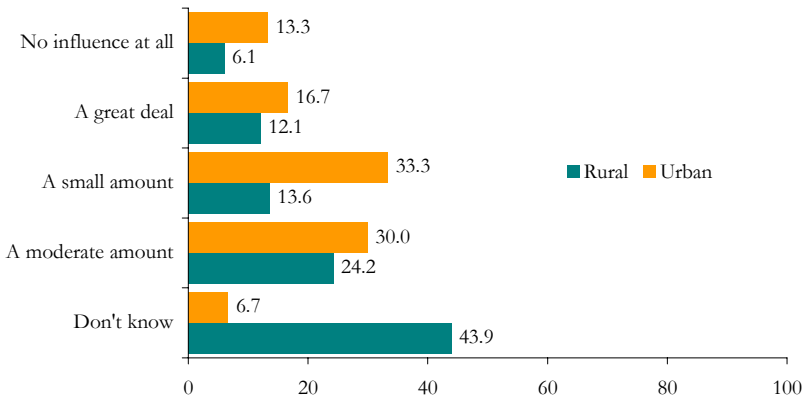
Respondents who indicated that they do listen to the radio were then asked to state where they listen to it. In urban areas, all the respondents who claimed to have access to a radio indicated that they have one at home. In rural Sukkur, 83 percent of the women indicated that they listen to a radio at home, whereas 12 percent said that they listen to the radio at a relative's house (table 3.8).

Table 3.8: Place where respondent listens to the radio by place of residence PAIMAN baseline survey Sukkur

Place	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
At home	83.3	55	100.0	30	88.5	85
At relative's house	12.1	8			8.3	8
At neighbor's house	1.5	1			1.0	1
Others	3.0	2			2.1	2
Total	100.0	66	100.0	30	100.0	96

However, in spite of the fact that a hundred percent of the people with radios in urban Sukkur indicated that they have access to it at home, only 3.2 percent of the total women can be reached through this media channel.

Figure 3.4: Influence of radio on health behaviors by place of residence

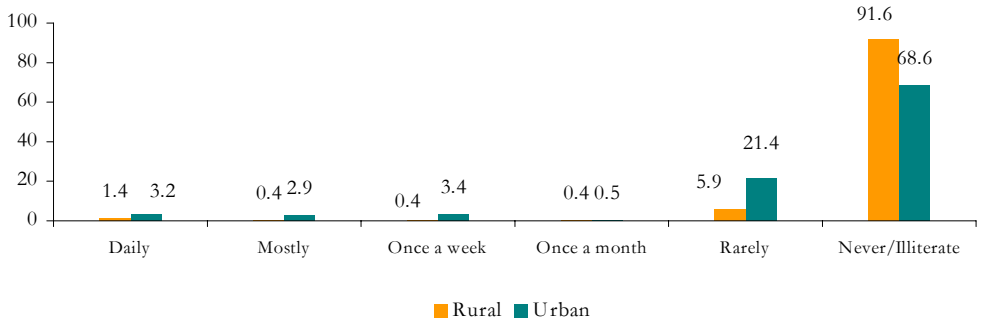


Respondents were asked if they believe radios have an influence on the health behaviors of people. The results are presented in figure 3.4. Most respondents indicated that radio has either a moderate or a small amount of influence on the health behaviors of people. In rural areas, a large portion of the respondents (44 percent) were unsure if radio has an effect on the way people behave, while most people in urban areas believe that radio does in fact have a small amount of influence on people. Very few people in both rural and urban areas (12 percent and 16.7 percent respectively) believed that radio has a great deal of influence on health behaviors and attitudes.

Newspapers

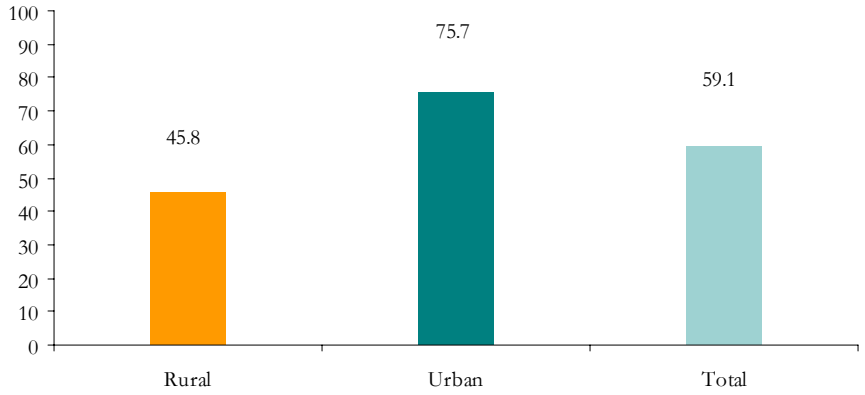
All respondents were asked to answer questions regarding their exposure and access to the print media. In Sukkur, the results obtained were quite unexpected. Nearly 92 percent of the rural women and almost 69 percent in urban Sukkur indicated that they never read the newspaper (figure 3.5). Only 3.2 percent of the urban women and 1.4 percent of the rural women stated that they read the paper on a daily basis, while 6 percent of the rural women and 21 percent of the urban women read the newspaper only "rarely". By looking at the proportion of respondents that never read the newspaper, it becomes clear that reaching a target audience through print media would not be an effective method.

Figure 3.5: Frequency of reading newspaper by place of residence



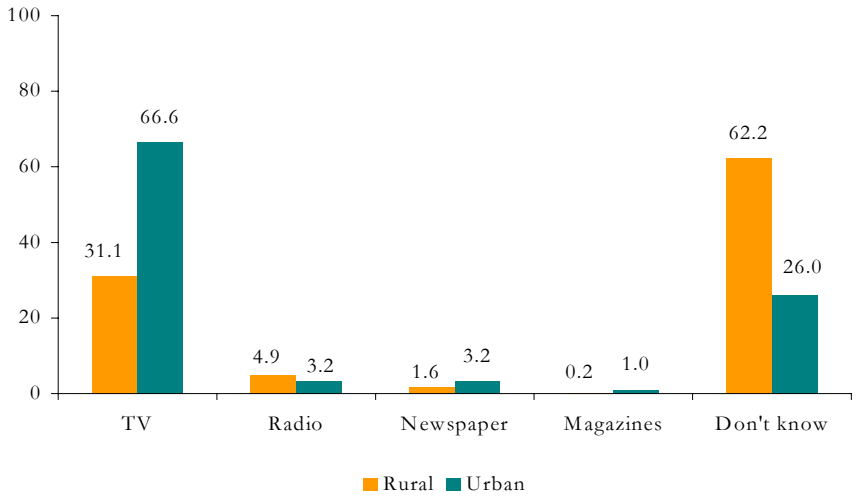
As seen in figure 3.6, a large percentage of the urban women (nearly 76 percent), along with a sizable portion of the rural women (almost 46 percent) of Sukkur has access to some media channel. While it may seem relatively easy to reach this large portion of women through one of the three main media channels, there are some obstacles that stand in the way including the lack of decision-making power for women and the infrequency of access to the media. As well, it is important to keep in mind that approximately 41 percent of the women of Sukkur have no access to any one of the three media channels mentioned above, and therefore cannot be reached by health campaigns and programs. In order to educate and inform this segment of women regarding maternal and newborn health and birth preparedness, a more grassroots method must be adopted. These grassroots efforts may include inter-personal communication through community workers, community gatherings, speeches and health education sessions.

Figure 3.6: Exposure to media (radio, TV or newspaper)



Even though television and radio were reported to have about the same level of influence on the health behaviors of people, according to the figures 3.7, a large portion of the people interviewed in both urban and rural areas believe that television is the most trustworthy form of media (66.6 percent and 31.1 percent respectively). The proportion that believe radio is the most trustworthy form of media is much lower. In 1975, radio is the most popular form of mass communication, whereas in recent years television has assumed that position (Syed, 1979). In fact, according to UNESCO, global access to television is increasing rapidly, especially in developing countries. For example, in 1965 only about five percent of the world's television sets were in developing countries; by 1997 however, the number of television sets in developing countries rose to 52 percent (UNESCO, 2006). This data would suggest that access to television in the developing world has increased, bringing with it a "globalizing effect". As a result, many feel that television brings them trustworthy information and news.

Figure 3.7: Most trustworthy media by place of residence



Newspapers and magazines were not cited as being very trustworthy sources of information, and therefore would not be effective in promoting birth preparedness and other maternal and infant health-related matters. Finally, a large portion of the surveyed women in urban and rural areas are unsure of which media channel is the most trustworthy (26 percent and 62.2 percent respectively). Therefore, perhaps the most efficient way to educate the married women of Sukkur in regards to maternal and neonatal health is through television, as well as through a more grassroots, community-based approach.

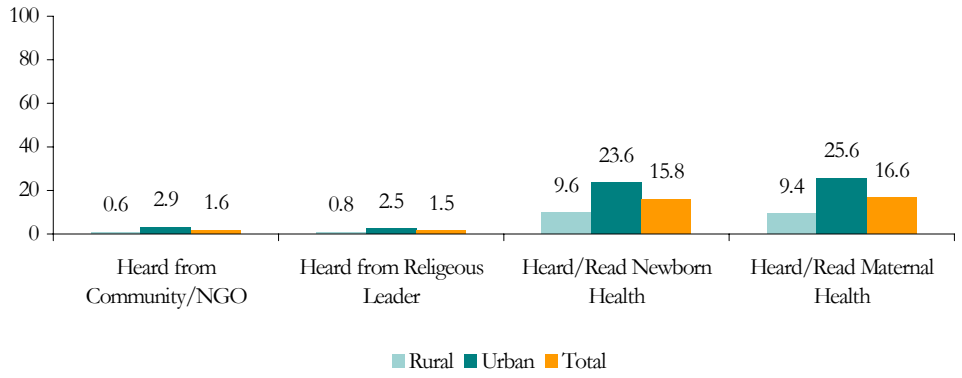
Information/Education through Media

Before moving on to questions regarding attitudes towards pregnancy, delivery and postpartum, respondents were asked to comment on whether or not they had heard or read anything about maternal and newborn mortality within the past three months. Figure 3.8 presents the responses given.

As seen in figure 3.8, one-fourth (25.6 percent) of the women in urban Sukkur had heard or read something regarding maternal health within the last three months. Less than ten percent (9.4 percent) said the same thing in rural Sukkur. Overall, a very large portion of the women (83.4 percent) indicated that they had not heard of anything regarding maternal health over the past three months.

Similarly, the sample women were also asked if they had heard or read anything regarding newborn health within the last three months. Once again, the figures were quite low. Only 24 percent of the urban respondents stated that they had in fact heard/read about newborn health, whereas less than 10 percent of the women in rural areas stated the same thing. However, 84.2 percent of the total women indicated that they had heard/read nothing about newborn health over the past three months. This data clearly indicates a lack of access to information in the district of Sukkur.

Figure 3.8: *Percentage of married women who had heard/read maternal and newborn messages during the last 3 months by place of residence*



Respondents were then asked to indicate if they had heard a religious leader or community/NGO worker speak about health care within the last three months. In urban areas, just under 3 percent of the respondents interviewed indicated that they had heard a community/NGO worker speak about health care, while 2.5 percent stated that they had heard religious leaders speak about the same topic. The numbers were even lower for rural areas. Less than 1 percent stated that they had heard a community/NGO worker or religious leader speak about health care within the last three months.

Upon reflection of the data provided above, it becomes quite evident that the percentages of married women who had heard anything about maternal or newborn health are very low for both urban and rural areas, indicating the absence of proactive education and awareness in many areas of Sukkur. Hence, it would be a challenge for the PAIMAN team to reach these women in both urban and rural areas, and convey messages regarding maternal and newborn health.

Chapter 4

Knowledge of Safe Motherhood, Birth Preparedness and Community Resources

This chapter explores the level of understanding women have of safe motherhood practices, birth preparedness and the use of community resources. It examines the level of health awareness women in the district possess and thus provides an explanation for the maternal and newborn mortality rates. Respondents were asked questions regarding knowledge of complications during pregnancy, delivery, the postpartum period and newborn health. They were also asked about the community resources available to them within the community. The findings of those responses are presented in this chapter.

Knowledge of Danger Signs

Knowledge of Danger Signs during Pregnancy

Respondents were asked to indicate which complications they believe are dangerous and require medical attention. Table 4.1 outlines the various complications that may occur during pregnancy. Surprisingly, a very small percent believe that most complications require a doctor's care, and agreed that medical attention should be provided only after being prompted. The prompted knowledge regarding these danger signs is not presented in this report.

The most known complication among the married women is severe abdominal pain. About three-fourths (73.3 percent) of the urban women know about severe abdominal pain as being a danger sign during pregnancy, whereas half (49.1 percent) the rural women are aware of this fact. Severe vomiting, high blood pressure, heavy vaginal bleeding and high fever are amongst the other danger signs during pregnancy that sizable portions of the women know about.

Upon analysis of these answers, it becomes evident that many women do have a basic understanding of the complications that may arise during pregnancy, but may fail to take action. This failure to take action might be due to numerous reasons including family pressure, lack of permission to seek medical attention and lack of transportation or financial means to travel to a health facility amongst other things. Moreover, many assume that the above-mentioned complications are part of the pregnancy process, and may therefore fail to take these signs seriously.

Figure 4.1: Knowledge of danger signs during pregnancy, which require medical attention

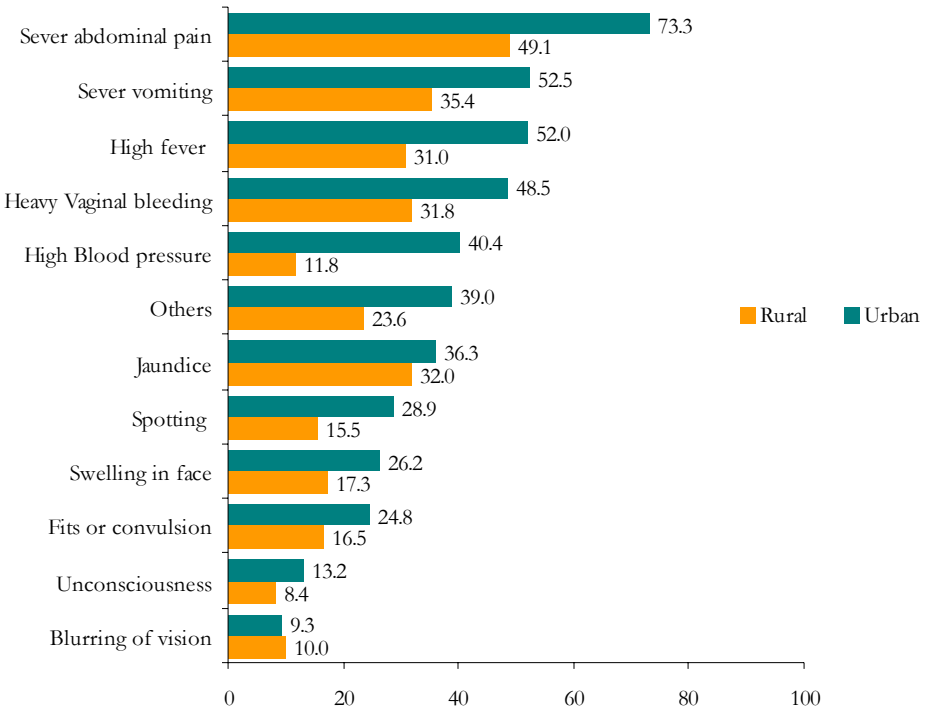
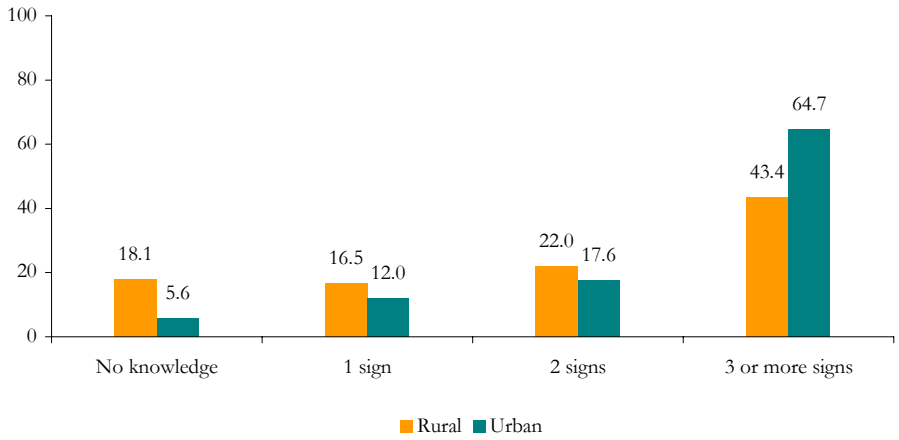


Figure 4.2 shows the percentage of married women in urban and rural Sukkur who have knowledge of danger signs during pregnancy. A much higher percentage of women (64.7percent) in urban areas were able to name three or more danger signs during pregnancy, than their counterparts in rural areas (43.4 percent). Only 5.6 percent of the urban women were unable to name any danger signs during pregnancy, whereas the figure was just over 18 percent for rural areas. Overall knowledge of complications during pregnancy was good in urban areas; this was not the case for rural areas where a sizable portion of the married women have no knowledge at all.

