THE CAUSES OF POVERTY AND INFANT MORTALITY IN THE DISTRICT KECH, TURBAT, BALOCHISTAN

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ABSTRACT

This study investigated the theoretical and empirical relationship among the income, poverty and infant mortality differences in district Kech, Turbat Balochistan. The study analyses the relative influence of a number of biological, social, and economic factors on the risk of infant mortality on the basis of national data collected since 2000 to 2016 in the concerned departments. The analytical methods used on multidimensional contingency tables offer an assessment of the relative risks of infant deaths in various sub-populations, with the documented combination of the birth and death data, with the coefficient estimates of these models being used. The Hospital care during the neonatal period, however, seems to reduce this increased risk for some high-risk infants. The continued poverty and unequal access to health care for expectant mothers and young moms in Turbat city and its environs show that these disparities have persisted into the present. To reduce these disparities, it is advised to increase access to and support for family health services through income subsidies and employment programming.

Keywords: Poverty, Urban, Rural, Turbat Kech, Term births, Infant mortality, statistical analysis.

1. INTRODUCTION.

The relationship among the population growth and economic outcomes is one of the dynamic issues to the significant policy implications in the society. However, the poverty can be studied by the occurrence of infant and children mortality and the certain aspects are identified as complimentary variables. This study highlighted the restored to examine about the poverty affects mortality associated to cause and effect particularly in Turbat city and its surrounding, district Kech, Balochistan. The occurrence and level of child mortality vary across different demographic consortiums, these disparities are attributable in part to socioeconomic and biological factors. It is commonly observed that the death rates among poor people are usually greater than in non-poor persons.

This is because of the poor peoples' attitude and behavior which being poor towards life which carries more deaths among them in the Turbat city and its sounding. The various ways of measuring poverty. According to demographers, the main indication of poverty (Mosley and Chen., 1984) is high child and newborn mortality; (Martin et al., 1983; Obermeyer C N., 1993). In other disputes, the incidence of newborn death and infant mortality may assess poverty and hence both are characterized as complementary variables, it is generally best to analyze that the poverty impacts mortality in the study of cause and effect. Encompasses by the (Mosley and Chen., 1984), variables such as dietary status, household intensity pollution, drinking water contamination, and faecal contamination potential, in addition to health services, are known.

Pakistan is ranked 26th among nations with the highest child death rates according to (Ali S M.,et al,. 1998) and (Ali S M and Rukanuddin A., 1992) in Pakistan. Newborn mortality rates rank 57.48% 423,000 children die annually in Pakistan (Nasir Z M., 1999). Mainly in the Balochistan, infant mortality is 75% percent and 58 % greater in the rural belts than in urban areas (Mohammed I., 1986). Early marriage the age 15 to 18 is also one of the main causes in rural regions in terms of infant mortality as women who get married in their early years suffer a great deal during their pregnancy. Women in poorer regions work in fields and houses to make their livelihood for their family, thus their health and children are not given full care, so that the likelihood of infant death is raised in these instances. (Ali S M., 2001).

These some reasons are identified as the closest factors affecting social, economic and demographic deaths. There is also an effort here to discover the links between child mortality and poverty, the harshness of domestic crowding water and faecal pollution and other socioeconomic factors, such as mother's education and mother job, instead of father education or father occuption, mother's education and job status was utilized intentionally in our research since moms are known to offer health care as first when needed and are regarded as the first provider. And the mothers' conduct when looking for and providing medical treatment for their sick children may be significant predictor of children's survival because of their natural sentiments of caring for their children. This study provoked the differ from an uneducated mother to an educated mother and

also via her working condition. The dependent variable is entered on an interval scale, whereas either dichotomous or ordinal predictor variables are included in the model. The variables used for the analysis are the predictor.

Specifically, the aim of this study is to examine the effect of one, infant mortality, population growth and the effects of policy on population management. Child mortality is commonly used as an advocate for poverty, and it is easier to quantify newborn deaths. Impactors of child death may also be considered to affect the occurrence of poverty.

2. Materials and Methods Procedure

This part of the research highlighted the method and procedure used to conduct the experimental study. The purpose to explore the factors which can affect the society to decrease the death rate of newborn babies in district Kech, Makran and the areal strategic on socio-economic problems which putted the huge impacts. The study is basically based on primary data which are collected through well-developed Questionnaire, such as is mixed method i.e. both Qualitative and Quantitative, which is obtained through sample survey and secondary source of data. The information/ data were collected through a survey. The survey was based on personal interviews and questionnaires. Quantitative data is the secondary data obtained from district Kech. data on health is taken from District Health Information System in DHQ Turbat, Kech. The primary data is collected directly from the source which respondent living in the study population, through a sample random sapling method survey method.

