



Access to HealthCare Swabi and Buner Districts

Khyber Pakhtunkhwa – Pakistan



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Medecins du Monde - France



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ACRONYMS AND ABBREVIATIONS

ACO	Assistant Coordination Officer
ANC	Antenatal Care
BHU	Basic Health Unit
DCO	District Coordination Officer
DHQ	District Head Quarter
EDO H	Executive District Officer of Health
EPI	Expanded Programme of Immunisation
FGD	Focus Group Discussion
IDP	Internally Displaced Person
KPK	Khyber Pakhtunkhwa
MdM	Médecins du Monde
NWFP	North West Frontier Province
LHV	Lady Health Visitor
LHW	Lady Health Worker
MCH	Mother and Child
OPD	Outpatient Department
PNC	Postnatal Care
RHC	Rural Health Centre
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UC	Union Council
WHO	World Health Organization



EXECUTIVE SUMMARY

In response to the military operations in Swat valley during the first half of 2009, Médecins du Monde initiated a programme to support the displaced population from Swat Valley, Northern Buner and their host population in Swabi and Buner districts of Khyber Pakhtunkhwa province. The programme consisted of providing primary and maternal health care including nutritional and immunization components. The programme has been able to reach over 77 400 patients up until today.

As part of the Médecins du Monde's operational and exit strategy, a survey on the access to health care has been conducted throughout July and August 2010 in order to identify the access to health issues one year after the crisis. The objective of this analysis is to increase insight for all partners involved from local and provincial authorities to several humanitarian actors present in order to effectively address health access problematic of this specific region.

The survey has been conducted in two phases in which all types of access restrictions have been taken into account. Physical and geographical accesses are linked to functional and quality questions, social cultural access and financial limitations. During the process we have given special attention to vulnerable groups such as children and pregnant women. The first phase consisted of focus groups discussions (FGDs) with men and women separately in four villages. The general insight resulting from these discussions supported the questionnaire for the cluster survey which has been conducted in July and August 2010. The questionnaire has been conducted in 31 villages reaching a randomly selected 617 head of household and mothers (50%/50%). Of the villages visited, 16 are located in Swabi (320 persons) and 15 in Buner (197 persons).

In this summary we will give a broad outline of our main findings while the underlying details can be found in the rest of the report.

General Healthcare Access

Global access to healthcare in Swabi and Buner is in line with the provincial average

Even though the access to health care in Swabi and Buner districts is comparable to the whole of Khyber Pakhtunkhwa province, in absolute terms, the access to health care is pretty low.

The access is unequal among the population. Households living in Swabi, educated, wealthier and living in an accessible village have a better access to healthcare.



Financial issues form the main constraint for healthcare access in both districts

52% of the interviewees mentioned that their main constraint to access a health care facility is of financial nature.

This financial issue is linked to the distance to the facility as the transportation cost constitutes a big part in the final cost. In Buner district where the villages are more remote than in Swabi, the average consultation cost including tests, medicines and transportation is approximately 30% higher than in Swabi.

Also, the financial issue has a bigger impact in Buner than in Swabi: A consultation to health facility represents 14% of the monthly income in Buner, where the households are usually poorer, and 9% in Swabi.

Geographical constraints are more important in Buner than in Swabi

Buner is a more remote district than Swabi. Therefore the accessibility to health facilities is more difficult than in Swabi which has an impact on the access to healthcare in many ways.

- Transportation fees represent 10% of the final cost of consultation, especially because there is no other option than taking a taxi, which is more expensive than other forms of public transport.
- In some villages, there is no car available during the day so the person sometimes has to wait for a minimum of one day for a car to return which can lead to some complications meanwhile.
- 31% of the children don't get fully immunized because the facility is too far.

Limited awareness on preventive care

Awareness seems to be a recurring problem for the preventive care such as antenatal care (ANC), postnatal care (PNC) and vaccination. Most of the time the people do not understand the purpose and therefore do not realise the importance of preventive care consultations.

Maternal Healthcare

Motive for having antenatal check-ups depends on the household profile

The percentage of pregnant women getting an antenatal check-up is 60% which is in line with the provincial average (54%).

However, there is a strong relationship between the level of education and income of the household and the reason why the antenatal check-up is attended. The higher educated and richer the household, the more routinely antenatal visits take place. 70% of the pregnant women living in a household earning more than 10000 rupees is going for a routine check-up.

On the other hand, 65% of the uneducated women going for an antenatal visit are going only in case of an assumed medical problem.

The low percentage of routine check up among the uneducated people is due to a lack of awareness (43% of the answers), financial issue (34% of the answers).

More than half of all antenatal care visits is taking place in private clinic due to unavailability in the public system

56% of all antenatal care visits is done in private clinics. Private clinics are mentioned to be preferred for the following reasons:

- The opening times of private clinics are more flexible, compared to the basic health units (BHUs) and rural health centres (RHCs) which are closing usually at 13:00.
- People have the idea they will get better treatment in a private clinic than in government health facility. Also, doctors are known to allocate more time to their patients in private clinic.
- Lady doctors are more available in private clinics than in government health centres.

Half of all pregnant women are not immunized against tetanus due to a lack of awareness

27% of the households where the mother did not get the TT injections mention this is because they were not aware they should have it. 21% of the interviewees say it is too far to get it and 10% answered it is not customary.

Pregnant women living in more educated families usually get vaccinated as they know about it.

Most of the time, TT vaccination is not part of the antenatal check-up when it is done in a private clinic. Either they do not have the tetanus toxoid available or charge for it. The women then have to specifically go to a government health centre to get the injection. There is apparently a lack of health education as the pregnant women who go to a private clinic for an antenatal check-up not necessarily go to a government health centre to get immunized.

One in two deliveries are not attended by a medically skilled person

People living in remote places, mostly also the poorer households, don't get the assistance of a medically skilled person and usually deliver home.

Financial issue remains the main reason why some women deliver without any skilled person. The average cost of a delivery in a facility is over 6000rs and cost of transportation to the facility have to be added to it. Then, the cost of a home delivery with a skilled person is around 1500rs which is still an considerable amount. Finally the average cost of the delivery attended by friends or relatives is a lot cheaper as the people buy just some medicines if need be and is less than 200rs.



Tradition of staying home 40 days after delivery prevents mothers of going for a postnatal check-up

73% of women do not get any postnatal check-up as they don't see the necessity of it and since the tradition that the mother should stay home during 40 days after delivery is well respected. 67% of the mothers in Swabi and Buner districts only leave the house for the first time after 40 days.

Among the mothers who got the postnatal check-up, 30% of them got it at home which is a good way to combine both tradition and medical check-up.

Curative Healthcare

One third of the households wait a minimum of 3 days before looking for professional medical care

The time to wait before looking for professional healthcare is strongly dependent on proximity of a health facility or professional. For the ones who wait the reasons vary as they think the problem is not serious enough (31%), a large group needs to find the money needed first (25%) and others prefer to treat the patient first at home (17%).

The waiting time varies between Swabi and Buner. 49% of the people in Swabi go straight to the doctor whereas in Buner, up to 12% wait more than a week before going there.

Choice of facility depends mainly on the availability and confidence in the doctors

58% of the people don't go to the closest facility. The main reason given (55%) is that the facility is closed most of time or they lack trust in the capacity of the closest facility or professional.

The problem of availability of facility is more often mentioned in Buner (65%) whereas in Swabi the trust in the health professionals (34%) appears to be the main problem. This significant difference shows that in Swabi the people have a choice in facilities and professionals. This therefore seems more of a choice than a primary constraint. In Buner, the availability of a health facility itself remains the first concern.

Immunization

Three quarters of all children under 5 is up to date with their vaccinations schedule

There is a reasonable percentage (73%) of children vaccinated throughout the districts. Normally, if they get vaccination, they are up to date in their immunisation schedule. The parents in this case appear to understand the full purpose and advantages of the vaccination, and therefore take the schedule seriously.

A smaller group within the population is reluctant to have injections or stops in the middle of the schedule after presented side effects. The main reason for both reactions appears to be a lack of awareness.

Disclaimer

Reasonable measures have been taken to ensure the reliability and accuracy of the information included in this report. This report is intended to provide information as per 31st of August 2010. If details are necessary, please contact Médecins du Monde France.

I. CONTEXT

1.1 Introduction

Buner and Swabi districts are both located in the Khyber Pakhtunkhwa (KPK) province, North of Pakistan. Around 95% of the inhabitants of these 2 districts are Pashto.

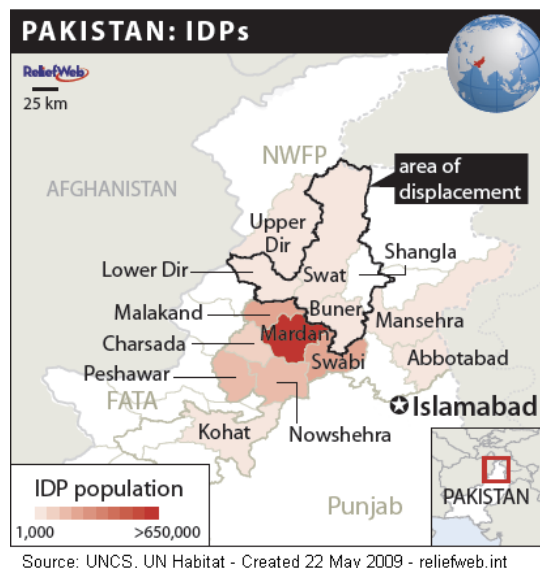
Buner consists of mountain valleys marked by small villages. Based on the 1998 Population Census, the population was 506,048 individuals with a density of 271 people per square kilometre. This district, divided in 27 union councils¹ (UCs), is a rural area and there is no big urban centre. Most of the people are poor, uneducated, living in mud houses. Even though the living conditions are improving as more and more families send people to work abroad, the incomes are low and the main source remains agriculture.

Swabi district borders the south of Buner. As opposed to Buner, this district consists mainly of big plains. Based on 1998 Population Census, its population was 1 026 804 inhabitants with a density of 665 people per square kilometre. The opening of the motorway two year ago improved a lot the accessibility to the district with a possibility to reach Islamabad in less than two hours. However, the district main source of income remains agriculture, with a lot of tobacco plantations. As for Buner, more and more families send their members abroad to get a better income.

1.2 Background

In May 2009, the Government of Pakistan launched a military operation against Taliban forces in Buner, Low Dir, and Swat Valley districts, located in KPK province. The majority of the local population started moving to Mardan and Swabi in order to avoid the conflict. By May 28, 2009, the number of IDPs had swelled to just over 3 million creating further pressure on the government, as well as the international community, to respond to the needs of the migrating population who had left their homes without money or other support.

In response to the evolving situation, Médecins du Monde (MDM) conducted a



¹ A union council is the first level of government administration in Pakistan. Each union council includes 8-15 villages and an average population of about 15,000-25,000.

rapid assessment in mid May 2009 in order to understand the needs of this latest group of internal displaced populations (IDPs). As IDP numbers increased, it was determined that the majority of IDPs were not in fact accommodated within IDP camps. Instead, IDPs preferred to stay with host families placing excessive strains on existing family support and coping mechanisms.

MDM has decided then to set up some mobile clinics in Swabi and Buner districts to respond to the needs of IDPs out of the camps, of the host families and support some existing health structures. The length of this operation was planned for 6 months in order to accompany the returnee's process. The mission has then been extended to respond to the humanitarian needs and the current situation.

MDM-France is providing basic health services to the IDPs in their current living conditions and to the host families affected by the crisis in Swabi and Buner districts (KPK) through mobile clinics and the support to health structures (drugs supplies) on sites.

1.3. MDM in Pakistan

MdM has been working in Pakistan since 1996 under an agreement signed with the Government of Pakistan's Economic Affairs Division (EAD) on the 3rd of August 1996. In accordance with its regional strategy, the primary aim of MdM in Pakistan is to focus on the access to health and status of women and children in the country.

For 8 years, MdM conducted the "Women's Reproductive Health Care Programme" in Khanpur, in southern Punjab province in close collaboration with the Ministry of Health and the Ministry of Population Welfare. The aim was to improve maternal health awareness, to ensure quality and availability of obstetric services. A maternal health infrastructure was established, based on strong links between government health facilities and trained community activists. This programme is now run by a Pakistani NGO.

Since 2004, MdM is working in cooperation with the Ministry of Social Welfare of Punjab in the "Dar-UI-Aman", social centres for women. The current programme is covering a total of 35 Dar-UI-Aman providing a legal, medical and psychosocial assistance and also management support.

In 2005 & 2006, MdM has intervened during 15 months to provide assistance to the victims of the earthquake which occurred in the Eastern North West Frontier Province (NWFP), now known as KPK.

Since June 2009, an additional emergency programme was launched in Swabi and Buner districts, to contribute to reduce the mortality and morbidity of the displaced population and the strained host population in KPK through the re-establishment of the access to primary health care units (BHUs and RHCs).

In February 2010, MDM responded the Orakzai crisis using the same modus operandi than in the Swat crisis to respond to the massive population displacement deploying medical team in Kohat and Hangu districts.

In August 2010, MDM responded to the flood crisis by providing in no time some mobile clinics in Charsada and Nowshera districts and two diarrhoea treatment centres in Kohat, at the LMH and District Heal Quarter (DHQ) Hospital.

MDM emergency program is currently working in 3 main locations, Swabi and Buner districts, Kohat and Hangu, and Charsada and Nowshera districts providing primary health care through mobile clinics. On average, MDM does 5000 consultations per month in the following activities: Curative consultations, reproductive health care and expanded programme of immunisation (EPI).

Map 1: MDM in KPK



1.4. Rationale

As MDM is looking at an exit strategy for Buner and Swabi, there is an increased need for assessing the health access situation 1 year after the peak of the crisis. The survey aims to create analysis, focusing on vulnerable groups to conduct advocacy activities and to help the authorities and the humanitarian community at understanding the health access problematic in these two districts.

The health access constraints identification may look at the following fields:

- Functional health access
- Financial constraint for health access

- Geographical constraint for health access
- Social-cultural constraint for health access
- Physical constraint for health access
- Security constraint for health access

In May 2009 WHO conducted a Rapid Health Assessment focusing on health availability in Swabi and did the same in February 2010 in Buner. Using this health availability baseline information, the survey may look at first on what is the link between the health availability and the health access.

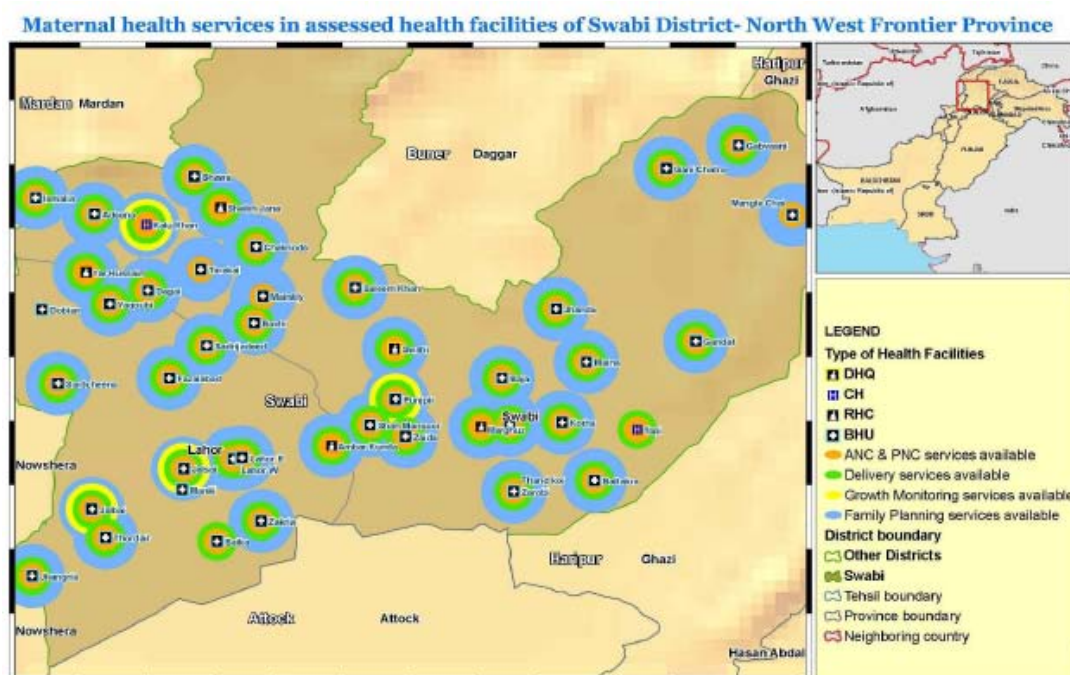
1.5. Health facilities in Swabi and Buner

1. Swabi district

Based on the latest assessment made by WHO on the health facilities in Swabi in May 2009, there are 3 hospitals (two civil hospitals and one DHQ hospital), 4 rural health centres (RHCs) and 38 basic health units (BHUs).

More than 90% of these facilities offer outpatient department (OPD), antenatal care (ANC), postnatal care (PNC), health education, family planning and routine expanded programme on immunization (EPI). More than 50% offer delivery services. Regarding MCH specifically the level of equipment for growth monitoring is low (8%).

Even though the health facilities in Swabi seem to be well equipped there is a regular shortage of medicines and also the lack of female medical staff makes the access to the facilities difficult for the women. Therefore there is a still large number of deliveries at home not attended by any skilled person. The long distance is also mentioned in the assessment as the geographical access remains difficult for the remote villages.

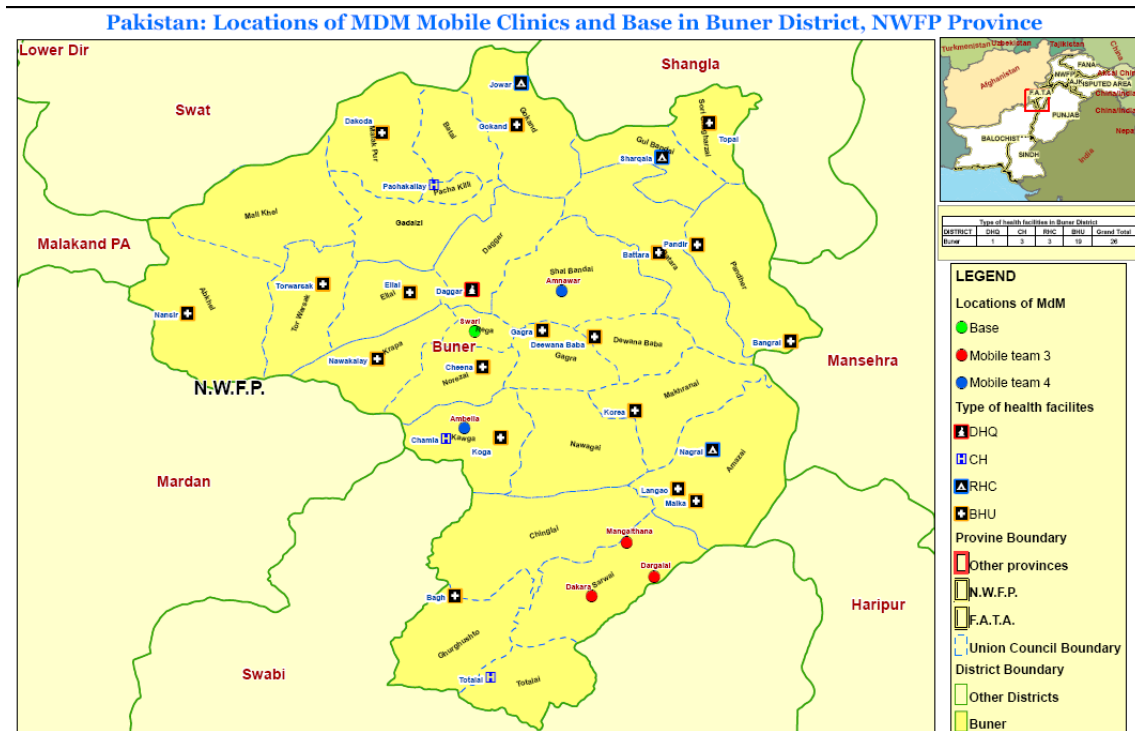


2. Buner district

In Buner, the latest assessment has been made in February 2010 by WHO. 4 hospitals (three civil hospitals and one DHQ hospital), 3 RHCs and 19 BHUs were listed for Buner district.

More than 100% of these facilities offer outpatient department (OPD). More than 60% presents ANC, PNC, health education, family planning, routine EPI and basic delivery services. However there is no specific MCH services in any of the facility in Buner and the growth monitoring equipment is very seldom.

The lack of services is mainly due to the lack of adequate medicines and equipment. Also the lack of female medical staff is also one of the main issue. The lack of preventive care such as ANC, PNC, growth monitoring and health education leads to an increased number of morbidity and mortality.



1.6. Survey Objectives

1. General objective

Measure and analyze the access to health services in Swabi and Buner districts (KPK)

2. Specific Objective

Provide key analysis describing burdens for the most vulnerable groups to access health services following the 2009 IDPs influx in Swabi and Buner districts putting a specific focus on the discrimination of structural and contextual problems.

3. Main activities

- Make a detailed statement of the health service offer constraints and challenges.
- Collect available data concerning health access in KPK and potentially in Buner and Swabi districts.
- Describe the social and economic parameters of health access in the two districts (socio-economic burden for vulnerable groups).
- Analyze the physical health access to health facilities.
- Identify the main constraints for vulnerable groups to access health services in Buner and Swabi.
- Propose recommendation for improving the health access of vulnerable groups in Swabi and Buner districts.

