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# Factors Affecting Utilization Of Maternal And Child Health Services: District Swat KPK Pakistan

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***Abstract:***
*Introduction:*
*Research was carried on 100, 14-49 year old mothers who had a child whose age was 0-3 years old and lived in the district of swat (Saidu Teaching Hospital Saidu Sharif Swat to determine use of maternal and child health care (MCH) services, their perception of needing these services, and the relationship between MCH utilization and social, economic, and demographic factors.*
*Materials and Methods:*
*A cross sectional study of 100 mothers was conducted in different union council of swat during the autumn 2012, a house to house survey in the villages was carried out and some half of the respondents was selected from the Saidu Teaching hospital that cover the health of the whole population of Swat District.*
*Results:*
*In the study sample 68% of women had 1-3 children. Only 57% had registered with a health facility, mainly primary health centres (17%), during their 1st trimester 22% women didn't visit a doctor, but only visit the health facility for delivery. The major reason for not visiting the facility was socio-cultural, financial and demographic problems. 84% of women gave birth to a child at home. A traditional birth attendant (dai), or Lady Health Visitor (LHV) were present for all home births.*
*Conclusion:*
*The result of a this study has shown that age, duration of marriage, education, occupation, family income, parity and distance are significantly correlated with the choice of MCH services used. The result of this discriminant analysis highlights distance, mother's education and age as the strongest determinants of the choice of MCH services, after adjusting for all other variables. Women of higher socioeconomic group, 15-29 years old, and with 03 children were more likely to adequately use prenatal care. These results highlighted the need to develop a strong health education program using the mass media, recruiting more female health guides than male and training dais in MCH services.*

***Key words**: Health, Health care system, Factors Affecting Health, Health Service Utilization, Pakistan*

## 1.Introduction

This report "study on the utilization of maternal and child health services in the district of Swat KPK Pakistan" that I have written is the exact image of factors affecting the services that the mother and child receive in the said district. Pakistan's maternal and child health indicators remain extremely poor. The infant mortality rate is 77 per 1,000 live births; new born morality rate is 55 per 1000 live births and the maternal mortality ratio (MMR) ranges between 350-400 per 100,000 live births. Prevalence of nutritional disorders, infectious diseases, and access to health care facilities are dire in Pakistan. Previous attempts to improve access to health care services through building of more health facilities and upgrading skill levels of health care providers have not led to significant improvement in the access and utilization indicators, partly because the rural poor have been excluded from these developments.
The death of a woman in childbirth is a tragedy, an unnecessary and wasteful event that carries with it a huge burden of grief and pain. Pregnancy is not a disease and pregnancy related morbidity and mortality are preventable. Half a million women die each year due to

pregnancy related complications and 95% of them come from developing world. The lifetime risk of a woman dying of pregnancy related causes in developing countries is 1:40 as compared to 1:3600 in the developed world.

The status of maternal health is poor in Pakistan. An estimated 30,000 women die each year due to pregnancy related causes. It is estimated that about 500 maternal deaths occur per 100,000 live births each year in Pakistan. Recent estimates (WHO & UNICEF) place the figures around 270/100,000 live births but in reality it may be higher because of under registration of deaths in the country and absence of cause of death information.

One of the major reasons for this high maternal mortality rate is malnutrition, which affects 34% of pregnant women. Around 48% of lactating mothers have a calorie intake of 70% less than the recommended level. This is bad for the health of the mother as well as the baby. In addition, 45% of Pakistani women suffer from iron deficiencies that result in stillbirths, birth defects, and mental retardation and infant deaths.

Haemorrhage, hypertension, unsafe abortion, infections and obstructed labour are other factors contributing to the higher mortality rate among women in rural areas. All of these causes are mostly preventable through proper understanding, diagnosis and management of labour complications. To reduce complications during pregnancy and labour it is essential to strengthen primary health care infrastructure. Provision of antenatal health care in the community by trained health personnel form the backbone of any such efforts.

Dawn reports that on 16th March, this year, 85 governments in a joint statement, delivered to the UN Human Rights Council (UNHRC), reaffirmed commitment to addressing maternal mortality as a human rights issue and that the magnitude of the problem calls for the renewal of political will to address it. However, Pakistan was not one of the signatories to this document, because the government refuses to recognize the death of Pakistani mothers, as a result of medical negligence and lack of awareness, a basic human rights issue.

This alarming attitude of the government has moved the civil society and various national and international NGOs to urge the Pakistan Government to sign the upcoming resolution on maternal mortality in the coming UN Human Rights Council session scheduled for June 2-18, 2009 in Geneva. More initiatives to prevent maternal mortality would be an obligation of countries which are signatories of this resolution. The condition in Pakistan requires some serious efforts.

