

Faculty of Social Sciences and Humanities

Influencing of Cultural Factors in Women Maternal Health Care: A Case Study in Tehsil Jampur, District Rajanpur of Punjab, Pakistan

Altaf Ghani

Doctor of Philosophy
2024

Influencing of Cultural Factors in Women Maternal Health Care: A Case Study in Tehsil Jampur, District Rajanpur of Punjab, Pakistan

Altaf Ghani

A thesis submitted
In fulfilment of the requirements for the degree of Doctor of Philosophy
(Anthropology)

Faculty of Social Sciences and Humanities
UNIVERSITI MALAYSIA SARAWAK
2024

DECLARATION

I declare that the work in this thesis was carried out in accordance with the regulations of Universiti Malaysia Sarawak. Except where due acknowledgements have been made, the work is that of the author alone. The thesis has not been accepted for any degree and is not concurrently submitted in candidature of any other degree.

……

Signature

Name: Altaf Ghani

Matric No.: 17010096

Faculty of Social Sciences and Humanities

Universiti Malaysia Sarawak

Date :

ACKNOWLEDGEMENT

It is all the grace of Allah Almighty who bestowed strength and capability upon me to undergo this PhD program and accomplish it. In the first place, I am sincerely grateful to my supervisor Dr. Zamri Bin Hassan for his invaluable professional supervision, critical engagement and encouragement throughout this process. I highly appreciate his patience and support through tough times, whether it was personal or professional. As well as, I am thankful to my co-supervisor, Dr. Dolly Paul Carlo for his worthwhile support for my thesis.

Additionally, I give my warmest thanks to my wife and sons whose patience and encouraging remarks sustained me this far. Words cannot express my gratitude to my parents, especially my father Mian Abdul Ghani Bhatti (Late) who trusted me when I lost faith in myself. I am blessed to have the love and prayers of my sweet mother and sincere wishes of my brothers and sisters. I would like to thank Durr-e-Sadaf, Shagufta Hamid, Ms. Farzana and Ms. Tahira who assisted me during my data collection. I appreciate Awais Raza and Hassam who helped me with transcription of the interview. Heartfelt thanks to Zahid Mehmood Dewal for his support in data analyses and proof reading. I owe thanks to Abdul Satar Khan Darreshak who provided me with all the required facilities during my field work. I indebted to my all-research participants, without their hospitality and cooperation, this research would not have been possible.

Last but not least I want to extend my gratitude towards Dr. Adnan Shahid Khan. his able guidance and kindness definitely means a lot to me. I am also thankful to all those in Faculty of Social Science and Humanities and Center for Graduate Studies (CGS) University

Malaysia Sarawak who facilitated me throughout the process of PhD. I cannot thank enough to all friends and colleagues who become my extended family in UNIMAS.

ABSTRACT

Reproductive health significantly influences the overall health of individuals and society. It has been the subject of increased attention from a health viewpoint. In 2014, World Bank also emphasized the reproductive health issue by revealing that globally, 287,000 women die from complications in pregnancy and childbirth each year. This is still one of the leading causes of death and disability among women of reproductive age in low-income countries including South Asian developing countries. Pakistan is in the South Asian region with poor health indicators coupled with high poverty and illiteracy. In Pakistan on average eighty women die every day because of pregnancy-related complications. Pakistan holds the fifth position throughout the world in accordance with population. The maternal mortality ratio in Pakistan is 186 deaths per 100,000 live births. The ratio is nearly 26% higher in rural areas as compared to urban areas. (Pakistan Maternal Mortality Survey, 2019). Design of study is qualitative to use the appropriate methods and document the maternal health services, common traditional/ Indigenous practices relating to pregnancy, childbirth, and the postpartum period. The study also explores the gender and prevailing decision-making beliefs in Pakistani rural cultures. Purposive sampling used to collect data from forty-two respondents through In-depth interview and in five group discussions. Sample was the married women from age group 15-49 and have at least one child. Twenty key informant / cultural consultant (Health Professional, Health Worker, TBAs, and experienced community men and women) were interviewed for data support in Tehsil Jampur District Rajanpur. Thematically the study was analyzed on the bases of structural-agency theory and delays Modal. Study observed the maternal health services, cultural beliefs such as food habits, gender norms, religious and behavioral taboos and herbal and traditional healthcare practices in all three stages of maternity, prenatal, natal and postnatal. The study also discovers the

systemic structural delays in care-seeking, household hierarchical system which marginalized the women in decision making. Male supremacy and dominancy effect the women decision-making power in healthcare-seeking and clinical intervention. Duality in faith was observed where both traditional /herbal remedies along with allopathic medicine were used simultaneously. Facility-based challenges were present in the health institutions and faced by participants including lack of equipment's, medicine and professionalism. Financial constraints and poor road infrastructure make it a gloomier. In the light of these finding, there is a need to adopt the gender mainstreaming policy and empower women culturally at household and community level. There is also a dire to involve and strengthen the role of man in women healthcare program.

Keywords: Reproductive health, cultural beliefs, maternal healthcare, gender, decision making, male dominance, dualism, ethno-medicine, home remedies

Pengaruh Faktor Budaya dalam Penjagaan Kesihatan Ibu Mengandung: Kajian Kes di Tehsil Jampur, Daerah Rajanpur Punjab, Pakistan

ABSTRAK

Kesihatan reproduktif sering kali mendapat perhatian kerana dikatakan mempunyai hubungan dengan kesihatan secara keseluruhan. Tahun 2014, Bank Dunia mendedahkan, sejumlah 287,000 wanita meninggal dunia kerana komplikasi kehamilan dan kelahiran. Ini menjadi salah satu sebab kematian wanita di Pakistan, negara yang mempunyai petunjuk kesihatan yang kurang baik dengan kemiskinan dan buta huruf yang tinggi. Di Pakistan, purata 80 orang wanita meninggal dunia setiap hari akibat komplikasi yang berkaitan dengan kehamilan. Kadar kematian akibat kehamilan adalah 186 kematian bagi setiap 100, 000 kelahiran – dengan hampir 26% peningkatan di kawasan pedesaan dibandingkan dengan kawasan perbandaran. Kajian ini dibuat secara kualititatif dengan menggunakan kaedah-kaedah yang bersesuaian termasuk penggunaan dokumen rasmi berkaitan perkhidmatan kesihatan berkaitan kehamilan, amalan etno perubatan dalam hubungannya dengan kehamilan, kelahiran, dan tempoh selepas bersalin. Kajian ini menjejaki isu berkaitan gender dan pengambilan keputusan di kawasan pedesaan. Pemilihan sampel bertujuan digunakan melibatkan 42 orang responden kajian, dengan pengumpulan data melalui wawancara selain lima diskusi berkelompok. Responden terdiri daripada wanita yang berkahwin berumur di antara 15–49 tahun dan sekurang-kirangnya mempunyai seorang anak. Seramai 20 orang pemberi makluman utama juga diwawancara di sekitar Tahsil Jampur, District of Rajanpur. Kajian mendapati, perkhidmatan kesihatan semasa kehamilan dan kepercayaan berkaitan budaya kehamilan diamalkan sepanjang proses kehamilan dan kelahiran yang meliputi pemilihan makanan, norma budaya dan agama, pantang larang dan sebagainya. Kajian juga menemukan adanya keterlambatan struktural

dalam pembuatan keputusan berkaitan jagaan kesihatan dan sistem hirarki rumahtangga yang menafikan wanita dalam pembuatan keputusan. Sifat ketuanan lelaki dan kesan dominasi mempengaruhi pembuatan keputusan dalam kalangan wanita dalam hubungannya dengan pencarian jagaan kesihatan dan intervensi klinikal. Walau bagaimana pun, kedua-dua kaedah pemulihan tradisional dan kaedah allopathic digunakan secara bersamaan. Cabaran berkaitan dengan kemudahan di institusi kesihatan ditemukan dalam kajian ini selain daripada cabaran kewangan dan sistem jalanraya yang kurang baik. Kesimpulannya, ada keperluan untuk menambahbaik dasar berkaitan peranan gender dan memperkasa wanita di peringkat keluarga dan komuniti. Terdapat juga gesaan untuk mengikutsertakan dan memperkuat peranan lelaki dalam program-program jagaan kesihatan terutama yang berkaitan dengan wanita.

Kata kunci: *Kesihatan reproduktif, kepercayaan budaya, jagaan kesihatan ibu, gender, pembuatan keputusan, dominasi lelaki, perubatan etnik, rawatan rumah*

TABLE OF CONTENTS

		Page
DECLARATION		**i**
ACKNOWLEDGEMENT		**ii**
ABSTRACT		**iv**
ABSTRAK		**vi**
TABLE OF CONTENTS		**viii**
LIST OF TABLES		**xv**
LIST OF FIGURES		**xvi**
LIST OF ABBREVIATIONS		**xvii**
CHAPTER 1	**INTRODUCTION**	**1**
1.1	Introduction	1
1.2	Background of the Study	1
1.3	Pakistani Women's Status and Reproductive Health	7
1.4	Research Gap	12
1.5	Problem Statement	16
1.6	Research Questions	18
1.7	Research Objectives	18
1.8	Scope of the Study	19
1.9	Significance of the Study	20

1.10 Chapter Organization: 22

1.11 Conclusion 24

CHAPTER 2 DEMOGRAPHIC BACKGROUND OF PAKISTAN AND PROFILE OF STUDY AREA 25

2.1 Introduction 25

2.2 Brief of Pakistan 25

2.3 Maternal Healthcare Interventions in Pakistan in 2019 29

2.3.1 Maternal, Newborn and Child Health (MNCH) Strategy in Pakistan 31

2.3.2 The Core Component of Integrated Reproductive Maternal Newborn, Child Health and Nutrition (IRMNCAH&N) Strategy (2016-2020) 32

2.3.3 Challenges of Plan 34

2.4 Punjab Profile 36

2.5 Study Site Brief 39

2.6 Conclusion 45

CHAPTER 3 LITERATURE REVIEW 47

3.1 Overview 47

3.2 Previous Studies 47

3.2.1 Maternal Healthcare Services 48

3.2.2 Socio-Cultural Determinants of Maternal Healthcare 51

3.2.3 Gender and Decision Making in Maternal Healthcare 56

3.2.4 Indigenous Remedies and Maternal Healthcare 59

3.2.5 Critical Summary 63

3.3 Conceptual Framework 65

3.4 Theories and Models of Healthcare Services Utilization 71

3.4.1 The Structure and Agency Theory 71

3.4.2 Structuration and Health Inequalities 73

3.4.3 Gender Empowerment Framework 74

3.4.4 The Three Delays Model 76

3.5 Conclusion 79

CHAPTER 4 RESEARCH METHODOLOGY 81

4.1 Introduction 81

4.2 Qualitative Design of Study 82

4.2.1 Justification of Qualitative Design of Study 83

4.3 Respondents and Key Informants Sampling Procedure 84

4.3.1 Respondents 85

4.3.2 Key Informants 86

4.3.3 Research Assistant 87

4.4 Data Collection Methods 89

4.4.1 Field Research 89

4.4.2 Focus Group Discussion (FGDs) 90

4.4.3 In-depth Interview 92

4.4.4 Face to face Interaction 93

4.5 Pilot Study 93

4.6 Data Saturation 95

4.7 Data Analysis and Presentation 96

4.8 Data Recording Procedure/ Transcription of Interview 97

4.9 Ethics of the Research 98

4.10 Validity and Reliability 100

4.11 Field Challenges 103

4.12 Conclusion 104

CHAPTER 5 MATERNAL HEALTH BELIEFS/ PRACTICES AND INFLUANCE OF FAMILY DECISION MAKING 106

5.1 Introduction 106

5.2 Attitude/ Perception of the Jampur Families 108

5.2.1 Family System and Ascendant Influence 109

5.2.2 Eating Food Habits 113

5.2.3 Food Diet (Cold/ Soft & Warm/ Hard Food) 114

5.2.4 Illness and Healing Practice 122

5.2.5 Physical Movement and Maternal Beliefs 129

5.3 Religious/Spiritual Beliefs and Practices Regarding Maternal Health 133

5.3.1 Mannat (Wish) 135

5.3.2 Taweez (Amulet) 136

5.3.3 Dam Kerna (Insufflate) 137

5.3.4 Sadqah (Charity) 137

5.3.5 Milad and Wazeefa (Meditation) 138

5.4 Rituals Regarding Mother and Newborn 138

5.4.1 Rituals Regarding Mothers 139

5.4.2 Rituals Regarding Newborn 144

5.5 Decision Making Towards Health Care Seeking 150

5.5.1 Influence of Family Decision Making on Maternal Health 153

5.5.2 Role of Husband in Maternal Health 157

5.5.3 Traditional Birth Attendant (TBA)'S Role in Decision-Making 163

5.6 Decision-Making and the Role of Traditional and Spiritual Methods 164

5.6.1 Prenatal and Postnatal care and Decision Making 165

5.7 Critical Analysis/ Commentary 171

5.8 Conclusion 177

CHAPTER 6 INDIGENOUS REMEDIES AS AN ESTABLISHED WAY OF MATERNAL HEALTH 180

6.1 Introduction 180

6.2 Efficacy of Traditional and Herbal Medicine as Indigenous Remedies 180

6.3 Indigenous Traditional Care System 183

6.3.1 Family Role 185

6.3.2 Role of Traditional Birth Attendant (TBA) as Herbalist 193

6.3.3 Role of Spiritual/Religious Healer 209

6.4 Critical Analysis/ Commentary 218

6.5 Conclusion 222

CHAPTER 7 COMMUNITY EXPERIENCES AND PERCEPTION TOWARDS PREVAILING HEALTH CARE SERVICES 223

7.1 Introduction 223

7.2 Mechanism of Health System in Pakistan 224

7.3 Integrated Reproductive Maternal Newborn, Child Health and Nutrition (IRMNCH&N) Programs Important Features 227

7.4 Provision and Reception of Community about MH Services 236

7.4.1 Financial Constraints 238

7.4.2 Lack of Professionalism 240

7.4.3 Lack of Facilities 242

7.4.4 Transportation Network 245

7.4.5 Poor Clinical Turnout 247

7.5 Critical Analysis/ Commentary 249

7.6 Conclusion 252

CHAPTER 8 CONCLUSIONS AND RECOMMENDATIONS 254

8.1 Introduction 254

8.2 Key Findings 255

8.2.1 Conclusion of the Key Finding 261

8.3 Contribution to Knowledge 263

8.4 Limitations of the Study 267

8.5 Recommendations/Outcomes of Research 268

8.5.1 Policy Recommendations 273

8.6 Conclusion 278

REFERENCES **280**

APPENDICES **314**

LIST OF TABLES

		Page
Table 2.1:	Major Population, Health and Education Indicators	27
Table 2.2:	Maternal Health Care Indicators of Pakistan	35
Table 2.3:	Administrative division of Punjab	37
Table 2.4:	Major Population, Health and Education Indicators of Punjab	38
Table 4.1:	Distribution of Cultural Consultants and key Informants	88
Table 5.1:	Thematic Analysis of Maternal Health Beliefs / Practices	107
Table 6.1:	Thematic Analysis of Indigenous Remedies and an Established Ways of Maternal Health	183
Table 6.2:	Home Remedies	186
Table 6.3:	Traditional Birth Attendant (TBA) Remedies	195
Table 6.4:	Spiritual and Religious Remedies	211
Table 7.1:	IRMNCH program staff and health centers at Tehsil Jampur District Rajanpur	235
Table 7.2:	Thematic Analysis of prevailing Health care System and Community Perceptions	237

LIST OF FIGURES

		Page
Figure 2.1:	Province Wise Map of Pakistan	28
Figure 2.2:	District Wise Map of Punjab Province	39
Figure 2.3:	Union Council Wise Map of District Rajanpur	43
Figure 2.4:	Study Area Map	44
Figure 3.1:	Empowerment Framework	76
Figure 3.2:	Three delay Model	79
Figure 5.1:	Rituals Regarding Mothers	139
Figure 5.2:	Rituals Regarding Newborn	145
Figure 7.1:	Organization of Public Health Care System	225
Figure 7.2:	Administrative Organogram Punjab	226
Figure 7.3:	Organogram of MNCH Program	233
Figure 7.4:	Organogram of Health Services Providers at Union Council Level	236
Figure 8.1:	Healthcare Service Utilization Model	266

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
BHU	Basic Health Units
CAM	Complementary and Alternative Medicine
CBO	Community Based Organization
CGS	Center for Graduate Studies
CMW	Community Midwife
CPR	Contraceptive Prevalence Rate
CSDH	Commission on Social Determinants of Health
DC	Delivery Care
DHQ	District Head Quarter
DNC	Dilation and Curettage
EmONC	Emergency Obstetric and Newborn Care
EoC	Emergency Obstetric Care
EPI	Expanded Program on Immunization
FGD	Focus Group Discussions
FP	Family Planning
FWW	Family Welfare Worker
GDP	Grass Domestic Product
GER	Gross Enrolment Rate
GIS	Geographic Information System
GoP	Government of Pakistan
HC	Health Care

HIV	Human Immunodeficiency Virus
HM	Herbal Medicine
ICPD	International Conference on Population Development
ICRW	International Center for Research on Women
IDI	In-Depth Interview
IEC	Information Education and Communication
IRMNCAH&N	Integrated Reproductive, Maternal, Newborn, Child & Adolescent Health and Nutrition
IUD	Intra Uterine Device
IYCF	Infant & Young Child Feeding
KM	Kilometer
KP	Pakhtunkhwa
LFPR	Labor Force Participation Ratio
LHS	Lady Health Supervisor
LHV	Lady Health Visitors
LHW	Lady Health Workers
LHWP	Lady Health Workers Program
MCH	Mother and Child Health
MCHC	Maternal and Child Health Center
MDGs	Millennium Development Goals
MICS	Multiple Indictor Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health

NATPOW	National Trust for Population Welfare
NGOs	Non- Governmental Organizations
NIPS	National Institute of Population Studies
PCP	Pregnancy, Childbirth and Postpartum
PDHS	Pakistan Demographic and Health Survey
PDHS	Pakistan Demographic Health Survey
PHC	Primary Health Care
PIHS	Pakistan Integrated Household Survey
PIHS	Pakistan Integrated Household Survey
PNC	Postnatal Care
RH	Reproductive Health
RHC	Rural Health Centre
RHCRA	Reproductive and Healthcare Rights Act
RMNCH	Reproductive, Maternal, Newborn and Child Health
SDGs	Sustainable Development Goals
SRH	Sexual Reproductive Health
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
THQ	Tehsil Head Quarter
TM	Traditional Medicine
UC	Union Council
UNDP	United Nation Development Program
UNFPA	United Nation Population Fund

UNICEF	United Nation International Child Fund
UNIMAS	University Malysia Sarawak
UNO	United Nation Organization
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

1.1 Introduction

This chapter begins by providing an overview of the significance of women's maternal health care worldwide. There is a brief description of cultural factors and how they influence women's maternal health. It also provides a description of important aspects of Pakistani society particularly the Rajanpur district on women's maternal health status. This chapter provides the problem statement, aims and objectives of the research study and also highlights the significance and scope of the current research.

