PUBLIC PERCEPTION REGARDING ACCEPTABILITY PROBLEMS IN UTILIZATION OF MATERNAL HEALTH SERVICES IN PAKHTOON SOCIETY WITH REFERENCE TO DIR LOWER

Ubaid Ullah**,** M.Phil. Scholar Department of Rural Sociology, Agriculture University Peshawar-Pakistan
Intikhab Alam, Department of Rural Sociology, Agriculture University Peshawar-Pakistan
Shahid Iqbal, Center for Disaster Preparedness & Management, University of Peshawar
Saima Sarir**,** Department of Rural Sociology, Agriculture University Peshawar-Pakistan
Sudhair Abbas, Department of Pharmacy, Sarhad University of Science and IT, Peshawar

Abstract. *The study was conducted in Dir lower with special reference to public perception regarding hurdles in utilization of maternal health services. The sample size of the study was 186 respondents, who were selected randomly. The data was analyzed through simple percentage and frequencies, while to see association between independent variable acceptability problems with dependent variable maternal health. Women confronted acceptability issue in availing maternal health services like; women are not encouraged to visit maternal health center, people fear of disclosing of privacy, discouragement of Lady health workers, strict purdah system, unable to decide child birth, child birth by traditional birth attendant and lack of education about antenatal and post-natal care, during pregnancy, childbirth and after birth. Due to cultural norms like purdah, women are not permitted to utilize maternal health care during pregnancy due to fear of disclosure of privacy, they perform domestic, Lady health workers are not encouraged to facilitate women during pregnancy, inability to decide child birth and preferring child birth at home by traditional birth attendant are the problems in shape of acceptability. Mass media, religious, political leaders, civil society should create awareness regarding maternal health issues to overcome the degraded maternal health situation.*

Keywords: Maternal Health, Acceptability, Purdah System, Cultural Norms, Traditional Birth Attendant

Introduction

According to WHO (2014) "Maternal health refers to health of women during pregnancy, childbirth and the postpartum period". Maternal death or mortality is when woman die during gestation or delivery. Maternal mortality is pivotal to let us know about the health condition of population and social and economic growth of society. Due to gestation and childbirth related complications about 800 women die daily (WHO, 2014). Majority, 99% maternal deaths occur in developing countries, which shows a high gape between developed and developing countries. The ratio of mortality in the context of developing countries is especially high in low resource rural setup. Globally, about 287,000 women died from reasons associated with being pregnant and baby birth in 2010. Of those, 162,000 have been in Sub-Saharan Africa and 83,000 were in South Asia. The ratio of maternal deaths in advanced countries are 16 per 100,000, the ratio in same context is 220 in south Asia and 500 in Africa (WHO, 2014).

Pregnant women can face death anytime, however, the time of delivery is more sensitive for both mom and infant (Medecins Sans Frontieres, 2012). Delivery by professional person can easily control complications to minimize mother child deaths. Delivery in hospital can prevent mother and child from dying, 42 percent births take place outside the hospitals in growing nations and 35 percent births are not attended by skilled persons. Moreover, 80 percent births take place outside the hospitals in less advanced nations like Nepal, Afghanistan, Bangladesh and Ethiopia (UNICEF, 2012).

Infant mortality ratio is 78 per 1,000 live births. This ratio of skilled delivery in Pakistan is 23 %, in India it is 43 %, and 97 % in Malaysia and Sri Lanka. This is a big hurdle for Millennium Development Goal to achieve the target of controlling maternal and infant mortality (UNDP ,2005; World Development Report 2010; MHHD Report 2004).

Services insufficiency, economic disability, distance, illiteracy, and traditional practices are hurdles in way of getting maternal health care (WHO & UNICEF, 2012). There is a big difference between advanced and developing countries in provision of maternal health care services, there are 0.4 beds to 0.2 beds approximately per thousand people respectively in less developed countries, while the ratio of doctors per thousand people is 6 and 3 in developing countries respectively. Money spend on maternal health care in low income nations is 26.8 dollars per capita, this expenditure is 224 US dollars in middle income countries, 382 dollars per capita is in top middle-

income countries and 4,879 dollars is in high income states (The World Bank, 2010). Accessibility is a primary aspect of "health for all" as focused in Alma Ata declaration, but there are various social and economic hurdles in way of getting full maternal health care (Sunil et al, 2006; Ram and Singh, 2006).

