FACTORS DETERMINING POVERTY AND CHILD MORTALITY IN PAKISTAN

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ABSTRACT

The aim of the study was to check the factors determining poverty and child mortality in Pakistan. The primary purpose of this study is to find out and explore the factors involved in poverty along with the child mortality rate within Pakistan. The data being used in this paper is taken from some authentic resources like documented economic surveys, reports of the World Bank, etc. To determine the relationship between variables, we used the OLS technique. Some independent variables which we are using in this study are GDP growth, Consumer Price Index (CPI), unemployment, and the number of hospitals. With poverty measurement, we considered 'female literacy rate, male literacy rate, immunization, and GDP growth' as independent variables. The findings of this study explained that CPI, GDP growth, and the unemployment rate are positively related to poverty. However, the link between the hospital numbers and poverty turns out to be negative. It was found that the relation between female literacy rate and infant mortality was negative. Whereas the literacy did not affect the rate of infant mortality. The infant mortality rate has negatively impacted and significantly with the immunization. Pakistan has high inequality. Because of which the relationship between GDP growth rate and infant mortality is positive. This study suggested that factors like quality of water, educational level of parents, and the inclination of mothers to well use healthcare provisions could be the helpful parameters in controlling and subsequently reducing the rate of poverty and infant mortality.

1.   INTRODUCTION

The children with more levels of deficiency of nutrients are more likely to have terrible health outcomes and eventually top death rates. Such young populations are more likely to have more infant mortality along with the risk of increasing maternal death rate. These strata of the population in Pakistan suffer from severe diseases, more difficulty to avail of healthcare, amenities, and social protection. Further gender inequality exacerbates the situation makes more grim circumstances for nutrient deficient females in society. The health of such communities also acts as a bringer of income and hence falling ill devastates the financial standing along with physical health. Women also face restricted mobility and relatively fewer choices of employment as compared to men which further shrinks their mean income. Hence the lack of provision of the necessities of life like nutrition, primary education, and sound physical health keeps them marginalized/ at the unhealthy quality of life which is an indicator

of poverty. All these components make them incapable to use the poorly state-provided healthcare facilities and social stigma attached to their employment choices. Resultantly it increases poverty.

Across and inside countries, varieties in salary can represent as much as 70% of the fluctuation in baby mortality. Immense incongruities exist in wellbeing between the rich and poor on the planet and between the rich and inadequate within developing nations. The poor are most extreme in danger of sick wellbeing and have a minimal way to deal with battle it. Demise is unavoidable; every individual who is brought into the world alive needs beyond words, the end. In the convoluted global, individuals are a hit in delaying passing on. In the creating global, even though there has been a considerable decrease inside the general mortality charge directly through a definitive four or five numerous a year, however a baby and kid mortality stay top.

In Pakistan, every 11th child who is born alive dies sooner than attaining one year of age. The mortality rate of kids below 5 years is 111 steady with 1000 are living births in 2012 and in 2018 it is 69.3 children per 1000. The prevalence and kid loss of existence varies between various groups of inhabitants. Some of those variations are on account of biological causes and some part of socio-economic variables. It is apparent that the mortality rate is upper amongst deficient people than non-poor. Poverty has many faces, a lack of shelter, being ill, and no longer with the ability to see a physician. Fewer skills to go to college, unemployment, losing a kid to sickness, loss of illustration, and freedom are also included in poverty. Poverty is a real situation and one cannot escape from it. It can affect human health, though many ways. Income provides maximum happiness while poverty hurts the physical and mental health of people. An occasional source of revenue limits peoples' possible choices and militates in opposition to desirable changes in conduct. Infant mortality is the selection of young children who die all over the place in their first 12 months of lifestyles. We frequently accept infant mortality fee is repeatedly as a measure of the overall health and well-being of inhabitants.

