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CHILD HEALTH RELATED PRACTICES IN
KARACHI SLUMS

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EXECUTIVE SUMMARY

In an effort to assess the child health and child rearing practices of young children, mothers and children from four Karachi slums were interviewed between February 1 and March 26, 1987. These slums were inhabited by eight ethnic groups. Two of the slums have settled populations; the other two were katchi abadies (areas with unauthorized temporary shelters). A random sample of one hundred mothers and their children under the age of four years was conducted.

Most of the mothers surveyed looked pale and tired. Their children were predominately born with the help of an illiterate and unskilled birth attendant and raised in extremely overcrowded and polluted environments.

Thirteen percent of children died during first four years of life. Thirty percent of these infant deaths occurring during or soon after birth were due to birth injuries and prematurity. Sixty-seven percent of the deaths occurred before the first birthday.

Ninety-eight percent of the sample mothers breastfed their children initially, and 71% continued breastfeeding from one to more than two years. Forty-eight percent of the mothers did not begin breastfeeding until 3 to 4 days or sometimes up to 7 or 8 days after the birth. Furthermore, 92% of the mothers expressed colostrum until "white and clean milk comes" prior to the first breast feed, thereby depriving the newborn child of this important nutrient. Supplemental feeding was started, at the earliest, on the 14th day after birth, but 22% of the children received their first solid food after the age of one year.

Due to extremely unhygienic living conditions, overcrowding, and contaminated food and water, diarrhea was by far the most common disease and was responsible for nearly half of all deaths of children under the age of four years. Oral Rehydration Therapy (ORT) was not understood by the mothers and was rarely prescribed by the doctors as a treatment for diarrhea. Prior to the ORT demonstration, mothers were asked to measure one litre of water. Only 15% of the women could measure one litre correctly; 48% measured the water below 75l cc. It was clear that the mass media campaign for ORT had not been understood by mothers living in slums.

Another message which had not reached the urban slums was family planning and the use of contraceptives. Frequent pregnancies are a major setback to child health. Lack of child spacing deprives young children of breastfeeding. The mother's attention must be shared with one or two brothers or sisters. Fourteen percent of the mothers surveyed had three children under the age of four years, and eight percent were pregnant at the time of the interview. Of the survey population's 400 living children, 44% were under the age of five years. Seventy percent of the mothers were below 31 years of age. Except for five women with tubal ligation, not a single couple reported using contraceptives regularly.

(ii)

The mothers generally believed that prolonged breastfeeding delays pregnancy.

In contrast to the ORT and family planning campaigns, the EPI campaign had made a distinct impact on the mothers' attitudes and practices. Eighty-two percent of the youngest children had received at least one dose of DPT vaccination; 10% had completed the course of immunizations. Not a single death was reported due to any of the immunizable diseases. At least 43% of the vaccination information was obtained through the EPI mass media campaign via radio and television. These findings indicate that if the correct approach is made and services are available, mothers will take advantage of these services.

For 50% of the residents of the surveyed areas, a public health facility could be found 2 to 4 miles from their homes. However, 85% of these mothers took their sick child to a private doctor. Some of these private practitioners were unqualified and/or inexperienced paramedics and quacks. Twelve percent of the mothers reported that their private doctor advised them to stop breastfeeding during diarrheal episodes. Many mothers were given a free tin of infant formula if the child was born in the hospital. Neither baby weighing scales nor ORS packets were found in any of the seven private clinics visited. Doctors focused more on the treatment rather than the prevention of disease.

The findings of this study may justify including in USAID Child Survival Project children under the age of 5 years at high risk of disease and death who are living or merely existing in slums and katchi abadies.

INTRODUCTION

Pakistan is one of the designated countries in a global strategy of USAID child survival programs, now called the healthy child project in Pakistan. The present interest in child survival is still focused on rural children. However, many urban children live in greater poverty than rural children due to high inflation in the cities, scarcity of essential commodities, pollution, unimaginable overcrowding, and lack of access to health services.

Karachi is one of the largest cities in the developing world, inhabited by nearly 8% of Pakistan's entire population, with over seven million people who speak more than seven languages. The majority of people living in Karachi are immigrants from India, Bangladesh and from other provinces of Pakistan. The following table illustrates the city's diversity and shows the changes in Karachi's ethnic population over a twenty year period:

TABLE - 1 - ETHNIC COMPOSITION OF KARACHI'S POPULATION

<u>Ethnic groups and languages spoken</u>	<u>Census Year</u>	
	<u>1961</u>	<u>1981</u>
Mahajar (Urdu)	54%	54%
Punjabi (Punjabi)	13%	14%
Pathan (Pashto)	5%	10%
Sindhi (Sindhi)	10%	7%
Baluchi (Baluchi)	5%	4%
Others (various)	12%	11%

Almost 60% of the people of Karachi live in overcrowded slums. They lack sanitation, clean water, education and health care. In terms of mortality and morbidity, Karachi's marginal urban population suffers from problems typical to both developing and industrial societies. These problems include poverty, ignorance, malnutrition, appalling sanitation, poor housing, extreme overcrowding, a very high prevalence of infectious and parasitic diseases, and inadequate access to health services.

This marginal urban population has been ignored by international development and assistance programs since these agencies have placed their emphasis on assisting the rural population. Although the cities receive a disproportionate share of the national health facilities and other resources, in Karachi these resources do not meet the needs of the majority. Most services are directed to approximately 40% of the urban population -- the relatively more advantaged. The remaining 60% are almost totally deprived of the city's social services. It is this marginal group that was the subject of this study.

PURPOSE AND OBJECTIVES

The purpose of the study was to assess the health status of children under the age of four years in slums and katchi abadies in Karachi and to highlight the avoidable causes of ill health and death in this age group. Specifically, the survey's objectives were:

1. To assess the health status of children under 4 years of age, in terms of mortality and morbidity focusing on diarrheal diseases, infant feeding patterns and immunization rates in selected slums of Karachi.
2. To assess the socio-economic status of families living in selected slums of Karachi.
3. To ascertain the beliefs, knowledge, practices and attitudes of women living in urban slums regarding child spacing, breastfeeding, supplemental feeding practices, immunizations, and common childhood diseases and their treatment.
4. To determine whether women can measure one liter of water and prepare and administer ORS correctly.
5. To determine what measuring utensils are available in the homes.
6. To determine the constraints women face in the treatment of their ailing children.

METHODOLOGY

The survey work of this study started in mid January 1987. From December 1986 through February 1987, Karachi was engulfed in the worst street riots in its history. After determining the comparatively safe sites for interviews, the research areas were selected according to two main criteria:

- (1) Ethnic diversity (total sample to include the immigrants from India and Pakistan's four provincial groups);
- (2) High disease prevalence among children in low income slum areas.

