



Women's Subordinate Position: The Determinant of Home Delivery in Khyber-Pakhtunkhwa

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ABSTRACT

In Pakistan the Maternal Mortality Rate (MMR) is 276/100,000 live births. The high maternal mortality in the country is acknowledged worldwide which occur during pregnancy and delivery time. The overall objective of this research was to study the women's position within the household in Pakhtun society as determinate to home preference for delivery. In the present study researcher used the quantitative research design in which the data were collected through household survey technique from (n=503) ever-married women having reproductive age (15-49 years) by using interview schedule. In the present study SPSS was used for data analysis and binary logistic regression was applied to draw the association between place of delivery and women's position in the Pakhtun society. The results shows that majority (80%) of the women prefer home delivery due to their inferior position within household. Similarly, majority (88%) Pakhtun women prefer to stay in home for their delivery due to their dependency on husband decision. The research study results concluded that women subordinate position and limited decision making in the domestic sphere are greatly responsible for home delivery which is a cause of high MMR in the study area. This study recommended that to achieving Sustainable Development Goal No. 3 and reducing MMR in the study area it is necessary to empower women in the decision making about accessing and utilization of maternal health care services and given financial autonomy to them in the study area.



Introduction

According to World Health Organization (WHO) estimates 358,000 pregnant women died due to complications in prenatal, delivery and postpartum period (Prata, 2011). Globally the deaths are 400/100,000 live births occurred annually (Shah, 2007; WHO, 2007) with 99 percent in the developing countries having 86 percent in Sub-Saharan Africa and South Asia (Nour, 2008). In Pakistan the MMR is 276/100,000 live births which estimated the maternal mortality proportion is 500/100,000 live births in the country (NIPS, 2013). Nearly one fourth percent pregnant women died due to postpartum hemorrhage few hours after delivery, one third percent in the first week of delivery and nearly fifty percent within first twenty four hours of postpartum (WHO, 2005).

According to world estimates 53 million pregnant women delivery take place without professional health service provider (WHO, 2012) in which nearly fifty percent are attended by *Traditional Birth Attendant* (TBA). Similarly, a study conducted in Thailand stated, that approximately fifty percent of the delivery attended by *Traditional Birth Attendant* (TBA) at home despite the availability of health facilities and services in the local community with very minimum financial cost (Ishikawaa, 2002). There is strong home delivery preference among the women in developing countries especially in rural mountains regions (Hassan, 2012). Several studies conducted in *Sindh* the province of Pakistan highlighted that *TBA* performing very harmful practice at the time of delivery such as massaging vagina with herbal oil and medicine (Fikree, 2004 & Fatmi, 2005). According to three delay model accessibility and utilization of maternal health care services is one of the major factors to high MMR in Pakistan.

World Health Organization (WHO) stated about three core factors which contribute to poor maternal health outcome and mortality in the developing countries (WHO, 2012). There is less attention paid to women socio-economic status and they are confined to domestic sphere for delivery due to their low status and limited decision making (WHO, 2012). A study conducted in Pakistan highlighted that women mobility during pregnancy is shameful for male family members therefore they are restricted to four wall for delivery which are attended by TBA (Mumtaz, 2007). It is very alarming situation that due to women subordinate position in home they having *No Say* to decide about her maternal health care accessibility and utilization in health facility without the approval of men family members (Shaikh, 2005). The men are in the dominant position in home and women are compelled to obey the decisions taken by their male family members (Ahmed, 2000; Shabbir et al., 2019). Several studies find out that checkup by male health service provider is one of the factors which determine the home delivery preference attended by *TBA* in the developing countries (UN, 2008 and AbouZahr, 2003). In the developing countries generally women having no income generating activity therefore men family members prefer home delivery because of less financial cost and even *TBA* in some cases accept the in kind material as a service charges for attending delivery. Women pregnancy are considered the sign of sham therefore men prefer the *DAI* services for attending delivery as she will kept the privacy of women and also available in postpartum period for offering massage and baby washing services (Sumaiya, 2008). Therefore, the present study was conducted to highlight the women subordinate position variables in the study area as a determinate of home delivery preference by herself and men family members.

