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**DECISION MAKING AUTHORITY AND ITS
INFLUENCE ON INSTITUTIONAL
ANTENATAL CARE AMONG MARRIED
WOMEN: A CROSS-SECTIONAL STUDY
CONDUCTED IN KHYBER PAKHTUNKHWA**

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ABSTRACT

Sociologists argue that maternal health care and its complications are socially and culturally constructed. In patriarchal structure of societies decision making authority influences the use of institutional antenatal care. According to Pakistan Demographic and health Survey, in Pakistan 49% of pregnant women had less than standard antenatal care visits. In the present study, the decision-making authority is explained in association with antenatal care in district Buner, Khyber Pakhtunkhwa. In the present study quantitative research design with simple random sampling techniques was applied and data was collected through interview schedule in household survey. A sample of 470 married women having current pregnancy and delivered in last 12 months is randomly selected for the study. The results explained that more than 50 percent respondents have no knowledge of standard antenatal care services and 33.6 percent married women stay in home during antenatal care in the study period. The study was conducted in 2022. The study described that 76 percent of men family members take the decision of girl's mate selection and 45 percent women's husband decide the women public sphere mobility in the study locale. The study concluded that men's decision-making influence the women public sphere mobility and due to men's authority, women are restricted to domestic sphere during pregnancy. It is also concluded that women's access and use of institutional antenatal care is discouraged in Pakhtun society. The study recommends engaging men community members as change

agent in the social sphere to encourage women use of institutional antenatal care in patriarchal structure of society.

Keywords: *Women, Antenatal Care, Decision Making, Men, Khyber Pakhtunkhwa.*

Introduction

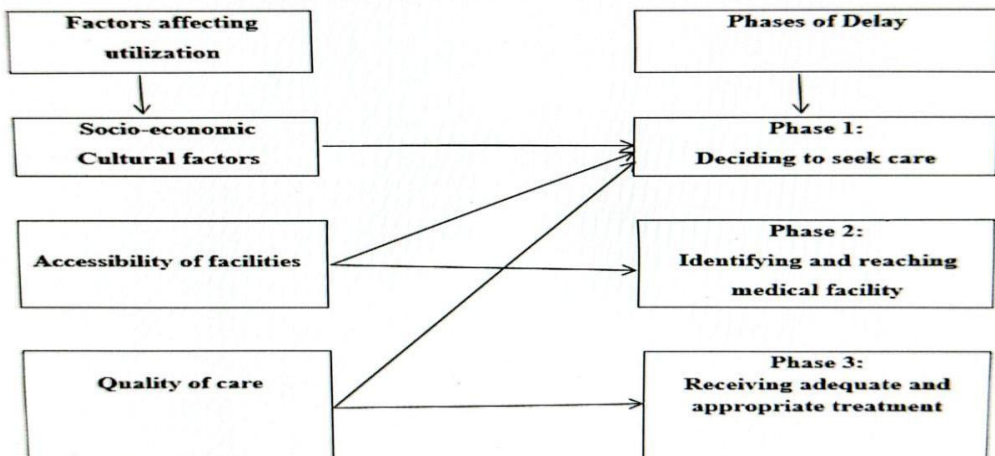
Social and behavioral scientists consider women's health problems to be socially, economically and culturally produced. Sociologist Conrad and Barker argue that women's health including reproductive health are not isolated, individuals and biological events which can be explained only with public health perspective rather women's health issues are created due to various social, cultural and economic factors. These factors are directly related with women social position and gender role assigned to women in the family and society (Conrad, 2010). According to the 2019 State of the World Population Report, the Maternal Mortality Rate (MMR) in Pakistan is 178 per 100,000 live births (United Nations Population Fund [UNFPA], 2019). In Pakistan, the infant mortality rate (IMR) is 62 per 1000 live births. In Pakistan, approximately five million women become pregnant each year, with 15% of all pregnant women experiencing medical difficulties. Punjab has an MMR of 157, Khyber Pakhtunkhwa has an MMR of 165, Sindh has an MMR of 224, Baluchistan has an MMR of 298, Azad Jammu and Kashmir has an MMR of 104, and Gilgit Baltistan has an MMR of 157 per 100,000 live births (National Institute of Population Studies [NIPS], 2018).