Figure 4.2: Percentage of married women by status of knowledge of danger signs during pregnancy and place of residence



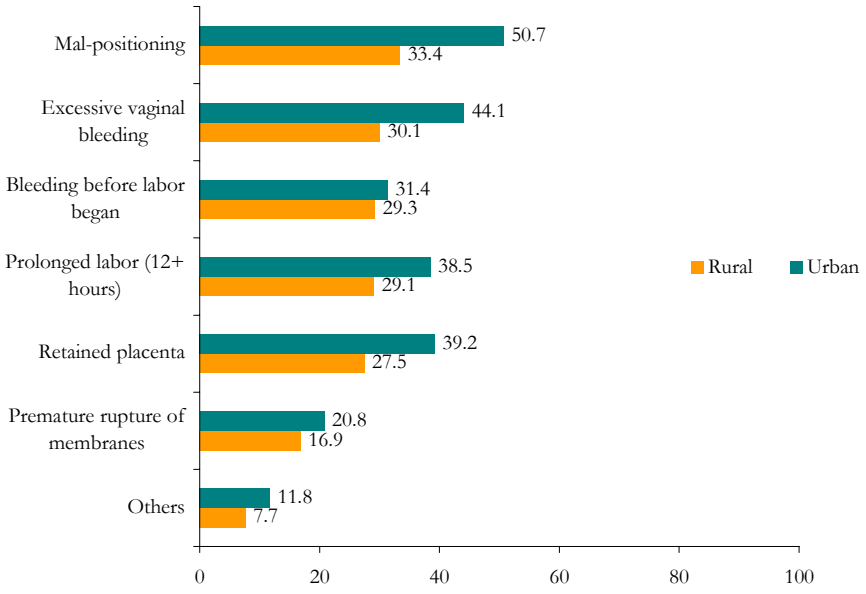
Knowledge of Danger Signs during Childbirth/Delivery

As in the case of pregnancy, many women are not aware of the complications that may arise during delivery. As a result, many women are not taken to a hospital in the event that such a complication should occur. Figure 4.3 below depicts the level of the respondents' understanding of complications during delivery.

In urban areas, certain danger signs were widely recognized as being a potential threat to the life of the expectant mother, as well as the newborn baby. These included "mal-positioning" (50.7 percent), "excessive vaginal bleeding" (44.1 percent), "retained placenta" (39.2 percent) and "prolonged labor" (38.5 percent). While a sizable portion of the women seemed to know about some of the danger signs, which may be noted during delivery, a large percentage of women remain unaware of such signs therefore putting their health, along with the health of their unborn children, at serious risk.

In rural areas, similar results were obtained; however, the percentage of women that believe these are danger signs is considerably less. For example, only 33.4 percent of the women believe that "mal-positioning" of the baby is a danger sign and 30.1 percent indicated that "excessive vaginal bleeding" is a danger sign. An ever smaller percent believed that "prolonged labor" (29.1 percent) and "retained placenta" (27.5 percent) are complications that could put the health of an expectant mothers at risk.

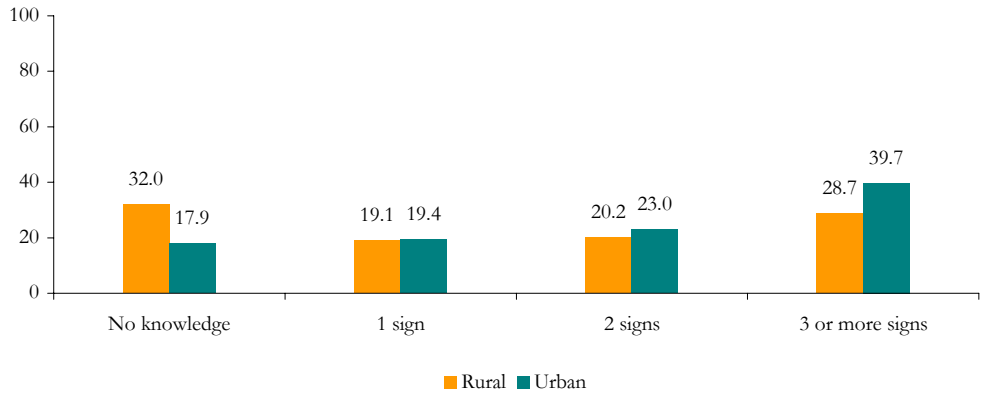
Figure 4.3: *Distribution of respondents, who had knowledge about complications during delivery by place of residence*



The fact is that the highest number of maternal deaths occur during delivery in developing countries. According to the data presented above, a large portion of the women are not aware of danger signs that may lead to severe consequences. Deliveries can only be made safe if married women are educated about danger signs that may lead to complications during delivery, so that they can decide when to seek treatment. Even under normal circumstances, some 15 percent of pregnant women require emergency obstetric care to avoid maternal and newborn deaths.

The baseline findings show that 40 percent of the women in urban areas and 29 percent of the women in rural areas recognize at least three danger signs during delivery. It is very difficult to save the life of a woman who is experiencing complications during delivery if she herself is unaware of the danger signs. Figure 4.4 below demonstrates that around 32 percent of the married women in rural Sukkur are unable to name a single complication during childbirth, while nearly 18 percent in urban Sukkur are in the same position. Only 19 percent of the women in both urban and rural areas were able to name one danger sign, while less than a quarter (23 percent) of the women are able to name two danger signs that may be noted during delivery.

Figure 4.4: Percentage of married women by status of knowledge of danger signs during delivery and place of residence



Knowledge of Danger Signs during the Postpartum Period

Postpartum hemorrhage is also a significant cause of maternal morality in developing countries. Although baseline survey findings indicate that excessive vaginal bleeding is the most known danger sign during the postpartum period, not all women were aware of this fact. In the baseline survey, postpartum period is defined as the 40 days after childbirth. Again, this calls for some innovative approaches to make these communities knowledgeable regarding the danger signs arises during the postpartum period. If mothers are not medically fit during the postpartum period they cannot take care of their newborns the way a healthy mother can.

Following excessive vaginal bleeding, high fever (64.5 percent in urban and 46.4 percent in rural area) is another commonly acknowledged danger sign during the postpartum period. A prolapsed uterus and the onset of fits and convulsions are some additional danger signs which respondents know. However, the level of awareness of the danger signs during the postpartum period is much lower in rural areas than in urban settings. For example, more than half (54 percent) the married women in rural areas believe that excessive vaginal bleeding is a danger sign during the postpartum period, compared to three-fourths (74.8 percent) of the women in urban areas. As well, only 21 percent of the rural women are aware of the onset of convulsions, as a danger sign, while less than half (46 percent) believe high fever is considered a complication.

Figure 4.5: *Percentage of married women who had knowledge about complication during postpartum period by place of residence*

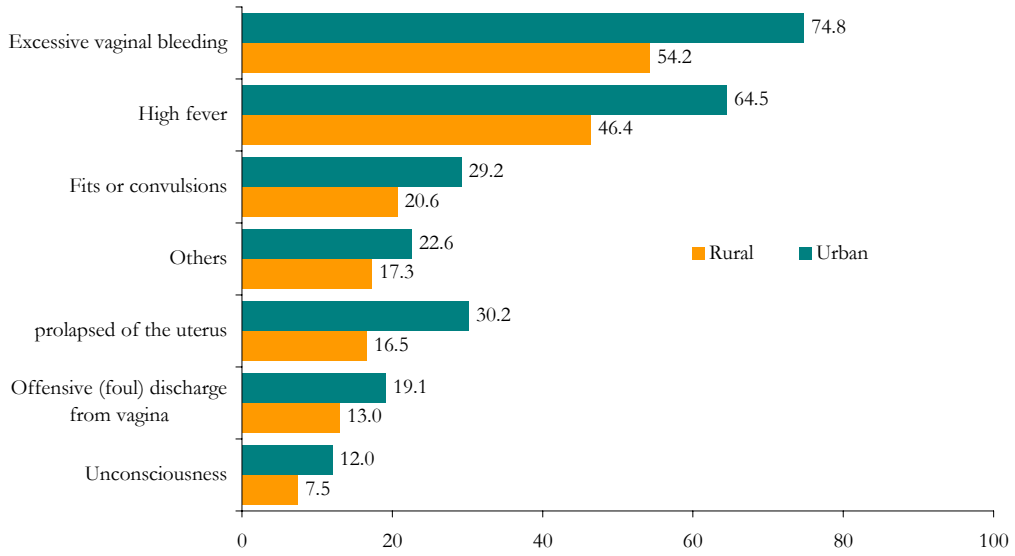
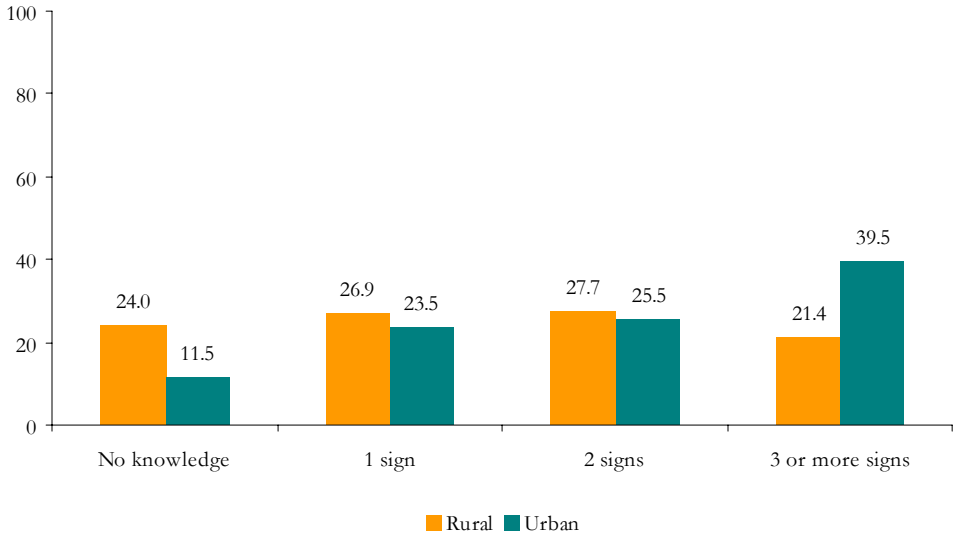


Figure 4.6: *Percentage of married women by status of knowledge of danger signs during postpartum period and place of residence*



Accoridng to figure 4.6 , about 24 percent of the respondents in rural areas and more than 11 percent in urban areas do not know even a single sign of complication. However, less than 40 percent in urban and more than 21 percent of married women in rural areas know of three or more danger signs during the postpartum period.

Knowledge of Danger Signs in the Newborn

Unfortunately, many women are also unaware of the danger signs that may appear in newborns, especially in the first seven days after the childbirth. The newborn period is defined as the first four weeks after birth. Table 4.7 outlines the percentage of respondents who believe that each complication listed below requires medical attention. More than two thirds (68 percent) of the respondents interviewed in urban areas indicated that yellow skin (jaundice) is a danger sign in newborns, whereas less than half (49 percent) of the women in rural areas stated the same knowledge. Difficulty breathing is another symptom that many respondents in urban and rural areas cited as being a danger sign in newborns (48.5 percent and 30.8 percent respectively). Inability to cry and suckle are also commonly cited symptoms and danger signs.

Figure 4.7 : Distribution of respondents who had knowledge about danger signs in newborns by place of residence

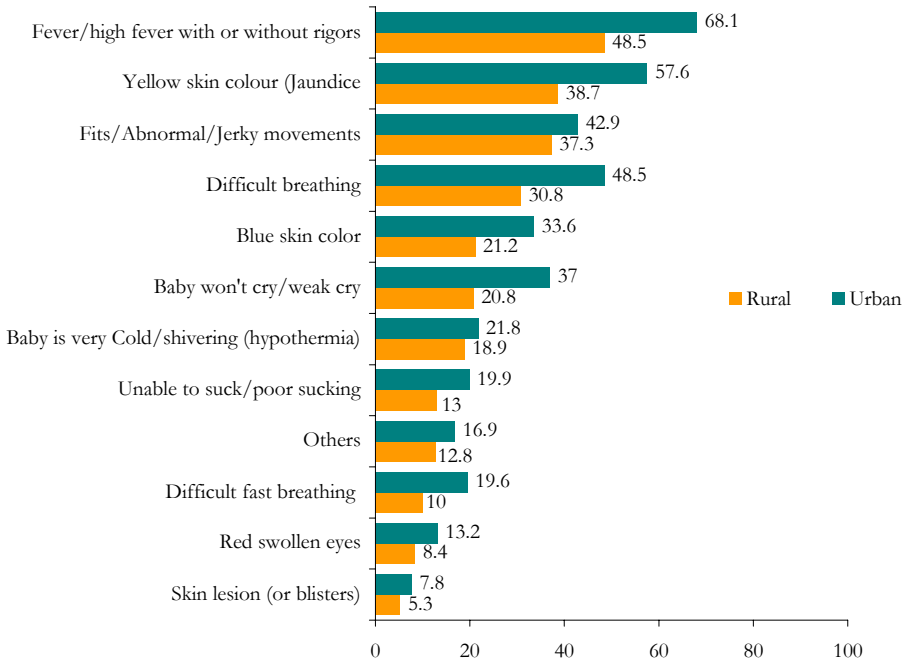
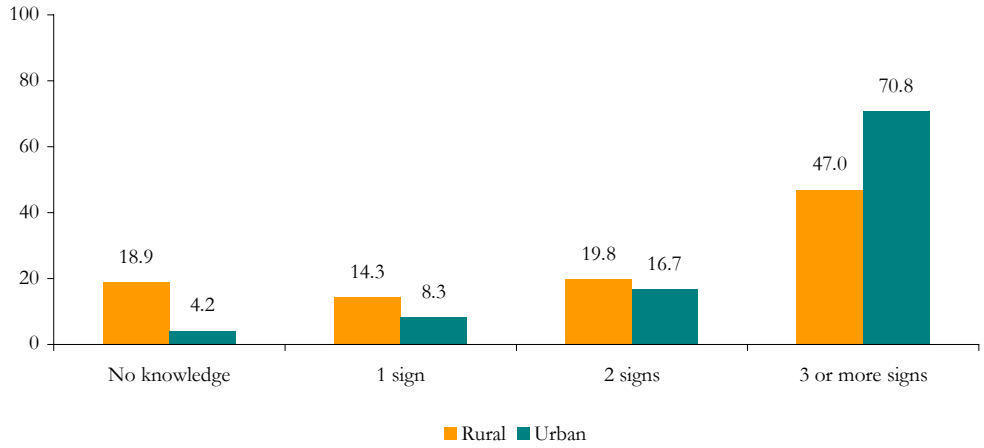


Figure 4.8 depicts the percentage of women in urban and rural areas that were aware of danger signs in newborns. Almost 71 percent of the urban women of Sukkur were able to cite three or more danger signs in newborns, whereas only 47 percent were able to do the same in rural Sukkur. Quite a large portion of the rural women had no knowledge at all regarding danger signs in newborns (18.9 percent), while just 4.2 percent of the urban women were unable to name any danger signs in newborns.