Due to poverty, there is a chance of children dying at the globe and infant mortality is the main factor for health. Ahmad, Lopez, and Inoue (2000) explained that infant and child mortality is considered a sign of social welfare and basic facilities. Pakistan's population is 207 million according to the 2017 census and 96 percent of neonates die in developing countries every year. The breach between rural and urban poor has grown to be wider over the years, which requires corrective motion. Now, the poverty index modified and MDPI used as a new index for poverty. Moreover, 54.6 % of poor are in a rural area whilst city poverty is 9.3 percent says UNDP. World Bank says that poverty has not increased during the 1990s whereas it has dropped. Inflation, slow down of the economy, rising unemployment, tight fiscal policy, and poor governance has made the poor more vulnerable in recent years. BISP, program instigated in 2008, now it is underneath the umbrella of the Prime Minister Ehsaas program. Ehsaas program has 30 subprograms to maintain poverty and rise up with monetary lend a hand, cattle, and other necessary life goods. Some fundamental tactics like Zakat/Usher and Pakistan, Bait-ul-Maal, and the Social Action Program introduced for poverty reduction.

Pakistan is the place there are important flaws with the two price indices. One is the consumer price index (CPI), which offers many commodities of intake on the other hand covers most effective city spaces; it does now not seize rate changes in rural areas the place the bulk of the deficient reside. The Survey Based Index (SBI) of costs has the advantage of being accrued at a similar time from the same households because of the intake data. Unfortunately, it is tricky to estimate payment changes for all items that households devour because prices of non-food items don't seem to be available within the survey. These are the 2 possible choices. Pakistan should strengthen its prices by way of indices with a way of urgency for a number of causes. Despite being a signatory to a number of global development strategies, alongside SDGs and determination to achieve a discount in Infant Mortality Rate (IMR) Ratio (MMR) by means of 2015. Pakistan suffered a prime toddler and maternal mortality and insufficient well-being care amenities with top populations expansion as compared to other regional international locations.

Economic Survey of Pakistan 2010-11 showed that we have infant mortality rate 63.6 and the maternal mortality rate is 89 with the burden of disease and less health care facilities in fast urban development. In 2018 mortality rate is 69.3 which decreased with the passage of time. To achieve SGDs target in health mortality and morbidity are primary issues and we have lost grip on these issues. Pakistan has a mix of health facilities and now we have a declined ratio of mortality both maternal and infant. Pre School youngsters in the country have a deficiency of iodine, Zinc and, Vitamin A. Pakistan has made many buildings of hospitals, improved medical equipment, training services, increase bed facilities and increase the number of LHVs. Our life expectancy has also increased which was 59 years in 1990 and was 63 years in 2001. The purpose of this study was to find information on poverty and child mortality. We have tried to figure out the poverty and child mortality in Pakistan through this study. This study will help practitioners of health and related departments as well as enhance the role of NGOs in the immunization program.

2.   LITERATURE REVIEW

In the literature, we have added literature related to poverty and child mortality and tried to establish the link between poverty and child mortality through the literature.

Ali (1995) in his study explained the link and frequency of poverty in Pakistan.Arif (2000) studied the 1990s poverty rise and its effect on the families. He also studied the impact on household health and other life matters. A study of (Irfan & Amjad, 1984) analyzed that agrarian structure was the major reason for the 1990s poverty rise. Kemal (2003) has studied institutional development and their role in poverty reduction and economic growth. He concluded that public investment is an asset and enhance the capacity of production.

High prices of food always target the lower-income group and the poor. Inflation is the prime reason for poverty in Pakistan. Haq, Nazli, and Meilke (2008) has investigated the food prices and its effect on poverty. In rural areas, people who have no link to the agriculture sector are less productive (Adams & He, 1995). Hymer and Resnick (1969) have made a model broaden it and they explain how can they will be helpful in declining rural non- agricultural sectors. Few studies have tested work for rural non-farm poverty and (Arif, 2000) work explained the non-farm employment and rural poverty issues in Pakistan.

Poverty in depth minimizes the range of our needs discussed by (Anwar & Siddiqui, 2005). Ranis and Stewart (2000) responded to the (Hymer & Resnick, 1969) their model was once for that colonial era, and the assumption made within the type used to be now not appropriate universally. The rural nonagricultural sector is a powerful supply of secondary employment for the landless farmers (Anderson & Leiserson, 1980). Omotesho, Adewumi, and Fadimula (2008) tested the foremost determinants of food safety and poverty in some rural families who are the most important manufacturers of meals in Nigeria.

