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Gendered Barriers to Safe Motherhood: Women's Social Status and Place of Delivery in Khyber Pakhtunkhwa

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ABSTRACT

According to Global Gender Gap Index-2025, in Pakistan the maternal mortality is 155 in 100,000 live births and still 32 percent of births are attended by other than skilled health service personals. In the present study social status of women and gender role is investigated to explain place of delivery in Buner, Khyber Pakhtunkhwa. Researchers used quantitative research design with probability sampling method to select 500 married women. The researchers used cluster and simple random sampling techniques to divide study locale. The researchers used interview schedule to conduct household survey through female research assistants in the area. Descriptive and inferential statistics are used to explain the results. In results 28.7 percent women shared that last delivery take place in home and other than a health facility. Among the respondent's 76 percent shared that women are treated inferior to men in family. The cross tabulation shows that decision taken by husband with home as place of delivery (OR 4.007, 95% CI (1.218-13.182) with significant level is .022. The study concluded that due to gendered barriers safe motherhood is a challenge in the study locale.

Introduction

Maternal health refers to a woman's overall health throughout pregnancy, delivery, and the postpartum period, according to the (Chou, 2016). Bergström (2016) defines maternal health as the state of being healthy during pregnancy, birth, and afterwards. Maternal health is concerned with women's well-being and health, particularly while they are pregnant, conceiving a child, and raising a kid. Maternal health includes antenatal care, labor, and the postpartum period (Aderoba, 2022).

According to Global Gender Gap Index-2025, in Pakistan the maternal mortality is 155 in 100,000 live births and still 32 percent of births are attended by other than skilled health service personals (WEF, 2025). According to a report of United Nations Population Fund published in 2019, the Maternal Mortality Rate (MMR) in Pakistan is 178 per 100,000 births (UNFPA, 2020). The high mortality rate in Pakistan is linked with the poor maternal health care utilization. According to a report of Pakistan Demographic and Health Survey (PDHS) (2018), 49% of pregnant women have fewer than the standard antenatal care visits. A report by National Institute of Population Studies (NIPS, 2018) revealed that 34% of pregnant women in Pakistan deliver the child at home and other places than hospital. A report revealed that 86% of women got antenatal care treatment from a Skilled Health Service Provider, among which the majority (82%) of the services were provided by doctors (NIPS, 2019). However, a rise in ANC utilization from a trained provider has been observed, increasing from 26% in 2012/13 to 86 percent in 2017/18. The report also shows that women who live in urban areas have more chances of receiving ANC from a qualified provide as compared to women who live in rural region (94 % vs. 82 %). The report further indicates that 22% of births in Pakistan occurred in government-run hospitals.

Studies show a significant difference between urban and rural areas of Pakistan in terms of the location or setting of deliveries (Zakar, 2017). It is revealed that 42% of childbirth in Sindh takes place at home in rural areas, while only 28% in central cities or urban areas. Among the deliveries occurring in the urban regions of Pakistan, almost 81% of deliveries occur in hospitals, while in rural areas only 50% take place at home (Sadia, 2022).

Literature reveals that maternal health is highly connected with socio-cultural factors. Social, cultural, and economic factors affect men's health as well as women's health, but these factors make women more vulnerable (Omer, 2021; Zakar, 2016). In a patriarchal society, such as Pakistan, socio-cultural factors like male dominancy, women decision making, mobility, education, financial dependency, and purdah have an impact on the choice of delivery (Mumtaz, 2009).

Women's position in society is one of the determinants of maternal health. In many developing countries women are treated subordinate with minimal decision making. There is a close relationship between women position and maternal health care. A study revealed that if a women position is higher her health would be better as compared to women with lower women position (Hosseinpoor, 2012). A study conducted in the same study locale of the present study discovered a positive connection between women's status and maternal health, longer birth intervals, and lower rates of unplanned pregnancy. Women's maternal health is adversely affected due to their low gender status and men's dominant status in society (Morgan, 2017).

In Pakistan, the household and financial decision makers are men. They have very limited space for decision-making, particularly the women of urban areas and slums (Jafree, 2020). Ahmed (2019) explained that rural women's healthcare decision making, especially deciding a place for childbirth, is greatly affected by factors like low gender status, male dominance, and limited decision-making power for women.