A large size map of Karachi was prepared with the help of the Director of katchi abadies, Karachi Metropolitan Corporation. The slums within the katchi abadies were highlighted on the map. Information on the population of the slums and the number of ethnic groups living in each area was collected from the Election Manager in the Mayor's Office. Data about the disease prevalence were obtained from the District Health Office (DHO) of Karachi. On the basis of the information gathered, four survey sites were selected: two katchi abadies (Shershah Colony and Bhutta Village) and two settled slums (Lyari and Kemari).

TABLE - 2 - LOCALITIES SURVEYED

<u>Localities surveyed</u>	<u>Number Interviewed</u>
Shershah (katchi abadi)	25
Lyari (settled slum)	25
Kemari (settled slum)	25
Bhutta village(Katchi abadi)	25

Sample selection was made within the selected research area on the following basis:

- Only mothers with children under the age of four years were interviewed. The reason for this selection was that these mothers were more likely to recall breastfeeding, weaning practices and other relevant information. Furthermore, children under the age of four years have the highest mortality rates in the selected settlements.
- Every fifth house was to be visited, starting from the right side of the central mosque. If there was no woman with a child under the age of four years in the fifth house, then the next house which had a mother with children under the age of four years was selected. This procedure continued until 25 women in each settlement were interviewed.

Since the houses or huts were often erected in quite an unorganized arrangement, sometimes it was difficult to determine which was exactly the fifth house or hut. Under these conditions selection of every fifth house was done as well as possible to meet the criteria of the fifth house. Women who lived in the houses that were not surveyed frequently protested that they were not interviewed. They asked if they did not deserve better health advice for their children or asked if they were excluded because they were not of the correct ethnic group.

The survey questions were first pretested in Jamhuria Colony, a slum area near Kala Pull, considered to be safe for surveying during unrest and riots in Karachi. In the pretest of the questionnaire, frequent pregnancies appeared to be the major problem damaging the health of mothers and their children. Consequently, questions regarding contraceptive use were added to the questionnaire. The final questionnaire included 75 questions (see Appendix 1).

The questionnaire was designed to address the beliefs, knowledge and practices of the mothers regarding breastfeeding, supplementary feeding, diarrheal diseases, use of oral rehydration therapy and immunization against communicable diseases. Questions were asked regarding child morbidity and mortality, contraceptive use and the use of television and radio. Information on the family's socio-economic status, including the education, occupation and income of the mother and father was also gathered.

All interviews were conducted by the evaluator and the author of this study. Answers were recorded verbatim on the questionnaire form (Appendix 1). Most interviews were conducted in Urdu. In Bhutta Village, a Kachhi interpreter helped in the interviews and ORT demonstrations.

The evaluator carried out ORT demonstrations for all mothers who were keen to learn, even though they were outside the research sample. The evaluator observed that women from all the ethnic groups living in these desperately difficult conditions wanted the best for their children's health. They claimed that the well being of their children was their first priority in life. The field for child health programs is quite fertile in the urban slums of Karachi.

CHARACTERISTICS OF THE SURVEY POPULATION

One hundred mothers, 25 from each of the four settlements, were interviewed. They represented eight ethnic groups. The majority of women (53%) were Kachhi and Baluchi. Among all the ethnic groups surveyed, the Kachhi and Baluchi were the most liberated women. They moved around and socialized freely with neighboring women. They would not let the evaluator pass their house without discussing the health of their children. They expressed the need for mobile immunization teams and maternity homes for safe childbirth. Compared with the Kachhi and Baluchi, the Pathan and Sindhi mothers were living a restricted life. They were more dependent than the other two groups on their husbands and mothers-in-law in all spheres of life, including taking children to the hospital for medical care and vaccination.

In this sample survey 36% of the families had an income of less than Rs. 500/- to Rs. 1000/- per month which is a sharp contrast to an average household income in Karachi of over Rs. 2500/- per month. (Source KMC statistics 1986).

ETHNIC COMPOSITION OF RESPONDENTS (No. of Respondents = 100)

TABLE - 3 -

<u>ETHNIC GROUP</u>	
<u>Ethnic Group</u>	<u>Percentage</u>
Kachhi	29
Baluchi	24
Punjabi	17
Pathan	10
Mahajar	10
Sindhi	8
Others (Gujrati and Kashmiri)	2

TABLE - 4 - AGE OF RESPONDENTS
(No. of Respondents = 100)

<u>Age</u>	<u>Percentage</u>
* 20 years or less	13
21-25 years	25
26-30 years	32
31-35 years	19
** 36- or more	11
* Youngest mother was 17 years	
** Eldest mother was 48 years	

TABLE - 5 - RESPONDENTS WITH NO. OF CHILDREN UNDER 4 YEARS
(No. of Respondents = 100)

<u>No. of children under 4</u>	<u>*Percentage of mothers</u>
One child	45
Two children	41
Three children	14

* 8% of the mothers were pregnant at the time of the interview

TABLE - 6 - AGE RANGE OF LIVING CHILDREN

<u>Age Range of Children</u>	<u>Percentage</u>
0 - 2 years	18
2 - 5 years	26
5 - 13 years	44
13 - 20 years	11
20 years or more	1

In the households interviewed, 44% of the fathers and 74% of the mothers never went to school. The majority of the fathers (60%) were unskilled, unemployed or engaged in unstable employment. Sixty-one percent of the fathers earned Rs. 501 - 2000 per month. Many of the unemployed and underemployed were drug addicts. Most of the families had 6 to 12 members living in one or two rooms. The following tables show the educational, occupational and income level of both the respondent and her husband.

TABLE - 7 - EDUCATION OF RESPONDENTS AND THEIR HUSBANDS
(No. of Respondents = 100)

	<u>No</u>	<u>5 years</u>	<u>6-8 years</u>	<u>10 years</u>	<u>College</u>
	<u>Schooling</u>	<u>Schooling</u>	<u>Schooling</u>	<u>Schooling</u>	<u>Education</u>
Respondents	74	17	4	5	0
Husbands	44	25	10	16	5

TABLE - 8 - OCCUPATION OF RESPONDENTS AND THEIR HUSBANDS
(No. of Respondents = 100)

	<u>Un- employed</u>	<u>Un-skilled</u>	<u>Semi-skilled/ Skilled</u>	<u>Professional</u>	<u>*Respondent did not know</u>
Respondents	90	0	10	0	N/A
Husbands	7	53	37	1	2

*Husband works abroad

TABLE - 9 - INCOME OF RESPONDENTS AND THEIR HUSBANDS
(No. of Respondents = 100)

	<u>Nil</u>	<u>Less than 501 Rs.</u>	<u>501 to 1,000 Rs.</u>	<u>1,001 to 2,000 Rs.</u>	<u>2,001 to 3,000 Rs.</u>
Respondents	90	0	10	0	0
Husbands	7	5	31	25	1

SOURCE OF HEALTH CARE

There are three major sources of health care in Karachi slums and katchi abadis.