Figure 4.8: *Percentage of married women by status of knowledge of danger signs in newborn and place of residence*



Source of Information Regarding Danger Signs

Finally, respondents were asked where they received their information regarding these complications during pregnancy, delivery and postpartum period. In urban areas, the most popular sources of information are private clinics/hospitals (48.3 percent). In contrast, the most cited source of information in rural areas is in-laws (59.1 percent). Similarly, a large number of respondents in both urban and rural areas indicated that friends and relatives are their source of knowledge regarding danger signs (41.7 percent and 48.1 percent respectively). The fact that most respondents indicated that they obtained information about pregnancy through in-laws, family members and friends shows that many women may not be getting accurate information. As well, many women are not receiving reliable information regarding the health and medical side of a pregnancy from a doctor's perspective.

Television is also cited (21.8 percent in urban and 12 percent in rural areas) as a source of information, whereas newspapers (less than 3 percent in urban and less than one percent in rural areas) and other print media are amongst the least cited sources.

Knowledge of Community Schemes for the Welfare of Women and Newborns

In addition to asking questions on the knowledge of danger signs, married women were asked whether they were aware of any existing schemes in their respective communities that would help women have a safe childbirth and also enable them to take care of newborns. The baseline focused on schemes pertaining to transportation, blood arrangements and funding, all services which help in ensuring that there are no delays during the delivery time. Lack of arrangement of transport to a health facility is a major cause of delay and can often lead to maternal and newborn mortality. It is very important to arrange transport ahead of time in order to eliminate that delay. Unfortunately, many households are unable to do so due to a lack of transportation in their communities.

Figure 4.9: Source of information about pregnancy by place of residence

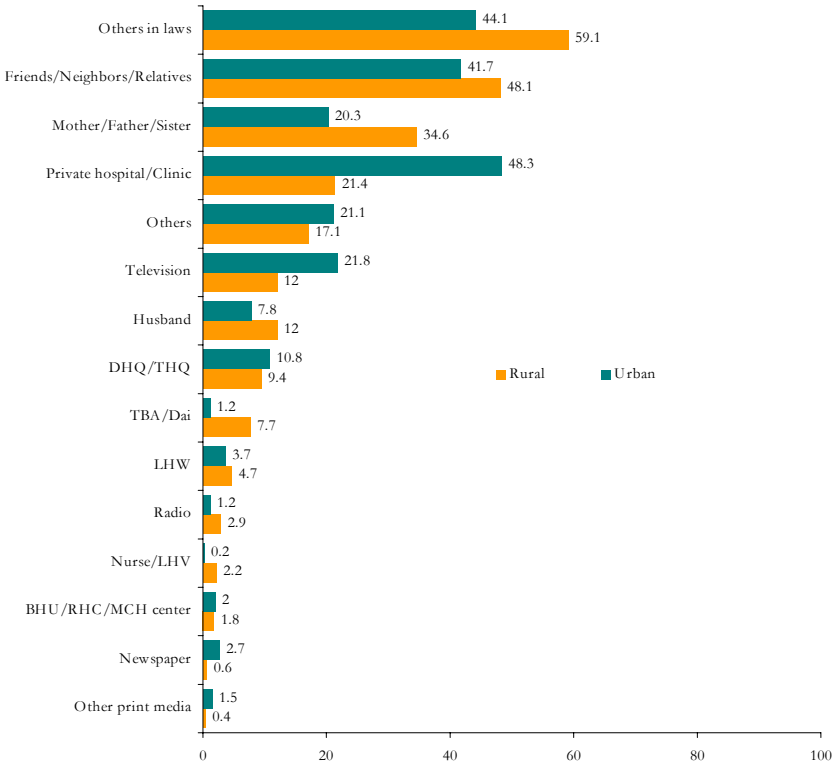


Table 4.1 presents the vast difference between the services that respondents indicate as being important, and the services actually available to them. For example, 98 percent of the women in rural Sukkur, and 99.5 percent of the women in urban Sukkur realize the importance of having community-provided transport. However, only 1.4 percent of the women of rural Sukkur indicated that they know of any transportation arrangements within the community. This figure is even lower in urban Sukkur, sitting at 0.2 percent. A similar trend can be observed with matters regarding the arrangement of blood for emergency, as well as money for the time of delivery.

Table 4.1: Knowledge of existence and importance of transport, blood and finances by the community at the time of delivery by place of residence

Committee Services	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Existence of transport by the community at delivery	1.4	7	0.2	1	0.9	8
Important to have community provided transport facility	98.0	499	99.5	406	98.7	905
Existence of blood by the community at time of delivery	1.2	6	0.5	2	0.9	8
Important to have community provided blood facility	97.2	495	99.8	407	98.4	902
Existence of money by community at the time of delivery	1.0	5			0.5	5
Important to have community provided money facility	97.4	496	100.0	408	98.6	904
Total	100.0	509	100.0	408	100.0	917

Unfortunately, most communities lack any arrangement for transport, provision of blood and finances for women at the time of need during delivery. This is a major obstacle to safe birth practices, as women are then forced to deliver at home, and may be exposed to infections and complications. Birth preparedness promotes the arrangement of such aspects.

Chapter 5

Attitudes Towards Pregnancy, Delivery and the Postpartum period

This chapter explores the attitudes of married women towards pregnancy and delivery, as well as during the postpartum period. Determining the attitudes and beliefs of women regarding pregnancy, delivery and the postpartum period can lead to the development of new strategies and methods that may bring about a change in traditional thinking.

Attitudes Towards Age at Marriage

In response to the question of whether or not women should get married soon after puberty, more than 50 percent in rural and 28 percent in urban believe a woman should be married just after puberty. A deeper look into this issue shows that many families do not value girls' education, and place greater emphasis on marriage. As a result, women are married at an early age and often do not have the opportunity to obtain any education whatsoever. There is also a link between the years of education obtained by women and the fertility rate of a country (Sathar *et al*, 1988). The younger the age at marriage, the greater the exposure to childbearing.

Table 5.1: Should women get married soon after puberty by place of residence

Get married soon	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Yes	50.7	258	28.2	115	40.7	373
No	41.7	212	69.4	283	54	495
No opinion	6.1	31	2.2	9	4.4	40
Don't know	1.6	8	0.2	1	1	9
Total	100	509	100	408	100	917

Attitudes Toward Antenatal Care

Respondents in both the urban and rural areas of Sukkur were then asked if they believed women need to receive antenatal check-ups. While a very large percentage of the women in urban and rural Sukkur believed that women should receive antenatal check-ups (89.4 percent and 72.8 percent respectively), a notable portion believe that such check-ups are not necessary (nearly 19 percent in rural areas and just under 10 percent in urban areas). Approximately 8.3 percent of the rural respondents were not sure if antenatal check-ups are necessary, whereas the figure was 2.5 percent for urban respondents. Table 5.2 below outlines the percentage of respondents who feel that antenatal check-ups are either necessary or not necessary by place of residence.

Table 5.2: Believe in necessity of antenatal check-up by place of residence

Have antenatal check-up	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Yes	72.8	370	89.4	363	80.2	733
No	18.9	96	8.1	33	14.1	129
Don't know	8.3	42	2.5	10	5.7	52
Total	100.0	508	100.0	406	100.0	914

Antenatal care also encourages mothers to be more aware of their own health as well as the health of their newborn babies. When asked to state in which month of pregnancy a woman should receive antenatal attention, the responses received varied. The table 5.3 below outlines the different responses and opinions.

Table 5.3: Month of the pregnancy when women go for antenatal care by place of residence

Month	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
1	5.9	22	14.3	52	10.1	74
2	2.4	9	8.0	29	5.2	38
3	10.8	40	15.7	57	13.2	97
4	4.6	17	3.9	14	4.2	31
5	8.9	33	6.6	24	7.8	57
6	1.4	5	1.1	4	1.2	9
7	4.1	15	3.6	13	3.8	28
8	2.7	10	1.1	4	1.9	14
9	1.6	6	0.3	1	1.0	7
As soon as possible after pregnancy	5.9	22	17.9	65	11.9	87
When check-up is needed	34.3	127	24.8	90	29.6	217
Don't know	17.3	64	2.8	10	10.1	74
Total	100.0	370	100.0	363	100.0	733

A very large portion of both urban and rural women indicated that an antenatal check-up is only necessary for a particular reason (24.8 percent and 34.3 percent respectively). Less than two fifths (38 percent) in urban and less than one fifth (19 percent) in rural areas believe that antenatal check-ups should take place within the first three months. However, in rural areas, nine percent of women indicated that the antenatal check-up should take place in the fifth month of pregnancy. Only 6 percent of the rural women indicated that an antenatal check-up should be carried out as soon as possible after pregnancy, while 18 percent said the same thing in urban Sukkur.

Respondents were also asked to state the number of antenatal check-ups they received during their pregnancy. Table 5.4 below indicates that a sizable portion of the women in both urban and rural areas received three or four antenatal check-ups. Nearly 59 percent of the rural women indicated they only received a check-up when they felt it was needed and 61 percent of the urban women shared this sentiment.

Table 5.4: Number of antenatal visits by place of residence

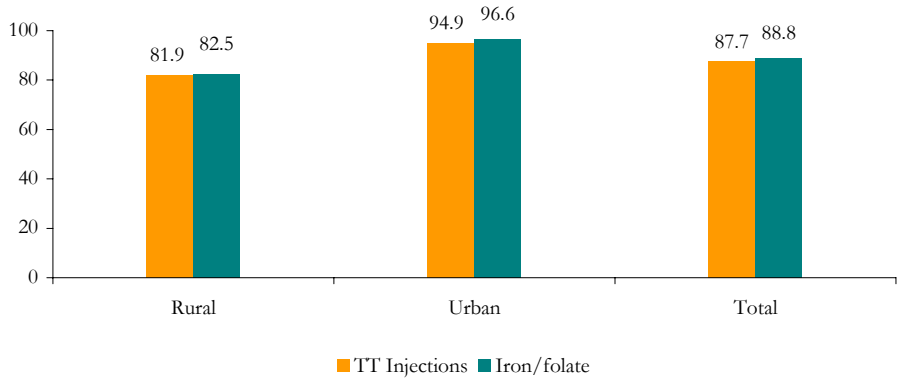
Number	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
1	1.6	6	0.6	2	1.1	8
2	3.5	13	1.4	5	2.5	18
3	6.2	23	5.0	18	5.6	41
4	4.9	18	5.0	18	4.9	36
5	4.1	15	2.2	8	3.1	23
6	1.9	7	3.6	13	2.7	20
7	1.9	7	4.1	15	3.0	22
8	0.8	3	3.3	12	2.0	15
9+	1.4	5	10.5	38	5.9	43
When check-up is needed	58.6	217	61.4	223	60.0	440
Don't know	15.1	56	3.0	11	9.1	67
Total	100.0	370	100.0	363	100.0	733

There is also the question of access to services and health care. What obstacles stand in the way of women receiving adequate antenatal care? Age, once again, is an important factor. Issues regarding transportation, financial constraints and tradition may also stand in the way.

According to figure 5.1, in rural Sukkur, over 82 percent of the women indicated that they should take iron/folate supplements and about 82 percent indicated that they should receive TT shots during pregnancy. In urban Sukkur, this figure is even higher, as 95 percent of the respondents indicated that they should receive TT shots, and nearly 97 percent of the women stated that they should take iron/folate supplements. While the numbers are quite high, there is a sizable portion of the women that believes TT shots and iron/folate supplements are unnecessary. Around 20 percent of the respondents in rural areas felt this way. This is due to a lack of widespread prenatal care and information regarding the necessity of shots and supplements during pregnancy.

Overall, prenatal care provides an opportunity to offer preventative care that will benefit the newborn as well the mother. Prenatal care allows women to learn about hygiene, the benefits of breastfeeding, nutrition and general health (Mahmood, 2002).

Figure 5.1: Percentage of married women who received TT shots and took iron/folate during pregnancy by place of residence



Attitudes Towards Delivery

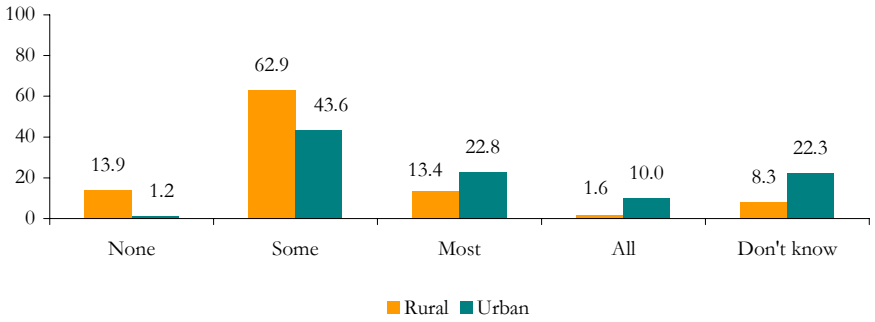
There are many misconceptions surrounding delivery and neonatal care. Many traditional families prefer the assistance of Traditional Birth Attendants or TBAs, who have vast experience but no formal training. However, many families do not realize the impact lack of training can potentially have on childbirth, and chose to opt for TBAs over health professionals. In fact, when asked to indicate if they would like to receive delivery services from a health professional, 77 percent of the rural women of Sukkur stated that they would like to. However, 14 percent indicated that they would prefer not to use the services of a health professional. In urban Sukkur, 95 percent of the women indicated that they would like to receive delivery services from an SBA. Unfortunately, while many women do want to receive care from an HP, they are unable to do so due to family constraints and pressures.

Table 5.5: Believe that women should receive delivery services from health professional by place of residence

Number	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Yes	77.2	392	95.1	388	85.2	780
No	14.0	71	2.7	11	9.0	82
Don't know	8.9	45	2.2	9	5.9	54
Total	100.0	508	100.0	408	100.0	916

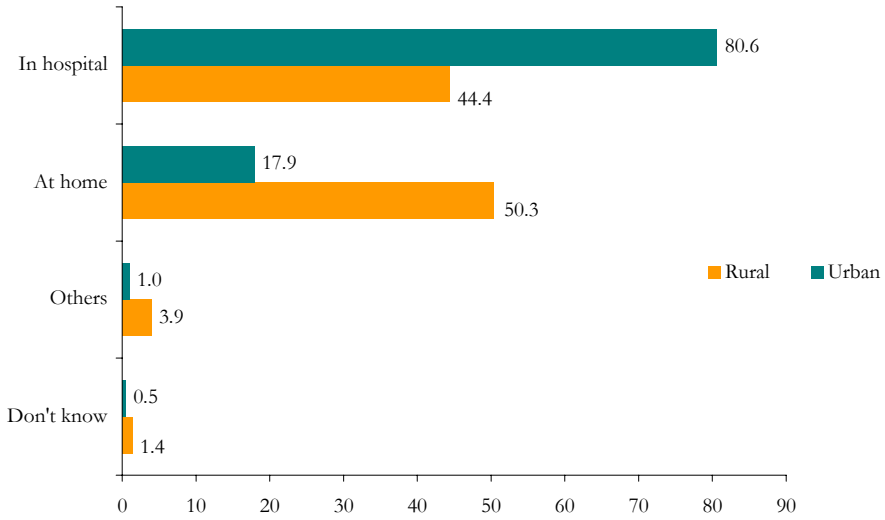
Figure 5.2 below depicts the proportion of women in the community that the respondent believed had sought the assistance of a health professional at the time of delivery. In urban and rural Sukkur, most respondents believe that "some" women receive delivery services from a skilled birth attendant (43.6 percent and 62.9 percent respectively), while a smaller percentage believe that "most" receive assistance from health professionals.

