Poverty and Access to Maternal Health Care Services in Pakistan: Evidence from Perception Based Data

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ABSTRACT[1]

Pakistan is on its way to achieving the targets of the fifth Millennium Development Goal in terms of reducing the maternal mortality ratio by three-quarters between 1990 and 2015. However, the rate of decline needs to speed up over the next decade as Pakistan has a high Maternal Mortality Ratio ranging between 400 to 1,400 maternal deaths per 100,000 live births.

The aim of this study is to explore the role of poverty status as a barrier in access to maternal health care services in Pakistan by regions and provinces. The analysis is based on *The Pakistan Social and Living Standard Measurement Survey 2004-05*. Four important indicators prenatal care, institutional delivery, postnatal care and utilization of family planning services are taken to assess the utilization of maternal health care services across perception based economic status. The findings of this study reveal that approximately 20 to 27 percent of women's economic status worsened in 2004-05 as compared to a previous year. The antenatal care services received by women suggest that 49 percent births are preceded by a single prenatal visit in Pakistan while variation is observed across economic status and provinces while delivery care is still dominated by home births particularly in rural areas and among the lower economic status groups. As far as health care providers are concerned, better off women avail the facility from private sector while majority of poor women visit government hospitals or clinics. The role and content of postnatal care has been paid less attention across region and provinces. Only a quarter of women ever utilized the facility of family planning center during the month preceding the survey. Finally, it can be concluded that the poor economic status of women is a barrier in utilizing the maternal health care services. Finally, it is suggested that the progress of policies and program related to maternal health care services should always be monitored and evaluated in terms of the success achieved not only on aggregate terms but for each group of the population.

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Introduction

Access to maternal health care services in order to reduce maternal mortality has received increasing importance since the 2000 UN Millennium Summit in which eight Millennium Development Goals were adopted for reducing extreme poverty, extending gender equality and advancing opportunities for health and education. The specific objective of goal one was 'Halve, between 1990 and 2015, the proportion of people below the poverty line' while improved maternal health comes under goal five which is targeted to 'Reduce by three quarter, between 1990 and 2015, the Maternal Mortality Ratio' (UNDP,2003). Maternal mortality is an indicator of poverty and inequality in the society and a sign of women's place in a society, health and nutrition services and to economic opportunities. The poor health and nutrition of women and the lack of care that contributes to their death is a tragedy for individual women, for families and for the communities. It is not only a health issue but also a matter of social injustice.

Poor health is both a cause and result of poverty and hunger. Evidence around the world suggests that being poor positively correlates with poorer health status and negative health outcomes. Much of this relationship is due to poor uptake of preventive and curative aspects of health care services by people belonging to the lower economic strata. Women among the poor are more vulnerable in terms of access to maternal health care plus women are more likely to demonstrate sharp inequality in utilization.

Poverty seems to have both a direct and an indirect relationship to a low level of utilization of maternal health care services. The direct consequences of poverty and inequality can be seen in the case of access to maternal health care utilization especially in rural area of Pakistan. The indirect consequence of poverty can be observed through a series of negative attitudes including feelings of marginality, helplessness, dependency and inferiority, particularly when there is illiteracy, low mobility etc. Once it develops it tends to perpetuate itself from generation to generation.

The immediate cause of maternal mortality is inadequate care of the mother during pregnancy and delivery but women's subordinate status is also a factor. However, the single most important determinant of maternal health and survival is the extent to which women have access to high-quality maternal health care services. These services include education on safe motherhood, antenatal care, maternal nutritional programs; adequate delivery assistance, post-natal care and family planning.

Pakistan has been experiencing two major socio demographic developments during the last two decades. First, poverty which decline in the 1980s because of high economic growth, a large inflow of remittances and foreign aid during the Afghan war, gained its momentum in the 1990s. The rise in poverty was mainly due to sluggish growth in GDP. Second development was witnessed in health sector where fertility and mortality declined simultaneously and life expectancy at birth increased steadily. The health indicators show optimistic but not promising figures relative to comparable countries. The total public sector expenditure on health has increased from Rs.25.4 billion in 2001-02 to Rs.40.0 billion in 2005-06 The share of federal and provinces in total public spending on health sector illustrate that, on average, the governments in the NWFP and Balochistan are spending the least while Punjab government spends the most, followed by Federal area. The distribution of health care expenditure in different subsectors of the health like maternal and child health, General Hospitals and Clinics and Preventive Measures also presents high inequalities across region and sectors and among different quintiles. The poor in Pakistan are not only deprived of financial resources but also lack access to secondary and tertiary health care services (Akram and Faheem, 2007).