Women's maternal health is also related with women's mobility. A study by Ali (2021) revealed that women's mobility restriction adversely affects their maternal health and those women who do not face mobility restriction prefer checkups from a health facility. Moreover, women with mobility restriction prefer to stay in home for checkup and even delivery. Mobility restriction discourages women from institutional checkup (Winata, 2024).

Women's education strongly affects the choice of delivery. Rural women who have less education mostly choose home for childbirth place, while women with high levels of education choose

healthcare facility for delivery. Rural women having low levels of education are less aware regarding the significance of skilled birth attendance. Furthermore, women's choice of delivery home is also caused due to lack of awareness regarding the availability of healthcare facilities. Moreover, rural women who have low levels of education are less likely to be aware about the potential risks of home deliveries (Agha, 2011).

A women financial dependency is also one of the key indicators. Financial dependencies are the main factor, which leads to poor maternal health care. Women in the rural areas are less involved in income earning activities, which make them financially dependent on their spouses, because of which they may choose home deliveries as a more cost-effective option (Cornish, 2021).

It is concluded from the study that various socio-cultural factors greatly influence the place of delivery among married women in Pakistan. In this study, the researcher focused to investigate the association between gendered barriers and place of delivery in Buner, Pakistan

Methods

The present study is derived from the MPhil thesis of the principal author of the paper. He received his MPhil degree in Sociology from the Department of Sociology, Abdul Wali Khan University Mardan. Social scientists utilize different research approaches to explain or explore a social phenomenon. Researchers in the field of social sciences use qualitative research approaches for the exploration of an explored social phenomenon, while quantitative approaches are used for the explanation of a social phenomenon and establishing an association or influence between two or more variables (Sileyew, 2019; Mann, 2003). The researcher used quantitative research design in the present study to describe and explain the correlation between the place of delivery and socio-cultural factors in the study locale. The present study used simple random sampling as probability sampling technique with household survey. In the present study, all married women aged 15-49 years living in district Buner were the study population among which, the researcher selected 500 currently pregnant women randomly. The researcher used multistage sampling techniques to divide the study district into various administrative units called tehsils and sub-administrative units called union councils. Multistage sampling is a complex form of cluster sampling in which each cluster of samples is further divided into smaller clusters and the members from each smaller cluster are selected randomly (Bhardwaj, 2019). From the total population of district Buner, one tehsil namely Gagra was selected as sample administrative unit of study by using Multistage Sampling technique. The process of data collection was completed in three months. The researcher collected data from educated respondents using a self-administered questionnaire, while for uneducated respondents, an interview guide was used.

Figure 1: Research Design and Research Techniques

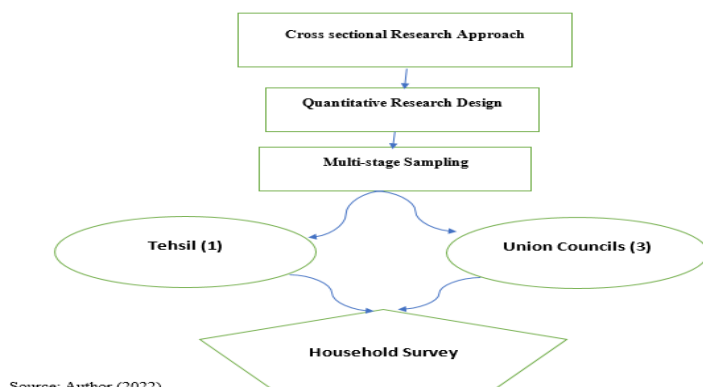
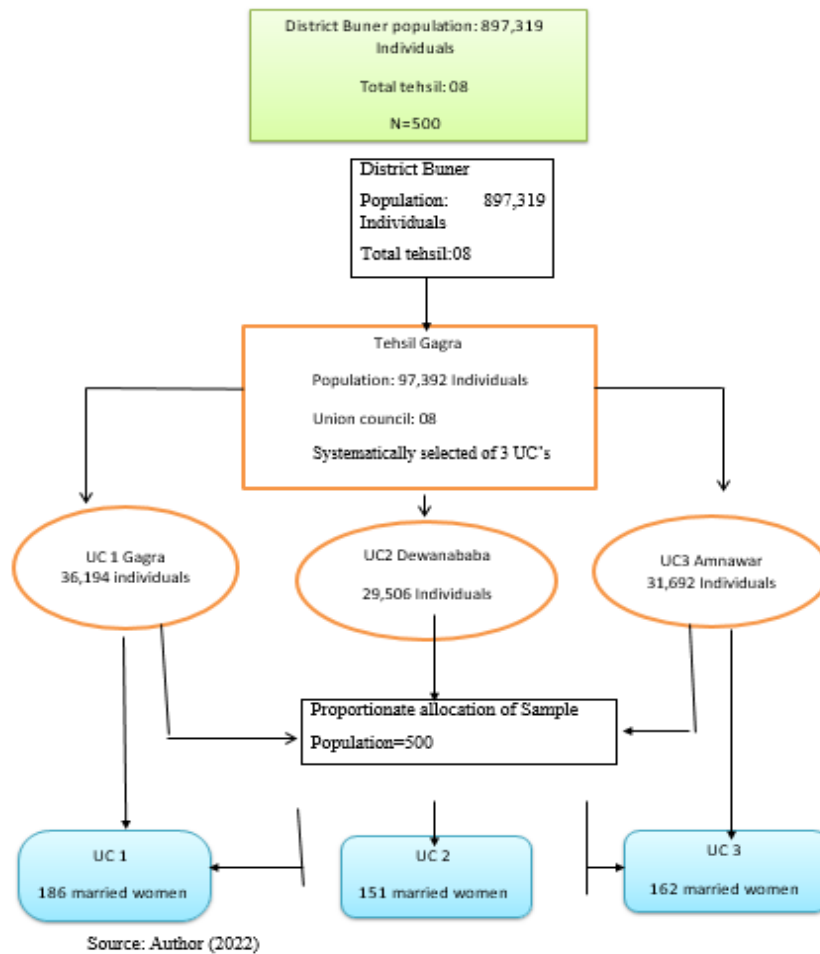