- 1) Home:
Mothers and grandmothers follow cultural and traditional trends in child health care.
- 2) Government Hospitals and Dispensaries:
Public health facilities are known for their casual and impersonal treatment. They often are not conveniently located.
- 3) Private Practitioners:
Included in this group are private doctors, quacks (unqualified medical practitioners), religious and traditional healers.

Medical services have not been kept up with the Karachi's 6% population growth rate. Enrollment in Pre-medical and Medical subjects in colleges and universities of Karachi has doubled since the early seventies without any major increase in funding or teaching staff. Karachi's Civil Hospital and Jinnah Hospital cope with over 20,000 out-patients every day. Even with an increasing number of hospitals in the public and private sector, the number of hospital beds in fact has declined from about 2 per thousand population to one per thousand population between 1973-1986.

Overburdened mothers with the responsibility of looking after large families cannot spare time and effort to take their sick child to a hospital beyond walking distance. Only 19% of mothers lived within one mile or walking distance from a hospital or a dispensary. The remaining 81% needed public transport to reach the nearest government hospital or dispensary. This distance from the hospital and the transportation problem could be one of the reasons that 85% of the women reported going to "private practitioners" near their homes.

These "private doctors" may be either inexperienced doctors, quacks (unqualified people practicing as a doctor) or salesmen at chemist shops. Private doctors' clinics have mushroomed all over the slums.

The evaluator met with 3 female and 4 male private doctors who had established their private practice in Bhutta Village and Kemari. None of them lived in the communities they served. All of the seven doctors had been engaged in private practice since their graduation; this practice was their first exposure to treating patients.

When one doctor was asked his views regarding his practice in the slums of Karachi, he replied, "I have to wait for the diarrheal season. Then you will find all waiting rooms full of patients." None of the doctors I met prescribed oral rehydration therapy. With further investigation it was clear that the private doctors, and the quacks, were not well informed about the treatment of diarrhea, oral rehydration therapy and the care needed to prevent diseases. Twelve percent of the mothers reported having been advised by the doctor not to breastfeed when their children had diarrhea. None of the clinics I visited had a weighing scales; only 3 of the 7 had a sterilizer.

Many of the children become the victim of these inexperienced practitioners. Eighty-five percent of the mothers go to private doctors because they find them more or less at their door steps. They can get the doctor's prescription, buy the medicine from the chemist and return home within 15 to 20 minutes. A hospital visit, on the other hand, takes up the best part of the day. Many mothers complained of the hospital doctors' hurried and impersonal treatment. They said that the doctors do not even touch the child. All of the mothers felt that their children received better treatment from a private clinic than a government health facility.

The following table shows the distance between the residence of the sample families and the nearest public hospital or dispensary.

TABLE - 10 - APPROXIMATE DISTANCE BETWEEN SAMPLE HOMES AND
THE NEAREST GOVERNMENT HOSPITAL OR DISPENSARY
(No. of Respondents = 100)

<u>Distance from the health facility</u>	<u>Percentage</u>
Less than one mile	19
One mile	31
Two miles	21
Four miles or more	29

In urban slums health services equivalent to basic health units and rural health centers are not available. Therefore, urban mothers have no female health workers for consultation and advice.

Child Morbidity and Mortality:

In urban slums most children are protected from many health hazards through a mother's devotional care and prolonged breastfeeding. When a child falls sick, none of the above mentioned sources of health care, including a mother's well-meaning but sometimes harmful customs, may provide adequate treatment. Frequent illnesses are not surprising given the poverty, ignorance, crowded housing, poor sanitation, infestation of insects and rodents, contaminated food and water, and inappropriate weaning and feeding practices.

A newborn baby comes from a sterile, nourishing and comfortable intra-uterine environment into this polluted and hostile environment. Forty-five percent of the mothers fed only sweetened water to the newborn for three to four and a few up to eight days after the birth. Prior to this delayed first feed, the most nutritious food-colostrum- was wasted. Ninety-two percent of the mothers expressed colostrum prior to the first feed. This starvation and deprivation of natural food during the first week of life makes a child fragile, weak and an easy victim of the polluted and hostile environment surrounding a newborn baby.

Diarrhea and parasitic diseases were the top killers, responsible for 47% of all childhood deaths. Another 27% of the deaths were the result of fever, respiratory tract infection and other infectious diseases.

Of the 72 children under the age of 4 years who died prior to the survey, 26% died as a result of birth injuries and prematurity. (The cause of death was determined on the basis of the mother's symptomatic assessment.) Deaths due to birth injuries were the result of malpractice on the part of unskilled birth attendants. Premature babies were also the victim of the birth attendants' ignorance plus the traditional 3-4 day deprival of a proper feeding.

A significant finding of this survey was that not a single death was reported due to immunizable diseases. Only 10% of the children, however, had received a full course of immunization. The evaluator did

not see any polio-crippled children in contrast to a previous field research study in 1984, when up to 3 polio-crippled children were found in one family. Sixty-eight percent of the reported deaths occurred before the first birthday. Only one death was reported of a child who was over four years of age. This death was of a 5 year old boy who fell into a blocked drainage pit. Clearly, the youngest age group (the under fives) are at greatest risk of disease and death. Of the sample population, 44% of the children were in this high risk group.

TABLE - 11 - AGE AT DEATH OF CHILDREN UNDER THE AGE OF 4
(No. of Deaths = 72)

<u>Age of deceased children</u>	<u>Percentage of Deaths</u>
Fresh still birth (death just before birth)	4
Under one month	30
One month - under one year	38
One year - under two years	12
Two years - under three years	10
Three years - under four years	6

TABLE - 12 - SEX OF DISEASED CHILDREN UNDER THE AGE OF 4 YEARS
(No. of Deaths = 72)

<u>Sex of deceased children</u>	<u>Percentage</u>
Male	50
Female	50

TABLE - 13 - CAUSES OF DEATH IN CHILDREN UNDER THE AGE OF 4 YEARS
(No. of Diseased Children = 72)

<u>Causes of Death</u>	<u>Percentage of deaths</u>
Diarrhea and parasitic diseases	47
Birth injuries and prematurity	26
Fevers	20
Respiratory tract infection and Pneumonia	7

Seventy percent of the mothers perceived that a child was not well if the child cried a lot or was unusually quiet and inactive. The mothers overwhelmingly turned to private doctors for advice. Almost one-third visited a government health facility as well as private doctors. Although 27% consulted with religious healers, none relied totally on their services. In response to the question "what treatment was given to the sick child", 100% of the mothers responded that the doctor had prescribed some sort of mixture, tablets and syrup.

