MATERNAL HEALTH CARE SEEKING BEHAVIOR IN WOMEN OF KHYBER PAKHTUNKHWA

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ABSTRACT

Objective: *To determine the maternal health care-seeking behavior amng women of Khyber Pakhtunkhwa.*

Materials and Methods: *This was a cross-sectional study using self-administered questionnaire to examine the maternal wellbeing care pursuing behavior of the women. The sampling technique used was random multistage sampling for 3320 females of seven districts of urban and rural areas of Khyber Pakhtunkhwa started from Feb 2016 to March 2017.SPSS version 22 was used for analysis.*

Results: *Most of the pregnant women preferred doctors for the last delivery of their child (20.9%), (14.2%) preferred Trained Traditional Birth Attendant, (5.0%) visited Nurse or Midwives, the delivery of (2.3%) pregnant females were attended by their Relatives/Friends, (1.8%) deliveries were made by LHWs, and LHVs were preferred by (0.8%) females.*

Conclusion: *Most pregnant women preferred doctors for delivery, Trained Traditional Birth Attendant, Nurse or Midwives, Relatives/Friends, LHWs, and LHVs.*

Keywords: *Maternal, Health Care Seeking, Behavior*

INTRODUCTION

The progress in creating pregnancy and child-bearing harmless for women and reducing levels of maternal mortality, Statistics remain subtle, approximately 525, 000 women, remain to die every year after maternal causes, roughly all from developing countries. Maternal mortality ratio in Pakistan is around 250/ 100,000 live births.[1] "Three delays" "framework of factors that affect safe motherhood service utilization and outcomes: delays in making the decision to seek care, in reaching a medical facility and in receiving adequate treatment or management at the facility.[2]"

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According to a study in Pakistan additional than one-third of females were not familiar with the reason of their stated illness. Women are usually not allowed in making the choice to spend money on health care.[3] Pakistan is second largest country in South Asia with people of 207.5 million (2014 estimation),[4] which makes Pakistan the sixth most thickly colonized country in the universe. Although, if we see the human development paradigm among 169 countries, it is ranked at 125th number.[5] However, the Developmental Index for Humans (HDI) of Pakistan used to be 0.346 in 1975. Since then, it has enhanced to 0.490 in 2010, but this is very slow development.[5,6] Pakistan's health system is consisting of private and public sectors.[7] The public sector consists of a broad network of hospitals, rural wellbeing centres, basic health divisions and dispensaries. While in the private sector, side by side with some certified hospitals and outlets, there is a rapidly increasing escalation of bonesetters,

herbalists, Grecoe Arab healers, traditional/spiritual healers, homoeopaths, medical general practitioners and above all frauds.[8]

On healthcare, the Government of Pakistan devotes 2% of the gross domestic creation (2006 estimate) that was 0.8% in 1998/1999, although augmented but is still lesser than other countries of South Asia especially Bangladesh (3.2% in2006).[9] A wide range of studies have been conducted in the context of the emerging world examining the consequence of autonomy of women and their reproductive health results. Results of the studies shown that desired fertility and lower family size are experienced amongst women with greater levels of autonomy[10] and amongst women with more decision-making authority, inferior rates of child mortality were experienced.[11] To create the health care system more reachable and responsive to women mainly in developing countries, this study may help to progress a rational rule to provide well-organized, real, acceptable, affordable and accessible facilities. The current study was targeted to investigate demographic plus socioeconomic connectivity of the maternal health-seeking behaviours among general female population in urban and rural areas of (seven 7) districts in the Khyber Pakhtunkhwa province of Pakistan, with the ultimate goal to address the needs of specific population groups and identify communal determinants for a better maternal health policy and health system improvement.