Figure 2: Study population and sampling population



Results and Discussion

Table 01 shows knowledge and practice of delivery among married women aged 15-49 years. Table also reveals the health service provider of last delivery. Among the total respondents, more than one fourth (29.1%) married women responded that their last delivery was attended by doctors in hospital. 12.6 percent married women's last delivery was attended by nurses and very less (5.3%) deliveries were attended by lady health visitor. One third percent (33.0%) married women's last delivery was attended by DAI/ TBA /LHW. 20.0 percent married women's last delivery is attended by family elder women. The table also shows the place of last delivery among married women. Among married women, 33.2 percent married women's delivery took place at home while 66.8 percent married women's delivery took place in hospital. Table also shows the place of future delivery of married women. Among the total respondents, 28.7 percent married women's place of future deliveries identified home as a place of future delivery, while majority (71.3%) married women identified hospital as place of future delivery.

Table 02 shows socio-cultural factors' influence on married women aged 15-49 years. Among the 470 married women, majority (76.6%) married women's status in family are inferior than men, 22.1 percent are treated equal to men and a very less (1.3%) number of women are superior than men. The table also reveals women's treatment permitted from male health service provider. Among the total respondents, majority (76.8%) married women are not permitted to take treatment from male health service provider, while nearly one fourth (23.2%) married women are permitted to

take treatment from male health service provider. Table also shows that purdah restricts women mobility. Among the total married women, majority (63.0%) married women are restricted from mobility due to observance of purdah and more than one third (37.0%) married women's mobility are not restricted due to purdah observance. Moreover, the table also shows the restriction of married women's mobility in public sphere. Among the 470 married women, a very less (4.7%) number of married women's mobility is restricted in public sphere, more than one fourth (30.4%) married women's mobility is not restricted in public sphere, more than one third (41.9%) married women are restricted from public sphere mobility, and nearly one fourth (23.0%) of the married women responded that they are treated equal to men in terms of public sphere mobility. Women's financial reliance on men's earnings is also shown in the table. The majority of the women respondents (78.1%) are financially dependent on their husbands' earnings, whereas 21.9 percent are not financially dependent on their husbands' earnings. Table 02 also shows husband's illiteracy as a barrier to married women maternal health care access to health facility. Among the total respondents, majority (53.0%) married women shared that husband illiteracy is a barrier to married women's maternal health care access, and 47.0 percent shared that husband illiteracy is not a barrier to married women maternal health care access. Table also reveals women's illiteracy as a barrier to maternal health care access to health facility. Among the 470 respondents, majority (61.5 %) married women shared that women illiteracy is a barrier to maternal health and more than one third (38.5%) married women responded that women illiteracy is not a barrier to maternal health care access to health facility. Women's preferred place of current and future delivery among married women is also shown in the table. Among the total married women, 20.6 percent married women preference place of current and future delivery are home (Grammar Check). Similarly, majority (79.4 %) married women preference place of current and future delivery are health facility.