2.1 Methods

The Analysis have based on married women with at least one birth but alive. For data collection non-probability sampling have been used because the exist population of pregnant women was not clear. Simple Random Sampling (SRS) Method have been used for data collection from District Kech, Balochistan. The obtained data set is analyzed using statistical and Econometrics technique, descriptive analysis, bivariate analysis, analysis of variance (ANOVA) and Pearson Coefficient Correlation.

3. RESULTS AND DISCUSSIONS

This study shows the significance relationship between mother and infant mortality with poverty which further disclosed in result and tables. Districts Kech, Balochistan there are 50 sample sizes have been taken in from the district.

Table 1: Descriptive Statistics of Responses

	Frequency	Percent		Frequency	Percent
Resident Location			**working During Pregnancy**		
Urban	32	64%	Yes	33	66%
Rural	17	34%	Somehow	11	22%
Separate room			No	6	12%
Yes	40	80%	**Taking Medicine During Pregnancy**		
No	10	20%	Yes	24	48%
Nutrients Used During Pregnancy			No	26	52%
Non	13	26%	**Working Outside During Pregnancy**		
Milk	18	36%	Yes	11	22%
Fruit	3	6%	No	39	78%
Milk and Fruits	16	32%	**Family Behavior During Pregnancy**		
Diet During Pregnancy			Aggressive	8	16%
Fish	7	14%	Friendly	33	66%
Chicken	17	34%	Supportive	9	18%
Vegetable	21	42%	**Smoking During Pregnancy**		
Dal	4	8%	Yes	22	44%
Other	1	2%	No	28	56%
Mother Education			**Age Less than 18 during First Pregnancy**		
Illiterate	28	56%	Yes	7	14%
Matric	8	16%	No	43	86%
Intermediate	6	12%	**How long after mirage come to know about Pregnancy**		
BA/BSc	7	14%	Less than 3 month	15	30%
MA/MSc	1	2%	More than 3 Month	4	8%
Sewing Clothes during Pregnancy			One Year	16	32%
Yes	35	70%	Two Year	10	20%
No	13	30%	3 Year	2	4%
Purpose Of Sewing Clothes			More Than 3 Years	3	6%
Income	30	60%	**Medical Insurance During Pregnancy**		
Obey	13	26%	Yes	5	10%
Time Pass	7	14%	No	45	90%

The table 1 results are states, 66% of the women work during their pregnancy and among of them 12% women do not work. The nutrition status of the pregnant women most of the women use fruits and milks during their pregnancy because of poverty. Most of the women do smoking during their

pregnancy. The education level of the women states that most of the women are illiterate. 70% of women swing clothes during pregnancy and main theme to increase their income and to fulfill their housed hold consumptions. The health situation of women is not well because 90% of the women do not take medical insurance during pregnancy. The 40 participants including the 80% are residing in house where they have separate room area. 56% of the women are uneducated among of them 16% women did matric and 15% did graduation. It depicts most of the women are uneducated. The nutrition of the pregnant women is not reliable in during pregnancy because 26% of women do not take milks and fruits. According to the study, pregnant females in most of the respondent's families drink milk as a nutrient during their pregnancy period. The second highest proportion of respondents' families is 34%, where the pregnant females take moderate diet during pregnancy period.

Table 2: Descriptive Statistics of Responses (Continue)

	Frequency	Percent		Frequency	Percent
Baby Protection Vaccine			**Doctor Behavior During Delivery**		
Yes	8	16%	Good	7	14%
No	42	84%	Normal	43	86%
Pregnancy Completion of 9 month			**Use of Vaccine During Delivery**		
Yes	39	78%	Yes	36	72%
No	11	22%	No	14	28%
Health care Facility from Family			**Ultrasound Every Month During Pregnancy**		
Yes	20	40%	Yes	6	12%
No	30	60%	Somehow	16	32%
Provision of First Breast Milk to Baby			No	28	56%
Yes	29	58%	**Go to Hospital every Month During Pregnancy**		
No	21	42%	Yes	4	8%
Supplement for child after birth			Somehow	16	32%
Yes	15	30%	No	30	60%
No	35	70%			

Table 2 resulted most of the study participants (28) are illiterate or uneducated. Majority of the females said that they sew clothes to get earn and the proportion of these ladies is 60% of the sample. The results show that only 2% percent of the survey participants have degree of M.A/M.Sc. Majority of pregnant ladies are taking medicine during their pregnancy period. Some families aggressively behave with their pregnant females in their homes. They do work outside of home during the time of pregnancy. 14% of women who argued they were less than 18 years during their first pregnancy. Majority of the husbands are behaving good with pregnant ladies in their

homes and 24% of the husband are friendly to their wives. The results show that 90% ladies did not have medical insurance during their pregnancy time period.