II. METHODOLOGY

The survey has been split into two parts:

- **A qualitative survey**, through focus group discussions (FGDs) and key informant interviews, to initially understand the main issues, their impact on people behaviour as well as reducing assumptions, preconceptions or prejudices.
- **A quantitative survey**, door to door, based on the results of the qualitative survey to validate or reject the results through measurable key indicators.

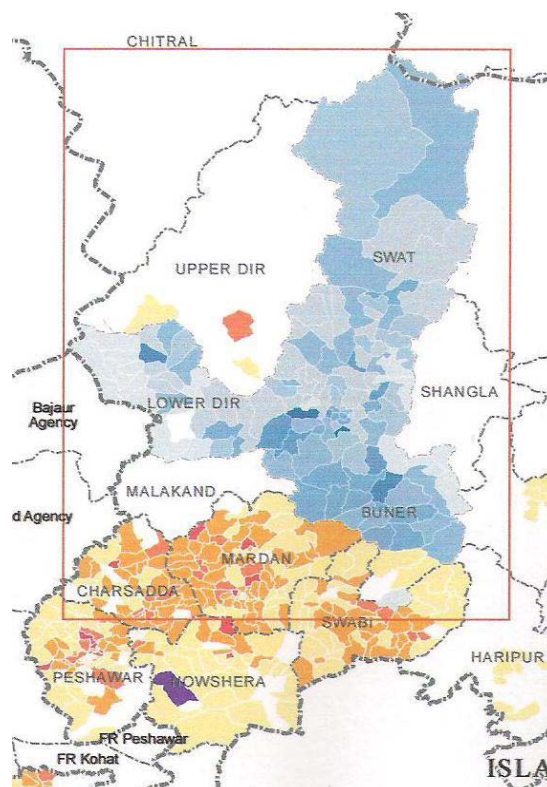
2.1. Study area

As part of MDM Emergency mission exit strategy, the survey had to focus on the IDPs as well as the host communities in Swabi and Buner districts during the crisis in May 2009.

A map analysis has been made to identify the UCs the most affected by the crisis and we came to the conclusion that the whole Swabi and Buner should be targeted for the survey.

The reason for this choice is the latest map found at UC level representing the IDP movements and the hosting communities is dated from April 2010 (one year after the crisis in this area). This map shows that Swabi and Buner are both still affected globally.

The sample will consist of a random selection of few villages in these 2 districts.



Extract from the OCHA map "Number of returned IDPs - Khyber Pakhtunkhwa as of 30 April 2010"
Blue = Number of families returned / Orange = Number of IDPs families.

2.2. Qualitative survey

In order to best prepare the door to door survey, 8 FGDs have been conducted to get information on the main constraints of access to health care for mother and child and the impact on the behaviour of these populations.

The FGDs have been made in separate groups with both, females and males and if possible, in the same villages. The idea is to get both point of view, and probably highlight the misconception of the access to health care for mother and child in one group or another.

The findings have then been used to build a final questionnaire taking into account the customs and habits of the population in these districts and identify the main indicators we want to include in the quantitative survey.

Then two additional FGDs have been organised, one with MDM male medical team and one with MDM female medical team working in Swabi and Buner districts, at the end of the door to door survey. The objectives of these focus groups were to get some explanation of some interesting results and based on the results of the door to door survey, get some ideas and recommendations on what should be done to face the identified issues.

1. Process

The process was as follow:

- 8 FGDs (4 with females and 4 with males) have been performed.
- 4 villages randomly selected in Buner and Swabi (see the maps in the following section to locate the villages)
- 6 to 10 people in each group.
- All the discussions were recorded with the agreement of the community.

2. Locations

Table 1: List of villages for the focus group

Villages	Population Size	Area	Gender	Group
Swabi				
Sat Khetar	437	Remote	Male	Head of families
Sat Khetar	437	Remote	Female	Elders / Mother in Law
Anbar	6095	Big village	Male	Educated
Anbar	6095	Big village	Female	Educated
Buner				
Girarai	3837	Remote	Male	Influent
Girarai	3837	Remote	Female	Influent
Banj Kara	868	Remote	Male	Illiterate
Gumbat*	4548	Remote	Female	Illiterate

* This focus group is not in the same location as the one for male because we were not welcomed by the community in Banj Kara to talk to the women.



3. Discussions

The open questions asked during the FGDs were the same in all groups and were around specific subjects.

1. If you/your wife or one of your children in your family gets sick, what is the first thing you do?
2. Where would you go if you/your wife or one of your children in your family gets sick (diarrhoea, scabies, etc.)? If you/your wife or one of your children gets really sick (trauma) or have an accident?
3. Who decides to take the person to the doctor? Who takes her to the doctor? Why?
4. Do you/your wife and your children get immunization? Vaccination?
5. During your last pregnancy, your delivery and after your delivery, did you see a doctor?

2.3. Quantitative survey

1. Study population

The survey includes both, mothers and men's opinions. It is important to interview men, head of family or not, as they are the one making the decision of sending the mother and children to the health facility or not. Approximately the same number of men and women were interviewed with the restriction of not belonging to the same household.

The selection of the households was as follow:

Inclusion criteria

- Household with at least one of these 2 criteria
 - A child under 5
 - A mother aged between 15 to 49
- Mother should be
 - Married or ever married
 - Aged 15 to 49 OR with a child under 5
 - Who have been pregnant at least once

Exclusion Criteria

- People refuse
- Communication problem

2. Methodology of sampling

A commonly used 2-stage sampling (also known as cluster sampling) scheme has been used.

First, we randomly selected the villages (cluster) in Swabi and Buner from the latest population census data (1998) and then we interviewed a certain number of random households in these selected villages.

Number of villages (cluster)

WHO recommends the “30x7” (30 clusters x 7 interviews) strategy for rapid assessments (1 month) such as cluster sample survey on health in developing countries or EPI coverage survey. So the minimum number of villages to select for this survey has been fixed to 30. Moreover, according to the budget allocated to the survey, we planned to visit 32 villages in both Swabi and Buner.

Table 2: List of selected villages for the door to door survey

Swabi			Buner		
Village	Union Council	Population (Census 1998)	Village	Union Council	Population (Census 1998)
AHAD KHAN	Chack Nodeh	3781	AMBELA	Kawga	4939
ASOTA	Asota	5407	BUDAL	Batara	2502
BATA KARA	Bata Kara	5336	CHALANDRAI	Pandher	857
BAZAAR	Beka	2503	CHANAR	Norezai	1965
DEWAL	Ganichitra	2822	DARGALAI	Sarwai	2469
GHULAMAN	Parmola	3563	INZARMAIRA	Sori Chagharzai	1899
HARYAN	Anbar	2181	KADAL/MENA	Makhranai	1838
JALBAI-MERA	Jalbai	1515	KANDER/KATAI	Gadaizi	1384
JHANDA	Jhanda	10185	KANGLAI	Chinglai	2087
KALU KHAN	Kalu Khan	25108	KAT KALA	Mali Khel	3097
MAINI	Maini	19556	KHADAR KHAN	Amazai	1025
NARANJI	Naranji	8977	MUGHDARA	Ghurghushto	1299
SHANGRAI	Gabasni	671	NAWAKILAY	Krapa	2030
SHEWA	Shewa	18767	PANDHER	Pandher	1475
URMAL DHERI	Sudher	6247	TOPDARA	Daggar	5047
ZAIDA	Zaida	4143	TOTALAI	Totalai	12754

This list represents the final selection as the villages with no accessibility, security problem and no support from the community have been excluded.

Sample size

The most frequently used formula to calculate the sample size is the following one, as it does not depend on the size of the total population.

$$N = D * Z^2 * (p) * (1 - p) / c^2$$

Where:

- N= Sample size
- D = Design effect
- Z = The level of confidence desired
- p = Prevalence of our main indicator
- c = The standard error

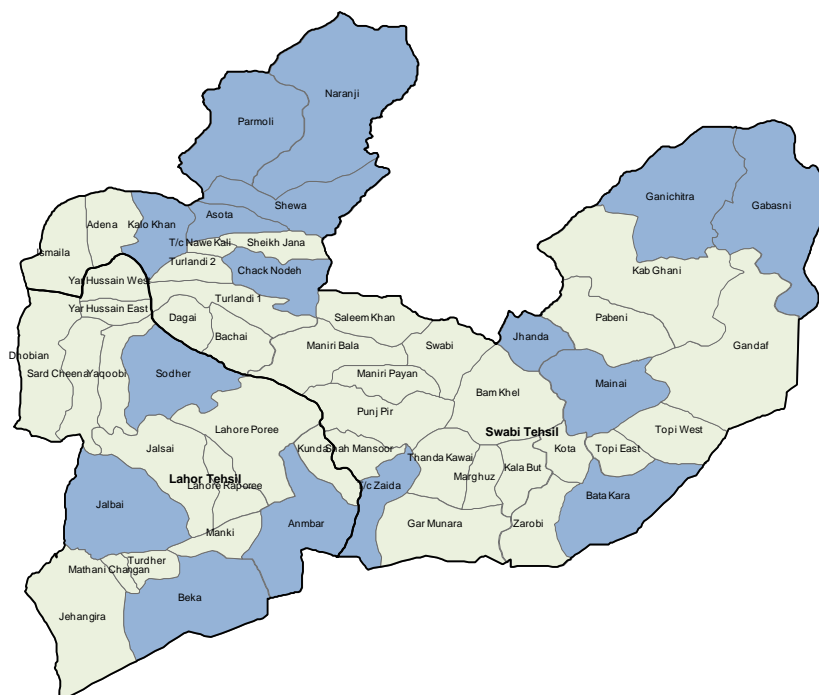
For a simple sampling, if we consider a prevalence of 50%, with a confidence level of 95% and a maximum error of 5.5%, the minimum sample size should be of 315 interviewed persons. But in case of a 2-stage sampling, our methodology, there is a design effect of 2, which brings the minimum sample size at 630 interviewed persons. 10 people will be added to this total number in case of bad quality data, outliers, etc.

For instance, with this definition, if our estimate is at 50%, we will be 95% sure that the real figure will be within this range [44.5%; 55.5%].

To sum up, we will visit 640 households in 32 villages which is 20 households per villages.

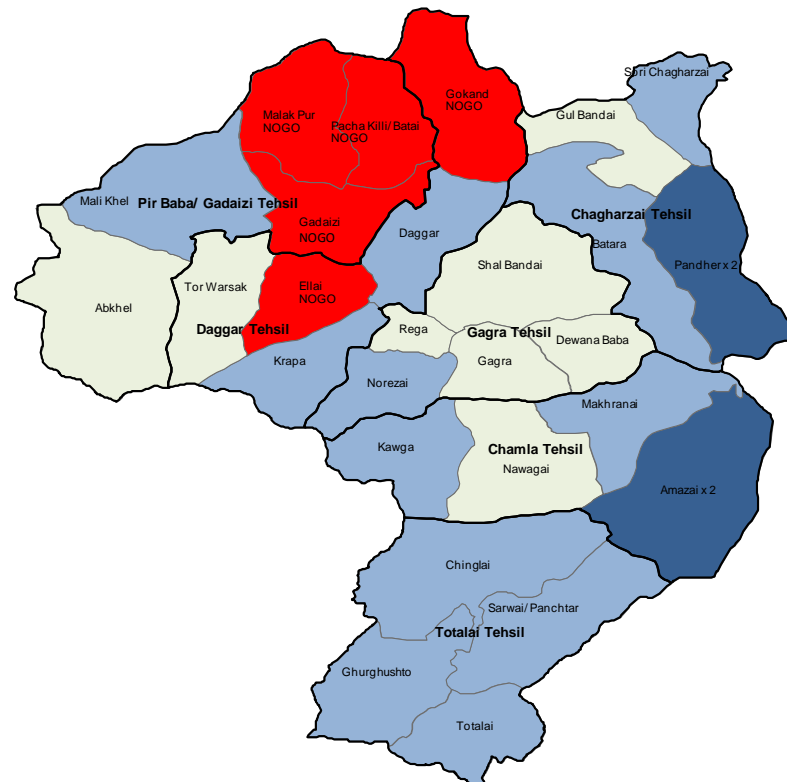
These 2 maps show the union councils where the villages have been selected.

Map 2: Swabi district with the selected UCs for the survey



Blue: Door to door survey

Map 3: Buner district with the selected UCs for the survey



Blue: Door to door survey
Red: No go area

Random selection of houses

In big villages, the selection of the houses was done according to the “methodology of the bottle” which consist of throwing a bottle on the floor and see the direction it points to. So it gives the first direction to follow and then every five houses are visited. If the household does not correspond to our target population the next house is visited. Then when the end of the road is reached, the street on the right was followed and the same technique was applied.

In smaller villages where all the houses are scattered in the mountain, mainly in Buner, every 3 houses were visited. The idea was to go from house to the closest one and leave each time two houses in between two visits.

3. Data collection

The interviewers were doing the interview as follow

- Door to door
- Individual questionnaires were administrated. Interview of mothers were made with female interviewers and interview of the men were done by male surveyors.
- The questionnaire was in English but the interview was made in Pashto, local language in Swabi and Buner districts. The interview lasted between 30 to 40 minutes in order to let each enumerator complete five interviews per day.



4. Human resources involved

Two assistants, one male and one female helped in the organization of the door to door survey, talking to the communities prior to the effective survey. Then, four additional enumerators joined to do the door to door survey. So in total, 6 enumerators did the survey.

At first, one day training were given in order for them to get an introduction of the survey, to make sure they understand the questions of the questionnaires, to agree on a translation in Pashto.

5. Questionnaire

The questionnaire has been split into 5 parts that all contain questions related to the main issues on access to health identified during the focus groups and the indicators we want to measure, defined at the end of the focus groups.

The questionnaire is divided as follow:

- Family background
 - Demographic
 - Education
 - Family size
 - Income
- Curative care
 - Homecare
 - Decision to go to the facility
 - First visited facility
 - Last visited facility
- Maternal care
 - ANC
 - Delivery
 - PNC
- Immunization
 - Children's immunization
 - Mother's immunization
- Conclusion

Tests of the questionnaire

Prior to the real survey, a test was made during one day with all the enumerator in one village: Anbar.

It allowed checking on the study population, the clarity of the questions, the ability of the interviewers and the logistic part of the project. This part was essential as during the next 3 days, part of the questionnaires was adjusted and also the study population was changed. At the beginning the objective was to compare the opinion differences of the mothers and their respective head of family. But we quickly noticed that it was difficult to find households where both, the head of family and the mother, were available at the same time, especially during daytime... So, trying to gather the information from both would have biased a lot the outcome of the survey because most of the time, the households were both were home during the day

at the same time was the poorest household... Otherwise, the heads of family or husbands are usually working in the field...

So we decided to change our study population to another one where we know the results would not be biased.

6. Data processing

The data were processed with the data analysis and survey software, Sphinx version 5.

2.4. Disclaimer

In total, 617 people were interviewed, 297 in Buner and 320 in Swabi. This difference results from the fact that one village in Buner could not be accessed anymore after the floods (July 2010). In addition, 3 questionnaires were excluded from the survey as they contained invalid information for the analysis.

The sampling of the survey has been made to respect the represent the whole population of Swabi and Buner districts. In addition, reasonable measures have been taken to ensure the reliability and accuracy of the information included in this report. This report is intended to provide information as per 31st of August 2010.

This survey presents some limitations as several external factors interfered during the project.

Some accessibility problems prevented us to go and visit certain villages, especially in Buner. In terms of accessibility, two rules were respected:

1. The village should be accessible on a day trip from any of the MDM bases in Swabi and Buner.
2. The village should not be more than 30 minutes away from the road, one way.

The door to door was during the rainy season and the flood disaster happened in the middle of the survey at the end of July in KPK, causing lots of landslides in Buner and cutting the road access to certain villages. In the end, only one village could not be visited, Kadal Mena, as the road was still not repaired before the end of the survey.

Also, some areas in Buner have been excluded from the survey as they are not so stable as they are known to have some militancy activities. It concerns 5 UCs were we could not go at all and one additional UC, Mali Khel, where we were requested to select only villages accessible from the road.

Also, we had to get the approval from the community in order to do the door to door survey. In one village in Swabi, Sat Khetar in Ganichitra UC, we were not welcome from the community so we had to exclude this village from our selection. The reason why the people did not want us to do the survey was because they had a disappointing previous experience with another organization promising a lot of things and not coming back to them at all.



III. RESULTS OF THE SURVEY

3.1. Focus Group Discussions

1. Main outcomes

The analysis of the FGDs gave the following outcomes that have been used to customize the questionnaire for the door to door survey. As expected from these discussions, some trends were easily identified.

General access to health care

Financial issue seems to be the main constraint for access to health for everyone, not only mother and child. One sentence that was stated in all focus group discussions was: “If no money, we don’t go anywhere and the person dies on her bed”.

In remote area, the transportation seems to be the second most important problem. In some villages, there is no car during working hours. So in case of emergency, they have to wait for a car to come back before being able to do anything.

The doctor’s availability is also another issue as in most of the government facilities, the doctors use to have their private clinic. After 1pm, the facility is then closed and the persons living far away from the facility have no other choice than going to a private clinic.

The lack of trust in the medical staff is one other factor. One good example is be that the doctors take their time in the government facility to redirect the patients in the afternoon to their private clinic where they charge few hundred rupees. Another one is the health professionals who charge for the medicines instead of giving them for free in the government facility, or sometimes they keep them for the people they know.

Maternal care

Awareness is the main factor. It is often that the mother gets a check up only when she has complications during her pregnancy. The awareness is higher among educated people even though a large proportion of people seems not to know about the routine check up.

From the discussion we learn that the social pressure plays an important role regarding ANC. Even if awareness is still the main factor, it appears from the FGDs that going to a check up is really influence from the community. The community has also the same impact on the place of delivery. In some villages, the community thinks it is better to deliver home and in some other, that it is said to be better to deliver in hospital, independently of education or financial level. Apparently, if you don’t follow the “customs” of the village, especially in small remote villages, you will be judged badly from the other people of the village and you could lose your honour if something happens to the mother. Anytime someone was saying “It is a custom”, “everyone does it in the village”, “if you don’t do it, you will be judged”, we had to understand they were talking about this social pressure presence in their village.

The 40 days period after delivery, which says that the mother should stay home, seems to play a minor role in the postnatal check up. In any case, when the mother has a problem or is sick after delivery the exception seems to be always made for her to go to the doctor and also, if they are willing to make a routine check up, usually they seem to easily break the rule.

Immunization

Our findings are that local convictions are the main reasons why people don't get vaccination. Polio seems to be more accepted as it is administrated in drops and not by injection. In all FGDs, everyone knows at least one family that does not get any injections because of belief, but it is never people directly related to the one speaking. This subject remains taboo... Vaccinations are most of the time assimilated to injections and some people believe that injections, coming from the western world, are a kind of complot to reduce the Muslim population and therefore, sterilise the people...

Awareness is once again another issue. This issue is two folds: First the people are not really aware of the importance of vaccination and second, they think as it brings sickness, this is not good and they should not do it any longer.

2. Indicators

Based on the results of the FGDs, a list of indicators was defined for the survey. For all these indicators, a measurement will be made and also a explanation of the main reasons why these indicators are so low or high.

The indicators are around 5 axes.

Curative care

- Percentage of illness treated by
 - Modern medicines
 - Traditional medicines
 - Spiritual medicines
- Percentage of illness treated by a MBBS doctor
- Average number of days before going to a facility
- Average total cost for the treatment including transportation, consultation fees, medicines, etc.
- Average distance to the facility.

Maternal care

- Percentage of ANC
 - When complication
 - For routine check-up
- Percentage of growth monitoring during pregnancy?
- Percentage of delivery
 - in a facility
 - at home?



- Percentage of delivery attended by a skilled person
- Average total cost for the delivery including transportation, consultation fees, medicines, medical tests.
- Percentage of PNC?
 - For mother
 - For the baby

Immunization

- Percentage of children vaccinated
 - Completely
 - Not completely
 - Not at all
- Percentage of pregnant women vaccinated against TT
 - Completely
 - Not completely
 - Not at all

Demographic indicators

Demographic indicators are added to the questionnaire in order to get an idea on the situation in Buner and Swabi and to be able to cross this information with the other indicators.

- Family size
- Education level
- Monthly income
- Household effects and mean of transportation owned
- Area
- Accessibility

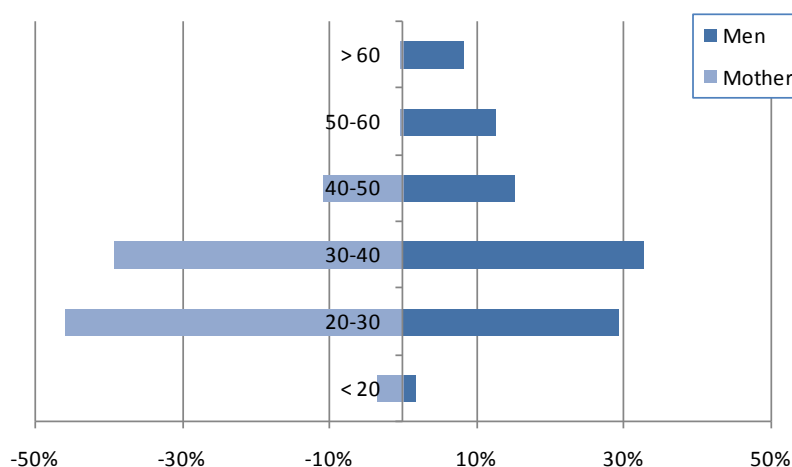
3.2. Quantitative survey

1. Sample description

Demographic characteristics

As part of the survey protocol, a choice was made to interview the 50% of mothers and 50% of men (head of family if possible). As a result, 308 mothers and 309 men were interviewed. Among the surveyed men, 223 (72%) are head of the family. They are the one responsible of the health of the family as well as the finance. Most of the time, they decide when to bring the person to a health facility.