Figure 5.2: *Percentage of women, who thought that women in their community went for skilled birth attendant by place of residence*



Furthermore, when asked where they would like their delivery to take place, respondents in urban and rural areas had different preferences. In urban areas, just under 81 percent of the women indicated that they would prefer to deliver in a hospital. Only 44 percent of the rural women stated the same thing, while 50 percent indicated that they would prefer to deliver at home. The result indicates that while many women, especially in urban areas do want to deliver at a hospital, many are unable to do so. As well, even though a large percent of the rural women do want to deliver at home, the other half would prefer to do so at a hospital.

Figure 5.3: *Percentage of women by their perception of where a delivery take place*



One reason, which explains why some women still want to deliver at home, is that many are not able to make decisions independently. Often, women are dependant upon their husbands or in-laws when it comes to major decisions. Respondents were asked who in their communities should take charge and care of a pregnant woman. According to table 5.6, 62 percent of the women in rural areas indicated that a woman's husband should be responsible for her during pregnancy, while only 14 percent indicated that a woman should be allowed to make decisions for herself during pregnancy. In

urban areas, 36 percent of the women indicated that a woman should make her own decisions, while 47 percent believed that her husband should be the decision-maker.

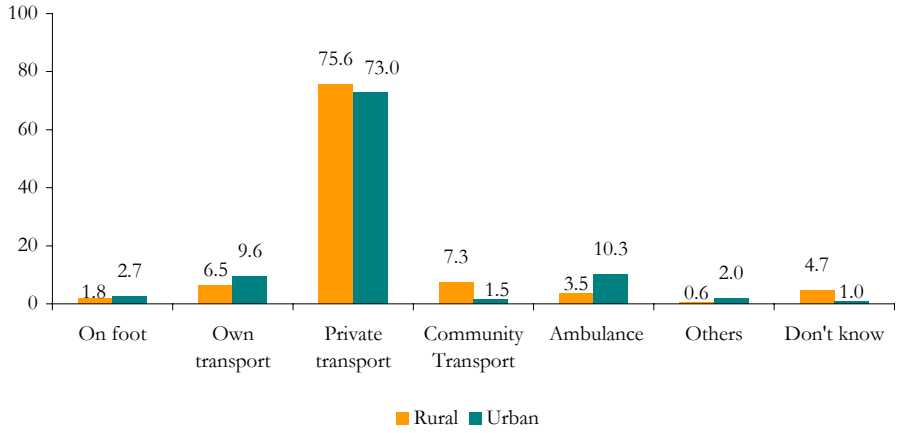
Table 5.6: Person women believe should take charge of the pregnant women by place of residence

Person	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Pregnant woman	14.3	73	35.5	145	23.8	218
Husband	62.1	316	47.3	193	55.5	509
Other family members	17.1	87	8.8	36	13.4	123
Friend/neighbor/relative	0.2	1			0.1	1
TBA/Dai	2.8	14	0.5	2	1.7	16
Others	1.0	5	7.6	31	3.9	36
Don't know	2.6	13	0.2	1	1.5	14
Total	100.0	509	100.0	408	100.0	917

Since women are sometimes unable to make decisions independently, they are unable to seek skilled medical care when they deem necessary, and often do not make decisions such as those regarding the location of delivery.

Finally, respondents were asked to state the mode of transport they would use in order to reach a health facility at the time of delivery. In the district of Sukkur, more than three quarters of the rural respondents indicated that they planned to use private transportation, whereas 73 percent of the rural women stated the same thing. Less than 10 percent of the women in both urban and rural Sukkur indicated that they had their own means of transport. However, a substantial portion of the women indicated that they would rely on community transportation and ambulance, both of which may be unreliable and cause delays. Some (almost 2 percent in rural areas and 3 percent in urban areas) even indicated that they planned on walking to a health facility at the time of delivery. The percentage of the women that indicated that they would walk to a health facility is higher in urban Sukkur.

Figure 5.4: Percentage of married women by mode of transport they would use to reach a health facility



Attitudes Towards Postpartum and Neonatal Care

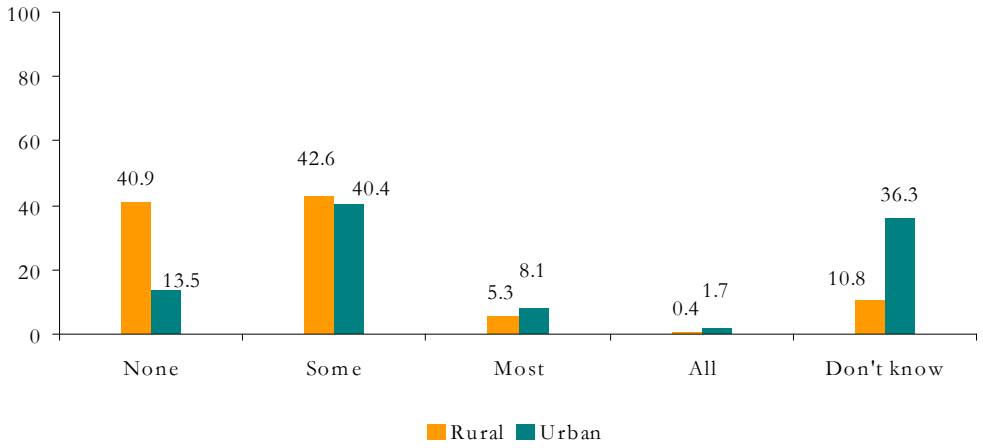
The importance of postnatal care is often undervalued. Postnatal care ensures that both mother and newborn are in good health, and monitors the recovery process of new mothers. However, when asked if women required postnatal care, a large segment of women indicated that postnatal care is not necessary.

Table 5.7: Belief in necessity of postnatal care by place of residence

Need postnatal	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Yes	41.5	211	57.8	236	48.7	447
No	51.9	264	37.0	151	45.3	415
Don't know	6.7	34	5.1	21	6.0	55
Total	100.0	509	100.0	408	100.0	917

In rural areas, nearly 52 percent of the women believe that postnatal care is not necessary, while 37 percent of the women in urban areas feel the same way. These women do not realize that the postpartum period (which is defined as the first forty days after delivery) is crucial, and hemorrhaging is not uncommon during this time. These figures further prove that people are unaware of the various complications that can arise following childbirth, and may therefore ignore the symptoms. A large number of maternal deaths occur during the 48 hours after birth (JHPIEGO). "In spite of the high risk associated with the postpartum period, people seem to know very little about health practices during this period" (JHPIEGO, 2004, pp.142).

Figure 5.5: Number of postnatal visits women should have in the community by place of residence



Furthermore, when asked if other women in the community receive postnatal care, 43 percent of the respondents in rural areas and 40 percent of the respondents in urban areas indicated that they know of "some" women who receive such care. However, more than 40 percent of the women in rural areas indicated that they do not know of anyone who received postnatal care. Since about 15 percent of pregnant women require emergency obstetric care to prevent mortality, it is important to have regular postnatal check-ups. A lack of knowledge during the postpartum period may lead to inappropriate or delayed care seeking, which may result in maternal morbidity or mortality.

Coverage of Lady Health Workers

Respondents were asked if a Lady Health Worker (LHW) had been to their community. According to table 5.8 below, 41.8 percent of the rural women and 58.3 percent of the urban women indicated that a LHW had been to their community. On the other hand, over 53 percent of the women in rural Sukkur indicated that no LHW had been to their community, while 31 percent of the urban women claimed the same thing.

Table 5.8: Presence of lady health worker in the community by place of residence

Has LHW been in the area	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Yes	41.8	213	58.3	238	49.2	451
No	53.8	274	31.4	128	43.8	402
Respondent herself is LHW	0.6	3	1.2	5	0.9	8
Don't know	3.7	19	9.1	37	6.1	56
Total	100.0	509	100.0	408	100.0	917

The next question was whether or not an LHW had ever been to the respondent's home three months before the survey. Approximately three quarters (73.2 percent) of the rural women indicated that a LHW had visited their home, whereas a quarter (26.8 percent) of the women stated that they had never been visited by a LHW. In urban areas, 63 percent of the women had had an LHW visit their home, while 37 percent had not.

Table 5.9: LHW ever visited home during last three months by place of residence

Ever visited	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Yes	73.2	156	63.0	150	67.8	306
No	26.8	57	37.0	88	32.2	145
Total	100.0	213	100.0	238	100.0	451

Chapter 6

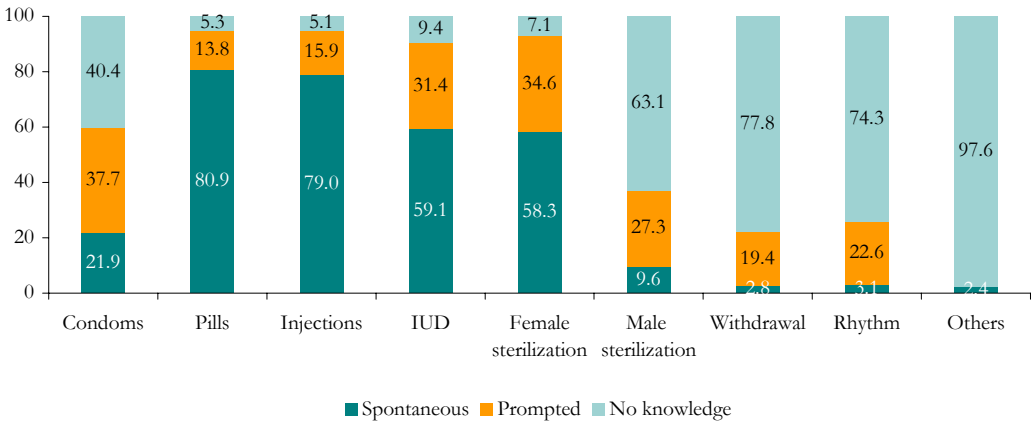
Contraceptive Knowledge and Use

Respondents were asked to name the ways in which a couple could delay or avoid a pregnancy. If the respondent did not spontaneously mention a particular method, the interviewer described different methods and asked the respondent to indicate if she recognized them. In the questionnaire, descriptions were included for six modern contraceptive methods and two traditional methods.

Knowledge of Contraceptive Methods

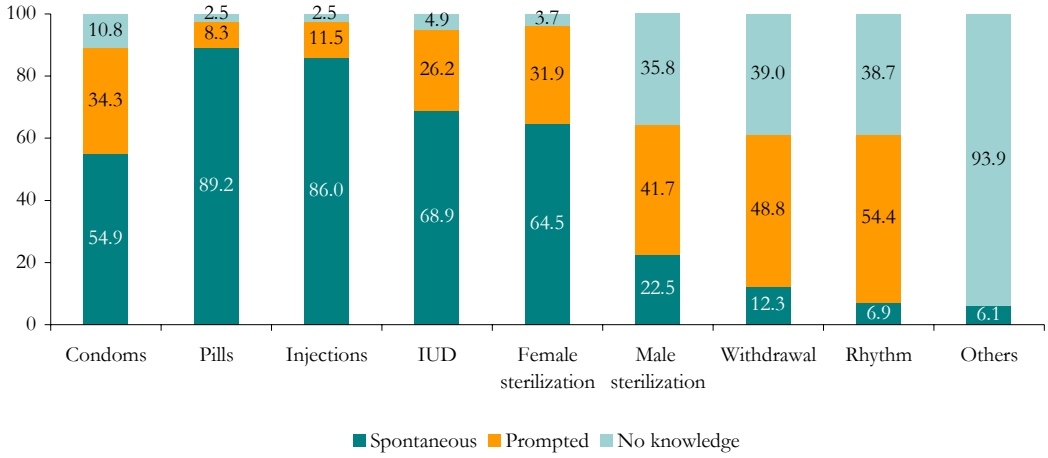
Many women are unaware of the different types of contraceptives that may be used to delay or prevent pregnancy. As women do not always have full control over the number of children they want to have, contraception is an important tool that helps give women that freedom of choice.

Figure 6.1: Percentage of married women by knowledge of specific contraceptive method Sukkur- rural



According to Figure 6.1, a large portion of the rural women know about pills (80.9 percent), injections (79 percent) and IUDs (59.1 percent). Female sterilization is also a well-known family planning method (58.3 percent) followed by the condom (21.9 percent). Interestingly, male sterilization (9.6 percent), along with the withdrawal (2.8 percent) and rhythm methods (3.1 percent) are not very well known by respondents.

Figure 6.2: Percentage of married women by knowledge of specific contraceptive method Sukkur- urban



Similar trends were noted in urban areas of Sukkur. The most popular family planning methods are pills (89.2 percent), injections (86 percent), IUDs (68.9 percent), female sterilization (64.5 percent) and condoms (54.9 percent). Once again, male sterilization (22.5 percent), along with the withdrawal (12.3 percent) and rhythm (6.9 percent) methods are not as well known.

Ever Use of Contraception

In this section of the survey, respondents were asked if they had ever used any contraceptive methods. The results were very different for urban and rural areas. According to table 6.1, 20.1 percent of the urban women indicated that they had used condoms, whereas only 3 percent of the rural women stated the same thing. Pills and injections were also very popular in urban areas, with about 16 percent of the women having used them. Injections were the most widely used contraceptive in rural areas, as 8.4 percent of the women indicated that they had used that method of family planning. Overall, 34 percent of the married women have ever used any type of family planning methods in Sukkur; 21 percent in rural and 50 percent in urban areas.

Table 6.1: Ever used FP method by contraceptive and place of residence

Contraceptive method	Place of residence		Total	
	Rural	Urban	Percentage	Number
Any method	21.2	49.8	33.9	311
Condoms	3.1	20.1	10.7	98
Pills	5.7	16.7	10.6	97
Injections	8.4	16.2	11.9	109
IUD	2.4	9.8	5.7	52
Female sterilization	4.9	10.0	7.2	66
Male sterilization		0.5	0.2	2
Withdrawal	3.1	12.7	7.4	68
Rhythm	5.3	3.7	4.6	42

Current use of Contraceptive methods

Contraceptive prevalence is defined as the proportion of currently married women age 15-49 using some method of family planning at the time of the survey. Table 6.3 shows the percent distribution of married women by their current contraceptive use status. Results indicate that 13.4 percent of the rural women use some method of contraception compared to 36 percent of urban women. Furthermore, 11.2 percent and 30.4 percent of the women in rural and urban areas respectively use modern contraceptive methods, whereas 2 percent of the rural women and 5.6 percent of the urban women use traditional methods. Interestingly, female sterilization is currently the most widely used family planning method in both urban and rural Sukkur, compared to other available methods. Condoms are the next most popular contraceptives in urban areas, while female sterilization followed by injectables are the most acceptable contraceptive methods in rural Sukkur.

Table 6.2: Method specific contraceptive prevalence by place of residence

Contraceptive Method	Rural	Urban	All
Any method	13.4	36.0	23.4
Any modern method	11.2	30.4	19.7
Any traditional method	2.2	5.6	3.7
Condom	1.6	8.1	4.5
Pill	1.6	3.9	2.6
Injectables	2.2	4.9	3.4
IUD	1.0	2.9	1.9
Female sterilization	4.9	10.0	7.2
Male sterilization		0.5	0.2
Withdrawal	1.2	5.6	3.2
Rhythm	1.0		0.5
Not currently using	86.6	64.0	76.6
Number	509	408	917

Source of Contraceptive Supplies

Respondents were then asked where they last obtained their contraceptive method supply. Table 6.4 indicates the most popular sources of contraceptives in urban and rural Sukkur. Interestingly, DHQ/THQs were the most popular source of contraception in rural areas, while private hospitals and clinics were most frequented in urban areas. In urban areas, 23 percent of the women obtained their contraception from medical stores, a trend which was not mirrored in rural areas where only 8.8 percent obtained contraception from medical stores. Just over 5 percent of the rural women did not know where they obtained their contraceptives from whereas the figure was 1.6 percent for urban respondents.