According to Pakistan Demographic and Health Survey (PDHS) report (2018), still in Pakistan 49% of pregnant women had less than standard ANC visits. According to National Institute of Population Studies (NIPS) still 34% of pregnant women deliver the child at home and other than hospital. It is also statically shown that still one-fourth (25%) of delivery is attended by doctors other than doctors. According to (PDHS) report, 86% of women received antenatal care from a Skilled Health Service Provider (NIPS, 2019). Doctors were the major service provider (82%). From 26% in 2012/13 to 86 percent in 2017/18; ANC from a trained provider has gradually grown. As a result, the percentage of women receiving ANC from a trained provider increased by a whopping thirteen percentage points. Women who lived in cities were more likely than those who lived in rural regions to receive ANC from a qualified provider (94 % vs. 82 %). Women who acquired ANC from a qualified service provider are referred to hospital doctors and nurses. In Pakistan, 22% of births took occurred in government-run hospitals (NIPS, 2019). It is explained in research studies that decision making authority is one of the

influencing factors which discourage women use of institutional antenatal care in patriarchal structure. Decision making is one of the important factors which directly correlate with a mother and her child health. In patriarchal structure and societies women are discouraged to be involved in decision making process. There is a close relationship between lack of decision making and maternal health care. It is studied in research that men family members are main decision makers even in the matter of a mother health checkup. In the study area it is seen that women with low authority to make decisions prefer to stay at home for checkup and even delivery. In the study area it is also shown that women with lack of decision-making power discourage her from outer mobility and institutional checkup. The same situation is also shown in other studies in developing countries (Ali, 2020). It is also explained that the use of maternal health care is strongly linked to women's decision-making. Women who have more probable decision-making authority to seek maternal health care. As a result, if a woman in her family has minimal decision-making authority and her husband or the household head discourages her from seeking maternal health care. She is unlikely to take advantage of their services. As a result of women's lack of decision-making authority, maternal health care is inadequate (Salway, 2007).

The present study investigates the decision-making authority influence on institutional antenatal care in district Buner, Khyber Pakhtunkhwa.

Fig.1.1 Theoretical framework the Three Delay Model



Source: Three Delay models by Thaddeus and Maine (1994)

Methods

This paper is developed from the MPhil thesis of the principal author of the paper. He has completed his MPhil in Sociology from the Department of Sociology, Abdul Wali Khan University Mardan. In social sciences researchers use various research approaches to explain or explore a social phenomenon. In social sciences, qualitative research approach is used to explore an un-explore social phenomenon, while quantitative research approaches are used to explain a social phenomenon and develop an association or influence between two or more variables (Bhasin, 2021, Sileyew, 2019). In the present research study, scholars used quantitative research design to describe and explain the association between decision making as a social power and use of institutional antenatal health care in the study locale. The research study used simple random sampling as a probability sampling technique with household survey. The present study statistics explain the views of 470 married women respondents permanently belongs to study area district Buner, Khyber Pakhtunkhwa. The research study used multi-stage sampling as a probability sampling technique to divide the study locale into few tehsils as administrative units and then into union councils as small sub-administrative units for service delivery and community development. Multistage sampling is a technique for acquiring a sample from a population that involves dividing the Individuals from the smallest of these groups are sampled from the population as it is divided into smaller and smaller groupings (Valerie, 1997). The researcher used self-administered questionnaire for educated respondents, while for uneducated respondents an interview schedule is used.