TABLE - 14 - SOURCES OF TREATMENT OF SICK CHILDREN
 (No. of Respondents = 100)
 (No. of Responses = 181)

<u>Source of Treatment</u>	<u>No. of Responses</u>
* Private doctor	85
Govt. hospital or dispensary	31
Leftover medicines or self-prescribed medicine from the chemist	13
Traditional home care (herb-tea, honey, massages, and elevation of fontanel)	25
** Religious healers	27

* Includes quacks. (unlicensed practitioners)

** All of the respondents who went to a religious healer also went to another source of health care.

TABLE - 15 - GENERAL TREATMENT GIVEN TO SICK CHILDREN
 (No. of Respondents = 100)
 (No. of Responses = 186)

<u>Treatment</u>	<u>No. of Responses</u>
Mixtures, tablets & syrups	100
Injections	26
Intravenous infusion	7
Consulted religious healers	27
Herb tea, elevation of fontanel, or massage.	26

BREASTFEEDING

Ninety-eight percent of the mothers felt that breastfeeding was best. Thirty-eight percent of the mothers breastfed for one to two years. One-third continued breastfeeding for more than two years. The women associated breastfeeding with delayed pregnancy.

Forty-eight percent of the mothers started breastfeeding on the third, fourth and sometimes up to the eighth day after the birth. Newborns initially were deprived not only of nourishment but of the important antibodies found in colostrum. Ninety-two percent of the mothers expressed and discarded the colostrum ("until white and clean milk comes") prior to the first breastfeeding.

While the majority of women breastfed for an extended period, a sizeable number (13%) discontinued breastfeeding before the infant was three months in age and depended on infant formula or animal milk only two percent of the women started bottle feeding from the outset. They used the infant formula that was given to them by the hospital doctor. Twelve percent of the mothers supplemented breastmilk with infant formula or animal milk; 14% started bottle feeding after they had stopped breastfeeding.

Of the mothers who used breastmilk substitutes, 8% used infant formula and 4% used cow, buffalo or goat's milk. Forty-six percent of the mothers who used infant formula prepared the milk at half strength, mixing one scoop of milk powder with two ounces of water. Twenty-three percent mixed one scoop of powder with 3 ounces of water. Hence, over two-thirds of the mothers overdiluted the formula.

TABLE - 16 - DURATION OF BREASTFEEDING
(No. of Respondents = 100)

<u>Duration</u>	<u>Percentage</u>
Did not breastfeed at all	2
Breastfed:	
3 months or less	13
4-7 months	9
8-11 months	5
1-2 years	38
Over 2 years	33

TABLE - 17 - FIRST FEED OF NEWBORN
(No. of Respondents = 100)

<u>Length of time from birth to 1st feed</u>	<u>Percentage</u>
First day of birth	13
Second day	37
Third day	17
Fourth day	28
Fifth to 8th day	3
Never breastfed	2

SUPPLEMENTAL FEEDING

A wide variety of trends were found regarding supplemental feeding. Thirty-four percent of the mothers offered solid foods when the child was 2 to 5 months of age. A few mothers started giving biscuits soaked in tea to the infant at the age of 14 days. Those who gave supplemental food during the first 2 to 5 months often gave cereal mixed

with water or milk, cake and 'maysu' (an oriental sweet prepared with egg and flour which is often sold in very unhygienic shops). When the child started sitting (at 6-7 months of age), then roti, khichri, rice, pudding and bananas were introduced. Twenty-two percent of the mothers did not give any supplemental food until the child was one to two years of age or until breastfeeding was discontinued. These mothers believed that no other food was necessary while the child was being breastfed.

Fifty-six percent of the mothers fed their babies on demand. Twenty-four percent first breastfed and then supplemented with solid foods, whereas 20% first fed the child solid foods and then breastfed. Those mothers who fed solid foods before breastfeeding said that the child would not eat solid foods after being breastfed. Some of them believed that breastmilk helped digest the solid food.

TABLE - 18 - AGE FOR INTRODUCING SUPPLEMENTAL FEEDINGS
(No. of Respondents = 100)

<u>Age</u>	<u>Percentage</u>
Less than 3 month (minimum age 14 days)	10
3 - 5 months	24
6 - 11 months	44
One - 2 years	15
More than 2 years	7

TABLE - 19 - SUPPLEMENTAL FOODS GIVEN TO BREAST AND BOTTLEFED CHILDREN
(No. of respondents = 100)
(No. of responses = 144)

<u>Type of Food</u>	<u>Percentage</u>
Biscuits & tea, bread, cake, cereal cream of milk	46
Khichri, mashed potatoes, egg, various types of milk puddings, banana	37
Fish, rice, roti, dal, vegetables	17

DIARRHEA AND ITS TREATMENT

As stated above, 47% of childhood deaths were due to diarrhea and parasitic diseases. Big garbage piles serve as a regular playground for

young children. A variety of intestinal parasites make their way to the digestive tract, causing gastro-intestinal diseases and recurrent attacks of diarrhea. Chronic malnutrition occurs both as a cause and as an effect of diarrheal diseases. Seventy-two percent of the mothers reported that their children suffered from diarrhea within the last 6-7 months. Because diarrhea is so common among children in the slums, many mothers considered "loose stools" an unavoidable hazard of childhood. One-fourth of the mothers regarded diarrhea as a normal childhood occurrence and not as a serious ailment. Twenty-eight percent of the women defined diarrhea as 7 to 12 loose stools per day.

Nearly one-third of the mothers did not know what caused diarrhea. Fifty-six percent gave a combination of reasons for diarrhea, e.g. dirty or difficult to digest food, teething and bottle feeding. Twelve percent mentioned superstitious causes such as the effect of fright or the evil shadow on the child. Many of these mothers considered a suppressed fontanel as one of the reasons for diarrhea and took their children to traditional healers for treatment. These healers elevated the anterior fontanel by massaging the throat or pushing the palate upwards.