1.2 Background of the Study

Reproductive health refers to the ability to enjoy a responsible, satisfying and safe sex life in association with all matters of the productive system, its functions and its process which is accomplished in a state of complete physical, mental and social well-being without any disease or disability (WHO, 2017). Reproductive health is not just about enjoying healthy sexual relationships but also about the ability to reproduce and safe fertility regulation concerning with accomplishment of reproduction, survival, infant healthy growth as well as sound pregnancy. The reproductive health of a woman is not just confined to reproductive years, which are generally from the age of 15 to 49, rather it is associated with different stages (Sully et al., 2019). These stages include infancy, adolescence, adulthood, and older age as the foundation of health in adult life is based on the well-being in earlier stages (Sully et al., 2019). In these stages of women, there are different reproductive health behavior and needs. Safe Pregnancy, childbearing, motherhood in teenage, postnatal, antenatal care, advice on family planning, post-delivery, place of delivery, infant care:

neonatal and post-neonatal mortality, intended births, unwanted births, abortion and maternal mortality are all main aspects of reproductive health of women.

In general, issues of reproductive health (RH) of women can be categorized into three types. That is intended or unintended births, childbearing and safe pregnancy, and healthy sexuality (Sully et al., 2019). The first two types are the major concern of the research study because these major issues lead to exposing the aims of the study. For example, if a woman gives birth to a child early, frequently or too late, her health is at risk. Maternal reproductive health is the focal concern of this research that emphasizes the pillars of safe motherhood including improved antenatal care, guideline towards family planning and delivery by skilled professional and obstetric care.

Women play a key role in developing society and up till now, they are facing these issues in terms of reproductive health (Fathalla, 2011). Women's health and its associated issues have been a topic of concern globally for decades. This concern is underscored because of women's unique role in the socio-biological construction and reproduction of society. Women's health is an indicator of the development of a nation. Reproductive health and rapid population growth have strong linkages with sustainable social development and economic growth (Pillai & Maleku, 2015). This viewpoint can be explained as if there is rapid population growth against scarce resources then it would be a major problem concerning socio-economic stability that is still being faced by most countries in the world today. Women's health would be affected as well because of scarce resources it is hard to maintain good healthcare (HC) facilities for them which may lead to endangering safe motherhood. So, it is important to build a secure healthy environment with all concerning facilities and amenities for women to improve their reproductive health. Such as safe

motherhood that includes a chain of schemes, practices, procedures and service delivery guidelines planned to guarantee that women receive first-class maternal care, prenatal, delivery and family planning services. It is pivotal to maintain a women's health because it is the only way to assure improved health and well-being of future generations including men, women and children.

Reproductive health significantly influences the overall health of individuals and society and has been the subject of increased attention from a health point of view. In 2014, World Bank also emphasized the reproductive health issue by highlighting that globally, 287,000 women die from complications in pregnancy and childbirth each year (World Bank, 2014) which is one of the leading causes of death and disability among women of reproductive age in low-income countries. According to the report, 45 low-income countries remain burdened by increasing rates of fertility and maternal mortality that are associated with gender inequality and high infant mortality (World Bank, 2014). In which South Asian developing countries also prevail. Pakistan is a South Asian region with poor health indicators coupled with high poverty and illiteracy indicators.

It was declared in the Reproductive and Healthcare Rights Act (2013) that the principal right is the right to life. However, in Pakistan on average eighty women die every day because of pregnancy-related diseases or illnesses (National Assembly of Pakistan, 2018). Similarly, millions of other women survive but suffer from complications such as infertility. This act promoted the reproductive healthcare rights of men and especially women. It readdressed the pregnancy and childbirth complications that lead to the main reasons and consequences of morbidity and mortality for women of reproductive age and reduced maternal deaths which have serious consequences within the family. An important

intervention to reduce the huge number of maternal deaths is to ensure appropriate care of women during childbirth. However, in many developing countries such as Bangladesh, women are considered to be responsible for any mishap related to reproductive health (Zahan, 2014). That reflects the lack of women's reproductive health knowledge among the people of these countries.

According to the Reproductive and Healthcare Rights Act (2013) by the national policy of Pakistan, women have the right to reproductive healthcare information. Women should be provided with reproductive healthcare information, which provides awareness regarding the mental and physical health and well-being of individuals and families. According to the act women have the right to ensure reproductive life decisions that are made with informed consent and the right to get public awareness on the prevalence and impact of morbidity and mortality and the availability of medical science to prevent this suffering.

At the 1994 International Conference on Population Development (ICPD), the governments agreed that services and information should be made available to women and men to help them to understand their sexuality and protect themselves from sexually transmitted diseases and infections (STDs/STIs), undesirable pregnancies, and consequent infertility problem. Education should be given to men to respect the self-determination of women regarding reproduction. However, such type of education is not disseminated in South Asian countries and the reasons behind it are cultural factors. Level of awareness regarding reproductive health matters because reproductive health information of women in rural areas is often influenced by myth (UNFPA, 2020).

Reproductive health information, counseling and delivery have been distinguished as vital for all people, irrespective of their age, gender or other characteristics for decades.

Reproductive health rights include the right to access information and services regarding RH and support the choices and promote reproductive health. Firstly, in 1994 Reproductive health rights were officially recognized in Cairo at International Conference on Population and Development (UN, 1995). Previous to this, only fertility control, safe motherhood, and family planning were focused on reproductive health programming among which population control was the only concern at that time. Later, the Fourth Worldwide Conference on Women, in Beijing in 1995, embraced the right of individuals to RH information and amenities (UN, 1995). Afterward, at the 2005 World Health Summit, world leaders perceived that Reproductive Health was basic to the accomplishment of the MDGs. Resolutions were planned to make universal access to reproductive health a reality by 2015 offering urgency for providing fundamental RH services information to the youth (UNFPA, 2009). However, regardless of the commitments, the progress towards the program of action was seen to be slow; because at ground level, there are different interpretations of reproductive rights because of cultural norms and lack of resources.

United Nations Population Fund (UNFPA), in 2004 declared that some countries have seen uncertain development in maintaining reproductive health, while others have seen none, which resulted in a high mortality rate of mothers and infants (UNFPA, 2004). It was also confirmed by World Health Organization (WHO), that issues of reproductive health have not been affected much more in developing countries. Inadequate management of reproductive health strategies has continuously worsened the vulnerability. Resultantly high infant and maternal mortality, increasing poverty, sexually transmitted infections (STIs) and a high incidence of morbidity and mortality have made it worse. Because of the cultural, and socio-economic implications and health-related problems, that high population growth rate can still be seen in developing countries.

Reproductive health care is not only a woman's matter, other entities such as paternity, family, society and laws have a great impact on women's reproductive health. These entities together make a culture for determining rules regarding the reproductive health of women. Federation accounts, in its 1994 World Report regarding the Health of women, that the health of women is so often compromised not by lack of medicinal knowledge, but rather by contraventions of the human rights of women and culture (Zahan, 2014). So, it can be said that culture matters and influences reproductive health, since people move to expand access to RH information and services, they need to use culturally sensitive approaches to ensure a better understanding of reproductive health and achievement of equity between genders. Positive values and norms are influenced by cultural and religious traditions that need to be understood so these traditions can be used as a tool to improve women's reproductive health awareness among vulnerable females.

As far as the health care providing system is concerned, the system of health care is comprised of informal and formal sectors in Pakistan (Sheikh et al., 2016). The local noncertified health care providers, like spiritual healers, Hakims (practitioners that use home remedies or Greek medicines), and TBAs are included in the informal sector. While in the Formal sectors, both public health facilities and private health facilities are included. As far as the public health system is concerned in Pakistan, it is recognized under the Federal Government and Provincial Health Ministries. There is also a private sector. In this sector, a large number of non-official tertiary, primary and secondary clinics and hospitals some official tertiary-level hospitals are included. The informal healthcare system is supported by a large number of people because of affordable treatment and its availability within the local community and its closeness to cultural beliefs. Keeping in view the above discussion about programs, policies, medical systems and socio-cultural strength of reproductive health.

This study is designed to identify the influence of cultural factors affecting women's maternal health in Jampur through studying their traditional practices. The reason to select the region of Jampur is that, according to Multiple Indicator Cluster Survey (MICS) report in 2011, whole district has a poor health infrastructure. Health services are correspondingly weak and literacy is low, particularly amongst women. Only 29% of young women are literate. About 60% of the population of Rajanpur is covered by Lady Health Worker program but Rajanpur district has amongst the poorest indicators for maternal and child health. The MICS survey in 2011 found that of every 1,000 children born, 104 died before the age of five, and 82 before completing their first year of life.

The purpose of this study is to provide a comprehensive review of the evidence regarding the most common traditional practices in Jampur relating to pregnancy, childbirth, and the postpartum period. This study will provide an explanation of the practices and beliefs that are prevailing in Pakistani rural cultures. This study will examine a broad range of beliefs and practices by geographic concentration. Before proceeding on, it is important to be acquainted with the status of Pakistani women in general as well as in association with maternal health to develop a good understanding of sociocultural norms and practices that affect their reproductive health. For this purpose, the discussion is given below.

1.3 Pakistani Women's Status and Reproductive Health

Pakistani women are facing culturally constructed discrimination on the basis of their sex (Nasrullah, 2015) which may start from childhood or sometimes right after birth (Qadir et al., 2011). That’s why after many decades of independence, Pakistani women are still deprived of their rights, including the right to live (Qadir et al., 2011) in spite of the Bill

passed by Govt. of Pakistan to redress RH-related complications like infertility, fistula, STDs and maternal mortality (Reproductive Healthcare and Rights Act, 2013).

Pakistan holds the fifth position throughout the world in accordance with population. The maternal mortality proportion in Pakistan is 276 deaths for every 100,000 live births (Sheikh et al., 2016). The latest review named 'Pakistan Maternal Mortality Survey 2019' led by the National Institute of Population Studies (NIPS) and financed by USAID shows impressive demographic variations in maternal mortality ratio that is almost 26% higher in rural regions when contrasted with urban regions (Pakistan Demographic and Health Survey, 2012). MMR for urban regions of Pakistan is 158 while the again MMR for rural regions is 199 which shows a distinction of 41 deaths for every 100,000 live births (Pakistan Maternal Mortality Survey, 2019).

There are inconsistent and biased gendered practices in Pakistan. Hanif et al. (2021) mentioned that as indicated by a recent survey report, 62% of rural women of reproductive age are uneducated which is much more than the uneducated ratio of the urban women (34%) population. While in urban Pakistan the ratio of women of reproductive age, having a secondary or higher education is 39% and 14% is of rural women. The present situation serves as a stimulus for expanding the maternal mortality ratio. Gender-based disparities such as denying their basic essential rights and independence greatly influenced women's reproductive healthcare behavior and practices (Rizvi et al., 2014). In the global gender equality scenario, Pakistan portrays an awful picture of a gender-based discriminatory society as it gained 151 positions out of 153 countries in Global Gender Gap Index (Global Gender Gap Report, 2020). It is a dreary situation where near about 48% of the population doesn't have equivalent opportunities for educational accomplishment, economic

establishment, political participation and even in health and survival assurance (Hanif et al., 2021). Women's reproductive health, just as maternal mortality rates, are to a great extent directed by their decision-making powers for their health (Jafree, 2020).

Violence against women particularly spousal viciousness has adverse consequences on maternal health as well as on antenatal consideration (Rizvi et al., 2014). As indicated by studies, spousal brutality aggravates the risks concerned with complicated maternal health conditions. Women encountering violence are probably going to have more possibilities of terminated or lost pregnancy. In regions where medical centers or healthcare services facilities are already scant, situations became more threatening (Hanif et al., 2021). In most pessimistic scenarios based on the account of female fetuses' women face an incline toward domestic abuse and are even beaten to death in some cases (Rizvi et al., 2014).

It is a fact that high MMR is associated with child marriage and early marriages which is basically not a more noteworthy concern for other south Asian countries like India, Bangladesh, and Nepal as it stays for Pakistan (Nasrullah et al., 2013). For instance, in the case of early marriage, women are probably not going to use maternal healthcare services by means of trained medical staff before the legal age of marriage as per law. Further, early marriage may lead to maternal complications such as anemia, premature and low-birth-weight infants, hypertension, abortion, and child and maternal morbidity and mortality (Nasrullah & Bhatti, 2012). Thus, they are bound to deliver their children at home which may be resulted in the expansion of maternal mortality and morbidity rate (Hanif et al., 2021).

Poverty is another barrier to good maternal health. Socio-economic factors are much time ascribed to the poor health status of women in Pakistan, particularly those living in rural

regions (Khan et al., 2009; Ariyo et al., 2017) as low resources restrict them to avail good health facilities and confined them to the traditional health system. The difference in the economic establishment between rural and urban populations increases rural women's concern for reproductive health (Muldoon et al., 2011; Rai & Tulchinsky, 2012). They become victims of undernourishment and their children face vulnerability to being malnourished. Then Poverty is an inclining factor in seeking healthcare facilities in the pre-natal, antenatal and post-natal periods. Women belonging to poor families usually have higher fertility rates, more rate of going through unsafe or traditional delivery practices performed by untrained people, and less proof of following a family planning routine (Hanif et al., 2021).

In many cultures, extended family members and parents provide knowledge about beliefs, values, and attitudes regarding women. In South Asian countries like Pakistan, women are more dependent on their elders regarding reproductive health issues (Anon, 2006). Women in Pakistan do not prefer doctors, midwives or nurses to seek care, rather they prefer decisions of in-laws or husbands (Tarar et al., 2015). In all factors, husbands are the most significant factors that influence the reproductive health of women negatively or positively, indirectly or directly (Tarar et al., 2015). While those women whose husbands are not concerned about their wives' complications of pregnancy are less likely to seek care from health professionals one and a half times. The culture of silence made women dependent on others even for their health matters (Rashid, 2016). For example, in rural areas, the major decisions related to care for pregnancy and childbirth are taken by mothers-in-law. The decision about how the delivery will be taken place; whether by a health facilitator or the traditional birth attendant (TBA) and likewise matters are influenced by the mother-in-law's decision (Omer, 2019). Because of the lack of work in terms of cultural factors' effect

on reproductive health in Pakistan's rural areas this research would be an extension to know such effects on the reproductive health of women in Pakistan.

Beliefs regarding health depend on religious and cultural norms. As maintained by Adelson (2014) that there are some factors that affect women's reproductive health status, such as the gender-based role of mothers in childbearing according to traditional and cultural beliefs, that can result in less empowerment of women regarding taking decisions about child spacing, fertility and aspects of family planning. It is well known that beliefs and practices, whether based on tradition or convention, have been found to have a strong influence even on educated persons and they cannot be easily overcome by ordering scientific proof (Withers et al., 2018). Women have a greater vulnerability to traditional beliefs and such beliefs are more concentrated around pregnancy and childbirth than on other areas of life (Hira et al., 2002). This study will not be judgmental of practices based on such beliefs. It will be concerned with their influence on reproductive health, their identification and their influence on respondents' behavior.

There is a culture of silence (Rashid, 2016). Lack of social interaction between males and females enforces restrictions in health-seeking for women. Mostly, women are not comfortable allowing male doctors to examine them, because it is also against religious or cultural norms. These traditional maternal health care practices lead rural women to access informal and private health care services such as traditional physicians, homeopaths, herbalists, spiritual and traditional healers, and other providers that are not qualified, for example, pharmacy dispensers and medical experts (Syed et al., 2008). The reasons behind the use of ethnomedicinal methods and their impact will be studied in order to get complete

information regarding the influence of beliefs on women's reproductive health and knowledge of women regarding their RH-seeking behavior.