Table 03 shows the association between place of delivery and the socio-cultural characteristics of married women aged 15-49 years. The cross tabulation shows that married women decision maker in household purchase choose home as place of delivery and the decision is taken by herself (56.2% vs 43.8%) as compare to married women choose hospital as place of delivery. The odd ratio is according to the binary logistic regression .407 times lower among married women with home as place of delivery (OR .407, 95% CI (.072-2.310) with no significant association. The cross tabulation shows that among the husband decision maker in household purchase, 68.3% husbands choose home as a place of delivery decision (68.3% vs 31.7%) as compared to the 31.7% of the married women's husband, who choose hospital as a place of delivery. The odd ratio is 1.548 times greater among married women who give birth at home, according to a binary logistic regression (OR 1.548, 95% CI (.375-6.393) with no significant association. The cross tabulation also reveals that in case of joint decision making of household purchase, 43.6% choose home as a place of delivery while 53.6% choose hospital as place of delivery (43.6% vs 56.4%). The binary logistic regression demonstrates that odd ratio is .425 times lesser among married women with home as place of delivery (OR .425, 95% CI (.103-1.756) with no significant association. Moreover, the cross tabulation shows that married women decision maker in women employment and livelihood activities choose home as place of delivery decision is taken by herself (58.3% vs 41.7%) as compare to married women choose hospital as place of delivery. The binary logistic regression shows that odd ratio is 1.213 times higher among married women with home as place of delivery (OR 1.213, 95% CI (.168-8.765) with no significant association. The cross tabulation shows that married women choose home as place of delivery decision is taken by husband (64.0% vs 36.0%) as compare to married women's husband choose hospital as place of delivery. According to the binary logistic regression, the odd ratio is 1.577 times greater among married women who choose home as the delivery location (OR 1.577, 95% CI (.387-6.433) with

no significant association. The cross tabulation shows that married women prefer to give birth at home. In comparison to the choice made by husband and wife to birth in a hospital (39.2 percent vs. 60.8 percent), the decision made by husband and wife to deliver in a home (39.2 percent vs. 60.8 percent). The odd ratio is 1.647 times greater among married women who give birth at home, according to the binary logistic regression (OR 1.647, 95% CI (.394-6.884) with no significant association. Furthermore, the cross tabulation shows that married women decision maker in women access to health facility choose home as place of delivery decision is taken by herself (75.0% vs 25.0%) as compared to married women choose hospital as place of delivery. The binary logistic regression shows that odd ratio is .094 times lesser among married women with home as place of delivery (OR .094, 95% CI (.007-1.270) with no significant association. It is also shown by the cross tabulation that married women choose home as place of delivery decision is taken by husband (53.8% vs 46.2%) as compared to married women's husband choose hospital as place of delivery. The binary logistic regression demonstrates that odd ratio is .182 times lesser among married women decision taken by husband with home as place of delivery (OR .182, 95% CI (.046-7.329) with significant level is .015. A study discussed that most married women deliver at home due to sociocultural norms and a poor view concerning the quality of hospital services (Sumankuuro, 2018).

The cross tabulation describes that married women choose home as place of delivery decision is taken by herself (81.1% vs 18.9%) as compared to married women choose hospital as place of delivery. The odd ratio is 24.422 times greater among married women who give birth at home, according to a binary logistic regression (OR 24.422, 95% CI (1.392-428.452) with significant level is .029.

A study discussed that empower women to make informed decisions about birthing and remove barriers that prevent them from arriving to the health facility on time and preferring to give birth at home (Yuill, 2020). The cross tabulation shows that married women choose home as place of delivery decision is taken by husband (54.8% vs 45.2%) as compare to married women's husband choose hospital as place of delivery. The odd ratio is 1.994 times greater, according to the binary logistic regression among married women decision taken by husband with home as place of delivery (OR 1.994, 95% CI (.542-7.329) with no significant association.

The cross tabulation shows that married women decision maker for PNC from health facility choose home as place of delivery decision is taken by herself (75.0% vs 25.0%) as compare to married women choose hospital as place of delivery. The odd ratio is 9.456 times greater among married women who give birth at home, according to a binary logistic regression (OR 9.456, 95% CI (1.503-59.489) with significant level is .017.