Agénor (2002) tested the context to which globalization affected the poor in developing international localities. He used a cross-country regression framework using unbalanced panel information for 30 growing countries. His result showed that there looked to be a somewhat powerful formed relationship between poverty and globalization. At low globalization, it hurt the poor. However, at higher rates, globalization results in a decline in poverty. Neutel and Heshmati (2006) showed the connection between globalization, poverty, and the source of revenue inequality. They took the information about 65 growing countries. Results from cross-sectional regression analysis confirmed that there was once a significant courting between globalization, poverty, and source of revenue inequality. Globalization resulted in poverty reduction, and it lowered income inequality.

Uthman (2008) has investigated the have the effect of low beginning weight on infant mortality. To read about the relationship between high-risk of an infant born with low delivery weight and toddler mortality in Nigeria. Birth weight is a powerful indicator not most effective of a beginning mom's wellbeing nutritional standing however and new kid's chances for survival, enlargement, long-term wellbeing, and psychosocial building. Low delivery weight strongly negatively associated with infant survival in Nigeria unbiased of different danger

elements. Huq and Tasnim (2008) investigated the maternal education and kid wellbeing care in Bangladesh. The writer investigated the influence of maternal schooling on well-being status and usage of kid healthcare services and products and merchandise in Bangladesh. He suggested that maternal training is an impressive necessary determinant of a child's effectively-being standing in Bangladesh. Chaudhury (2006) have investigated the district degree variations in infant mortality in Sri Lanka. The function of this paper was once as soon as to check the inter-district variation in infant mortality with regards to certain facets of monetary and vitamin status; get right of entry to health and use of health care. They conclude that the targeted consideration for neonatal survival can be the most important coverage imperative. Stock well (2005) have investigated kid mortality and socio-economic standing. This paper gifts the results of ecological research on the relationship between infant mortality and financial status. They concluded that whilst public health techniques are important, any progress in narrowing this lengthy status differential is not going unless ways discovered to make stronger the industrial wellbeing of the lower socio-economic groups.

Mahmood (2002) has investigated the determinants of neonatal and post-natal mortality in Pakistan. The survival and wellbeing of kids in a priority of families, communities, and countries all through the field. Father's coaching, mom's training, and their working status every variable effect on kid survival in rising countries. In Pakistan day by day breastfeeding culture is declining due to modernization effect. The nature of housing, water availability, sanitary facilities also play an important role in children's survival. Parental meetings with physicians and training can improve the status of mothers for postnatal time.

Gokhale, Rao, and Garole (2002) have investigated the baby mortality in India: the use of maternal and child neatly being products and services and products when it comes to literacy status. The researcher found out that gradual relief in infant mortality prices in an ultimate couple of decades is a big fear in India. The primary function of the creator was that the literacy of ladies strongly related to all variables with regards to maternal care and in addition to a toddler mortality rate.

Agha (2000) has investigated the determinants of infant mortality in Pakistan. We slowed the kid mortality worth down between 1960 to 1970. The author was as soon as also advised concerning the reasons for the bogged down in toddler mortality decline, like distributional problems which comprise a source of revenue, nutrition, schooling, housing, water, and sanitation inside and between areas. Women keep an eye on (autonomy) and their social and economic standing have very important implications for their children's wellbeing, gender; inequalities remain a very powerful determinant of kid mortality in Pakistan. Determinants of child mortality have investigated by (Terra de Souza et al., 1999). They discussed parental autonomy and other socio-demographic predictors.

Majumder, May, and Pant (1997) investigated the two heading about child mortality. One is socio-economic and the other is parental caching. They also checked how income, residence, the order of kid is associated with child mortality. A study conducted by (Gürsoy-Tezcan, 1992) has investigated about child mortality in Turkey. They try to find the mortality link in relatives but this is unexplained in a study at older ages. This factor of child mortality is associated with relatives and cultural conditions.

3.   DATA METHODOLOGY

The data collection, model specification, methodology and source of data discussed in detail. Time series data is collected for the analysis. The data collected to analyze the factors determining poverty and child mortality in Pakistan.

The headcount poverty greatly influenced by GDP growth, the number of hospitals and unemployment, consumer price index (CPI), and infant mortality significantly influenced by immunization, male literacy rate, female literacy rate and GDP growth.

3.1. Data Source

This paper is based on the secondary data, time series data has been used from (1980-2010). Data is collected from the "World Bank" and Economic Survey of Pakistan."