Figure 1.2 Research Design and Research Techniques

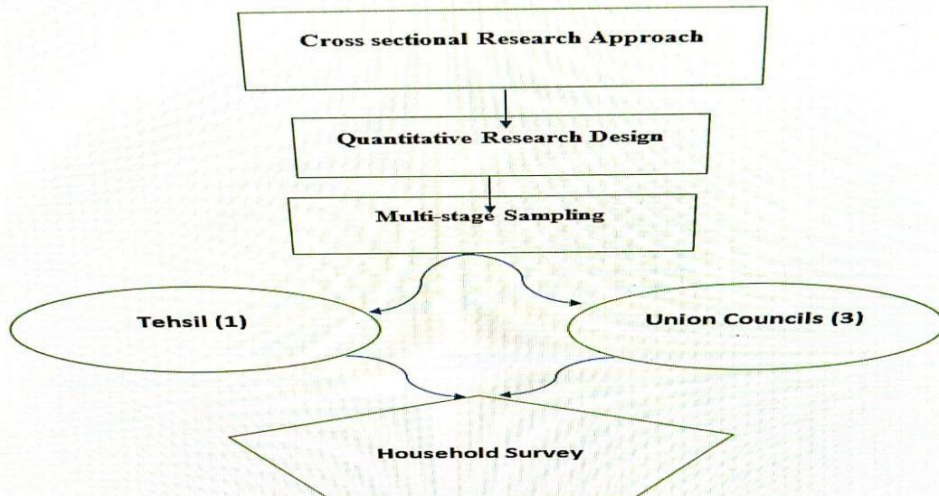
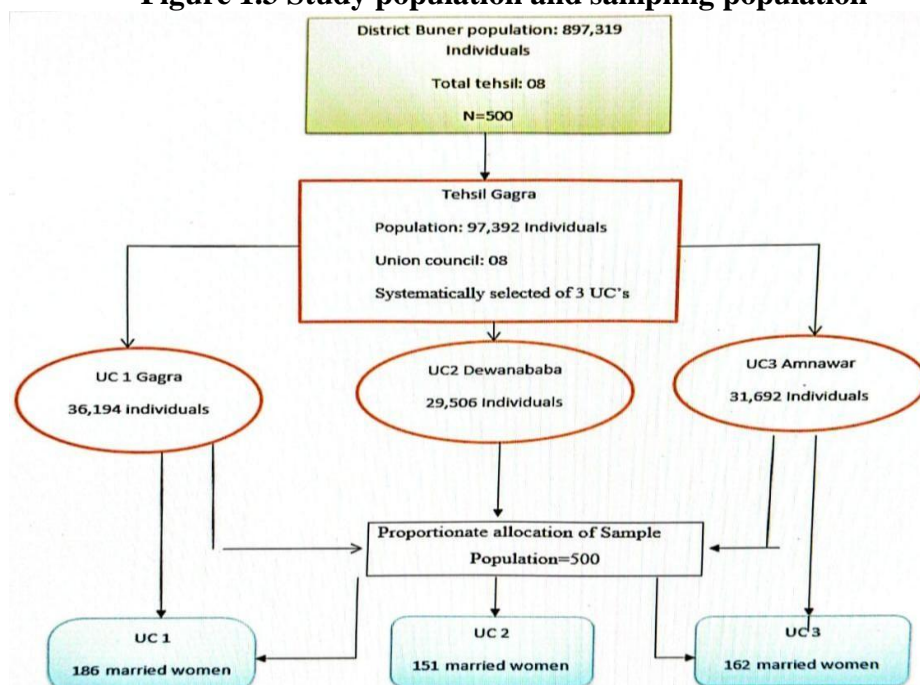


Figure 1.3 Study population and sampling population

Source: Author 2022

Results and Discussion

Table 01 shows knowledge and practice of Antenatal Health Care among married women aged 15-49 years. Among 470 married women majority 54.9 percent married women do not know ANC while 45.1 percent married women knows about ANC. Table also shows married women visits for ANC checkup. Among the total 470 respondents, majority 80.2 percent married women having ANC checkup while 19.8 percent married women do not made visits for ANC checkup. Table revealed number of ANC visits of married women during her pregnancy. Among the total 470 married women 42.6 percent married women having less than 4 numbers of ANC visits. Similarly, more than one third (37.7%) married women having above than 4 numbers of ANC visits and 19.8 percent married women having no ANC visits during her last pregnancy. Table described health service provider during ANC checkup. Among total 470 respondents, majority (36.5%) married women received ANC from other than health service provider as DAI/TBA/LHW. Among the respondents, 24.6 percent married women received ANC from doctor, 14.9 percent married women received ANC from nurses, 11.5 percent married women received ANC from family elder women while 7.4 percent married women

received ANC from Lady Health Visitors. Place of ANC checkup is also explained in the table. Among the total respondents, majority 66.4 percent married women place of ANC are health facility including hospitals, BHU, dispensary and private hospitals. While the remaining 33.6 percent married women are provided ANC services at home. Table described visits for ANC of married women in current and last pregnancy. Among the total respondents, majority 71.9 married women made visits for ANC in her current and last pregnancy. Similarly, more than one fourth (28.1%) married women do not made any visit for ANC in her current and last pregnancy. The components of ANC checkup is explained in the table. Among 470 married women, majority 40.0 percent married women are provided iron folic acid supplements and vaccination. Similarly, more than one fourth (30.9%) married women the components of ANC checkup are blood and urine test. More than one fourth (29.1%) married women the components of ANC checkup are BP and weight.

