Woman’s Traits and Birth Services Of Child: A Systematic Qualitative Review of Multan District

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ABSTRACT

The existing study purposes to empirically observe the relationship between women’s traits and healthcare utilization services, including Media, Antenatal care and postnatal care of a child. Reproductive ages of 21 to 49 years of married women with a sample size of 322 were used. The Binary Logistic regression technique was used to evaluate the impact of women’s attributes (i.e., age, marriage age, education, paid job, and personal income) on Antenatal care and postnatal care of a child. The result indicates that chronological age and age at marriage appeared as significant predictors of antenatal care and postnatal care of the child. While personal income significantly influenced antenatal and postnatal care. Education appeared as a significant determinant of postnatal care of the child. Findings bring to light the considerable relationship between women’s traits and child’s health care services awareness. To address children's undernutrition should also focus on antenatal care as well as postnatal care.

1. INTRODUCTION

Eight millennium development goals were signed by 189 countries in 2000, a commitment to endorsing empowering women and gender equality was also included in (MDG3) (United Nations, 2000). The Pakistan Health and Demographics Survey (Pakistan Demographic, 2008) shows that in the sample, fully vaccinated children aged 12-23 were only 47%. Pakistan is an Islamic state (Alavi, 1991). The well-regarded position is given by Islam to all women in the household and society (Islam, n.d). Family is everything in Islam, it strengthens the family system by making the role of the mother sacred. As Holy Prophet (PBUH) stated ''paradise lies under the feet of the mother'' (Khan, 2011). Kabeer (1999) delineates women empowerment as “to make strategic life choices acquire such an ability is possible for those who have not been able to achieve it”. Women’s empowerment is an assimilation term generally distinct as a procedure in which deviations in autonomy are chased by an era taking into the version of the societal framework, or structure of choosing capacity, resolute in part by locus and expression of women (Alsop&Heinsohn, 2005; Ibrahim &Alkire, 2007).

According to many scholars, women’s empowerment is multidimensional. Women’s progress in one dimension necessarily does not even mean improvement in all dimensions (Alkire, 2005, 2008; Mason, 2005; Kisher, 1995; Hashemi et al., 1996). to achieve identical constitutional rights, occasions, and status to achieve their objective, education plays a great role in the growth of women’s minds. Females who are financially supporting their families with paid jobs, and education and possess a bank account have a significant relationship with women’s autonomy and feel fewer barriers to take decisions (Bushra, 2015. the woman is a dominant driver behind the use of parental healthcare services, e.g. antenatal care accessing (ANC), it has been well documented. Higher years of schooling for women are associated with ANC. four ANC visits by trained personnel at least correlate with education (Haider, Qureshi& Khan, 2017). Women’s age, (demographic position) asset quintile, (economics status), and women’s schooling (social status) are the basic determining factor of women’s autonomy (Jejeebhoy, 2002). The objective of the study is to find the relationship between women’s traits (age, age at marriage, education, p. job and personal income) and child’s health care services.
In the production of a child’s health, parental education is well-established (Behrman & Deolalikar, 1988; Strauss & Thomas, 1995). According to Andersen’s model enabling (wealth), predisposing (age and education) and need based (birth order and women’s autonomy) factors together determine the use of maternal health care services (1995). Women are more responsible for huge participation in family work especially in a situation when they belong to a low economic background as compared to men (Christopher, 2012). Maternal autonomy and maternal health awareness are closely related. “Global strategy for infant and young child feeding” by The World Health Organization (2014) indicated that for children to have positive health care outcomes it is imperative to have access to consistent information on various care practices. Victoria et al. (2008) in their study finds maternal and child health. The present study examines the overall relationship of attributes of women on child’s health care services.

To drive child and maternal health care, women empowerment has long been a hypothesis in the developing world (Dyson & 1983, Filippi et al, 2006). The main concerns in inauguring the links between women’s empowerment and health consequences are deficiency of strong and direct indicators of women’s autonomy and lack of data on society, domestically and individual level that reflects all magnitudes of women’s autonomy (Alkire, 2005; Malhotra & Schuler, 2005). Khan and Maan (2008) declared that an educated woman was more likely to be conscious of getting a job and equal rights to get opportunities, which further contributes to boosting her empowerment. The economic aspect of women’s empowerment denotes mainly the earning autonomy and lack of data on society that reflects all magnitudes of women’s autonomy (Alkire, 2005; Malhotra & Schuler, 2005). Khan and Maan (2008) declared that an educated woman was more likely to be conscious of getting a job and equal rights to get opportunities, which further contributes to boosting her empowerment. The economic aspect of women’s empowerment denotes mainly the earning autonomy and lack of data on society that reflects all magnitudes of women’s autonomy (Alkire, 2005; Malhotra & Schuler, 2005). Khan and Maan (2008) declared that an educated woman was more likely to be conscious of getting a job and equal rights to get opportunities, which further contributes to boosting her empowerment. The economic aspect of women’s empowerment denotes mainly the earning autonomy and lack of data on society that reflects all magnitudes of women’s autonomy (Alkire, 2005; Malhotra & Schuler, 2005).