The study investigates the role of poverty status as a barrier to the utilization of preventive maternal health care services in Pakistan by regions and provinces. Three important indicators antenatal care, institutional delivery and post natal care are taken to assess the utilization of maternal health care services across perception based economic status. The analysis is based on the *Pakistan Social and Living Standard Measurement Survey 2004-05* in which five different economic situations are used as proxy for poverty status.

The nexus between poverty and maternal health care services has been well documented in literature. The persistence of poverty in different dimensions of health care use has been documented across countries, regions and different population groups.

Akram and Faheem (2007) explain that the health care system in Pakistan is inadequate, inefficient and expensive; and comprises an under-funded and inefficient public sector along with a mixed, expensive and unregulated private sector. It is also investigated that the poor in Pakistan are not only deprived of financial resources but also lack access to secondary and tertiary health care services especially in rural areas. The expenditures in health sector are overall regressive in rural Pakistan as well as at provincial and regional levels. It is concluded that public health expenditures are pro-rich in Pakistan.

Khalil (2004) found that three quarter of women utilized female doctors or Lady Health Visitors services at least once for antenatal care. The study investigated that antenatal care has not yet made its way to the routine practice of women in the district under study.

Although a high proportion of women had at least one antenatal visit, the minimum number of recommended checkups is three. The study also explored that women continue to use services of *Dia* or lady doctor as a first choice, in particular for delivery. Hospitals are the first choice in case of an obstetric emergency.

Ali, T. Saeed *et al* (2004) revealed that the postpartum health care is not being properly utilized in poor urban settlements of Karachi despite the global acceptance of its significance. The proportion of women who sought health care services during the postpartum period was 24 percent as compare to 19 percent in Pakistan overall which is much lower as compared to other developing countries such as India (40%) and Philippines (58%). It is also found that advances maternal age and prolong duration of labor are associated with perceived postpartum hemorrhage.

Sathar *et al* (2003) looked at the rising levels of poverty and the associated changes in indicators of fertility and mortality behavior. The study concluded that the relationship between poverty and reproductive health indicators remains strong and significant. Poverty in the household continues to have an overriding negative effect on the already poor results of reproductive health outcomes of uneducated rural women despite the gains they made over the past decade.

Mahmood and Nayab (2000) analysed that high maternal mortality rate is primarily related to pregnancy and childbirth complications because of neglect in seeking appropriate health care. Social and economic constraints in accessing services and

inadequacies in the health care system for obstetric emergencies are additional causes of high maternal mortality rate, especially in the rural areas. It is concluded that reproductive health education programs should be enhanced for raising the level of awareness among both women and men.

Khan and Asma (1995) identified the impact of paid employment in the informal labor market on the household decision making and health seeking behavior of poor women in squatter settlements of Karachi. Women who do not use contraceptives, prenatal care and immunizations belong to poor families and are less likely to have access to information through either media or social networks. A significantly greater proportion of women in the user group are literate and employed outside their homes for income.

The major issues that emerge from the review of earlier studies suggest that economic ability has been one of the most significant barriers of access to and utilization of health care services, particularly for the poor segment of the society. The next section examines the trends in poverty and maternal health care indicators, followed by a brief review of literature in Section 3. Data sources are discussed in Section 4 while results and conclusions are given in Section 5 and 6 respectively.

Poverty and Health Indicators in Pakistan

There has been a sharp increase in poverty in Pakistan since the 1990s, after declining during 1980s. The magnitude of poverty increased from 17.5% in 1987-88 to 26.1% in 1990-91 then 29.8% in 1996-97 and finally to 32.1% in 2000-01 (Arif, 2004). It appears

to have increased with the sluggish growth rate of GDP from more than 6 percent in the 80s to around 4 percent in the 90s. During the same period Pakistan implemented 'Structural Adjustment and Stabilization Programs' which had serious repercussions for growth of GDP, employment and poverty levels. Distributional changes during this period suggest that declining economic growth appears to have adversely affected the income share of the bottom 20% poor. Moreover, prevalence of poverty in rural areas has historically been higher than in urban areas. The economy is once again witnessing a revival of growth since 2003 due to strong growth performance of the economy in the last two years. At the same time an appreciable decline in poverty rates has occurred between 2000-01 and 2004-05 (Table 1).