Many policies have been adopted to overcome these socio economic and infrastructural hurdles in way of providing proper maternal health care, women health utilization is highly influenced by social, cultural and financial factors whose degree range from community level to individual (Griffiths & Stephenson, 2001; Ram & Singh, 2006). These influencing factors are unequal allocation of health services, lack of infrastructural bodies, and lack of human resources. It is undoubtedly proven that maximum utilization of health services and delivery by professional persons has positive impact on women health (Bloom et al, 1999).

A massive range of women are unable to use the health services because of unknown reasons and have child birth in the absence of professional person (WHO & World health report, 2005). A huge frame of evidence on factors contributing to terrible delivery service utilization throughout the region comes from quantitative research, which continually record physical and economic barriers as well as low social reputation of women as crucial barriers (Ronsmans and Graham, 2006). Different researches emphasize traditional beliefs and socio-cultural effects on use and non-use of health care facilities in growing nations (Jafarey, Kamal and Qureshi, 2008; WHO, 2010). This warrants an in-depth understanding of the multiple elements that restrict use of available maternal healthcare services within the local context, especially in rural regions and specializes in the beliefs, perceptions and knowledge regarding being pregnant and delivery and how health care seeking behavior among pregnant women is conditioned in rural Pakistan.

Hall (2001) and Gilson (2003) defines trust as the positive acceptability of a happening event where the trustier believe that the trusty will care for the trustier interests, which are probably based on affective response. Competence, Honesty, and integrity are the major components of trust. Walt (1990); Macinko and Starfield (2001) and Goudge and Gilson (2005) argues that, community health workers are in local residency where they do their jobs, so they need community support. Though they are not always accepted and trusted when they perform on the basis of history, previous performance and other problems. If they have low knowledge about the situation, then they will not be able to provide good care to people, which will cause the mistrust in the community towards them, which can lead to demoralization of community health workers and failure of the program.

Kumar and Chaturvedi (2012) stated that, the gender variations and discrimination has usually been a trouble of challenge in presenting and utility of health care facilities in growing nations specifically in low income countries. The health expenditure is considered costly consisting of physician fee, medicines, surgical treatment if wanted and transportation cost. Relatively women are less prioritized in the context of health care provision as compared to men. So, we can say that women face more health problems in financial sphere, which has negative influence on mother and child.

Shariff and Singh (2002); Mullany, Becker, and Hindin (2007) mentioned that, earlier investigations perceive that the man centric nature of most Asian social orders imply that women role is not static, and they are expected to perform various roles at one time. Male association in regenerative medicinal services use is, accordingly, progressively perceived. Ladies with instructed life partners have a tendency to use antenatal care, safe conveyance and postnatal care all the more viably.

Elo (1992); Celik and Hotchkiss (2000); Amin et al. (2010); and Singh et al. (2012) are of the opinion that, an intriguing perception is that education has an immediate and backhanded impact on result factors. While schooling expands ladies' health learning, the intellectual aptitudes obtained at school increment their capacity to evaluate and acclimatize data and increment their load of health information even they are at home. However, notwithstanding the acknowledged significance of training for maternal wellbeing, most investigations have neglected to recognize the basic component through which ladies' schooling influences their health-seeking behavior.

Some exceptions are Elo (1992); Celik (2000); and Levine et al. (2004), who contend that education changes family unit flow and alters ladies' beliefs to such an extent that educated ladies are better ready to process information. Be that as it may, while talking about the conceivable means through which ladies' training influences their wellbeing looking for conduct, they don't experimentally test any such instrument.

Thomas et al. (1991); Glewwe, (1999) and Kovsted et al. (2002) argue that, the later writing on child health supports the education– wellbeing nexus. The exact proof recommends that a significant part of the training impact converts into health looking for conduct through the health learning that ladies amass with the assistance of the proficiency and numeracy abilities they gain at school.

Attachment theory assumptions and relevance to maternal health services

Attachment theory was popularized by Bowlby, 1969. This theory can be called relevant on the basis of notion that women cannot utilize maternal health services because of cultural values, high level of illiteracy among pregnant women who are mostly poor and in the rural areas. (Bowlby, 2008).

