Antenatal Care: Accessibility Issue among Pakhtun Women in Malakand, Pakistan

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ABSTRACT

OBJECTIVE: To analyze the effect of socio-demographic and cultural factors in restricting Pakhtun women for antenatal health care in Malakand District.

STUDY DESIGN: A cross sectional survey research design.

PLACE AND DURATION: Household survey was conducted in District Malakand Khyber-Pakhtunkhwa, from 1st May to 30th November, 2016.

METHODOLOGY: Socio-demographic characteristics (age of women, women education, husband education, women occupation, monthly family income, and family type), and cultural factors (authority to make family planning decision, authority to make household decision, authority to decide maternal health care services, visit to outdoor) were taken as independent variables while antenatal care visits was taken as dependent variable.

RESULTS: Overall, more than 53% of the respondents had inappropriate antenatal care visits during their last pregnancy. Nearly 50% pregnant women preferred home as a place for antenatal care services. Majority (88%) women are confined to domestic sphere by men family members. Similarly, 76% women have limited decision making in maternal health care access and treatment. The respondent shared that 70% of the women faced physical violence during pregnancy and 31% of the women are restricted from outdoor mobility.

CONCLUSION: The women education, occupational status, and husband's education were key socio-demographic factors restricting women to access antenatal healthcare in Malakand District.

KEYWORDS: Women, Antenatal Care, Accessibility, Pregnancy, Pakhtun Culture. Education, Decision Making Authority

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INTRODUCTION

Antenatal care accessibility is a reproductive health right guaranteed to all mothers. Antenatal care is the basic component for better maternal health care[1]. In 2008, it is estimated that 358,000 women died worldwide from prenatal, delivery and postpartum complications[2]. A report published by WHO, 400 maternal deaths occurred globally per 100,000 live births in which 99 percent of maternal deaths were reported from developing countries with 86 percent in Sub-Saharan Africa and South Asia[3]. According to Pakistan Demographic and Health Survey (2012-13), Maternal Mortality Rate is 276/100,000 live births[4] in Pakistan. The maternal mortality proportion is likely to be 500 mortalities per 100,000 live births in Pakistan[4].

The world acknowledges high maternal mortality in Pakistan where most of the poor maternal health outcome occurs at the time of pregnancy and delivery[5]. In Khyber-Pakhtunkhwa, nearly 40 percent of women received antenatal care from unskilled birth attendants in both urban and rural areas while 44 percent mothers received antenatal care from Traditional

Birth Attendants TBA in rural areas. Similarly, the study area (Malakand district) has one of the highest maternal mortality rates which are 276 per 100,000 live births[4].

To find out factors responsible for maternal mortality in developing countries, research studies focused on the availability of health services, structural factors and geographical accessibility to health services[6].

In Pakistan, the research has been conducted on the initiatives taken by the government to reduce maternal mortality. However, limited academic scholarship is available to support the hypothesis that socio-cultural factors also contribute in the prevalence of high maternal mortality. It is believed that lack of women autonomy is a major contributing factor to poor accessibility among the pregnant women at the time of antenatal care visits.

The indigenous informal rules limit women autonomy on family resources, freedom to access and utilize public health services[7,8]. More importance is given to the willingness of husbands and other family elders to determine women accessibility to health facilities[9]. Cosnquently, their subordinate status prevents them from recognizing and voicing their health issues within families[10].

Like other traditional societies, Pakhtun women prefer to assume traditional roles of housewife and avoid outdoor activities[11]. Generally, they are not allowed to go outside the home without any male companion. Furthermore, their mobility becomes a subject matter of family honor and pride. Being pregnant women, they face this problem more strictly because movement of pregnant women in a public is taken as shameful act. Their husband, mother in law and other family members have the authority to decide about their accessibility to health care facility during the duration of pregnancy and delivery[12]. In most of cases, family prefer to seek consultation of a Dai to confirm pregnancy, and its related matters[13].The primary reason of giving preference to Dai because she keep privacy of pregnant women, take nominal money for delivery and also regularly visits during and after pregnancy to look after the mother. This situation becomes worst in the rural areas[14].The study area mostly consists of rural areas. Due to remote settings, women of this district are in more trouble in accessing antenatal care during pregnancy. Married women in Pakhtun society are facing serious maternal health care issues during pregnancy, delivery and postpartum period. Besides structural barriers and poor infrastructure, there are various socio-cultural factors which are mainly responsible for maternal mortality and morbidity in study area. The main objective of present study is to know the socio-demographic and cultural factors restricting Pakhtun women accessibility for antenatal health care in Malakand District.