In a word, Pakistani women have to follow the socio-cultural norms in all spheres of life including their reproductive health and have to be dependent on others. However, this study is specifically concerned with the reproductive practices and beliefs of a neglected region Jampur and its influence on women's reproductive health in the area.

1.4 Research Gap

Each culture is unique in its nature. Culture shapes the personality and attitude of the people, strengthening their belief system in addition to the provision of set patterns for specific traditions and customs that will be appropriate for that culture. It covers all aspects of community life and reflects in each and every action of daily life so it is inseparable from daily routine habits. Like other set patterns, women's maternal health status and its relevant practices describe which type of cultural practices habitats do. Time around pregnancy to childbirth is governed by social norms (Coast et al., 2014) that is why it is considered a cultural practice, as all the patterns from decision-making to facility provision and caretaking practices portray the reflection of that culture.

Rajanpur portrays a true picture of the diffusion of culture as Rajanpur district connects three provinces of Pakistan: Punjab, Baluchistan and Sindh. So, it provides the space to diffuse and reflect the culture of all provinces. Further, as it is allocated with the other two provinces, tribal communities and their feudal system can be seen there. Sindhi, Saraiki and Balochi cultures are dominant there. Bordering with Baluchistan province makes the socio-cultural fabric unique by providing rural-tribal traditions. This uniqueness of socio-cultural fabric gives a space to observe rural-tribal traditions and customs of this agro-tribal

setting. It creates ambiguity about the residents' nature of beliefs and their customs in general and for women in particular especially in the case of maternal health.

It is obvious that regional differences not only exist in place of residence, religion and cultural beliefs, socio-political setup, availability of MH services (including distance to HC facilities and their quality as well as quantity), educational attainment and mothers' age (early marriage) but also affects people lives (Obasi, 2013). Although Punjab has a better progress level as compared to other provinces, Southern Punjab has disparities because of the overriding effect of existing social and environmental factors (Cesare et al., 2015). The selected region is comprised of a feudal setup with patriarchal dominance where natives have rigid behavior towards their women. The status of women and their maternal health, are neglected in all domains. The perception of women's negligence is based on their low living status and fewer intentions in the development sector. The region is totally neglected in all domains of life. Education can be the strongest instrument for changing people's mindsets and improving their living status. Unfortunately, the region has a low literacy rate comprising a total of 34% only from which 45% are boys and 22% (that is half of the boys' ratio) are girls. Similarly, the health system is not in good condition. For women, the situation is worsen. For evidence, the sex ratio is 111 males/100 females which is higher than the ratio at the national level which is 106 males/100 females. Females are considered to be confined to homes as caretakers. So, the situation develops the preamble of the study that how women avail maternal health facilities in such a ridiculous environment where maternal health issues are considered a very cautious topic and what type of practices, they perform to deal with reproductive health issues.

This study provides a qualitative description of reproductive health beliefs and practices in the context of a socio-cultural framework. Earlier very few studies, approach this neglected region perhaps because of its complex socio-political background. Further, the majority of the earlier studies are concerned with quantitative facts and figures of maternal health issues and status (UNFPA, 2005) while this study has an addition to provide baseline data of beliefs and practices practiced by indigenous people to maintain maternal health. Thus, it focused on qualitative description of the maternal health practices. Additionally, it provides a detailed description of family patterns and the role of family members in decision-making and transforming the beliefs and practices of the next generation. Similarly, trended methods of curing as well as their source of knowledge, utilization and preparation of remedies and their influence (either good or bad) on maternal health are transcript comprehensively.

The study not only depicts the cultural beliefs and practices linked with maternal health among native women but also analyses the cultural rituals and actions of women. Women's role in maternal health behavior will be emphasized within a cultural framework to see to what extent women have decision-making power regarding their reproductive health care. For this purpose, the daily hygiene routine of pregnant women, exercises, massages, dietary, and eating habits, and also the taboos and maternal health tips from the eldest in maintaining maternal health has also been focused on.

Reproductive health programs and contributions of government and non-government organizations for reproductive well-being remained underpinned by many researchers for years. Studies concerned with the history of government and non-government FP and RH programs, the success or failure of the programs as well as their contributive factors, and the

figures of achievements both on a national and regional level (Ali et al., 2008; El-Saharty et al., 2014; Lucy et al., 2015). Fewer studies have focused on the source of medication along with methods of medication, the role of health care providers in disseminating RH awareness and knowledge in addition to observing the response and perception of the knowledge by the community. In the selected region, such type of work in the domains mentioned above had not been done earlier so filling up this gap was the groundwork of the current study.

Family members, especially husband and mother-in-law/ascendant, and healthcare providers are usually seen as decision-makers in women's reproductive health (Omer, 2019). The role of ascendants as well as health providers in disseminating maternal health information is discovered under the influence of culture. This study will find out to what extent women are getting maternal health services from health providers and how health providers are working to disseminate MH information to women under the realm of cultural beliefs and practices.

Medication through a broader aspect is also influenced by culture. People rely on traditional cultural methods for ailment. While talking about reproductive health, ethnobotanical (Aziz et al., 2018; Silalahi et al., 2020) and ethno-gynecological (Belica et al., 2017; Ahmed et al., 2021) studies attempt to explain medicinal use of flora, on the contrary, some studies limited the scope of traditional healing to traditional birth attendants (Gogoi, 2021; Mudonhi & Nunu, 2021; Ope-Babadede et al., 2021). A few focused on a broader aspect i.e., spiritual healing (Mudonhi et al., 2021) neglecting stakeholders like spiritualists, medicine vendors, and herbalists. This study has focus on types of traditional medicinal methods utilized in Rajanpur, especially for women's maternal wellbeing, sources

of ethno-medication information/services dissemination, remedies and influence on women's reproductive wellbeing.

1.5 Problem Statement

Pakistan is geographically located in South Asia with over 207 million population. The province of Punjab is the most populous province of Pakistan. Pakistani has failed to maintain a prosperous annual growth rate that affects almost all areas and domains of its socio-economic picture. The continuously growing population is one of the biggest issues for the government of Pakistan in general and the Punjab province in particular. The large fertility rate and ignorance of family planning results in the poor maternal health of women. The question arises whether the maternal health of women has been neglected. Or some factors are preventing people to neglect maternal health services. This study focuses the maternal health status of women in rural Punjab. The myth is believed to be true not just related to maternal health but also to the values of women in their role as wives. Reproductive health education is also unavailable at school levels despite given policies by the government that woman has a right to get information regarding maternal health. If there are institutes in specific rural areas to give awareness about reproductive health, why women do not avail of that information. If some problem happens then why women are placed as responsible for the maternal health measurements. These situations emphasize studying whether socio-cultural factors determine the way to get knowledge of maternal health.

Rural Punjab is entangled with numerous problems regarding maternal health. Many factors are the cause of keeping the maternal health status of women in Pakistan low. Lack of access to reproductive health information and services leads to increased levels of mortality and morbidity for mainly preventable problems of MH for women living in rural

areas of Punjab. It is because of religious practices and harsh cultural beliefs and practices that cause a lack of knowledge and information about reproductive health services. These cultural and religious beliefs discourage women's access to MH services. Though some societal or religious values allow women access to maternal health services, mostly elders discourage women access to modern MH care information and services regarding family planning including but not limited to the use of contraceptive methods. This study aims at focusing how such socio-cultural practices influence the maternal health care processes of females in the Punjabi setup.

Females in a Punjabi setup mostly work in the domestic sphere where the patriarchal system mostly decides the matters related to marriages of the girls, education and occupation as well as their spatial mobility. The mother-in-law, though a female encourages the patriarchy in the rural areas. This research study has investigated how social and cultural aspects shape and affect MH behavior and motivations and how these aspects are significant in understanding issues regarding the utilization of maternal health services. It also aims at studying the gaps in concepts, knowledge, and notions regarding maternal health and the government's role in the dissemination of awareness on MH.

It would be unfair to say that the government is not paying attention to women's reproductive health. NIPS has been working to ensure better maternal health of women and also different researches and literature have been conducted regarding the influence of culture, religion and myths on maternal health care and services (Munir, 2015). But rural areas of Punjab have not been studied yet in the cultural context of maternal health particularly. The proposed study focuses on the cultural methods of dealing with women's maternal health in Punjab. In this scenario, the indigenous methods of health care that are

being practiced has studied. The selected locale of the study is district Rajanpur which is the lowest performing district in Punjab in the fields of education and health. The social and cultural fabric of the district makes it to be half agricultural and half tribal, due to its bordering with Baluchistan province. It is, therefore, the rural-tribal traditions and low rates of literacy that are hindering the progress of modernizing the health sector. The study looks for reasons why there is traditional and indigenous reliance on traditional medicine and its real-time utilities. Why traditional medicinal practices are being done for maternal health care? And how traditional health care strategies are being practiced by women?

1.6 Research Questions

1. How do cultural beliefs/practices affect women's maternal health and influence the women perception regarding health care pregnancy and childbirth in Jampur?
2. How do families' norms influence the decision-making process, choice and practices towards maternal health care services?
3. Is there any effectiveness of indigenous remedies in health care services at traditional setting in selected study area?
4. How does the institutional mechanism work and influence the perception of women and access to utilization of health care services?

1.7 Research Objectives

The main objective of this study was to find out the experiences of women in maternal healthcare in the socio-cultural setting in the selected study area. The specific objectives were to:

1. Explore the maternal health beliefs and practices around pregnancy and childbirth.

2. Find the role of gender in decision making towards women access to utilization of maternal health care services
3. Explore the indigenous remedies and practices in socio- cultural setting.
4. Provide the insight into provision of effectiveness and perception towards women health care services.

1.8 Scope of the Study

The scope of the study includes maternal health care services only. Other RH aspects like family planning, STDs that are sexually transmitted diseases in men and measurements regarding abortions are outside the study's scope. The study covers cultural beliefs and perceptions of married women regarding their maternal health in Tehsil Jampur of district Rajanpur. Together with the cultural perception and beliefs of women, the study also covers indigenous practices of women and acceptance of RH service provision by women and from health providers rather than from formal or informal sectors. Maternal health is the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the healthcare dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality (WHO, 2013). In medical sciences, the study of maternal health is normally viewed with two lenses; the medical/clinical perspective and the socio-cultural perspective. The medical perspective explains the causes of maternal mortality and morbidity using the medical models by focusing on the direct causes such as hemorrhage, infection, high blood pressure, unsafe abortion and obstructed labor amongst other conditions, whilst the socio-cultural dimension examines this phenomenon with a sociological view on the indirect causes - resulting from factors in the socio-cultural environment which impede or mediate to delay or deny women's access to maternal healthcare services (WHO, 2002). Some of the socio-cultural factors include social

infrastructure like road network, health facilities, equipment and drugs, and cultural factors like health beliefs of people about the causes and treatment of diseases, gender, socio-economic status of the woman/family and the behavior and competence of health professionals. Most often, people tend to center issues on maternal healthcare around women. Study ensures appropriate and expected returns of interventions, the safe motherhood program and effective management and monitoring of the program, it is sub-divided into six major areas; antenatal care, labor and delivery care, postnatal care, family planning, prevention and management of unsafe abortion, and finally health education. However, for the purpose of this study, only the first three areas – the pregnancy-postpartum period is covered with the focus on women and spouses, traditional care-givers and health professionals as participants for the study.

1.9 Significance of the Study

It is already defined that, for the prosperity of any country, the reproductive health care system is much more important than any other factor. However, this is only possible if reproductive health services are available for all women in society and they can also utilize these services freely. In Pakistan, and particularly in southern Punjab, females face problems related to reproductive health services, like the non-availability of these services in rural areas. It is also observed that if these MH care services are available but females in these areas are not able to utilize these services. If women are deprived of health facilities, the hurdles must be assessed and removed.

Ensuring healthy lives and promotion of well-being for all at all ages as well as promotion of gender equality and women's empowerment are Sustainable Development Goals (SDGs). The findings of this study will be able to helpful for the government, NGOs

and all stakeholders to adopt strategies of making health services more accessible to pregnant women, nursing mothers and newly-born babies from different backgrounds for the achievement of these goals. Safe motherhood is a constitutional right recognized by the Constitution of Pakistan and the Millennium Development Goals. Furthermore, the findings indicate how cultural factors mediate to influence the utilization of the maternal healthcare services and this will facilitate understanding of who uses which services, why they access these services and when those services will be utilized. This provides crucial guidelines to inform policy formulation and implementation on maternal healthcare services utilization.

The study reveals how traditional and indigenous remedies manage pregnancy and related complications and suggest ways of improving maternal healthcare. Thus, the study provides guidelines on cultural norms to stakeholders for the promotion of safe motherhood by recognizing the culture and tradition of people as a basis for positive outcome. This study recognizes the effective health campaigns, policy formulation and health promotion programs for prevention and treatment of complications related to pregnancy and childbirth. Previous studies had limited emergency care and attached importance to only emergency obstetric complications or the delivery stage. The present study recognizes all the stages of maternity as inter-connected parts of maternal healthcare system. Since these stages are inextricably connected, they are all equally important and deserve the best of medical attention. Above all, harmful gender roles to women's health which have been discovered will be used to educate the public especially, men on women's rights to health and the need to take collective decisions within the household to promote maternal and child health. This will also serve as additional source of literature on gender and health promotion for further research.

Finally, this study has developed a conceptual model to explain utilization of maternal healthcare services, which adds to theory building by addressing limitations in the reviewed theories and models on maternal healthcare services utilization. This contributes to knowledge by adding to existing theories and showing a new dimensional approach to promoting safe motherhood.

It was envisaged that the findings of this study will be helpful for the health service providers to arise with worthwhile mechanisms to make their services women-friendly and accessible to the youth. The study has contributed to an in-depth understanding of the processes underlying social identities in shaping women's reproductive health-seeking behaviors. The study will be helpful for organizations that are working for population welfare such as NIPS and also policy-making bodies, including national health policymakers and Pakistan's population policymakers.

1.10 Chapter Organization:

This thesis is organized to eight chapters. Chapter 1 is the introduction comprising background to the study, Pakistani women's status and maternal health, the study setting, gaps in existing studies and problem statement. In addition, the research questions, study objectives, significance of the study, scope of the study.

Chapter 2 concentrates on background of Pakistan, province of Punjab and profile of study area district Rajanpur and maternal healthcare including the geographical and socio-demographic information, and maternal healthcare policies, strategies, interventions plan and challenges. Also, the rationale for the choice of study site is presented in this chapter. Chapter 3 presents review of previous studies as well as theories and models on healthcare services utilization. The main model and theories include review of the Structure and Agency

Theory, Gender Empowerment Framework, and the Three Delays Model. Critical review of the previous studies, the structure and agency theory, the gender empowerment framework and the three delays model are presented in this chapter. In addition, the conceptual framework for this study is also presented in this chapter.

Chapter 4 comprises on methodology which discusses the research design, sources of data, target population, sample size and sampling procedures, research instrument, pilot study, ethical and political considerations, and training of a field assistant for focus group discussions. It further addresses how trustworthiness and dependability are ensured in the research, how the actual field work was organized in the study, data management and analysis, and field challenges and how they were solved.

Chapter 5 focuses on results and discussions on, health beliefs and practices regarding pregnancy and childbirth rituals and this chapter also presents results and discussions on gender, decision-making and utilization of maternal healthcare services. Chapter 6 presents the indigenous remedies practices in the study areas and TBA's and spiritual healers in birthing practices. Chapter 7 Provides the insight into provision of effective health care services and perception of women about maternal health services Finally, Chapter 8 presents key findings of the study, conclusions to the key findings, the contribution of this study to knowledge, implications of the findings for healthcare, education and policy development as well as recommendations for policy consideration and further research. Finally, the general conclusion of the thesis is presented at the end of chapter.

1.11 Conclusion

The chapter begins by providing a global overview of the significance of women's maternal health care worldwide. The general components of reproductive health, general issues of women's maternal health, safe motherhood, reproductive health rights and maternal mortality ratio are discussed. There is a brief description of cultural factors (such as health beliefs and the role of ascendants) and how they influence women's maternal health. It also describes important aspects of Pakistani society and its reproductive health care system for women and particularly it focuses on Rajanpur district regarding women's maternal health status. This is followed by a problem statement, research objectives and research questions. The chapter concludes with the significance and scope of the current research. Maternal health care is the provision of effective methods and health services to prevent and treat illnesses and injuries associated with reproduction to ensure the healthy development of mother and child.

CHAPTER 2

DEMOGRAPHIC BACKGROUND OF PAKISTAN AND PROFILE OF STUDY AREA

2.1 Introduction

This study attaches importance to the socio-demographic profile and geographical position of the study site in the provision of maternal healthcare services. Resultantly, this chapter briefly discusses the geographical and socio-demographic background of Pakistan, Punjab and maternal healthcare policies and interventions. Additionally, a brief background of the district Rajanpur and Tehsil Jampur, the selected site for the study and the rationale for the choice of the site are discussed. The fieldwork was conducted in Jampur District Rajanpur Province of Punjab. Most of the activities regarding the aims of the study the problem of maternal health and other service-related information will be available to the population from the same area. Other factors for choosing this district are; my prior fieldwork experience in this district, easy access to the district from Multan, having good personal contacts, particularly in the district population department, local NGOs, especially the SAYYA foundation Rajanpur and availability of the safe residential facility. The fieldwork is further limited to Tehsil Jampur, as this will allow easier access to villages from the city center, where I was staying. Detail glimpse of Pakistan, Punjab and district can be shown in the following.