In Swat valley the Primary Health Care Facility is providing health services for the population, particularly the poor, marginalised and disadvantaged segments. The facility is providing outpatient services to adult men, women and children, and maintains an added focus on strengthening Mother Child Health services with inpatient and outreach services.

This paper will help towards achieving the Millennium Development Goals (MDG) in maternal and child health, by reducing mortality, new born fatalities and improve maternal health and wellness through the suggestions at the end.

Health seeking behaviour and health care utilization is determined by the organization of the health system. Health system does not merely represent the structures that provide health care but it encompasses various other elements which constitute the system as a whole. These are economic conditions, family system, social support network, cultural forces, environmental conditions, political systems and so on, which invariably affect the health care seeking patterns.' As for health care system, in almost all the developing countries, the public and the private health sector co-exist, complementing or conflicting with each other. Yet, in health planning, least consideration is given to harmonize this co-existence in the larger benefit of the users? In developing countries, health seeking behaviours and health care service utilization patterns have been studied and the determinants have been classified in physical, socioeconomic, cultural and political contexts. A number of studies show that trends in utilization of a health care system, public or private, formal or non-formal, by and large, vary depending on factors such as age, gender, women's autonomy, urban or rural habitat, economic status, severity of illness, availability of physical infrastructure, type and cadre of health provider, etc.

This paper is based on a systematic review of peer reviewed literature on the relationship

of factors affecting health service utilization and the focus has been on District Swat KPK Pakistan. There is a clear dichotomy of the health care system in Pakistan; public sector financed by the state and private sector working independently for profit. Government of Pakistan spends less than 1% on health care, even lower than Bangladesh and Sri Lanka. Even then, some health indicators have been improved such as immunization coverage and the knowledge of family planning. For 66% living in the rural part of the country, poverty along with illiteracy, low status of women and inadequate water and sanitation facilities had remarkably slowed down the progress in health indicators. Cultural and social barriers hinder health seeking from an effective and modern health care service. At the community level, the Lady Health Worker programme has gained an international reputation due to its grass root level coverage and the support of an elaborate network of primary to tertiary level health facilities. However, the basic level facilities' restricted hours of operation and distant locations have been unable to change the picture. Most of these facilities lack trained personnel especially female health providers. In the private sector, besides few accredited outlets and hospitals, many unregulated hospitals, medical general practitioners, homeopaths, traditional/spiritual healers, Unani (Grecoarab) healers, herbalists, bonesetters and quacks provide unchecked health care. As a consequence, improvements in health behaviours and practices, especially of rural population groups have been very slow.

Factors affecting health seeking behaviour; A variety of factors have been identified as the leading causes of poor utilization of primary health care services: including poor socioeconomic status, lack of physical accessibility, cultural beliefs and perceptions, low literacy level of the mothers and large family size. Review of the global literature suggests that these factors can be classified as cultural beliefs, socio-demographic status, women’s autonomy, economic conditions, physical and financial accessibility, and disease pattern and health service issues Maternal and Child Health in Pakistan Although the millennium development goals reports show some progress in the attainment of women and children’s health, there is much remaining to be done in this area. This is a major concern, for Pakistan ranks sixth in the world as the most populous population, with a very high morbidity and mortality rate for

children and mothers (Yin, 2007). The lack of health infrastructure lies at the core of the problem, and there have been very few attempts by the governments to create new facilities in new locations. The already present hospitals are overcrowded with the number of patients needing attention, leading to poor or inadequate quality of care. The lack of education among the medical staff about the needs and requirements of women and children at this critical step remain unknown (Yin, 2007). The estimated annual death rate of women and children in Pakistan are 16,500 and 400,00 respectively. Sadly, most of these deaths are caused by conditions and health problems that are easily manageable (Siddiqui et al, 2004). The lack of government response to this high number of deaths has been translated in to apathy in policy making and creating programs for the health of the public. There is a complete lack of proper records and documentation, which prevent the government from creating meaningful and sustainable developments. The improper structural organization of the health sector leaves many health issues unaddressed. Since most of the policies fail to work, the mother and infant mortality rates continue to rise (Siddiqui et al, 2004). The lack of education among the masses prevents them from being educated or informed about pregnancy issues and maternal and child health issues. Since allopathic and hakeem culture is widely prevalent among Pakistani societies, the patients prefer to hear ungodly claims of miracles regarding health and wellness of mother and child, rather than listen to the correct and unbiased judgment made by the doctor. Secondly, women are not allowed to take up decisions regarding their health, social status and position, their reproductive health etc. This makes them entirely incapable of taking decisions for themselves. With lack of education or skills, the mothers are left to deal with the issue of pregnancy based on half with enunciations of older women, or by enduring relentlessly. Women in Pakistan at the start of the new millennium still live in a time where they have no access to health care. They are not allowed to be examined by male doctors. They are not allowed to take any decisions regarding their reproductive health or the health of the child.