2. REVIEW OF LITERATURE

Aslam and kingdom (2012) and Tariq et al., (2014) analyzed the relationship between parental education and a child’s well-being in two provinces of Pakistan, Punjab and Khyber Pakhtunkhwa. Data was collected from nine districts of Punjab and ten from Khyber Pakhtunkhwa with a proposed design survey of above 1000 households in 2006-07. The child’s health was measured by the indicators of height, weight and immunizations status. Female maternal empowerment, education, health knowledge, labor market participation and media exposure were used as independent factors. Data examined by ordinary least square and community fixed effects. Instrumental variable estimated that father’s knowledge about health is a key determinate of child’s health. The study accomplished that a mother’s empowerment and knowledge have a significant association with a tyke’s health. Rife (2010); Iliyas and Ali (2011); Raisat et al., (2015) investigated the relationship between reproductive experience and women’s empowerment (WE) from a survey in India. WE variables were measured by several dimensions including financial decision making, mobility, threats of homelessness, and experience of violence. Reproductive events were measured by numerous events containing unwanted pregnancy, miscarriages, stillbirth, and abortions. The required information was gathered through a house-hold based probability survey in Madhya Pradesh, India with a 2435 sample size in 2002 with a logistic regression model. The study concluded that the receiving threats of homelessness are positively related to unwanted pregnancy, and the proportion of abortions is intensely and positively associated with violence.

Ibrahim and Pandey (2015) explored the women’s empowerment indicators and their relationship with child’s health using the sample of 45,516 children in India and 22,462 from Nigeria. Women’s empowerment is examined in two parts, such as decision making self-sufficiency and approach to wife beating. A child’s health is determined in three areas like immunization, nutrition and mortality status. A significant association between women’s empowerment on child’s wellbeing was established. Women’s power of decision making associated with full immunization and stunting. Prately (2016) and Fatima et al., (2015) analyzed women’s empowerment quantitative indicators and their association with parental and child health and maternal health seeking behavior. Data for evidence was collected by 67 eligible studies that reported the direction indicators. Child’s health outcomes like birth skilled attendance, antenatal care, child’s mortality, complete vaccination, contraceptive use, nourishing position and experience with violence were used. The study found that generally, women’s empowerment has a positive and significant relationship with motherly and child wellbeing outcomes.

Aloofe, Zhu, Burney, Naylor and Douglas (2017) examined whether women’s empowerment status, mobility, leadership, economic security, decision making, nonfamily group domain, male involvement in housework are correlated with child’s and women’s health status in the district of Northern Benin, Kalale by using the data of Solar Market baseline study of 2014. To identify the women’s empowerment structure, an exploratory principal component factor analysis was conducted. Dietary diversity score and body mass index were used for measuring the
association between child’s health and women's empowerment. The study established that there is a constructive
association between women's composite empowerment and tyke’s health. Haider, Qureshi and Khan (2017) studied
the effect of women empowerment on maternal health care utilization in Bangladesh using data from the Bangladesh
demographics health survey (BDHS) 2011 with a sample size of 8753. The women empowerment variable was
obtained through factor analysis related to autonomy in decision making regarding health care, financial autonomy
and freedom of movement. The researcher used the conditional mixed process (CMP) model fitted for three
maternal health care indicators, at least four antenatal care visits by trained personnel, postnatal care and
institutional delivery. The study revealed that in Bangladesh, women’s autonomy has a constructive effect on the
maternal health care utilization of kids.

Brajesh, Shekhar, Ranjan, and Chaurasia (2017) and Hassan et al., (2013) analyzed the association of child
health and increased utilization of reproductive services with women’s autonomy in India, Nepal and Bangladesh.
Data was collected from the Demographics National Health Survey of all states. Independent variables were
included two indicators like women’s decision making ability and attitude towards wife beating. A child’s health
was measured by three indicators like postnatal care visits, antenatal care, delivery in the institution, immunization
and modern family planning. The research question was explored with the use of bivariate and multivariate
analysis. The study found a significant association between females’ authorization and deployment of reproductive
child health facilities in all these states

3. METHODS
To succeed the objectives of the present study the set of following research questions and hypotheses were used:

Q1: Do women’s attributes affect the healthcare utilization services, such as antenatal care (ANC) of a child?
Q 2: Do women’s attributes affect the healthcare utilization services like postnatal care (PNC) of children?