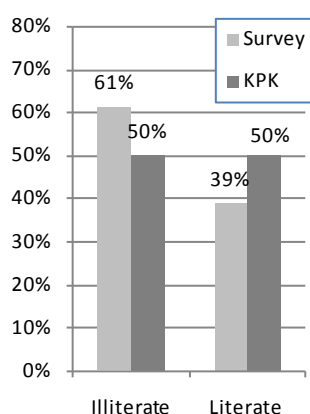
Graph 1: Age pyramid



Looking at the age pyramid for both sexes, a concentration of women between 20 to 40 years old confirms the study population definition (mother aged between 15 to 49 years old). As for men, more than 20% of them are more than 50 years old. This is explained by the fact that the head of families were interviewed in priority if they were available in the household, and most of the time the head of family is the father in law or the elder of the household.

Literacy/Education

Graph 2: Adult Literacy rate



Source: Pakistan Social & Living Standard Measurement Survey 2008-09

Table 3: Level of education

Characteristics	Uneducated	Primary	Secondary	Higher	Total	Number
Gender						
Mother	72%	16%	10%	1%	100%	308
Men	48%	8%	28%	17%	100%	307
District						
Swabi	53%	13%	25%	9%	100%	318
Buner	68%	11%	13%	8%	100%	297
Total	60%	12%	19%	9%	100%	615

The literacy rate of 39% in Swabi and Buner districts is lower than in the rest of KPK. In Pakistan, the literacy rate has a strong relationship with the place of residence: In urban centres, the literacy rate is higher than in rural places. As Swabi and Buner are considered as rural districts, this confirms this low figure. However, the level of education is even lower in Buner (32% of educated persons) which is a more remote area as compare to Swabi.

The gender also has an important influence on the literacy rate. 72% of the interviewed mothers are uneducated. This gender differential in education could be attributed to cultural

“norms” and the social constraints faced by women in Pakistan. During the survey, a large number of people mentioned that they were missing primary schools for girls in their area so only boys could go to school.

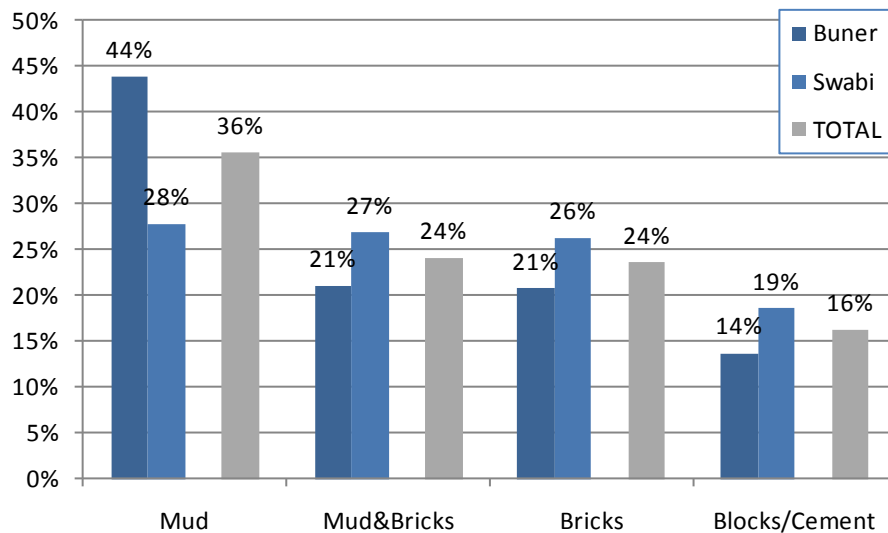
Location and accessibility

81% of the households are living in villages considered as remote places as opposed to the 19% of the households that are living in bigger villages that could be called urban centres. These urban villages are Kalu Khan, Maini, etc.

In terms of accessibility, 25% of the villages are not accessible by road which means that we usually have to walk to reach these places. The other 75% of the villages are accessible by car.

Social situation

Graph 3: House type



There is a significant difference between Swabi and Buner in terms of housing. Almost half of the surveyed household in Buner lives in mud houses whereas in Swabi the population lives more in houses with bricks, blocks or cement.

Table 4: Households' effects and means of transportation

Characteristics	Buner	Swabi	Total	KPK	Number
In the house					
Electricity	94%	98%	96%	93%	617
Watch/Clock	84%	91%	88%	88%	617
Radio	21%	25%	23%	43%	617
Telephone	50%	63%	56%	41%	617
Television	17%	37%	27%	39%	617
Fridge	28%	51%	40%	31%	617
Transportation					
Bicycle	4%	24%	14%	25%	617
Motorcycle	9%	21%	15%	6%	617
Car/Truck/Tractor	8%	10%	9%	5%	617

Source: Demographic and Health Survey 2006-07 - National Institute of Population Studies Islamabad, Pakistan – June 2008

In terms of housing, Swabi and Buner are significantly different. The population in Buner seems to be poorer than Swabi. 6% of the households live without electricity in Buner. Also, if we compare Buner KPK, we can see that for most of the goods and means of transportation, the proportion of households having all these goods is lower. On the other hand, the proportion of households having these effects is higher in Swabi than KPK and the difference can be important for some of the effect. For example, half of the surveyed households in Swabi have a fridge whereas it is only one third in KPK and 28% in Buner.

Also, 80% of the surveyed people own their house, 12% rent it and 8% live in places let for free. These houses given for free are usually let by a relative or the community. The households living there are the poorest and they have nothing, even no electricity.

Family structure

Table 5: Average household size

Family structure	Average
Number of babies, < 5	2.2
Number of children, 5 - 14	2.6
Number of women, 15 - 49	2.8
Number of men, 15 - 49	2.7
Number of elders, > 50	1.0
Total family members	11.2

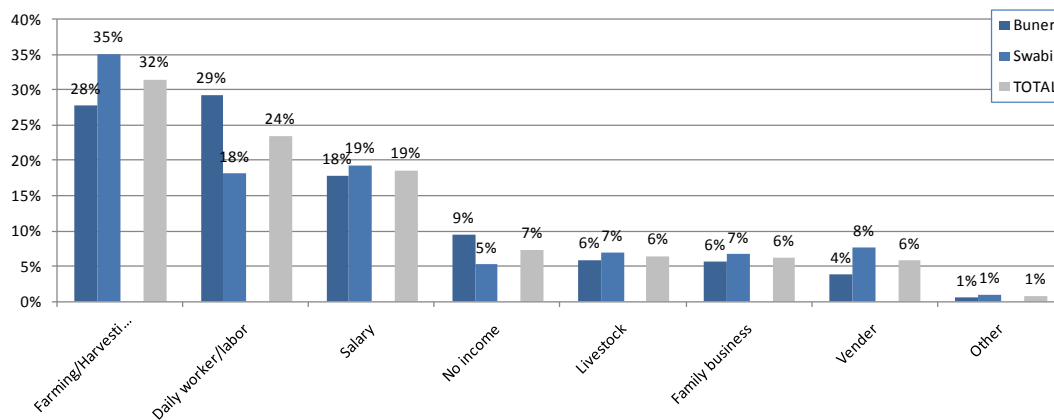
The average family size in Swabi and Buner districts is around 11 persons, including around 2 babies under 5 years old. In KPK in general, the size of the household is big as it includes the elders, the father and mother in law, then all the sons, their wives and children. They all live together in the same house. The structure is approximately the same in Swabi and Buner districts. Nuclear families are very rare and can be found in bigger villages like in Kalu Khan (census population 1998, 25000 inhabitants). The only reason why they left their community is to find a job.

Income

During the survey, we noticed that this question on the income remains a delicate topic... and the results might be biased. To make sure they are not, we crossed check the information with the households' effect and means of transportation owned by the people and there is a strong relationship between the level of income (monthly income or money from outside). Therefore we can conclude the results are not biased.

Nowadays, there are two main sources of income in Swabi and Buner. The monthly income is still the most common source but the money received from someone working abroad or somewhere else in Pakistan like in Karachi or Islamabad is also another main source of income.

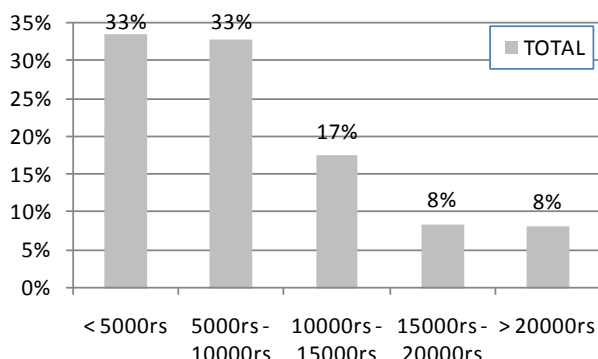
Graph 4: Income source



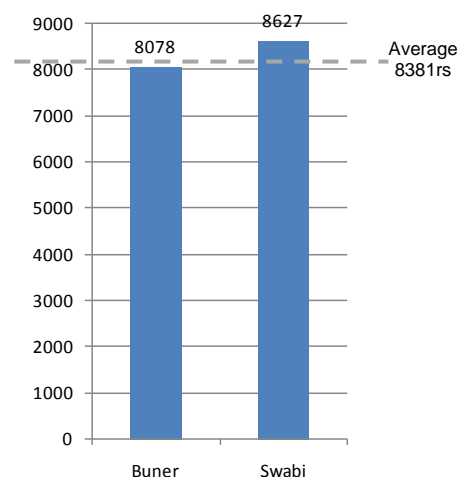
The number of households getting some income from a daily work is significantly higher in Buner than in Swabi whereas Swabi has a significant higher number of vendors than Buner.

7% of the households declare having no income at all. But 54% of them receive some money from abroad. So 3% of the households have no income at all.

Graph 5: Monthly income earned in Pakistan



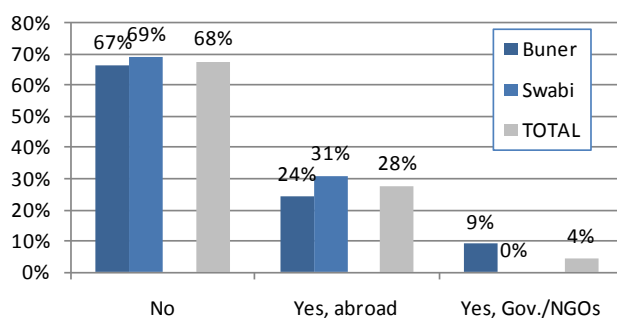
Graph 6: Average monthly income earned in Pakistan



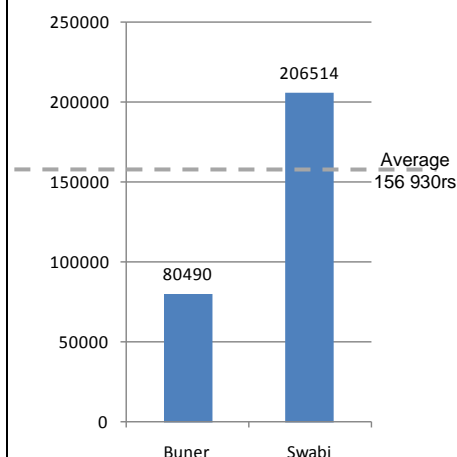
Only 63% of the people answered. This is mainly due to a lack of knowledge among the women. They often don't have access to the money as the finances are managed by the head of family (usually a man). Consequently, 80% of the men answered the question and only 43% of the women.

The average monthly income for a household in both districts is pretty low, 8381rs. However, households living in Swabi appear to be wealthier than in Buner with an average income per household of 8627rs in Swabi and 8078rs in Buner. In total, one third of the population interviewed live with less than 5000rs a month. The range is wide as it goes from 1000rs a month to 50000rs a month in Buner and 80000rs a month in Swabi.

Graph 7: Households receiving money



Graph 8: Average amount received from abroad the past year



One third of the households got some money from abroad during the past year. This practice is still very localized and very specific to some villages. There are some villages with many households having someone abroad and some with none. Normally, people from the same



community send their relative to the same country. The four most common places are: Karachi, Saudi Arabia, Dubai and Malaysia.

The average amount received differs a lot between Buner (80 490rs) and Swabi (206 514rs) and the maximum amount is at 360 000rs a year in Buner whereas it reaches 2 400 000rs a year in Swabi. This trend is the same as per the monthly income where households from Swabi are wealthier than Buner. There is a strong correlation between the level of education and the amount of money received from abroad and as households in Swabi are more educated than the one in Buner, the amount of money receives from abroad is higher in Swabi than Buner.

In Buner only, 5 villages, Chalandrai, Kanglai, Khadar Khan, Pandher, Totalai, got some money from the government or an NGOs for an amount of 15000rs approximately.

Crisis

In Swabi, 10% of the surveyed households hosted relatives during the Swat crisis. More than 80% of them took in the IDPs for less than three months. 55% of the time, they hosted more than 10 persons at a time.

In Buner, 41% of the surveyed households were displaced mainly to Mardan, Swabi and Buner districts. They are all returned and 80% were displaced for less than 3 months.

Two distinct profiles, Swabi versus Buner

From this first description of the households, we can distinguish two groups:

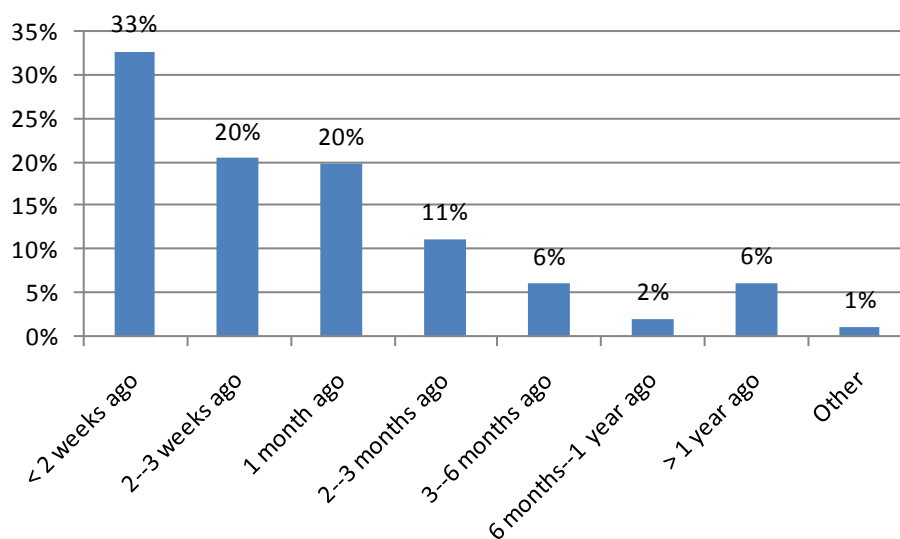
- People living in Buner are usually living in remote village, with less accessibility, no facility nearby, illiterate and poor.
- People living in Swabi are usually living in more accessible and bigger villages than in Swabi. They often have a health facility in the village and if not, the facility is nearby. They are more educated and richer than in Buner.

2. Curative care

The objective of this part is to understand the process of going to a health centre when a child under 5 years old or a mother is sick in a household. What makes them go to a facility? What are their limitations? What do they do first at home? How long do they wait before going to a facility?

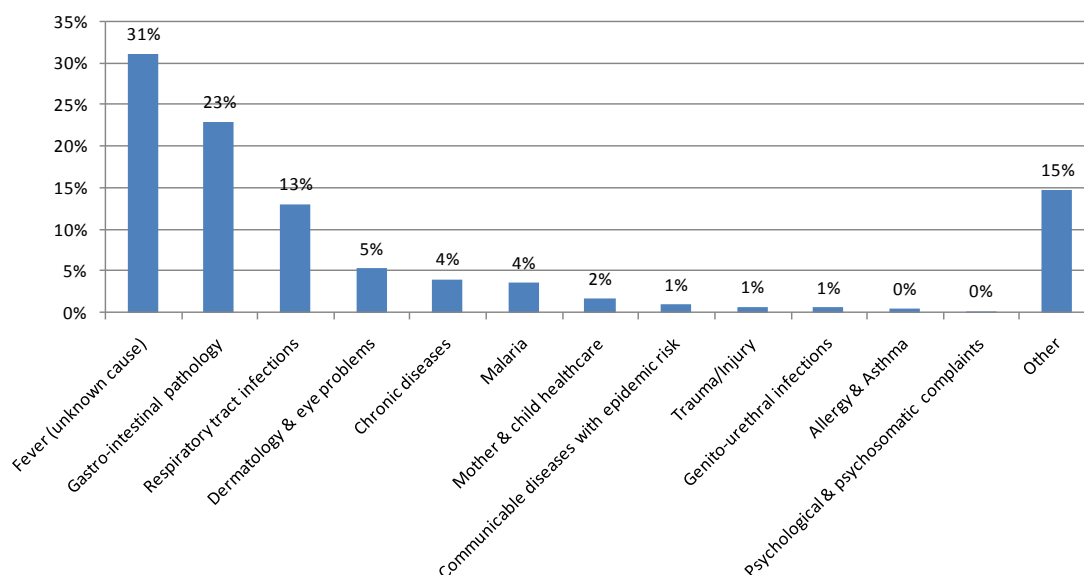
Diseases descriptions

Graph 9: When the last illness happened



73% of the households have had a child under 5 years old or a mother ill recently, within the last month. Among the sick people, 75% were children and 25% were mothers.

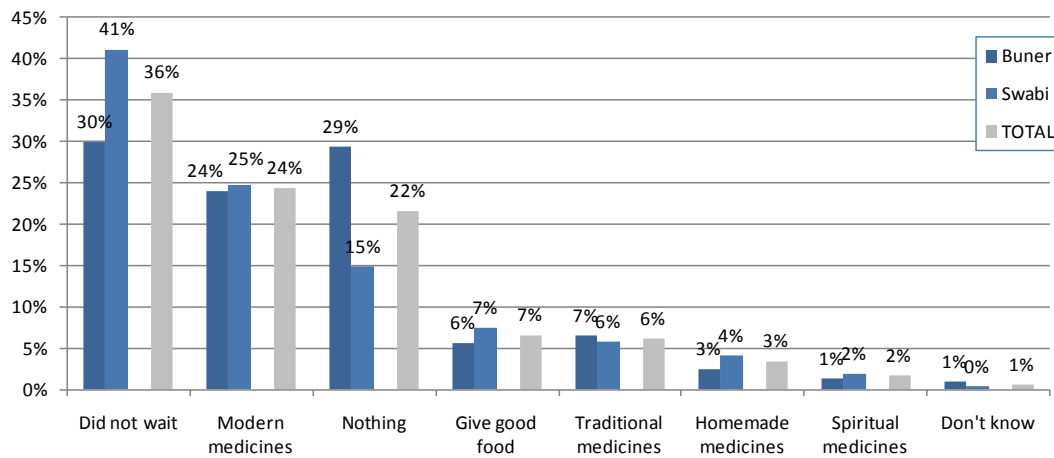
Graph 10: List of illness



The main reason why the people go to a facility is because of a fever with an unknown cause. Then, it is for gastro-intestinal pathology and respiratory tract infections.

Before going to a health professional

Graph 11: Type of homecare



To the question “what do you do first when someone is ill before going to a health professional?”, one third of the households don’t wait and go straight to see a someone, 24% give modern medicines that they have home and 18% uses more traditional approach by giving homemade medicines, or good food, or spiritual medicines, etc. A large part also does not do anything while waiting (22%).

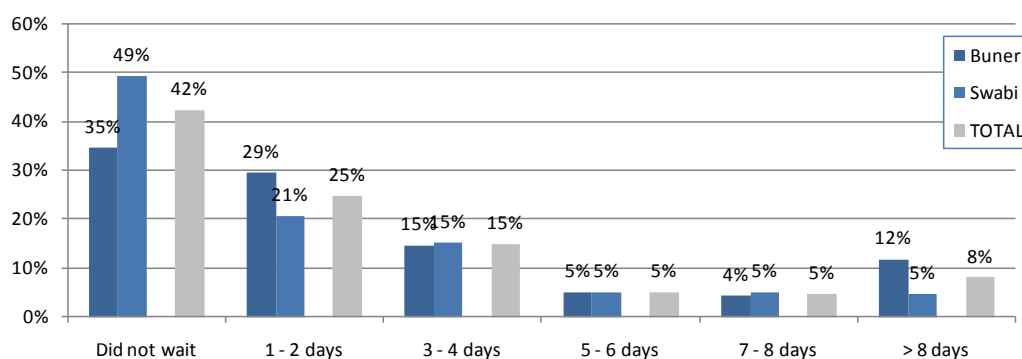
We notice a significant difference between Swabi and Buner specifically regarding the waiting time. A larger proportion of people go straight to the facility in Swabi and do not wait while in Buner one third of the people wait home but do not do anything specific in terms of care.