Data and Methods

The three delay model was applied in the present study as theoretical model. The quantitative data were collected through interview schedule from ever married women having reproductive age (15-49 years). In the present study the data were collected from n=503 respondent. The researcher translated the interview schedule to local language to collect data from the respondents. The study

was conducted in *Khyber-Pakhtunkhwa* province of Pakistan is one of the high maternal mortality rate (MMR) reported province in the country (NIPS, 2013). The data were collected from women having current pregnancy or given delivery in the last twelve months and reside permanently in the study area. Due to cultural sensitivity and women confinement to domestic sphere the data were collected through Lead Health Visitors (LHVs). Before field activity LHVs were trained and orient about the project objectives and significance of the study. The verbal consent was taken from the respondent to ensure their privacy and confidentiality as written consent was not permitted by their men. SPSS software was used for data analysis and the researcher applied binary logistic regression to study the relationship between place of delivery as dichotomous outcome and women subordinate position as independent variable. In the present study delivery was measured with place of delivery while the women subordinate position at household was measured from inferior status of women, mobility restriction, early marriage preference, *purdha* restriction, intimate partner violence, decision making for maternal health care, decision making in household purchases/affairs and decision to visits outdoor socialize.

Results

Table 1 indicates the socio-demographic characteristics of married women aged 15-49 years. Among the total 503 respondents nearly half 43.1% of the women fall in the age bracket of 15-30 years, and more than fifty percent (56.9%) were in the age of more than 30 years. The data was collected from 99% married women, among these married women 90.3% responded regarding their husband's that are living with them. Interestingly, more than one-third (40%) married at the age bracket 14-18 years, 45% in the age of 19-23 years and only 2% above than 28 year of age. More than fifty percent (53.7%) women had no or incomplete primary education, nearly one third 31.2% had secondary education and only 15% had passed intermediate. Similarly, among husband's 31% had no or incomplete education, 40% had passed secondary and more than one-fourth 27% passed intermediate. It is interesting to share, majority 80% women had reside in plain while minimum 9% in mountainous area. The results shows, majority 81% doing nothing as a work and only engaged in routine domestic unpaid work while only 18% doing different paid work. Most of the respondent were in poor condition and nearly one-fourth had only income between 40000-50000 Rs/M while minimum 9.7% had income more than Rs. 50000/M. As the study conducted in *Paktun* society which is mostly reside in joint family structure. The present study also indicted, majority 87.6% were reside in joint family system while few 9.3% in nuclear family system. Majority 98% *Pushto* had their mother tongue.

Table 1: Socio-Demographic characteristics of currently married women aged 15-49 years

Characteristics	Frequency	(%)
Age of women (years)		
15-30	215	(43.1)
>30	288	(56.9)
Marital Status		
Married	498	(99.0)
Widow	2	(.4)
Divorced	3	(.6)
Husband living with you or not		
Living with her	454	(90.3)
Staying elsewhere	49	(9.7)
Marriage age		
14-18	201	(40.0)
19-23	229	(45.5)
	3304	

24-28	63	(12.50)
>28	10	(2.0)
Women education		
None or Incomplete primary education	270	(53.7)
Secondary level	157	(31.2)
Intermediate and above	76	(15.1)
Husband education		
None or Incomplete primary education	156	(31.0)
Secondary level	210	(41.7)
Intermediate and above	137	(27.2)
Area of residence		
Plain	406	(80.7)
Mountains	49	(9.7)
Semi Plan	48	(9.5)
Women Occupation		
Employed	91	(18.1)
House wife	412	(81.9)
Monthly income in Rs.		
1-10000 Rs	64	(12.7)
10001-20000 Rs	83	(16.5)
20001-30000 Rs	119	(23.7)
30001-40000 Rs	65	(12.9)
40000-50000Rs	122	(24.3)
>50000Rs	49	(9.7)
Type of family		
Nuclear	47	(9.3)
Joint	441	(87.6)
Extended	15	(2.9)
Mother Tongue		
Pushto	493	(98.0)
Other Than Pushto	10	(2.0)

