Summary Report
SR-PK-rwpboc-99

Pakistan

The bond of care: Rawalpindi district

CIETinternational
Action summary
The Bond of Care in Rawalpindi

Education of women
Improved antenatal care
Promote colostrum for newborns
Prevent domestic violence

Care is the bond between women’s rights and children’s rights.

The Bond of Care approach unpacks the actionable components of this connection to identify how better care for women and greater respect for their rights can have an important impact on children.

This initiative is a collaboration between the District Administration of Rawalpindi, UNICEF and CIET. It is part of a larger project to build the community voice into planning through development of credible stakeholder information systems on issues that affect the lives of the residents of Rawalpindi.

Objectives of the study

- To learn about community perceptions and practices on care of women and children.

- To identify actionable interventions for the care of the mother that can change her care of her child, ultimately leading to improved child survival, protection, and development.

- To identify care resources at household and community level (time, energy, knowledge, or money) that are necessary to bring about change in care practices.

| Information base on Bond of care cycle Rawalpindi |
|---------------------------------|---|
| Number of sentinel sites        | 20 |
| Population of sample            | 25114 |
| Number of households            | 3963 |
| Number of women interviewed with children under 3 | 2966 |
| Average household size          | 6.3 |
| Children aged 3 years and under |   |
| females                         | 2978 |
| Anthropometry                   | 52% |
| % of all children               | 2342 |
| % of all children               | 79% |
| Health institutions reviewed    | 29 |
| Focus Groups                    |   |
| Female preliminary              | 20 |
| Mother’s feedback               | 20 |
| Father’s feedback               | 20 |
| Mothers-in-law’s feedback       | 20 |
| Key informants                  |   |
| Community leaders               | 20 |
| Dais/TBAs                       | 44 |
| LHV/LHW                         | 20 |
**Methods:** CIET methods combine quantitative and qualitative data in a way that facilitates action. In 20 representative sites, several instruments were administered: a house-to-house survey identified the care received during pregnancy and care given to the child under three years of age. Female fact-finding focus groups enabled a closer look at feeding practices and domestic violence. Feedback focus groups with fathers, mothers-in-law and mothers provided community level dialogue on the evidence and at the same time suggestions for change. Key informant interviews with community leaders provided an overview of each of the 20 communities. Key informant interviews with Dais, LHV/LHWs provided their experience, training, and information on services and advice they give to pregnant women; and institutional reviews of health facilities gave information on health resources at community level.

**Four action areas**

1. **Women and education**
   In 1998, 12% of children under three in Rawalpindi were acutely malnourished. A child of a woman with no education in Rawalpindi is 35% more likely to be acutely malnourished than a child of a mother with some education. A child of an illiterate mother is 38% more likely to be delayed in sitting up without support than a child of a literate mother. Although literacy is more common among poorer groups, and poverty is also associated with child nutrition and development for other reasons, this link between mother’s education and child development is independent of poverty, father’s education and antenatal care as measured in this survey.

2. **Antenatal care**
   Almost one-half of the women of Rawalpindi do not go for antenatal check-ups. A mother who does not go for a check-up is 34% more likely to have an acutely malnourished child than a mother who does go for a check-up. Low antenatal care attendance is common among the poor and less educated, factors that themselves determine acute malnutrition, so a key part of the analysis was to untangle the effects on malnutrition of antenatal care, mother’s education and socio-economic level. Although it does not explain the effect of antenatal care on malnutrition, education is a factor in antenatal care attendance. A mother with no education is three times more likely not to go for a check-up than a mother with some education. Lack of awareness, the belief that check-ups are not necessary and financial reasons are the main reasons given by Rawalpindi women for not going for check-ups.

3. **Colostrum - the first milk**
   Colostrum, the best source of immunity for newborns, was given to 69% of babies born in Rawalpindi. There is a strong link between colostrum and chronic malnutrition, which affects 35% of children under three years of age. A child who did not have colostrum is 22% more likely to be chronically malnourished than a child who received colostrum. Use of colostrum is demonstrably related to care of the mother. A mother who does not go for a check-up is 30% more likely to not
give her child colostrum than a mother who does go for check-ups. A woman who did not feel
cared for during her pregnancy was 52% more likely to not give her newborn colostrum
compared with a woman who felt cared for. Furthermore, a woman reporting to having less or the
same amount of food during her pregnancy was 35% more likely to not give her newborn
colostrum.

Traditional beliefs explain in part why 31% of babies do not benefit from something so valuable
yet without any cost. There is a widespread need for information on the benefits. Focus groups
called for help from mothers-in-law to ask daughters-in-law to give colostrum to the baby and for
doctors. They also said lady health visitors and dais should inform mothers of the advantages of
colostrum. Television was also suggested as a medium to reach women about the benefits of
colostrum.

4. Domestic violence
The bond of care is broken with domestic violence. Despite the difficulties in communicating
openly about this, more than one out of every ten women (13%) openly reported a serious quarrel
in the last year. It seems likely that this is only the tip of the iceberg. One half of these quarrels
were with their husbands (57%) and one-quarter with their mothers-in-law. When asked what
happened during the quarrel, 30% did not answer, 47% indicted that it was only verbal, with the
remaining identifying some sort of physical abuse (23%).

A child living in a household where a serious quarrel was reported is 29% more likely to suffer
chronic malnutrition. In comparison with a child in a house not reporting a serious quarrel, an
average child whose mother has serious quarrels is:
- 42% more likely to sit after the Denver II standard of six and a half months;
- 64% more likely to stand after the Denver II standard of 12.5 months; and
- 70% more likely to walk after the Denver II standard of 13.5 months.

Concluding remarks
By improving the position of women, we can take better care of our children. The dialogue that
has begun on the evidence is a result in its own right. It has motivated some members of
communities, organisations and governments to act.

In the words of the Deputy Commissioner of Rawalpindi, Mr. Shamail Ahmed Khwaja:

“This project gives us the evidence to strengthen the bond of care, making
sure our resources go to actions that give us the greatest impact.”