2.2 Brief of Pakistan

Pakistan is situated in South Asia; it is placed between Latitude 23 and 36 North and between Longitude 61 and 75 east. It covers an area of 796,095 square km (Saeed, S. 2022). India, China, Afghanistan and Iran are Pakistan neighboring countries whereas Arabian Sea

offers along coastline in the south of Pakistan. The Islamic Republic of Pakistan is a federal republic with a federation of four provinces (Punjab, Sindh, Khyber Pakhtunkhwa (KP) and Baluchistan), Islamabad is the capital Territory and tribal area under federal administration. It is now merged into KP. The provinces have a local government system that incorporates divisions, districts, Tehsil and union councils. The provinces vary in the matter of their demography and socio-economic development. Their traditions and cultural norms are also different comparatively. Within the province, districts and tehsils are also dissimilar on the same grounds. Of the four, Punjab is the most populous and developed socio-economically.

Pakistan is appraised as a country with a lower–middle economy with a GDP of US $ 279.057 in 2019. (World Bank, 2019). The economy is largely agrarian, with agriculture reports for about 25% of GDP. The contribution of women to economic life is scant. The recent data from the labor force survey states that women's labor force participation rate (LFPR) in 2018-2019 was only 21.67%. As compared to the other provinces, Punjab is the highest LFPR of women at 36.7% the percentage in the rural area is 43.4% is more than in urban areas i.e 24.9%fallowed by Sindh at 15.9% then KP at 14.7% and in the last place Baluchistan at 9.2%. The two-third population of the country lives in rural areas. The annual population growth rate (1998-2017) at the national level is 2.4%while growth in urban areas is 2.70%. On the other hand, this percentage is 2.23 in rural areas (National Institute of Population Studies, 2019). The Islamic Republic of Pakistan consists of 97% of the Muslim population. Religion has been the most important doctrine of Pakistani identity. It not influences the daily lives of people but also states laws. Mostly, issues related to gender, family, inheritance, marriage and divorce are handled by a conflation of Islamic customary and state laws in Pakistan. This is a country with multi-lingual and multi-ethnic dimensions. Urdu is the national language but there are several regional languages and dialects in each

province. Different ethnic groups practice different cultural norms. The speculation and physical mobility of women which run along ethnic lines have diversity. Punjabi women are more likely to be mobile in comparison to women from Pukhtun and Balochi ethnic groups (Ayres, 2009).

Ethnicity has an impact on the demand for children, at marriage and bearing upon fertility levels in Pakistan (Brown et al., 2017). Pakistan has to face various developmental challenges due to recent security issues and instability as a result of violence. These comprise reducing poverty, better education and health status, gender equality of its citizen and slowing down population growth. Pakistan is ranked 154th among 189 countries on the human development index (UNDP, 2020). Approximately 22% of its population is forced to live below the poverty line. The health condition of women and children is depressing. According to an estimate from 2019, around 186 women die per 100,000 births. About 476,000 children under five years of age die of veritable causes. Besides this, 14000 women lose their lives due to preventable complications linked to pregnancy and childbirth. This unacceptable ratio of deaths is definitely avoidable by ensuring that all women and children get proper health facilities and care. Complete access to reproductive, maternal, newborn and child health services is a high priority need of time. Though Pakistan stands at low position in development indicators, it has some noteworthy improvements regarding education and health since the 1990s that are now discussed one after the other.

Table 2.1: Major Population, Health and Education Indicators

Indicators	Pakistan
Total Population	207.8 million
Population Growth Rate	2.4%
Population Density (per sq. km)	236 persons

Table 2.1: continued

Urban Population	75.6 million
Rural Population	132 million
Crude Birth Rate	25.6 per 1000
Crude Death Rate	6.7 per1000
Adult Literacy (10year and above)	70% Male 49% female
Primary net enrollment	975 boys 81 % girls
Income per capita	$1560.7
Infant Mortality Rates	66 per 1000 live birth
Maternal Mortality Rate	178 per 100,000
Contraceptive Prevalence Rate	35.4
Total fertility rate	3.1
Unmet need of contraceptives	20%

Source: Pakistan Bureau of Statistics Census Results 2017, Pakistan



Figure 2.1: Province Wise Map of Pakistan

Source: Google Map

2.3 Maternal Healthcare Interventions in Pakistan in 2019

Pakistan is one of the countries in South Asia ranking high in maternal mortality rate. Though, a signatory of Agenda 2030, the country still lags behind considerably in achieving Sustainable Development Goals (SDGs). The ratio of maternal mortality is, even higher in rural areas of the country. Lack of health care facilities, education, malnutrition, poverty, high prevalence of violence against women in rural areas, and socio-economic factors are some of the major contributing elements for elevated levels of maternal mortality and morbidity rate in Pakistan. By making inclusive policies at the national level to improve the reach of the rural population to healthcare facilities, educating women and eliminating gender-based disparities, introducing family planning interventions, accountability, and continuity of democracy are essentially needed to improve maternal health in Pakistan's rural areas.

During the last three years, nine out of ten women of age 15-49 who have had a live birth, attained antenatal care (ANC) from skilled providers including specialist doctors, nurses, LHV and CMW etc. among those 46% visited the specialists. ANC coverage by the skilled provider has vividly improved from 26% to 91% (1990-2019). About two third 68% of women who suffered abortion or miscarriage received ANC from a skilled provider along with 90% of women who had stillbirth (PMMS, 2019). It is also important that how many ANC visits are paid (PMMS, 2019). More than half of the married women, aged 15-49, had their first ANS visit during the first trimester whilst half of them made four or more visits.

According to the data, three in ten live births are delivered at home, while 71% in a health facility of the private sector. Highly educated women in rich households 93% are more probably delivered at a health facility. Health facilities deliveries range from 75% in

Punjab to 55% in Baluchistan. Such types of deliveries adequately increased since 1990. Home deliveries have been decreased from 85% in 1990 to 29% in 2019 (PMMS, 2019).

To avert complications after childbirth, postnatal care helps a lot. Almost 7 in 10 (69%) married women received a postnatal checkup within two days of delivery, on the other hand, 29% did not get a postnatal checkup within in41 days of delivery. Statics show that postnatal checks within 2 days of delivery range from a low of 31 % in Baluchistan to a high of 81 % in Punjab. The women who are least likely to have checkups within two days of delivery belong to poor households 53% and among those about 58% of women are uneducated. A most postnatal checkup is executed by skilled providers 59%. third of those who did not deliver in health facilities were given a postnatal checkup from Dai/TBA. to receive postnatal care from a skilled provider depends on the fact that married women belong to a wealthy family. As for as postnatal care is concerned 82%married women from rich families have this compared to women from a poor family where the percentage is only 36 (PMMS, 2019).

Health problems proclaimed by married women during pregnancy, childbirth or within 42 days of the end of pregnancy are part of maternal health issues. The most commonly reported complications are feeling extreme weakness 58% body aches 44 % and severe headaches 42%. Health problems differ according to region. Most Punjabi women reported anemia than 24 % of Balochi women. Almost one out of five women from Punjab and Baluchistan described the complaint of high blood pressure. maternal health problem is mostly related to pregnancies compared to delivery. Some of the common complications during delivery were prolonged labor pains 12 %, laceration in the vagina 9% and the body not breathing 6%. About one out of four women suffer prolong labor pain in Baluchistan.

Seven percent of deliveries in Sindh had premature babies. Other common problem during the postpartum period was fever, pallor, and extreme weakness. Women were informed about high blood pressure 14% and the problematic position of babies 7% by a health provider. Complications including blood deficiency, problems with the placenta, jaundice or hepatitis and slow growth of the baby were also informed. Half of the Pakistani women got treatment for one or more maternal morbidities. Treatment seeking is not common in Baluchistan where only 31% of women look for treatment for maternal morbidities. The ratio is highest in Punjab 51%. majority of women are diagnosed by health care providers. The ratio of diagnoses of maternal morbidities increases with better financial conditions of families (PMMS, 2019).

2.3.1 Maternal, Newborn and Child Health (MNCH) Strategy in Pakistan

Pakistan is the fifth largest country in the world in terms of population. According to the survey held in 2019, its estimated population is 216.6 million. Its annual growth rate indicates that population will double in the upcoming 34 years. It is the 33rd largest nation on the planet with an area of 796,096 Km. The normal population density is about 166.3 per Km with Punjab having the highest of 358.5 while the lowest is Baluchistan at 18.9. The average life anticipation has expanded from 59 years to 67 years during the previous decade (Punjab Population Policy 2016). It is on account of the wide exceed of national lady health worker (LHW) program correspondingly, infant and under 5 ratios of loss of life has upgraded but the neonatal mortality rate has unfortunately persisted. In Pakistan, the government must provide health care. The government has deputed several ministries to the provinces including health and population welfare. They provide opportunities for prudent planning and management at the regional level. The poor health condition is the result of poverty, low level of education, the stunted status of women in society, deficient sanitation

and drinkable water facilities and little expenditures on health structure etc. all these factors have developed the existing conditions of low-quality primary healthcare services in Pakistan, leading towards the high maternal mortality ratio. Maternal health issues, undernutrition and diarrhea form the biggest share of the burden of disease in Pakistan. Currently, on the direction of the national leadership, a comprehensive national vision has been developed for communicating the challenges to provide the best care to mothers and children. The document of national vision served as a guide for the articulation of national and protentional The Core Component of Integrated Reproductive Maternal Newborn, Child Health and Nutrition (IRMNCAH&N) strategies.

The basis of the national strategy 2016-2020 is the perception to improve the health of women and children with the help of general access to quality health services that can be delivered only through a strong health system. The aim is to achieve sustainable development goals such as zero poverty, no hunger, complete access to health services, basic education and clean water etc.

2.3.2 The Core Component of Integrated Reproductive Maternal Newborn, Child Health and Nutrition (IRMNCAH&N) Strategy (2016-2020)

1. To improve the availability of standard primary health care by making sure of the utmost coverage of rural areas and slums. It can be possible through the introduction of new community-level health staff LHWs and CMWs and by the approachable essential infrastructure for capacity building.
2. To improve the quality of health care facilities at primary and secondary levels. It can be attained by increasing the relevant knowledge and skills of the health care staff, consisting of LHWs, CMWs, LHVs, LHSs, teaching and clinical staff etc.

Another important task for effective health care is to provide the necessary medicines, vaccines and other medical equipment.

3. To improve the financial availability so that the hurdles to care can be lessened for the most at-risk parts of the community. It will be possible to achieve this through evolving the coordination among different social security institutions and income support programs.
4. For strengthening the health system, the prevailing healthcare facilities will upgrade and the expansion of the needed medicines list will be prioritized to enhance healthcare by managing issues related to reproductive health like early detection of breast, and cervical cancers and HIV. Another principal theme is the provision of required infrastructure with complete family planning services. Strengthening the feedback mechanism is an essential part of the plan which also anticipates the usage of new technologies for decision-making and analyses for example GIS, smartphone and m-health etc.
5. Orientation sessions, advocacy seminars and international conferences are the major ways of social mobilization and political links to raise awareness related to RMNAH&N and the provincial and District levels. Internationally acknowledged days will be observed to enhance awareness about issues affecting health. To proclaim public health issues like family planning promotion, various media channels will be used. different community-based organizations (CBOs), and local influential and religious leaders will be involved in demand creation.
6. At the district, division and provincial level, a monitoring structure will be developed comprising TORs, reporting formats and checklists. The entire responsibility of M&E will stand with the protentional department of health. While on the contrary,

the MNCH program will be in share for collecting monitoring and evaluation (M&E) reports on quarterly bases and submitting them to the district office Health (DoH) on annual basis regularly. The program has a detailed financial action plan that serves as a resource mobilization tool. it could be extensively used for mobilizing financial resources and accumulating donor support at the national level. The IRMNCAH&N strategy is amid as decreasing maternal, child and neonatal mortality with the help of localized interventions. another action plan goes along with it which is designed to use prevailing resources and reach the SDGs target of Pakistan.

2.3.3 Challenges of Plan

The health indicators of Pakistan badly fail to meet standards. The outlay on health per capita is insufficient in Pakistan and it is noteworthy that there is no increase in the previous eleven years. In 2011, it was less than 0.5% of the GDP. Pakistan has to face a double burden of disease (BoD). Most of the conditions can be handled and managed at low-cost involvement and best practices at primary and secondary healthcare levels. Infectious diseases, under nutritional and maternal health issues form almost half of BoD. Respiratory diseases and diarrhea are the major killers among young children. Maternal death caused by sepsis, hemorrhage and hypertensive crises is recurrent.

There are very few doctors, dentists and paramedics available in Pakistan in proportion to the population. Paramedics such as nurses, LHVs and midwives have a significant role in keeping people healthy. Only 43% of Pakistani women are attended to by skilled health staff during childbirth. The maternal mortality ratio in the country has become lesser from 521(1990) to 332 (2012). The mortality ratio under-five children are 36/1000 live birth born to mothers with more than a secondary education. While 57/1000 mothers

with secondary education. At the same time, the proportion found of illiterate women 112/1000 is a matter of concern (Planning Commission, Ministry for Planning, Development & Reform Pakistan).

The staff is insufficient in the public health sectors. some other complications are the development workforce, skill mix and deficient resource allocations at different healthcare levels whether primary, secondary or tertiary. Many other elements contribute to the health of people such as poverty, food insecurity, access to clean drinking water and poor sanitary conditions. In Pakistan, 44% of under five children suffer from chronic malnutrition only 47% population has the Facility for improved sanitation (Pakistan Vision, 2025). If the country is determined to achieve the health-related development goals SDGs it needs extensive research regarding maternal and child health.

Table 2.2: Maternal Health Care Indicators of Pakistan

Indicators	Percentage
Women Mortality rate age 15-49 per 1,000	1.72
Male mortality age 15-49 per 1,000	2.48
Antenatal Care visit with a skilled provider (%)	91
Births assisted during delivery (%)	74
Deliveries in a health facility (%)	71
Births delivery by (C-section) (%)	23
Postnatal check during first 2 days (%)	69
Complete maternity care (%)	57

Source: Pakistan Maternal Mortality Survey,2019 by (NIPS)

2.4 Punjab Profile

The land of five rivers, Punjab, is population-wise, the largest province of Pakistan, with around 52% to 53% of Pakistan's population housed here. The province spreads over 205,345 sq. km. area with over 17 million households. 2017 Census un-published results put the population of Punjab as 110.012 million (55.959 males & 54.047 million females, 6,709 transgender) (Population of Punjab Census, 2017) The Province has 36 districts and nine administrative divisions. It shares border with Jammu and Kashmir, Indian Punjab, Rajhistan, KP, Sindh and Baluchistan. Punjab is also called the main food basket for Pakistan. Punjab's land is generally fertile and arable due to the system of five rivers. The province of Punjab is divided into three major part's north Punjab, central Punjab and south Punjab. The District of Rajanpur is located in south Punjab. South Punjab has possessed profound historical and geopolitical significance (Rajanpur District Administration, 2017). This region consists of Bahawalpur, Multan and Dera Ghazi Khan Divisions. Rajanpur district is in D.G Khan Division. The history of the area can be tracked down since 200 BC. South Punjab is the mainstay of the whole of Punjab economically with an ample rural-to-urban migration. The total population of south Punjab is around 39.14 million while the ratio of urban and rural crowding is 23% and 77 % respectively. South Punjab consists of 116,518KM square which is 57% of the total area of Punjab (Government of Punjab, 2016). It shares 36% of the total population of the province. The region has fertile agricultural fields, canal-irrigated land and rainfed irrigation. Most people are Muslim with a small Christian community. Punjabi is the mother language of the majority. The official language is Urdu, followed by English. The famous ethnic groups are, Rajput, Arain, Jat, Awan and Gujar. In south Punjab, especially in DG Khan Division Baloch tribes are in majority. Gradually, the

caste system has become blurred. Social mobility has resulted in inter-caste marriages which are changing public opinion.

Panjab is situated on the verge of a monsoon climate, where the temperature is normally hot. Most of the Punjab remains very hot in Summer and cold in winter. In Punjab the main source of income is agriculture. The major crops are cotton and wheat with rice, sugarcane, millet, corn, pulses, oilseed fruits and vegetable. Livestock and poultry are nurtured in vast number. Punjab holds highly developed industries, such as textiles, electro appliances, surgical instruments, machinery, bicycles and rickshaws, floor coverings and processed food etc. it's dairy and poultry industries meet the local needs of the country. So, South Punjab has an attributed role in the collective progress of Punjab and Pakistan. Under are the administrative division and major Population, Health and Education Indicators of Punjab.