Table No. 02 indicates the association between women subordinate position and place of delivery in *Pakhtun* society. In the selected population, statistically significant difference was found with place of delivery among women with their inferior status in *Pakhtun* society has delivered their child in home (80.6% vs. 64.0%) compared to those who have institutional delivery in hospital. By applying binary logistic regression the odd ratio of women inferior status than men in *Pakhtun* society is 2.331 time higher than women superior status to men (OR 2.331, CI 95% 1.546-3.514). This shows that there is statistical significant association between the women status in *Pakhtun* society and place of delivery (P-value .000). In the selected population, statistically significant difference was found with place of delivery among women with their total restricted mobility in *Pakhtun* society delivered their child in home (27.6% vs. 16.9%) compared to those who have institutional delivery in hospital. By applying binary logistic regression the odd ratio of totally restricted women from mobility is 1.873 times higher than women are less mobile than men in *Pakhtun* society (OR 1.873, CI 95% 1.61-3.022). This shows that there is statistical significant association between women mobility restriction and place of delivery (P-value .010). In the selected population, statistically significant difference was found with place of delivery among women with their subordinate position in family as main reason for marriage in 18 or less than 18

year of age in *Pakhtun* society has delivered their child in home (55.4% vs. 41.3%) compared to those who have institutional delivery in hospital. By applying binary logistic regression the odd ratio of women subordinate position in *Pakhtun* family is 1.764 times higher than women with no right to choose her life partner (OR 1.764, CI 95% 1.219-2.552). This shows that there is statistical significant association between the reason of early marriages and place of delivery (P-value .003). In the selected population, statistically negative significant difference was found with place of delivery among women with *purdha* restriction has delivered their child in home (64.0% vs. 58.9%) compared to those who have institutional delivery in hospital. By applying binary logistic regression the odd ratio of women with *Purdha* restriction is statistical negative significance and association between *purdha* restriction and place of delivery (P-value .251). In the selected population, statistically significant difference was found with place of delivery among women who facing physical violence in *Pakhtun* family has delivered their child in home (66.0% vs. 42.3%) compared to those who have institutional delivery in hospital. By applying binary logistic regression the odd ratio of women having physical violence during pregnancy is 2.657 times higher than women having no physical violence (OR 2.657, CI 95% 1.831-3.856). This shows that there is statistical significant association between women physical violence during pregnancy and place of delivery (P-value .000). In the selected population, statistically significant difference was found with place of delivery among women with decision making by husband in household purchase in *Pakhtun* family has delivered their child in home (62.3% vs. 43.3%) compared to those who have institutional delivery in hospital. By applying binary logistic regression the odd ratio of decision by her husband is 2.164 times higher than decision taken jointly (OR 2.164 CI 95% 1.502-3.116). This shows that there is statistical significant association between decisions making in family matter and place of delivery (P- valve .000). In the selected population, statistically significant difference was found with place of delivery among women with their husband decision about women access to maternal health care in *Pakhtun* family has delivered their child in home (76.4% vs. 64.2%) compared to those who have institutional delivery in hospital.

By applying binary logistic regression the odd ratio of decision taken by husband is 1.809 time high than decision jointly (OR 1.809, CI 95% 1.206-2.713). This shows that there is statistical significant association between household decision making authority and place of delivery (P-value .004). In the selected population, statistically significant difference was found with place of delivery among women with their husband decision about women restriction from outdoor mobility in *Pakhtun* family has delivered their child in home (88.8% vs. 64.5%) compared to those who have institutional delivery in hospital. By applying binary logistic regression the odd ratio husband decision about use of family planning method is 4.363 time higher than family planning decision taken jointly (OR 4.363, CI 95% 2.725-6.986). This shows that there is statistical significant association between family planning decision making and place of delivery (P-value .000).