Table 6.3: Source/place where got FP method last time by place of residence

Source/Place	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
LHW	1.8	1	4.8	6	3.9	7
BHU/RHC/MCH center	3.5	2	4.8	6	4.4	8
DHQ/THQ	43.9	25	21.0	26	28.2	51
Private clinic/hospital	24.6	14	34.7	43	31.5	57
Nurse/LHV	3.5	2	0.8	1	1.7	3
FWC/RHSA			0.8	1	0.6	1
Medical store	8.8	5	23.4	29	18.8	34
General store/shop	1.8	1	4.8	6	3.9	7
Others	7.0	4	3.2	4	4.4	8
Don't know	5.3	3	1.6	2	2.8	5
Total	100.0	57	100.0	124	100.0	181

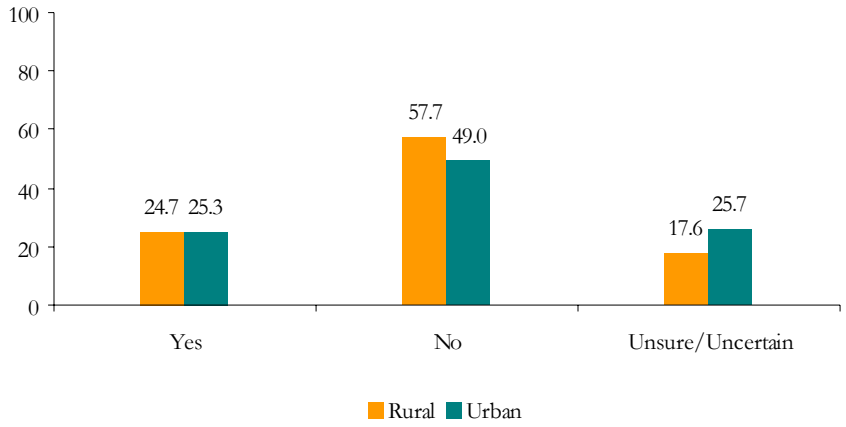
Interestingly, LHWs were not a common source of contraception in rural areas; however, 4.8 percent of the women in urban areas indicated that they obtained their contraception through LHWs.

Intentions of Future Use

When the non-users of family planning were asked if they would like to use family planning methods in the future, the answers obtained were quite interesting. A quarter (24.7 percent in rural and 25.3 percent in urban areas) of the women in both urban and rural Sukkur indicated that they would like to use contraception in the future. However, a very large percentage of the urban and rural non-users (49 percent and 57.7 percent respectively) indicated that they do not want to use any contraception or family planning methods.

It is often assumed that rural communities are more conservative and therefore would be more hesitant to use contraceptive methods; while urban women tend to be better educated and therefore are willing to adopt means of contraception. However, this does not seem to be the case here as the figures for urban and rural areas are very similar.

Figure 6.3: Percentage of married women by future intention to use contraceptives



Along with the portion of the women that did not want to use contraception, a large number of people were also uncertain as to whether or not they wanted to try family planning methods.

Chapter 7

Behavior Regarding Maternal and Newborn Health

Many of the women who were interviewed were pregnant at the time of the survey. However, some women, especially those in the early stages of pregnancy, had not yet experienced the full range of events that take place over the nine-month gestational period. Women who had recently given birth were able to provide a full range of information on these events and thus constitute an important part of the sample population in terms of understanding attitudes and behaviors concerning maternal and newborn health. This chapter pertains to the respondents' last pregnancy, given that it was within the past three years. Respondents were asked several questions regarding their experience during their last pregnancy including antenatal and delivery care, complications during pregnancy and delivery, postnatal care, and problems in accessing health care.

Information on antenatal care, delivery services and postnatal care is of great value in identifying segments of married women who do not utilize such services, and it is useful in planning for future improvements in these services. Delivery services are described according to the person assisting and the rate of caesarean section. Information on postnatal care was collected for women who did not give birth in a health facility, and it describes the time since delivery when it was received, as well as the caregiver.

Gestational Age

The respondents were asked to indicate gestational age at the time at which the pregnancy ended. Table 7.1 below shows that from those pregnancies that ended in live births, almost 85 percent of them were completed after nine months. As well, both spontaneous and induced abortions occurred during the first and second trimesters of pregnancy.

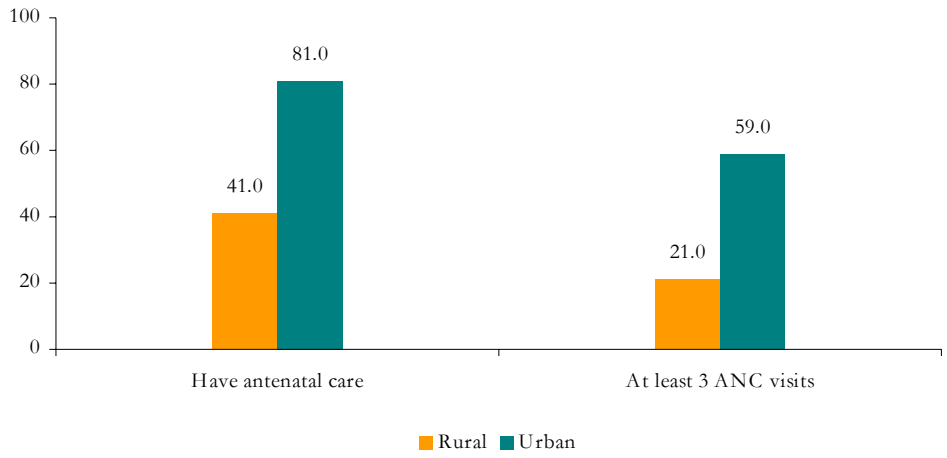
Table 7.1: Pregnancy outcome by gestational age

Gestational Age When Pregnancy Ended	Outcome of last pregnancy			
	Live Birth	Still birth	Spontaneous Abortion	Induced Abortion
First trimester of pregnancy			43.3	66.7
Second trimester of pregnancy		5.6	53.3	33.3
7	0.2	5.6	3.3	
8	1.0	16.7		
9	85.5	61.1		
10	13.1	11.1		
11	0.2	0.0		
Total	100	100	100	100
Total Pregnancies	489	18	30	6

Antenatal Care

In the baseline survey, antenatal care was defined according to the type of provider, the number of visits made and the stage of pregnancy at the time of the first visit, including whether tetanus toxoid injections and iron/folate tablets were received. The baseline survey also included questions regarding the antenatal care received by the respondent during the last pregnancy. The results obtained were very different for urban and rural areas.

Figure 7.1: *Percentage of pregnant women by their antenatal care status for the pregnancy three years preceding the survey*



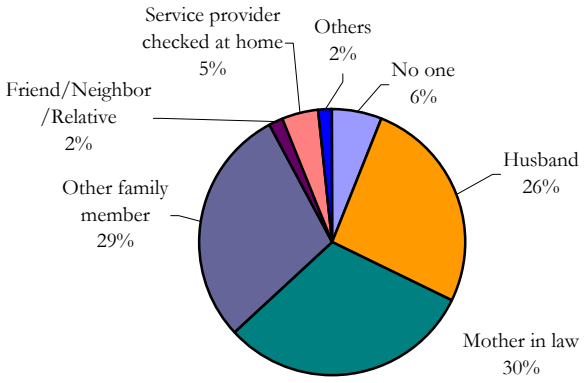
In rural areas, only 41 percent of the women indicated that they obtained antenatal care during their past pregnancy, whereas in urban areas 81 percent of the women claimed to have received antenatal care. Figure 7.1 shows that only 21 percent of pregnant women in rural Sukkur and 59 percent of the urban Sukkur reported having 3 or more ANC visits during their last pregnancy.

According to table 7.2, for those who sought antenatal care services, nearly 43 percent went in their first trimester, 27 percent went in their second trimester, while 24 percent obtained antenatal care in their third trimester. Figure 7.2 below indicates that from the proportion of women who went for antenatal check-ups, 42 percent were accompanied by their husbands, 24 percent were accompanied by a family member, and 23 percent went with their mother-in-law. About 4 percent went unaccompanied, whereas 1 percent indicated that they received antenatal checkups at home.

Table 7.2: Antenatal check-ups by place of residence

Check-ups		Rural		Urban		Total	
		Percent	Number	Percent	Number	Percent	Number
Gestational age of pregnancy at first antenatal care	0			0.7	1	0.3	1
	1	4.8	7	19.7	29	12.2	36
	2	4.8	7	15.0	22	9.9	29
	3	19.0	28	23.1	34	21.1	62
	4	10.9	16	12.2	18	11.6	34
	5	15.0	22	6.8	10	10.9	32
	6	4.8	7	3.4	5	4.1	12
	7	11.6	17	7.5	11	9.5	28
	8	10.9	16	4.8	7	7.8	23
	9	9.5	14	3.4	5	6.5	19
	10	2.0	3			1.0	3
	Don't know	6.8	10	3.4	5	5.1	15
Number of antenatal check-ups during pregnancy	1	18.4	27	13.6	20	16.0	47
	2	21.8	32	12.2	18	17.0	50
	3	11.6	17	10.2	15	10.9	32
	4	10.9	16	12.9	19	11.9	35
	5	7.5	11	5.4	8	6.5	19
	6	6.1	9	10.2	15	8.2	24
	7	2.0	3	4.8	7	3.4	10
	8	4.1	6	8.2	12	6.1	18
	9	6.2	9	19.1	28	12.5	37
	Don't know	11.6	17	3.4	5	7.5	22
Total		100.0	147	100.0	147	100.0	294

Figure 7.2: Percentage distribution of married women by persons who accompanied for ANC to the health service delivery



Components of Antenatal Care

In Pakistan, it is recommended that every pregnant woman receive the following services: height and weight measurements, blood pressure measurement, iron tablets, tetanus toxoid immunization, and an abdominal examination. In any antenatal care visit, a woman should be informed of the danger signs of pregnancy, have her weight measured, and provide blood and urine samples for testing. Antenatal care can improve certain outcomes through the detection and management of possible complications. Antenatal care can also prevent, identify and treat iron deficiency and anemia in pregnant mother, and improve the birth weight of the newborn.

Figure 7.3 presents an outline of the services performed at the antenatal check-ups received by respondents. The figures were almost always consistently lower for women in rural areas, as a higher percentage of urban women received more complete and thorough check-ups. In urban areas, blood and urine tests were performed on 73 percent and 65 percent of the women respectively. However, in rural areas only 38 percent had their urine tested and only about 42 percent had blood tests done. As well, only 30 percent of the rural respondents indicated that they were weighed during their antenatal check-up, while 60 percent of the urban women were weighed. However, 57 percent of the women in rural areas had their blood pressure measured, while only 5 percent of the urban women received the same service during their antenatal check-up.

Figure 7.3: Services performed/asked during antenatal check-up by place of residence

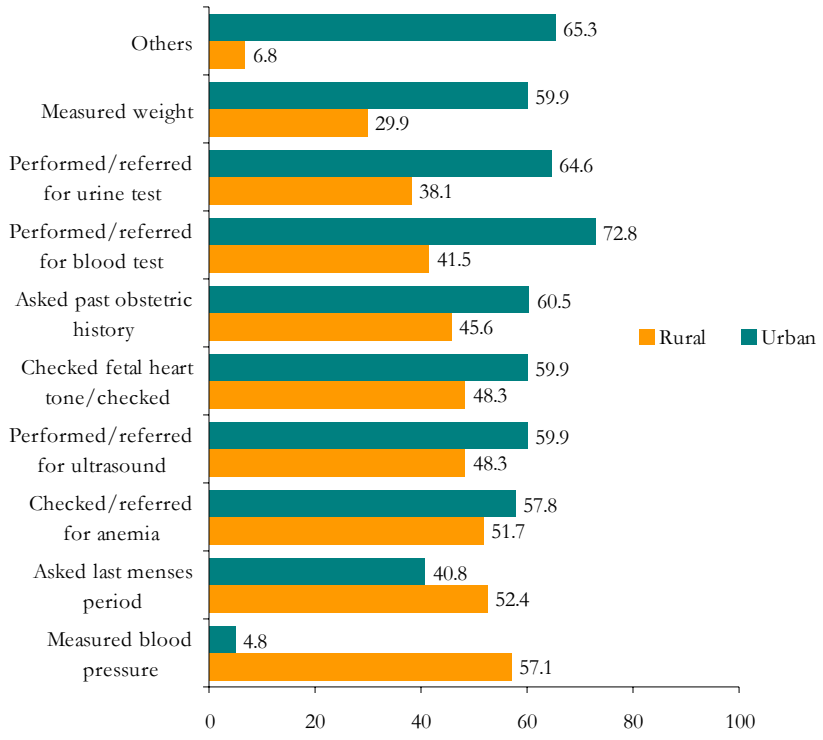
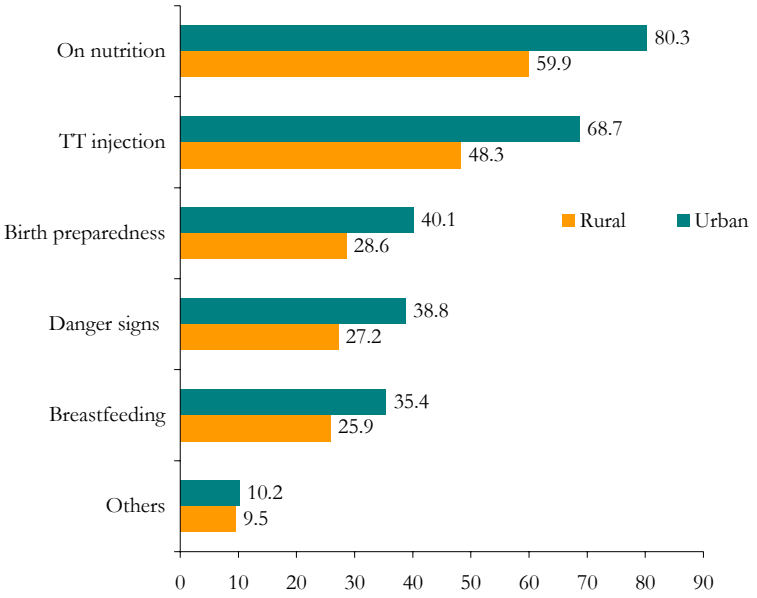


Figure 7.4 appears to indicate that while the important topics were discussed with respondents during their antenatal visits; the proportion of women with whom these topics were discussed was not very high. More than 80 percent of the respondents in urban areas indicated that their health provider discussed nutrition with them during their check-up while only 60 percent of the urban women said the same thing. Furthermore, only 48 percent of the rural women were informed about the necessity of TT shots and only 28 percent were told about the importance of birth preparedness. Worse still, only 27 percent of the rural women and 39 percent of the urban women were educated to recognize danger signs during pregnancy.

Figure 7.4: Percentage of pregnant women by issues discussed during antenatal check-up and place of residence



TT Injections and Iron/Folate Tablets

Respondents were also asked to state whether they took iron and folate supplements and received TT shots during the last pregnancy. In Pakistan, the immunization of pregnant women is enforced by a program coordinated by the Expanded Program on Immunization (EPI) and the Maternal and Child Health Care (MCH) departments at the district level. The program recommends that women receive two tetanus toxoid (TT) injections during their first pregnancy. Booster injections are given once during each subsequent pregnancy to maintain full protection. In recent years, TT immunization has also been given to women before marriage, so that any pregnancy occurring within three years of their marriage would be protected against tetanus.

Figure 7.5 indicates the number of women who received TT shots during their last pregnancy. The figures for both rural and urban Sukkur were surprisingly low. A little over half (51.6 percent) the women in urban areas 39 percent of the women in rural areas had received only at least one TT shot during their last pregnancy. However, more than 43 percent in urban and 22 percent in rural areas pregnant women received 2 or more TT shots. Figure 7.5 also shows that 62 percent of the rural women and 38 percent of the urban women had not received any TT shots to protect them against infections and diseases during pregnancy.