3.2. Variables Selection

This study has included indicators like, Consumer price index, GDP growth, number of hospitals and unemployment, female literacy rate, male literacy rate, and immunization as explanatory variables. Headcount (poverty) and infant mortality have been used as dependent variables.

Function
HD= f (CPI, GDP, HOS, UNEM)   (1)
IMR= f(FML,MLT,IMMU,GDP)   (2)

3.3. Variables

Dependent variables
HD= Headcount ratio (% population below poverty line)
IMR= Infant mortality rate

3.4. Explanatory Variables

CPI= Consumer price Index
GDP= Gross Domestic Product (annual %)
HOS= Number of Hospitals
UNEM= Unemployment rate
FML= Female literacy rate
MLT= Male literacy rate
IMMU= Immunization

3.5. Estimation

Ordinary Least Squares (OLS) has used for estimation. To estimate the unknown parameters we used the OLS. The resulting estimator can be expressed by a simple formula, especially in the case of a single repressor on the right-hand side. In the case of single repressor on the right hand side, the resulting estimator can be expressed by a simple formula.

In the regression process, the OLS estimator is optimal in the class of linear unbiased estimators when the errors are homoscedastic and serially uncorrelated and consistent when the regressors are exogenous and there is no multi co-linearity. OLS is the maximum likelihood estimator. Ordinary least square (OLS is used in econometrics as a one of simpler regression model. OLS main goal is to closely fit a data with function.

To check the significance of the factors determining poverty and infant mortality, we have regressed all these variables through Ordinary Least Square (OLS) method.

$$HD = \beta_0 + \beta_1 CPI + \beta_2 GDP + \beta_3 HOS + \beta_4 UNEM + \mu i \qquad (3)$$
$$IMR = \beta_0 + \beta_1 FLR + \beta_2 MLR + \beta_3 IMMU + \beta_4 GDP + \mu i \qquad (4)$$

4. RESULTS AND DISCUSSION

For the purpose of analysis we defined the regression models. We regressed the two dependent variables headcount, and child mortality. The results have shown in the tables given below with respect of the specification of the model.

4.1. Results of Model (1)

HD= f (CPI, GDP, HOS, UNEM)   (5)

4.1.1.Discussion of Results

As we took headcount as a dependent variable and CPI (Consumer price index), GDP growth, No. of Hospitals, and unemployment rate are explanatory variables. The Independent variables CPI (Consumer price index), GDP growth, No. of Hospitals, and unemployment rate are affecting the dependent variable headcount. CPI, GDP growth and unemployment rate show a positive relationship with the headcount ratio giving significant t-value. No. of Hospitals demonstrates a negative relation with the dependent variable headcount giving significant t-statistical value. R^2 has value of 0.52 that explained the explanatory power for headcount ratio by the independent variables. F-Statistics has largest value 7.06 and Prob. (F-statistics) 0.000550. Now, with this value in the model the explanatory variables have mutually significant influence on the headcount ratio. Durbin-Watson value is 1.4 that showed that overall results were good and significant.

Table 1
Results of OLS Model for Headcount

Model	Variables	Coefficient	t-value	Prob
01	CPI	0.070881	2.095480	0.0460
	GDP	.054668	3.318556	0.0027
	HOS	-0.030078	-2.014775	0.0544
	UNEM	1.999529	3.121379	0.0044
	C	27.97134	3.438665	0.0020
	Model Diagnostics			
R^2				0.52
Adjusted R^2				0.45
Durbin-Watson Stat				1.4
F-statistics				7.055
Prob. (F-statistics)				0.000

Source: World Bank, Economic Survey of Pakistan

4.1.2. Consumer price index (CPI)

The results in regression model showed that CPI (consumer price index) has positive influence on headcount and the t-statistical value is 2.095 and probability 0.05 showed the significance of the variable. This means if the CPI increases by 1 unit than the headcount (poverty) will also increase by0.07. If the CPI decreases the headcount will also decrease. Increases in the prices of the commodities discourage people to have basic necessities items. When people deprived of basic necessary goods there is high poverty in the country. On the other hand, if the prices are lower it will encourage the consumer to consume the goods and services. As a result, it will reduce poverty. The high CPI in Pakistan is said to be responsible for the high rate of poverty in the region.