**2.Statement Of The Problem**

Factors affecting Utilization of maternal and child health services in the district of Swat KPK Pakistan

**3.Objective Of The Study**

- To know the maternal and child health services utilize in Swat
- Strengthen health systems through improvement in technical and managerial capacity as well as equipping and upgrading the facilities
- Increase awareness around Maternal and Child Health

4.**Significance Of The Study**

- To find out, how mother and child get health care in the district of swat.
- To know how many organizations working in Swat for the mother and child health.
- To know the ratio of the population of mother that take benefit from the health care setting of professionals and those who have no excess to health settings.
- Information for health regulators, and different organization working on maternal and child health.

**5.Limitation Of The Study**

- The study is limited to the people of district swat.
- Purposive sampling was done.
- Need to replicate in different modification objective for another area.
- More accurate results can get through extending sample size and carrying out the study in different hospitals and health centres in Swat even door to door visits in many of the villages in Swat, that need proper budget and human resource.

**6.Methodology**

*6.1.Study Design*

The quantitative research approach and the descriptive cross-sectional study design assisted in addressing the research question. A cross-sectional design is considered to be the best design when the researcher wants to assess the prevalence and contributing factors of a phenomenon at one specific period (Polit & Beck, 2008). Descriptive study involves systematic detail observation of peoples' behaviour and talk that is what they talk, think and do. It is also referred to field research (Polit & Beck, 2008). Descriptive research describes phenomena as they exist. It is used to identify and obtain information on the characteristics of a particular issue. The central rationale for selecting this design was to know the factors affecting utilization of maternal and child health services in District Swat KPK, Pakistan. Another reason for choosing this design was the fact that limited studies have been conducted in the Pakistani context, and there is a need to have a thorough understanding of this study. Brink (1998) stated that this approach is used when a problem has been identified but the existing literature does not offer a very comprehensive understanding in the subject. Moreover, it assists in determining the level of association among the variables (Burn & Grove, 2007). In addition, this design supports the application of different types of statistical analysis; such as logistic regression analysis (Polit & Beck 2008). Thus, the descriptive cross sectional study design was appropriate design for this study.

*6.2.Study Setting*

Tertiary care hospital, Civil Hospital Kabal, and health care facilities at union councils, along with the household was the setting for the data collection. The patients come to the hospital, belong to a wider socioeconomic strata, different geographical locations, and educational background. Hence the selection of the study site and the enrolment of the clients offered better opportunities to address the research question, and ensured the external validity of the study by establishing the generalizability of the findings.

The settings of the study 'Civil Hospital Kabal' come under the supervision of Executive District Health Officer. Permission for the setting and data collection has been taken.

*6.3.Study Population*

The universe of the present study was District Swat and the population of the study was all the child bearing married women aged 14 t0 49 years. According to Center for Public Policy and Research Report (2010) on "District Swat: Socioeconomic Baseline and Displacement Impact" the total population of Swat in 2009 was 18,11,425 with the growth rate of 3.37, so the estimated population of 2012 is approximately 20,00,000. Most of the area of this district is rural, comprise of almost 07 Tehsils with a total population of 20,00,000. As my research study was quantitative, the sample size that I used was according to the tehsil Kabal population.

*6.4.Eligibility Criteria*

6.4.1.Inclusion Criteria

- All married women ages 14-49 years will be included in the study
- Literate and illiterate
- Know English, Urdu or Pashto language
- At least having 2 children with recently given birth to a child age 0-3years.

6.4.2.Exclusive Criteria

- Women who are diagnosed as mentally ill or retarded will not be included.
- Those women who are migrants will also be excluded.

*6.5.Sample And Sampling*

6.5.1.Sample Size

The sample size was calculated by using the Epi Info software, with the help of an epidemiologist. The sample size was based on the 50% prevalence (Supposed value because no statistics available on the male family planning), using the level of significance 5% and bound of error 10%. The calculated sample size of the study was 97, so a total of 100 participants selected.

6.5.2.Sampling Strategy

Convenience sampling strategy was utilized to select the participants and collecting data. According to Polit and Beck (2008), convenience sampling allows enrollment of the specific participants who fulfil the eligibility criteria of the study and selected according to the convenience of the researcher. This technique helped to identify the participants according the study phenomenon and gathering data in a specified time. This sampling strategy was the most suitable technique for the present study because the participants were recruited from the daily patient flow according to the convenience of the researcher and the selection of the participants in the community.