Seventy-two percent of the mothers continued breastfeeding during a diarrheal episode. They recognized the child's need for food and nutrients. Furthermore, 22% stated that the child demanded to be breastfed. Of the 28% who discontinued breastfeeding when their children had diarrhea, most of them (57%) did so because they thought that milk was not good for a child suffering from diarrhea. The other 43% discontinued because they were advised to do so by a doctor.

U.S OF ORS

In light of the prevailing conditions which exist in the slums, prevention of diarrhea is very difficult since it essentially means striking at the roots of the poverty and ignorance with which it is so closely linked. The immediate preventive measure against diarrheal dehydration among very young children is oral rehydration therapy, which is inexpensive and simple to administer. In this survey 94% of the respondents used the name "Nimkol" for all types of flavored and unflavored ORS. (Nimkol is the brand name for one-half litre ORS packets produced in the National Institute of Health Laboratory in Islamabad).

Eighty-four percent of the mothers had heard of Nimkol. Thirty-eight percent claimed to have used ORS during the last 6-7 months. Of these ORS users, 82% bought ORS packets from a chemist shop. Some mothers adopted rather strange methods of administering ORS. For example 7% of the mothers who used ORS described the method of ORS preparation as follows: add 1/2 teaspoon of salt to 1/2 packet of ORS, mix with one glass of water and administer two teaspoons 3 to 4 times a day. The evaluator found this practice of adding salt to ORS in Sind during a study in 1984-85.

When asked how diarrhea should be treated, almost all of the women suggested obtaining antidiarrheal medicine from a private doctor.

One-fourth of them included Nimkol with antidiarrheal medicinal therapy. No one thought that Nimkol could work without the medicine. Almost all of the mothers recognized that ORS was a treatment to stop diarrhea. Many of them tried ORS once or twice and then discontinued its use after deciding ORS was not effective in the treatment of diarrhea.

When the evaluator asked the respondents to measure one litre of water, only 15% of the women could measure one litre of fluid correctly. Thirty-eight percent mixed ORS with less than 75l cc of water. Various sizes and types of utensils were used to measure water for ORS preparation. Not a single utensil measured exactly 1 litre. A universally used measuring utensil could not be identified in any of the four slums surveyed.

The above findings strongly suggest the need of one universal name for ORS (preferably Nimkol or any other Urdu term) and one type of covered measuring utensil with ORS logo for use throughout the country.

TABLE - 20 - RESPONDENTS' DEFINITION OF DIARRHEA
(No. of Respondents = 100)

<u>No. of Loose Stools Per Day</u>	<u>Percentage</u>
3 - 4	38
5 - 6	31
7 - 8	9
8 - 12 or every 5 minutes	19
Don't know	3

TABLE - 21 - RESPONDENTS' PERCEPTION OF THE SERIOUSNESS
OF DIARRHEA AS A DISEASE
(No. of Respondents = 100)

<u>Whether diarrhea is a Serious disease</u>	<u>Percentage</u>
Yes	67
No	25
Do not know	8

TABLE - 22 - RESPONDENTS' PERCEPTION
'WHY DIARRHEA IS A SERIOUS DISEASE'
(No. of Respondents = 100)
(No. of Responses = 107)

<u>Reasons</u>	<u>Percentage of Reasons</u>
Water drains away from the body	65
Child can die	15
Diarrhea leads to other diseases	14
Do not know	6

TABLE - 23 - RESPONDENTS' PERCEPTION OF THE CAUSES OF DIARRHEA(No. of Respondents = 100)(No. of Responses = 173)

<u>Cause of diarrhea</u>	<u>Percentage of Responses</u>
Do not know	18
Wrong food or mother eats wrong food while breastfeeding	21
Dirty food, water or feeding bottle	17
Too much food or milk (indigestion)	13
Child caught cold	9
Teething	15
Superstitions (fright, suppressed fontanel, evil shadow,	7

TABLE - 24 - AMOUNT OF WATER USED BY RESPONDENTS IN ORS PREPARATION(No. of Respondents = 100)

<u>Qty. of Water needed for ORS Preparation</u>	<u>Percentage</u>
Do not know	24
One glass (approx. one quarter of a litre)	*19
One-half litre	10
One litre	47

7 respondents added half teaspoon of salt to half packet of ORS mixed in one glass of water.

TABLE - 25 -UTENSILS USED TO PREPARE ORS(No. of Respondents = 100)

<u>How to Measure 1 litre of water</u>	<u>Percentage</u>
Do not know	24
Measured water with a glass	29
Measured water with a mug	17
Measured water with a tea cup	6
Measured water with a water jug	8
Measured water with various other utensils	16

TABLE - 26 - RESPONDENTS' MEASUREMENT OF ONE LITRE OF WATER*
(No. of Respondents = 100)

<u>Mother's measurement of water</u>	<u>Sample percentage</u>
250 c.c or less	10
251 to 500 c.c	12
501 to 750 c.c	16
751 to 1250 c.c	43
1251 to 1750 c.c	11
1750 to 2000 c.c	8

* Respondents used their own utensils to measure the water. The capacity of these utensils varied from 125 cc to 2,000 cc.

IMMUNIZATION AND PREVENTION OF DISEASE

As noted earlier one of the findings of this study is that not a single child death was reported due to any of the immunizable diseases. The immunization rate for the children is encouraging. Eighty-two percent of the mothers had their child vaccinated with at least the first dose of DPT. Forty-four percent of the mothers had completed or were in the process of completing the full course of vaccination for their youngest child.

Only thirteen percent of the women did not know the purpose of immunizations. Fifty-three percent of the women learned about immunization through television and radio messages. Hospital doctors informed 46% of the women while only 4% of the women received information on immunizations from a private doctor. Seventy percent of the vaccinated children were vaccinated at public hospitals and 25% at private hospitals. Only 5% of the vaccinations were administered by a mobile team in a satellite clinic.

Eighteen percent of the mothers had not vaccinated their youngest children. Out of this number, 17% associated an illness with a previous vaccination. Sixteen percent relied on God to prevent diseases. But the majority of these mothers (67%) complained of the scarcity of time and the long distance between their home and hospital. Fifty percent of the women lived 2 to 4 miles from a public hospital. There was a shortage of public transport vehicles in those areas. In talking to their neighbors and friends about the mobile vaccination teams and satellite clinics, the Punjabi women in the survey appealed for similar services so that the vaccination course could be completed without spending a lot of time going to the hospital.

Interestingly, 49% of the women were vaccinated against tetanus during pregnancy inspite of the high rate of home deliveries. Of the fifty-one percent of the mothers who were not vaccinated against tetanus, over half of them did not know about the tetanus vaccination; the others had home deliveries and did not like the prick of an injection. The unprotected mothers risk their own health as well as their child's.