The descriptive statistics explained that women with their ANC checkup in health facility are treated well as compared to women who remains in home and avoid visiting health facility during her pregnancy which later cause complications

Table 02 shows decision making authority among married women aged 15-49 years. Among 470 married women, 6.2 percent married women are the decision makers in household affairs by herself, more than one third (37.2%) married women's husband are the key decision makers in household affairs, more than one fourth (27.9%) of the decision makers in household affairs are jointly performed by husband and wife and more than one fourth (28.7%) married women are in-laws the key decision makers in household affairs. Table explained the married women key decision makers in public sphere mobility. Among the total married women, a very less 2.1 percent decision makers in outer mobility are the married women by herself. Majority 45.5 percent of married women's husbands are decision makers in outer mobility. Similarly, nearly one fourth (24.3%) married women decision makers in outer mobility are jointly performed by husband and herself and more than one fourth (28.1%) married women decision makers in outer mobility are in-laws. Table described the married women key decision makers in household purchase. Among the total married women, a very less 3.4 percent decision makers in household purchase are the married women herself. Similarly, more than one fourth (29.6%) married women's husband are decision makers in household purchase, more than one third (38.5%) married women decision makers in outer mobility are jointly performed by

husband and herself and more than one third (28.5%) married women decision makers in household purchase are in-laws. Table revealed the married women key decision makers about women education. Among the total married women, a very less 2.1 percent decision makers about women education are the married women by herself, more than one third (40.9%) married women's husband are decision makers about women education. Similarly, more than one fourth (28.9%) married women decision makers about women education are jointly performed by husband and wife and more than one fourth (28.1%) married women decision makers about women education are in-laws. Table shows the married women key decision makers in women employment and livelihood activities. Among the total married women, a very less 2.6 percent decision makers in women employment and livelihood activities are the married women by herself, Majority 43.2 percent married women's husbands are decision makers in women employment and livelihood activities. Similarly, more than one fourth (26.6%) married women decision makers in women employment and livelihood activities are jointly performed by husband and wife and more than one fourth (27.7%) married women decision makers in women employment and livelihood activities are in-laws. It is described that key decision makers in girls mate selection. Among the 470 married women, a very less 3.2 percent decision makers in mate selection are the married women by herself. Majority 76.4 percent married women's husbands are decision makers in mate selection. Similarly, 20.4 percent married women decision makers in mate selection are jointly performed by both husband and wife.

Table 02 explained that in patriarchal structure of society (*Pashtun*) men are mostly take the household and public sphere decisions. Only in few circumstances women are involved in joint decision making like household items purchase or to participate in community gatherings where women presence is considered important like in funerals. It is also alarming, that the maternal health care decision makers are also men in majority of the families.

Table 03 shows the association between Antenatal care service providers and decision makers in the study locale. The cross tabulation shows that married women decision maker in household purchase for health service provider in ANC decision is taken by herself as doctor/nurse/LHV (43.8% vs 56.2%) as compared to married women health service provider in ANC as TBA/DAI/LHW/ Family elder women. The binary logistic regression demonstrates that odd ratio is .119 times lesser among