Table 1. Poverty and Health Indicators in Pakistan.

Indicators	**1998-99**	**2000-01**	**2004-05**	**2015 MDGs Targets**
GDP Growth Rate (%)	4.2	2.2	6.5	-
Poverty Incidence (%)	30.6	32.1	24.9	13
Health Exp as % of GDP	0.58	0.58	0.57	-
Maternal Mortality Ratio	350	500	400	140
Total Fertility Rate	4.5	4.3	3.9	2.1
Antenatal Consultation (%)	31	35	49	100
Tetanus Toxiod (%)	39	46	51	100
Post Natal Consultation (%)	9	9	22	-
Births attended by Skilled Personnel (%)	28	40	48	>90
Prevalence of Contraceptive (%)	17	19	26	55

Source: Pakistan Economic Survey, Pakistan Integrated Household Survey (various Issues), *PSLMS (2005-06).

Pakistan is expected to reduce poverty from 26.1% in 1990-91 to 13% in 2015. To fully endorse the achievement of the Millennium Development Goals, the

Government of Pakistan adopted a strategy for poverty reduction in 2001 as outlined in the Interim Poverty Reduction Strategy Paper (PRSP) which rests on four pillars that include accelerating economic growth, improving governance, investing in human capital and expanding social safety nets.

It is observed that health sector has not received adequate allocation in GDP during the same period as the share of total public health expenditure was 0.58 percent of GDP whereas average health spending is 1.0 percent in South Asia, 2.7 percent in developing countries and 6.3 percent for high income countries. This demonstrates how the public sector in Pakistan spends the least amount of money on health. Some basic facts about the country's reproductive health situation indicates that more than 20,000 women die each year due to pregnancy related complication and maternal mortality remains 300 to 700 per 100,000 live births thus ranked second in South Asia in terms of absolute number of total maternal deaths (WHO,2003). Similarly, the highest lifetime risk of maternal death (1 in 31 that is the probability of dying as a result of pregnancy cumulative across pregnancies in a woman's life) is observed in Pakistan. Lack of timely obstetric care utilization is major contributor to these deaths. Studies indicate that these barriers arise at three different levels: delay in the decision to seek care, obstacles in reaching the hospital and delay in receiving adequate treatment at the hospital. These levels are further influenced by cultural, social, economic, medical, geographical and environmental factors.

The level and causes of maternal mortality vary between regions and districts depending upon accessibility of emergency obstetric care. Maternal Mortality is considered to be the one of the most sensitive indicator of women's health and of the quality and accessibility of health services available to women which is measured through, proportion of births attended by skilled professionals, place of delivery, contraceptive prevalence rate, total fertility rate and antenatal and postnatal care consultation. The WHO estimates suggest that 88% to 98% of pregnancy–related deaths are avoidable by providing quality health care during and after labor and delivery. It is the single most important way of saving the lives and preserving the health of mothers and babies (WHO, 1996).

Pakistan has gained improvement in these health indicators but still it has high fertility, inadequate institutional deliveries, under utilization of antenatal care and family planning methods. The progress in these indicators are insufficient to achieve fifth Millennium Development Goal to reduce by three quarters between 1990 and 2015, the Maternal Mortality Rate from 550 to 140 per 100,000 live births and to achieve its targets in proportion of birth attended by skilled birth attended from 18 percent in 1990 to 90 percent in 2015, contraceptive prevalence rate from 12 percent in 1990 to 55 percent in 2015 , total fertility rate from 5.4 in 1990 to 2.1 in 2015 and at least one antenatal consultation from 15 percent in 1990 to 100 percent in 2015 (UNDP, 2005).

Data and Methods

The present study is based on *The Pakistan Social and Living Standard Measurement Survey (PSLMS) 2004-05* conducted by Federal Bureau of Statistics (FBS). It is one of the main mechanisms for monitoring the implementation of the 'Poverty Reduction Strategy Paper (PRSP)'. The PSLM survey relies on Core Welfare Indicators Questionnaire (CWIQ) which intends to provide data for formulating the poverty reduction program initiated under Poverty Reduction Strategy Paper and Medium Term Development Framework (MTDF) in the overall context of MDGs. The present study is based on a sample survey covering approximately 73,424 households in the four provinces of Pakistan excluding Azad Kashmir and Northern Areas. The survey provides information on variety of social sector issues such as Education, Health, Water Supply & Sanitation and Household Economic Situation and Satisfaction by facilities and services use (Pakistan, 2005).