MATERIALS AND METHODS

Data was collected from seven districts of Khyber Pakhtunkhwai.e. Abbottabad, Swabi, Malakand, Kohat, Haripur, Dera Ismail Khan and Bannu. The sample size includes the rural and urban population of Khyber Pakhtunkhwa. All the seven districts were selected as study settings. This was a cross-sectional study started from Feb 2016 to March 2017. The study population was all the females of seven districts of province Khyber Pakhtunkhwa. Our target population was all the married women of reproductive age of these districts.Multistage sampling method was used for this study. Calculated sample size was set to be 3320, using 50% prevalence based on recommendations of World Health Organization (WHO). All the women of child bearing age 16 and above, were included in the study. Those women who were not willing to participate were excluded from the study.The sampling frame comprises 1933 enumeration blocks in urban parts and 7337 villages in rural parts. Primary sampling units (PSUs) are included in sample frame covering 313 PSUs of urban areas and 748 in rural areas; creating1061 figure PSU size. Secondary sampling units (SSUs) will rely on real listing of all PSU by skilled staff of field; 12 households SSUs will be chosen from all urban PSU, creating a figure of 3756 SSUs (households) from urban parts and 16 households SSUs will be chosen from all rural PSU, creating a households SSUs of 11,968 from rural areas. This will create a last sample size which is3320 households.Data from 3320 completed questionnaires were entered and analysed in SPSS version 22.0. Descriptive statistics were performed to generate frequency tables for all the variables. Data results were displayed in the form of plain text, tables. To summarize, it was a cross-sectional study using a self-administered questionnaire to assess maternal health care-seeking performance in women of Khyber Pakhtunkhwa. The sampling technique used was random multistage sampling for 3320 females, young/old and middle age females from seven districts of Khyber Pakhtunkhwa. Multistage sampling method was used to select our sample. The selected sample size was 3320, calculated on 50% prevalence according to World Health Organization (WHO) sample size calculator.

RESULTS

The total number of respondents are 3320 in which number of respondents from Abbottabad are 411 (13.3%), Swabi 606 (18.3%), Malakand 498 (15.0%), Kohat 510 (15.4%), Haripur 402 (12.1%), Dera Ismail Khan 516 (15.5%) and from Bannu 347 (10.5%). 2114 (63.7%) are from rural areas and 902 (27.2%) from urban areas. The remaining 304 respondents did not mentioned the type of area.

The results show that out of 2244, 2128(64.1%) females reported pregnancy and only 116 (3.5%) females were not pregnant. 1324 (39.9%) females did regular checkup during pregnancy.

The results show that most of the pregnant women preferred doctors for the last delivery of their child 964 (20.9%), 472 (14.2%) preferred Trained Traditional Birth Attendant, 167 (5.0%) visited Nurse or Midwives, the delivery of 76 (2.3%) pregnant females were attended by their Relatives/Friends, 59

(1.8%) deliveries were made by LHWs, and LHVs were preferred by 28 (0.8%) females.

Table Number 4.29 shows that most of the deliveries of pregnant women attended at home i.e. 788 (23.7%). Public Sector Hospitals were preferred by 445 (13.4%) females, 105 (3.2%) females preferred Private Hospitals, 89 (2.7%) visited Private Clinics, the delivery of 50 (1.5%) pregnant females were done at Midwife/LHV Homes, 33 (1.0%) deliveries were made at other Public Sector maternity homes.

DISCUSSION

For women, to have better health outcomes, many researches and strategies have remained based on the hypothesis that if females are more involved in family unit choice making and encompass additional control on economic resources, they will be addition alliable to use maternal health care facilities. Our

Table 1: Maternal Health

Pregnancy		
Status	**Number**	**Percentage**
Yes	2128	64.1
No	116	3.5
Total	2244	67.6
During Pregnancy Checkup		
Status	**Number**	**Percentage**
Yes	1324	39.9
No	119	3.6
Total	1443	43.5

Table 2: Child Delivery

Last Delivery attended by		
Status	**Number**	**Percentage**
Doctor	694	20.9
Nurse or Midwife	167	5.0
LHV	28	.8
LHW	59	1.8
Trained Traditional Birth Attendant	472	14.2
Relative/Friend	76	2.3
Other	5	.2
Total	1501	45.2

Table 3: Place of Delivery

Place of Delivery		
Status	Number	Percentage
At Home	788	23.7
Public Sector Hospital	445	13.4
Public Sector Health Centre or Clinic	19	.6
Other or Public Sector	33	1.0
Private Hospital	105	3.2
Private Clinic	89	2.7
At Midwife/LHV Home	50	1.5
Other	9	.3
Total	1538	46.3

survey displays that only 40% pregnant females of province Khyber Pakhtunkhwa were privileged to get antenatal care. The result can be compared to the statistics for other parts of country.[12] Answers of our study show that doctors could provide only 21% of maternal care, 14%by a Trained Traditional Birth Attendant and 5% by either a Nurse or Midwife.