METHODOLOGY

This cross-sectional household survey was conducted at District Malakand, Khyber-Pakhtunkhwa over a period of seven months form 1st May to 30th November, 2016. A total of 503 ever-married women were included. The criteria for inclusion in this study was ever-married women, having delivery in last twelve months or currently pregnant and permanently resided in the study area. The criteria for exclusion in this study was with women temporary resided in the area and had no pregnancy or delivery

The researcher used systematic approach and selected every fourth union council of a total of twenty eight in District Malakand. Then, the study participants were selected randomly from eight union councils who fulfilled inclusion criteria and gave verbal informed consent. Sample size calculation was performed using the proportionate method. In Pakhtun society men are not allowed to interact with women therefore, three Leady Health Visitors (LHV) were hired and trained on tool and process of data collection. Study participants' demographics were obtained and for assessment the accessibility of antenatal care to health facility a validated questionnaire from Pakistan Demographic and Health Survey (PDHS), which contained both the multiple-choice questions and open-ended questions were employed. This questionnaire is very effective tool for studying the maternal health care condition. After every five years in the country a PDHS is conducted on the employed questionnaire. The antenatal care in the questionnaire was measured with two categories appropriate (04) visits and inappropriate (Less than 04) visits during pregnancy. Inappropriate visits were coded as 0 while the appropriate visits were coded as 01. Similarly, all the cultural variables were divided into two categories.

Data Analysis: All data were analyzed through SPSS version 21.0. Categorical variables were reported through frequencies and percentages and odd ratio and confidence interval were calculated for quantitative variables. The logistic regression test was used to find out the association of accessibility of antenatal care to health facility with other independent variables.

RESULTS

Out of 503 respondents, majority of them 56.9% (n=503) were above than 30 years. More than fifty percent 53.7% (n=503) women had no or incomplete primary education and almost one third 31.2% (n=503) of the respondents had secondary education. Likewise, their husband did not have higher level of education. More than eighty percent of the respondents performed traditional roles of housewife and they also belonged to the lower class of the society.

The results revealed that educated women had more appropriate antenatal care visits and uneducated women had inappropriate antenatal care visits. The odds ratio of uneducated women was 14.858 times higher than the women having education (OR 14.858, CI: 9.504-23.228). This shows that women qualification was significantly associated with number of antenatal care visits ($p<.05$).

The findings indicted that husband's education also had a role in determining antenatal care. As shown in Table I, 192 (86.3%) respondents, their husbands were educated, reported appropriate antenatal care visits as compared to 107 (42.6) respondents, their husbands were uneducated, had inappropriate antenatal care visits. The odds ratio of uneducated husbands was 4.92 times higher than the husbands

having education (4.920, CI: 3.094-7.822). This shows that husband's education was significantly associated with number of antenatal care visits (p<.05). While comparing results for women occupation, it was found that housewives had more inappropriate visits (87.3%) as compared to employed women. The odds ratio of housewives was 3.960 times higher than employed women (OR. 3.960, CI: 2.497-6.278).

It was found that if the husbands were against family planning then women had inappropriate antenatal care services (84.9%) and if the husbands were in favor of family planning then women had appropriate antenatal care services (70.6%). The odds ratio of husband against family planning was 2.343 times greater than husband not against the use of family planning method (OR 2.343, CI: 1.481-3.708).

Regarding decision to visit outdoor, the analysis indicated those respondents (33.6%) who jointly took this decision had more appropriate antenatal care visits. If husband took the decision to visit outdoor, the findings indicated that women had more inappropriate antenatal care visits (76.7%) in comparisons with appropriate antenatal care visits (66.4%).

The findings indicated that the women, who reported about physical violence, had more inappropriate antenatal care visits as compared to those women who did not face physical violence. The odds ratio of women who faced physical violence was 3.803 times greater than who did not physical violence (CI: 2.584-5.597).

In the selected population, statistically significant difference was found with number of antenatal care visits among women with total mobility restriction having inappropriate antenatal care services (31.0 vs. 12.2%) compared to those who have appropriate antenatal care visits. The odds ratio of totally restricted women from mobility was 3.213 times higher to women had lesser mobility than men in Pakhtun society (OR 3.213, CI: 1.914-5.391).