H1: demographic variables (age, married age, education, paid job and personal income) will significantly influence
the antenatal care (ANC) of the child.

H2: demographic variables (age, married age, education, paid job and personal income) will significantly influence
the postnatal care (PNC) of the child.

4. DATA SOURCES

4.1. Sample
Reproductive age of females between 21 and 49 years from diverse socioeconomic backgrounds and statuses with
varying education levels- excluding widows or divorced who had not married again was selected as a participant
with a sample size of 350. The District of Multan city was used to collect the sample, which involved the central city
and also its suburbs. Conveniently home base and employed females were particularly selected from randomly
nominated parts of city Multan.

4.2. Measures

Socio-demographic datasheet: To measure the relationship among the variables a socio-economic data sheet was
used. independent and dependent variables are consist of current age, age of marriage, educations years, paid job,
personal income media awareness, antenatal care and postnatal care of a child in district Multan.

In the study Existing age was used as a never-ending form of variable. A questionnaire with self-report was used;
contributors stated their age on their own. In the study age at marriage was taken as a continuous variable. It was
conveniently reported by respondents. The education variable was identified by primary level, matric, F.A/F.Sc.
B.A/B.Sc. M.A/ M.Sc. M.Phil. PhD and if any further categories please identify them. Only physically salaried jobs
(not any hidden jobs) were measured. Occupation position was considered as having =1 paid job and not in paid
job=0. Monthly Income was taken in Pakistani rupee.
4.3. Dependent variable

The minimum frequency of antenatal care visits by trained professionals was recommended by the world health organization. ANC was defined as a dichotomous variable in the empirical model of study. Whether women had at least four ANC visits during the pregnancy from a skilled health care provider, as a ‘yes’ or ‘no’ variable. In the empirical model, within 48 hours of delivery by skilled personal use of PNC is also defined as dichotomous with a ‘yes’ or ‘no’ variable.

4.4. Procedure

After the endorsement of the matter, the data collection was started. Through a convenient sampling strategy, women were communicated at their households and place of occupation. The questionnaires were circulated, after captivating their approval. It was prepared in Urdu keeping in mind the convenience and understanding of respondents. It was verbally explained by the researcher in Saraki and Punjabi language according to the need and for the comfort of the respondent.

4.5. Technique of Estimation

4.5.1. Binary Logistic Regression

Logistic regression is a statistical procedure of estimating the event likelihood within the set of predictor variables. In case the dependent variable has only two values like ‘Yes’ or ‘No’ or ‘0’ or ‘1’ (generally 0 represents the negative and 1 for the positive response). The positive response proportion will be the mean of this variable. In other cases, if the dependent variable has more than two exclusive values like the single, married, widow, or divorced, in this case, the multinomial regression will be used. It describes the association between a set of explanatory variables and a dichotomous response variable. It also reports on the regression line as well as the odd ratios, goodness of fit, likelihood, deviance, and confidence limits. To predict the mean and to envisage a logit transformation of the continuous explanatory variable and dependent variable, we used a mathematical model. If \( \pi \) is the ratio of observation with an outcome of 1, then 1-\( \pi \) is the probability of outcomes of 0. The ratio \( \frac{\pi}{1-\pi} \) is known as odd ratios.

B is the parameter, which determines the rate of intensification or reduction of \( X \) on the log of odds. It is the populace regression coefficient that is to be assessed from the available data.

4.5.2. Log Odd Ratio

For the comparisons of two proportions as like female versus male, two log-odds differences can be used. The log odds ratio is referred to as this difference. It is repeatedly used to relate to extents through groups. The odds ratio is closely connected to the logistic transformations. It reveals the increase and decreases the chance of an event. If the estimated value of odds is greater than 1.0, it indicates that the chance of an event is higher. If the estimated value is less than 1.0, it indicates the chance of an event is less.

4.5.3. Goodness of Fit of the Model

For hypothesis analysis whether the model is well fitted or not, there are some techniques to use. The Hosmer-Lemeshow test is a statistical technique for testing the overall fitness of the model. The Chi-square test was applied on 2xg a likelihood table, the possibility table is assembled by cross-classifying the dichotomous reliant variable with the unassembled age variable. The interpretations are clustered into deciles concentrated on the anticipated probabilities. In the calculation, just about 10 groups are used (g=10). “deciles of risk” are often referred to as the corresponding groups. The test has the advantage of segregating the observed values into specific groups of around identical extent, so less chance to be grouped with very low expected and observed occurrences is present.