It is significant to perceive here that most women availed maternal healthcare from doctor at home, but skilled traditional birth attendants provide their services in most of deliveries in Khyber Pakhtunkhwa. The quality of maternal health care studies is in the lowest limit range associated to average value for maternal healthcare use for the development in countries.[13] The extremely strong relationship between education of women and the usage of maternal health care services recommends that the geographic and financial convenience of facilities is not the only aspect. The link of education with women illustrates our concentration to the broader gender system which operates beyond the family circle might influence the maternal health concern. There are many directions of grounds that may clarify this strong effect. Previous studies conducted in Asia has advised that this relationship might be because of in any case partially to a development of new attitudes and values that are favourable in using the contemporary maternal health care.[14]

In a study it was revealed that even if females knew about their complications of obstetric, several of them chose to not pursue maternal care due to the expected receiving of poor quality maternal care.[15] All types of medicines, together with listed medicines could be purchased over the counter in Pakistan, as in most other developing countries, without a prescription. In Pakistan, it is also frequent for the pharmacologist to propose or "prescribe" a treatment, and this is categorized as self-medication. Additionally, people continue to buy medicines that were prescribed before. In the favour of this behaviour, people argue that because self-medication decreases the load on medical professionals and reduces the price of healing, it should be relaxed the constraints on access to drugs.[16]

Pregnancy information was collected retrospectively from women who have previously given birth to a child. To minimize recall bias, information was gained about the woman's previous (most recent) pregnancy. The importance of women's autonomy and independence related to her husband and family, that abundant in reproductive health literature, is not as appropriate to this culture as a whole and ignores mandatory aspects of women's experience. Amendments to improve the social, mental & economic status of women can help recover maternal, prenatal and perinatal care in rural and urban areas of Khyber Pakhtunkhwa, Pakistan.

CONCLUSIONS

The results show that most of the pregnant women preferred doctors for the last delivery of their child 964 (20.9%), 472 (14.2%) preferred Trained Traditional Birth Attendant, 167 (5.0%) visited Nurse or Midwives, the delivery of 76 (2.3%) pregnant females were attended by their Relatives/Friends, 59 (1.8%) deliveries were made by LHWs, and LHVs were preferred by 28 (0.8%) females.

RECOMMENDATION

With this intricate image of maternal health system use and health search performance in Pakistan, a more coordinated effort is required to design health promotion campaigns through intersectoral teamwork that emphases more on vulnerable segments of the population. So, a comprehensive health care system should emphasis on the rural population that develops visible only when the programs are signed with international donors; as well as the urban population that suffers consistently its own burden of morbidity attributed to the contaminated urban setting.

REFERENCES

1. Fraser A, Kamal M, Watkins K. The cost of childbirth: how women are paying the price for broken promises on aid. J Ox Int. 2004 April; 1 – 29
2. Thaddeus S, Maine D. Too far to walk: maternal mortality in context. Soc Sci Med. 1994; 38(8): 1091-110.
3. Shaikh T, Hatcher J. Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers. J pub health. 2004;27(1):49-54.
4. Ali F, Sami F, Rehman H, Siddique I. Relation of gender education and health seeking behaviour of the general population regarding psychiatric illness. JPMA. 2006; 56(9): 421-2.
5. Qureshi A, Morkve O, Mustafa T. Patient and health system delays: health-care seeking behaviour among pulmonary tuberculosis patients in Pakistan. JPMA. 2008;58(6):318.

6. Hakim F. Role of health systems research in policy, planning, management and decision-making, with reference to Pakistan. Eestern Meditteranean Health Journal. 1997; 3(3): 556-566.

7. Shaikh T, Haran D, Hatcher J. Where do they go, whom do they consult, and why? Health-seeking behaviors in the northern areas of Pakistan. Q Health Res. 2008;18(6):747-55.

8. Ferroni M. World development report-knowledge for development: The World Bank. 1999; 1-266. https://openknowledge.worldbank.org/handle/10986/5981

9. Mason K. The impact of women's social position on fertility in developing countries. Sociological forum. 1987; 2(4): 718-719.

10. Dharmalingam A, Philip S. Women's work, autonomy, and birth control: Evidence from two south Indian villages. Population Studies. 1996;50(2):187-201.

11. Demographic P. Health Survey, Islamabad. NIPS. 2013; 1-366. http://int.search.myway.com/search/GGmain.jhtml

12. Fatmi Z, Avan B. Demographic, socio-economic and environmental determinants of utilisation of antenatal care in a rural setting of Sindh, Pakistan. Journal of Pakistan Medical Associations . 2002;52(4):138-42.

13. Kazi S, Sathar Z. Gender and development: searching for explanations for fertility changes in rural Pakistan. Physician Desk Reference. 1997; 415-432.

14. Maine D, Akalin M. The design and evaluation of maternal mortality programs. Center for Population & Family Health. 1997; 1-171 https://www.ncbi.nlm.nih.gov/books/NBK222105/

15. Cargill D. Self-treatment as an alternative to rationing of medical care. The Lancet. 1967;289(7504):1377-8.