USE OF COMMUNICATION MEDIA

Forty-one percent of the families possessed radio/cassette recorders; 68% of the mothers in these households did not listen to the radio. They preferred cassette recorded music in their own language. Sixty-four percent of the families owned television sets. Urdu plays and stage shows were by far the most popular programs watched by the mothers. Nine percent of the mothers who possessed a TV set did not get time to watch any TV program. Women's interest in the television program makes this media useful for child health care publicity. A message in a local language has a special appeal.

The immunization media campaign has proved that families in shanty slums respond to television and radio messages.

TABLE - 27 - NO. OF FAMILIES OWNING TELEVISION AND/OR RADIO CASSETTE RECORDER
(No. of Respondents = 100)

Families with radio only	3
Families with television only	26
Families with radio and TV	38
Families without radio and TV	33

TABLE - 28 - RESPONDENTS' SOURCE OF VACCINATION INFORMATION
(No. of respondents = 100)
(No. of responses = 125)

<u>Source</u>	<u>Percentage of Responses</u>
Hospital doctor	37
Private doctor	3
Television	33
Radio	10
Neighbours and relatives	17

TABLE - 29 - PLACE OF VACCINATION OF YOUNGEST CHILD
(No. of Respondents = 82)

<u>Institution</u>	<u>Percentage of Responses</u>
*KMC Hospital	44
Provincial govt. hospital and dispensaries	26
Private hospital or doctor	25
Satellite clinic	5
*Karachi Metropolitan Corporation	

TABLE - 30 - REASONS FOR NOT GETTING THE YOUNGEST CHILD VACCINATED
(No. of Respondents = 18)
(No. of Responses = 18)

<u>Reasons</u>	<u>Percentage</u>
Did not get time to go the to hospital	67
Bad experience with vaccination	17
Rely on God to prevent diseases	16

TABLE - 31 - DEGREE OF COMPLETION OF VACCINATION COURSE
(No. of Respondents = 100)

<u>Vaccination Course</u>	<u>Percentage of Respondents</u>
Not started	18
One dose of DPT	38
Nearly completed	34
Completed	10

TABLE - 32 - RESPONDENTS VACCINATED AGAINST TETANUS DURING
THEIR LAST PREGNANCY
(No. of Respondents = 100)

<u>Vaccinated against Tetanus</u>	<u>Percentage</u>
Yes	49
No	51

TABLE - 33 - PLACE OF TETANUS VACCINATION
(No. of Respondents = 49)

<u>Institutions</u>	<u>Percentage</u>
Govt. hospital or dispensary	84
Private hospital or doctor	16

TABLE - 34 - REASONS RESPONDENTS DID NOT RECEIVE TETANUS VACCINATION
(No. of Respondents = 51)

	<u>Percentage</u>
Did not know about this injection	59
Home delivery	29
Dislike injections	12

FAMILY PLANNING

This section analyzes the survey's questions related to:

1. Family planning behavior and ever use of contraceptives by sample couples living in slum areas; (Ever use of contraceptives includes past and present contraceptive practices.)
2. Current level of contraceptive use;
3. Identification of future contraceptive acceptors.

In the sample population 83% of the couples had never used any method of contraception. Table 38 indicates that the most frequently used methods of contraception among those 17% who had ever practiced family planning were pills, injectables, condoms and withdrawal. Those individuals who had used a method of contraception and discontinued its use did so because of dizziness, bleeding or contraceptive failure.

Fifteen of the couples were using contraceptives at the time of the survey. None of the women were taking contraceptive pills. In one-third of the couples that were practicing family planning, the wife had received a tubal ligation. All of these women lived in Shershah Colony and were motivated to have a tubal ligation by the same family planning motivator. This motivator worked for the Family Planning Association of Pakistan. With the exception of these women who had been sterilized plus another woman who used injectables, contraception was primarily the responsibility of the husband. Out of the fifteen couples practicing contraception, 9 relied on condoms or withdrawal. Of the ten couples that depended on a contraceptive method other than sterilization, not a single one reported regular use of contraception.

When asked about their contraceptive preference, 72% of the women said that they did not want to practice contraception. Another 12% were undecided. Of the 16% favoring contraception, 56% preferred the use of injectables, the others preferred tubal ligation. Eight percent of the women had no knowledge about the use of contraceptives. The primary reason given for failure to use contraceptives was that they were not good for the health.

Forty-eight percent of the women reported having discussed contraception with their husbands. Out of this number, 19% of the

husbands disapproved of contraceptive usage and another 20% were undecided. There appeared to be less resistance to contraception on the part of some of the men than on the part of the women. Although twelve husbands agreed to have tubal ligation for their wives, only 5 wives acted on this consent. This suggests that the other seven women either lacked the motivation or the availability of surgical contraceptive services.

As the survey shows, the impact of family planning programs on the fertility of women living in the slums is very low indeed. As stated in the World Bank's paper on Population and Development, Series No.2, "There are no differences in the fertility decline between countries that have weak programs or that have no programs." This same paper includes Pakistan's family planning program among the weak programs. If child survival programs are to make an impact on child mortality and morbidity in Pakistan, family planning should be an integral part of the strategy.

TABLE - 35 - USE OF CONTRACEPTIVES
(No. of Respondents = 100)

<u>Ever used contraceptives</u>	<u>Percentage</u>
Yes	17
No	83

TABLE - 36 - TYPES OF CONTRACEPTIVE METHODS EVER USED
(No. of Respondents = 17)
(No. of Responses = 32)

<u>Type of ccs</u>	<u>No. of Responses</u>	<u>Percentage of Responses</u>
Pills	8	25
Injectables	7	22
Tubal ligations	5	16
I.U.D.	1	3
Sampoons	1	3
Condoms	6	19
Withdrawal method	4	13

TABLE - 37 - REASONS FOR DISCONTINUING CONTRACEPTIVE USE
(No. of Respondents = 17)

<u>Reasons for discontinuing cc use</u>	<u>Percentage of Responses</u>
Dizziness and bleeding	68
Contraceptive failure	32

TABLE -42 - HUSBAND'S RESPONSE TO DISCUSSION WITH WIFE
ON CONTRACEPTIVE USE
(No. of Respondents = 48)

	<u>Percentage</u>
Agreed for wife to use contraceptive	7
Agreed to give consent for tubal ligation	25
Made no decision	20
Used condoms	5
Used withdrawal method	4
Disapproved of contraceptive usage	19

CONCLUSIONS AND RECOMMENDATIONS

Three million people or 40% of Karachi's population live in katchi abadies (areas of unauthorized temporary shelters); an other 20% live in settled slums. Infant death rates are high as are maternal death rates. Health services available to the people in slums are limited or ineffective. Government hospitals and clinics are either overcrowded or, on the other hand, vacant because people think there is little purpose in going there.