It also provides a set of district level representative population based estimates of social indicators and their progress under the PRSP. The survey also try to establish what the distributional impact i.e., whether the poor have benefited from increased government expenditure on the social sectors. The government is spending a lot to improve the economic situation of the people and also investing considerable amounts in providing different types of facilities for improving core welfare indicators. The study described here is done to investigate the role of poverty status as a barrier to the utilization of preventive maternal health care services. This perception of the economic situation of the household compared to the previous year before the survey is taken as a proxy of poverty status.

Results

The health module of the PSLMS 2004-05 provides information on approximately 78944 women age 15-49 years. This represents 68.6% of women and 15.7% of overall population, whereas change in perception of the economic situation of the household compared to previous before the survey is taken as proxy for poverty status. The scenario of maternal health care utilization and poverty in Pakistan, as emerging from the present analysis along with its regions and provinces are presented in this section. The statistic in table 2 indicates that approximately 20 percent to 27 percent women's economic status become very worsens across the region and provinces. These estimates reflect the magnitude of national poverty, i.e. 23.94% poor based on a poverty line that is Rs.878.64 per capita per month. The percentage of poor population can further be identified as extremely poor 1.0%, ultra poor 6.5% and poor 16.4%, [Pakistan,2005] . The perception of economic situation is close to estimated magnitude of poverty in the country. The decomposition of the above table indicates that about half of the women's economic status has not changed across the region while there is variation across four provinces. A very thin population becomes better off in 2004-05 in over all Pakistan.

Table 2: Distribution of women Age (15-49) by Economic status, Region and Province (%)

Change in Perception of Economic Status in 2004-05	Region			Provinces			
	Pakistan	Urban	Rural	Punjab	Sindh	NWFP	Balochistan
Worst	3.9	3.4	4.2	3.1	5.1	4.5	3.3
Worse	19.9	18.9	20.5	18.7	20.9	23.2	17.2
Same	51.4	50.6	51.8	49.4	56.8	40.5	62.8
Good	22.4	24.4	21.4	25.7	15.4	29.0	15.9
Better	2.3	2.8	2.1	3.0	1.7	2.7	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Computation Based on PSLMS (CWIQ) 2004-05

Table 3: Distribution of women Age (15-49) by Economic status, Region and Province (%)

Change in Perception of Economic Status in 2004-05	Given birth to a child during past 3 years.						
	Pakistan	Urban	Rural	Punjab	Sindh	NWFP	Balochistan
Worst	44.7	41.2	46.2	42.1	45.6	47.2	44.6
Worse	46.7	43.8	48.1	45.9	47.3	48.5	45.0
Same	44.6	41.6	46.1	44.5	46.0	47.0	40.4
Good	43.2	39.5	45.4	42.0	40.7	48.2	40.6
Better	43.5	40.2	45.8	41.9	36.6	52.4	43.8
Total	44.7	41.4	46.4	44.0	45.3	47.8	41.4

Source: Computation Based on PSLMS (CWIQ) 2004-05

Table 3 shows that approximately 45 percent women have given birth to a child during the past 3 years irrespective of economic status of the women in Pakistan. In urban areas the proportion is less compared to rural areas whereas provincial variation is not significant except in NWFP. It is also observed that economic status of women does not play a significant role in reproductive behaviour across Pakistan.

Table 4: Distribution of women Age (15-20 years) by Economic status, Region and Province (%)

Change in Perception of Economic Status in 2004-05	Given birth to a child during past 3 years age 15-20 years						
	Pakistan	Urban	Rural	Punjab	Sindh	NWFP	Balochistan
Worst	12.5	10.4	13.3	8.5	14.1	13.2	16.8
Worse	10.6	8.3	11.6	8.3	11.6	14.0	9.1
Same	10.1	8.0	11.1	7.8	11.5	12.9	10.7
Good	9.7	7.7	10.8	7.5	10.4	13.0	10.1
Better	8.1	5.7	9.6	4.2	6.7	15.1	12.8
Total	10.2	8.0	11.2	7.7	11.4	13.3	10.5

Source: Computation Based on PSLMS (CWIQ) 2004-05

The table 4 gives statistic of high risk age group of women (15-20 years of age) who have given birth to a child during past 3 years. It is observed that Punjab has lowest percentage of women who have given birth irrespective of the economic status thus minimize the risk of maternal mortality. Variation is seen across provinces and economic status as NWFP has highest percentage of women placed in this age group while in Balochistan poorest women are concentrated in this age bracket.