married women with doctors/nurse/LHV as service provider (OR .119, 95% CI (.032-1.238) with no significant association. The cross tabulation explained that married women health service provider in ANC decision is taken by husband as doctor/nurse/LHV (54.7% vs 45.3%) as compared to married women health service provider in ANC as TBA/DAI/LHW/ Family elder women. The binary logistic regression demonstrates that odd ratio is 1.394 times higher among married women with doctors/nurse/LHV as service provider (OR 1.394, 95% CI (.332-5.846) with no significant association. The cross tabulation described that married women health service provider in as a doctor/nurse/LHV, husband and wife make the ANC choice together (42.0% vs 58.0%) as compared to married women health service provider in ANC as TBA/DAI/LHW/ Family elder women. The binary logistic regression demonstrates that odd ratio is .302 times lesser among married women with doctors/nurse/LHV as service provider (OR .302, 95% CI (.071-1.289) with no significant association. The cross tabulation revealed that married women decision maker in women employment and livelihood activities for health service provider in ANC decision is taken by herself as doctor/nurse/LHV (6.7% vs 33.3%) as compared to married women health service provider in ANC as TBA/DAI/LHW/ Family elder women. The binary logistic regression demonstrates that odd ratio is 2.975 times higher among married women with doctors/nurse/LHV as service provider (OR 2.975, 95% CI (.381-23.250) with no significant association. The cross tabulation shows that married women health service provider in ANC decision is taken by husband as doctor/nurse/LHV (52.2% vs 47.8%) as compared to married women health service provider in ANC as TBA/DAI/LHW/ Family elder women. The binary logistic regression shows that odd ratio is .877 times lesser among married women with doctors/nurse/LHV as service provider (OR .877, 95% CI (.210-3.659) with no significant association. The cross tabulation shows that married women health service provider in ANC decision is taken jointly by husband and wife as doctor/nurse/LHV (38.4% vs 61.6%) as compared to married women health service provider in ANC as TBA/DAI/LHW/ Family elder women. The binary logistic regression demonstrates that odd ratio is 1.935 times higher among married women with doctors/nurse/LHV as service provider (OR 1.935, 95% CI (.450-8.321) with no significant association. It is explained in the cross tabulation that married women decision maker in women access to health facility for health service provider in ANC decision is taken by herself as

doctor/nurse/LHV (80.0% vs 20.0%) as compared to married women health service provider in ANC as TBA/DAI/LHW/ Family elder women. The binary logistic regression demonstrates that odd ratio is .281 times lesser among married women with doctors/nurse/LHV as service provider (OR .281, 95% CI (.023-3.384) with no significant association. The cross tabulation shows that married women health service provider in ANC decision is taken by husband as doctor/nurse/LHV (54.7% vs 45.3%) as compared to married women health service provider in ANC as TBA/DAI/LHW/ Family elder women. The binary logistic regression demonstrates that odd ratio is .223 times lesser among married women with doctors/nurse/LHV as service provider (OR .223, 95% CI (.056-.898) with no significant association. The cross tabulation explained that married women decision maker for ANC from health facility for health service provider in ANC decision is taken by herself as doctor/nurse/LHV (86.5% vs 13.5%) as compared to married women health service provider in ANC as TBA/DAI/LHW/ Family elder women. The binary logistic regression demonstrates that odd ratio is 17.002 times higher among married women with doctors/nurse/LHV as service provider (OR 17.002, 95% CI (1.103261.987) with significant level is .042.

A study of WHO (2016) discussed that throughout pregnancy, ANC services offered by doctors in hospitals have a crucial role in preventing difficulties, and that pregnant women should seek prenatal care as soon as possible to promote maternal health (WHO, 2016). The cross tabulation shows that married women health service provider in ANC decision is taken by husband as doctor/nurse/LHV (47.0% vs 53.0%) as compared to married women health service provider in ANC as TBA/DAI/LHW/ Family elder women. The binary logistic regression demonstrates that odd ratio is .891 times lesser among married women with doctors/nurse/LHV as service provider (OR .891, 95% CI (.225-3.537) with no significant association. The cross tabulation explained that married women decision maker for PNC from health facility for health service provider in ANC decision is taken by herself as doctor/nurse/LHV (66.7% vs 33.3%) as compared to married women health service provider in ANC as TBA/DAI/LHW/ Family elder women. The odd ratio is 5.083 times greater among married women who have a doctor/nurse/LHV as a service provider, according to the binary logistic regression (OR 5.083, 95% CI (.895-28.863) with no significant association.

The cross tabulation described that married women health service provider in ANC decision is taken by husband as doctor/nurse/LHV (51.8% vs 48.2%) as compared to married women health service provider in ANC as TBA/DAI/LHW/Family elder women. The odd ratio is 5.517 times greater among married women who have a doctor/nurse/LHV as a service provider, according to the binary logistic regression (OR 5.517, 95% CI (1.488-20.453) with significant level is .011. A study of Perkins (2018) discussed that husbands accompanying their wives were positively related with women obtaining ANC from doctors in health facilities, and husbands are crucial decision-makers in women's access to health service providers in ANC. (Perkins, 2018).