A model is fitted by the set of observed data; it is quite normal to investigate the degree to which the fitted values of the observed values under the model are associate with the response variable. The model may be acceptable if the arrangement between the corresponding and the observations fitted values is good. If this case will not happen, then the present form of the model will surely be rejected and the model will be reviewed. This characteristic of the capability of a model is generally mentioned as a goodness of fit. To conclude the whole
consequence of a logistic model, Hosmer and Lemeshow’s goodness-of-fit test was used. STATA statistical software was used to analyze the data in the study.

4.6. Results and Discussion

Table 1. Intercorrelation among the Study Variables (N = 322)

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
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<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ANC</td>
<td>-</td>
<td>.93**</td>
<td>.73**</td>
<td>-.11</td>
<td>.15**</td>
<td>.43**</td>
<td>.32**</td>
<td>.12</td>
<td>.57**</td>
<td>.51**</td>
<td>.32**</td>
<td>.48**</td>
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<tr>
<td>2. PNC</td>
<td>-</td>
<td></td>
<td>.74**</td>
<td>-.12</td>
<td>.15**</td>
<td>.46**</td>
<td>.29**</td>
<td>.09</td>
<td>.54**</td>
<td>.46**</td>
<td>.25**</td>
<td>.43**</td>
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<tr>
<td>4. AGE</td>
<td>-</td>
<td></td>
<td></td>
<td>-.65**</td>
<td>.08</td>
<td>-.02</td>
<td>.10</td>
<td>.05</td>
<td>.07</td>
<td>.10</td>
<td>-.05</td>
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<td>5. M.AGE</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td>-.30**</td>
<td>.17**</td>
<td>.23**</td>
<td>.28</td>
<td>.30**</td>
<td>.23**</td>
<td>.16**</td>
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<tr>
<td>6. EDU</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.61**</td>
<td>.28**</td>
<td>.69**</td>
<td>.67**</td>
<td>.44**</td>
<td>.58**</td>
<td></td>
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<tr>
<td>7. P.JOB</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.59**</td>
<td>.61**</td>
<td>.63**</td>
<td>.38**</td>
<td>.58**</td>
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<tr>
<td>8. P.INC</td>
<td>-</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.40**</td>
<td>.36**</td>
<td>.22**</td>
<td>.34**</td>
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</tbody>
</table>

Note. **p and *p show significance level at .01 and .05 respectively.

Table 1 presents that all variables of the have a significant intercorrelation.

Table 2. The summary of binary logistic model outcomes of ANC (N = 322)

| Variables | Coefficient | Odd ratio | SE | Z  | P|z| |
|-----------|-------------|-----------|----|----|----|----|
| AGE       | -.12389     | .8834771  | .0432486 | -2.86 | 0.004**|
| M-AGE     | .1301707    | 1.139023  | .0469926 | 2.77  | 0.006**|
| EDU       | .1201383    | 1.127653  | .1048504 | 1.15  | 0.252**|
| P-JOB     | -.0892345   | .9146311  | .5575303 | -0.16 | 0.873***|
| P-INCOME  | -.0000162   | .9999838  | 7.39e-06  | -2.19 | 0.029*|

* Significant at 0.05 level, ** Significant at 0.10 level, *** Not significant

Goodness of fit model for ANC.

Number of observation = 322

Number of groups = 10

Hosmer -Lemeshow chi 2 (8) = 14.55

Prob> chi2 = 0.0686

Table 1 shows the coefficients of the determinants of antenatal care of the child.

Table 3. The summary of binary logistic outcomes of PNC (N = 322)

| Variable | Coefficient | Odd ratio | SE | Z  | P|z| |
|----------|-------------|-----------|----|----|----|----|
| AGE      | -.1401825   | .8691996  | .044365 | -3.16 | 0.002*|
| M-AGE    | .1465738    | 1.15786   | .0475266 | 3.08  | 0.002*|
| EDU      | .277427     | 1.31973   | .1095857 | 2.53  | 0.011*|
| P-JOB    | -.3542755   | .7016816  | .563541 | -0.63 | 0.530**|
| P-INCOME | -.0000166   | .9999834  | 7.66e-06  | -2.17 | 0.030*|

* Significant at 0.05 level, ** Significant at 0.10 level, *** Not significant
The goodness of fit test for PNC
Number of observation = 322
Number of groups = 10
Hosmer – Lemshow chi2 (B) = 9.36
Prob> chi2 = 0.3127