Table 5: Distribution of women Age (15-49) by Economic status, Region and Province (%)

Change in Perception of Economic Status in 2004-05	Utilization Of Antenatal Consultation.						
	Pakistan	Urban	Rural	Punjab	Sindh	NWFP	Balochistan
Very worse	41.0	63.5	32.7	51.7	44.4	35.4	15.5
Worse	43.7	61.4	36.1	51.6	49.4	33.4	26.3
Same	45.9	64.2	37.6	51.8	50.4	34.3	35.1
Good	55.6	72.3	47.0	62.0	64.7	47.4	33.0
Better	67.4	80.5	59.3	71.8	70.0	58.3	64.1
Total	49	65.9	39.5	54.8	52.1	38.7	32.7

Source: Computation Based on PSLMS (CWIQ) 2004-05

Table 5 presents antenatal care services received by women suggest that approximately 49 percent births are preceded by even a single antenatal visit as compare to 31 percent in 1998-99 in Pakistan. The urban area shows a quite encouraging picture among different economic status while the rural area remains lag behind in service utilizations. Across provinces the range is varied from 54.8% in Punjab to 32.7% in Balochistan. The lower status groups consistently display lower rates of antenatal care utilization across Pakistan whereas women in Balochistan are the most vulnerable in this context. Punjab stands first in terms of antenatal care utilization. However, the result presented here suggests that patterns of maternal health care utilization in Pakistan are more complex than this urban/rural differential implies.

Table 6: Distribution of women Age (15-49) by Economic status, Region and Province(%)

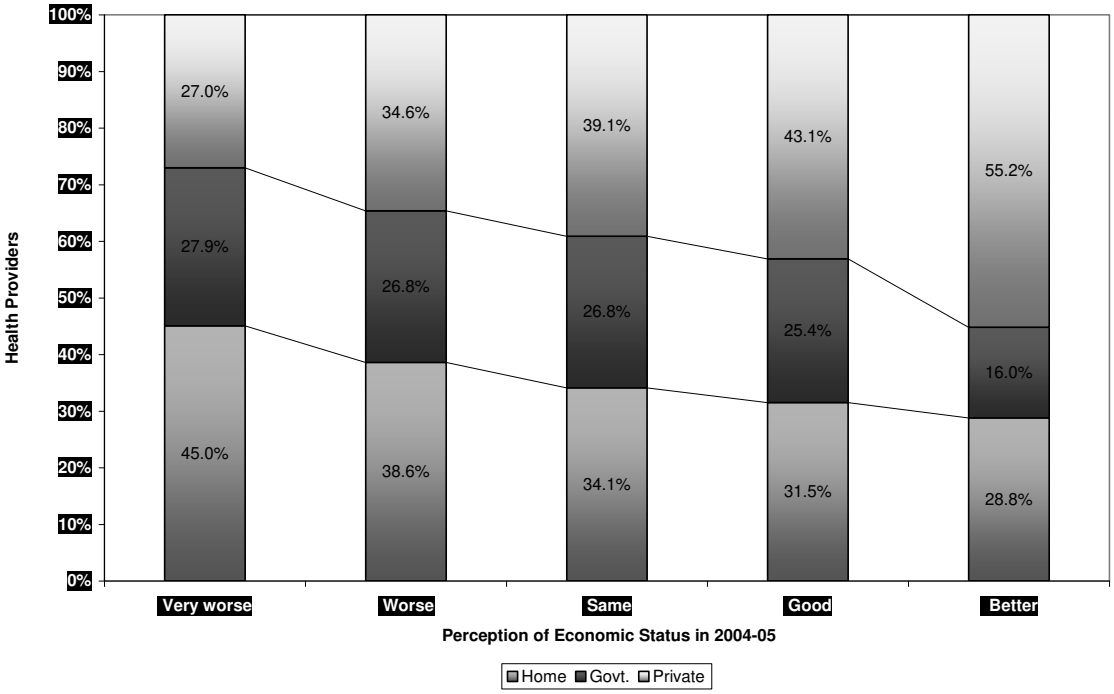
Change in Perception of Economic Status in 2004-05	Received Tetanus Toxoid Injection						
	Pakistan	Urban	Rural	Punjab	Sindh	NWFP	Balochistan
Worst	40.4	57.7	33.9	53.4	38.2	40.7	11.9
Worse	43.3	60.7	35.7	56.6	39.9	40.2	13.7
Same	46.5	65.1	38.0	58.0	45.8	40.7	24.3
Good	57.9	73.4	50.0	68.3	58.9	49.9	29.8
Better	71.4	84.8	63.2	75.8	63.0	70.2	59.0
Total	48.6	66.4	40.4	60.6	46.2	44.1	23.1