Table 6: Type of homecare

Characteristics	Did not wait	Modern medicines	Nothing	Give good food	Traditional medicines	Homemade medicines	Spiritual medicines	Don't know	Total	Number
Accessibility										
Non accessible	24%	29%	28%	5%	9%	2%	4%	1%	100%	176
Accessible	40%	23%	19%	7%	5%	4%	1%	1%	100%	516
Facility in the village										
No	32%	28%	21%	6%	7%	3%	2%	1%	100%	286
Yes	41%	19%	22%	8%	5%	4%	1%	0%	100%	400
Total	36%	24%	22%	7%	6%	3%	2%	1%	100%	686

These differences mentioned for Swabi and Buner could be explained by the fact that when the village is more accessible like in Swabi, the people go more easily to the facility and don’t wait. In Buner, where we have more remote villages, the people wait for many reasons without doing anything at the same time. Also when the facility is in the village, 41% of the people go straight to the facility and don’t do any homecare.

Graph 12: Waiting time



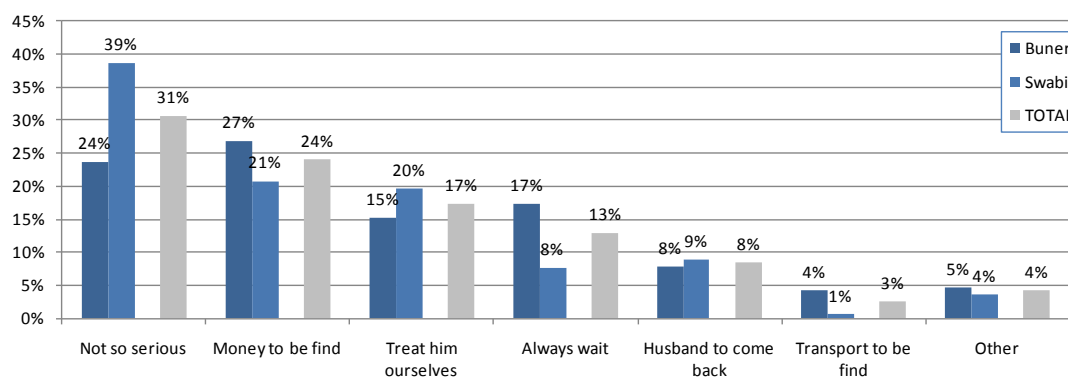
People living in Buner wait longer than people living in Swabi, more than 8 days for 12% of them.

Table 7: Waiting time

Characteristics	Did not wait	1 - 2 days	3 - 4 days	5 - 6 days	7 - 8 days	> 8 days	Total	Number
Accessibility								
Non accessible	30%	28%	16%	7%	5%	14%	100%	134
Accessible	46%	24%	15%	5%	5%	7%	100%	434

This table confirms the graph just above as we can see that people living in non accessible are more likely to wait before going to a facility. 14% of people living in not accessible villages wait more than one week.

Graph 13: Reasons for waiting



The main preoccupation for people living in Swabi is to know if the illness is serious or not. In Buner the main preoccupation is to find some money first. Transport also is a minor problem but still more important than in Swabi.

Table 8: Reasons for waiting

Characteristics	Not so serious	Money to be find	Homecare first	Always wait	Husband to come	Transport to be find	Other	Total	Number
Accessibility									
Non accessible	23%	26%	6%	17%	10%	9%	8%	100%	99
Accessible	34%	23%	22%	11%	8%	0%	3%	100%	259
Monthly income									
< 5000rs	21%	38%	10%	12%	8%	4%	8%	100%	77
5000rs - 10000rs	33%	18%	19%	13%	13%	3%	1%	100%	72
> 10000rs	43%	15%	22%	11%	4%	3%	3%	100%	74
Total	31%	24%	17%	13%	8%	3%	4%	100%	358

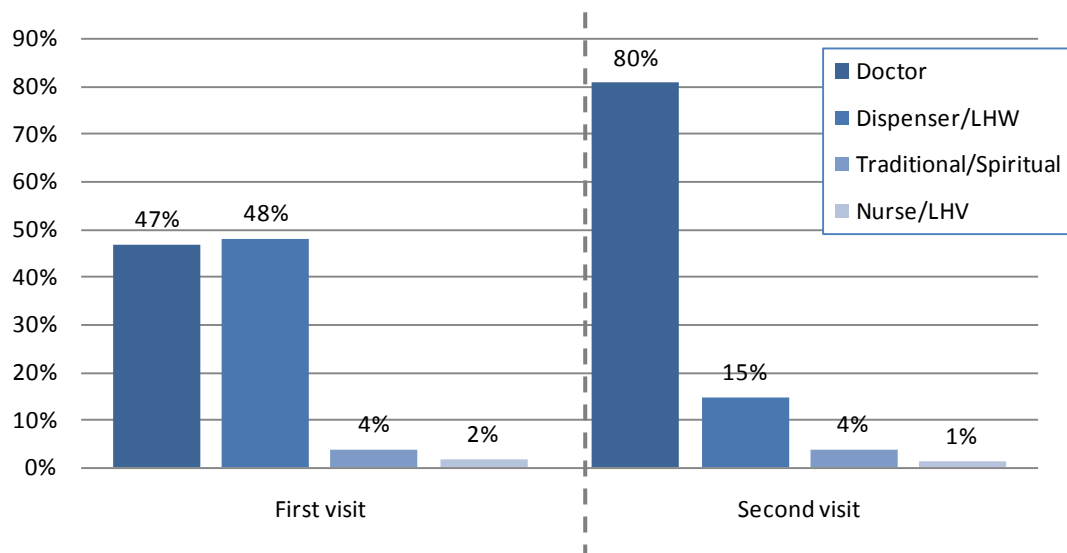
This table confirms the two main issues mentioned above which are financial and with transportation. This means that the poorer households living in remote places are more likely to wait longer before going to a facility.

Also there is a strong relationship between the number of days the people wait and the cost of the consultation, medicines and transportation. The longer people wait, the more expensive the cost is.

However, there is no correlation between the duration of the waiting period and the reason why people wait.

Visit to a health professional

Graph 14: Type of health professional



Regarding the first visit, we can observe two trends. Some people go straight to the MBBS doctor and this is significantly linked to the importance of the illness. If the people think the person might die, they go straight to the doctor. Also if a doctor is nearby they go there. Otherwise, people usually go first to the dispenser as this is often the closest facility and it is

often in their village which mean that the women can easily go, alone with the children and with little money or they can pay later.

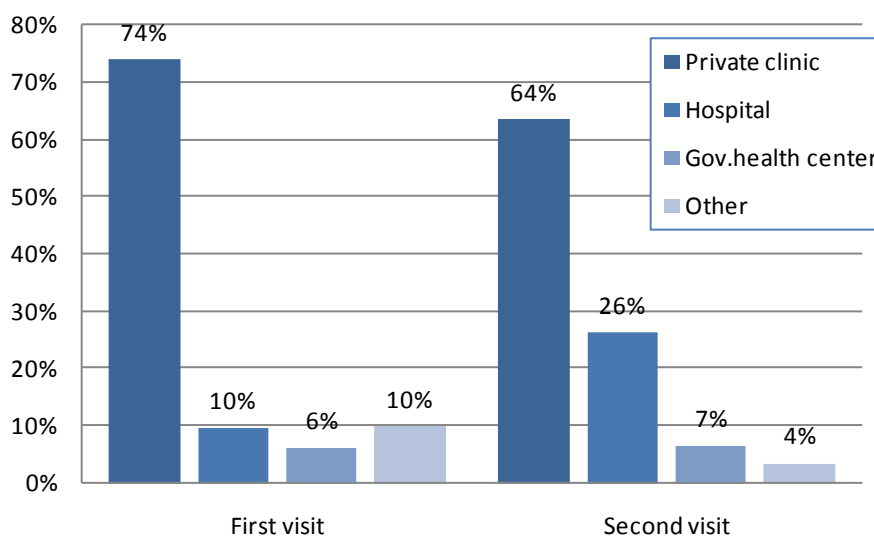
22% of the people go for a second visit. In this case, people usually go to see a doctor. This may be because of referral because the dispenser cannot do anything or because of a lack of trust in the first doctor and they are seeking for a second opinion.

Table 9: Type of health professional

Characteristics	Doctor	Dispenser/L HW	Traditional /Spiritual	Nurse/LHV	Total	Number
Education						
Uneducated	49%	45%	3%	3%	100%	400
Primary	49%	45%	5%	0%	100%	79
Secondary	54%	41%	5%	0%	100%	135
Higher	62%	37%	2%	0%	100%	64

The level of education has an influence on the choice of the health professional. The more educated the family is, the more likely they will visit a MBBS doctor. On the contrary, uneducated people would also go and see a dispenser which is normally based in the village so easier to visit and for them this is a “doctor”.

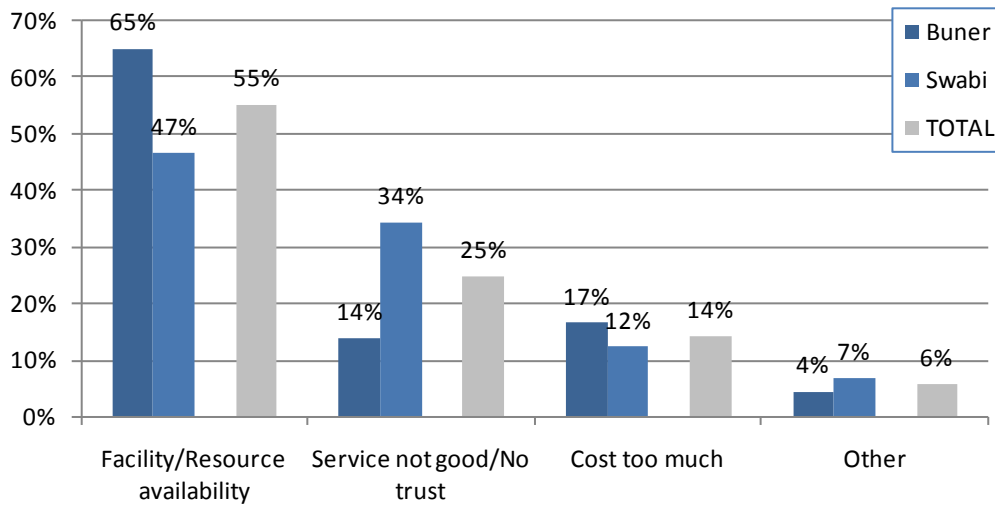
Graph 15: Place of visit



22% of the people go to a second facility but in any case, the private clinic remains the most common one. After a cross check, we conclude there is no pattern saying that when we go to a certain facility, then we go to this specific one after.

Regarding the distance to the facility, 52% of the people go to the closest facility which means that 48% still do not go to the closest for the following reasons:

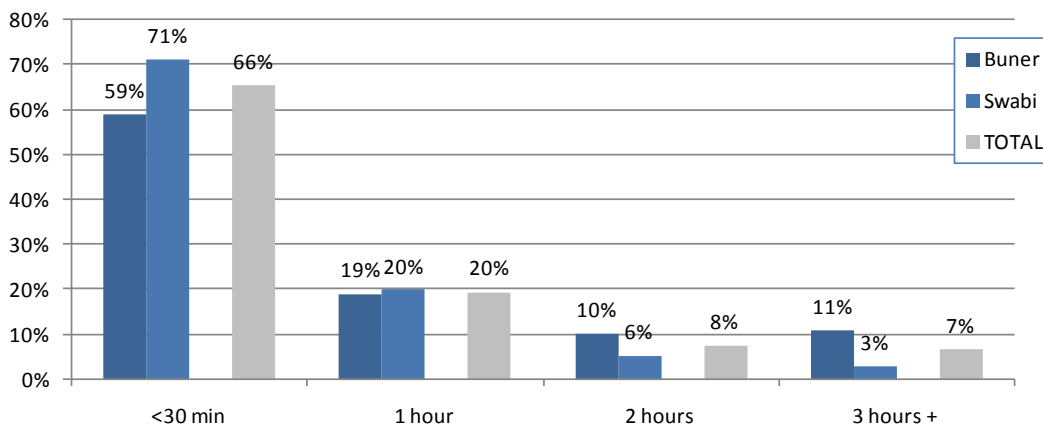
Graph 16: Reasons why they don't go to the closest facility



There is a significant difference between Swabi and Buner districts. Buner has an important constraint of facility and resource availability and Swabi has a problem of trust. This means that people living in Swabi are more choices than people living in Buner as they can go elsewhere if they don't trust the health professionals while in Buner they have to go to a facility which is opened first.

Transportation to the facility

Graph 17: Time to go to the facility (one way)



People living in Buner are significantly living further away from the facilities compare to Buner. 11% needs more than 3 hours to go there, one way.

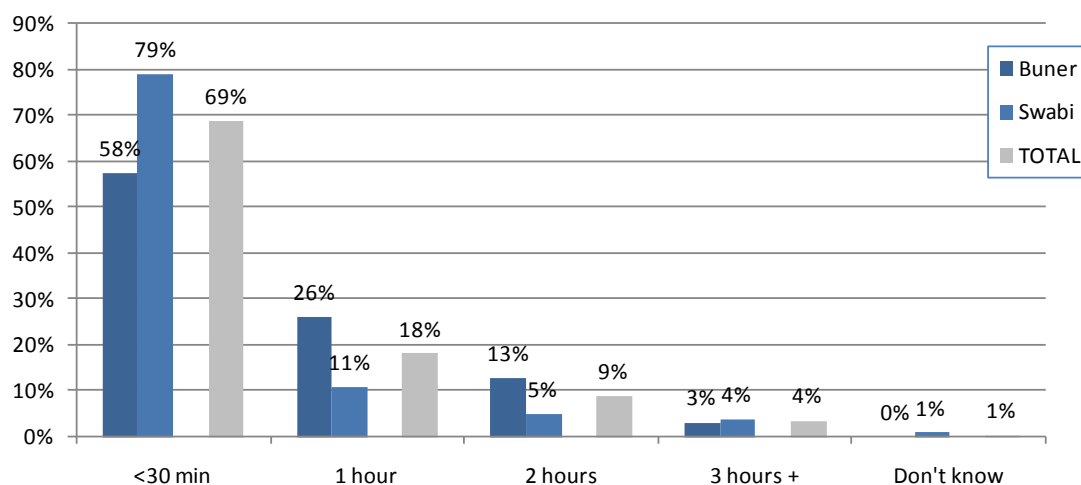
Table 10: Time to go to the facility

Characteristics	<30 min	1 hour	2 hours	3 hours +	Don't know	Total	Number
Own transportation							
Buner	29%	71%	0%	0%	0%	100%	14
Swabi	55%	37%	8%	0%	0%	100%	38
Public transportation							
Buner	21%	25%	21%	33%	0%	100%	57
Swabi	43%	36%	12%	9%	0%	100%	76
Taxi							
Buner	18%	44%	24%	15%	0%	100%	34
Swabi	30%	48%	15%	7%	0%	100%	27
Walk							
Buner	86%	7%	5%	2%	1%	100%	154
Swabi	97%	3%	0%	0%	0%	100%	148
Total	66%	20%	8%	7%	0%	100%	551

If we compare the time to access the facility between Swabi and Buner by means of transportation we can see that for all means of transportation, people living in Buner need significantly more time to access the facility than people living in Swabi.

In terms of mean of transportation, we observe a significant difference between Swabi and Buner only when people have their own transportation. People using their own transportation are also more educated and with a higher monthly income. Even though it is not significant, people in Buner walk more often than in Swabi (60% versus 51%) but they also walk longer. 7% of people walking in Buner walk more than 2 hours one way to reach a facility whereas in Swabi, when the people go to the facility by walk, it almost never exceeds 30 minutes. As half of the people in Swabi walk to the facility, it means that half of the people living in Swabi live within less than 30 minutes walking distance from a facility (including dispensers).

Graph 18: Time to find a transport

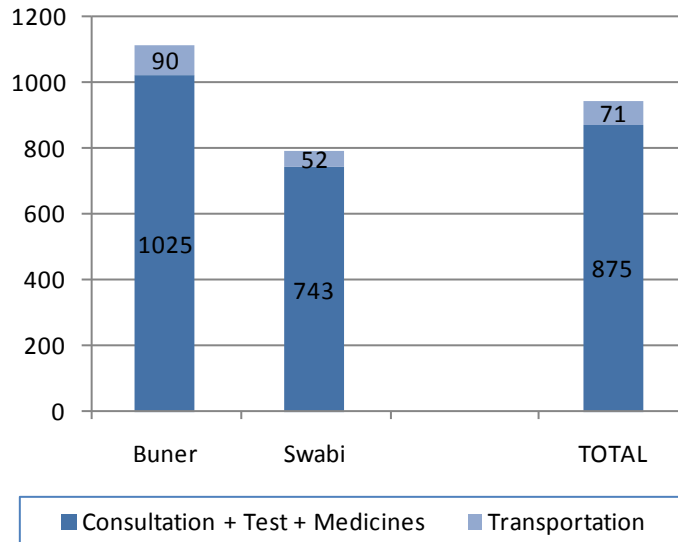


Another issue to take into consideration when talking about transportation is the time to find a transport. 79% find a transport within 30 minutes in Swabi. In Buner, it can take up to a day if

there is no car in the village during daytime and therefore they have to wait for the car to come back in the evening.

Cost

Graph 19: Total cost



The total cost, including consultation, medical tests, medicines and transportation costs, is 30% higher in Buner than in Swabi. When there are less health professionals in a certain area, the staff has a tendency to charge more that is why we can observe such a difference in terms of price between Swabi and Buner. Also, transportation represents a larger part of the final cost in Buner than in Swabi as people in Buner have to travel longer distance to go to a facility and public transport are less present in Buner too.

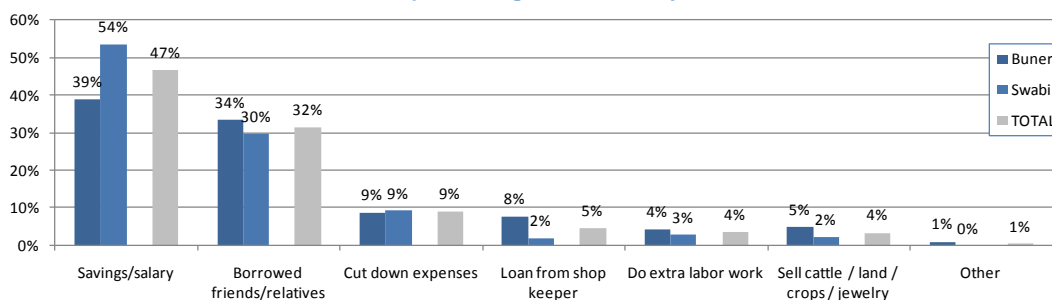
Getting the medicines

Regarding medicines, in 99% of the cases, the patient is prescribed medicines and in only 11% of the case, they get them at the health facility. This reflects the lack of medicines issue as the medicines should be available and given for free in public facilities. However this is only in very few cases that people get the medicines at the health facility and most of the time they have to go to the market or the dispenser to buy them and the price can be really high.

Consequently, 3.3% in Buner and 1.7% in Swabi don't get all the medicines but only one part of them because they do not have enough money to buy all of them.

Where the money comes from

Graph 20: Origin of the money



Half of the households in Swabi are using their savings or salary to pay for their health expenses. In Buner, the situation is significantly different as only one third of the people can afford their health expenses by using their savings or salary. Another third is borrowing the money from the rest of the community which is usually relatives and friends in the village. Another practice which is mainly specific to Buner is the loan from the shop keeper. People have a bill at the shop keeper and pay after the sale of the crops, once or twice a year.

Table 11: Origin of the money

Characteristics	Savings/ Salary	Borrowed friends/relatives	Cut down expenses	Loan from shop keeper	Do extra labor work	Sell cattle / land / crops / jewelry	Other	Total	Number
Accessibility									
Non accessible	35%	36%	16%	2%	7%	4%	0%	100%	170
Accessible	50%	30%	7%	6%	3%	3%	1%	100%	594
Education									
Uneducated	36%	38%	12%	5%	5%	4%	0%	100%	444
Primary	42%	38%	12%	2%	4%	1%	1%	100%	93
Secondary	68%	21%	3%	5%	1%	3%	0%	100%	151
Higher	77%	10%	3%	4%	0%	5%	1%	100%	73
Monthly income									
< 5000rs	34%	41%	8%	6%	6%	4%	0%	100%	157
5000rs - 10000rs	47%	37%	8%	4%	3%	1%	1%	100%	158
> 10000rs	74%	15%	3%	2%	0%	4%	1%	100%	172
Total	47%	32%	9%	5%	4%	4%	1%	100%	764

We observe the same tendency as in Buner for the remote places, uneducated households and poorer people. Accessible village, educated and richer people follow mainly the same pattern as for Swabi which means they use mainly their saving to pay for their health expenses.

3. Maternal care

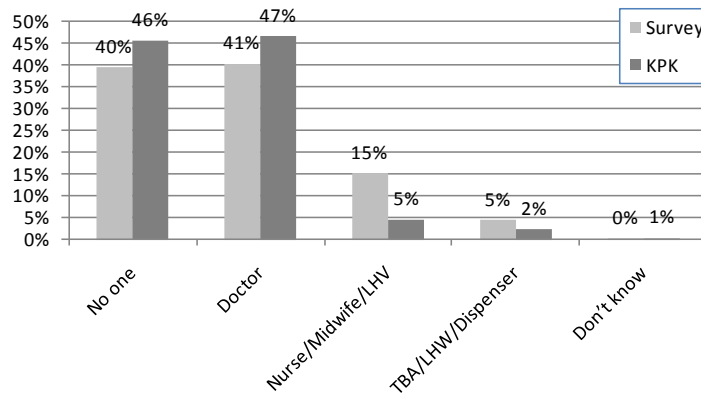
For the mothers or households with more than one child under 5 years old, the data refer only to the latest pregnancy.