Table-I: Socio-Demographic characteristics association with antenatal care visits (N=503)

Socio demographic characteristics	Antenatal Care Visits		OR, 95% CI	P. Value
	Appropriate visits	Inappropriate visits		
	N (%)	N (%)		
Women's Education				
Uneducated	48 (21.7%)	202 (80.5%)	14.858 (9.504-23.228)	.000
Educated	173 (78.3%)	49 (19.5%)	1.00	
Women's age				
15-30 years	107 (48.6%)	93 (37.5%)	1.00	.015
Above than 30 years	113 (51.4%)	155 (62.5%)	1.578 (1.091-2.282)	
Husband's Education				
Uneducated	29 (13.1%)	107 (42.6%)	4.920 (3.094-7.822)	.000
Educated	192 (86.9%)	144 (57.4%)	1.00	
Women's Occupation				
Employed	81 (36.7%)	32 (12.7%)	1.00	.000
House wife	140 (63.3%)	219 (87.3%)	3.960 (2.497-6.278)	

Table-II: Association of cultural factors with antenatal care visits of reproductive Age (15-49) Years (N=503)

Cultural Factors	Antenatal Care Visits		OR, 95% CI	P. Value
	Appropriate visits	Inappropriate visits		
	N (%)	N (%)		
Husband against family planning				
Yes	154 (70.6%)	203 (84.9%)	2.343 (1.481-3.708)	.000
No	64 (29.4%)	36 (15.1)	1.00	
Decision to visits outdoor				
Husband	142 (64.3%)	222 (88.4%)	4.259 (2.649-6.847)	
Jointly	79 (35.7%)	29 (11.6%)	1.00	.000
Decision making for maternal health care				
Husband	142 (66.4%)	181 (76.7%)	1.669 (1.103-2.525)	.015
Jointly	72 (33.6%)	55 (23.3%)	1.00	
Decision making in household purchases/affairs				
Husband	96 (43.4%)	158 (62.9%)	2.212 (1.529-3.200)	.000
Jointly	125 (56.6%)	93 (37.1%)	1.00	
Physical violence during pregnancy				
Yes	85 (39.0%)	175 (70.9%)	3.803 (2.584-5.597)	.000
No	133 (61.0%)	72 (29.1%)	1.00	
Mobility Restriction				
Lesser than men	172 (87.8%)	145 (69.0%)	1.00	.000
totally restricted	24 (12.2%)	65 (31.0%)	3.213 (1.914-5.391)	

DISCUSSION

This study revealed socio-demographic and cultural factors affecting antenatal care of Pakhtun pregnant women. The results of current study were aligned with previous studies conducted in Pakistan, Indonesia, India and Nepal[4, 15]. A research study conducted by Adam and Salihu, identified that low literacy levels, confinement of women to the domestic sphere with limited mobility promotes poor maternal health[16]. Similarly, husband's education reveals a similar pattern[15]. Husband's permission to use health services is also reported as a barrier to use of institutional delivery by women[15]. An International report also supports the findings of this study[17].

In developing countries from studies conducted on women who lived in the hills it was observed that a majority (70%) not involved in decision making process regarding domestic issue including access to maternal health care services due to which they are forced to take services from unskilled persons at home[8]. In developing countries it is focused by many researchers that women are treated as inferior in household affairs[11]. The studies explained that the weak position of women within the house restricts them for antenatal care and postnatal care services at home from unskilled personnel[18]. Similarly studies found that lack of women autonomy and inferior status has perilous impact on their maternal health care[19].

In Pakistani society the factor of restricted mobility affects women's maternal health care[20]. In some developing countries it is found that men control the finances and decide about women outdoor mobility which badly affect as maternal health. Early marriages are a custom that still prevails in Pakistan, Nepal and India. These early marriages cause maternal death[21]. Research study found that early marriages highly prevail in KPK which not only restricts women's right to education rather their health is badly affected when they become pregnant[22].

Several studies find out that men are key decision makers in all household affairs in developing countries like Pakistan. They decide about women access to maternal health care services for pregnancy and child birth. Traditionally this comes under the authority of husband and older women. Many research studies in Pakistan found that women had limited access to outdoor world which affects the access to maternal health care services [23].

CONCLUSION

This study indicated that women education, occupational status, and husband's education were key socio-demographic factors restricting women to access antenatal healthcare in Malakand District.

LIMITATIONS

This is a cross-sectional study. Other longitudinal studies would be conducted to confirm the present conclusions. Moreover, the sample was taken from one district in Khyber-Pakhtunkhwa, Pakistan. Thus, the findings must be tested in other districts of the province.

CONTRIBUTION OF AUTHORS

Ali H: Conceived idea, Designed research methodology, data collection and Manuscript writing
Ali A: Statistical Analysis and Interpreted data
Mehmood K Q: Manuscript writing and Data collection
Jalal A: Data collection
Ali R: Final approval

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