The study further observed that the participants from poor families usually are subjected to remain in deficit to meet their monthly expenditure and hence they are 84% who didn't get the facility of baby protection vaccines, when they were pregnant during their babies. They did not get any kind of health care. 86% of the respondents who have said that the behavior of the doctor during their delivery was good. Majority of the females are feeling mental stress during their pregnancy. Results show that majority (76%) of the participants reported that they were subjected to have medical problems during pregnancy.

Table 3: Age factors and House Condition

	No	Mean	Standard Deviation	Minimum	Maximum
Girl Age During Marriage (15 -30)	50	21	3.32	15	30
Husband Age (20- 50)	50	32.28	7.84	20	50
Family Member (3 – 18)	50	10	3.82	3	18
Rooms in House (1 – 12)	50	4	2.06	1	12
Mother Age During Pregnancy (18 – 39)	50	25.3	4.78	18	39
Husband's Monthly Income (7000 – 60, 000)	50	23232.6	12877.54	7000	60000
Child Weight During Birth (1 – 4)	50	2.32	0.61	1	4

The Table 3 indicates that **the** average age of a girl to get married is 21 years in the study sample, with minimum 15 years and maximum 30 years. The average family size is 10 members with minimum 3 members and maximum 18 members. Average reported child weight at the time of birth is 2 kilograms (kg).

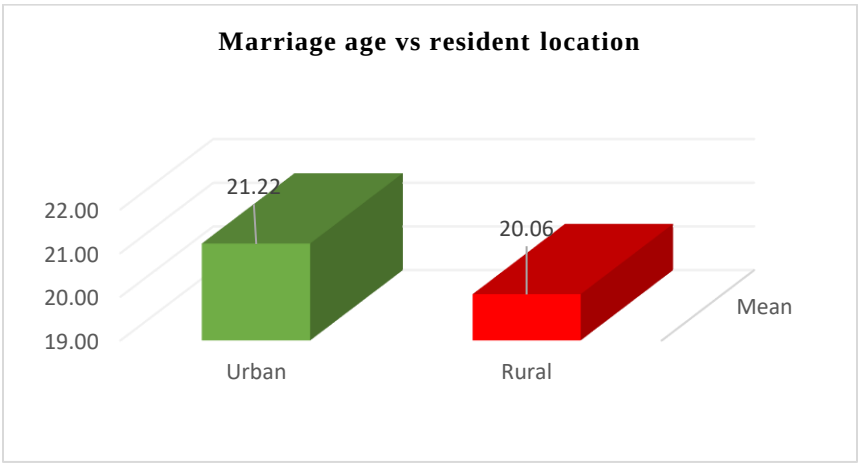

Figure 1(a): Marriage Age Vs Resident Location

The average age at which a woman is got married in rural areas is 21 years when a female is got. Married in urban livings while this average in rural area is 20 years. Early marriages are held in the rural areas as the sample calculated average is less for rural setting. The average age of a woman to be married in urban areas is better for a female to be got married in urban areas than rural areas. Husband age is 34 years approximately in rural setting while this average is 31 for urban localities. The figure shows that the average age is higher for a male to be married in urban areas.

Table 4: Distribution of Husband Monthly Income and Resident Location

Husband Monthly Income (Rs)			
Resident Location	**N**	**Mean**	**Standard Deviation**
Urban	29	22172.41	11272.82
Rural	13	27384.62	15803.68
Total	42	23785.71	12877.54

The table 4 indicates that Average husband monthly income is 22172 rupees for the families who living in urban setting. Women whose families are resident of rural belt has on average 27385 rupees as their husband's monthly income. The average husband monthly salary is 23786 rupees.

Table5: Distribution of Resident Location and Household Monthly Income

Household Monthly Income (Rs)			
Resident Location	**No**	**Mean**	**Standard Deviation**
Urban	28	21571.43	11855.39
Rural	13	27769.23	15401.05
Total	41	23536.59	13211.92

The table 5 indicates that Average household monthly income is 21571 rupees for the families who resides in urban setting. Women whose families are resident of rural localities has on average 27769 rupees as their household monthly incomes. The average household monthly salary is 23537 rupees.

Table 6: Distribution of Resident Location and Room in House

Room in House			
Resident Location	**No**	**Mean**	**Standard Deviation**
Urban	17	3	1.46
Rural	32	4	2.68
Total	49	3.77551	2.0743

The table 6 expresses that the average number of rooms in home is greater in rural localities than the in the homes of urban residents. Women whose families live in rural areas have an average of 5 rooms at home on average compared to 3 in urban areas.

