Illiteracy: The Cause of Poor Maternal Health among Ever-Married Women in Malakand, Pakistan

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Abstract

Education is the basic source to empower women in all spheres of life. Among the various socio-cultural factors, family restriction on women to access and getting formal education and preference to religious education within the family is contributing to poor maternal health care access and utilization in the study area. The major objective of the study was to analyze the association between education and maternal health condition among ever-married women. In the present study researchers used the quantitative research design and household data were collected through interview schedule from (n=503) ever-married women having reproductive age (15-49 years). The data was analyzed through SPSS and binary logistic regression is applied to draw the association between illiteracy and poor maternal health care. The statistical results show the majority ever-married women are illiterate (53.0%). The OR is 14.85 times higher among illiterate ever-married women toward inappropriate maternal health care as compare to literate women with C.I (9.504-23.228) P-Value 0.001. In order to achieve Sustainable Development Goal No. 3, 4 &5 the study recommends women should be provided equal educational opportunities, empowering women in the decision making and gender equality in all social services to them.

Keywords: Illiteracy, Confinement, Domestic sphere, Women, Poor Maternal Health

Introduction

Pakistani women are facing maternal health complication which is the violation of fundamental women rights in Pakistan (Bhutta, 2004). According to the recent WHO estimates 358,000 women died around the world because of poor maternal health conditions. According to the recent statistics of WHO maternal deaths are 400/100,000 live births globally with 99 percent reported from less developed countries (WHO, 2012).

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According to the last Pakistan Demographic and Health Survey (2013) report the maternal mortality statistics in the country are 276/100,000 live births. According to the same report the proportion of maternal deaths in the country are likely 500/100,000 live births (NIPS, 2013).

In developing countries researches discussed mostly the supply side hinders responsible for poor maternal health in Pakistan (Fikree, 2004). In Pakistan a recent study highlighted gaps in program designing and implementation to improve maternal health condition among ever-married women (Bhutta, 2013).

According to PDHS (2013) statistics in *Khyber-Pakhtunkhwa*, still more than one third ever-married women (40.0%) staying in home for ANC from women and health service provider with no skill both in rural and urban area while traditional birth attendant still attending 44 percent mothers in rural areas (NIPS, 2013). Similarly, majority 52 percent women delivery take place in home while very less percent (15%) are visited public health facilities for their delivery (PDHS, 2013). According to the recent PDHS (2013) report nearly two third (60%) women delivery is attended by traditional birth attendant.

The research study conducted in the country highlighted that majority of the women are residing in rural setting. Women are treated subordinate in the family and their access to formal education is restricted. The male family members are preferred women religious education which confined women to domestic sphere and they are deprived from formal education especially higher education institutions (Mumtaz, 2007). Similarly, another study highlighted that women having no decision making to continue their studies and their outdoor mobility are restricted (Mahmood, 2002). The women in Pakistani society are engaged in domestic affairs and their education is not considered important. On the other side men are not only prefer to work in public sphere rather they decide about the women out sphere mobility including access to education and health care services (Stephenson, 2004 & Bhatti, 2002). Some other research studies highlighted that gender perception by male family members toward their women are responsible for poor condition of maternal health among ever-married women in the developing world (Gupta, 2015; Ganle, 2014). In patriarchal society women are not allowed to get formal education and access maternal health facility (Moyer, 2013).

Methodology

The researchers used quantitative research model and the respondents are interviewed from Malakand Pakistan in the period of May to November, 2016. The sample size of the study is 503 ever married women. The present paper is extracted from PhD work of the first author. The women having delivery in last twelve months or with current pregnancy and permanently living in the study area are selected randomly. The unmarried women in the specified age, married women with no birth experience and women with no permanent residence are excluded from present research study. Among the total 28 union councils researchers used systematic selection approach and selected every forth union council from the official list of district local government. The entire respondents are selected randomly through proportionate distribution among the selected union councils. In the study area men interaction is not permissible with *pakhtun* women therefore the researchers hired the services of graduate women enumerators to collect the data through interview from randomly selected women. They are fully trained about the research objectives, tool of data collection and process of data collection before collection of data. The researchers analyzed the collected data through statistical package for social science. In the present research first the descriptive analysis are drawn and then the odd ratio, confidence interval are calculated for quantitative variables. The researchers draw the association between illiteracy and poor maternal health among *Pakhtun* women by application of logistic regression test. The significance level is considered on P Value < 0.05 in the present study.