Table 2.3: Administrative division of Punjab

Name	Numbers
Divisions	09
Districts	36
Tehsils	146
Union Councils	7602

Source: Pakistan Bureau of Statistics Census 2017

Table 2.4: Major Population, Health and Education Indicators of Punjab

Indicators	Punjab
Total Population	110 million
Population Growth Rate	2.13%
Population Density	536 persons
Urban Population	40 million
Rural Population	70 million
Adult Literacy (above 10 year)	71% Male 55% female
Primary net enrolment	101boyes 92 % girls
Income per capita	2081$
Maternal Mortality Rate	157per 100,000
Infant Mortality Rate	65 per 1000 live birth
Total fertility rate	3.5
Contraceptive Prevalence Rate	40.7
Unmet need of contraceptives	17.5%

Source: Pakistan Bureau of Statistics Census 2017

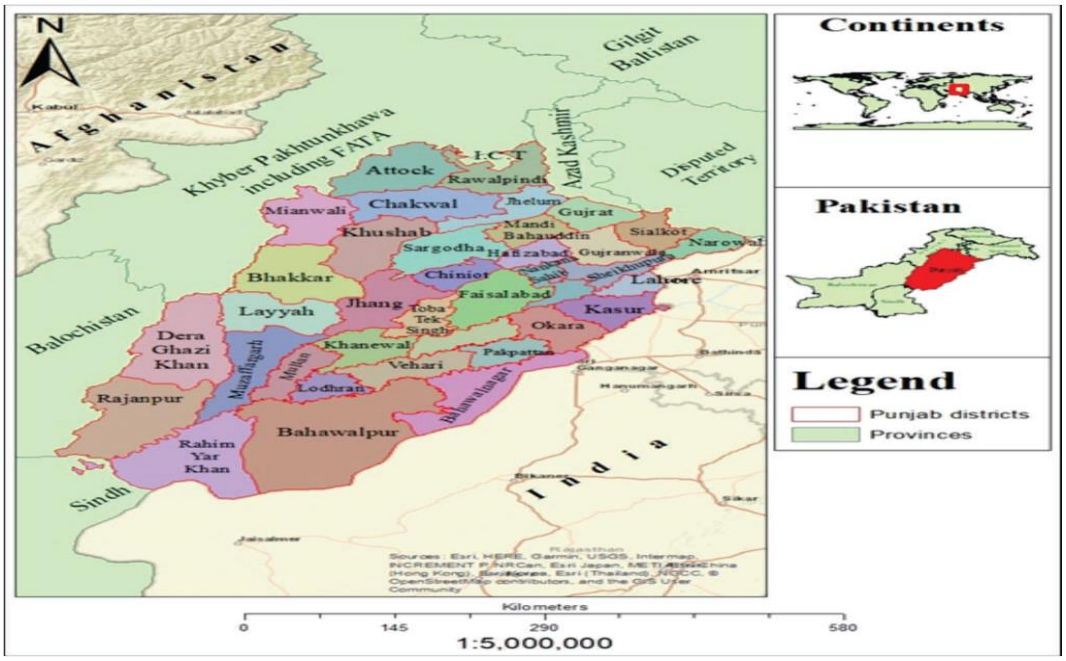


Figure 2.2: District Wise Map of Punjab Province

Source: Google Map

2.5 Study Site Brief

Rajanpur was given the status of district in 1982. It lies in the southwest of the Punjab Province at 29°06' N latitude and 70°19' E longitude. The district lies towards the west bank of the Indus River (Ismail et al., 2019). The district was named after the headquarters town Rajanpur, which was founded by Makhdoom Sheikh Rajan in 1772. The district comprises three Tehsils namely Rajanpur in the center, Tehsil Jampur in the North and Tehsil Rojhan in the South. The Rajanpur town is approximately 9 miles from the west bank of the river. The district has a vital historical, cultural and geo-strategic position as it is a gateway to Sindh as well as Baluchistan Province. Rajanpur is famous due to the shrine of Hazrat Khawaja Ghulam Farid in Mithan Kot. He was a famous Sufi Saint of the Sub-continent. He expressed his ideas in Punjabi & Seraiki poetry. His famous book is Dewan-e-Khawaja

Farid. The Sufi saint still has a huge spiritual followership in the area (Rajanpur District Administration, 2017).

The district of Rajanpur is located on the band between the river Indus and the hilly region of Baluchistan. It has an area of 123182 square KM. to the north; it borders DG Khan while touching Jacobabad of Sindh in the south. Towards the west of Rajanpur, the district Sibi of Baluchistan is situated. The mighty Indus makes the eastern boundary of Rajanpur by parting it from the district of Raheem yar Khan and Muzaffargarh. The Indus arises during the month of May as a result of snow being melted on the Himalayan. It gradually fills its bed, driving flood waters down the recession in Rajanpur. It also causes the filling of the swamp canals. It starts receding when cold weather approaches by the end of September.

The climate of Rajanpur district is very hot in summer while chilly in the winter season. There are low mountainous regions on the north-eastern side of the district. The district is dry in general with low annual rainfall. On the other hand, rainfall history indicates floods every year causing a lot of damage. A huge population of the district remained badly affected due to the monsoon flood and Hill Torrents in past. A visible climate change can be easily observed in the district as the frequent happening of floods have become uncertain (Qazlbash, 2021).

The people of Rajanpur follow different traditions and customs. Most people, living in rural areas, wear a shirt & Dhoti (unstitched garment worn by men in some rural areas of Punjab) and in the urban area's shirt and Shalwar (loose trousers). In marriage, they follow (mostly in rural areas) a tradition of Watta Satta (Exchange Marriages). Four tribes Laghari, Mazari, Dreshak and Gurchani are ruling for a long time (Ahmed, 2019). The main languages which are spoken in the Rajanpur district are Saraiki and Balochi. Though Urdu

is now widely spoken, its ratio is only 10%. Feudal system also exists in Rajanpur. The main tribes of the district are Gopang, Gurchani, Dreshik and Mazari. The political scene of the district is also dominated by the heads of these tribes. These tribal elders adjust their political affiliations as they deem fit and as such candidates of different parties have been winning elections at different times (Ahmed et al., 2019).

The recent provisional population census of 2017, the total population of Rajanpur District is 1,995,958, out of which 337,202 (16.9%) population are lives in urban areas, while the rest of the population of 1,658,756 (83.1%) is the part of rural areas. Tehsil Jampur and Rajanpur have the majority of the population contributing 78% of the total population. As mentioned by population demography statistics, Rajanpur district contains 262,490 households and Tehsil Jampur 92801(Government of Pakistan, 2017). The leading sources of income for the rural population are agriculture and livestock. The prominent crops of the district are cotton and sugarcane whilst rice and wheat are also used to grow. Agriculture production is mostly at risk due to climatic conditions and the geographical location of the area. Just because of minor rainfall in the region, agriculture in Rajanpur merely depends upon canal irrigation.

The famous small industries of district Rajanpur are cotton ginning, carpet weaving, husking, pressing rice, flour mills, sugar mills, oil mills and brick kilns etc. the prominent fruits are mangoes and oranges. Rajanpur is commercial nexus with rail and road network. Lack of resources and education are factors responsible for the insufficient development in the district. Yet the government as well as non-government organizations (NGOs) are working for the betterment of locals. The health care coverage indicators show considerable gap between the service providers and the population how need to serve. Because of the

rapid population growth, 1,995,958 heads have access to only one District Head Quarter (DHQ) hospital, 2 Tehsil Head Quarter (THQ) hospitals, 06 Rural Health Centre (RHC) and 33 Basic Health Units (BHU), 1 mother and child health center. Health services are correspondingly weak and adult and child literacy is low, particularly among women. Only 29% of young women are literate, under half of Punjab Province's figure of 66%. About 60% of the population of Rajanpur is covered by the Lady Health Worker program but Rajanpur district has the poorest indicators regarding maternal and child health. It has been found that of every 1,000 children born, 104 died before the age of five, and 82 before completing their first year of life (Pakistan Bureau of Statistics, 2017). This is due to low awareness and poor practices relating to the care of mothers and newborns. Over half of children (51%) in Rajanpur are severely stunted. Antenatal coverage from skilled personnel is low. Only 17% of births occur in the presence of a skilled attendant. Overall prenatal consultation percentage in urban areas is higher than in rural areas. Private hospitals, Government hospitals and Traditional Birth Attendants provide health care services to the area where Postnatal consultation rates though improved in 2010, are still lower than the Prenatal rates (MICS, 2011).

Rajanpur has a total of 1,190 government schools out of which 41% (488 schools) are available for girl students. The total number of enrolment (male and female) in these Government schools is 155,751 students. The number of male and female teachers in government schools is 2541 and 2001 10 respectively. In District Rajanpur there is a poor education status. The literacy rate (10 years and above), for the whole district, is 34 percent out of which 45% are males and 22% are females. For the urban and rural comparison, the urban literacy rate is higher that is 71 percent (male 81% and female 62%) and the rural

literacy rate is 28 percent (male 39% and female 14%). (District Education dept Rajanpur, 2011).

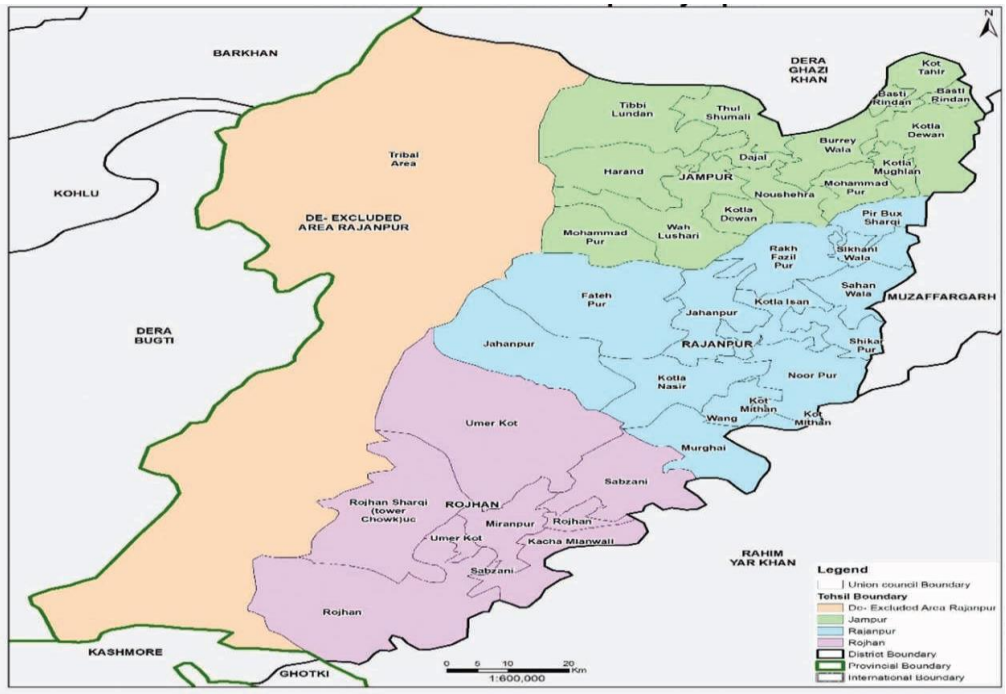


Figure 2.3: Union Council Wise Map of District Rajanpur

Source: Google Map

Jampur is a Tehsil headquarter in the district of Rajanpur, Punjab, Pakistan. Jampur is located at 70°35'45"E, 29°38'32" N, and it is south of D. G. Khan which is almost at the center of the country. The total area of the Jampur Tehsil is 2,322 square kilometers. having a population of 849,393. Its population density is 365/Km. Jampur is sparsely populated and famous for its woodwork. It's a fertile area with less industry. An eminent local educational institute is Govt Boys' High School Jampur. It was founded in 1857 as an outcome of the establishment of the British Government system in 1857. There are two public girls' high schools, one public college for girls and another for boys. The city has 19 union councils

i.e., among these two union councils are in an urban setting and four are in the area near the foothill of Koh-e- Suleman. The tribal area and these four union councils are directly affected areas to the Hill Torrents. The remaining union councils are in plain rural areas. The tribal and sub-tribal system is prevalent in the city because the Baloch tribes are settled there. Local tribes include Pitafi (Baloch), Jamali (Baloch), Lashari (Baloch), Leghari (Baloch), Ahmadani (Baloch), Khethran (Baloch) Chandia (Baloch), Sial, Lound, Gorchani, Rind, Mazarin, Mirza, Rata, Manjhota, Arwal, Meo, Niazi, Domki, Muhammadani, Waswani, Mundrani, Ghilzai (Pashtun), Syed Tribe (Inayat Shah Grandsons) Ghauri, Mohana, Khokhar, Babbar (Baloch) and other Jat tribes. There is one Tehsil headquarters hospital in Jampur city, and 3 Rural health centers one in Muhammad Pur, one in Dajal and one in Hurand. Eleven Baic health centers are in different union councils where basic medical facilities and maternal health services are available.

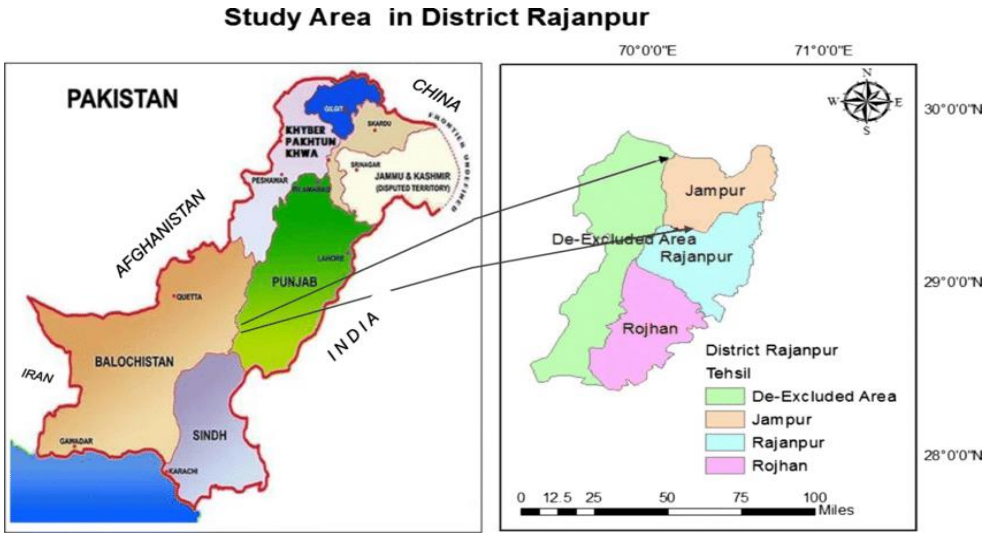


Figure 2.4: Study Area Map

Source: Google Map

2.6 Conclusion

This chapter presented the profile of Pakistan, and Punjab and a brief discussion of the district Rajanpur and Tehsil Jampur which are the study sites. The MNCH strategy, action plan and interventions in Pakistan have also been discussed. Given the statistics on population health and education facilities and the human resource base of Pakistan are included in this chapter.

Among the world's most populous countries, Pakistan has fifth place with about 220 million population size (world meter,2020). Although about 50% of Pakistan's population constitutes females (country meters, 2020). However, according to "Global Gender Gap Report 2020", Pakistan stands at 151st place in the list of 153 countries in terms of gender disparities (World Economic Forum, 2019). The population means that a greater percentage of people is within the sexually active category, which suggests a high fertility rate especially in rural areas and among the illiterates who might not subscribe to modern methods of birth control. This calls for urgent attention to maternal healthcare in the country. Though successive governments have been committed to instituting measures to improve maternal and child health, some institutional and sociocultural conditions in the community and facility environments have hampered the success of those measures. A closer look at the maternal healthcare policy in the population policy indicates sound implementation strategies. However, even though some progress is made, a lot is left to be fulfilled. Analysis of the implementation challenges points to the attitudes of professionals and lack of political will to deal with culture and the demands of clients to encourage service utilization. If we have a look at provincial cultures, all areas show cultural diversity within a nation. As Shah & Amjad (2011) discuss that due to distinctions in geographical circumstances, demographic and development measurements; all provinces differ greatly in their traditions and cultural

norms. Within the provinces, depending on their topographical position, economic patterns, and growth conditions, the districts are also heterogeneous and provide a variety of cultural beliefs and practices. Among the four provinces, the country holds up far behind in almost all demographic and individual indicators of development, particularly for natal and neonatal health (UNDP, 2014).

CHAPTER 3

LITERATURE REVIEW

3.1 Overview

This chapter provides a significant review of the work that had been done before in the field of reproductive health, to comprehend the relevance between reproductive health and cultural values and helps to develop a rational theoretical structure to proficiently analyze the data. The review preferentially considers studies involving cultural beliefs and practices, the role of service providers and issues concerning maternal health. In this chapter, a description of basic concepts, perceptions, beliefs and practices concerning maternal health is given in a thematic pattern.

3.2 Previous Studies

This section reviews the literature. Firstly, the different variables like sexual and maternal health care and its relevant issues. It also includes people's perceptions of MH services and their effects on their well-being. Secondly, it presents information about Pakistan and its structural system including gender inequality, family role and likewise variables that influence health-seeking behavior, especially in regard to maternal health. Thirdly, Socio-cultural perceptions of women toward MH are also described in this chapter since each society has a special cultural belief that shapes their life accordingly; so those perceptions are also included in literature to be familiar with the mechanism of these beliefs and perceptions in giving space for better sexual and maternal health and developing constraints. It also includes socio-cultural values that people took under consideration for adopting sexual and reproductive health and for curing its relevant issues. Fourthly, it

elaborates indigenous aspect of MH remedies and practised by women relying on home remedies, TBA and spiritual healings and herbal or another type of cure.