Table 7: Distribution of Resident Location and Age at Pregnancy

Age at Pregnancy			
Resident Location	**No**	**Mean**	**Standard Deviation**
Urban	17	25.59	4.92
Rural	32	24.06	3.91
Total	49	25.06	4.62

The table 7 indicates that the average age at the time of pregnancy of participant is 26 years for the families who reside in urban setting. The ladies whose families are resident of rural localities has approximately at 24 years age when they got pregnant. Average age of ladies at the time of pregnancy is greater in urban localities than among the rural residents.

Table 8: Distribution of Mother Education and Age at Pregnancy

Age at Pregnancy			
Mother Education	**No**	**Mean**	**Standard Deviation**
Illiterate	28	25.68	4.47
Matric	8	25.13	5.84
Inter	6	25.67	6.86
BA/BSc	7	24.14	3.24
MA/MSc	1	20.00	0.00
Total	**50**	**25.26**	**4.78**

The table 8 shows the age at the time of pregnancy of uneducated ladies is 26 years on average. The age at time of pregnancy of matriculated ladies is also 26 years, according to a new study by the National Statistics Agency. This compares to 25 years for inter-educated ladies and 24 years for graduated ladies.

Table 9: Distribution of Mother Education Level and Less than 18 during First Pregnancy

Less Than 18 During First Pregnancy			
Mother Education Level	**Yes**	**No**	**Total**
No	5 (10)	23 (46)	28 (56)
Matric	1 (2)	7 (14)	8 (16)
Inter	1 (2)	5 (10)	6 (12)
BA/BSc	0 (0)	7 (14)	7 (14)
MA/MSc	0 (0)	1 (2)	1 (2)
Total	**7 (14)**	**43 (86)**	**50 (100)**

The table 9 shows that here is no respondent who smoke during pregnancy period and educated up to matriculation. 56% of the respondents are illiterate and 14% have smoking habit during their pregnancy period. There are 46% of respondents who are illiterate and said that they didn't smoke during their pregnancies.

Table 10: Distribution of Mother Education Level and Breast Feeding After Birth

Breast Feeding After Birth			
Mother Education Level	**Yes**	**No**	**Total**
No	13 (26)	15 (30)	28 (56)
Matric	6 (12)	2 (4)	8 (16)
Inter	4 (8)	2 (4)	6 (12)
BA/BSc	5 (10)	2 (4)	7 (14)
MA/MSc	1 (2)	0 (0)	1 (2)
Total	**29 (58)**	**21 (42)**	**50 (100)**

The table 10 indicates that there 26 % uneducated ladies who have given breast feeding to baby after birth while 30 % uneducated ladies did not feed their breast milk to bay after birth. There 10 % ladies feeding their babies after birth through their breast and are educated up to B.A/B.Sc. There are 58 % of the respondents who have given breast feeding to baby after birth.

Table 11: Distribution of Mother Education Level and Self- care During Pregnancy

Self- care During Pregnancy				
Mother Education Level	**Yes**	**Somehow**	**No**	**Total**
No	4 (8)	17 (35)	7 (14)	28 (57)
Matric	3 (6)	2 (4)	3 (6)	8 (16)
Inter	2 (4)	3 (6)	0 (0)	5 (10)
BA/BSc	2 (4)	4 (8)	1 (2)	7 (14)
MA/MSc	1 (2)	0 (0)	0 (0)	1 (2)
Total	**12 (24)**	**26 (53)**	**11 (44)**	**49 (100)**

The table 11 indicates that there 35 % uneducated ladies who care about their self somehow while 14 % uneducated ladies did not do this. There are 6 % matriculate educated ladies who are caring about their self somehow. There are 4 % graduate ladies who reported that they care about their self during pregnancy period. There are 24 % of the respondents who care about their self during pregnancy period.

Table 12: Distribution of Mother Education Level and Place of Delivery

Place of Delivery				
Mother Education Level	**Home Delivery**	**Govt. Hospital Delivery**	**Private Clinic Delivery**	**Total**
No	1 (2)	7 (14)	20 (41)	28 (57)
Matric	2 4)	2 (4)	4 (8)	8 (16)
Inter	0 (0)	2 (4)	3 (6)	5 (10)
BA/BSc	1 (2)	1 (2)	5 (10)	7 (14)
MA/MSc	0 (0)	0 (0)	1(2)	1 (2)
Total	**4 (8)**	**12(24)**	**33(67)**	**49 (100)**

The table 12 shows that there are 41% of uneducated ladies who have reported that their delivery happened in a private clinic while 14% went to government hospital for this purpose.