A study explained the ability of married women to make decisions was also linked with PNC use and PNC are estimated to be able to reduce Neo-natal deaths (Yuill, 2020).

The cross tabulation shows that married women choose home as place of delivery decision is taken by husband (57.7% vs 42.3%) as compared to married women's husband choose hospital as place of delivery. The binary logistic regression shows that odd ratio is 4.007 times higher among married women decision taken by husband with home as place of delivery (OR 4.007, 95% CI (1.218-13.182) with significant level is .022.

The results are supported by a study that husband high decision-making power has positive association and husband involvement was linked to the usage of hospital-based maternal health services (Hamid, 2011).

Table 01: Place of Delivery among married women aged 15-49 years (N=470)

Place of delivery	F	(%)
Service provider of last delivery		
Doctor	137	(29.1)
Nurse	59	(12.6)
LHV	25	(5.3)
DAI/TBA/LHW	155	(33.0)
Family elder women	94	(20.0)
Place of delivery		
Home	156	(33.2)
Hospital	314	(66.8)
Place of future delivery		
Home	135	(28.7)
Hospital	335	(71.3)

Table 02: Gendered Barriers influence on married women aged 15-49 years (N=470)

Socio-cultural variables	F	%
Women status in the family		
Inferior than men	360	(76.6)
Equal to men	104	(22.1)
Superior than men	06	(1.3)
Women treatment permitted from male health service provider		
Yes	109	(23.2)
No	361	(76.8)
Pardha restrict women mobility		
Yes	296	(63.0)
No	174	(37.0)
Women mobility is restricted in public sphere		
No response	22	(4.7)
Mind it	143	(30.4)
Strictly prohibited	197	(41.9)
Equal like other women	108	(23.0)
Women Financially dependent on men earning		
Yes	367	(78.1)
No	103	(21.9)
Husband illiteracy barrier to women maternal health care access		
Yes	249	(53.0)
No	221	(47.0)
Women illiteracy barrier to maternal health care access		
Yes	289	(61.5)
No	181	(38.5)
Women Preference place of current/future delivery		
Home	97	(20.6)
Health facility	373	(79.4)

Table 03: Association between Place of Delivery and Gendered Barriers among married women aged 15-49 years (N=470)

Socio-cultural variable	Place of delivery		OR,95 CI,EXP(B)	P-value
	Hospital F (%)	Home F (%)		
Decision maker in household purchase				
Herself	07(43.8)	09(56.2)	.407(.072-2.310)	.310
Husband	44(31.7)	95(68.3)	1.548(.375-6.393)	.546
Jointly	102(56.4)	79(43.6)	.425(.103-1.756)	.237
In-laws	68(50.7)	66(49.3)	1.00	
Decision maker in women employment and livelihood activities				
Herself	05(41.7)	07(58.3)	1.213(.168-8.765)	.848
Husband	73(36.0)	130(64.0)	1.577(.387-6.433)	.525
Jointly	76(60.8)	49(39.2)	1.647 (.394-6.884)	.494
In-laws	67(51.5)	63(48.5)	1.00	
Decision maker in women access to health facility				
Herself	10(25.0)	30(75.0)	.094(.007-1.270)	.075
Husband	153(46.2)	178(53.8)	.182(.046-.720)	.015
Jointly	58(58.6)	41(41.4)	1.00	
Decision maker for ANC from health facility				
Herself	07(18.9)	30(81.1)	24.422(1.392-428.452)	.029
Husband	152(45.2)	184(54.8)	1.994(.542-7.329)	.299
Jointly	62(63.9)	35(36.1)	1.00	
Decision maker for PNC from health facility				
Herself	03(25.0)	09(75.0)	9.456(1.503-59.489)	.017
Husband	150(42.3)	205(57.7)	4.007(1.218-13.182)	.022
Jointly	68(66.0)	35(34.0)	1.00	

Conclusion and Recommendations

It is concluded that study locale is male dominant and due to defined gender roles women are confined to domestic sphere. The decision of access to maternal health care is made by the husband and other male family member due to women financial dependency. In the study locale women mobility is restricted and most of them are illiterate due to which they prefer home delivery. The study suggested that community awareness program shall be started to encourage women and their families to access health facilities for delivery. Health sector should engage gynecologists in medical camps in local areas to reduce the financial burden on poor families.

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