6.5.3.Recruitment Of The Participants

After allocating the sample size, participants were selected conveniently. The researcher utilized different departments (Medical, Surgical, outpatient, dental, ENT, other) of the setting and community to collect data from the participants. Attendants of the patients were selected as a participant by avoiding discomfort to the patients. The permission letter for the data collection and ethical consideration was taken from the EDHO Swat. The consent form was given to the participants who meet the inclusion criteria. Once they agreed and volunteered to participate in the study they were selected.

6.5.4.Data Collection Tool

The instrument tool used to collect data for "Factors affecting utilization of maternal and child health services in District Swat" was comprised of five sections. The first section comprised of 10 questions related to demographic data. The second section consisted of 07 questions related to the social - cultural profile. The third section of the knowledge had 08 questions; individual knowledge about maternal and child health services. The fourth section of the instrument consisted of 07 questions related to the attitude of women towards maternal and child health service. Lastly, the fifth section of this instrument comprised of 09 questions related to the affecting factors. At the end one subjective question was given to the suggestion, how to improve the maternal and child health practice. Approximately 40-50minutes were taken by each participant to complete the questionnaire along with the consent form. A questionnaire was translated to both Urdu and Pashto language.

6.5.5.Validity Of The Questionnaire

The questionnaire has been prepared by the researcher, having closed ended questions and sent to the experts for the face validity. After assessing the face validity, the questionnaire was translated into Urdu and Pashto language by an Urdu and Pashto language experts to make it understandable for all the study participants. Further, modification and appropriateness for the area context was verified by the experts in the field.

The validity and reliability of the questionnaire was tested before conducting the study, since these were not established. As cited in Polit and Beck (2008), the face validity of the instrument "refers to weather the instrument looks as if it is measuring the appropriate construct" (p.458). Thus, face validity provides and understanding about what the questionnaire appears to measure. Therefore, the questionnaire was sent to experts observe the face validity. Experts had thoroughly checked the instrument for depth, clarity, and relevancy. The experts include PhD scholar and Biostatistician. Expert opinion was taken to check the context and language used in the questionnaire. The changes that were made based in the expert's feedback were adding new questions. Likewise, in certain instances, the choices of responses were modified and added, keeping in view the target population. For example, in section A, the choices were modified and given the score so that we could evaluate person knowledge on the basis of the scoring they obtained. Moreover, questions to identify the participants age and age at the time of marriage were changed from the categorical to the continuous scale form. Feedback received from the experts was incorporated.

Content validity is another way for examining the representativeness of the content in the questionnaire, and is based on the consensus among the group of experts in the field (Polit & Beck 2008). A committee of experts, including Epidemiologist, biostatistician, and PhD scholar, assesses the content validity of the questionnaire.

The questionnaire was again shared with the experts, after incorporating their feedback, which was finally agreed on the administration of the questionnaire to the study participants. The questionnaires are also translated back in to English from the translated versions to ensure the actual meaning of each question.

6.5.6.Interrater Reliability Of The Questionnaire

The inter-rater reliability of the questionnaire was checked on 20 participants 10 for each translated version (i.e. 20% of the calculated sample size of 97). Inter-rater reliability determines how well the two different evaluators or data collectors measure the same phenomenon of interest (Polit & Beck, 2008). The Inter-rater reliability of the questionnaire was come out to be 98%.

6.5.7.Pilot Testing Of The Questionnaire

Pilot testing of questionnaire was performed to test its functional and face validity. Pilot sample is independent to the final sample (i.e. 20% of the calculated sample size of 97). It helped to determine the problems in the administration and interpretation of the questionnaire, and to ascertain the clarity, appropriateness, and the understandability of the Urdu and Pashto questionnaire separately. Pilot testing of the instrument also facilitated in determining the appropriate length of time (30-40) that was required by the participants to complete the questionnaire. Each question was reviewed, and explanation was added to few questions for better understanding and to get appropriate responses from the participants.

**7.Data Collection Process**

Data collection was done from April to June 2011, after seeking approval from the EDHO Swat for ethical consideration and data collection. Data was collected by the principal investigator (PI). PI approached to the participants in Swat. The study participants were informed about the nature of the stud, purpose of the study, and their rights as research participants. In addition the consent form was explained clearly to participants. Signature of the participant was taken after their willingness to participate in the study. A copy of the consent was provided to the research participants on their demand. After they had signed the consent form, the questionnaire was administered and responses from the study participants were filled by the PI. Questionnaire will be filled by the investigator in the language that the participant know and speak (Urdu or Pashto).