Table 13: Distribution of Mother Education Level and Go to Hospital every Month during Pregnancy

Go to Hospital every Month During Pregnancy				
Mother Education Level	**Yes**	**Somehow**	**No**	**Total**
No	1 (2)	9 (18)	18 (37)	28 (57)
Matric	0 (0)	1 (2)	7 (14)	8 (16)
Inter	0 (0)	3 (6)	2 (4)	5 (10)
BA/BSc	2 (4)	2 (4)	3 (6)	7 (14)
MA/MSc	0 (0)	1 (2)	0 (0)	1 (2)
Total	**3 (6)**	**16 (33)**	**30 (61)**	**49 (100)**

The table 13 shows that 37% uneducated ladies who have reported that they go to hospital every month during their pregnancy period. There are 61% of the ladies who didn't report going to hospital each month during pregnancy during their pregnant period according to a new study.

Table 14: Distribution of Mother Education Level and Feel Mental Stress during Pregnancy

Feel Mental Stress During Pregnancy				
Mother Education Level	**Yes**	**Somehow**	**No**	**Total**
No	12 (24)	11 (22)	5 (10)	28 (57)
Matric	5	1 (2)	2 (4)	8 (16)
Inter	3 (6)	2 (4)	0 (0)	5 (10)
BA/BSc	4 (8)	1 (2)	2 (4)	7 (14)
MA/MSc	0 (0)	1 (2)	0	1 (2)
Total	**24 (49)**	**16 (17)**	**9 (18)**	**49 (100)**

The table 14 shows that there are 24% uneducated ladies who have reported that they feel mental stress during their pregnancy period. There are 67% of the respondents who went to private clinic for their delivery case.

3.1 Analysis of Variance (ANOVA)

Table 15: Descriptive Statistics

Household Monthly Income			
Place of Delivery	**Mean**	**S. D.**	**F**
Home Delivery	21000	12727.92	2
Govt. Hospital Delivery	19333.33	9354.144	9
Private Clinic Delivery	24793.1	14467.65	29
Total	**23375**	**13339.14**	**40**

The table 15 shows that the average household monthly income is 2100 rupees for the families whose ladies stay at home for their delivery. It is 24793 rupees per month. Women who deliver in private clinic have highest monthly income of 24793 rupee per month according to the study.

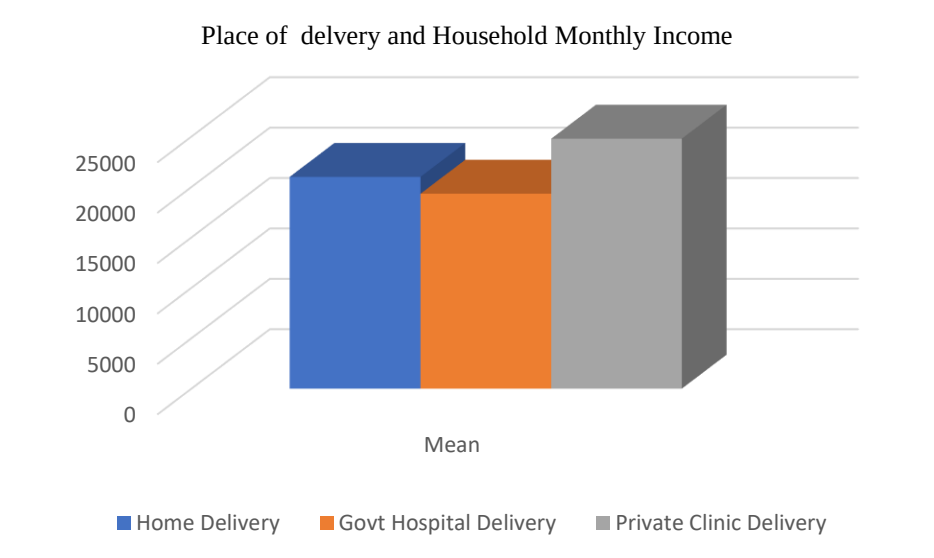

Figure 2; Place of delivery and Household Monthly Income

Table 16: Analysis of Variance

Source	S.S.	D.F.	M.S.	F	P Value
Between groups	1146616379	2	573308190	3.16	0.0462
Within groups	6.72E+09	37	181696179		
Total	6.94E+09	39	177932692		

Bartlett's test for equal variances: chi2 (2) = 1.6809 Prob>chi2 = 0.0432

The table 16 indicates that the results of ANOVA table suggest that the average household monthly income across different family provision of medical to mother during pregnancy is different. The table given below presents the detail about these statistics and their implications for the study. Findings are consistent with the null hypothesis, but we still do not know which of the average household monthly income is different until multiple comparison of these means.

Table 17: Bonferroni Multiple comparison

Row Mean		
Col Mean	**Home Delivery**	**Govt. Hospital Delivery**
Govt. Hospital Delivery	-1666.67	
Sig	1	
Private Clinic Delivery	3793.1	5459.77
Sig	1	0.0486

The table 17 shows that the mean difference of monthly household income of family provision of medical facility at the time of delivery at government hospital between family keep the mother is statistically insignificant.