Next, we will look at the demographic predictors. Chronological age, marriage age, education and personal income are significantly influenced by PNC. Paid job is not significantly influenced at a 0.05 level. Chronological age significantly influences the PNC of the child. The coefficient of age is negative and equals -.1401. It shows that women who have one unit increase in age will be less likely to take PNC of a child towards a skilled professional. We can say that one unit increase in the age of women would lead to a decrease in the odds of PNC by .869 means 86.9%. The coefficient of age at marriage is positive and equal. to 1465, which shows that one unit increase in the age at marriage of women will lead to a .1464 increase in PNC of a child, with an odd ratio1.157, which shows that women who have a small increase in the age at marriage are more likely to have PNC of the child.

The Coefficient of education is positive with the value of .27742, which clearly shows that women who have more educated would have a .27742 increase in PNC of a child, with an odds ratio of 1.3197. It shows that women who have a one unit increase in education would lead to an increase in the odds by 31.9% and have more PNC of the child. When we look at the coefficient of personal income, it is negative and equals the value -.0000. This means that if women have a high income, they will have decreased logit of -.0000. In other words, we can say that women who have increased in personal income are .9999 times less likely to have PNC of the child.

5. Discussion

In this study, we empirically examined the effects of women’s attributes on the health utilization services of the child (ANC and PNC ) in Multan by using the binary logit model. Our women’s authorization patterns are in line with Haider, Qureshi and Khan (2017) that in reality there has no straightforward measure or indicator of women’s autonomy. A host of social, cultural and economic aspects affect women’s empowerment in society. Individual levels covariates of health care utilization were most commonly used like age, wealth status and education contributing to the shaping of women’s empowerment.

Economic participation as a significant influence is reconcilable with Bushra & Wjiha (2015) that availability of economic opportunities, participation and education positively influences women’s empowerment. The results are consistent with Sado, Sapho, & Hotchkiss (2014) that the richer women’s level of ANC tended to be high than the poor. If we look at the results of women’s attributes, we can say that the current age increase by one unit, the probability of being taken care of the child will be decreased, so it has a negative effect on ANC. Sado, Sapho, & Hotchkiss (2014) also found that age is not significant in ANC & PNC visits.

Age at marriage has a positive effect on the ANC of the child. It means that with one unit increase in the age at marriage probability of taking care of the child will also increase. The results of personal income are in line with Khan et al (2017) that personal income has a negative effect on health care utilization services. As concerned with women’s attributes, chronological age and marriage are found to be significant predictors of PNC of child chronological age is negatively influenced the PNC. The result is consistent with Ibrahim & Pandey (2014) that older women are less likely to have decision-making power than younger women. Results are insignificant for the older age group in Nigeria. For improving women’s empowerment the fundamental mechanism is economic progress. It will affect the women’s life quality and it is a time-consuming process. The economic domain positively influences the PNC. Ibrahim & Pandey (2014) also found that the wealth status of the household has a direct impact on kids’ health. They are 1.95 and 2.34 times more likely to have ANC and PNC visits.

A highly educated woman has more power to take health care utilization services of a child. Education is found to be a positive determinant of the PNC of the child. The results are consistent with Haider, Qureshi, & Khan (2017) that ANC and PNC are associated with a higher level of education. The education of the mother has a positive association with the child’s weight and height. (Aslam & Kingdon., 2014).
6. POLICY IMPLICATION AND LIMITATION

This is an initial study in district Multan. It has to be studied further in other city districts and also in other provinces of Pakistan. The study was carried out from a selected area of the district area not cover the overall area, so we should be cautious in generalization the results. Most of the respondents (women) included in the research were belong to the rural area of Multan, so women from the urban area should also be included in further investigation. A significant limitation of our study is that it does not take account of the other neighborhood-level factors such as the quality and availability of parental health care facilities. We can re-estimate the study by including these factors.

7. CONCLUSION AND RECOMMENDATIONS

We may conclude that all empowering domains significantly influence the antenatal and postnatal of the child. Some are negative and some with positive relationships. Results are fluctuating from condition to condition. Women’s attributes (e.g., age, marriage age, education, paid job and Personal income) are significantly influence the antenatal and potential of the child. It seems that women’s attributes are vital in making women more empowered in taking health care services. Tangible steps of making policy should be seriously be taken by the government. Non-government institutions and women’s organizations are also responsible to motivate and target the process of making women empower. Government policy should be directed to provide an encouraging atmosphere for women so that they can achieve good and equal opportunities in society.

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