Ante Natal Care

Prenatal care is important for the health of mother and child. It refers to pregnancy-related health care checkups provided at a medical facility or at home. Ideally, ANC comprises at least three visits and includes monitoring the pregnancy for signs of complications. The access

to ANC can be assessed by the type of provider, the type of facility and the type of checkup they got.

Graph 21: Type of antenatal care providers



Source: Demographic and Health Survey 2006-07 - National Institute of Population Studies Islamabad, Pakistan – June 2008

60% of the pregnant women in Swabi and Buner districts go for ANC. This figure is higher than for the whole KPK. This could be explained by the fact that the numbers from KPK are already 4 years old and since then the government in Swabi and Buner districts had put in place a programme to train more medical staff, especially LHV. That is why we notice that there are more check-ups done by nurses, LHV and midwives in Swabi and Buner districts than in KPK.

Table 12: Type of antenatal care providers

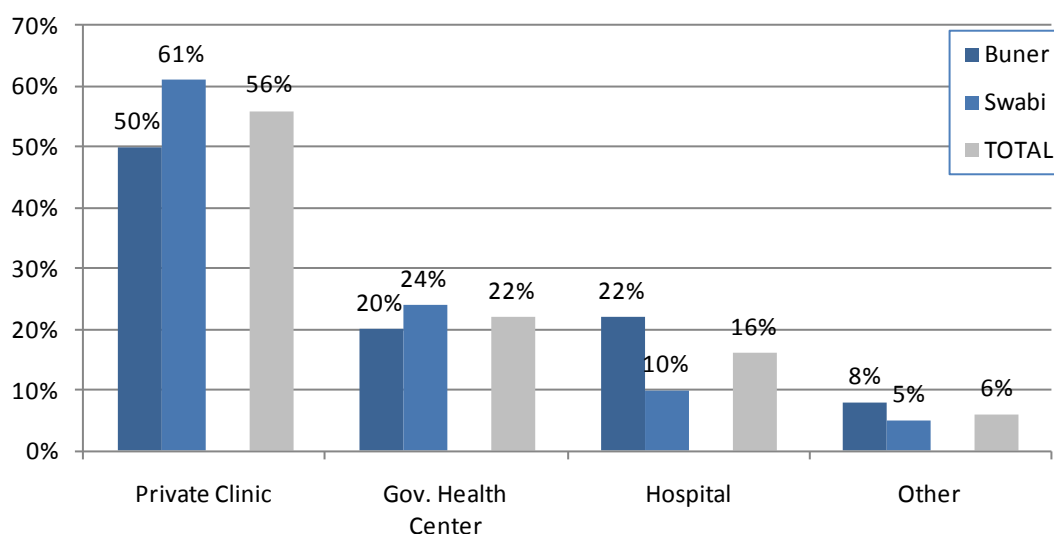
Characteristics	No one	Doctor	Nurse/Midwife/ LHV	Dai/TBA/LHW/ Dispenser	Don't know	Total	Number
Accessibility							
Non accessible	47%	32%	19%	2%	0%	100%	469
Accessible	37%	43%	14%	5%	1%	100%	156
Education							
Uneducated	47%	35%	12%	6%	0%	100%	375
Primary	32%	44%	22%	1%	1%	100%	72
Secondary	29%	48%	18%	3%	2%	100%	120
Higher	20%	57%	23%	0%	0%	100%	56
Monthly income							
< 5000rs	55%	29%	13%	3%	0%	100%	131
5000rs - 10000rs	40%	36%	19%	5%	0%	100%	126
> 10000rs	27%	48%	21%	3%	1%	100%	138

The accessibility seems to have an influence on the fact of going for an ANC or not. Also, the more educated and wealthier the household is, the more often the mother go for ANC.

Also, the reason why the mother sees a doctor is linked to the education and the income. The richer and more educated, the more often they are going to see a MBBS doctor.

Then, if we cross check between the type of provider and the facility, we can see a strong relationship between both. Doctors are mostly visited in hospitals and private clinic whereas nurses, midwife and LHV are more visited in BHUs, RHCs.

Graph 22: Type of facility for antenatal care



Looking at the facility where the pregnant women go for their antenatal check up, we notice a significant difference between Swabi and Buner districts. The antenatal checkups are done more in private clinics in Swabi (61%) than in Buner (50%). In Swabi, the population is globally wealthier so they can afford the price of a private clinic. Going to the hospital is more frequent in Buner than in Swabi. That is the consequence of not going to a private clinic as often as in Swabi.

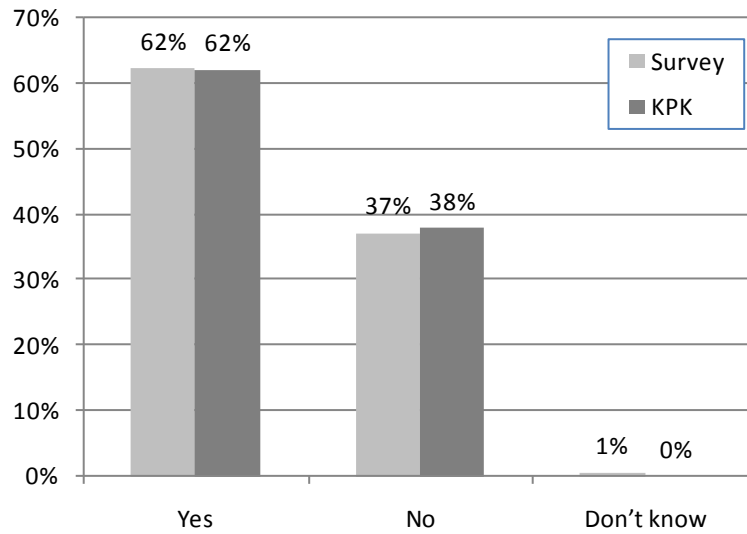
Table 13: Reasons for antenatal check-up

Characteristics	For checkup	For problem	Total	Number
Education				
Uneducated	35%	65%	100%	192
Primary	46%	54%	100%	50
Secondary	69%	31%	100%	80
Higher	86%	14%	100%	43
Monthly income				
< 5000rs	43%	57%	100%	58
5000rs - 10000rs	50%	50%	100%	76
> 10000rs	70%	30%	100%	93
Total	50%	50%	100%	365

The reason why the pregnant women go for ANC is strongly linked to the level of education. The proportion of women going for routine check-up increases with the level of the education of the household. On the contrary, women living in uneducated household have mainly ANC only when they have some complications. This shows that awareness is an important factor for the ANC.

We observe the same relationship between the reason why the pregnant women go for ANC and the level of monthly income. Women living in the poorest family mainly go for ANC if they have problem. This means that the financial aspect remains a limitation to a routine ANC.

Graph 23: Proportion of monitoring growth during the ANC visit

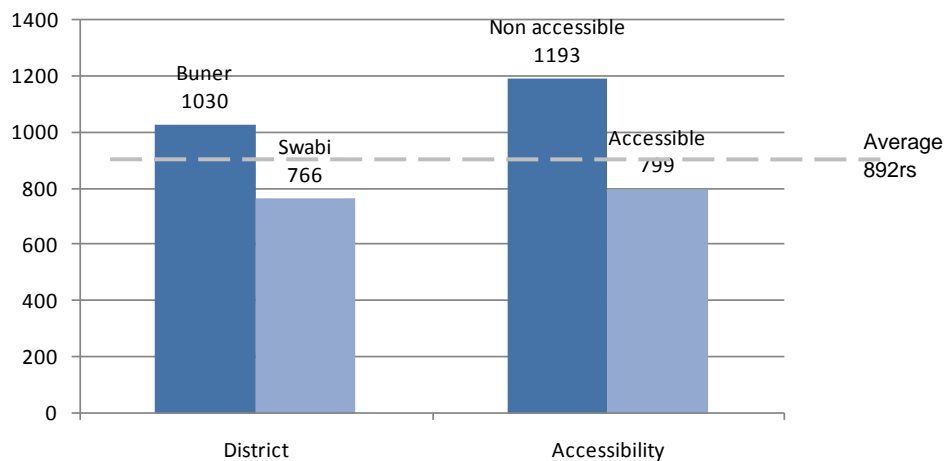


Source: Demographic and Health Survey 2006-07 - National Institute of Population Studies Islamabad, Pakistan – June 2008

Swabi and Buner districts are in line with KPK figures in terms of monitoring growth. The main reason of not having any monitoring growth is because 40% of the time, there is no equipment available in the facility. We notice that the lack of equipment is more important in Buner than Swabi even though this difference is not significant.

Cost

Graph 24: Average cost for antenatal check-up

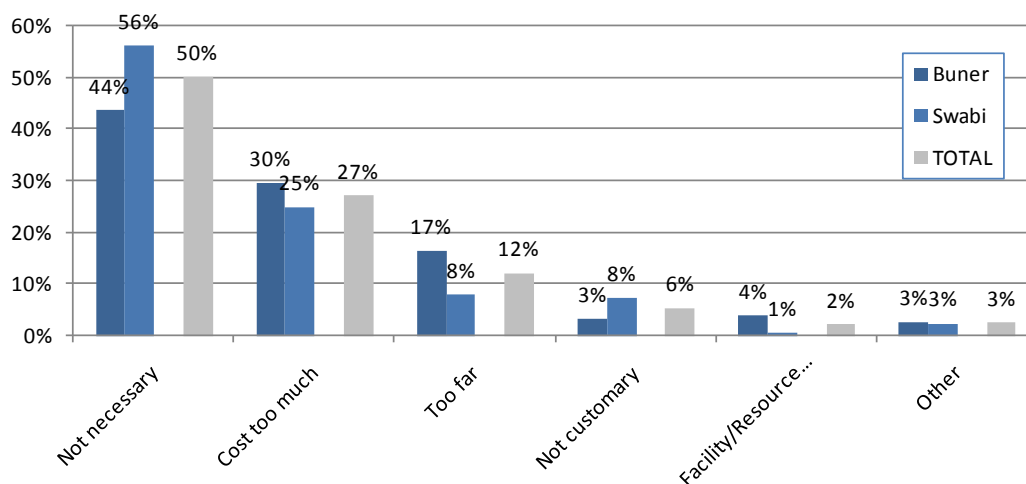


The only significant difference in terms of cost is linked to the location of the village: District and accessibility. In Buner the price for ANC is 25% higher than in Swabi. This is mainly due to the lack of facility in remote places so that the health professionals have more freedom to set higher prices.

This rejects the assumption that the educated and wealthier households would pay more on average for the ANC as it appears that the cost is not linked at all to the level of education or the income.

Motives for not having ANC

Graph 25: Reasons why no antenatal care



Among the 40% of pregnant women who do not go for ANC, the main reason is because people “don’t bother” or they think “it is not necessary because the person is not sick”. Based on this, we can see an important lack of awareness regarding ANC. Then, the reasons why people don’t go for ANC differ between Swabi and Buner. Financial, accessibility and facility and resource availability issues are significantly higher in Buner than Swabi whereas in Swabi customs and awareness are more important.

Table 14: Reasons why no antenatal care

Characteristics	Not necessary	Cost too much	Too far	Not customary	Facility/Resource availability	Other	Total	Number
Accessibility								
Non accessible	35%	26%	20%	9%	5%	5%	100%	97
Accessible	57%	28%	9%	4%	1%	1%	100%	214
Literate								
Illiterate	43%	34%	12%	6%	3%	2%	100%	232
Literate	73%	8%	12%	4%	0%	4%	100%	77
Gender								
Mother	33%	36%	13%	10%	3%	5%	100%	139
Men	64%	20%	12%	2%	2%	1%	100%	172
Total	50%	27%	12%	6%	2%	3%	100%	311

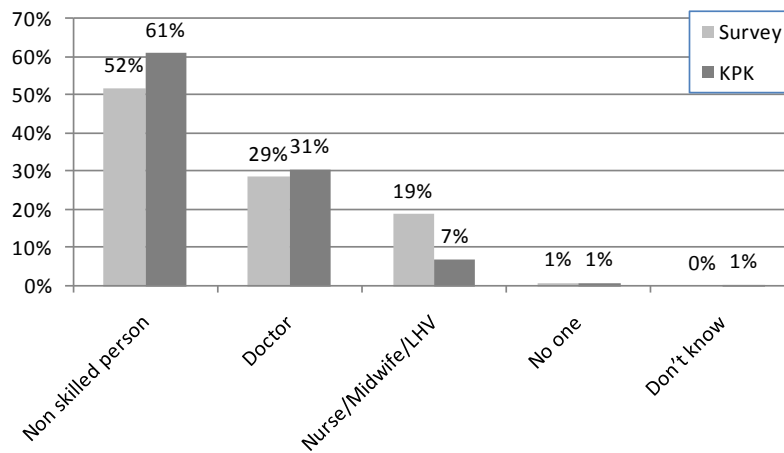
Accessibility to the facility remains an important problem for the remote villages as 20% of the people living in non accessible villages say they don’t go for ANC because “the facility is too far”. Among the literate people who are usually educated and wealthier we can see a high percentage of people answering this is because “it is not necessary” or “they don’t bother”. It

could be interpreted as it is not customary as usually we can assume this people are aware about the routine ANC. Then, there is a difference in opinion between mother and men as for the mothers the financial issue is the main reason they don't go for ANC whereas for the men it is because it is not necessary.

All these observations have been confirmed during the FGDs. As awareness, accessibility and financial issues were always mentioned in the discussions.

Delivery

Graph 26: Assistance during delivery



Source: Demographic and Health Survey 2006-07 - National Institute of Population Studies Islamabad, Pakistan – June 2008

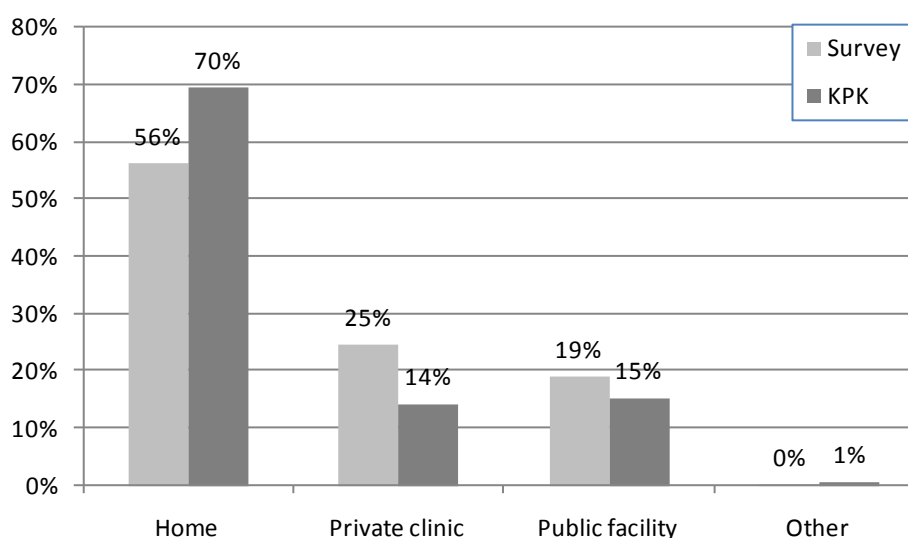
The assistance during delivery by a medically skilled person is considered to have an effective impact in the reduction of the maternal and neonatal mortality. However, in Swabi and Buner districts, there is still more than one delivery out of two that are attended by non medically skilled persons such as traditional birth attendants or friends and relatives. These figures are in line with the whole KPK even if we can observe a small improvement compare to KPK in 2007. These days, there are more deliveries attended by nurses, midwives or LHVs in Swabi and Buner compare to the whole KPK 3 years ago. The explanation is because the government decided to train more LHVs over the past year in this province.

Table 15: Assistance during delivery

Characteristics	No skilled person	Doctor	Nurse/Midwife/LHV	No one	Total	Number
Accessibility						
Non accessible	67%	15%	17%	2%	100%	157
Accessible	46%	34%	20%	1%	100%	463
Education						
Uneducated	57%	25%	16%	1%	100%	374
Primary	51%	15%	32%	1%	100%	74
Secondary	42%	38%	20%	0%	100%	116
Higher	33%	52%	15%	0%	100%	54
Monthly income						
< 5000rs	57%	23%	18%	2%	100%	129
5000rs - 10000rs	56%	24%	18%	2%	100%	126
> 10000rs	44%	41%	15%	0%	100%	133
Total	52%	29%	19%	1%	100%	620

As for ANC, people living in remote places, usually poorer households, don't get the assistance of a medically skilled person. This is confirmed by the strong relationship between the proportion of deliveries attended by a doctor and the level of education and income.

Graph 27: Place of delivery



Source: Demographic and Health Survey 2006-07 - National Institute of Population Studies Islamabad, Pakistan - June 2008

We notice a slight improvement during the past 3 years in terms of place of delivery. Usually mother delivering home are delivering without any skilled person so this trend is in line with the assistance during delivery. However, the biggest increase between Swabi and Buner districts and the whole KPK 3 years ago, goes for the private clinic and not really for the public facilities. However if we look more into details regarding the public facilities, there is a significant difference between Swabi and Buner: In Buner, people go more to the hospital and

in Swabi they go more to the BHU This shows the lack of BHUs with delivery services in Buner as people have to go straight to the hospital.

Table 16: Place of delivery

Characteristics	Home	Private clinic	Public facility	Total	Number
Accessibility					
Non accessible	72%	16%	12%	100%	155
Accessible	51%	27%	22%	100%	460
Education					
Uneducated	61%	21%	17%	100%	369
Primary	58%	26%	16%	100%	73
Secondary	49%	22%	29%	100%	117
Higher	39%	46%	15%	100%	54
Monthly income					
< 5000rs	67%	18%	15%	100%	130
5000rs - 10000rs	62%	17%	21%	100%	126
> 10000rs	49%	32%	20%	100%	132
Total	56%	24%	19%	100%	615

As for the assistance during delivery, we find the same factors that influence the place of delivery. The more educated and richer households go to a private clinic where there is usually a doctor and the people living in remote place deliver more at home.

Delivery in a facility

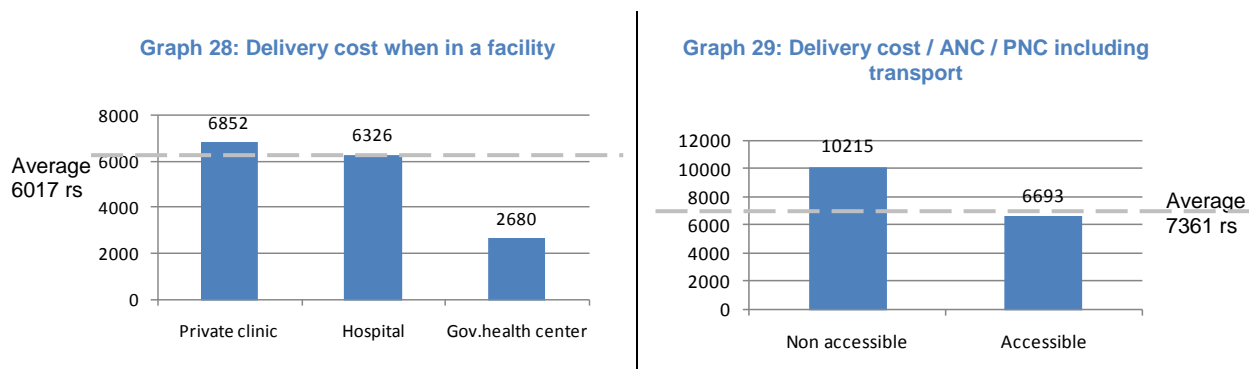
Table 17: Reasons why the delivery is in a facility

Characteristics	Problems during pregnancy	Safer	Customary	Other	Total	Number
Accessibility						
Non accessible	77%	23%	0%	0%	100%	44
Accessible	45%	45%	6%	4%	100%	220
Gender						
Mother	66%	30%	2%	1%	100%	116
Men	30%	55%	9%	6%	100%	148
Total	50%	41%	5%	3%	100%	264

The main reason why the people go to a facility for delivery is because of complication during the pregnancy and it is not because there is a facility nearby that the people would go more often. In remote areas, 77% of the people go to a facility because the mother got some complication during pregnancy. Also the difference of opinion between men and mothers shows that the choice of going to a facility is not done for the same reason as for men, the main reason of going to a facility is because a facility is safer than home.

Regarding the transportation to the facility, 74% of the people go by taxi, 10% with their own transportation and 7% by walk. There is no significant difference between Swabi and Buner district. The only difference is that the rich people get their own transportation to the facility.

Also, there is no relationship between the place of delivery and the distance to the facility. The choice of the place seems to depend more on trust in the doctors than the rest.

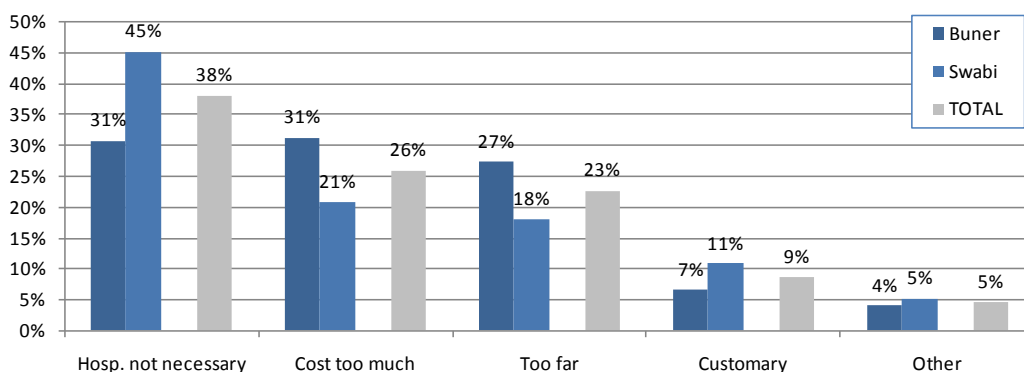


The delivery cost is linked to the facility and is more expensive in private clinic. People usually go to the hospital if they need surgery and that is why the price is also high. But the other government health centres are two third cheaper than the private clinic.