Results

Among the total 503 respondents, majority of them 56.9% (n=503) are above than 30 years. Majority (53.7%) women are illiterate and nearly one third 31.2% (n=503) of the respondents having primary to middle level of education. Likewise, their husband did not have higher level of education. More than eighty percent (81%) of the respondents performed traditional roles of housewife and they also belonged to the lower class of the society. The monthly income of more than fifty percent of the respondents is less than 30000 PKRS. Similarly, majority (87.6%) women are residing in the families with their married children (joint families) where their husband or father in law is key decision makers.

Table 01: Socio-Demographic Characteristics of Ever-married Women (N=503)

Characteristics	Frequency N (%)
Women age (years)	
15 to 30 years	215 (43.1)
Above than 30 years	288 (56.9)
Women Literacy	
Illiterate	270 (53.7)
Primary to Middle Education	157(31.2)
Metric to Intermediate Education	76 (15.1)
Husband Literacy	
Illiterate	156 (31.0)
Primary to Middle Education	210 (41.7)
Metric to Intermediate Education	137 (27.2)
Women Employment	
Government or Self Employed	91 (18.1)
House wives	412 (81.9)
Family income/M	
Less than 10000 Rs	64 (12.7)
Less than 20000 Rs	83 (16.5)
Less than 30000 Rs	119 (23.7)
Less than 40000 Rs	65 (12.9)
Less than 50000Rs	122 (24.3)
Above than 50000Rs	49 (9.7)
Family Size	
Nuclear family size	47 (9.3)
Joint family size	441 (87.6)
Extended family	15 (2.9)

The correlation table indicates significant differences in women education and maternal health condition. It is found that women with illiteracy having inappropriate maternal health (80.5 vs. 21.7% (n=472) as compare with educated women having appropriate maternal health. The association highlighted that OR of illiterate women is 14.858 times higher than

educated women (OR 14.858, CI 95% 9.504-23.228). This shows that women education is significantly associated with maternal health condition (p- Value .000).

Among the ever-married women, statistically significant difference is found between men response toward women education and maternal health condition. It is found that there is no need for women higher education and they are discouraged. Such response of the men toward women education is found significant with women having inappropriate visit (29.2% vs. 14.4%) as compare to men encouraging their women toward education having appropriate maternal health condition. The OR of women with no permission from husband toward formal education is 3.023 times higher than women permitted by men toward higher education with good maternal health condition (OR 3.923, CI 95% 1.800-5.078). The results indicate highly significant correlation between men response toward women education and maternal health care of ever-married women (P-value .000).

In the correlation it is found that husband's with illiteracy significantly influence the women maternal health condition (42.6% vs. 13.1%) compare to husband's having literacy about maternal health complication. The regression result shows the OR is 4.920 times higher among illiterate husbands toward poor maternal health (OR 4.920, CI 95% 3.094-7.822). The association is highly significant between husband illiteracy and maternal health (P-value .000).

The regression table shows that women with restricted access from formal education prefer to stay in home for maternal health care and their maternal health care is inappropriate as compare to women having access to formal education institutions (63.8 vs. 52.9% (n=468). The logistic regression present that the odd ratio of women no access to formal education institutions is 1.578 times higher than women their access (OR 1.578, CI 95% 1.091-2.282). Women access to formal education institutions is statistically significant and associated with maternal health condition (p-Value .015).