Table 01 Knowledge and Visits of Antenatal Health Care among married women aged 15-49 years (N=470)

Statement	F	(%)
Women know about ANC		
Yes	212	(45.1)
No	258	(54.9)
Women performed ANC Checkup		
Yes	377	(80.2)
No	93	(19.8)
No. of ANC Visits performed		
No	93	(19.8)
Less than 4	200	(42.6)
4 and above	177	(37.7)
ANC Health Service Provider		
Doctor	139	(29.6)
Nurse	70	(14.9)
LHV	35	(7.4)
DAI/TBA/LHW	172	(36.5)
Family elder women	54	(11.5)
Place of ANC		
Home	158	(33.6)
Health facility	312	(66.4)
Visit for ANC in current/last pregnancy		
Yes	338	(71.9)
No	132	(28.1)
Components of ANC checkup		
BP and weight		(29.1)
Blood and urine test	145	(30.9)
Iron and vaccination	198	(40.0)

Table 02 Decision Making Authority among married women aged 15-49 years (N=470)

Decision making authority	F	%
Decision maker in household affairs		

Herself	29	(6.2)
Husband	175	(37.2)
Jointly	131	(27.9)
In-laws	135	(28.7)
Decision maker in public sphere mobility		
Herself	10	(2.1)
Husband	214	(45.5)
Jointly	114	(24.3)
In-laws	132	(28.1)
Decision maker in household purchase		
Herself	16	(3.4)
Husband	139	(29.6)
Jointly	181	(38.5)
In-laws	134	(28.5)
Decision maker about women education		
Herself	10	(2.1)
Husband	192	(40.9)
Jointly	136	(28.9)
In-laws	132	(28.1)
Decision maker about women employment and livelihood activities		
Herself	12	(2.6)
Husband	203	(43.2)
Jointly	125	(26.6)
In-laws	130	(27.7)
Decision maker in girls mate selection		
Herself	15	(3.2)
Husband	359	(76.4)
Jointly	96	(20.4)

Table 03 Association between Antenatal Care Service Provider and decision makers among married women aged 15-49 years (N=470)

Decision Makers	Health service provider in ANC		OR,95 EXP(B)	CI,	P-value
	Doctor/Nurse / LHV F (%)	TBA/DAI/L HW Family elder women F (%)			
Decision maker in household purchase					
Herself	09(56.2)	07(43.8)	.199(.032-1.238)		.083
Husband	63(45.3)	76(54.7)	1.394(.332-5.846)		.650
Jointly	105(58.0)	76(42.0)	.302(.071-1.289)		.106
In-laws	67(50.0)	67(50.0)	1.00		
Decision maker in women employment and livelihood activities					
Herself	04(33.3)	08(6.7)	2.975(.381-23.250)		.299
Husband	97(47.8)	106(52.2)	.877(.210-3.659)		.857

Jointly	77(61.6)	48(38.4)	1.935 (.450-8.321)	.375
In-laws	66(50.8)	64(49.2)	1.00	
Decision maker in women access to health facility				
Herself	08(20.0)	32(80.0)	.281(.023-3.384)	.318
Husband	63(45.3)	76(54.7)	.223(.056-.898)	.035
Jointly	59(59.6)	40(40.4)	1.00	
Decision maker for ANC from health facility				
Herself	05(13.5)	32(86.5)	17.002(1.103-261.987)	.042
Husband	178(53.0)	158(47.0)	.891(.225-3.537)	.870
Jointly	61(62.9)	36(37.1)	1.00	
Decision maker for PNC from health facility				
Herself	04(33.3)	08(66.7)	5.083(.895-28.863)	.067
Husband	171(48.2)	184(51.8)	5.517(1.488-20.453)	.011
Jointly	59(59.6)	40(40.4)	1.00	

Conclusion and Recommendations

The study concluded that access to and use of maternal health care services is a social phenomenon which is delayed due to social and cultural factors in traditional structure of society. The study concluded that in patriarchal structure of family's men are the key decision makers in household affairs. In the study setting, women access to, and use of antenatal health care services are not only restricted due to supply side issues, rather the men's control over domestic and public sphere decision making is greatly prevent married women to access and use institutional antenatal care facilities in the study area. It is also concluded that women are treated subordinate and their involvement in decision making is discouraged, only in certain situations they are allowed to take decisions like household items purchase.

The study recommended that to improve the married women access to and use of antenatal health care services in available institutions community awareness should be started. In traditional and male dominant structure of society men shall be engaged in community campaign as change agent to sensitize men and other decision makers within the family to encourage women institutional antenatal care in the local area. The government should provide doorstep facilities to mother and newborn children to reduce the risk of maternal and infant mortality in Pakistan.

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