Source: Computation Based on PSLMS (CWIQ) 2004-05

Tetanus Toxiod (TT) injections are given to women during pregnancy to protect infants from neonatal tetanus, a major cause of infant death that is due to poor hygiene during delivery. The TT immunization also protects women from developing tetanus themselves. Maternal tetanus is also responsible for at least fifteen percent of total maternal deaths in the world (WHO, 2003). Table 6 gives analysis for tetanus immunizations which gives

even worse picture as compare to antenatal care. On average one half of pregnant women receive tetanus injections in Pakistan. Urban area show relatively satisfactory figures compared to rural area. The range of variation across provinces is considerably greater than it is for either antenatal care since only 23.1% have immunization in Balochistan. The disparity is also profound in terms of economic status, regions and provinces as again Balochistan appears the most vulnerable in all respect.

Figure 1: Distribution of Women Utilizing Antenatal Care by Economic Status:Pakistan



The distribution of women receiving antenatal care services by health providers are given in figure 1. It indicates that as economic status improves women are switching from home to privates health personnel. The same trend continues in regions and provinces.

An important element of maternal health care services is to encourage institutional (hospitals/clinics) deliveries under the supervision of trained health professionals. The majority of maternal death and morbidity resulting from childbirth can be avoided by getting timely help for complications during delivery. Delivery conducted by health professionals ensures safety of mother as well as the child as it is a key factor for maternal mortality. The estimates of PSLMS indicate that in Pakistan on average one fourth of deliveries take place in a health facility and are assisted by skilled personnel.

The statistic in Table 7.a revealed that most often particularly in rural areas and among the lower economic status groups, delivery care is dominated by home births either in the natal or the marital household. Hence high risk pregnancies are often not identified, obstetric histories are ignored, opportunities for transmitting family planning messages are missed and important information on child nutrition and health care is not disseminated to a large proportion of mothers. Home delivery may be appropriate for normal deliveries, provided the person attending the delivery is suitably trained and equipped and referral to a higher level of care is an option (WHO, 1996).

Table 7.a: Distribution of women age (15-49) by Economic Status and Place of Delivery (%)

Change in Perception of Economic Status in 2004-05	Place of Delivery								
	Pakistan			Urban			Rural		
	Home	Govt.	Private	Home	Govt.	Private	Home	Govt.	Private
Worst	79.8	8.6	11.7	66.2	15.4	18.4	84.8	6.0	9.2
Worse	78.0	8.6	13.4	61.8	15.2	23.0	85.0	5.7	9.2
Same	75.4	8.8	15.8	58.4	13.6	28.1	83.2	6.6	10.3
Good	68.3	9.6	22.0	49.7	14.5	35.7	77.8	7.1	15.1
Better	56.8	9.3	33.9	37.0	11.4	51.5	69.0	7.9	23.1
Total	74.2	8.9	16.9	56.7	14.1	29.1	82.2	6.5	11.3

Source: Computation Based on PSLMS (CWIQ) 2004-05

In terms of provincial differentials, 88 percent of all births in Balochistan take place at home, compared to 67 percent in Sindh. Childbirth at home is also linked with economic status. In Sindh, 43 percent of births in the highest economic status take place at home whereas in Balochistan 91 percent of births in lowest economic status take place at home as presented in Table 7.b. The high incidence of child delivery at home without assistance from trained medical personnel can be attributed to high maternal mortality rate; i.e. 281 in urban Karachi whereas 673 in rural Balochistan (Tinker, 1998).