Objectives:

1) To study the acceptability problems in utilization of maternal health services in the sampled area
2) To measure the association between independent variables (acceptability) with dependent variable utilization of maternal health services
3) To suggest policy recommendations on the basis of study findings

RESEARCH METHODOLOGY

The study was carried out in Tehsil lal Qila Dir Lower Women from different age groups, educational backgrounds and different socio-economic status were selected. Total population of potential respondents with said characteristics came out to be 186 Sekaran (2003) simplified the sample size decision process, for multiple variables, by providing a table that greatly simplify the decision of sample size and ensure good decision model. A conceptual framework was devised, a well-structured interview schedule was constructed on the analogy of Likert scale were asked accordingly from the respondents. The dependent variable (maternal health) was indexed and cross tabulated with independent variable (acceptability) to measure the association. Chi-square test outlined by Tai (1978) at bivariate level statistic was used.

Results and discussions:

Acceptability Problems

Table described that majority 83.9 respondents reported that pregnancy appreciated in their community. These findings are similar to the study of Shariff and Singh, (2002); Mullany, Becker, and Hindin, (2007). Moreover, 79.0 percent respondents argued that women perform domestic work during pregnancy. These results are in line with Shariff and Singh (2002).

Table-1 Acceptability Problems in The Study Area

S#	Statement	Yes	No	Uncertain	Total
1	Is pregnancy appreciated in your community	156 (83.9)	13 (7.0)	17 (9.1)	186 (100)
2	Are women in your family permitted to attend/visit hospital for maternal health care	76 (40.9)	96 (51.6)	14 (7.5)	186 (100)
3	Are women allowed to decide child birth	65 (34.9)	112 (60.2)	9 (4.8)	186 (100)
4	Are women educated about antenatal and post natal care	47 (25.3)	74 (39.8)	65 (34.9)	186 (100)
5	Do women perform domestic work during pregnancy	147 (79.0)	19 (10.2)	20 (10.8)	186 (100)
6	Is purdah system a hurdle in utilization of maternal health	117 (62.9)	67 (36.0)	2 (1.1)	186 (100)
7	Do you prefer child birth at home by traditional birth attendant	109 (58.6)	71 (38.2)	6 (3.2)	186 (100)
8	Lady health workers are encouraged to facilitate women during pregnancy	43 (23.1)	129 (69.4)	14 (7.5)	186 (100)
9	Do you think privacy is disclosed when you visit maternal health center	134 (72.0)	48 (25.8)	4 (2.2)	186 (100)

Source: survey, 2018

Furthermore, 72.0 percent respondents reported that privacy is disclosed when they visit maternal health center. These findings are supported by Gilson (2003) and Hall (2001). In addition, 69.4 percent respondents mentioned that lady health workers are not encouraged to facilitate women during pregnancy. These results have similarity with Walt, (1990); Macinko and Starfield (2001); and Goudge and Gilson, (2005). Furthermore, 62.9 respondents reported that, veil (Purdah) system is a hurdle in utilization of maternal health services. These findings are in line with Kumar and

Chaturvedi (2012). Moreover, 60.2 percent respondents described that, women are not allowed to decide child birth. These results are supported by the preceding review. Furthermore, 58.6 percent respondents described that they prefer child birth at home by traditional birth attendant. These results are similar with Gilson (2003). Moreover, 51.6 percent respondents described that, women are not permitted to attend/visit hospital for maternal health care. These findings are in line with the report of PDHS (2007). Furthermore, 39.8 percent respondents argued that, women are not educated about antenatal and post-natal care. These findings are supported by Amin et al. (2010) and Singh et al, (2012).

Acceptability Problems and Maternal Health

Table -2 showed that, pregnancy is appreciated in community is found highly significant P≤ (0.000) with maternal health. These results are in line with Shariff and Singh (2002) and Mullany and Becker, (2007). Moreover, women in family permitted to attend/visit hospital for maternal health care was found significant (P≤0.034) with maternal health. These results are supported by PDHS (2007). Furthermore, women allowed deciding child birth was found not significant (P≥0.632) with maternal health. These findings are in line with Gilson (2003). Moreover, women are educated about antenatal and post natal care was found not significant (p≥0.732) with maternal health. These outcomes are in line with Amin et al. (2010) and Singh et al. (2012). In addition, Women perform domestic work during pregnancy was highly significant (P≤ (0.000) with maternal health. These findings are supported by Hindin (2007).