Figure 7.5: Percentage of married women by status of TT injections during the last pregnancy and place of residence

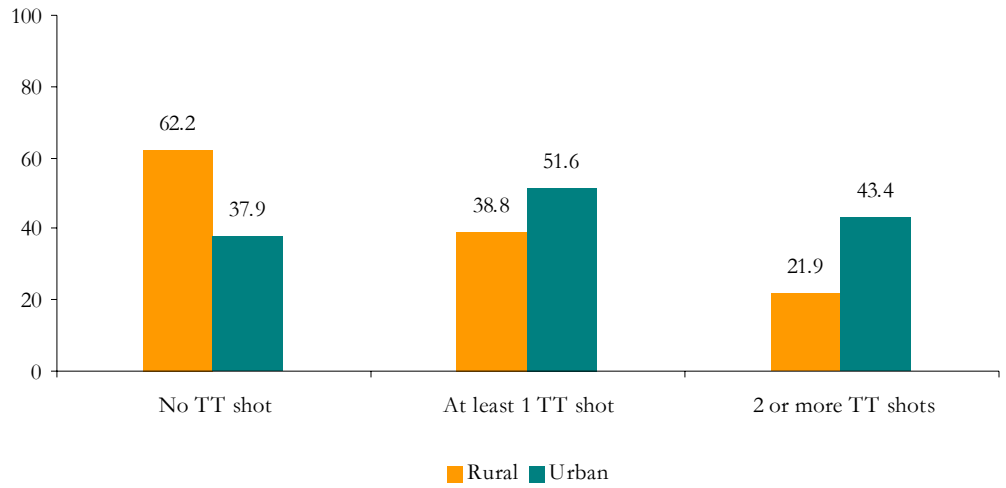
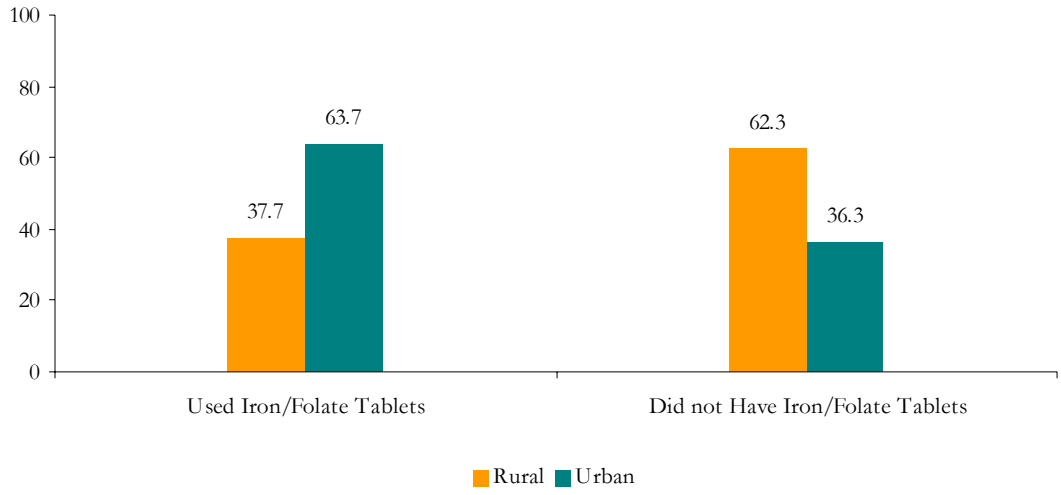


Figure 7.6 depicts the proportion of women who took iron/folate supplements during their most recent pregnancy. Again, the figures for both urban and rural areas were not impressive. Less than two thirds (64 percent) of the urban women indicated that they used iron/folate tablets, while only 38 percent stated the same in rural Sukkur. This leaves a large percentage of women who did not take any iron/folate supplements during pregnancy to protect them against anemia and other potentially harmful deficiencies.

Figure 7.6: Percentage of married women by status of iron/folate tablets during the last pregnancy and place of residence



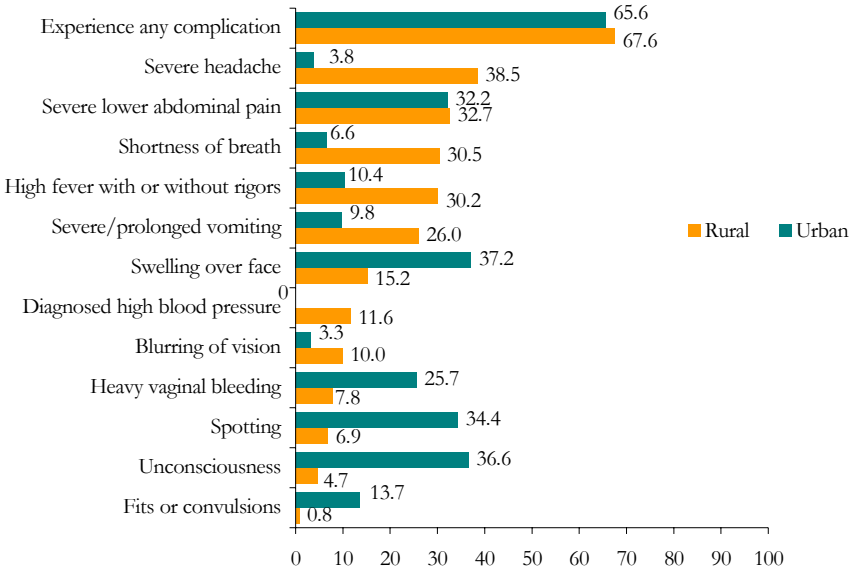
Women may not have the decision-making power to obtain these supplements and vaccinations and may be dependent upon husbands or family members/in-laws to make these important decisions for them.

Experience of Complications and Birth Preparedness

Complications During Pregnancy

To identify complications associated with pregnancy, women were asked about certain signs and symptoms that they had experienced in association with their last pregnancy during the past three years. Over 65 percent of both urban and rural married women indicated that they did in fact experience some type of complications during pregnancy.

Figure 7.7: Percentage of married women who experienced complications during their last pregnancy



Interestingly, according to the data presented in figure 7.7, the pattern of complications during pregnancy is quite different among rural and urban women. Swelling of the face (37.2), unconsciousness (36.6), spotting (34.4), heavy vaginal bleeding (25.7 percent), and fits or convulsions (13.7 percent) were the complications that urban women experienced more than their rural counterparts. However, in rural areas, severe headache (38.5 percent), shortness of breath (30.5 percent), high fever (30.2 percent), and prolonged vomiting (26 percent) were the more reported complications during pregnancy. Severe lower abdominal pain was reported by 32 percent of the women in both rural and urban Sukkur.

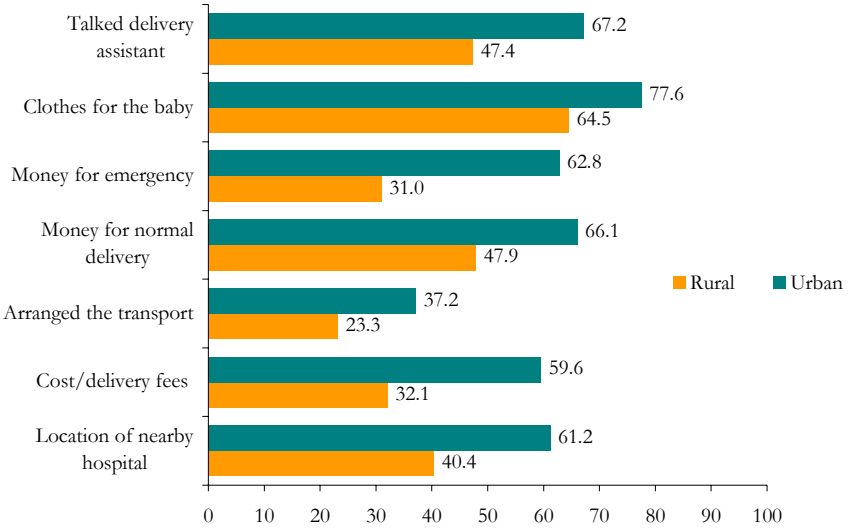
Preparedness for Childbirth

To ensure the safety of the mother and newborn at the time of delivery, certain preparations need to be made. These include deciding who is going to assist in the delivery, where the delivery is going to take place, how the woman is going to get to this place, and how much the delivery is going to cost. Delivery services, especially emergency obstetric care, are critical for pregnant women. Emergency care is important if pregnant mother experience obstructed labor, pregnancy-induced hypertension, eclampsia or severe untreated anemia. Obstructed or prolonged labor is one of the more serious complications that can cause maternal death and morbidity. Obstetric care can also prevent or treat complications that affect the neonate, such as birth asphyxia.

In the survey, women were asked whether they had discussed any of these specific topics during pregnancy. The questions asked assessed the arrangements that were made for the time of delivery, the removal of various delays, which may affect the health of both mother and baby. Respondents were asked if they had made necessary arrangements regarding transport, money, blood, location and hours of operation of the nearest hospital, as well as clothes for the newborn baby.

According to figure 7.8, a very large percentage of women appeared to have made all the necessary arrangements for the time of delivery. Most respondents claimed that they had arranged for transport, money, and hospital fees etc. prior to the time of delivery, therefore eradicating any major delays.

Figure 7.8: Percentage of married women who made arrangements for their last delivery by place of resident



A large portion of the women in urban areas indicated that they had prepared clothes for the baby (77.6 percent), arranged for money for a normal delivery (66 percent), talked to a health provider (67 percent), located a nearby hospital (61.2 percent), arranged for any extra costs and fees (59.6 percent) and arranged for money in the case of an emergency (62.8 percent). However, transport was something that had not been arranged for by a large portion of the urban women. Only 37 percent of the women stated that they had arranged for adequate transport at the time of delivery. The situation in rural Sukkur was even worse. While 65 percent of the women had prepared clothes for the

newborn baby, under 48 percent had arranged for money for a normal delivery, and only 31 percent had arranged for money in the case of an emergency. Only 40 percent had identified a nearby hospital, 47 percent had talked to a health provider, and under a quarter (23.3 percent) had arranged for transport at the time of delivery.

Delivery Characteristics

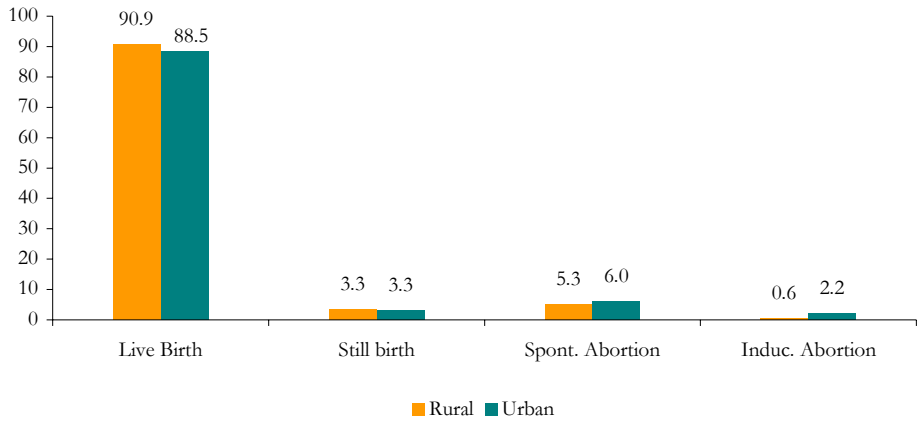
Respondents were asked to indicate the status of their last delivery. In rural areas, 89 percent had normal vaginal deliveries, while in urban areas the figure was 75.8 percent. About 11 percent of the urban women had Caesarean section deliveries, while only 3.3 percent in rural areas reported having delivered that way. Just over 5 percent of the rural women indicated that their pregnancies ended in a spontaneous abortion, while nearly 8 percent of the respondents in urban areas indicated the same thing. The percentages for induced abortions were very low, sitting at under 1 percent for both urban and rural areas.

Table 7.3: Status of last delivery by place of residence

Status	Rural		Urban		Total	
	Percent	Number	Percent	Number	Percent	Number
Normal vaginal delivery	89.2	322	75.8	138	84.7	460
Assisted vaginal delivery	1.7	6	4.9	9	2.8	15
Caesarean section	3.3	12	11.0	20	5.9	32
Spontaneous abortion	5.3	19	7.7	14	6.1	33
Induced abortion	0.6	2	0.5	1	0.6	3
Total	100.0	361	100.0	182	100.0	543

Furthermore, according to figure 7.9, 91 percent of the pregnancies in rural Sukkur resulted in live births, while 88.5 percent of the pregnancies in urban Sukkur yielded live births. Stillbirths accounted for 3.3 percent of the pregnancies in both urban and rural Sukkur.

Figure 7.9: Percentage of pregnancies by outcome and place of residence

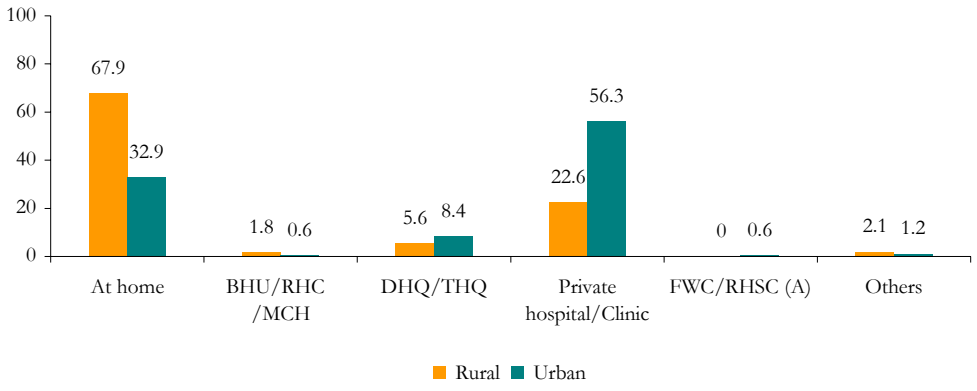


Place of delivery

When asked to state where their delivery took place, an overwhelming majority of respondents in rural areas (68 percent) indicated that they delivered at home. One-third (32.9 percent) of the urban respondents also delivered at home.

Private hospitals and clinics were also popular choices in both urban and rural areas (56.3 percent and 22.6 percent respectively) when it came to place of delivery.

Figure 7.10: Percentage of women by place of delivery

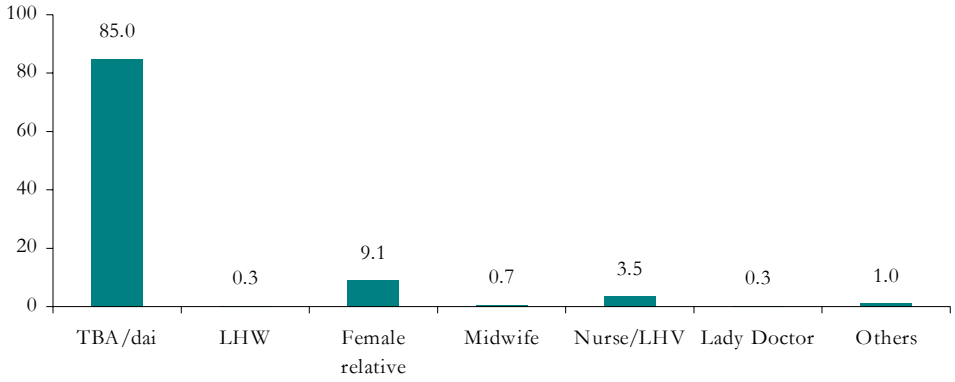


Financial constraints may be the leading cause which forces some women to deliver at home, in spite of their desire to deliver their babies at a health facility. Also, women may not be allowed to deliver at a health facility by their husbands, in-laws or family members.