Table 18: Descriptive Statistics

Family Behavior During Pregnancy	**Household Monthly Income**		
	Mean	**S. D.**	**F.**
Aggressive	20000	6123.724	5
Friendly	22392.86	11079.98	28
Supportive	29750	21076.39	8
Total	23536.59	13211.92	41

The table 18 indicates that the average household monthly income is 20000 rupees for the families who aggressively behave to their pregnant ladies. The families with supportive behavior to their pregnant ladies have highest household monthly incomes as it is 29750 rupees per month. Pregnant ladies whose family behavior is friendly have 22392 rupees a month.

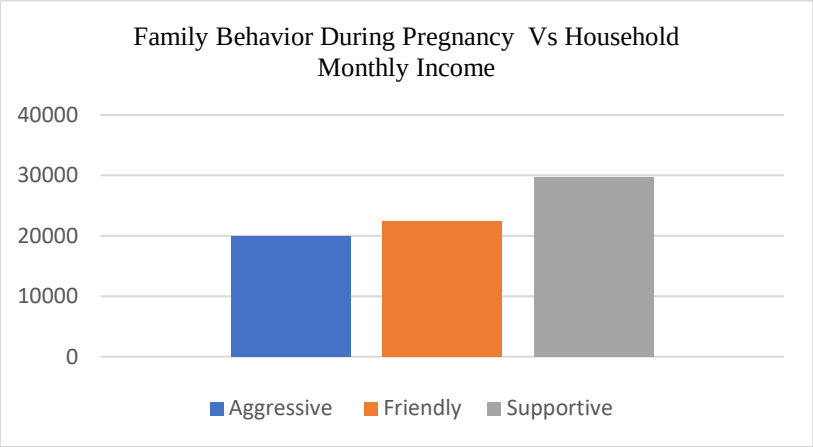

Figure 3: Family Behavior During Pregnancy Vs Household Monthly Income

Table 19: Analysis of Variance

Analysis of Variance					
Source	**S. S**	**D.F.**	**M.S.**	**F**	**P Value**
Between groups	708016551	2	354008275	2.046	0.0318
Within groups	6.57E+09	38	173004699		
Total	6.98E+09	40	174554878		

Bartlett's test for equal variances: chi2 (2) = 8.2239 Prob>chi2 = 0.016

The table 19 shows that the results of ANOVA table suggest that the average household monthly income across different family behavior with mother during pregnancy is different. The p-value of the test suggests that null hypothesis is rejected, and we conclude that average household monthly income is different.

Table 20: Bonferroni Multiple comparison

Row Mean		
Col Mean	**Aggressive**	**Friendly**
Friendly	2392.86	
Sig	0.004	
Supportive	1750	1357.14
Sig	0.604	0.513

The table 20 indicates that the mean difference of Aggressive family behavior with mother between friendly family behaviors with mother during pregnancy period is statistically significant. The results of the above multiple comparison are calculated using Bonferroni method of multiple comparison, and the p-value of the difference is greater than 0.5.

3.2 Correlation Analysis

This section of study provides the correlation analysis of variables. If there is a high correlation between any two independent variables than we should be careful about the issue of multicollinearity with the regression model. We are going to check these correlations before we proceed with the regressions.

Table 21: Correlation Matrix of Independent Measure

	Household Monthly Income	Room at Home	Age at Pregnancy	Childbirth weight
Household Monthly Income	1			
Number of Rooms at Home	0.335	1		
Age at Pregnancy	-0.214	-0.0267	1	
Childbirth weight	0.2118	-0.2515	0.1588	1

Table 21 shows the correlation analysis among four variables such as l household monthly income, number of rooms at home, age at time of pregnancy and weight of a child at the time of birth. The table also shows that there is a very low correlation between household monthly income and the weight of child.

Table 22: Correlation Matrix of Covariates

		Resident Location	Separate Room at house	Diet During Pregnancy
Resident Location	Correlation Coef.	1.000	0-.050	0.285*
	P value		0.733	0.047
Separate Room at house	Correlation Coef.		1.000	0.120
	P value			0.407
Diet During Pregnancy	Correlation Coef.			1.000

The table 22 indicates that Low correlation between source of respondents' resident location and mothers' diet during pregnancy. Spearman rho correlation coefficient between source and Mothers' separate room at house is -0.050 and statistically insignificant. The above discussion may be concluded as the model will not suffer from multi collinearity on the inclusion of these covariates.