The accessibility of the village has an important impact on the maternal cost (including ANC / PNC / Delivery / Transportation). The transportation cost is the main reason why the cost differs that much. There is no significant difference between Swabi and Buner. However, people living in Buner spend more money in transportation cost to access the facility while people living in Swabi spend more money because they choose to go to the private clinic.

Delivery at home

Graph 30: Reasons why the delivery is at home



The main reason why people deliver home is because they think hospital is not necessary. During the FGDs, people explained that if the first delivery went well they usually assume there will not be any problem in the other delivery so they don't go to the hospital. Another explanation given during the FGDs is that they prefer to stay home as it is more intimate and they don't want the mother to be "shown" to many people they don't know.

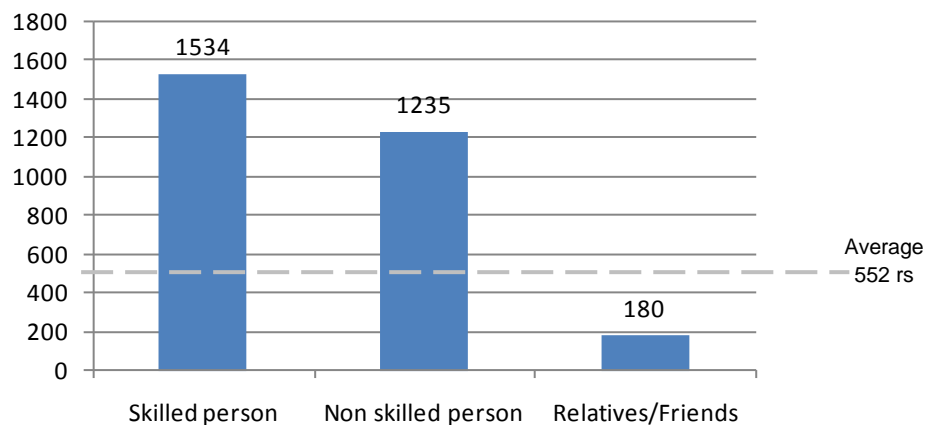
However, the three main reasons why the mothers deliver home in Buner are the financial issue, the custom when they say that "hospital is not necessary" and the long distance to the facility while in Swabi, the people talk mainly about the fact that the hospital is not necessary (custom). It means that it is not a financial problem or an accessibility problem for them to go but more a choice.

Table 18: Reasons why the delivery is at home

Characteristics	Hosp. not necessary	Cost too much	Too far	Customary	Other	Total	Number
Accessibility							
Non accessible	28%	26%	32%	10%	5%	100%	156
Accessible	44%	26%	18%	8%	5%	100%	303
Gender							
Mother	31%	33%	17%	11%	8%	100%	201
Men	43%	20%	27%	7%	2%	100%	258
Education							
Uneducated	34%	33%	20%	10%	4%	100%	316
Primary	38%	11%	34%	9%	9%	100%	47
Secondary	50%	13%	27%	4%	6%	100%	70
Higher	62%	4%	27%	4%	4%	100%	26
Total	38%	26%	23%	9%	5%	100%	459

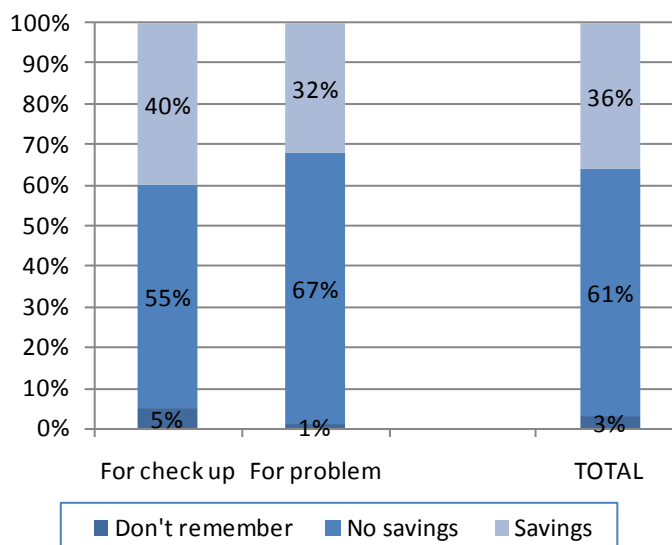
This table shows that accessibility and awareness (level of education) are both the explanations why the people deliver home. As the educated people are also the wealthiest, it means that the financial issue is also a reason why people deliver home.

Graph 31: Delivery cost when at home



This confirms that the financial issue is also one of the main reasons why the people deliver home as it is a lot cheaper even with a skilled person. The delivery in a facility costs on average 6017rs which is at least 5 times higher than a delivery at home. But looking at this graph, we can notice the tendency for the non skilled professional such as traditional birth attendant, LHWs or dispensers to charge almost as much as skilled persons which are mainly LHVs when at home. Delivering with friends and relatives is still very popular and a lot cheaper as usually the people pay for some medicines or nothing if they don't buy anything.

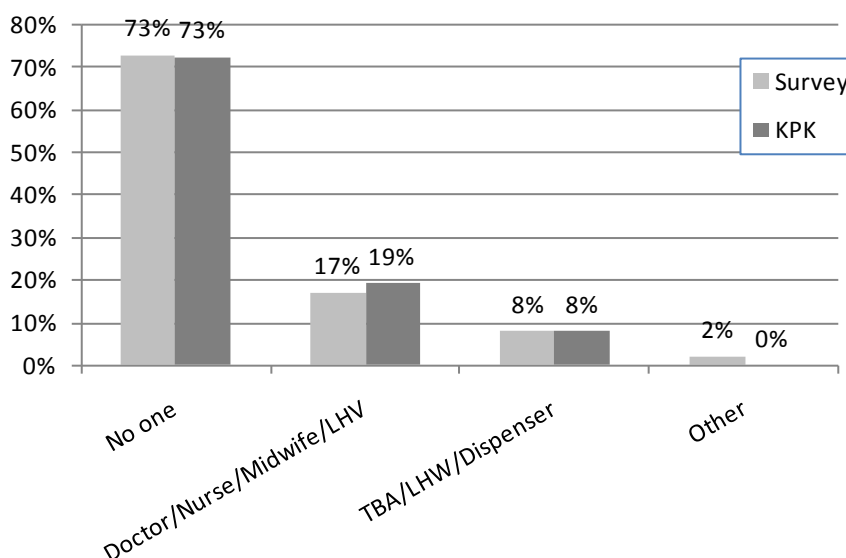
Graph 32: Emergency savings



When we ask the people if they put some money aside during the pregnancy in case of emergency, we can see that most of the time they don't save any money even if there are some complications during the pregnancy. Most of the time, the people cannot put some money aside so they wait until the last minute and borrow some money from their relatives and friends within the community. This is only a small part of the population who can save some money and this is not linked to the fact of having a complication or not.

Postnatal Care

Graph 33: Type of postnatal care providers



Source: Demographic and Health Survey 2006-07 - National Institute of Population Studies Islamabad, Pakistan – June 2008

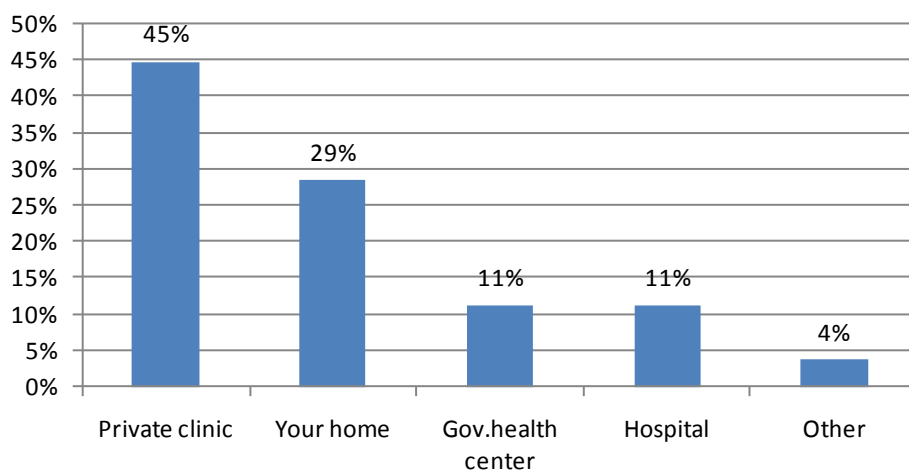
Even though the numbers are in line with the whole KPK, the proportion of mother going for a PNC is very low. Only 27% of the mothers go for PNC and most of the time they go because of a problem which reduce the proportion of mothers having a routine PNC to 14%.

Table 19: Type of postnatal care providers

Characteristics	No one	Doctor/Nurse/ Midwife/LHV	TBA/LHW/ Dispenser	Other	Total	Number
Monthly income						
< 5000rs	82%	10%	7%	1%	100%	129
5000rs - 10000rs	72%	16%	11%	2%	100%	123
> 10000rs	65%	29%	5%	2%	100%	131
Facility in the village						
Yes	67%	22%	10%	2%	100%	
No	78%	14%	7%	1%	100%	

Financial issue seems to be a major problem to access to PNC as 29% of the wealthier people can afford to go to MBBS doctors while 82% of the poorest don't see anyone. Also, people having a facility in their village go more often for PNC than the others. During the survey, we have been explained that in some villages with a facility, the LHV was visiting the mothers' home after delivery for a routine PNC. This is why there is a significant difference between the people living in a village with facility who have a PCN more often than the others.

Graph 34: Place of postnatal care



As for the ANC and the delivery, the private clinic seems to be the common place to go for PNC. Also, 29% of the PNC are done home with the visit most of the time of the LHVs. This practice seems adequate to the 40 days period after delivery where the mother is not allowed to go out. The place of PNC is not linked to any subgroup such as education, district, etc.

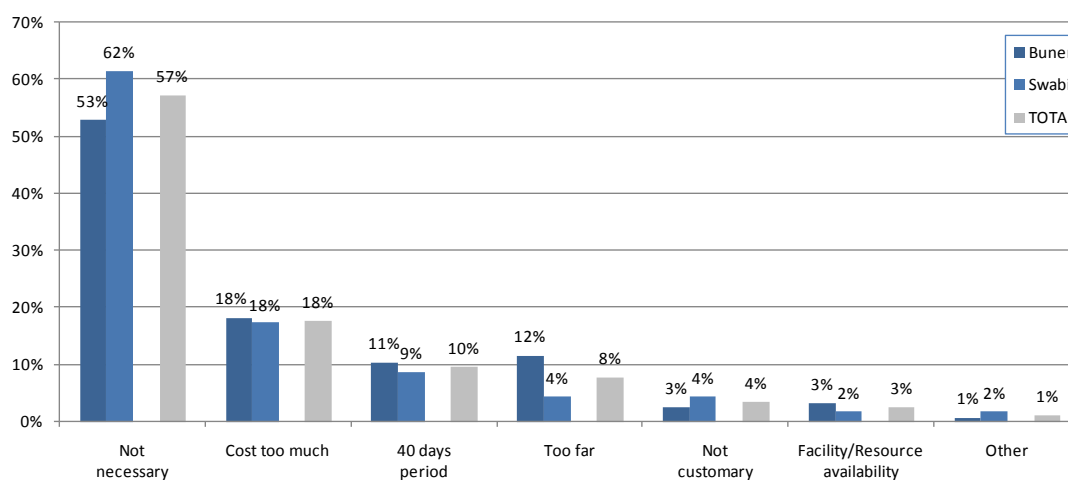
Table 20: Reasons for postnatal check-up

Characteristics	For checkup	For problem	Total	Number
District				
Buner	42%	58%	100%	74
Swabi	61%	39%	100%	84
Accessibility				
Non accessible	31%	69%	100%	29
Accessible	57%	43%	100%	129
Literacy				
Illiterate	36%	64%	100%	87
Literate	73%	27%	100%	67
Monthly income				
< 5000rs	23%	77%	100%	22
5000rs - 10000rs	54%	46%	100%	35
> 10000rs	67%	33%	100%	43
Total	52%	48%	100%	158

From the above table, we can see that people living in Buner, in remote villages, illiterate and poorer are going for a PNC only in case of problems. On the other hand, people living in Swabi, in accessible places, literate and wealthier are going more for a routine check-up. This shows that the main constraints to the access to PNC are accessibility, awareness and financial issues.

Motives for not having any PNC

Graph 35: Reasons why no postnatal care



The main reason why people don't go for ANC is because they think "it is not necessary" and "they don't bother". This reason includes both awareness and custom as the tradition of the

40 days period after delivery where the mother does not go out is very well respected in Swabi and Buner. So it prevents also the mother to have a PNC unless it is done at home. During the FGDs, some stories explained that often, the family of the mother wait until the situation gets very bad before taking her to a health facility in order to respect this tradition which could lead to some big damages in some cases. The reasons are mainly the same between Swabi and Buner apart from the distance to the facility (“too far”) which is a bigger issue in Buner than in Swabi.

Table 21: Reasons why no postnatal care

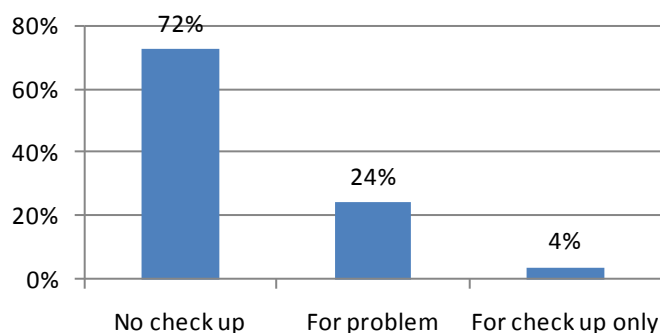
Characteristics	Not necessary	Cost too much	40 days period	Too far	Not customary	Facility/Resource availability	Other	Total	Number
Accessibility									
Non accessible	48%	19%	4%	18%	5%	4%	3%	100%	160
Accessible	61%	17%	12%	4%	3%	2%	1%	100%	381
Gender									
Mother	48%	31%	1%	10%	6%	1%	2%	100%	250
Man	66%	6%	17%	6%	1%	4%	0%	100%	291
Education									
Uneducated	50%	24%	9%	9%	4%	2%	2%	100%	343
Primary	61%	12%	5%	13%	5%	5%	0%	100%	61
Secondary	70%	7%	13%	5%	1%	3%	1%	100%	99
Higher	87%	0%	11%	0%	0%	3%	0%	100%	37
Monthly income									
< 5000rs	48%	22%	7%	11%	7%	3%	3%	100%	134
5000rs - 10000rs	56%	13%	14%	7%	2%	6%	2%	100%	121
> 10000rs	75%	4%	11%	7%	1%	1%	1%	100%	101
Facility in the village									
No	58%	18%	7%	10%	4%	2%	1%	100%	325
Yes	57%	18%	13%	5%	2%	4%	1%	100%	216
Total	57%	18%	10%	8%	4%	3%	1%	100%	541

The reasons why people do not go for PNC are the same as for ANC with the addition of the 40 days period. We can notice that people living in remote area, uneducated and poorer go less often for PNC than the others because it is too far and it costs too much. The other group of people living in accessible villages, educated and wealthier are more concerns about respecting the 40 days period and the custom as they can access the facility but they are attached to their traditions.

Actually, the 40 days period after delivery when the mother cannot go out is an important factor as 67% of the mothers stay home during a minimum of 40 days and 60% bath for the first time after 40 days. This is the same for all the subgroups which means that educated, uneducated, rich, poor, they all respect this tradition the same way. Also, 7% of the people who declared having done a PNC did it after 40 days after delivery in order to respect the tradition where the mother has to stay home.

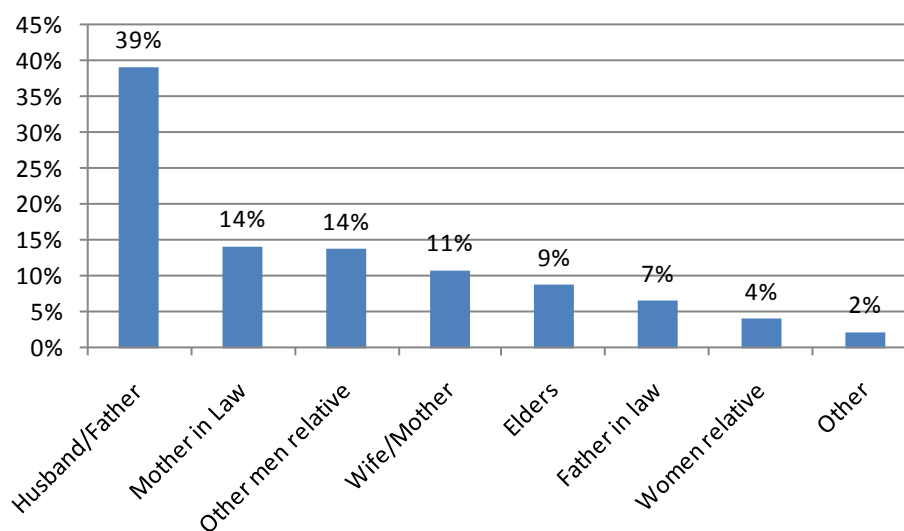
Postnatal care for the baby

Graph 36: Reasons of postnatal check-up for the baby



As for the PNC for the mothers, the people usually do not bring the baby for a PNC unless there is a problem. Only 4% of the babies have a PNC and most of the time it is done when the mother has a routine check-up at home and the LHV checks also the baby.

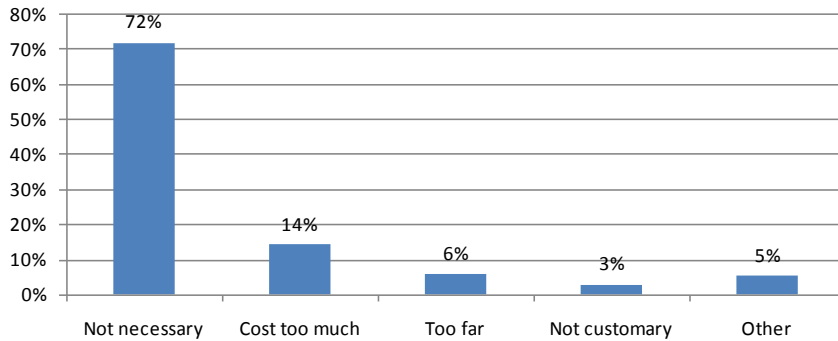
Graph 37: Person who brings the baby for PNC



This is mainly the husband, the mother in law or another man who brings the baby for a PNC as the mother normally do not go out within 40 days after delivery.

Motives for not having any PNC for the baby

Graph 38: Reasons why no postnatal care for the baby



Even though awareness is not the only reason included in “not necessary” as it could include also the custom, this graph shows there is an important lack of awareness. Only 4% of the babies have a routine PNC. There is no significant difference for the subgroups.

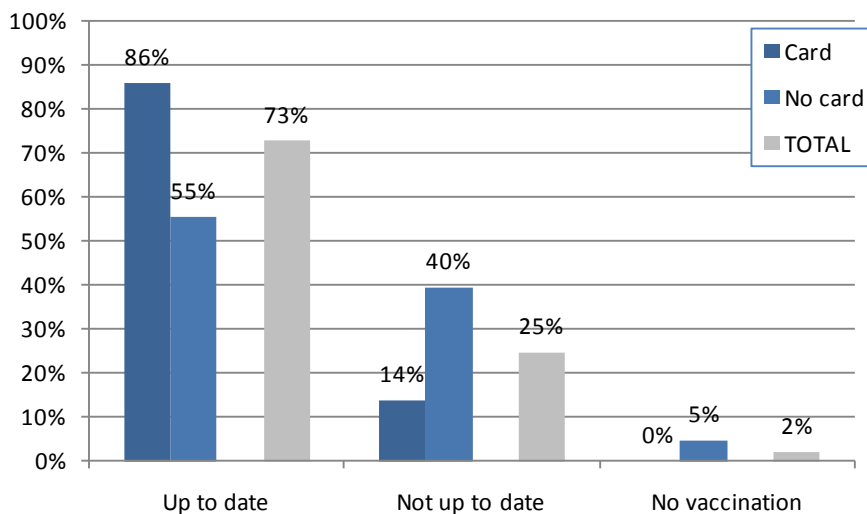
4. Immunization

Another part of the health of mother and child is the immunization. EPI program is everywhere in Pakistan and in all the villages where we did the survey an EPI team visits regularly, monthly to yearly basis, to vaccinate the children and the pregnant women.