**8.Results**

In the study sample 68% of women had 1-3 children. Only 57%had registered with a health facility, mainly primary health centers (17%), during their 1st trimester 22% women didn't visit doctor, but only come to the facility for delivery. Most (22%) registered during the 4th-6th month of pregnancy. 56% of registered mothers visited the facility 4 times. The major reason for visiting the facility was socio-cultural, financial and demographic problems. 27/100 mothers were not vaccinated against tetanus. Only 18% of the 68, receive the tetanus toxoid 2nd doses. Just 54% took iron/folic acid tablets. Only 13 women went to a facility for postpartum follow up; 8 went to a private practitioner. 84% of women gave birth to their child a home. A traditional birth attendant (dai) were present for all home births. The leading reasons for delivering at home were tradition (79%), no obstetric problems (75%), family demanded a home delivery (61%), convenience (48%), and high hospital costs (48%). Reasons for having a dai present included tradition (77%), family preferences (65%), privacy (60%), and less expensive (47%). 18% children did not receive any kind of vaccinations. 29% used family planning methods especially female sterilization (10%) and copper T IUD (7%) in late child bearing age. 61% believed they need prenatal services. 78% perceived the need for intra-natal care. 70% and 80% expressed the need for child care/immunization and family planning, respectively.

| Age of Respondent | Frequency | Percentage | Cumulative percentage |
|---|---|---|---|
| 15-20 | 12 | 12 | 12 |
| 21-25 | 15 | 15 | 27 |
| 26-30 | 27 | 27 | 54 |
| 31 -35 | 16 | 16 | 70 |
| 36-40 | 13 | 13 | 83 |
| 41-45 | 09 | 9 | 92 |
| 46-49 | 8 | 8 | 100.00 |
| Total | 100 | 100.00% | 100.00% |

*Table 1: Frequency And Percentage Distribution Of Respondents By Age*

*8.1.Interpretation Of Data*

- The above table shows the ages of the respondents. It indicates that highest number of respondents is within 26 to 30 years of age group which formed 27.00%.
- The third highest number of the respondents is fallen within the age group of 15 to 20, which formed 13.00%.
- 27.00% of respondents are coming under the age group of 21 to 25 years, 16.00% of respondents are of the age group of 31 to 35 years, 13.00% of respondents belong to the age group of 36 to 40 years and, 09.00% comes in the age group of 41 to 45 years, while the least number of respondents are of the age group of 46 to 49 years, which the 08.00% of the total population.

| Occupation | Frequency | Percentage% | CumulativePercentage% |
|---|---|---|---|
| House wife | 77 | 77 | 77 |
| Domestic maid | 10 | 10 | 87 |
| Govt. servant | 02 | 02 | 89 |
| Private Service | 03 | 03 | 92 |
| Self Employed | 08 | 08 | 100.00 |
| Total | 100 | 100.00% | 100.00% |

*Table 2: Frequency And Percentage Distribution Of Respondents By Occupation*

*8.2.Interpretation Of Data*

- The above table indicates that the highest number of respondents is house wives. They have formed a percentage of 77%.
- The second highest number of respondents is the domestic maids by their occupation, which has formed a percentage of 10%.
- 08% of the respondents are self-employed women.
- The table shows that 03% of respondents are engaged in private service.
- Whereas only 02% of respondents are in Government service

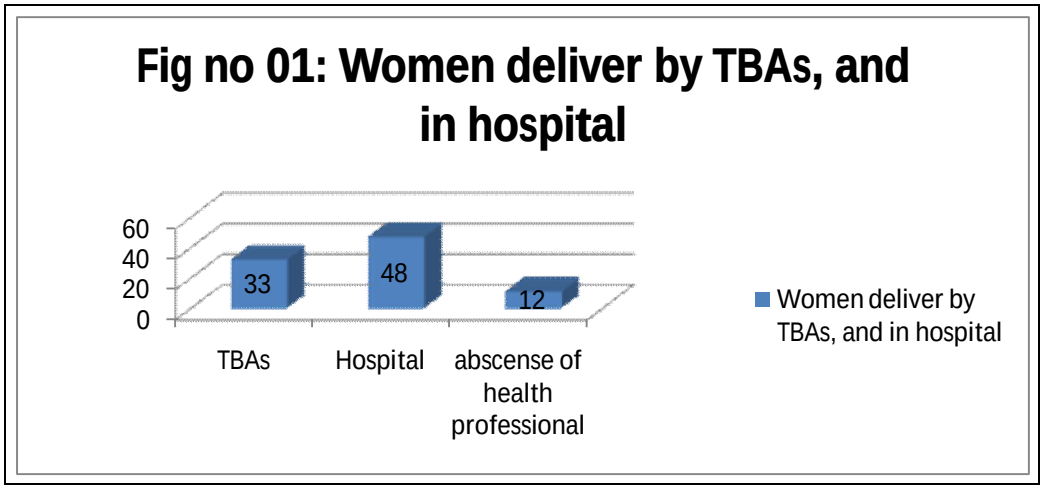


*Figure 1*

*8.3.Explanation*

- Most of the women of Swat has been delivered in home or delivered by untrained birth attendant at home**,** that lead to many complication. It is because of the unawareness, financial status, unavailability of transport, or other related norms.