Table 7.b: Percentage of women age (15-49) by Economic Status and Place of Delivery (%)

Economic Status in 2004-05	Place of Delivery											
	Punjab			Sindh			NWFP			Balochistan		
	Home	Govt.	Private	Home	Govt.	Private	Home	Govt.	Private	Home	Govt.	Private
Worst	77.7	8.0	14.3	76.2	9.0	14.8	81.5	11.4	7.1	91.3	3.1	5.6
Worse	76.7	7.7	15.7	73.6	8.5	17.8	78.1	11.9	10.0	92.0	5.1	2.9
Same	74.6	7.4	18.0	68.8	8.3	23.0	77.7	13.1	9.2	87.2	8.5	4.3
Good	66.4	8.8	24.8	50.9	12.4	36.7	75.1	11.4	13.5	87.1	3.6	9.4
Better	51.6	8.0	40.4	43.3	6.7	50.0	72.5	11.9	15.6	64.1	15.4	20.5
Total	72.4	7.8	19.8	67.4	8.9	23.7	77.0	12.2	10.7	88.0	7.0	5.0

Source: Computation Based on PSLMS (CWIQ) 2004-05

Figure 2: Distribution of Women by Birth Attendants and Economic Status:Pakistan

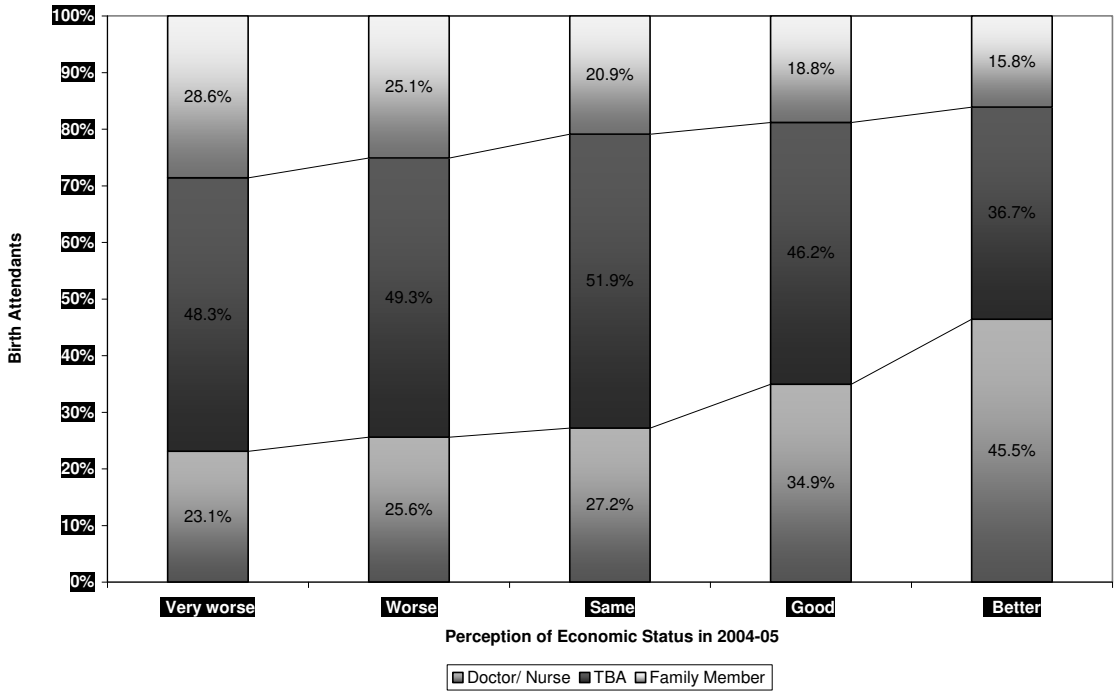


Figure 2 portrays the distribution of births attended by health personnel. It is observed that the majority of deliveries are still attended by traditional birth attendants in Pakistan. It is also depicted that as economic status improves more births are attended by doctors and nurses.