4.1.3. GDP growth

The regression result printed that GDP growth has a positive impact on headcount and coefficient value is 0.05 and P value is 0.0027 which shows the significance of the variable. This approach if the GDP increase 1 unit in Pakistan than it will increase the headcount (Poverty) by 0.05 units. On the other hand, if the GDP growth will decrease the headcount will decline. The reason is this because in the case of Pakistan there is found highly inequality in the country which is responsible for the poverty. When the GDP growth ups it satisfies the only some people due to the inequality in the country that causes to enhance the poverty.

4.1.4. Number of Hospitals (HOS)

Health is very imperative for human being to earn their livelihood. The regression result shows that the number of hospitals has a negative impact on headcount and the coefficient value is -0.03 and probability 0.06 shows the significance of the variable. This means if the number of hospitals in Pakistan will increase by 1 unit than the headcount (Poverty) will reduce

by 0.03. On the other hand, if the numbers of hospitals will decreases the headcount will raise. Poverty and wellbeing is the likelihood for ill wellbeing to restrict an individual's ability to engage in paid paintings and hence cut back his or her income, even supposing she or he comes from an affluent background. If the number of hospitals is sky-scraping and people have the facility of hospitals they can get cured their disease easily and come in the race of the people who are earning their livelihood that will be beneficial for the growth of the economy. As a result, it will reduce poverty. Conversely, if there is not as much of a number of hospitals in Pakistan it will increase the headcount ratio.

4.1.5. Unemployment Rate (UNEM)

The regression result shows that the unemployment rate has positive impact on headcount and coefficient value is 1.9. Whereas, P value 0.0044 shows the significance of the variable. This means if the unemployment rate in Pakistan increases by 1 unit than the headcount (Poverty) will also increase by 1.9. If the unemployment ratio will decrease, the headcount may also decrease. The most sensible charge of unemployment in the country is answerable for the high poverty in Pakistan because if the persons are unemployed they have much less alternative to earn their livelihood.

4.2.   Results of Model 2

IMR= f(FLR, MLR,IMMU,GDP)   (6)

Table 2
Results of OLS Model for Infant Mortality

Model	Variables	Coefficient	t-value	Prob
2	FLR	-1.541011	-10.46162	0.0000
	MLR	-0.012808	-0.189550	0.8511
	IMMU	-0.143876	-2.157032	0.0404
	GDP	0.822272	2.476066	0.0201
	C	162.7576	46.54538	0.0000
	Model Diagonistics			
R^2				0.98
Adjusted R^2				0.97
F-statistics				227.52
Prob. (F-statistics)				0.0000

Source: World Bank, Economic Survey of Pakistan

In the second model, we have used IMR (infant mortality rate) as a dependent variable and the FLR (female literacy rate), MLR (male literacy rate), IMMU (immunization), and GDP as independent variables in our study.
From the results shown in table FLR, MLR, IMMU and GDP has effect on the dependent variable

IMR (Infant Mortality Rate). The results has been showing that FLR, MLR, IMMU have negative relationship with IMR. FLR, IMMU, GDP has significant relationship while MLR has no significant association with IMR. Only GDP has significant and positive relationship with IMR.

The value of R2 is zero.98 within the kid mortality rate explained by way of the explanatory variables integrated within the type. The higher value of F statistics shows that the explanatory variables incorporated in the type collectively have an important influence on child mortality.

4.2.1. Female Literacy Rate (FLR)

The regression result displayed that the feminine literacy have a destructive impact on child mortality and coefficient of female literacy is -1.54 and Prob value is 0.0000 this is significant. Results showed that if one unit FLR increases it will reduce IMR by1.54 unit. Literate female gives birth to a fit baby and the feel healthy themselves than illiterate female.

Moreover, literate mothers are much conscious to provide healthy environment and food nutrition to their babies. They have extra details about health care and they have greater influence inside the relative to take ill children for treatment. These characteristics are more likely to lead to decrease mortality of children at every under age 5.

4.2.2. Male Literacy Rate (MLR)

The result are presenting that male literacy rate negatively affects the infant mortality and the coefficient of male literacy rate is -0.01 and Prob value 0.85 that is insignificant. In Pakistan, male literate persons have no major role for child mortality because of parental work to earn their livelihood. They don't have any particular consequence proceeding juvenile mortality.