*8.4.Findings*

- 48% of women delivered in hospital, 33% delivered by TBAs and 12%deliver in absence of health care professional.

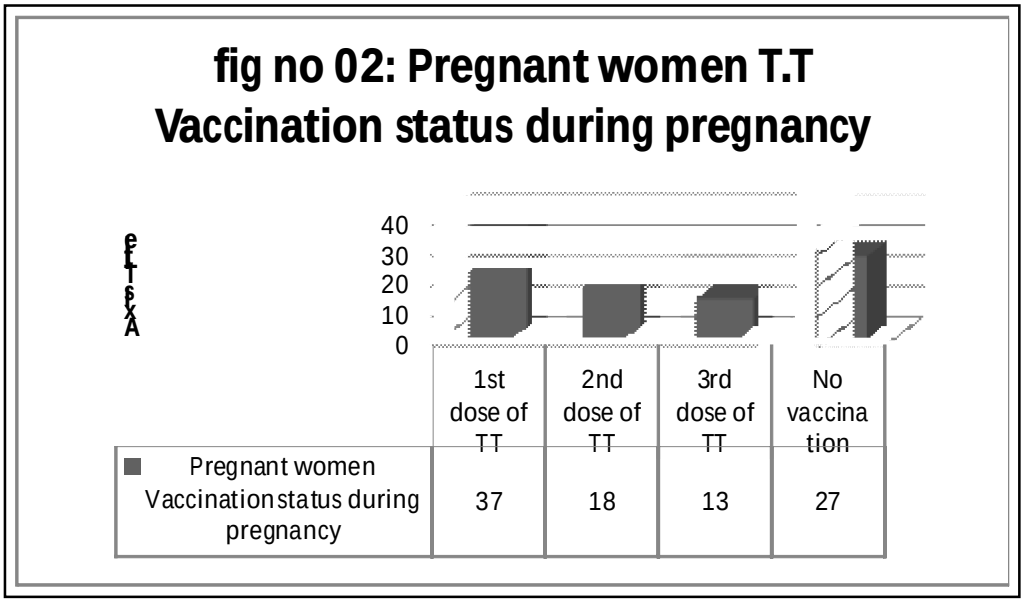


*Figure 2*

*8.5.Interpretation*

The vaccination of the women is less common in the district of swat.

- 37% get the first dose of vaccination.
- 2nd dose 18%.
- 3rd dose 13%.
- 27% of the women did not vaccinated

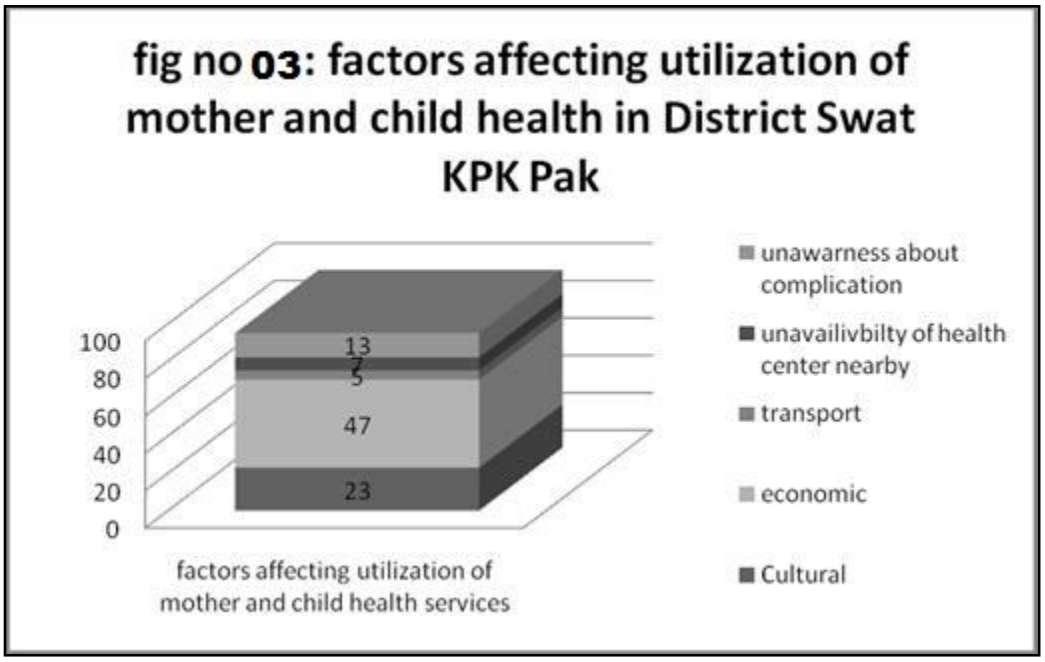


*Figure 3*

*8.6.Interpretation*

Many of the factors contribute to the utilization of maternal and child health services.