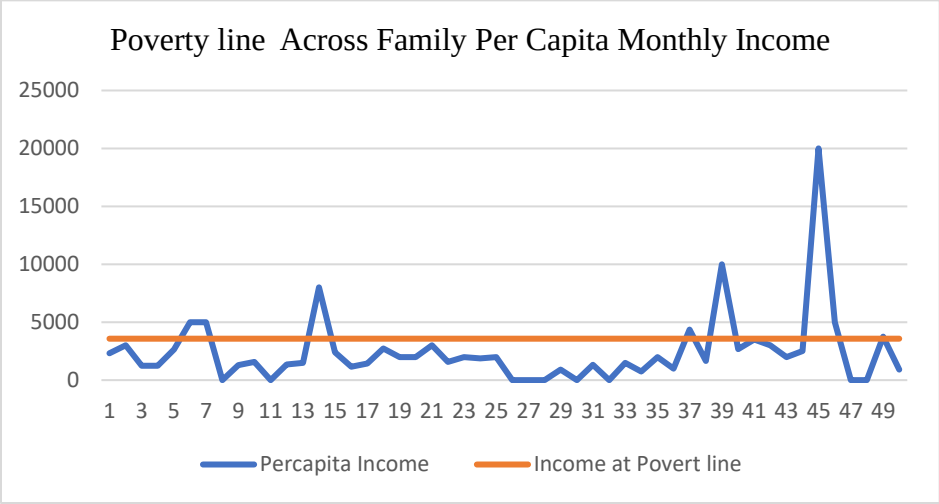

Figure 4: Poverty Line

The data predicts that head number proportion in light of neediness line of US $ 1.25 for every individual every day. The study reflects that the poverty is much more in rural settings than the urban area. Most of the sample families are living below the poverty line.

3.3 Secondary Data Analysis

The section provides the analysis of the data obtained from sources of, District Health Information System District Health Department Kech, Balochistan. The data is analyzed by using various statistical and econometrical techniques which are given below.

3.4 Analysis of Situation

The analysis presented below is based on secondary data which was obtained from district health information system Kech. The analysis tool in this section includes descriptive analysis and correlation analysis

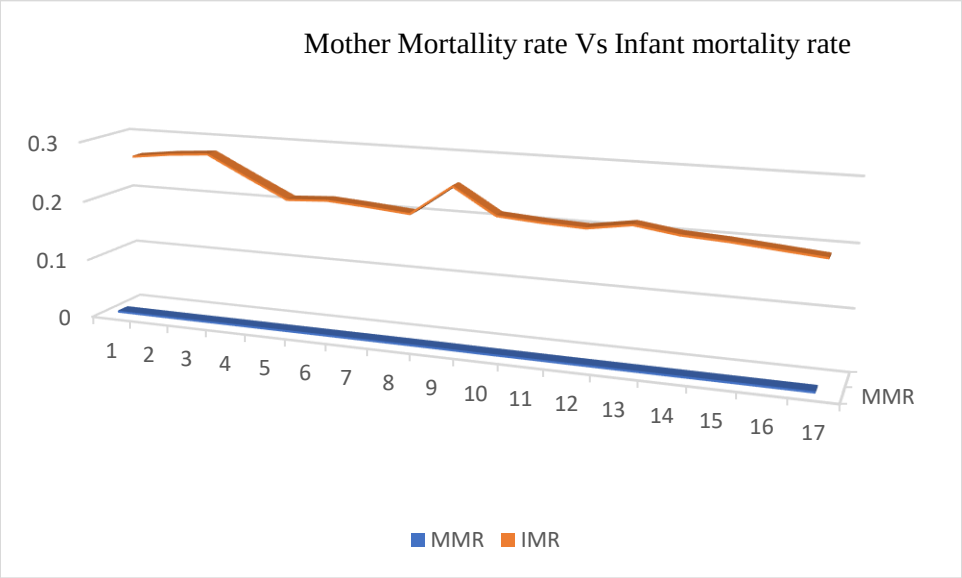

Figure 5:(a) MMR Vs IMR

The Figure explored the Mother Mortality rate Vs Infant mortality rate, the above diagram presents the relationships among the mother mortality rate or number of deaths of mother recorded per hundred thousand pregnant ladies and the number of infant deaths recoded per year in the district Kech Balochistan, Pakistan. The figure depicts that the mother mortality rates are laying at the bottom whereas the infant mortality line is up from the down line which indicate that the annual infant mortality rates are higher than mother mortality rates in district Kech Balochistan.

The above table shows that the mother mortality rate which are calculated by number death diving the number of 100000 pregnant females for the district Kech. The results show that for the study period (2000 to 2016) the average mother mortality rate is 600 per hundred thousand pregnant females. The median is 625 deaths per hundred thousand pregnant ladies with smallest 521 and highest 648 deaths per hundred thousand pregnant females per year.