Children’s immunization

Vaccination coverage

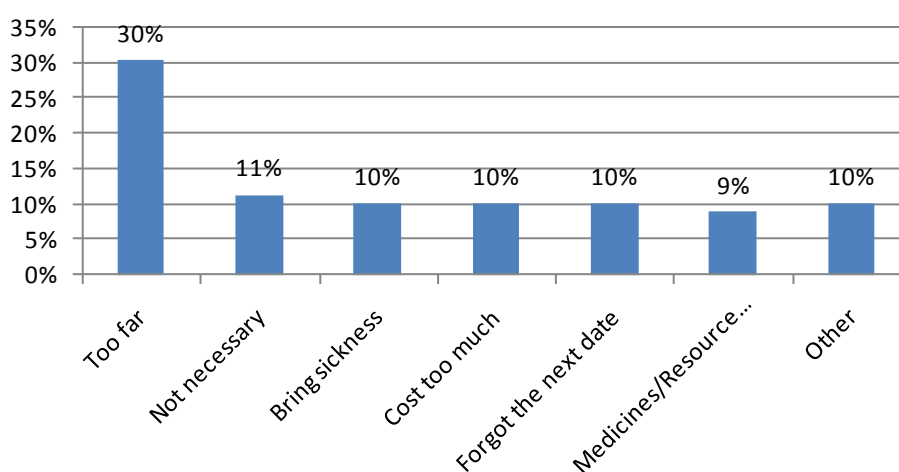
Graph 39: Children’s vaccination



During the interview, we asked the people to see the vaccination card of the children so we could have a status on the immunization level for each child. In total, we manage to see the card for 57% of the children. For the others, the answers are purely declarative so the results might not reflect the exact status but mainly show a trend.

Looking at the graph, we can see that people having a card understand the true meaning of vaccinating the children as compare to the people without any vaccination card that don't really care about the vaccination of their children as 40% of them are not up to date. Also, another explanation is that people make a difference between drops and injections. So, 94% of the children are vaccinated against polio as it is administrated with drops and it has apparently not the same impact on the population's belief. But if we exclude the children who only got the polio drops, then there are 15% of the children who did not get any injection at all.

Graph 40: Reasons why the vaccination are not completed



The main reason why people miss some vaccination for their children is because the facility is too far. Then all the other reasons are mentioned with the same frequency. We can observe that people miss the date which means that they don't really understand the importance of vaccination and do not really know why they should do it. Another reason is that it brings sickness. In this case, people stop definitely the vaccination of their children as they think it is not normal that the child becomes sick after an injection. This shows a lack of health education and awareness around the benefits of the vaccination and how it works. This could be combined together with the number of people who think it is not necessary. It is another part of awareness. Usually people who mentioned this said that it is not necessary as the elder people in the family did not get any vaccination and they don't have any health problem so they don't understand why they should do it. In this case, people change their mind usually because of a past event that make them understand the benefits of vaccinations.

Graph 41: Children without any injection

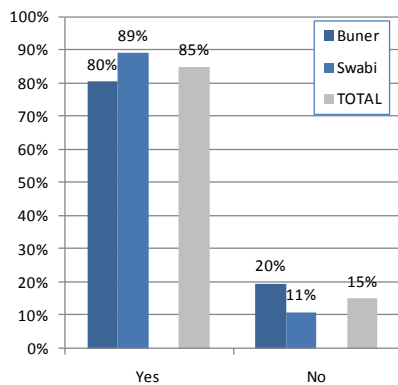


Table 22: Children without any injection

Characteristics	Yes	No	Total	Number
Accessibility				
Non accessible	74%	26%	100%	155
Accessible	89%	12%	100%	460
Education				
Uneducated	79%	21%	100%	369
Primary	90%	10%	100%	73
Secondary	97%	3%	100%	117
Higher	94%	6%	100%	54
TOTAL	85%	15%	100%	613

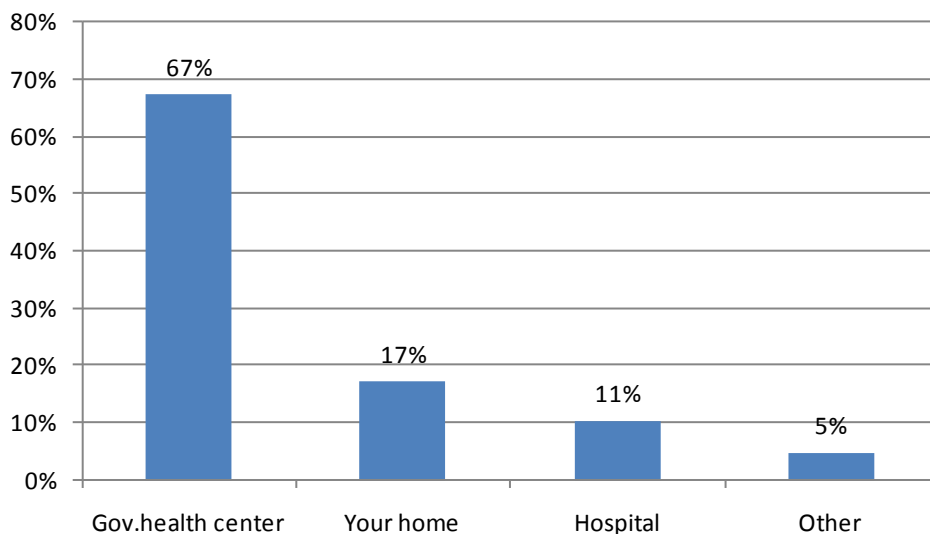
If we look at the subgroup for the polio drop, the coverage is the same among all the groups which means that we have the same percentage of children not getting any vaccination at all even the polio drops. It does not depend on the level of education, the monthly income, the place of residence, the district, etc.

Regarding injections only (excluding the polio drops), the remote places seem to be more reluctant to injection than the populations in the more accessible villages. This could be also because these remote villages are more traditional. We observe the same if we focus on the education level. Uneducated people are more reluctant to injections than educated people. Awareness seems to play a big part in the decision of getting injection or not.

Regarding the BCG for babies, 58% of the babies get their injection within the first 6 weeks after birth.

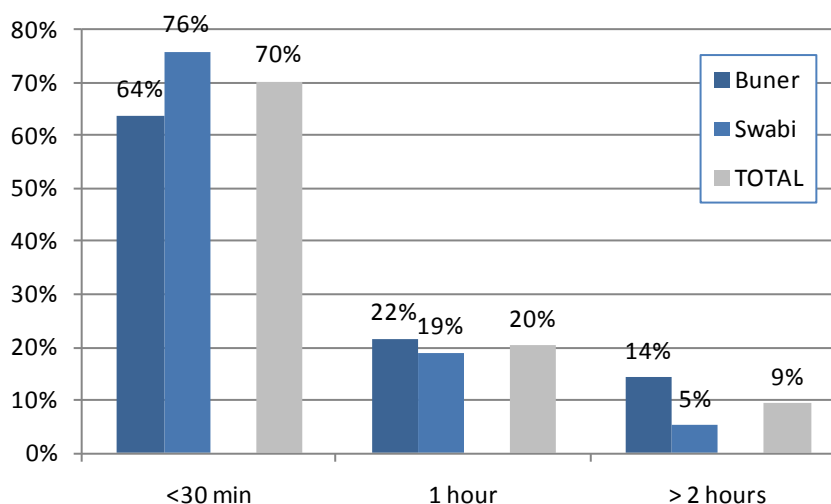
Going for vaccination

Graph 42: Places of vaccination



Two third of the vaccinations are done in BHUs or RHCs. People are then well aware on where to go to get free vaccination. The 17% of vaccination at home includes partly the EPI programme that visit the children home in each village.

Graph 43: Distance to the facility



Households living in Buner are definitely further away from the facilities for vaccination than households living in Swabi.

Table 23: Distance to the facility

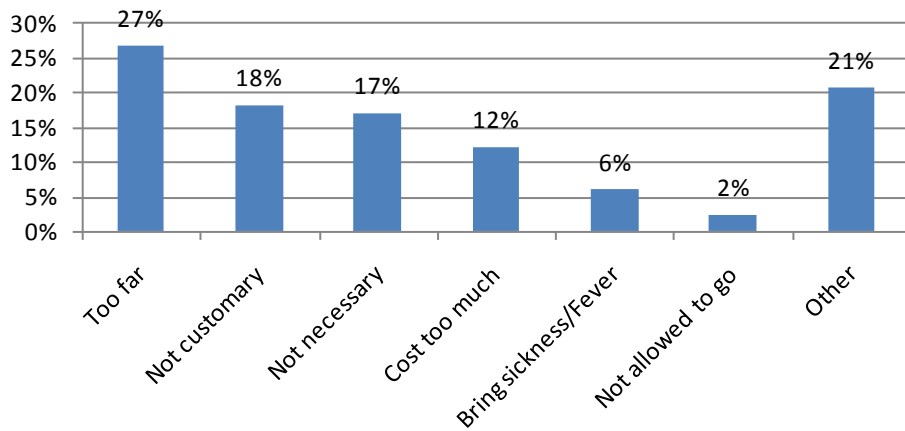
Characteristics	<30 min	1 hour	> 2 hours	Total	Number
Accessibility					
Non accessible	24%	43%	34%	100%	101
Accessible	84%	14%	2%	100%	340
Education					
Uneducated	64%	23%	13%	100%	254
Primary	58%	29%	14%	100%	52
Secondary	85%	13%	2%	100%	91
Higher	91%	10%	0%	100%	42
Total	70%	20%	10%	100%	439

People living in remote places and uneducated are living further away from the facility and need more time to access to facility.

The mean of transportation to go to the facility for vaccination is significantly different between Swabi and Buner. People go more often to the facility with the own transportation in Swabi and in Buner, people uses more public transport (30%) and taxis (6%).

Motives for not having any vaccination at all

Graph 44: Reasons why no vaccination

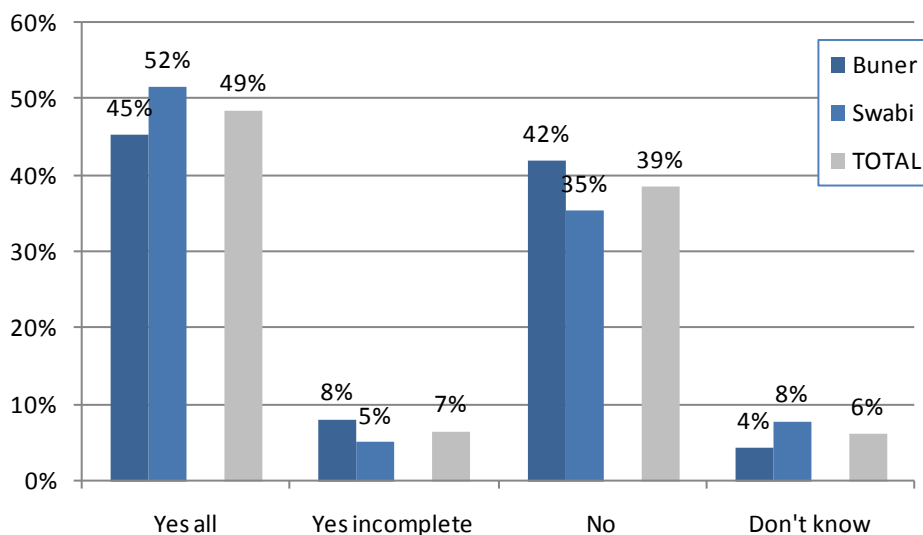


The reasons why some children do not get any vaccination at all are because the facility is too far and then because it is not customary. This statement includes all the belief that are behind the vaccinations and also a lack of awareness which seems to be a big issue in terms of vaccination.

Mother's immunization

Vaccination coverage

Graph 45: Pregnant women's vaccination against TT



Only 49% of the pregnant women are vaccinated completely against TT and the frequency is slightly higher in Swabi than in Buner. Also, as compare to the proportion of pregnant women having an ANC (60%), the proportion of women getting the TT vaccination is lower. There is

apparently a lack of health education around this vaccination and people seem not to be aware they should do it.

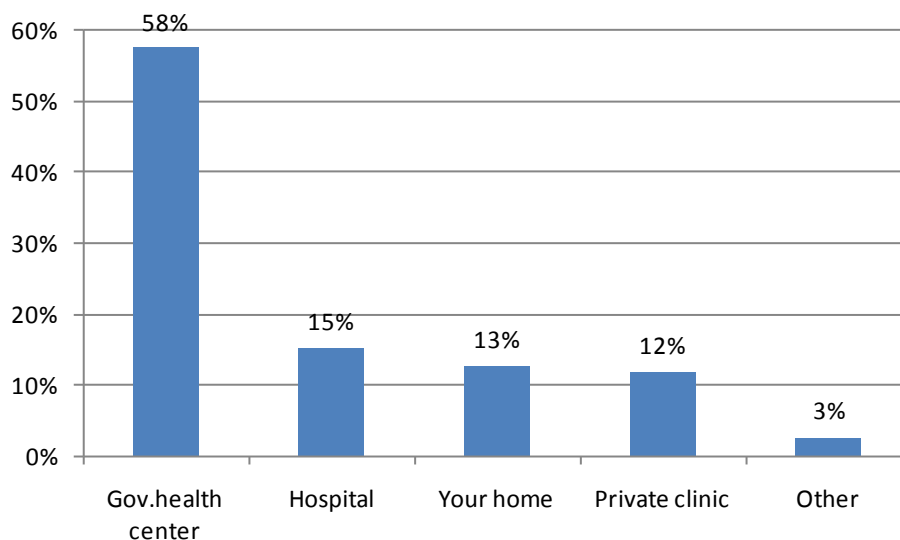
Table 24: Pregnant women's vaccination against TT

Characteristics	Yes all	Yes incomplete	No	Don't know	Total	Number
Accessibility						
Non accessible	33%	13%	54%	1%	100%	154
Accessible	54%	4%	33%	8%	100%	455
Education						
Uneducated	40%	7%	49%	5%	100%	366
Primary	55%	12%	32%	1%	100%	73
Secondary	64%	5%	22%	10%	100%	116
Higher	71%	2%	14%	14%	100%	52
Monthly income						
< 5000rs	35%	9%	49%	8%	100%	130
5000rs - 10000rs	50%	8%	41%	1%	100%	125
> 10000rs	55%	8%	27%	11%	100%	130
Facility in the village						
No	42%	9%	42%	6%	100%	352
Yes	57%	3%	34%	6%	100%	257
Total	49%	7%	39%	6%	100%	609

From this table, we can see that people more educated, richer and living in accessible villages get the TT vaccination more frequently. This shows that accessibility and awareness are the 2 main reasons why the people get TT vaccination.

Going for vaccination

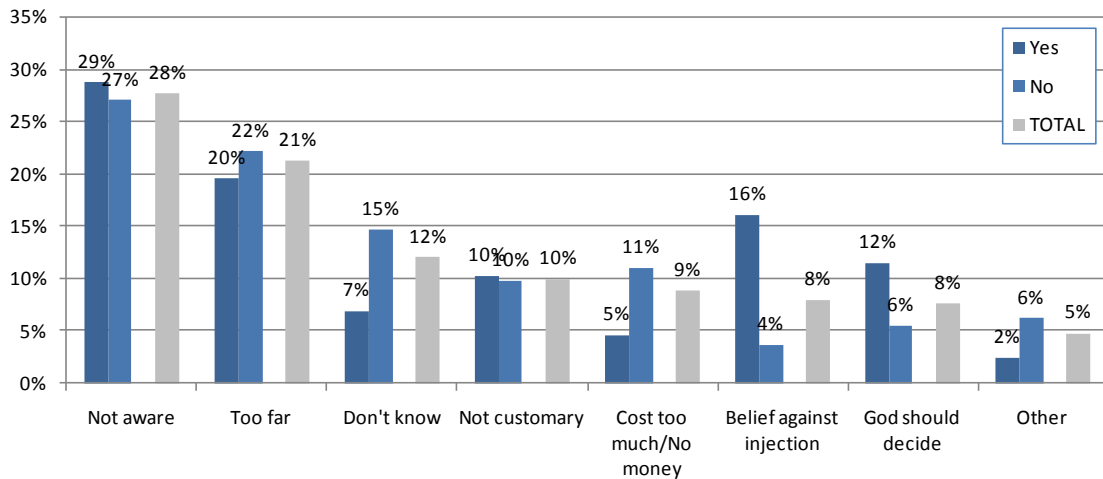
Graph 46: Place of vaccination



This graph is interesting because if we compare it with the place for ANC (graph 22) we can see that the ANC is totally disconnected from the TT vaccination. Most of the ANCs are done in private clinics where there is no vaccine available or people have to pay for it, so the people who want to get vaccinated against TT have to go to a public facility.

Motives for not having any vaccination

Graph 47: Reason why no vaccination for pregnant women

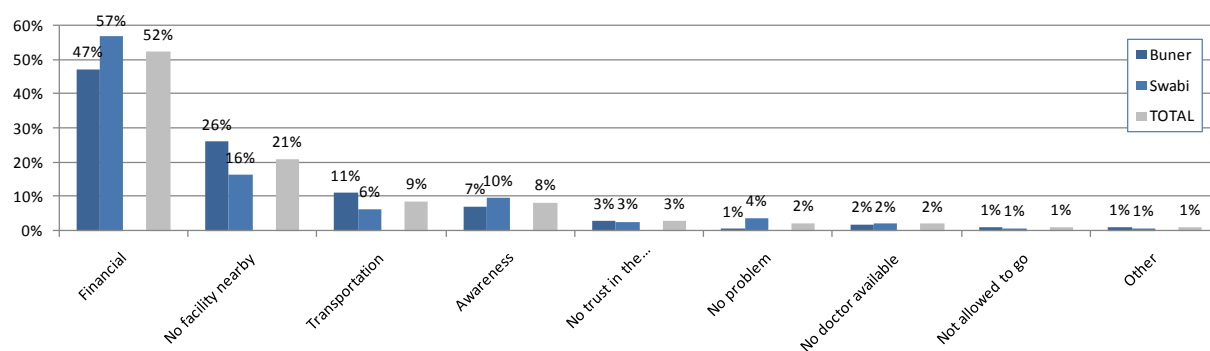


In general, people seem not to be aware about this vaccination. Even if there is a facility in the village, we have the same proportion of people saying they are not aware about this vaccination as the people living in a village without any health facility. The second reason is because the facility is too far even if there is a facility in the village.

There is a difference in terms of behaviour between the people who have a facility in their village and people who do not, especially if you look at the belief and the religious aspects. People who have the facility in their village declare that they have some belief against injections and that it is against their religion in third and fourth positions. The people living far away from a facility declare more often that it is because of financial issue (transportation cost).

5. Conclusion

Graph 48: Main difficulties for access to health care for mother and child



In general, when we ask the people what is the main difficulty for the access to healthcare for mother and child, the main answer is the financial issue. Then we notice a significant difference between Swabi and Buner for the lack of facility nearby which is another major issue in Buner and transportation issue as well for Buner.



APPENDIX 1: QUESTIONNAIRE

Access to Health Care for Mother and Child

QUESTIONNAIRE FOR MEN or MOTHER IN LAW

Eligible Men or Mother in Law = Household with at least 1 child under 5. If mother in law, she should be head of family.

SURVEY INFORMATION - BEFORE THE INTERVIEW		
1. Village _____	2. Household Number _ _	
3. Interviewer Name & Team Number Name _____	S4. Supervisor Name Name _____	
5. Date of the interview ___ ___ / ___ ___ / 2010	6. House type Mud.....1 Bricks.....3 Mud & Bricks.....2 Blocks/Cement4	
7. Area Urban.....1 Rural/Remote.....2	8. District Swabi.....1 Buner.....2	9. Road from village to main city Katcha.....1 Pukka.....2

SURVEY INFORMATION - AT THE END OF THE INTERVIEW	
Result of the interview Completed 01 Not completed..... 02 Refused..... 03 Other (<i>specify</i>)..... 97	Data entry clerk & Team Number Name _____
Interview of the mother Yes.....1 No.....2	Interview of the head of the family Yes.....1 No.....2
Comments from interviewer	
Comments from Supervisor / Reviewer	

WE ARE FROM MDM. WE ARE WORKING ON A PROJECT CONCERNED WITH ACCESS TO HEALTH FOR MOTHER AND CHILD. WE WOULD LIKE TO TALK TO YOU ABOUT THIS SUBJECT. THE INTERVIEW WILL TAKE ABOUT (NUMBER) MINUTES. ALL THE INFORMATION WE OBTAIN WILL REMAIN STRICTLY CONFIDENTIAL AND YOUR ANSWER WILL NEVER BE SHARED WITH ANYONE OTHER THAN OUR PROJECT TEAM.

MAY I START NOW?

- Yes, permission is given ⇒ Begin the interview.
- No, permission is not given ⇒ Go to the next house.

Family's background

We are going to start this discussion with the structure of your family.

- B1. How old are you? (years old)**
1. < 20 2. 20 - 30 3. 30 – 40 4. 40 – 49
5. 50 - 60 6. > 60

- B2. Who is the responsible of the health in your household?**
1. Elders 2. Father in law 3. Husband
4. Wife 5. Mother in law 6. Herself
7. Other (specify) _____

More than one response can be selected.

- B3. Why is it this person?**

- B4. What is your education level?**
1. Uneducated 2. Class _____
10. Matric 11. Intermediate
12. Bachelor & Higher 98. Don't know
97. Other (specify) _____

- B5. Can you read and write?**
1. Yes 2. No

- B6. How many people are living in this household?**
- 0-4 years old (babies) | | | |
 - 5 – 14 years old (children) | | | |
 - Men 15 – 49 years old (men) | | | |
 - Women 15 – 49 years old (women) | | | |
 - > 50 years old (elders) | | | |
 - Total (people) | | | |

B7. How many people have died in this household in the last 12 months?

	Age	Reason
Death #1		
Death #2		
Death #3		
Total		

- B8. What is the main source of income in your household?**
1. No income 2. Farming/Harvesting
3. Livestock 4. Vender
5. Daily worker/labor 6. Family business
7. Salary
97. Other (specify) _____

More than one response can be selected.