Moreover, purdah system is a hurdle in utilization of maternal health service was found significant (P≤ 0.065) with maternal health. These findings are similar to Kumar and Chaturvedi (2012). In addition, preferring child birth at home by traditional birth attendant was found highly significant P≤ (0.000) with maternal health. These results are supported by Gilson (2003). Similarly, Lady Health workers are encouraged to facilitate women during pregnancy was found not significant (P≥0.598) with maternal health. These outcomes are in line with (Walt, 1990; Macinko&Starfield,2001). In addition, privacy is disclosed when visit to maternal health center was found highly significant (Þ≤ 0.000) with maternal health. These results are supported by Hall (2001).

Table-2 Association Between Acceptability Problems and Maternal Health Services in The Sampled Area

S#	Statements	*Responses*	*Yes*	*No*	*Uncertain*	*Total*	*Statistics*
1	Pregnancy is appreciated in community	Yes	81(43.5)	75(40.3)	0 (0.0)	156(83.9)	$x^{2=}$94.482 P=0.000
		No	0 (0.0)	13(7.0)	0 (0.0)	13(7.0)	
		Uncertain	0 (0.0)	5(2.7)	12(6.5)	17(9.1)	
2	Women in your family permitted to attend/visit hospital for maternal health care	Yes	76(40.9)	0 (0.0)	0 (0.0)	76(40.9)	$x^{2=}$98.203 P=0.034
		No	5(2.7)	91(48.9)	0 (0.0)	96(51.6)	
		Uncertain	0 (0.0)	2(1.1)	12(6.5)	14(7.5)	
3	Women allowed to decide child birth	Yes	65(34.9)	0 (0.0)	0 (0.0)	65(34.9)	$x^{2=}$ 131.304 P=0.632
		No	16(8.6)	93(50.0)	3(1.6)	112(60.2)	
		Uncertain	0 (0.0)	0 (0.0)	0 (0.0)	9(4.8)	
4	Are women educated about antenatal and post natal care	Yes	47(25.3)	0 (0.0)	0 (0.0)	47(25.3)	$x^{2=}$98.773 P=0.732
		No	34(18.5)	40(21.5)	0 (0.0)	74(39.8)	
		Uncertain	0 (0.0)	53(28.5)	12(6.5)	65(34.9)	
5	Women perform domestic work during pregnancy	Yes	81(43.5)	66(35.5)	0 (0.0)	147(78.0)	$x^{2=}$92.457 P=0.000
		No	0 (0.0)	19(10.2)	0 (0.0)	19(10.2)	
		Uncertain	0 (0.0)	8 (4.3)	12(6.5)	20(10.8)	
6	Veil (Purdah) system a hurdle in utilization of maternal health	Yes	81(43.5)	36(19.4)	0 (0.0)	117(62.9)	$x^{2=}$166.581 P=0.065
		No	0 (0.0)	57(30.6)	10(5.4)	67(36.0)	
		Uncertain	0 (0.0)	0 (0.0)	2(1.1)	2(1.1)	

7	You prefer child birth at home by traditional birth attendant	Yes	81(43.5)	28(15.1)	0 (0.0)	109(58.6)	$x^{2=}$186.479 P=0.000
		No	0 (0.0)	65(34.9)	6(3.2)	71(38.2)	
		Uncertain	0 (0.0)	0 (0.0)	6(3.2)	6(3.2)	
8	Lady health workers are encouraged to facilitate women during pregnancy	Yes	43(23.1)	0 (0.0)	0 (0.0)	43(23.1)	$x^{2=}$169.217 P=0.598
		No	38(20.4)	91 (48.9)	0 (0.0)	129(69.4)	
		Uncertain	0 (0.0)	2 (1.1)	12(6.5)	14(7.5)	
9	You think privacy is disclosed when you visit maternal health center	Yes	81(43.5)	53(20.5)	0 (0.0)	134(72.0)	$x^{2=}$117.692 P=0.000
		No	0 (0.0)	40(21.5)	8(4.3)	48(25.8)	
		Uncertain	0 (0.0)	0 (0.0)	4(2.2)	4(2.2)	

Source: Survey, July 2018

Conclusion and recommendations:

Women confronted acceptability issue in availing maternal health services like; women are not encouraged to visit maternal health center, people fear of disclosing of privacy, discouragement of Lady health workers were strict purdah system, unable to decide child birth, child birth by traditional birth attendant and lack of education about antenatal and post natal care, during pregnancy, childbirth and after birth. Due to cultural norms like purdah system, women are not permitted to utilize maternal health care during pregnancy due to fear of disclosure of privacy, they perform domestic, Lady health workers are not encouraged to facilitate women during pregnancy, inability to decide child birth and preferring child birth at home by traditional birth attendant are the problems in shape of acceptability. These conclusions are in line with attachment theory (Bowlby, 2008). Mass media, religious, political leaders, intellectuals and educational institutions should create awareness regarding maternal health issues to overcome the degraded maternal health situation.