4.2.3. Immunization (IMMU)

The results confirmed that immunization is negatively affecting the infant mortality and the t-value of immunization is -2.16, coefficient value -0.14 and Prob value 0.0404 that is significant. If one unit of vaccine immunization increases it will decrease the IMR by 0.14 units. Vaccine-preventable illnesses had been a significant cause of morbidity and mortality. Punjab Primary health care department has made a schedule of vaccine plan to prevent from harmful diseases that helps the children to survive, thus mortality rate is decreasing.

4.2.4. GDP Growth Annual (%)

In the table GDP Growth rate annual has a positive relationship with the IMR and significant Prob value 0.02. This means if the GDP growth in Pakistan will increase 1 unit the child mortality will goes up 0.08 units. The reason is this because in the case of Pakistan there is found highly inequality in the country which is responsible for the poverty. When the GDP growth ups it satisfies the only some people due to the inequality in the country that causes to enhance child mortality.

5. CONCLUSION

Poverty and Poverty and low socioeconomic status have a profound effect on child health. Poverty caused infant mortality. Poverty has many ways to affect health. Income is necessary for everybody because it provides food, clothes and shelter and very important for health. Having money people become able to take part in society, otherwise has very serious consequences on people's lives, especially mental health. Poverty and low living standard have a profound impact on child health, and it is the major cause of infant mortality.

It is clear from the discussion that the headcount (poverty) rate is decreased by decreasing the consumer price index and unemployment. When CPI decreases the purchasing power of the people goes up and causes to reduce poverty. If the maximum people found employment it will reduce unemployment and people could earn their living and there will be less poverty in the country. GDP has a positive relationship and if it increases, then causes to increase the poverty due to unequal distribution of income in Pakistan. There is a larger income inequality gap between rich and poor people, and the benefit of GDP growth did not reach the poor. That is why poverty does not reduce.

Health is very essential for human beings to live in a society. The number of hospitals shows the significance associated with the headcount variable. People will find the facility to cure their disease if the number of hospitals increased as a result more labor force will be available to work and causes reducing poverty. By enhancing the number of hospitals, people will get employment.

For the aim of figuring out the factors of infant mortality, we used multiple regression models through the use of secondary data. Underdeveloped nations have failed in declining total mortality and experiencing a top infant and child mortality. About 10.8 million children

beneath age 5 are dying all over the world and 50% of those are passing away in Pakistan, India, China, Nigeria, the Democratic Republic of Congo, and Ethiopia reference.

Nowadays education is cheaper and almost free in government schools. Mother and father education is playing an important role in reducing infant mortality. Educated women are better at safeguarding their babies because they avoid traditional ways and pay routine checkup visits to qualified physicians. We have seen that if we improve the human capital of female that has a positive effect on reducing the infant mortality

Male literacy rate plays a role, but slightly, it has an insignificant role in reducing child mortality. We have used GDP growth as an independent variable that shows a significant positive relationship. This means if the GDP growth in Pakistan will increase, the infant mortality will go up. The reason is this because in the case of Pakistan there is found high inequality in the country which is responsible for infant mortality. When the GDP growth ups it satisfies only some people. due to the inequality in the country that causes to enhance the mortality.

Further, Immunization is negatively affecting infant mortality. Vaccination of children and injections during pregnancy are the main reasons for reducing child mortality and infant mortality.

Immunization is a very important variable. Despite, considerable gains in immunization coverage at least two million children die from vaccine-preventable diseases every year. Including more than a million from measles, 430000 from neonatal tetanus, and close to 400000 from per uses.refrence.

The explanation why is that because of Pakistan there discovered extreme inequality within the country accountable for the kid mortality. When the GDP expansion which satisfies only a few folks because of the inequality in the nation that reasons to make stronger the mortality. Immunization of the pregnant female displays a considerable impact in lowering toddler and kid mortality in Pakistan, whilst it gave the impression insignificantly related to neonatal mortality.

6.   POLICY RECOMMENDATIONS

- The role of NGOs should increase for better coverage and monitoring for immunization programs. They can help in a better way to locate migrant mothers and their children.
- It is necessary to increase tracking and communique methods to make certain that migrant mothers have to get entry to emergency services. It must strengthen public health awareness systems as part of its health promotion effort.

- Policymakers should pay special focus on stakeholders participation and feedback by society, physicians and NGOS to formulate the better policy of immunization.