Statistically significant difference is found in maternal health condition among women who living as housewife having inappropriate maternal health condition (87.3 vs. 63.3% (n=472) compared to those who having appropriate maternal health condition. The binary logistic regression result shows that the odd ratio of housewives is 3.960 times higher than employed women (OR. 3.960, CI 95% 2.497-6.278). There is statistical significant association between women occupation and maternal health condition (p-Value .000).

Table 02: Illiteracy Association with Poor Maternal Health among Ever-Married Women

Association of illiteracy with poor maternal health among ever-married women having age (15-49) years				
Attribute	**Maternal Health**			
	Appropriate Maternal Health	**Inappropriate Maternal Health**	***OR, 95% C.I***	***P. Value***
	N (%)	***N (%)***		
Women literacy				
Illiterate	*48 (21.7)*	*202 (80.5)*	14.858 (9.504-23.228)	.000
Literate	173 (78.3)	49 (19.5)	1.00	
Men's response toward women education				
Only religious education	64 (31.8)	82 (34.7)	1.628 (1.056-2.510)	.027
No need for formal education	29 (14.4)	69 (29.2)	3.023 (1.800-5.078)	.000
Only allowed up-to primary education	108 (53.7)	85 (36.0)	1.00	
Husband literacy				
Illiterate	*29 (13.1)*	*107 (42.6)*	4.920 (3.094-7.822)	.000
Literate	192 (86.9)	144 (57.4)	1.00	
Women's access to formal education				
Easy access to education institution	*107 (48.6)*	*93 (37.5)*	1.00	
Restricted from access	*113 (51.4)*	*155 (62.5)*	1.578 (1.091-2.282)	.015
Women's religious education				
Outer mobility	*81 (36.7)*	*32 (12.7)*	1.00	
Confinement to domestic sphere	*140 (63.3)*	*219 (87.3)*	3.960 (2.497-6.278)	.000

Discussion and Conclusion

The present research studied the correlation between education influences on maternal health condition in the study area. All most same results are recorded in other developing Asian countries including India, Bangladash, Nipal, Indonesia and Pakistan. The studies in developing countries also stated that her own education and husband formal education greatly influenced the maternal health condition (Adamu, 2016; Nasrullah, 2014; NIPS, 2013). A study conducted in Papua New Guinea stated that poor maternal health condition is strongly associated with women and her husband education level in the country (Hinton, 2010). Beside the women own education, the husband's literacy is greatly contributed to maternal health condition. The research study covered that women age at the time of delivery is also responsible for maternal health condition. The other studies indicated that ever-married women having age of 30 years or above prefer to stay in home for ANC, delivery and PNC services attended by TBA (Ganle, 2015). Women are preferred to limit their services within domestic sphere. Mostly in developing countries women are performing their role within four walls of their houses. In the joint families the in laws especially men are decision maker about maternal health checkup and visits to health care facilities (WHO, 2009). The research study conducted in Pakistan stated that women outer mobility is restricted both for education purpose and access to health facility which ultimately affects the maternal health condition (Khan, 2008). In developing countries early marriage is socially approved practice which affects women education as well as maternal complication occurs. Due to maternal health complication the maternal mortality and morbidity rate is high in developing countries (Banerjee, 2009). A recent research study stated that due to illiteracy women prefer traditional birth attendant to attend the delivery process and women are keeping herself in domestic sphere for delivery in developing countries and traditional societies around the world (Titaley, 2010). Husband is the key decision makers and a woman has very limited autonomy to decide about her health and checkup in *Pakhtun* society (Khan, 2008).

Conclusively, the above discussion stated that women are in subordinate position in the study area. In research area women restricted to four wall of the home and they are restricted from formal education. It is statistically found that men decide about her women health and education in the study area. The study recommends to achieve the sustainable development goals 3, 4 and 5 it is necessary to educate the women, avoid early marriage and empower women to take decision about her health and education in the family.

Limitations

The present study is a cross-sectional study. Therefore, the other longitudinal studies would be conducted to check and confirm the present research results and conclusion. Similarly, the sample for present study are taken from one mountains district of Khyber Pakhtunkhwa thus the study may be conducted in other districts of the province.

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