3.2.1 Maternal Healthcare Services

Maternal health can be defined as women's reproductive health including periods of pregnancy, postpartum and also childbirth (WHO, 2016). It is important to consider maternal health under great consideration to secure women as well as neonates. But unfortunately, people do not pay attention to this health concern. Maternal health care services utilization is affected by multiple factors including individual concerns, institutional facilities and socio-demographic patterns of people. Interconnectivity of socioecological factors including individual's attitude towards preventive sexual practices as well as knowledge on sexual health and contraception utilization; interpersonal sexual relationships; institutional availability of health services provision and societal attitude toward women influence the sexual and reproductive health experience of women (Gray et al., 2021).

Maternal mortality is a serious global issue that is considered a challenging subject even in developing regions of the world with almost 216 maternal deaths per 100,000 live births (Ozimek & Kilpatrick, 2018). WHO (2018) reported that due to maternal issues relevant to pregnancy and childbirth, about 830 maternal deaths per day occur around the world. In 2015, roughly 303,000 maternal deaths are estimated during and following the reproductive period and among these cases almost 99% were found in developing countries making the issue more alarming (WHO, 2015; Kalisa & Malanda, 2016; Ozimek & Kilpatrick, 2018).

Motherhood is a blessing in many countries. But in some parts of Pakistan, it becomes a suffering phenomenon that results in poor health and sometimes even death of

mothers. Because of obstetric problems, 30,000 women die every year, although advanced medical technology is also available here, instead the situation remains the same each year, which means in every twenty minutes' women are dying (Khan et al., 2009).

World widely, Pakistan is among the top 5 countries with the highest mortality rate with 9,700 maternal deaths in 2015. Compared to South Asian neighboring countries, the performance of Pakistan is poor in terms of reducing maternal mortality as well as infant mortality. This study demonstrates that in Pakistan though having a large variety of programs implemented to improve health facilities especially maternal health services but still poorest women are at high risk of mortality (Agha, 2015). The mortality rate is estimated to be 175 per 100,000 live births in urban areas and 319 per 100,000 live births in rural areas of Pakistan (Khan et al., 2009). However, according to a recent analysis estimated MMR in Pakistan is about 178 deaths per 100,000 live births (CIA, 2020).

Mumtaz et al. (2011) argued that improvements in the quality and physical availability of services play a significant role in addressing good maternal health conditions. However, such measurements are fruitless until we ensure the access of women (at risk of maternal mortality) to safe maternal health services. By focusing on the geographically isolated and poor women's maternal health, the study explores that the combination of poverty and social exclusion produces a lethal mixture of constraints for women to access healthcare services even when the health services are approachable, especially in the case of women belonging to heavily indebted families.

Antenatal care (ANC) is a cautious, deliberate follow-up of pregnant women, that includes instructional counseling, guiding, screening, and treatment to guarantee the most ideal well-being of the mother and her baby. The principles of ANC for females with

uncomplicated pregnancies are to give counsel, instruction, consolation, and support to make them aware and address the minor issues of pregnancy and to facilitate complete screening during the pregnancy (Dayal, M. 2013). It is an important need to address both the psychosocial and therapeutic needs of women (Fawole et al., 2008).

According to the WHO (2016), the ANC model pregnant women should have to access ANC services at least eight times; ANC contact should be done in the first trimester, two should be during 20-26th week and the remaining five should be scheduled in the third trimester. But there are some factors responsible for delay of ANC that include attitudes toward pregnancy, inefficient medical facilities, spousal involvement and gaps in promotions (Taylor et al., 2017). Promotion of ANC utilization within the initial 12 weeks of growth is crucial as it provides the base for diagnosis and treatment of different confusions and complications of an expectant lady (Tuladhar & Dhakal, 2012).

The absence of familiarity with the importance of regular antenatal care shapes the behavior of women and their decision-makers and strengthen the belief that female should consult antenatal services if they found any complication. Another reason for this behavior is hospital inefficiency; the magnitude of clinical practices compromise exceeds to lack women's knowledge on proper and correct maternal care (Taylor et al., 2017).

The gap in clinical operations becomes an obstacle to developing a trustworthy relationship between patients and HC providers that result into hindering the proper implementation of ANC services (Roberts et al., 2015). Some issues of pregnancy are considered as usual symptoms (of conceiving which is why people take them for granted and do not need to consult medical services. Beebe (2017) stated that some symptoms of pregnancy are common that’s why people remain satisfactory and do not bother for medical

attendance or caretaking. One of those issues is high blood pressure, which may prevent women to take nutrient-dense foods, such as fats, meat, and eggs (Asim et al., 2022), can be addressed without any objective measurement through headache, dizziness, back pain and swelling (Qureshi et al., 2016). More than it, association of headaches with Preeclampsia is also erratic, generic and inaccurate which predict maternal and fatal outcome adversely (Sperling et al, 2015). These perceptions are not only confined to headache but to other illnesses too. Food patterns play a pivotal role in maintaining healthy pregnancy as it helps not only fetus growth but also to maintain the health of the mother. Some studies found that some social and physiological factors restrict women not to take proper diet. For instance, food classification (hot and cold foods), fear of taking food may result in a C-section or complicated delivery, household food politics due to household food-sharing dynamics reflect some social constraints while food aversion and craving for non-edible or non-nutritive items, such as ice, chalk or dirt (Asim et al., 2022) are some physiological factors that prevent women to take supplementary food during ANC. In many societies, people adopt specific food patterns during the postpartum period. In Malay, new mothers have to be restricted from certain food as food is regarded as cold and hot. Study shows Malay belief according to the women postpartum period has a cold state because of hot bleeding during delivery. That's why hot foods should be added to their diet plan instead of cold food. (Syraya & Jamaludin, S. 2014). Among many other factors, birth order and birth interval play a crucial role in acquiring postnatal care. It was customary not to seek postnatal check-up unless there was a complication or threat to the mother's/baby's life (Memon et al., 2016).

3.2.2 Socio-Cultural Determinants of Maternal Healthcare

Cultural and social norms play a significant role in governing social structures as well as shaping the behavior of people that's why they are inseparable from daily interactions

(Ministry of Health, 2019). Maternal health is a complex indicator of measuring women's health status all around the world (Ministry of Health, 2019) as it portrays the picture of women's status in that territory (Roudsari et al., 2015). Pregnancy, childbirth and time around the birth are the events very often linked to socio-cultural practices and that is why these are governed by social norms (Coast et al., 2014). Cultural and traditional pressures shape the social and clinical behavior of the people which could lead to poor maternal health outcomes including maternal mortality (Khan et al., 2020).

Study reveals that females remain silent because of feeling hesitation due to cultural stigmatization that is: a woman who talks about sexual and reproductive life is not good. So, females feel hesitation in discussing reproductive health issues. There are some religious beliefs that prevent women from accessing maternal health services. For instance, the veil that is also known as Purdah prevents women to seek reproductive health care services from outside their houses in Pakistan (Rashid, 2016). Similarly, it is considered that a woman is encouraged to have many children in religious teachings that prevent them to use contraception or adopting family planning (Kaneoka & Spence, 2020) Such beliefs that are based on religious and cultural norms regarding maternal health are the main causes of the poorer MH status of women.

Cultural Taboos have been affecting human lives since the birth of civilization. Taboos impose some restrictions on women for reproductive and maternal health practices including praying, rituals or ceremonies and food taboos (Cukarso & Herbawani, 2020). In some societies, if a woman becomes pregnant, she should not be touched by anybody. It is believed that if everyone knows about pregnancy, maybe one of them does anything bad like evil eye, witchcraft etc. (Withers et al., 2018) that can lead to harm mother or her baby. So,

they seek help only from someone trustworthy and not from many people for getting safe and protected.

Even in developing countries females suffer from malnutrition like iron deficiency, overburdened duties and poor health care services that result in maternal deaths and injuries because of holding strict cultural roles and infringement restrictions on females. The husband's low-level perceptions about complications of pregnancy and RH issues also result in a restricted healthcare attitude. The growth of the baby is associated with food restrictions (Saleem et al., 2011). In order to promote excessive fetal growth, mostly prenatal vitamins were avoided (Culhane-Pera et al., 2015). Studies reveal that fear of complicated pregnancy may restrict women to eat nutritious food. It is believed that taking supplements and nutritious food may increase the size of the baby and cause pain in full labor (Gardner et al., 2019) or C-section (Asim et al., 2020). However, sometimes it is believed that restriction or consciousness about eating during pregnancy may negatively affect the baby if the mother doesn't eat what she wants. So, in these areas, women are encouraged to eat more (Gardner et al., 2019) without any restricted taboo. In many areas, people had strong beliefs about traditional practitioners. Women in Pakistan favored using holy water and amulets that are provided by religious/spiritual leaders rather than seeking formal healthcare services (Reimer-Kirkham et al., 2012). A message related to the prenatal period given by a traditional/spiritual healer was also considered a common practice (Agus et al., 2012). conducted a study in rural Punjab, a province of Pakistan, and found that people perceived pregnancy as predestined to childbirth. That's why it should not interfere with otherwise medical interventions can create complications and can be harmful to the pregnant lady and her baby.

Cultural perception of reproductive healthcare works as a barrier; as ANC is thought to be for only those women having health problems or any reproductive complication instead of prevention from complication or general well-being (Ndidi & Osermen, 2010). Women living in South Asian countries and belonging to the lower caste traditionally have given birth in a cowshed or a place like a special hut that was specially constructed for the process of delivery (Vallely et al., 2015). It was so because this time was seen as a time of impurity, where it is avoided to contact anything with a bodily fluids of a pregnant woman (Choudhury et al., 2012).

The association between early marriage and pregnancy leads to poor health outcomes like anemia, premature and low-birth-weight infants, hypertension, abortion, child and maternal morbidity and mortality (Nasrullah & Bhatti, 2012), nutritional deficiencies and intentional injuries. Mass ignorance about legal rights and "true Islamic creeds" along with the element of fear among females restricted them not to question the scriptures from childhood and made them dependent (Bhattacharya, 2014) may result in a restricted socio-cultural environment where a female may not enjoy the basic rights such as the right to live (Reproductive Healthcare and Rights Act, 2013).

Religion has prime importance in the lives of the masses. The role of religious groups (like Muslims) in criticizing RH policies and programs of a development organization that is a serious obstacle in the provision and access of RH services (Lucy et al., 2015). The opposition to the Program "Bache do hi Ache" in Pakistan from such religious groups can be quoted as an example of the obstetric role of religious groups in RH services. However, the web of social norms and customs in association with demographic indicators of people

affects the phenomenon. However, instead of the discussion mentioned above, women who have good positions and empowerment in the family, utilize better healthcare facilities.

Geographical settings along with socio-economic and demographic conditions of people affect people's practices and methods of HC utilization. Studies reveal that Pakistan has discrepancies in its different regions in regard to maternal nutritional status. Almost 30 districts succeeded with children stunting and underweight well above the highest reported at the national level among developing countries (Stevens et al., 2012). On contrary, 10 districts reported the prevalence of child stunting and underweight as low as the best low-middle income countries (Stevens et al., 2012). Although Punjab has better nutritional status as compared to other provinces because of its progress level (Cesare et al., 2015). However, nutritional status is not supplemented in agrarian districts of Sindh and Southern Punjab because of the overriding effect of existing social and environmental factors. Studies observed that it is common practice in Southern Punjab that family members prefer Dai (TBAs) for delivery at home who often plays a crucial part in high maternal mortality. Delivery in unhygienic conditions like cutting the umbilical cord of the mother from the knife they use in daily routine to cut vegetables and other things cause infections that may lead to the death of the mother (Omer, 2019) as well as it may harm the newborn.

It is observed, in most of the rural areas of Pakistan where common people have no access to skilled staff to attend birth, they employ traditional herbal methods during delivery that might have included the use of weeds and other herbal products. Consequently, those methods harm mothers and disturb their reproductive health badly. As described earlier perceptions of women and birth attendants are that mothers have to face poor quality of care and unskilled attendants because they are restricted to visit a doctor by their male members.

Besides, they have to face other factors that restrict them to go to attend a hospital for a healthy procedure. Regarding this, they have developed their own customary practices and wisdom of elder women that help during the pregnancy period. Furthermore, after delivery, they are given herbs to get rid of the infection and to make clean their body and uterus while these practices sometimes might harm their reproductive health and cause stillbirths too (Omer, 2019). Studies prove that maternal education has a strong impact on healthcare-seeking behavior as educated women are much more conscious about health. That's why healthcare practices can be seen as more common among educated women as compared to uneducated women (Asif & Akbar, 2020).

According to the study, educational status of married couples, and knowledge about maternal issues and birth order increase, utilization of healthcare facilities and health-seeking behavior decrease) are individual-level factors influencing healthcare facilities. Institutional influencing factors include a lack of medical staff, long waiting hours, poor transportation, long distant health facilities and electricity interruptions. Lastly, the study reveals that women prefer female traditional birth attendant and delivery at home as religion influences their behavior towards health-seeking behavior. Mostly pardah observing Muslim women feel hesitant to utilize the services at the hospital, especially by male attendants (Kaneoka & Spence, 2020).

3.2.3 Gender and Decision Making in Maternal Healthcare

In Pakistan, the expected traditional gender-based role of a woman regarding childbearing activities is mainly constructed by cultural beliefs that results in the lack of empowerment regarding RH decisions and poor health status of women (Ghimire (2019). It

is observed that shyness is considered a part of pregnancy or negotiation about pregnancy and reproductive health (Kaneoka & Spence, 2020).

Thus, the woman is not a true measure of her autonomy as an independent decision maker. Instead, it reflects the influence of family opinions. Family patterns and family size significantly play a vital role in individual consumption patterns even in Reproductive Health issues. Multigenerational families are comprised of a hierarchal structure and elders have the authority to take decisions about the family. Thus, a lady cannot take her own decision. Women are typically restricted to make independent decisions regarding their perceived health and need for health care. The majority of rural women take permission, usually from a male family member, before accessing any health care service (PRHS, 2001). Fathers are considered responsible for making any decision regarding maternal care services when there are any financial hurdles (Sarfraz et al., 2015). Fathers act upon the advice of an elder community member, preferably their mothers regarding maternal care issues. This happens because in rural areas of Pakistan, elder women are considered to be wise and can better take any decision regarding maternal care aspects for family well-being so a pregnant woman is supposed to follow them and not voice her opinion (Singh et al., 2012).

Instead of a country that evolves on the notion of religious freedom, people prioritize socio-cultural and tribal customs more and impose them in their daily life. In the Subcontinent, preference is given to traditions and customs over religious laws which resulted in a negative impact on the society of Muslims (Pakeeza, 2015), especially in regard to the gender-oriented issue. Bukhari & Ramzan (2013) state that gender discrimination is deeply rooted in socio-cultural norms instead of religious teaching as religion is practiced for political purpose and profit maximization in this area as still Islam is not being practiced

and prevalent in full form; further cultural factors like poverty, unawareness, unemployment and gender-based roles are more active factors for prevalence of gender discrimination. Women's access to health services is limited by restrictions on their independence for making decisions within their husband house (Rizvi et al., 2014). They claim that the decision to seek care depends on who controls the household resources, a decision which often lies with the man and he then decides when and where the woman should seek care. More than it, cultural norms tend a woman to follow her husband or mother-in-law as it is considered "respecting behavior" that may result in the overestimated influence of family members especially in the case of teens (Upadhyay et al., 2014) as they are assumed to be less aware, inexperienced and immature and need more guidance and supervision than an adult.

Women are culturally considered to be a liability from birth and are destined to face gender-based discrimination in Pakistan. Usually in a male-dominated society women are considered inferior to men. The root cause of gender discrimination against women in Muslim societies is the patriarchal system. For ages, women are seen as the men's property (Pakeeza, 2015) that is why, males are often considered a source of socio-economic utility for families because of bread winning ownership. So, males are preferred over females. This subordination sometimes, exceeds domestic violence too that had a negative effect on them. As Ferdous et al. (2017) documented that domestic violence also affects the physical health and mental health of women. Social isolation, lack of knowledge and no control over their lives make them unfamiliar with the legal system and keep them away from utilizing health care services.

Women living in rural areas are more prone to face problems due to beliefs related to reproductive health practices. It can be seen that in rural areas of Pakistan; women are more likely to depend on their husband's or mother-in-law's decisions regarding their reproductive health matters. Such as where the delivery will take place, and whether women will seek traditional RH services or modern health providers (Omer, 2019). In some cases, grandmothers or other elderly women are considered responsible for maternal issues. Their knowledge, experience and traditional techniques of handling pregnancy in general and delivery, in particular, make people satisfactory to take their assistance instead of medical staff (Buser et al., 2023).

3.2.4 Indigenous Remedies and Maternal Healthcare

Culture influences remarkably the behavioral pattern of natives to develop strong beliefs linked with health issues. It enforces people to use traditional medicines. According to World Health Organization (2002), traditional medicine refers to the health-related practices, methods, knowledge and beliefs that are incorporated with plant and animal-based remedies, manual skills, spiritual healing and other exercises partially or in combination to treat, identify and preclude some disease as well as for maintenance of well-being. It is not confined to using medicinal plants/herbs or relying on spiritual etiologies but also includes sacred-profane constructs and hot-cold-like dichotomies that influence cultural practices and maybe sometimes become harmful for mothers and newborns (Ahmed et al., 2021). It is not only culture but society also plays a significant role in shaping traditional remedial beliefs and practices that is why instead of the fact that herbal therapies may not necessarily be cheap and un-expensive traditional remedies are often used when people perceived that the economic and socio-cultural charges of using public health services are too much expensive and unaffordable (Obasi, 2013).