- The parental education should be push upward, and motivation to mothers for safeguarding their children can play important role as well as awareness related to neonatal and post-natal can make a difference regarding child mortality.
- To improve the health condition of children, there should be a support of training for better child health and utilization of healthcare services in Pakistan.

Conflict of Interests/Disclosures
The authors declared no potential conflicts of interest w.r.t the research, authorship and/or publication of this article.

REFERENCES

Adams, R. H., & He, J. J. (1995). *Sources of income inequality and poverty in rural Pakistan* (Vol. 102): Intl Food Policy Res Inst.

Agénor, P.-R. (2002). *Does globalization hurt the poor?* : The World Bank.

Agha, S. (2000). The determinants of infant mortality in Pakistan. *Social science & medicine, 51*(2), 199-208.

Ahmad, O. B., Lopez, A. D., & Inoue, M. (2000). The decline in child mortality: a reappraisal. *Bulletin of the World Health Organization, 78*, 1175-1191.

Ali, M. S. (1995). Poverty assessment: Pakistan's case. *The Pakistan Development Review*, 43-54.

Anderson, D., & Leiserson, M. W. (1980). Rural nonfarm employment in developing countries. *Economic development and cultural change, 28*(2), 227-248.

Anwar, T., & Siddiqui, R. (2005). Prevalence of Relative Poverty in Pakistan [with Comments]. *The Pakistan Development Review*, 1111-1131.

Arif, G. (2000). Recent rise in poverty and its implications for poor households in Pakistan. *The Pakistan Development Review*, 1153-1170.

Chaudhury, R. H., Gunasekera. P (2006). *'District-level Variations in Infant Mortality in Sri Lanka: A Challenge to Achieving the Millennium Development Goals on Child Survival'.* Paper presented at the Regional Health Forum.

Gokhale, M. K., Rao, S. S., & Garole, V. R. (2002). Infant mortality in India: use of maternal and child health services in relation to literacy status. *Journal of Health, Population and Nutrition*, 138-147.

Gürsoy-Tezcan, A. (1992). Infant mortality: a Turkish puzzle? *Health Transition Review*, 131-149.

Haq, Z. u., Nazli, H., & Meilke, K. (2008). Implications of high food prices for poverty in Pakistan. *Agricultural Economics, 39*, 477-484.

Huq, M. N., & Tasnim, T. (2008). Maternal education and child healthcare in Bangladesh. *Maternal and Child Health Journal, 12*(1), 43-51.

Hymer, S., & Resnick, S. (1969). A model of an agrarian economy with nonagricultural activities. *The American Economic Review, 59*(4), 493-506.

Irfan, M., & Amjad, R. (1984). Poverty in rural Pakistan. *Poverty in Rural Asia, Bangkok: ILO/ARTEP*.

Kemal, A. R. (2003). Institutional change, growth, and poverty levels in Pakistan. *The Pakistan Development Review, 42*(4), 299-311.

Mahmood, M. A. (2002). Determinants of neonatal and post-neonatal mortality in Pakistan. *The Pakistan Development Review*, 723-744.

Majumder, A. K., May, M., & Pant, P. D. (1997). Infant and child mortality determinants in Bangladesh: Are they changing? *Journal of Biosocial Science, 29*(4), 385-399.

Neutel, M., & Heshmati, A. (2006). Globalisation, inequality and poverty relationships: a cross country evidence.

Omotesho, O., Adewumi, M. O., & Fadimula, K. (2008). *Food security and poverty of the rural households in Kwara State, Nigeria*. Retrieved from

Ranis, G., & Stewart, F. (2000). Strategies for success in human development. *Journal of human development, 1*(1), 49-69.

Stock well, E. G., Goza, W.F and Balistreri, K.S (2005). *"infant mortality and socioeconomic status: Family and demographic research"*.

Terra de Souza, A. C., Cufino, E., Peterson, K. E., Gardner, J., Vasconcelos do Amaral, M., & Ascherio, A. (1999). Variations in infant mortality rates among municipalities in the state of Ceará, Northeast Brazil: an ecological analysis. *International Journal of Epidemiology, 28*(2), 267-275.

Uthman, O. A. (2008). Effect of low birth weight on infant mortality: analysis using Weibull hazard model. *Int J of Epidemiol, 6*(1), 8.