- 23% cultural factors
- 47% economic the major factor.
- 5% transport.
- 7% unavailability of health centre nearby home.
- 13% unawareness about the complication.

**9.Discussion**

In Pakistan, utilization of maternal and child health services are poor in general, but they are particularly deficient for maternal and child health leading to adverse outcomes for both women and newborns. Antenatal care is named as one of the four pillars of the safe motherhood initiative: although it's relative contribution to mother and child health care has been under debate, its importance cannot be denied. Less than one-third of pregnant women receive care, with a large urban and rural difference: 17% of pregnant women in rural areas receive antenatal care, while 71% of women in major cities are able to take advantage of service. (N. Nisar, F. White, 2003)

Findings showed that about half the women sampled received maternal and child health care while the remainder did not. A review of studies reported that age serves as a proxy for women's accumulated knowledge of health care utilization: older women are more likely to use maternal health care services than younger women.

In Pakistan, the adult literacy rate for female is quite low when compared internationally. Only 16% of girls are enrolled for higher secondary school, with only 7 percent enrolled in rural areas (compared with 33% of boys (Nisar &White, 2003). Education is significantly associated with utilization of maternal and child health services: 22% of mothers with no education receive antenatal care while 85% of mothers with at least secondary education do so. A review of studies reported that education of women is positively associated with utilization of maternal and child health services.

There are a many explanations for why education is a key determinant of demand. Education is likely to enhance female autonomy and create awareness: women thereby develop greater confidence and capabilities to make decisions regarding their own health, as well as their children's health. It is likely that more educated women seek higher quality services and have greater ability to use health care inputs to produce better health.

Income of households and husband's education serve as indicators to assess socioeconomic status. Thirty three percent of those who received care did so from untrained care providers specifically dais. These are illiterate women living in the community, practicing without training. In spite of the availability of trained assistance only 20% of deliveries were conducted by trained health care providers, one of the lowest rates in Asia (UNICEF 1997; NHSP1996; PDHS 1992).

According to World Bank Study, public and private expenditure on health in Pakistan represents 3.4% GDP while public expenditure alone accounts to 1% of GDP, a low figure by international standards. A much higher proportion of women reported care received from private doctors (44%) according to the National Health Survey of Pakistan (NHSP1996). In the private health sector such services are expensive, while government health services for maternal and child health care is available at very subsidized rates.

Pakistan has experienced only a modest economic growth and the per capita income is $500 and about one third of the population lives below the poverty line. 37 Poverty negatively affects the utilization of health services.

Cultural restrictions and norms on mobility are a significant barrier to women's access to maternal health services. Most women did not have permission to move about freely, and most are forbidden to be alone when in public. According to a recent survey of women between the ages of 15 and 40 years in rural Punjab, only 28% can go unescorted to the local health centre and only 12 percent can travel alone to the nearest village. Over two-thirds of the women interviewed to require an escort to leave home. In our study 18% of women reported that they can go alone to a health care facility for antenatal checkup, while 82% reported that they accompany a family member (e.g. Mother in law, husband and mother).

The WHO mother baby package stated that during pregnancy, iron/folic acid is beneficial to the healthy growth of the fetus. In Pakistan more than 40 percent of women are anemic (NHSP 1996): this suggests that iron supplementation coverage is low. The aim is to achieve 100% coverage of iron supplementation for prevention of anaemia, as this is one of the main causes of maternal mortality. Half of the women reported that they did not receive iron supplementation and had not received tetanus immunization. Pakistan is thus the third ranking country in the world for neonatal tetanus. Malnutrition is a major problem among the poor community in Pakistan. The reason is inadequate food intake because of poverty and lack of knowledge about what constitutes a balanced diet. Pregnant women receive 87% of the recommended calories and lactating women 74% (Pakistan, Federal Bureau of Statistics 1995). In my study, knowledge about the quantity and type of food included in pregnant women's diet was found significantly associated with maternal and child health care utilization.

Through proper knowledge of danger signs in pregnancy, lives could be saved by emergency obstetric care. Emergency obstetric care comprises the elements of care that are most often needed for the management of complications, such as ante partum haemorrhage, postpartum haemorrhage, eclampsia, obstructed labour, sepsis and anaemia.