References

Ali, M., Bhatti, M. A., & Kuroiwa, C. (2008). Challenges in access to and utilization of reproductive health care in Pakistan. *J Ayub Med Coll Abbottabad*, *20*(4), 3-7.

Bloom, S. S., Lippeveld, T., & Wypij, D. (1999). Does antenatal care make a difference to safe delivery? A study in urban Uttar Pradesh, India. *Health policy and planning*, *14*(1), 38-48.

Celik, Y., & Hotchkiss, D. R. (2000). The socio-economic determinants of maternal health care utilization in Turkey. *Social science & medicine*, *50*(12), 1797-1806.

Elo, I. T. (1992). Utilization of maternal health-care services in Peru: the role of women's education. *Health transition review*, 49-69.

Gilson, L. (2003). Trust and the development of health care as a social institution. *Social science & medicine*, *56*(7), 1453-1468.

Griffiths, P., & Stephenson, R. (2001). Understanding Users' perspectives Of Barriers to Maternal Health Care Use In Maharashtra, India. *Journal of biosocial science*, *33*(3), 339-359.

Hall, M. A., Dugan, E., Zheng, B., & Mishra, A. K. (2001). Trust in physicians and medical institutions: what is it, can it be measured, and does it matter? *The milbank quarterly*, *79*(4), 613-639.

Jafarey, S., Kamal, I., Qureshi, A. F., & Fikree, F. (2008). Safe motherhood in Pakistan. *International Journal of Gynecology & Obstetrics*, *102*(2), 179-185.

Kumar, K & Chaturvedi, A. (2012). *Some Recent Developments in Statistical Theory and Applications*: Selected Proceedings of the International Conference on Recent Developments in Statistics, Econometrics and Forecasting, University of Allahabad, India, December 27-28, 2010: Universal-Publishers.

LeVine, R. A., LeVine, S. E., Rowe, M. L., & Schnell-Anzola, B. (2004). Maternal literacy and health behavior: a Nepalese case study. *Social science & medicine*, *58*(4), 863-877.

Frontieres, M. S. (2012). *Urgent delivery maternal death: the avoidable crisis*. Tech. Rep.

Mullany, B. C., Becker, S., & Hindin, M. J. (2006). The impact of including husbands in antenatal health education services on maternal health practices in urban Nepal: results from a randomized controlled trial. *Health education research*, *22*(2), 166-176.

Ram, F., & Singh, A. (2006). Is antenatal care effective in improving maternal health in rural Uttar Pradesh? Evidence from a district level household survey. *Journal of biosocial science*, *38*(4), 433-448.

Ronsmans, C., Graham, W. J., & Lancet Maternal Survival Series steering group. (2006). Maternal mortality: who, when, where, and why. *The lancet*, *368*(9542), 1189-1200.

Shariff, A., & Singh, G. (2002). *Determinants of maternal health care utilisation in India: evidence from a recent household survey* (No. 85). New Dehli: National Council of Applied Economic Research.

Sunil, T. S., Rajaram, S., & Zottarelli, L. K. (2006). Do individual and program factors matter in the utilization of maternal care services in rural India? A theoretical approach. *Social science & medicine*, *62*(8), 1943-1957.

World Bank. (2010). World development indicators database.

Thomas, P. (2013). The midwife you have called knows you are waiting... A consumer view. In *Failure to Progress* (pp. 38-56). Routledge.

UNDP. Human Development Report. New York, 2005.

UNICEF. (2012). "*Maternal and newborn health*," Young Child Survival and Development, The United Nations Children's Fund

Walt, G., Heggenhougen, K., Knudsen, T., Owuor-Omondi, L., & Perera, M. (1990). *Community health workers in national programmes: just another pair of hands?* L. Gilson (Ed.). Philadelphia: Open University Press.

World Health Organization, & Unicef. (2014). *Trends in maternal mortality: 1990 to 2013: estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division: executive summary* (No. WHO/RHR/14.13). World Health Organization.

WHO, U. (2012). Countdown to 2015: building a future for women and children. *Geneva: World Health Organization and UN Children's Fund*.

World Health Organization. The world health report; Make every mother and child count, Geneva. 2005.