Most mothers seek advice from private practitioners. These "doctors" seem to contribute little to the health and well being of mothers and children. "In one of the katchi abadies there is one doctor for every 600 of population, the same as Canada, but the IMR (infant mortality rate) is 10 times that of Canada. Here is a mismatch between the numbers of doctors available and effectiveness of their services." (Quote from Dr. Jack Bryant's article in "Dawn" dated April 24, 1987.)

Among the many deep rooted problems associated with poverty and ignorance, the following four problems were found in urban slums to cause the most chronic ill health and avoidable deaths in children under the age of 4 years.

1. Inappropriate weaning and feeding practices;
2. Incorrect and at times traumatic treatment of diarrhea and a general lack of understanding of oral rehydration therapy;
3. Improper practices of illiterate and unskilled birth attendants, resulting in the second highest number of child deaths as well as unmeasurable morbidity;
4. Lack of preventive health care services and female outreach health workers.
5. Very low use of family planning services and frequent pregnancies.

The Government's Accelerated Health Program (AHP) has been comparatively successful in terms of its Expanded Program of Immunization. Not a single child was reported by the mothers interviewed to have died from one of the diseases covered under the immunization program, although one would have expected one. The two other components of AHP (use of ORT and training of traditional birth attendants) seem to have little impact on the mothers and children living in the sample slum areas.

The biggest killer of children under the age of four years was diarrheal and parasitic diseases followed by birth injuries and prematurity. For the most part, the causes of child morbidity and mortality are preventable. Expensive curative services and high level technology can do little to change the present health conditions of children living in slum areas. Of greater importance is the need to educate mothers regarding appropriate feeding practices and the correct use of ORT and to train birth attendants to provide antenatal care, safe

deliveries and postnatal care for mothers and children. Skilled birth attendants, if trained in appropriate interventions, can go beyond their traditional functions and become a health resource for mothers of children under the age of 5.

Based on these conclusions, the following recommendations are made:

1. In the urban slums of Karachi, the Accelerated Health Program should be restructured to concentrate on its areas of weakness, that is the control of diarrheal diseases, the distribution of ORS and the training of traditional birth attendants.

2. Traditional Birth Attendants (TBAS) need to be trained in child birth techniques, appropriate feeding and weaning practices, ORT administration and family planning services.

3. Well baby clinics should be established in the urban slums, these clinics staffed with Lady Health Visitor and Trained Birth Attendant will have the following functions:

- Regular growth monitoring and health check-ups of children under the age of 5
- Advice on breastfeeding, weaning foods and the control of diarrheal diseases through the correct use of ORT
- Antenatal and postnatal care
- Information on family planning services

Mobile well baby clinics could perform the initial task of preparing records of pregnant women and mothers and their children under the age of 5 years prior to the establishment of well baby clinics. These well baby clinics should be coordinated with the trained TBA services.

4. Medical and para medical practitioners in the slums should be prepared to provide preventative and not just curative child health services. Training of preventive health care can be organized with the help of Pakistan Medical Association, Karachi.

5. More concentrated efforts are required by the Population Welfare Program to reach couples in low income areas through more innovative community based programs. Every hospital, dispensary and clinic should provide clinical and nonclinical family planning services.

6. All of the above mentioned services should be supported by a well planned and sustained mass media campaign. The use of a standardized measuring utensil with the ORS monogram could be promoted through posters, television and radio advertising.

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Appendix I

1. Locality:
2. Approximate distance from Govt Health Facility: _____
3. Ethnic Group: _____
4. Name _____ : Age: _____

BREASTFEEDING:

5. Number of Children under age of 4: _____
6. How long after the birth of the baby did you start breastfeeding and why?

7. What do you think of first milk after the birth?

8. How long did you breast feed your under 4 children?

9. At what age did you start supplementary feeding?

10. What supplementary food and fluids did you give to your breastfed children under the age of 4 years?

11. When was solid food given in relation to breastfeeding?

BOTTLE FEEDING:

12. Type of milk:

13. Preparation, quantity and frequency of feeds given:

DIARRHEA AND USE OF ORS:

14. What is diarrhea?

15. What causes diarrhea?

16. Do you consider it a serious disease?

17. If yes WHY? (Probe if it is considered to be hot or cold or any other concepts)

18. How should the diarrhea be treated?

19. Do you continue breastfeeding during a diarrheal episode?

20. Why do/do not you continue breastfeeding during a diarrheal episode?

21. Did your youngest child suffer from diarrhea since last Eidul-Fitr (6-7 months)?

22. What did you do when your child had diarrhea?

23. Have you heard of ORS?

24. If yes, what is ORS? (effects of ORS)

25. Have you used ORS packets since last Eidul-Fitr (6-7 months)?

26. Where did you get the ORS from?

27. Do you have an ORS packet in the house?

28. If yes, # of packets and brand of ORS packets

29. How much water do you use for ORS preparation and how do you measure the water?

30. Mother was requested to measure one litre of water, actual amount of water measured by the evaluator and correct ORS preparation demonstrated

IMMUNIZATION:

31. What is vaccination and what is it for?

32. From whom did you hear about vaccination?

33. What does it do to the body (concept re: hot and cold and other notions)?

34. Were you vaccinated against tetanus?

35. If yes, where were you vaccinated?

36. If not, why were you not vaccinated against tetanus?

37. Did you have your children under 4 vaccinated?

38. If not, why did you not vaccinate your children?

39. If yes, where was the vaccination was administered?

40. How many doses of each vaccine were given to your youngest child?

41. Who made the decision to have the child vaccinated?

42. See the vaccination card. If not available why?

CHILD MORBIDITY AND MORTALITY:

43. Number of live births Male _____ Female _____

44. Number of children died Male _____ Female _____

45. What were the causes of death of each child (in terms of signs and symptoms)

46. Age and sex of living children

47. How do you assess your child is not healthy and not growing normally?

48. What did you do when X child became sick?

49. Where did you take the child for treatment?

50. What treatment was given to the child?

51. What would you do if your child fell sick now and why would you choose that treatment?

52. Father's Formal Education: _____

53. Father's Occupation _____ Monthly income(Rs.) _____

54. Mother's Formal Education: _____

55. Mother's Occupation _____ Monthly income(Rs.) _____

56. Any other earning member in the family.

Occupation and Monthly Income (Rs.) _____

57. Does the family have a radio or TV in the house?

Radio: Yes _____ No. _____. TV: Yes _____ No. _____

58. What programs do you listen or watch most often?

Radio: _____

Television: _____

59. Have you ever used a contraceptive (CC)?

60. If not, why?

61. If yes: What CCs did you use?

How long did you use the CC?