Assistance during Delivery

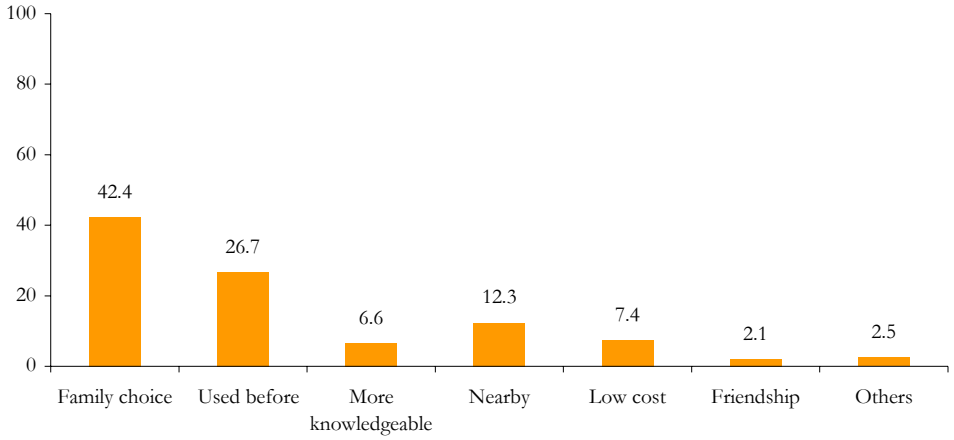
According to figure 7.11, 85 percent of the women in Sukkur had the assistance of a TBA/Dai during their last delivery. As mentioned previously, TBAs/Dais may have a lot of experience dealing with deliveries, but often have no formal training. Therefore, this data indicates that 85 percent of all deliveries in the district of Sukkur are performed not by health professionals, but by women with no medical knowledge. This jeopardizes the lives of both mothers and newborns. Female relatives (9.1 percent) were the next most popular choice of person to assist with a delivery. Once again, this suggests that women who have no formal training or experience when it comes to childbirth assist 10 percent of the deliveries in Sukkur. Nurses/LHVs assisted 3.5 percent of all deliveries, while Lady Doctors only assisted with 0.3 percent of the total deliveries in the district of Sukkur.

Figure 7.11: Percentage of married women who delivered their last child at home by type of delivery attendant



About 42 percent of the respondents cited family choice as the reason for choosing a TBA/Dai to assist with the delivery. Meanwhile, 26.7 percent indicated that the TBA/Dai had assisted with a previous delivery, while 12 percent indicated that a TBA/Dai was chosen due to geographical reasons. Low cost was another major reason for 7.4 percent of the women and 6.6 percent of the respondents believed that TBAs/Dais were more knowledgeable.

Figure 7.12: Percentage of married women by reported main reason to choose a Dai as delivery attendant



Clean Delivery Practices

Respondents were asked to state if the TBA who assisted with the delivery followed safe health practices such as washing their hands with soap prior to deliveries and using clean delivery kits. Over 80 percent in both urban and rural Sukkur indicated that the TBA who assisted with the delivery did wash her hands prior to delivering the baby. About 4 percent in rural areas indicated that their TBA did not wash her hands prior to delivery while nearly 2 percent of the urban women stated the same thing. A sizable portion of the women in both urban and rural areas (18.2 percent and 13.9 percent respectively) did not know if their TBA washed her hands or not.

Figure 7.13: Percentage of delivery attendants who reported washed hands before conducting the delivery

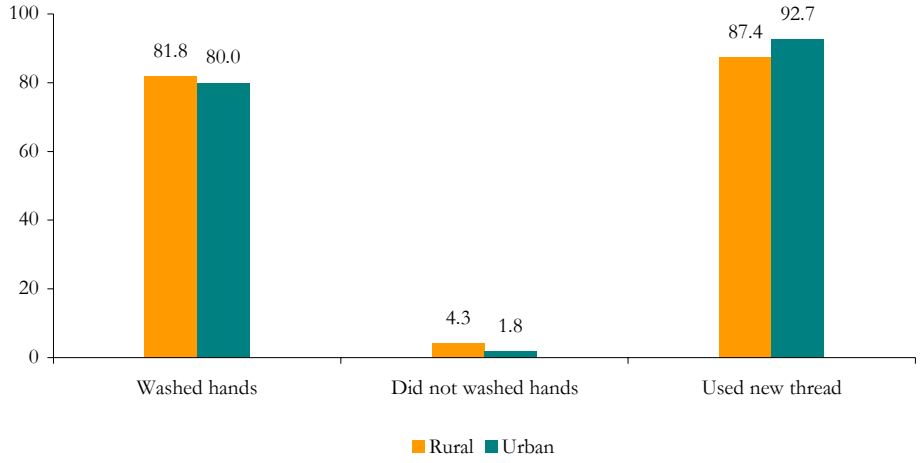
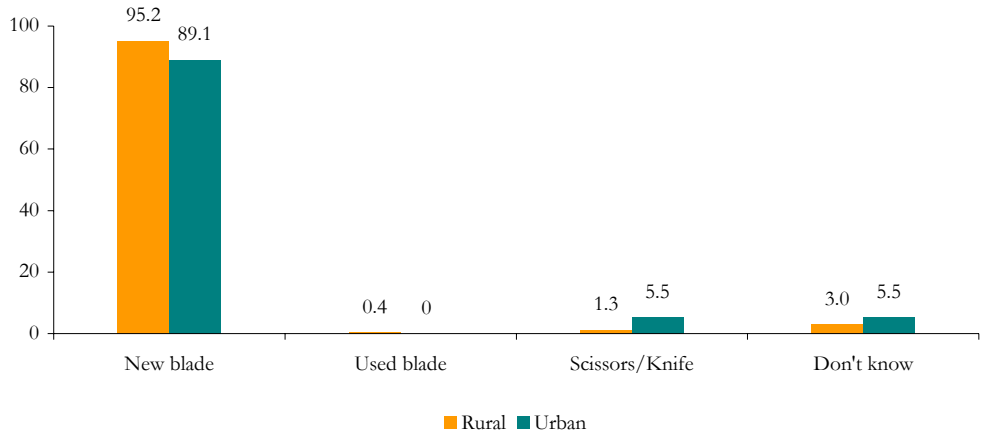


Figure 7.14: Percentage of delivery attendants who reported instruments for cutting the cord



As seen in figure 7.14, a large percentage of the urban and rural women indicated that a new blade was used to cut the cord of the newborn baby after delivery.

Complications During Childbirth

During the baseline survey, severe complications during childbirth were also discussed, and respondents were asked to indicate the complications they may have experienced. The highest proportion in urban and rural areas reported excruciating abnormal pain as being the complication experienced most during childbirth (20.2 percent and 21.1 percent respectively). Excessive postpartum bleeding (6.9 percent in rural areas and 8.2 percent in urban areas), prolonged/obstructed labor (14.7 percent in rural areas and 12 percent in urban areas), and fever (16 percent in rural areas and 10.9 percent in urban areas) were also widely reported complications.

Table 7.4: Experienced complication during last delivery by place of residence

Complications	Rural	Urban	Total	
			Percentage	Number
Prolonged/obstructed labor	14.7	12.0	13.8	75
Bleeding before labor began	5.8	6.6	6.1	33
Excruciating abnormal pain	21.1	20.2	20.8	113
Premature rupture of membranes	7.2	6.6	7.0	38
Delay in delivery of placenta/retained placenta	2.8	1.1	2.2	12
Excessively postpartum bleeding on day of deli./abort.	6.9	8.2	7.4	40
Tear in vagina, cervix or uterus	5.3	7.1	5.9	32
Prolapsed of the uterus	3.6	6.6	4.6	25
Fever	16.1	10.9	14.3	78
Abnormal position fetus	5.8	6.6	6.1	33

Decision-making Within Family

Delays in seeking care, in reaching adequate health facilities and in receiving appropriate care at health facilities are recognized barriers to care for pregnant women, and these factors may be especially pronounced for young and old pregnant mothers. Timely and appropriate care provides an opportunity to prevent or manage the direct causes of maternal mortality such as hemorrhaging, obstructed labor, infection and hypertensive disorders. It also reduces fetal and neonatal deaths related to obstetric complications. Table 7.5 indicates that only 15.3 percent of the respondents in rural areas were able to decide when to seek emergency obstetric care after facing complications during delivery. About 56 percent of the respondents indicated that their husbands were the ones who decided when to seek emergency obstetric care. In urban areas, the situation was slightly better. Nearly 43 percent of the respondents indicated that they were able to determine for themselves when to seek care in the event that a complication was experienced. However, even in urban Sukkur, 36 percent of the respondents relied on their husbands to make that decision for them.

Availability of Transport

The mode of transport to a health facility was also an issue that was discussed during the survey. Table 7.5 also outlines the mode of transport used to reach a health care facility. The largest proportion of the women in rural and urban areas (62.2 percent and 71.4 percent respectively) indicated that they used private transport to reach a health facility, while under 10 percent in rural areas and under 20 percent in urban areas had their own transport. While private transport is a better option than community transport or walking to a health care facility, it is not very reliable and may cause delays that jeopardize the health of both mother and child.

Table 7.5: Measures taken to address complications by place of residence

Measures taken		Rural		Urban		Total	
		Percent	Number	Percent	Number	Percent	Number
Person who made decision to seek health care	Self	15.3	15	42.9	24	25.3	39
	Husband	56.1	55	35.7	20	48.7	75
	Mother in law	11.2	11	10.7	6	11.0	17
	Other family member	14.3	14	10.7	6	13.0	20
	TBA/Dai	3.1	3			1.9	3
Mode of transport to reach health care service	Service provider visited at home	17.3	17	1.8	1	11.7	18
	On foot	2.0	2	3.6	2	2.6	4
	Own transport	9.2	9	17.9	10	12.3	19
	Private transport	62.2	61	71.4	40	65.6	101
	Community Transport	6.1	6	5.4	3	5.8	9
	Others	3.1	3			1.9	3
Total		100.0	98	100.0	56	100.0	154

More than a quarter of the pregnant women were able to reach a health facility within 15 minutes, while the same proportion reached the facility within 16-30 minutes. About 16 percent of the respondents reportedly took one to two hours to reach a health facily. Figure 7.15 shows the distribution of respondents by the time they took to reach a health facility. It shows that 6 percent of the pregnant women reached the facility after a drive of more than two hours.

Figure: 7.15: Time taken to reach the health facility for childbirth

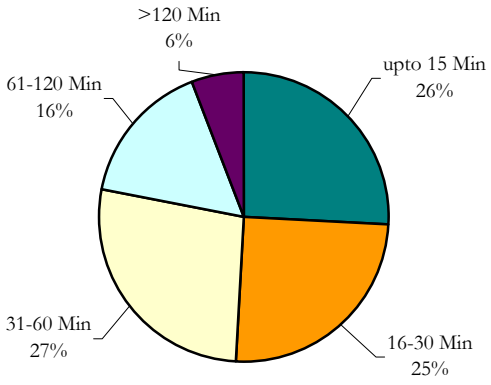
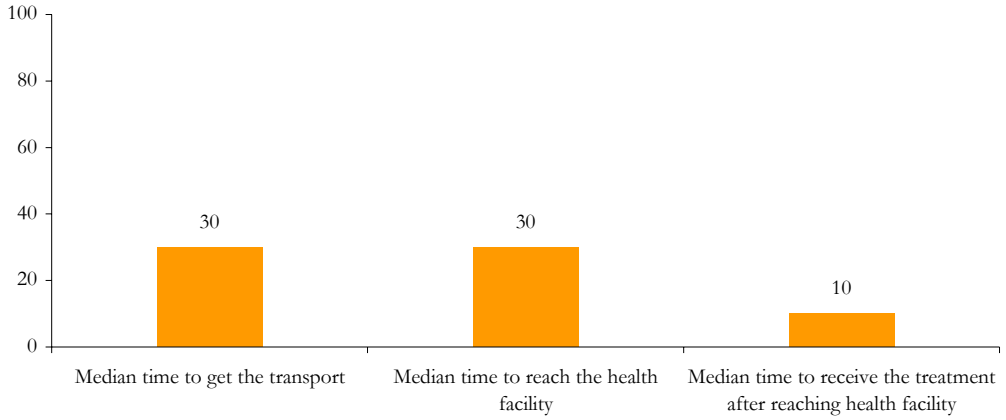


Figure 7.16 shows the median time to get the transport, to reach the health facility and to obtain the treatment after reaching the facility. It shows that in Jhelum, it takes only 30 minutes to find a mode of transport for the pregnant women for hospital. On average it took 30 minutes to travel to reach the health facility. Another 10 minutes were the waiting time to obtain the delivery services in Sukkur.

Figure 7.16: Average median time to get the transport, to reach the health facility and to obtain the treatment after reaching the facility



Postpartum Care

The postpartum period is a critical time for both mother and newborn. Respondents were asked about the quality and level of postpartum care they received after their last delivery. Surprisingly, a large portion of the women failed to received postpartum care. About 73.5 percent of the women in rural Sukkur indicated that they did not receive any postpartum check-ups, while 43 percent in urban areas indicated the same thing.

Table 7.6: History of postpartum care by place of residence

History		Rural		Urban		Total	
		Percent	Number	Percent	Number	Percent	Number
Have postnatal check-ups	Yes	8.2	28	9.6	16	8.7	44
	No	73.5	250	43.1	72	63.5	322
	Delivered in hospital	18.2	62	47.3	79	27.8	141
No. of days after delivery, have first check-up	Same day	32.1	9	12.5	2	25.0	11
Experience complications during postpartum period	Yes	32.7	118	33.5	61	33.0	179
	No	67.3	243	66.5	121	67.0	364
Total		100.0	361	100.0	182	100.0	543

Newborn/Infant Care

The care provided to a newborn upon birth is crucial to the baby's health. Survey questions regarding initial infant and childcare help determine the cause of newborn morbidity and mortality.

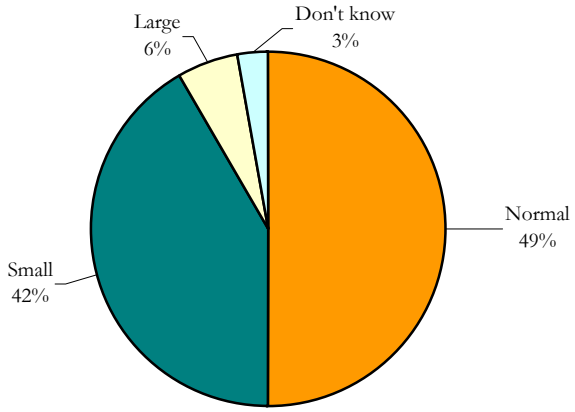
Child Care during Birth

Respondents were asked where their child was placed immediately after delivery. While most newborns in urban and rural areas were placed with their mothers immediately after delivery, a large portion were either placed on a piece of cloth or on a mattress. It is very important to record the percentage of women following harmful or unhealthy procedures in order to understand the root causes of infant mortality.

As well, respondents were asked if their newborn babies were dried and cleaned before being given a bath. Approximately 95 percent in both urban and rural areas indicated that their newborns were in fact dried and cleaned prior to their first bath. The remaining indicated that they were unsure if this was done.

It is not very common to weigh a newborn in a district where most of the births take place at home. For those women who did not weigh their newborns, a question was asked about the size of the baby at the time of birth. Figure 7.17 depicts the percentage distribution of babies by their size at birth. Less than half (49 percent) of the mothers reported that the size of their babies at the time of birth was normal. A large percentage of (42 percent) reported that their baby was smaller than average, and 6 percent reported that their baby was bigger than average.

Figure 7.17: Percentage of live births by their size (small, normal and big) at birth



A question on the practice of bathing babies after birth was also asked, and figure 7.18 shows the responses obtained. It shows that almost two-third (65 percent) of the babies were given a bath within the first hours after the birth. Only 22 percent of the babies were given a bath after the recommended time of 6 hours.