Table No. 02 Women's Subordinate Position association with place of delivery

Women's Subordinate Position association with place of delivery				
Women's Position	Place of delivery		OR, 95% C.I	P. Value
	Hospital facility Frequency, %	Home Frequency %		
Status of women				
Inferior than men	139 (64.1)	216 (80.6)	2.331 (1.546-3.514)	.000
Equal to men	78 (35.9)	52 (19.4)	1.00	
Mobility Restriction				

Lesser than men	157 (83.1)	165 (72.4)	1.00	
Totally restricted	32 (16.9)	63 (27.6)	1.873 (1.161-3.022)	.010
Early marriage Preference				
Women subordinate position	86 (41.3)	143 (55.4)	1.764 (1.219-2.552)	.003
No right to choose	122 (58.7)	115 (44.6)	1.00	
Purdha Restriction				
Yes	123 (58.9)	169 (64.0)	1.244 (.857-1.806)	.251
No	86 (41.1)	95 (36.0)	1.00	
Intimate partner violence				
Yes	90 (42.3)	175 (66.0)	2.657 (1.831-3.856)	.000
No	123 (57.7)	90 (34.0)	1.00	
Decision making in household purchases/affairs				
Husband	94 (43.3)	167 (62.3)	2.164 (1.502-3.116)	.000
Jointly	123 (56.7)	101 (37.7)	1.00	
Decision making for maternal health care				
Husband	131 (64.2)	198 (76.4)	1.809 (1.206-2.713)	.004
Jointly	73 (35.8)	61 (23.6)	1.00	
Decision to visits outdoor socialize				
Husband	140 (64.5)	238 (88.8)	4.363 (2.725-6.986)	.000
Jointly	77 (35.5)	30 (11.2)	1.00	

Discussion

The present study reveals that women subordinate position in the family including inferior status of women, mobility restriction, early marriage preference, *purdha* restriction, intimate partner violence, decision making for maternal health care, decision making in household purchases/affairs and decision to visits outdoor socialize are significantly associated with place of delivery among *Pakhtun* pregnant women. Similarly, a research study conducted in Pakistan highlighted that *Pakhtun* women mobility are restricted which contribute to poor maternal health and home delivery (Ahmed, 2004). In the developing countries majority of the women (70%) reside in rural mountains areas are not involved in decision making about her access to maternal health care facilities in the area and they are compiled to be attended by *DAI/TBA* in home (Jokhio, 2005). A study conducted in *Malakand* Pakistan stated that *Pakhtun* women are treated subordinate and

inferior in household affairs with no or limited decision making (Naz, 2011). A recent study explained about the women weak position and their restriction to domestic sphere due to which they take delivery in home by unskilled personnel (Iyayi, 2009). Many researchers found that women subordinate position and lack of autonomy negatively affect the women maternal health care condition (Bhutta, 2004). Early marriage preference and practice is one of the major contributors to poor maternal health care among pregnant women in Pakistan, India and Nepal (Nasrullah, 2014). In the study area early marriage preference and practice still prevail which not only reduce the women access to education and other basic services rather increase the maternal mortality in the study area (Perveen, 2009). In the developing countries including Pakistan most of the decisions regarding household purchase, access to maternal health care services and using the family planning method are taken by men (Kadir, 2013; Fatmi, 2005). Similarly, a study conducted in Pakistan highlighted that women are not permitted to access public sphere without the consent of her men family member due to which they prefer home delivery (Fatimi, 2005). The women with their need for accessing and utilization of institutional maternal health care services face intimate partner violence. The intimate partner violence (IPV) was highlighted in various other research studies which has significant association with poor maternal health outcome and home delivery in the traditional societies (Pallitto, 2013; Cripe, 2008; Pallitto, 2005).

Conclusively it is stated that women subordinate position in the family including inferior status of women, mobility restriction, early marriage preference, *purdha* restriction, intimate partner violence, decision making for maternal health care, decision making in household purchases/affairs and decision to visits outdoor socialize are significantly associated with place of delivery among *Pakhtun* pregnant women. *Pakhtun* society is patriarchal in its nature where according to the study, women are treated as inferior than men and their mobility is restricted from the public sphere. In the study area, women are married off at an early age and because of their subordinate position in the family they have no say in selection of life partner. It is very alarming to share that women are facing both physical and psychological violence during pregnancy in *Pakhtun* society due to which they are compelled to prefer home delivery. The study recommend to overcoming the issue it is mandatory to involve women in public sphere activities and empower them to take equal part in the domestic decision making process especially in relation to their maternal health care. Similarly, this is the responsibility of concern authorities to design the public health programmes and strategies with full involvement of the men family members.

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