The table 21, presents the descriptive analysis of the study variable yearly infant mortality rates from 2000 t0 2016. The results show that for the study period (2000 to 2016) the average infant mortality rate is 220 per thousand live births. The median of infant deaths is 208 deaths per 1000 live births with lowest 186 and 251 deaths per 100 live births for the year.

Table 23: Descriptive of Infant Mortality Rate

	Percentiles	Smallest		
1%	0.186	0.186	Obs	17
5%	0.186	0.192	Sum of Wgt.	17
10%	0.192	0.198		
25%	0.201	0.201	Mean	0.219471
			Std. Dev.	0.028476
50%	0.208			
		Largest	Variance	0.000811
75%	0.241	0.251	Skewness	0.901984
90%	0.27	0.262	Kurtosis	2.320955
95%	0.275	0.27		
99%	0.275	0.275		

Table 24: Correlation Analysis of MMR and IMR

	MMR	IMR
MMR	1	
IMR	0.713	1

The correlation analysis shows that there is a significant correlation between yearly mother mortality rates and infant mortality rates for the Kech district of Balochistan. There is strong correlation among these two study measures which shows a that these two death rates move together, as increase in one cause increase in another and vice versa.

Number of motherly deaths recorded per month from January 2010 to December 2016. Relationship between number of deaths and baby birth's weight less than 5 Kg is 'statistically insignificant'

4. CONCLUSION

By concentrating on factors related to infant mortality in a segment of births with particularly high mortality, our study filled a vacuum in the body of literature. The discovery of a mortality gradient associated with county poverty and rurality among term infants highlights the need for additional research into the underlying mechanisms by which county poverty and rurality impacts term infant survival, for instance through an analysis of cause-specific term infant mortality. This is true even though our analyses cannot be strictly interpreted as a mediation analysis. Compared to living in rural areas, residing in an urban location decreases the likelihood of being impoverished by 3.23%. Pregnancy-related consumption of chicken raises the likelihood of poverty by 0.99%. Being impoverished has a 0.052% higher chance of occurring if you live in a remote location. Being poor has a bad effect on a girl's age at marriage and her diet while her mother is pregnant.

The findings demonstrate that being poor is more likely if you have a separate room at home. There isn't a single respondent who smoked while pregnant and had at least a matriculation degree. 14% of respondents smoke while pregnant, while 56% of respondents lack literacy. The 46% of respondents who reported not smoking during their pregnancies are uneducated. When compared to metropolitan areas, the average number of rooms in a home is higher in rural areas. Participants' average age at conception was 26 years for families living in district Kech, Balochistan, which is an urban area. Women who live in rural areas typically became pregnant when they were 24 years old or older. According to a recent study by the National Statistics Agency in the district of Kech, Balochistan, matriculated women are also 26 years of age when they become pregnant. According to the report, women who give birth at private clinics get the highest monthly income, which is 24793 rupees. Findings are in line with the null hypothesis, however unless many comparisons of these means in district Kech Balochistan are made, we won't know which of the average household monthly incomes is different.

However, the findings point to a continuing need for initiatives aimed at promoting the social determinants of health, as well as a focus on contextual aspects like neighbourhood deficiencies, housing and residential reliability, protection, and food security in addition to distinct factors like the declining teen pregnancy rate and inspiring the higher educational realisation among women in district Kech Balochistan.

REFERENCE

Ali, S. Mubashir (forthcoming) Gender and Health Care Utilisation in Pakistan. Based on

Ali, S. Mubashir and Rukanuddin A., (1992) Family Size Preferences. Chapter 8 in *Pakistan Demographic and Health Survey 1990-91*. NIPS/DHS/IRD-Macro International Inc.

Ali, S. Mubashir, G. M. Arif, and Z. M. Nasir (forthcoming) Characteristics of Households and Respondents. Based on *1998 PSES* data.

Irfan, Mohammed (1986) Mortality Trends and Patterns in Pakistan. United Nations. (ESCAP No. 33.)

Martin, L. G., J. Trussell, F. R. Salvail, and N. M. Shah (1983) Covariates of Child Mortality in Philippines, Indonesia, and Pakistan: An Analysis Based on Hazard Model. *Population Studies* 37:4 417–432.

Mosley, W. H., and Lincoln C. Chen (1984) An Analytical Framework for the Study of Child Survival in Developing Countries. *Population and Development Review*, a Supplement to Vol. 10: 25-45.

Nasir, Z. M. (1999) Labour Market and Poverty Linkages in Pakistan. PIDE, Islamabad. (Mimeograph.)

Obermeyer, C. M (1993). Culture, Maternal Health Care and Women' s Status: A Comparison of Morocco and Tunisia. *Studies in Family Planning*, Volume 24, number 6, 354-365.

Syed Mubashir Ali (2001) Poverty and Child Mortality in Pakistan *MIMAP Technical Paper Series, 06*