Table 8: Women Receiving Post Natal Care by Economic status, Region and Province (%)

Change in Perception of Economic Status in 2004-05	Received a post natal care within 6 week of delivery						
	Pakistan	Urban	Rural	Punjab	Sindh	NWFP	Balochistan
Worst	18.0	29.7	13.7	20.1	19.5	19.7	5.0
Worse	19.9	30.0	15.5	19.9	24.1	19.6	10.9
Same	20.0	32.6	14.3	21.0	22.6	17.9	14.8
Good	26.2	39.4	19.5	26.9	35.8	22.3	18.5
Better	39.6	57.6	28.5	39.4	47.5	34.4	46.2
Total	23.0	34.3	16.0	23.0	27.0	20.2	16.0

Source: Computation Based on PSLMS (CWIQ) 2004-05

The role and content of postnatal care received less attention than other aspects of maternal morbidity even though mortality occurs during the post-partum period. Early post-partum care is essential in order to diagnose and treat complications, as estimated average interval from onset to death for major obstetric complications is from two hours to six days (Maine,1992). It is crucial to check the general well-being of mother and infant and a time to discuss birth spacing and different methods of contraception. The analysis presented in Table 8 suggests that economic differential is important in the utilization of post natal consultation ranging from the lowest in Balochistan to highest in Sindh across different economic status.

Table 9: Percentage of women Age (15-49) by Economic status, Region and Province

Change in Perception of Economic Status in 2004-05	Women Ever Utilized the Facility of Family Planning Center						
	Pakistan	Urban	Rural	Punjab	Sindh	NWFP	Balochistan
Worst	**18.4**	**23.5**	**16.6**	**20.7**	**11.0**	**32.0**	**6.2**
Worse	**18.8**	**24.3**	**16.5**	**17.2**	**15.8**	**29.5**	**9.2**
Same	**17.2**	**20.3**	**15.7**	**16.5**	**17.9**	**23.5**	**11.0**
Good	**23.4**	**25.8**	**22.0**	**18.8**	**25.2**	**32.4**	**15.1**
Better	**31.7**	**32.3**	**31.3**	**28.2**	**30.0**	**40.7**	**23.1**
Total	**19.2**	**22.8**	**17.6**	**17.7**	**18.2**	**28.4**	**11.3**

Source: Computation Based on PSLMS 2004-05

Table 9 shows the distribution of women who have given birth during the last three year and ever (occasionally, often or always) utilized a family planning center in last month before the survey. Regional and provincial distribution shows that more wealthy women avail the facility of family planning center than poor women. It can be assumed that many

barriers such as physical, economic, social and cultural stand between the poor women and the use of services.

Finally, results presented in this section suggest that pockets of high maternal health care utilization exist within urban areas and are associated with upper economic status. Provincial comparison suggests that Punjab presents a better picture whereas Balochistan is the most vulnerable province in terms of health care services utilization.

Conclusions

The study described here is done to investigate the role of poverty status as a barrier in access to maternal health care services in Pakistan by regions and provinces. The analysis is based on 'The Pakistan Social and Living Standard Measurement Survey 2004-05' conducted by Federal Bureau of Statistics (FBS) which provide ample of information on poverty status and maternal health care services. Three important indicators prenatal care, institutional delivery, post natal care and ever utilization of family planning services are taken to assess the utilization of maternal health care services across perception based economic status.

The study revealed that approximately 20 percent to 27 percent women's economic status has worsened while 50 percent of the women population observed no change in their economic status across the region. However, there is vast variation across four provinces. Although the share of health sector budget in GDP remains small and stagnant during the last two decades but its health indicators improved to some extent. The antenatal care services received by women suggest that 49 percent births are preceded by at least a

single prenatal visit in Pakistan. Across the country, Tetanus immunizations had some widespread improvement but in Balochistan it has not improved across different economic status. In Pakistan delivery care is still dominated by home births, particularly in rural areas and among the lower economic status groups. As far as health providers are concerned, better off women avail the facility from private sector while majority of poor women visit government hospitals or clinics. The role and content of post natal care has received less attention across region and provinces. Only a quarter of women ever utilized the facility of family planning center during the last month preceding the survey. Finally, it can be concluded that poor economic status of women is a barrier in utilizing the maternal health care services. In provincial comparison Balochistan is the most vulnerable province in all respects.

Finally, it can be concluded that the progress of maternal health care indicators are yet to be seen across Pakistan, and substantial efforts are still required to meet the goals by 2015 as outlined in the Millennium Development Goals documents. However, the targets can be achieved without making much of an impact on the lives of the poorest. This can be true for any health or development program which is often judged by averaged improvement. Lastly, the progress of policies and program related to maternal health should always be monitored and evaluated in terms of on-the-ground achieved success, and not only on aggregate figures but for each group in the population.

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