- B9. What is approximately the monthly income in your household? (help the person to calculate)**
 _____ Rs 2. Don't know

- B10. In the past year, did your household receive some money from abroad, the government (not salary) or a humanitarian organization?**
1. Yes, abroad 2. Yes, government
3. Yes, humanitarian 4. No *

More than one response can be selected.

* Go to B12

- B11. How much did your household receive last year?**
 _____ Rs 2. Don't know

- B12. Do you rent or own this house?**
1. Rent 2. Own

- B13. Does your household have? (tick when Yes)**
1. Electricity 2. Radio 3. Telephone
4. Television 5. Fridge

- B14. Any member of your household has? (tick when Yes)**
1. Watch/Clock 2. Bicycle
3. Motorcycle 4. Animal drawn cart
5. Car/Truck/Tractor
7. Other (specify) _____

- B15. During the June crisis last year, have you been displaced or did you host people in your house?**
1. Displaced 2. Host * 3. Nothing **

* Go to B18

** Go to B20

B16. Where did you go? (District and UC)

B17. How long were you displaced? (circle days or months)

___ ___ days weeks months

Go to Sickness

B18. How many people did you host?

_____ people

B19. How long did you host these people for?

___ ___ days months

B20. What is your marital status? Are you married, widowed, separated, divorced?

- 1. Married
- 2. Widowed
- 3. Divorced
- 4. Separated
- 5. Never Married
- 7. Other (specify) _____

B25. When was the last birth in your household (even if she or he has died)?

___/___/___

Sickness

Now, we are going to talk about sickness like fever, diarrhea, headache, appendix, accident, severe trauma, etc.

S1. When was the last time a mother or a child under 5 in your household got sick?

- 1. < 2 weeks ago
- 2. 2 to 3 week ago
- 3. 1 month ago
- 4. 2 to 3 months ago
- 5. 3 to 6 months ago
- 6. 6 months to 1 year ago
- 7. > 1 year ago
- 98. Don't know
- 97. Other (specify) _____

S2. Who was sick?

- 1. Mother
- 2. Child

S3. What was the sickness?

- 1. Complicated delivery
- 2. Fever
- 3. Diarrhea
- 4. Chest infection
- 5. Cough
- 6. Malaria
- 7. Appendix
- 97. Other (specify) _____

More than one response can be selected.

S4. Did you think the sickness was so serious the person might die?

- 1. Yes
- 2. No
- 8. Don't know

S5. What did you do first to treat the person at home? (probe) Any traditional? Spiritual? Homemade medicine?

- 1. Give good food
- 2. Homemade medicines
- 3. Spiritual medicines
- 4. Traditional medicines
- 5. Modern medicines
- 6. Nothing
- 8. Did not wait
- 98. Don't know
- 97. Other (specify) _____

More than one response can be selected.

S10. Whom did you see? (probe) Anyone else? Spiritual? Traditional?

- 1. Doctor (MBBS)
- 2. Medical staff
- 3. Health professional
- 4. Traditional
- 5. Spiritual
- 6. No one *
- 8. Don't know
- 7. Other (specify) _____

More than one response can be selected.

* Go to S50

S11. In which order did you visit these people? (write numbers)

- 1. Doctor (MBBS)
- 2. Medical staff
- 3. Health professional
- 4. Traditional
- 5. Spiritual
- 8. Don't know
- 7. Other (specify) _____

S7. How many days after the illness began did you show the person to someone?

___ ___ days

If no wait or few hours, write 0 and go to S9

S8. Why did you wait? (probe) Anything else?

1. Treat him ourselves 2. Money to be find
 3. Transport to be find 4. Husband to come back
 5. Always wait 6. No so serious
 7. Other (specify) _____

More than one response can be selected.

S9. Who in the family took the person to the facility?

1. Elders 2. Father in law
 3. Husband/Father 4. Brother in law
 5. Mother in law 6. Mother
 97. Other (specify) _____

—

S12. Where did you go first?

1. Your home * 2. Hospital
 3. Gov. health center 4. Private clinic
 5. Mobile clinic / NGO 6. Traditional
 7. Spiritual 98. Don't know
 97. Other (specify) _____

* Go to S20

S13. Where is the first facility you went to? (Name & City)

S14. Is it the closest facility?

1. Yes * 2. No 3. Don't know

* Go to S16

S15. Why did not you go to the closest facility?

1. Doctor not available
 2. Facility not open
 3. Medicines not available
 4. Cost too much/No money
 5. Don't trust the person/Service not good
 6. Did not want to see a male doctor
 7. Long time waiting
 97. Other (specify) _____

More than one response can be selected.

S16. How long does it take to go to this facility? (circle min or hours)

___ ___ minutes hours

S17. How did you go there? Which transportation?

1. Walk * 5. Suzuki van / Tractor trolley
 2. Own transportation * 6. Tonga / Cattle cart
 3. Rickshaw 7. Bus / Truck
 4. Taxi 98. Don't know
 97. Other (specify) _____

More than one response can be selected.

* Go to S20

S18. How long did it take to find transportation?

___ ___ minutes hours

S19. How much did you pay in total for the transportation? (one way)

___ ___ Rs.

S20. How much did you pay for the consultation?

___ ___ Rs.

S21. Did the person get some tests?

1. Yes 2. No * * Go to S23

S22. How much did you pay for the tests?

___ ___ ___ ___ ___ Rs.

Go to S24

S23. Why did not you get any test?

1. Cost too much/No money 2. No laboratory
 3. Laboratory closed 4. No electricity
 5. Test unavailable 6. No necessary
 97. Other (specify) _____

More than one response can be selected.

S24. Were the person prescribed some medicines?

1. Yes 2. No * * Go to S29

S25. Did you get all, one part or none of the prescribed medicines?

1. All 2. One part 3. None *

* Go to S28

S26. Where did you get the medicines?

- 1. At the health centre
- 2. Another health centre
- 3. Dispenser
- 4. Market/Shop keeper
- 97. Other (specify) _____

S27. How much did you pay for the medicines?

_____ Rs.

S28. (if none of not all medicines) Why did not you get all the medicines or none of them?

- 1. Cost too much/No money
- 2. Not available
- 3. No trust
- 4. Wrong prescription
- 5. Prescription too complicated
- 97. Other (specify) _____

More than one response can be selected.

S29. For all the expenses, where is the money coming from?

- 1. From savings/salary
- 2. Cut down of the expenses
- 3. Sell of the harvest of the crops
- 4. Sell cattle
- 5. Sell land
- 6. Do extra labor work
- 7. Borrowed from friends/relatives/villagers
- 8. Borrowed from relatives/friends abroad

More than one response can be selected.

Go to S31

S30. After this first facility, did you visit others?

- 1. Yes
 - 2. No *
- * Go to S51

S31. What is the last facility you visited?

- 1. Your home *
- 2. Hospital
- 3. Gov. health center
- 4. Private clinic
- 5. Mobile clinic / NGO
- 6. Traditional
- 7. Spiritual
- 98. Don't know
- 97. Other (specify) _____

* Go to S33

S32. Where is this facility? (City & Name)

S33. Whom did you see? (probe) Anyone else?

- 1. Doctor (MBBS)
- 2. Medical staff
- 3. Health technician
- 4. Traditional
- 5. Spiritual
- 8. Don't know
- 7. Other (specify) _____

More than one response can be selected.

S34. How long did it take to go to this facility?

(One way)

_____ minutes hours days

S35. How did you go there? Which transportation?

- 1. Walk *
- 2. Own transportation *
- 3. Rickshaw
- 4. Taxi
- 5. Suzuki van / Tractor trolley
- 6. Tonga / Cattle cart
- 7. Bus / Truck
- 98. Don't know
- 97. Other (specify) _____

More than one response can be selected.

* Go to S38

S36. How long did it take to find transportation?

(one way)

_____ minutes hours days

S37. How much did you pay in total for the transportation? (One way)

_____ Rs.

S38. How much did you pay for the consultation?

_____ Rs.

S39. How much did you pay for the facility cost?

_____ Rs.

S40. How much did you pay for the surgery?

_____ Rs 2. No surgery

S41. Did the person get some tests?

- 1. Yes
 - 2. No *
- * Go to S44

S42. How much did you pay for the tests?

_____ Rs

Go to S44

Go to S51

S43. Why did not the person get any test?

1. Cost too much/No money 2. No laboratory
 3. Laboratory closed 4. No electricity
 5. Test unavailable 6. No necessary
 7. Other (*specify*) _____
-

More than one response can be selected.

S44. Were the person prescribed some medicines?

1. Yes 2. No * * Go to S49

S45. Did you get all, one part or none of the prescribed medicines?

1. All 2. One part 3. None * * Go to S48

S46. Where did you get the medicines?

1. At the health centre
 2. Another health centre
 3. Dispenser
 4. Market/Shop keeper
 97. Other (*specify*) _____
-

S47. How much did you pay for the medicines?

___ ___ ___ ___ ___ Rs.

Go to S49

S48. (if none of not all medicines) Why did not you get all the medicines or none of them?

1. Cost too much/No money 2. Not available
 3. No trust 4. Wrong prescription
 5. Prescription too complicated
 97. Other (*specify*) _____
-

More than one response can be selected.

S49. For all these expenses, where is the money coming from?

1. From savings/salary
 2. Cut down of the expenses
 3. Sell of the harvest of the crops
 4. Sell cattle
 5. Sell land
 6. Do extra labor work
 7. Borrowed from friends/relatives/villagers
 8. Borrowed from relatives/friends abroad

More than one response can be selected.

S50. Why did not you see anyone? (probe) Any other reasons?

1. Illness not serious enough
 2. Cost too much/No money
 3. Too far
 4. No transport
 5. No one to go with
 6. Don't trust the person/Service not good
 7. No time to go
 8. Did not know where to go
 9. Did not want to see a male doctor
 10. Long time waiting
 11. Not allowed to go
 97. Other (*specify*) _____
-

More than one response can be selected.

S51. In the end, was the person better?

1. Yes 2. No
 3. Dead 4. Still sick
 97. Other (*specify*) _____
-

Maternity = Pregnancy / Delivery / Post natal care

Now, we are going to talk about the last pregnancy in this household.

M1. During her last pregnancy, what health professional did she see? (Probe) Anyone else? Spiritual? Traditional?

- 1. Doctor (MBBS)
- 2. Nurse/midwife
- 3. LHV
- 4. LHW
- 5. DAI/TBA
- 6. Health professional
- 7. Traditional
- 8. Spiritual
- 9. No one *
- 98. Don't know
- 97. Other (specify) _____

More than one response can be selected.

* Go to M8

M2. Where did she go during this pregnancy? (probe) Anywhere else? Traditional? Spiritual?

- 1. Your home *
- 2. Hospital
- 3. Gov. health center
- 4. Private clinic
- 5. Mobile clinic / NGO
- 6. Traditional
- 7. Spiritual
- 98. Don't know
- 97. Other (specify) _____

More than one response can be selected.

* Go to M4

M3. Where is this facility? (Name and place)

M4. During her pregnancy, did she go to the health professional because she had a problem or just for a check-up?

- 1. For problem
- 2. For check-up only

M5. Did she get any ultra-sound tests during her visit?

- 1. Yes *
 - 2. No
- * Go to M7

M6. Why did not she get any ultra sounds? (probe) Any other reasons?

- 1. Cost too much/No money
- 2. God only should know
- 3. Not available
- 4. Not customary
- 8. Don't know
- 7. Other (specify) _____

More than one response can be selected.

M7. How much did she pay for the first visit (including tests, ultrasounds and medicines)?

____ _ Rs

Go to M9

M8. Why did not she see anyone? (probe) Any other reasons?

- 1. Not necessary/Don't bother
- 2. Cost too much/No money
- 3. Too far
- 4. No transport
- 5. No one to go with
- 6. Service not good/Don't trust facility
- 7. No time to go
- 8. Did not know where to go
- 9. Did not want to see a male doctor
- 10. Long time waiting
- 11. Not allowed to go
- 97. Other (specify) _____

More than one response can be selected.

M9. During her pregnancy, did your household set aside any money in case of emergency?

- 1. Yes
- 2. No
- 3. Don't remember
- 8. Don't know

M10. During her delivery, who assisted her?

- 1. Doctor (MBBS)
- 2. Nurse/midwife
- 3. LHV
- 4. LHW
- 5. DAI/TBA
- 6. Health professional
- 7. Traditional
- 8. Spiritual
- 9. Relatives/Friends
- 10. "Old"/Experience women
- 11. No one
- 98. Don't know
- 97. Other (specify) _____

More than one response can be selected

M11. During her last delivery, where did she give birth to?

1. Your home * 2. Hospital
 3. Gov. health center 4. Private clinic
 5. Mobile clinic / NGO 6. Traditional
 7. Spiritual 98. Don't know
 97. Other (specify) _____

* Go to M14

M12. Where is this facility? (Name & City)

M13. During her last pregnancy, why did she deliver in a health centre? (probe) Any other reason?

1. Safer
 2. Problem/Sick during pregnancy
 3. Needed C-section/Caesarian
 4. Customary
 5. Husband who decide
 6. Don't know
 7. Other (specify) _____

More than one response can be selected.

Go to M15

M14. During her last pregnancy, why did she deliver home and not in a health centre? (probe) Any other reason?

1. Hospital not necessary
 2. Cost too much/No money
 3. Too far
 4. No transport
 5. No one to go with
 6. Service not good/ Don't trust facility
 7. No time/Baby came too fast
 8. Did not know where to go
 9. Did not want to see a male doctor
 10. Long time waiting
 11. Not allowed to go
 12. Facility not open
 13. Not customary
 15. More intimate
 16. Don't go out because of security
 97. Other (specify) _____
 98. Don't know

More than one response can be selected.

M15. (If health centre) How did she go there?

(If home and a skilled person) How did you go and pick up the person?

1. Walk * 5. Suzuki van / Tractor trolley
 2. Own transportation * 6. Tonga / Cattle cart
 3. Rickshaw 7. Bus / Truck
 4. Taxi 98. Don't know
 97. Other (specify) _____

More than one response can be selected.

* Go to M18

M16. In total, how much did you pay for the transportation? (one way)

_____ Rs.

M17. In total, how long did it take to go there? (one way)

_____ Minutes _____ Hours.

M18. In total, how much did you pay for the delivery including doctors' fees, facility cost and medicines (not transportation)?

_____ Rs.

M19. Within the 40 days after delivery, what health professional did she see? (probe) Anyone else? Spiritual? Traditional?

1. Doctor (MBBS) 2. Nurse/midwife
 3. LHV 4. LHW
 5. DAI/TBA 6. Health professional
 7. Traditional 8. Spiritual
 9. No one * 98. Don't know
 97. Other (specify) _____

More than one response can be selected.

* Go to M25

M20. Where did she go? (probe) Anywhere else?

1. Your home * 2. Hospital
 3. Gov. health center 4. Private clinic
 5. Mobile clinic / NGO 6. Traditional
 7. Spiritual 98. Don't know
 97. Other (specify) _____

More than one response can be selected.

* Go to M22

M21. Where is this facility? (city and name)

M22. Within the 40 days after delivery, did she go because she had a problem or just for a check-up?

1. For problem 2. For check-up only

M23. How many days after delivery did she first go?

___ ___ days

M24. How much did she pay for the visit (including tests and medicines)?

___ ___ ___ ___ Rs.

Go to M26

M25. Why did not she see anyone? (probe) Any other reason?

1. Not necessary/Don't bother
 2. Cost too much/No money
 3. Too far
 4. No transport
 5. No one to go with
 6. Service not good/Don't trust facility
 7. No time to go
 8. Did not know where to go
 9. Did not want to see a male doctor
 10. Long time waiting
 11. Not allowed to go
 12. 40 days period
 97. Other (specify) _____

More than one response can be selected.

M26. After how many days after delivery did she first go out?

___ ___ days 2. Not allowed to go out

M27. Within the 40 days after delivery, what health professional did the baby see? (probe)

Anyone else? Spiritual? Traditional?

1. Doctor (MBBS) 2. Nurse/midwife
 3. LHV 4. LHW
 5. DAI/TBA 6. Health professional
 7. Traditional 8. Spiritual
 9. No one * 98. Don't know
 97. Other (specify) _____

More than one response can be selected.

* Go to M34

M28. Where did the baby go? (probe) Anywhere else?

1. Your home * 2. Hospital
 3. Gov. health center 4. Private clinic
 5. Mobile clinic / NGO 6. Traditional
 7. Spiritual 98. Don't know
 97. Other (specify) _____

More than one response can be selected.

* Go to M30

M29. Where is this facility? (city and name)

M30. Who brought the baby to the health professional?

1. Elders 2. Father in law
 3. Father 4. Brother in law
 5. Mother in law 6. Mother
 97. Other (specify) _____

More than one response can be selected.

M31. Did the baby go because he had a problem or just for a check-up?

1. For problem 2. For check-up only 3. For vaccination

M32. How many days after birth did he first go?

___ ___ days

M33. How much did you pay for the visit (including tests and medicines)?

___ ___ ___ ___ ___ Rs.

Go to Immunization

M34. Why did not he see anyone? (probe) Any other reason?

- 1. Not necessary/Don't bother
- 2. Cost too much/No money
- 3. Too far
- 4. No transport
- 5. No one to go with
- 6. Service not good/Don't trust facility
- 7. No time to go
- 8. Did not know where to go
- 9. Did not want to see a male doctor
- 10. Long time waiting
- 11. Not allowed to go
- 97. Other (specify) _____

More than one response can be selected.

Immunization

Now, we are going to talk about immunization for you and your children.

I1. Do you have a vaccination card for all the children under 5 in your household? (if yes) Can I see it?

- 1. Yes * 2. No * Go to I3 or I4

I2. Did these children under 5 have ever had vaccination?

- 1. Yes 2. No * * Go to I16

I3. If card available, fill in the form and go to question I7

	Yes, complete	Yes, incomplete	No
BCG			
Polio			
Penta			
Measle			

If no card available, ask the following questions

I4. Among all these children under 5, did they all get injection on the shoulders one week after birth? (BCG)

- 1. Yes 2. No

I5. Among all these children under 5, did they all get drops in their mouth? (Polio)

- 1. Yes 2. No

I6. Among all these children under 5, did they get other injections? (Penta & Measle)

- 1. Yes 2. No

I7. Do you always follow the date of injection or do you miss some?

- 1. Follow date 2. Miss date

I8. (if incomplete or miss date) Why did you miss some vaccinations?

- 1. Too far
- 2. Cost too much/No money
- 3. No vaccines
- 4. Not enough children to get vaccination
- 5. EPI does not come back
- 6. Forgot the next date
- 97. Other (specify) _____

More than one response can be selected.

I9. Where do you go for the vaccination?

- 1. Your home * 2. Hospital
- 3. Gov. health center 4. Private clinic
- 5. Mobile clinic / NGO 6. Traditional
- 7. Spiritual 98. Don't know
- 97. Other (specify) _____

* Go to I17

I10. Where is this facility? (City & Name)

I12. How long does it take to go to there? (one way)

_____ minutes _____ hours

I13. How do you go to this facility?

- 1. Walk *
- 2. Own transportation *
- 3. Rickshaw
- 4. Taxi
- 97. Other (specify) _____
- 5. Suzuki van / Tractor trolley
- 6. Tonga / Cattle cart
- 7. Bus / Truck
- 98. Don't know

More than one response can be selected.

* Go to I15

I14. How much do you pay for the transportation? (one way)

_____ Rs.

I15. Who brings the children to the vaccination?

1. Elders 2. Father in law
 3. Husband/Father 4. Brother in law
 5. Mother in law 6. Mother
 7. Neighbors
 97. Other (specify) _____

More than one response can be selected.

I16. Why none of these children get any of the injections? Anything else?

1. Don't know why we should do it
 2. Too far
 3. Cost too much/No money
 4. Bring sickness/fever
 5. God should decide
 6. Afraid of infertility
 7. Not allowed too
 97. Other (specify) _____

More than one response can be selected.

I17. Does EPI team come to your village?

1. Yes 2. No

I18. How often the team comes to your village?

1. Every month 2. Few times a year
 3. Twice a year 4. Every year
 5. Less often 6. Never

I19. During the last pregnancy in your household, did the mother get any vaccination against tetanus?

1. Yes, all * 2. Yes, incomplete * 3. No

** Go to Conclusion*

I20. Why did not she get vaccination?

1. Too far
 2. Cost too much/No money
 3. Bring sickness/fever
 4. God should decide
 5. Afraid of infertility
 6. Not allowed too
 6. Don't want to have it from a male doctor
 97. Other (specify) _____

More than one response can be selected.

I21. Where did she get the vaccination?

1. Your home * 2. Hospital
 3. Gov. health center 4. Private clinic
 5. Mobile clinic / NGO 6. Traditional
 7. Spiritual 98. Don't know
 97. Other (specify)

** Go to Conclusion*

I22. Where is this facility? (City & Name)

Conclusion

To conclude, I would like to ask you 1 more question.

C1. In your opinion, what is the main difficulty to access to health care for mother and child?

(read the answers)

1. Financial problem
 2. No facility nearby
 3. Transportation problem
 4. Education / Awareness problem
 5. No trust in the doctors
 6. No time to go
 7. Only male doctors available
 8. Not allowed to go
 97. Other (specify) _____

Only 1 possible answer

THIS IS THE END OF THE SURVEY. I WANT TO THANK YOU FOR YOUR TIME AND YOUR SUPPORT IN OUR PROJECT.



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MEDECINS DU MONDE IN PAKISTAN

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