Last but not the least, for any risk factor to be considered as a true determining of association as distinct from the risk factors, it is necessary to establish a cause and effect relationship between the factor and the outcome.

**10.Conclusion**

With this intricate picture of health system utilization and health seeking behaviour in Pakistan, a more coordinated effort is imperative in designing health promotion campaigns through inter-sectorial collaboration focusing more on vulnerable segments of the population. A comprehensive health care system, therefore, must focus on the rural population who becomes visible only when programs are signed with international donors; as well as urban population which is evenly suffering from its own disease burden attributed to the fouled urban environment. Overall knowledge about utilization of maternal and child health services was found to be better among women who had utilized care during pregnancy as compared to women who did not receive antenatal care. Women of reproductive age (15-49 years) need to recognize the importance of antenatal care and to receive such care in the community. Underlying this need, there is also a need to uplift the socioeconomic status and literacy level of women through community based education. In particular, there is need to increase nutrition education, highlighting the importance of iron supplementation, appropriate food during pregnancy and recognition of sign and symptoms and danger signs in pregnancy. The study finding suggests that there is a need to increase tetanus immunization coverage of mothers as a part of prenatal care. There is also a need to increase tetanus immunization coverage of mothers as a part of prenatal care. There is also a need to evaluate the services provided by government health facilities and to find out why women are not utilizing government health services, even though these services are available at subsidized rates.

Emphasis needs to be given on reorienting health systems in support of non-communicable diseases prevention and control. Hitherto, the public sector has always been struggling with growing health care costs, for that reason, public-private partnerships in operating and managing public hospitals can provide a window to share financing, improve performance and ultimately enhance the quality of services. Investing in health necessitates an in-depth research to visualize the real picture of the habits and practices of the people towards health. The advent of decentralization in Pakistan provides a unique opportunity for tackling multifaceted issues by multi-sectorial approaches. It is of utmost importance to design policies by developing the understanding of behaviors and health care utilization trends at the district levels and to give enough credence to all the determinants in the background. More challenging would be translating such research and understanding into policy and action

**11.Recommendation**

The present study was conceived, planned and undertaken to review the specific situation of rural society in the reference of rural women, their level of knowledge, awareness and other factors affecting the utilization of maternal and child health.

On the basis of finding of the study, following recommendations are suggested:

- It is recognized that educated women have direct influence on the utilization of maternal and child health services. Therefore it is suggested emphasis on female education has to be doubled, not only on plans and policies, but also more important in their implementation.
- A large number of schools in remote areas, especially girl's schools are inactive. They should be rehabilitated and restarted. Teachers need to be trained from and posted to backward areas.
- Awareness must be created through media campaigns. TV is strong medium which should be used to convey the message of the importance of maternal and child health to both men and women. Information about the availability of health centre and

services should be given to the masses through television. The Law limits the showing of mother and child health on TV, It must be reconsidered.

- Coverage of the population for maternal and child health services, especially in rural areas is a serious handicap in achieving the objectives. More emphasis and encouragement of the private sector is essential. NGOs with community communication have to be strengthened for a wider role of in making utilization of services available to women in rural areas.
- Health rights of women are hardly discussed or heard about. Sexual awareness is limited. Thus this is the duty and liability of the State that it should make women aware of rights over their bodies, and provides the means of utilizing these for their personal welfare and protection
- It is suggested that opinion of leaders, teachers, and health professionals must be involved in the task of utilization of the maternal and child health services.
- Government should have to seriously consider legal measures for increasing the minimum age for marriage women to 18 years and men to 21 years. No marriage before these ages should accept as valid.
- Lady health workers and lady health visitor working in the community should be properly given the objective for the women's education for the utilization of maternal and child health services.
- The local health centre should be made available for the women and child health, on behalf of early detection of pregnancy and early care, even the vaccination of the newborn and children.
- Women should be educated through mass media and community campaigns for safer motherhood and visits to doctors during pregnancy, even to deliver in the hand of a qualified health professional.
- Health education about care during pregnancy and after pregnancy.
- Hospital, BHUs, RHCs and local health centre should focus on the maternal and child health.
- The government should allocate proper fund for the mother and child health and eradicate the maternal mortality and infant mortality.
- TBAs should be properly trained in remote areas.
- The factors discuss above that influence on the utilization of maternal and child health, the community should be properly taught by the misconception of traditional issues, social issues and other that affect the utilization of health. It can also be done through religious leaders and mass media
- The education of women should be made compulsory by the government to create awareness.
- NGOs should also be involved in the same programme for the utilization of maternal and child health.
- By the application of the above mention strategies the utilization of maternal and child health services can be properly improve and mother and child will become healthy.

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