Figure 7.18: Percentage of babies by time of given bath after birth

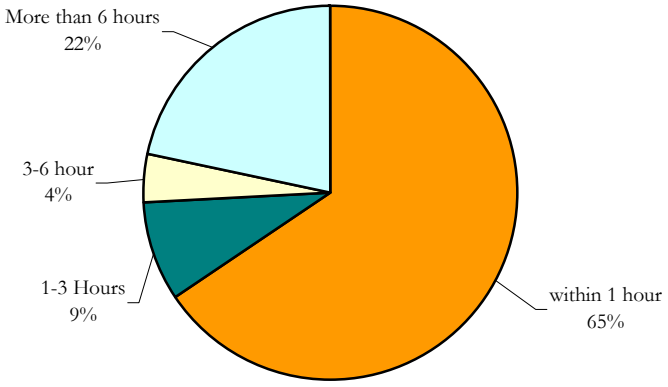


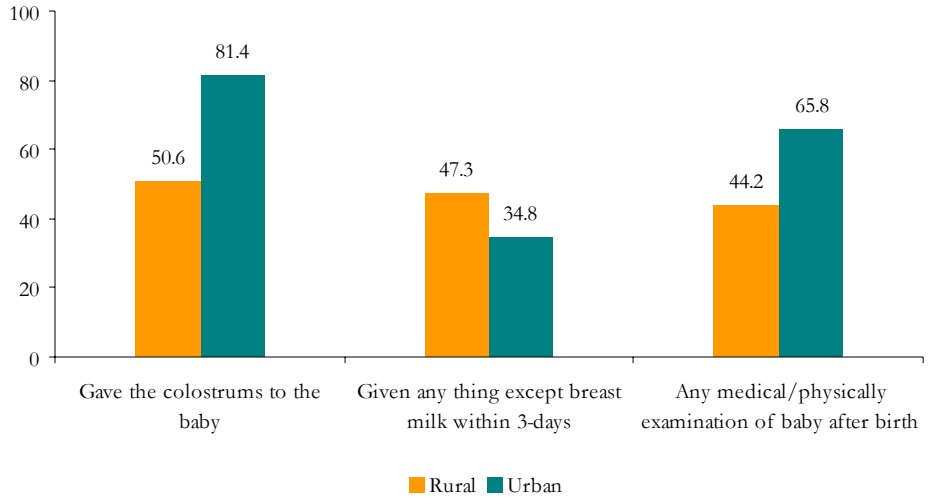
Table 7.7: History of last childcare by place of residence

History		Rural		Urban		Total	
		Percent	Number	Percent	Number	Percent	Number
Placed child immediately after delivery	On floor	7.9	26	2.5	4	6.1	30
	On mattress	11.9	39	16.8	27	13.5	66
	On a piece of cloth	26.8	88	13.0	21	22.3	109
	Put with the mother	47.3	155	54.7	88	49.7	243
	Others	1.8	6	2.5	4	2.0	10
	Don't know	4.3	14	10.6	17	6.3	31
Child dried up/cleaned before giving bath	Yes	94.5	310	95.0	153	94.7	463
	No	0.6	2			0.4	2
	Don't know	4.9	16	5.0	8	4.9	24

Colostrum and Breastfeeding

Respondents were also asked if they ever breastfed their infants. Colostrum is a very important aspect of newborn health, and respondents were asked if they gave colostrum to their newborn babies. More than half (50.6 percent) of the rural women stated that they did give colostrum to their newborns, whereas 81.4 percent of the women in urban areas stated the same thing.

Figure 7.19: Newborn feeding and health indicators



Respondents were also asked if the newborn was given anything aside from breast milk within the first three days of its birth. Figure 7.19 shows that about 47 percent of the rural respondents and 35 percent of the urban respondents indicated that they did feed their newborn something other than breast milk. Finally, and perhaps most surprisingly, only 44 percent of the rural women and 65.8 percent of the urban women had their newborn physically and medically examined after birth. Not having physical and medical examinations conducted after birth may potentially result in complications being left undetected, which in turn could be harmful to the health of a newborn. Respondents were asked to recall any complications or symptoms they noted in their newborn soon after delivery.

Newborn Medical Check-ups

Respondents were asked to state if they noted any danger signs/symptoms in their newborn babies. Difficulty breathing, weak cries, fever, and inability to suckle were amongst the most reported danger signs.

Figure 7.20: Percent of newborns with appeared signs/symptoms soon after deliver by place of residence

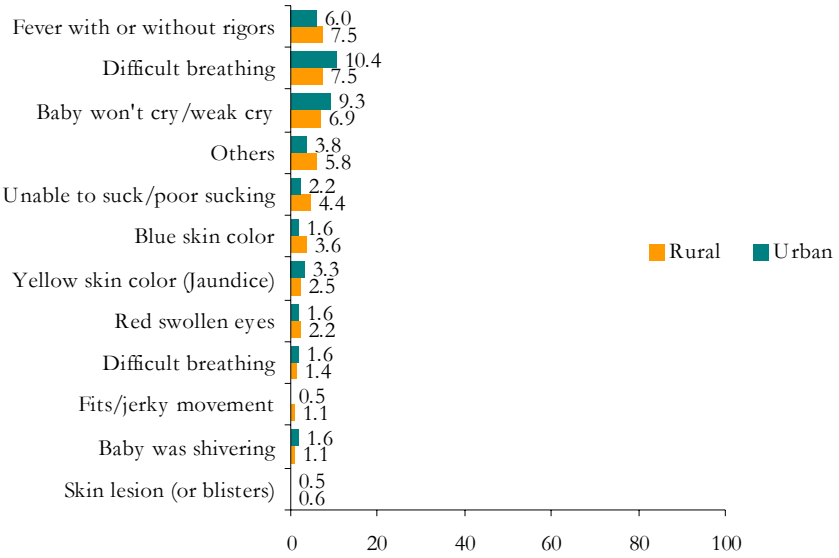
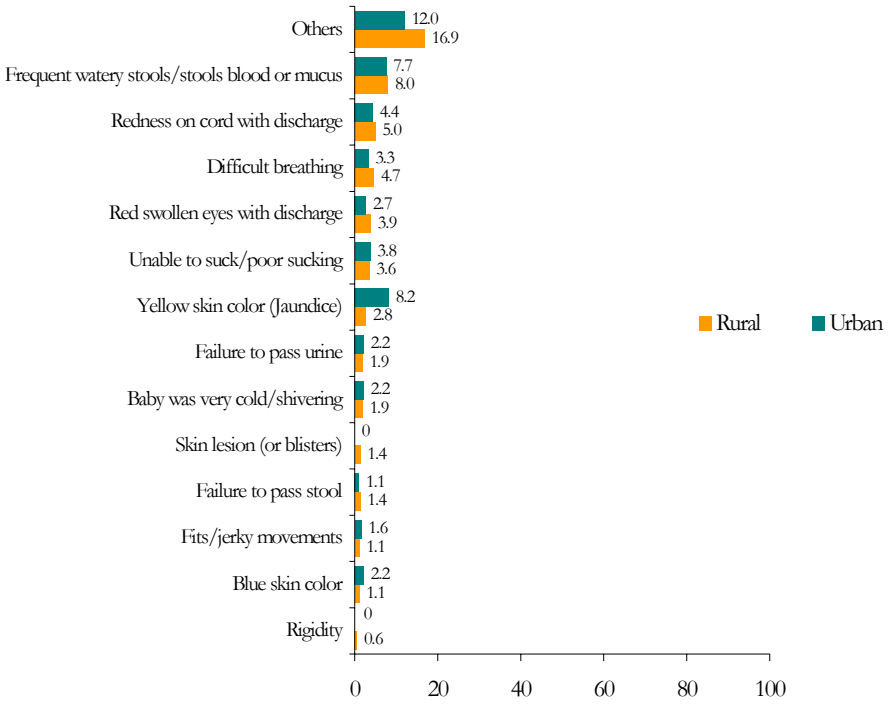


Figure 7.21: Percent of newborns with appeared signs/symptoms within 7-days after last delivery by place of residence



As well, respondents were asked to report any danger signs which appeared in their newborns seven days after delivery. Frequent watery stools, redness of cord and yellow skin color (jaundice) were the most widely reported complications.

Finally, respondents were asked to indicate the measures they took to get their newborn treated once the symptoms mentioned above were noted. While the largest percent of respondents in both urban and rural areas sought treatment at private clinics/hospitals (76 percent and 57 percent respectively), a sizable portion of the women (17 percent in rural areas and 10 percent in urban areas) sought no treatment whatsoever. This may be due to a lack of the financial resources required to seek assistance, or due to a lack of education, which would result in families failing to realize the magnitude of such complications, especially within the first seven days of birth.

Figure 7.22: Percentage of newborn with measures taken to have complications treated by place of residence

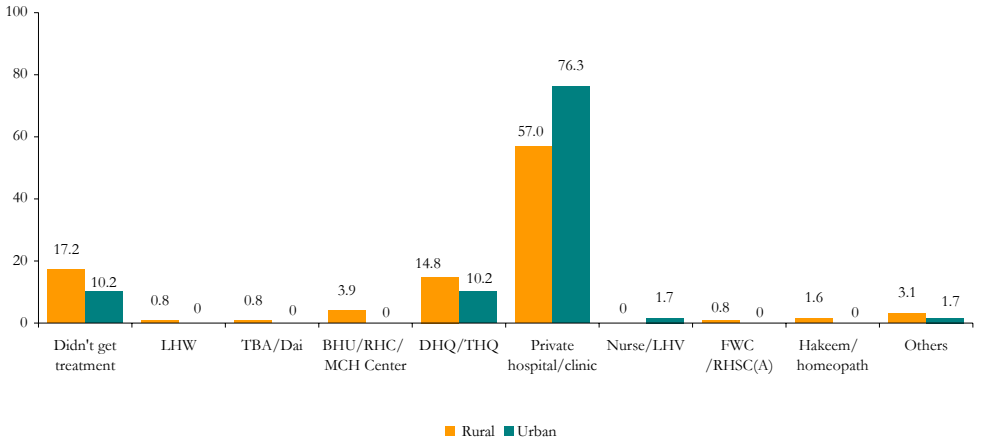
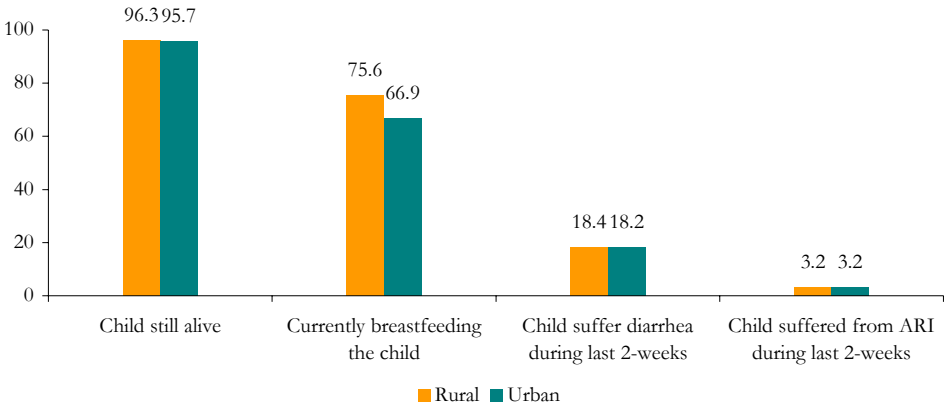


Figure 7.23: Status of last live birth by place of residence



Finally, respondents were asked to indicate the status of the health of their last child. Over 95 percent of the respondents in both urban and rural Sukkur indicated that their child was still alive, while 76 percent in rural areas and 67 percent in urban areas stated that they were still breastfeeding their children. When asked if their children suffered from diarrhea within the past two weeks, 18 percent in both urban and rural Sukkur answered in the affirmative. Similarly, 3.2 percent of the total respondents stated that their children had suffered from ARI during the past two weeks.

Chapter 8

Conclusions

The baseline household survey conducted in Sukkur is an essential tool in the process of understanding the different attitudes towards and misconceptions regarding pregnancy and neonatal care. Since PAIMAN is intended to improve the health of all pregnant women as well as their newborn children, it is important to understand the obstacles that stand in the way of good health. Since the baseline survey is based largely on the opinions and experiences of married women of reproductive age (MWRA), the information obtained is from the very individuals who are to be the primary recipients of the work carried out through PAIMAN.

Findings of the baseline show that more than half of the women in the district of Sukkur have access to some sort of media (59 percent); whether it is television, radio or newspapers. While it may seem relatively easy to reach this large portion of the women through one of the three main media channels, there are some obstacles that stand in the way including the lack of decision-making power for women and the infrequency of access to the media. As well, the approximately 41 percent of the women without access to any sort of media must also be reached. Even though television and radio were reported to have about the same level of influence on the health behaviors of people, a majority of the women interviewed in both urban and rural areas believed that television was the most trustworthy form of media.

With regards to antenatal care, an overwhelming majority believe it necessary for women to receive antenatal check-ups, while only about 19 percent and 8 percent of the married women in rural and urban areas respectively felt it was not necessary. Findings show that all the major issues were discussed with a majority of the women during their antenatal visits.

Respondents were asked to indicate which complications they believe are dangerous and require medical attention. The findings show that 43.4 percent of the married women in rural areas knew three or more danger signs during pregnancy, compared to 64.7 percent in urban areas.

The baseline findings show that over 38 percent of the married women in rural areas and 51.6 percent in urban centers indicated that they did in fact receive TT shots during their last pregnancy. A very large portion of the rural women (62 percent) and urban women (36 percent) indicated that they took no iron or folate supplements during their pregnancy.
The findings also show that 85 percent of the deliveries in Sukkur are carried out by TBAs/Dais. Not all women are allowed to deliver with the help of health professionals even if they want to. One reason, which explains why some women still want to deliver at home, is that many are not able to make decisions independently. Often, women are dependant upon their husbands or in-laws when it comes to major decisions. However, most of the respondents claimed that they had arranged for

transport, money, and hospital fees etc. prior to the time of delivery, therefore eradicating any major delays.

Overall, 11 percent of the urban respondents had Caesarean section deliveries, while only 3.3 percent in rural areas reported having delivered that way. Caesarean sections are generally performed only for certain medical reasons and for complicated deliveries. Just over 5 percent of the rural women indicated that their pregnancies ended in a spontaneous abortion, while nearly 6 percent of the respondents in urban areas indicated the same thing. The percentages for induced abortions were very low, sitting at under one percent for rural and 2.2 percent for urban areas.

Married women in Sukkur undervalue the importance of postnatal care. Surprisingly, the percentage of those who do not feel postnatal care is necessary is higher for urban centers than rural areas. Furthermore, in both urban and rural areas of Sukkur, most respondents believed that only some women in their area received postnatal care.

As in the case of pregnancy, many women are not aware of the complications that may arise during delivery. It can be very difficult to save a pregnant woman who is unable to recognize danger signs during pregnancy, and therefore unsure of when to seek medical attention. Deliveries can only be made safe if married women are educated regarding the danger signs during the delivery, so that they can decide when to seek treatment. Innovative approaches are therefore needed to make these communities more aware of issues regarding maternal and newborn health.

Although baseline survey findings indicate that even though excessive vaginal bleeding is the most known danger sign during the postpartum period, not all women were aware of this fact. Unfortunately, many women are also unaware of danger signs that may appear in newborns, especially in the first seven days after delivery. The postpartum period is a critical time for mother and newborn. A very large portion of the married women did not receive any postnatal check-ups after their last pregnancy. More than 73 percent of the women in rural areas received no postnatal check-ups, whereas the figure was 43 percent even in urban Sukkur.

Arrangement of transport to a health facility is a major cause of delay and can often lead to maternal and newborn mortality. It is very important to arrange transport ahead of time in order to eliminate that delay. Unfortunately, many households are unable to do so due to a lack of transportation in their communities. Most communities do not have any arrangements made for transport, provision of blood and finances for women at the time of need during delivery. Birth preparedness promotes the arrangement of such aspects.

The various sections of the survey allow for a comprehensive analysis of all areas concerned with maternal and infant health and well-being. The separation of rural and urban areas makes it easier to compare results, and analyze the reasons behind the differences. The indicators obtained will be used to monitor and evaluate the success of the project upon completion.

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