When was CC use discontinued and why?

62. What do you think of CC usage now (Problems and apprehensions)?

63. Would you like to use CC services now?

64. If not, why?

65. If yes, what CC would you like to use and why?

66. What does your husband think of CC use?

67. Has he ever used a CC?

68. Would he like to use CC now?

69. If yes, what CC would he like to use?

70. If not, why would he not like to use a CC?

71. Have you ever discussed CC use with your husband?

72. If yes, what was the outcome of the discussions?

73. Have you ever discussed CC use with any one else?

74. If yes, with whom?

75. What was the outcome of the discussions?

circulation coverage is estimated
of about 36%

LETTERS

ANTI-DIARRHOEALS

A news item in an Urdu daily from Lahore stated that two children from the same family died after taking an Anti Diarrhoeal preparation. When analysed at Drug Testing Laboratories, it was found to contain poisonous ingredients. It was just by chance that such a tragic episode came into lime light and drug was analysed. Who knows how many such incidents take place daily with the slightest negligence on the part of manufacturing chemist supplying such drugs. The parents of victims are consoled by saying that it was 'Allah Ki Merzi' and thus the matter is hushed up.

The market is flooded with substandard and spurious drugs, often containing toxic substances. Usually manufacturers of such drugs offer more than 50% discount to the chemists and such drugs are dispensed by chemists themselves or quacks. It is irony of fate that such manufacturers/chemists have full liberty to play with the lives of poor masses.

There is a common consensus that Anti Diarrhoeal drugs are useless in more than 90% cases of Diarrhoea in infants and children and some of these drugs are even harmful. But ignoring this hard fact shelves of chemists are full of Anti Diarrhoeal drugs with great variety and there is no restriction to dispense or prescribe them.

It appears that either there is no Drug Policy in our country or it is not properly enforced. The agencies responsible for this should take pity on the plight of poor people and eliminate these substandard and spurious drugs.

DR. MUMTAZ AHMAD,
Azad Road, Goal Chowk,
Sardodha

200,000 babies die due to bottle-feeding

Down
May 22, 1987

By Nafisa Hoodbhoy

KARACHI, May 21: About 0.2 million infants die annually in Pakistan from diarrhoea and malnutrition, caused mainly by bottle-feeding.

Despite this, the nation's import of infant milk powder has more than tripled in recent years from Rs. 83.12 million in 1982-83 to Rs. 257.35 million in 1985-86 according to the Federal Bureau of Statistics.

While infant powder milk sales are declining in the developed countries, the multinationals based in Pakistan are "dumping" their products here.

Their latest strategy is the "follow-on formula" according to which they give free samples of milk powder to mothers six months after delivery, encouraging them to adopt bottle feeding rather than the semi solid foods that paediatricians advocate.

This active marketing is going on in Pakistan despite the World Health Organisation and UNICEF warning.

The Pakistan Paediatrics Association (along with WHO and UNICEF) are negotiating with the Pakistan Government to implement a Code of Ethics for the Marketing of Breast Milk Substitutes which was adopted by WHO in May 1981, and to which Pakistan is a signatory.

The Code of Ethics specifies the type of companies and amount of milk that they may market in Pakistan. It also lays down that the multi-nationals may not advertise any milk product competing with breast milk and any free sample and promotional material must be given to the doctor and health workers rather than directly to the public.

The association points out that implementation of the Code of Ethics is necessary in a country like Pakistan where, on account of high illiteracy, mothers do not mix milk powder and water in proper proportions. Neither do they boil water or sterilise milk bottles, nipples,

leading to high levels of contamination.

Even so, the paediatricians are fighting a losing battle in convincing mothers that breast milk (or alternately pasteurised milk) is best for babies. Particularly, where the mother is under-nourished or has not spaced her large number of infants, the free powder milk becomes an attractive incentive for her to put the baby on the bottle.

Aggressive salesmen have now moved to rural areas, where they have begun distributing free milk powder samples. Where the village or the rural health worker does not understand the implications of the milk bottle, infant deaths are a likely occurrence.

While on the one hand, bottle milk is causing diarrhoea and malnutrition among babies, on the other hand it is hurting the local dairy industry. With the market flooded with all types of milk powder, it has become virtually impossible for dairy farmers to compete. This is despite the obvious advantage of pasteurised milk being more wholesome, less subject to contamination and cheaper.

Paediatricians have pointed out that the main responsibility for regulating infant milk powder lies with the Government. (In less than 2 per cent cases, where the mother cannot breast-feed her child the milk powder may be allowed as a substitute, they argue.)

JAN 8, 1987.

20352 KMC NEGLIGENCE

An old city area still without amenities

By SHABBIR DURRANI

Mrs. Kulsoom Ismail Agaria, the lady councillor of Karachi Metropolitan Corporation, has lamented that her unit is being



ignored as far as the development programmes are concerned. She said that her unit comprising Ghanchi Para and Bhimpura, having a population of about four lakh has been there for more than 100 years but still lacks in basic amenities for the residents.

Elected as councillor on women's reserve seat, Mrs. Kulsoom Ismail Agaria said that KMC and other concerned departments never even tried to do something for the betterment of the people of these localities. "In every street and lane one can see dumps of garbage and overflowing gutters."

She further said that the area has not been provided with any maternity home, dispensary or any type of health centre. She said that several complaints were lodged but the KMC health staff did not clean the area of pye dogs which have increased in hun-

dreds and have become a danger to the residents. She complained that the poor residents of the area are living in most unhygienic conditions.

Mrs. Agaria said that only one KMC primary school exists in the entire locality. She demanded that at least two high schools for boys and one for girls be opened immediately so that the poor residents of the locality could get their young generation properly educated, and lead a better life and serve the nation.

The KMC councillor said, "new buildings are being constructed in the area ignoring the rules and regulations of the Building Control Authority which needs immediate and effective attention."

She also demanded that at least one maternity home, one general hospital and at least one community centre for the ladies of the area should be opened.

She complained that due to the negligence and inefficiency of the Land Department of KMC one finds encroachments in every lane, street and road. Due to heavy encroachments the residents of the area are facing great hinderance in their daily life.

BEST AVAILABLE COPY