Like other diseases, culture influences the reproductive health of women too in accordance with societal beliefs that may cause self-medication and consultation with a traditional healer (Ahmed et al., 2021; Mudonhil & Nunu, 2021). Many studies explore that women use plants for curing different diseases related to maternal and reproductive issues including abortion, anti-fertility, leucorrhea and menstrual trouble. Such females rely on home remedies through herbal treatment suggested by old women or after consulting with experienced ones and avoid visiting the doctor (Patel & Patel, 2012; Rahman et al., 2012). Such ethnic-gynecological use of traditional plants had been carried out by Rahman (2014) who documented 35 medicinal plants including herbs, shrubs, climbers, trees and seeds that are used by females of Joypurhat, Bangladesh for gynecological issues

It is usually seen that people tend to treat their serious medical problems with herbal medicines or herbs because of their affordability and easy availability without knowing their side effects. Similarly, in most countries around the globe, traditional cultures still follow those herbal treatments even for pregnant women which could be dangerous for their baby and their own health. As Bruno et al. (2018) explained that only some women know about the risks of herbs while most of them do not have any idea that it affects their gestational periods, especially those herbs derived from soy because the days are gone when herbs are supposed to be the cure of every disease but in fact, women are being more prone to illness from those herbs as most of the herbs have molecular structure just like progesterone and estrogen hormone then if anyone intakes them, they could occupy the receptor sites in the body. Consequently, it would be risky for maternal health.

Identically, this stabilized trend of using ethnomedicinal plants also followed in Pakistan where in rural areas people are not much educated to grab the side effects of these

plants and traditional ways of ailment. As (Abbas et al., 2017) reported in Shigar valley local inhabitants have versatile sources for their survival in mountain areas. Therefore, local healers there extend their traditional therapeutic knowledge to resolve females' pregnancy issues free of cost. Asteraceae, Lamiaceae, Ranunculaceae and Rosaceae are some of the famous common plants that are used to treat any prenatal, postnatal or neonatal issue without knowing the facts if it's good for use or effective for maternal reproductive health. By the same token, midwives in areas near the Pak-Afghan border treat a vaginal infection with the seeds of Phyllanthaceae locally known as "Alam" while during delivery use leaves of Brassicaceae to relax the uterus muscle, although it could harm the mother's health.

Another running trend is self-medication comprised of home remedies, spiritual healing and sometimes the use of conventional medicine by utilizing the experience and knowledge of friends or family members. Drinking warm milk, usage of green tea or mint tea, using of hot water bottle on the affected area, taking a boiled egg or raw egg with warm milk, resting and usage of dry fruit may help with menstrual pain (Anwar et al., 2015). These hot food items are considered good to get relief from backache or lower abdominal pain in case of bleeding.

Some evidence from rural communities too shows a decline in traditional medicine used for healing practices (Kumar et al., 2021). The decline has the association between the medicinal plants used with the distance (time of access) from home to the hospital. This implies a risk of losing precious heritage which is vital information regarding medicinal plants and their usage over generations. Another aspect of traditional practice for ailment or cure is to rely on THs and SHs which can be attributed to strong religious beliefs and the influence of peers and family members. Tarafder & Sultan (2014) explore the mythical

beliefs and misconceptions of Santal, comprised of malicious spirit and evil eye, about RH issue and found that the ratio of participants who believed in THs and SHs ranges up to 80 percent for determining the cause of disease, administer remedies and drive away malicious and malevolent spirits as well.

Traditional healers which are generally women known as TBAs/Dais play a pivotal role in assisting with childbirth or other concerning issues, especially in rural or poor-resources areas. These TBAs have many techniques to tackle different pregnancies concerning complications such as prolonged labor pain, retained placenta, breech position baby etc. by using their traditional knowledge. For instance, using a number of blankets, giving black tea or fomenting women's backs with warm clothes are some techniques to tackle prolonged labor (Gogoi, 2021). Tying a chitenge (Traditional Fabric) around the mother's waist and then pulling it to let the mother deliver quickly is another reported technique done by grandmothers who work as TBA in society (Buser et al., 2023). The study further elaborates on the ways of dealing with resuscitation problems by pumping the placenta into the water for a few seconds or by frying the placenta on a hot pan (Gogoi, 2021). Abdomen massage and vulva massage are also practiced by TBAs that naturally help in releasing oxytocin in the body that is more secure instead of injecting oxytocin for the same purpose. Further techniques that are practiced by TBAs for breech position babies are the same taught by a student gynecologist (Gogoi, 2021) that may challenge the skepticism on traditional healing methods by the health service providers.

Another aspect of ethno-medication is spiritual healing based on the mythological beliefs of people that give them satisfaction and peace to be cured well because of spiritual powers. It is observed that women use holy water during pregnancy to safe completion of

pregnancy (Mudonhi et al., 2021). Similarly, the recitation of religious verses is also believed to be beneficial. As mentioned by (Anwar et al., 2015) the Muslims believe that there are many verses known as “verses of cure” that help in treating different conditions. Identically, this stabilized trend of using ethnomedicinal plants also followed in Pakistan where in rural areas people are not much educated to grab the side effects of these plants and traditional ways of ailment. Comprehensive knowledge of traditional establishments concerning women's pregnancy is required to completely comprehend the patterns and approach of women toward maternal healthcare administration. Cultural as well as religious beliefs have a great contribution to determining the type of care for maternal health assurance. That is why traditional healers like, herbalists, TBAs and spiritual healers are considered more reliable and seem to be engaged in the traditional system of maternal healthcare (UNDP, 2007).

3.2.5 Critical Summary

Women health is of much more importance specially in the case of maternal health. It is considered to be a fulfilling and positive experience to be a mother throughout the world, but for many women, motherhood is associated with illness and suffering that result in poor well-being and even mortality of that women. Among the many determinants of maternal health care, that are responsible for access to health facilities, the family plays a vital role in the provision of information and health services. Many studies highlight the influence of family on the maternal health of women.

In the preceding sections, empirical studies on utilization of maternal healthcare services have been reviewed and categorized into four sub-themes; maternal health services at organization level, gender factors, socio-culture traditions and indigenous remedies and

traditional practices. The major factors in these themes are embedded in the theories and models of healthcare services utilization. These theories recognize social, cultural and political structures, which affect the individual at the agency level in the use of healthcare services. The four main themes influence a woman's utilization of healthcare services in the various stages of maternity as they are inter-connected and interact to influence health services use. The review of the literature concluds on cultural environment, family and community networks and accessibility to services as important determinants of maternal healthcare service. Maternal healthcare services utilization which forms the central theme across the literature is composed of ANC, skilled delivery (SD) and PNC. However, these stages have been treated and discussed individually in the literature. They are not isolated stages but inter-connected like a system to impact women's health in maternity. Therefore, these inter-connected stages of maternal healthcare system need to be understood holistically. The literature presents a limited discussion to the individual stages of the maternal healthcare system. ANC and PNC must equally be treated with urgency as important stages in maternity like the delivery stage. Again, normal check-ups for screening or any uncomfortable conditions in these stages should be considered as serious issues. This is not adequately addressed in the literature. The focus of maternal healthcare is centered around emergency obstetric care or delivery, thereby, overlooking other equally important medical conditions like sexually transmitted infections (STIs) screening and treatment, which can also harm both the mother and child. Screening and treatment of infectious and parasitic diseases or other health conditions cannot be neglected in maternal healthcare because they have cumulative effects on the final outcome. Though, the safe motherhood interventions in Pakistan recognize the three stages at constitutional level, delivery of care at the implementation level is more skewed towards skilled delivery - i.e, relaxed towards

ANC and PNC. However, the outcome of delivery can be linked to the type of care given to women during pregnancy, which also has implications for postnatal maternal and child health. The use of indigenous and traditional remedies has been extensively researched and discussed with more attention focused on the family, TBAs, and spiritual level. Hence, they overlook the activities of the female and male traditional practitioners (TBA, and spiritual partitioners etc.). It is usually old women who control the remedies at the family level affairs within the family. The activities of the TBAs often at the community level and reflect the culture of the society, but cultural preservation of every society is enforced by men. Again, though the literature recognizes gender issues, the practices of the TBAs are not linked to gender. The existing literature assumes that the TBAs prepare the herbs and administer on their own, free from male influence. TBAs are women whose powers may be customarily limited to men especially in patriarchal society. The TBAs mostly give assistance to women at all the MH care but at the delivery, her role was more important and the issue of who initiates or contracts the services of TBAs is not adequately addressed in the available literature.

3.3 Conceptual Framework

This study is guided by the Structure and Agency (SA) Theory inclined to Giddens' dualism philosophy (1984) and the three delays model. The SA theory has been widely used in different disciplines in the social sciences to explain how social, cultural and political structures constrain the individual at the agency level or influence their behavior, and in turn being shaped by human actions. In recent times, in recognition of the influence of social and structural injustices especially towards minority groups in society, the SA theory is being used as a suitable framework to explain constraints and health inequalities (UNDP, 2011; ICRW, 2014; Germov, 2014). Apart from adopting the homogeneous sampling technique of

the purposive sampling to select only women, the use of the delays model in previous studies concentrated heavily on emergency obstetric complications, neglecting the direct causes of maternal mortality and other medical conditions which produce the emergency complications. Again, the inter connectedness of ANC, delivery and PNC are not emphasized in the previous studies. Given that previous studies which centered more on quantitative methods overlooked maternal healthcare as a holistic issue and at the neglect of the role of men, traditional practitioners such as herbalists, spiritualists as well as the techniques employed by the TBAs in the traditional medical care, it becomes necessary for this study to find answers to the research question; How do cultural beliefs/practices affect women's maternal health and influence the women perception regarding health care pregnancy and childbirth in Jampur? Answering this question calls for a comprehensive qualitative data from the key actors in maternity care such as women and their spouses, traditional practitioners including TBAs and the healthcare professionals for a balanced discussion. To direct this study to its focus requires a suitable theoretical model that identifies how socio-cultural contexts including the structure of the society and social relationships create social stratification and assign individuals to different social positions and roles. This, therefore, informed the choice of the SA theory and the delays model as the conceptual framework for this study.

The two models are compatible as they both recognize the interaction between structure and agency. The SA theory provides a conducive platform for analyzing the distribution of access roads, healthcare facilities, equipment, drugs and health personnel. It is able to analyze inequalities in access to health services amongst different segments of the population. The delays model is able to analyze socio-cultural structures within households and at community level to discover their influences on maternal healthcare services

utilization, by combining these two makes it possible to analyze gender issues such as decision-making and access to healthcare services. In this framework, women are placed at the agency level, and socio-cultural and organizational/institutional structures as well as environmental conditions at the structural level. The delays model is useful in categorizing the contributing factors that hinder maternal healthcare services utilization and establish in where improvements could best be made during maternity for promotion of maternal healthcare (Combs Thorsen et al., 2012). Again, it recognizes the three phases of delays in analysis by linking them up and showing their inter-relationship, and provides feedback for improvement in the form of recommendations in analysis. The model is useful for discovering and gaining knowledge about the barriers between the onset of obstetric complication and its outcome, and establish the point at which optimization of healthcare delivery is needed (Combs Thorsen et al., 2012). The model helped to ascertain the mediating barriers to timely and regular care during ANC and PNC and suggest ways for improvement. The limitations in the original delays model discussed above have been addressed to make it capable of modeling women's healthcare from ANC, through delivery to PNC and to be able to analyze the status of women's health in each of these stages. It will further link the stages up to establish a complete state of women's health in maternity as a whole.

Whilst the theories and models dispense detailed information for understanding the complexities of healthcare services utilization and inequalities, they have some limitations. The structuration theory does not adequately focus on culture and its influence on humans, especially women towards healthcare services utilization. However, "to understand how social practices are sustained over time, researchers need to study the particular setting in which they take place, rather than ignoring or seeking to control this setting" (Jones &

Karsten, 2008, p.135). The healthcare system structures should be examined in a "culture-specific context" because there is no unitary meaning for constraint in the social analysis since "a variety of different types of constraint may enable or restrict individuals in a particular setting" (Jones & Karsten, 2008, p.135).

However, individuals vary in their levels of knowledge, experiences and reasoning capabilities as well as in values and orientation. It is often argued that all human beings are knowledgeable agents (Jones & Karsten, 2008) as individual differences are not adequately addressed, the structuration theory overlooks cultural factors (Wafa & Jamel, 2013), but cultural behavioral codes are very influential, especially in maternal healthcare services utilization. The Structure and agency philosophy tends to center more on the individual, however, according to Wafa and Jamel (2013), the power of the individual is limited and all transformation requires a number of individuals to act together. Women may be knowledgeable about pregnancy and related complications as well as the need to attend hospital but based on their cultural beliefs they may choose to seek spiritual healing or traditional herbal care. Aside, the ability of knowledgeable and conscious individuals to act and influence social structure depends of the level of empowerment of the individual.

It is worth saying that not all women and people from all backgrounds can have opportunities and capabilities to occupy spaces within structures and effect changes by making free choices. Thus, the free choices to make as stated in the structuration theory are not "freely free". Only the "empowered' will have capabilities in the form of power, resources or voices to influence structures in society and choose alternative healthcare services other than what is prescribed by the social setting. The gender empowerment framework contains the three central components of health utilization theories and models -

that is, culture, social networks and accessibility (Rebhan, 2008). It contains variables such as informal fees, demand and supply factors, and difficulties in the acquisition and supply of drugs which are emerging and showing significant importance in recent healthcare services utilization research. Although relevant to the study, the model fails to indicate the interaction between structure and agency, thereby, treating them as separate entities. If effective utilization of maternal healthcare services is a function of demand and supply, and supply is on the side of the structure whilst demand is on the agency/individual side, there should be an interaction between structure and agency as the dualism theory holds (Barus, 2013; Germov, 2014). In addition, the biological/genetic factors of the individual are not considered in the model, women are different in physiology, response to health conditions and reasoning implying that with equal opportunities to resources, women will still behave differently towards healthcare. Again, the model does not include epidemiological issues, thus, centered on only structural inequalities, poverty and maternal healthcare. Furthermore, the framework places emphasis on economic factors and can best determine the function of its variables through measurement of those variables, which is more inclined to quantitative research.

The delays model was designed for emergency obstetric care (EoC) and has been commonly used to explain why delays occur in accessing EoC. The original model does not adequately address issues regarding ANC and PNC because the model assumes that delays are linked especially to delivery or EoC, which are usually the outcome of the direct causes of maternal deaths. It does not take into account that in the absence of obstetric complications a woman might be carrying a medical condition that may not be known and may delay seeking ANC or PNC. However, these conditions also require timely and appropriate management during the maternity period if the woman and her fetus/baby are to have good

health because obstetric conditions are products of these medical conditions. For instance, timely ANC screening allows for the detection of HIV and AIDS for the prevention of mother-to-child transmission. For comprehensive data analysis, the model needs to consider all three stages (ANC, Skilled Delivery and PNC) of maternity as equally important without limiting care seeking to only emergency obstetric care (EoC) and delivery. That is maternal healthcare needs to be considered a system with ANC, skilled delivery and PNC as individual parts which are interconnected; therefore, the model should function by linking up these three stages, which form individual parts of the maternal healthcare system and it is not well addressed in the previous model and existing studies have treated the stages separately. The rationale is that, analyzing each stage of the pregnancy-postpartum processes as separate entities produce findings related to these stages as individual parts. The most widely used model in healthcare research is Andersen's Model (Rebhan, 2008; Babich et al., 2012). This model discovers and measures conditions that either facilitate or impede the utilization of healthcare services (Andersen, 1995; Andersen & Newman, 2005; Porteous et al., 2015). An individual's access to and use of healthcare services is considered to be a function of three characteristics; predisposing factors, enabling factors and need factors (Porteous et al., 2015).

The predisposing factors are the socio-cultural features of individuals that exist prior to their illness. The empowering factors refer to the logistical aspects of obtain care; include income, travel and quality of social relationships. The need recognized give better help to understand care-seeking and adherence to medical administration this is closer to the kind and amount of treatment provided after a patient. And the perceived need explains how people view their health, experience symptoms of illness. Evaluating need is professional

judgments about people's health and their need for medical care (Andersen, 1995; Rebhan, 2008).

As considering maternal healthcare as a system, any pregnancy-related condition in the pregnancy-postpartum continuum is treated as important and equally requiring timely intervention by health professionals. Thus, maternal healthcare is perceived as a system, with the individual stages forming parts of the whole - implying, that in analysis, poor ANC affects delivery and the health of the woman after delivery. Evaluating maternal healthcare in totality requires a complete analysis of all the stages as a system.

3.4 Theories and Models of Healthcare Services Utilization

In this research theoretical and conceptual issues discussed relating to healthcare services utilization include the Structure and Agency Theory, the Gender Empowerment Framework, and the Three Delays Model.

3.4.1 The Structure and Agency Theory

There is a standing debate over the extent to which human behaviors are determined by social structure (Germov, 2014; Raffiee & Mirzaee, 2014). The structure may be described as the recurring patterns of social interaction through which people are related to each other (Germov, 2014). In contrast, agency is defined as the ability of people, either as individuals or groups to influence their own lives in society. An agent is an individual who takes action to effect changes, and whose behavioral outcomes can be evaluated in terms of his or her own values and goals (Sen, 2001). Whilst agency may be referred to as choices made within social structures in society, structures are about differences in power that empower individuals and classes differently (Abel & Frohlich, 2012).

This means that people within the same environment may have different opportunities within given social structures. Thus, the structure is the arrangements within a given society that influences the choices and opportunities available to individuals. Agency, however, is the capacity of persons to act by making their own free choices. The structure-agency debate is an issue of socialization against autonomy in determining whether an individual acts as a free agent or in a manner dictated by social order (Abel & Frohlich, 2012; Raffiee & Mirzaee, 2014). The debate over the primacy of structure and agency in influencing the behaviors and the conditions of individuals in society has generated arguments from three different philosophical viewpoints (Abel & Frohlich, 2012; Germov, 2014; Raffiee & Mirzaee, 2014).

Whilst some social theorists like Karl Marx believe that it is the social structures that shape humans by causing people to behave in a particular manner, others like Weber & Popper are of the view that it is the agency that is responsible for human behavior. Placed at the center of these two groups is another group of philosophers such as Giddens & Germov who theorize that there is an interaction between structure and agency and that both structure and agency are capable of influencing human behavior. In spite of the controversies, most sociological theories can be located in the category that emphasizes the complementarity of both philosophies.

The UNDP (2011), ICRW (2010, 2014) and the WHO Commission on Social Determinants of Health recognize the interaction between social structure and agency. According to the Germov (2014) there is no conclusion to the debate on structure and agency, but it is helpful to recognize that humans influence society and are at the same time influenced by society. He argues that although in countless ways our actions and thoughts

are shaped by our social environment, humans have the capacity to think and act to change the society into which they are born. The structure and agency are not propositions in the form of a choice between constraints and freedom, but are part of the interdependent processes of social life. According to him, the social structure should not be perceived as negative and only serves to constrain human freedom because in many ways structure enables individuals to live, by providing healthcare, welfare, education and work.

3.4.2 Structuration and Health Inequalities

Global attention on health inequalities started to be more serious in the mid1980s after the publication of thought-provoking articles by Rosenfield and Maine (1985), Harrison (1985) and WHO (1986) to alert the world on the state of women's health during pregnancy and childbirth. Since then, reduction of health inequalities has remained central as evidenced by the first Safe Motherhood Conference in Nairobi, Kenya in 1987, the 1994 Cairo Conference, the fourth world conference on women in Beijing, the 2000 World Summit and the 2014 World Women's Conference in Paris. Both structural conditions and individual agency were identified by these conferences as influential to health inequality for women in reproduction. In recognizing the importance of the structure and agency interaction, health researchers now call for the removal of factors at the structural level which create inequalities and develop or strengthen the agency level through empowerment to ensure effective utilization of maternal healthcare services (ICRW, 2010; UNDP, 2011; Germov, 2014; UNFPA & ICRW, 2014).

At the structural level, there is unequal governmental allocation and distribution of resources such as medical facilities and personnel; creating inequalities between different groups within the society e.g., rural-urban, between regions, the poor and rich and men and

women (UNDP, 2011; Baru, 2013; ICRW, 2014; Germov, 2014). According to the UNDP (2013), patriarchal system structured a society where women are denied to their rights like education and paid labor. They ultimately suggested from diseases and early death. (ICRW, 2010; UNDP, 2011). The capability approach (Sen, 1999) has been suggested as being potentially important for understanding inequalities in health and for public health action toward reducing social inequalities (Marmot, 2010; Ruger, 2010). According to Robeyns (2005), the core of the capability approach is its focus on what people are effectively able to do or what they are based on their capabilities. The perspective for collective action for a change allows for linking the capability approach to the current sociological discourse on the role of agency and in particular, to the concept of structurally transformative agency (Abel & Frohlich, 2012).

3.4.3 Gender Empowerment Framework

This framework was established by ICRW (2010) for measuring the determinants and barriers to maternal healthcare services utilization. According to this model there are many factors (economic, socio-cultural and gender-related) that shape the women's health-seeking behavior, their demand for maternal healthcare services, and their ability to access such services. The framework measures the experiences of women by explaining how structure and agency interact to influence maternal healthcare. Whilst considering poverty as a key determinant of maternal mortality and morbidity, the model perceives poverty as a consequence of gender inequality, which is located in social structures and operates at the individual and collective levels through discriminatory socio-cultural ideological norms. The model also considers the effective use of maternal healthcare services as a consequence of the forces of demand and supply of healthcare services. On the demand side, these strategies range from the removal of user fees to the provision of conditional or unconditional cash

transfers. On the supply side, the delivery of services is shaped by financial, physical and human resources to provide sustained, high-quality, accessible and affordable care. From the supply side, strategies designed to increase utilization include performance-based incentives for providers and contracting private organizations to provide maternal healthcare services. Strategies that empower women to become active healthcare consumers are also needed but are much less common. They include education, employment, social networks and increased mobility. Poverty and gender inequality are major behind poor healthcare services. These variables form the center of the factors that influence effective utilization. They are crucial because they act as barriers or filter that mediates an individual's women's ability to translate demand into effective utilization. Poverty and gender inequality are closely linked. The gender inequality limits women's sphere of activities. There are two types of gender inequality firstly, institutional (Agency) such as culture, social values and the secondly, the factors (to seek care, engage in social interactions, move freely outside the home, etc.) that affect individual autonomy ability to make decisions, control over vital resources (income and assets, time, etc.), and gender-based violence (ICRW, 2010; Dayal, 2013).

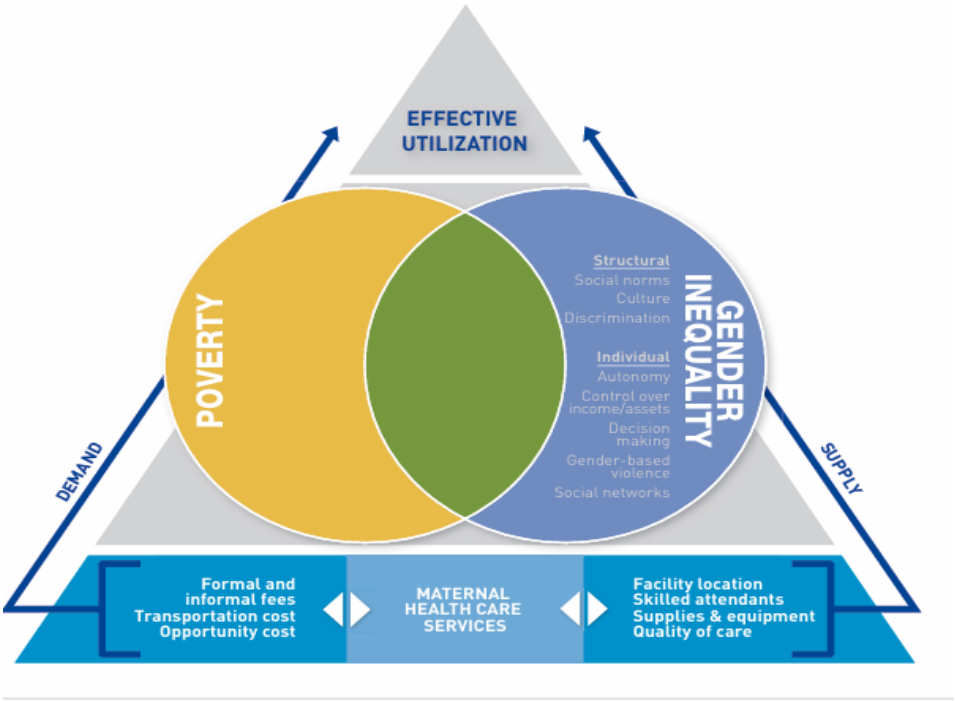


Figure 3.1: Empowerment Framework

Source: ICRW, 2010

3.4.4 The Three Delays Model

This model elucidates how socio-cultural conditions conciliate to influence maternal healthcare services utilization (Thaddeus & Maine, 1990, 1994; Combs Thorsen et al., 2012). The fastest intervention becomes must in the management of obstetric emergencies (UNDP, 2007) The position of this model is that the ability of the healthcare system to effect rapid intervention is usually mediated by socio-cultural factors (Thaddeus & Maine, 1990, 1994; Combs Thorsen et al., 2012). Thaddeus and Maine, the proponents of this model, identify three delays namely; the delay to seek care (Delay 1), the delay to reach proper medical services (Delay 2), and the delay in accessing quality care at the facility (Delay 3). The delay to seek care is normally referred to as delay one. Timely reception of care especially in emergencies by the woman lies in the woman's ability or her caregiver's ability to recognize

a medical condition, or its severity for intervention. This also depends on whether the medical resources are in the position or ready to offer timely care. Thaddeus and Maine (1990, 1994) maintain that the inability of the woman or the caregiver to quickly recognize a potentially severe medical condition will result in delays in taking appropriate decisions or seeking appropriate care, which in turn results in delays in professional intervention. The model holds that when the woman or her caregiver after appreciating that the condition needs care perceives available facilities to be in the position of providing quality care, they will go for medical care. However, where the care quality cannot be guaranteed by the woman or the caregiver, reception of care may delay. Taking quick action at this level depends on the decision of the woman or her caregiver, which is informed by their knowledge about the condition, their perception of the severity of the condition, and their beliefs about pregnancy and childbirth. For instance, it is a norm that pains at the onset of labor must be borne with stoicism until the fetus is ready for expulsion. In some instances, pregnant women regard a small amount of blood discharge as normal (Senah, 2003).

In traditional communities, over-reliance on husbands and family heads for money and decision-making may end the woman who needs medical care home care, either to conform to societal norms or for fear of poor-quality care from the professionals. The delay to reach proper medical services is delay two. This delay often occurs after the need to seek professional care or an emergency situation is appreciated and the decision to seek care has been reached, but the action to move is delayed or hindered by the difficulty in transportation such as poor roads or in some areas no road network for cars to use lack of means of transport, and the cost of transportation, which is compounded by long distance to the facility.

The delay three is the delay in accessing quality care at the facility. This delay is associated with the delays in obtaining care within the health facility after the woman has finally located the facility. These delays are normally due to inadequacy or lack of facilities, equipment (blood banks, laparotomy set, autoclaves) and professionals (obstetricians, gynecologists, anesthetists, midwives) as well as difficulties in obtaining medical supplies or a regular supply of electricity and water. Within the health facilities, women who have been referred from other facilities or traditional practitioners are subjected to long waiting periods. Sometimes, the private maternity homes, and the district and regional hospitals may delay intervention due to some problems peculiar to them. The midwives may lack the skills required for the use of special life-saving instruments and other modern obstetric techniques. The professionals may also delay referrals, especially in private facilities for financial reasons hoping for spontaneous delivery (Senah, 2003).

The problem is compounded by a lack of ambulances and other necessary medical equipment and supplies to handle obstetric emergencies. The facility-based delays take the form of delays in providing appropriate care at the initial facility, delays in transferring women to other facilities for specialist care, and delays in providing appropriate care within the facility to which the woman is referred (Thaddeus & Maine, 1994).

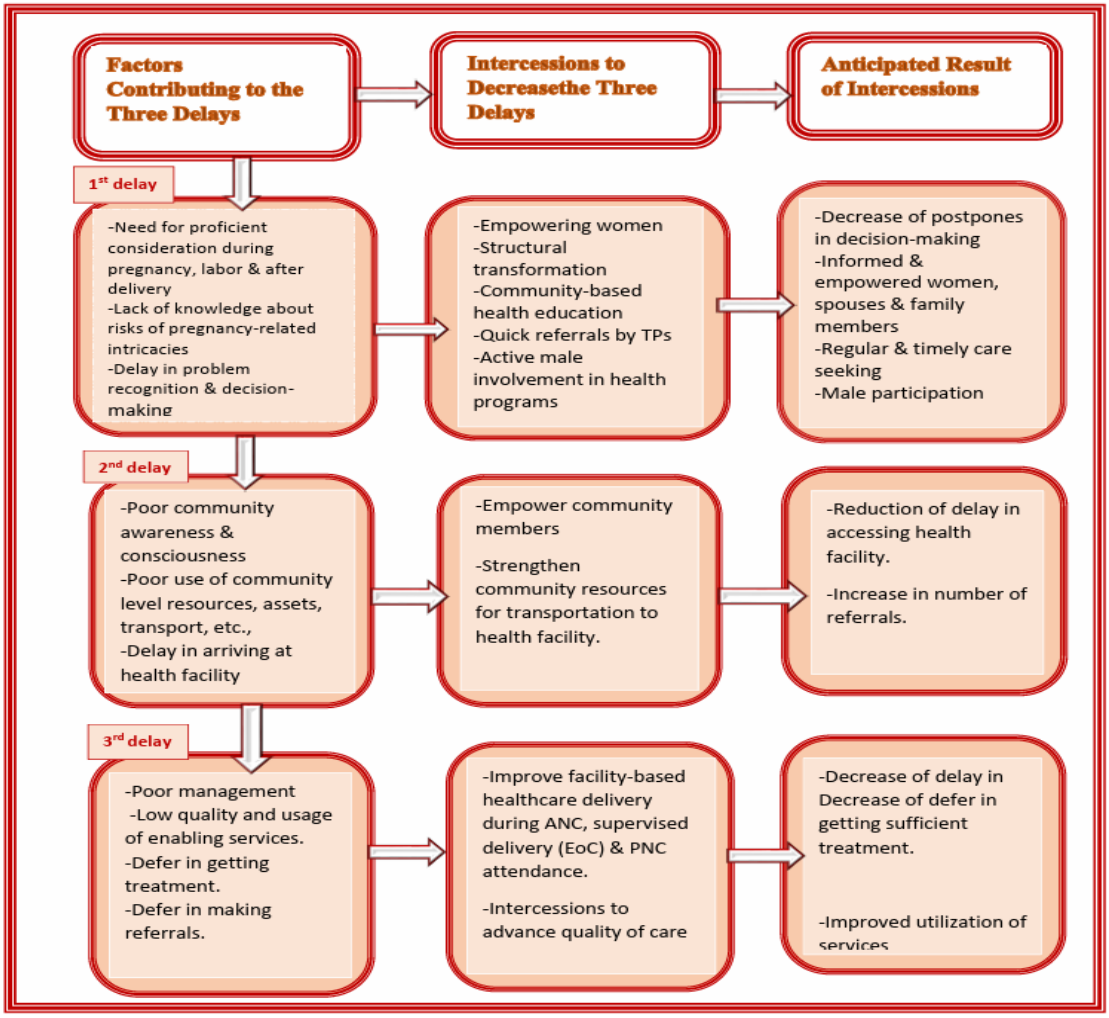


Figure 3.2: Three delay Model

Source: Modified version of Thaddeus and Maine (1994)

3.5 Conclusion

Empirical studies on the utilization of reproductive and maternal healthcare services and their concerning issues have been reviewed it is dig out from the literature that the reproductive problems including maternal health and its' relevant maternal stages (antenatal care, postpartum care, family planning, maternal mortality, abortion, infertility, and HIV/AIDS) are influenced by cultural practices, socio-cultural systems (demographic parameters as well as non-figurative parameters) religious teachings and taboos influence

the RH. All they collectively shape the behavior of masses and thus guided them to choosing the ways of sexual and reproductive practices, prevention of STIs. They are all contributing to select the way to cure of sexual and reproductive issues (relying on indigenous remedies, traditional healers and TBAs). It is observed that during this study that instead of many services provided by the government and non-government organizations, people mostly rely on ages old primitive medicinal methods (herbal remedies, spiritual healing, self-medication, and old techniques provided by TBAs) because of their cultural constraints and religious beliefs. This chapter also contains a review of previous studies, theories and models on maternal healthcare services utilization.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction

This chapter discusses the components of the research design adopted for this study. The formulation of the research design considered the issues raised in the problem statement, the research questions and the research objectives for the study. The sample size for the study, the research instruments and the rationale for using the instruments are also analyzed. A pilot study was conducted before the main data collection. The selection and training of a field assistant, ethical validity and reliability and how they were ensured in the study are part of this chapter. The organization of field-work and challenges encountered during data collection are discussed respectively. Additionally, data management and analysis comprising translation, transcription as well as coding of the field data are discussed.

The qualitative research design for the study under which justification of qualitative method for the study and culturally appropriate approach are discussed. Keeping in view the poor reproductive health status in Jampur, a study is designed to identify the influence of cultural factors affecting women's maternal health through studying their traditional practices. The purpose of this study is to provide a comprehensive review of the evidence regarding the most common traditional practices in Jampur relating to pregnancy, childbirth, and the postpartum period. This study has provided an explanation of the prevailing practices and beliefs in Pakistani rural cultures. This study has examined a broad range of beliefs by geographic concentration.

4.2 Qualitative Design of Study

In this research qualitative design was characterized with by philosophical underpinnings of phenomenology, based on a detailed description of people's experiences of events in their socio-cultural setup. This method of research was used to gain a naturalistic approach that seeks to understand phenomena in context-specific settings such as the real-world setting, where the researcher does not attempt to manipulate the phenomenon of interest. The Qualitative research design was preferred as opposed to the quantitative design because this study was exploratory in nature which required the researcher to seek and explain reality in its natural setting. The logic behind qualitative epistemology is to understand and explain or interpret patterns of social relationships rather than determining the causality of dependent and independent variables for generalization as in quantitative method.

The design and the investigation processes both empower the individual participants to share their views, make their voices heard and minimize power relations that often exist between researchers and participants (Nwokocha, 2007). The qualitative research design is flexible and this defining characteristic of the research design enables the researcher to direct the discussions to other areas even though the focus of the investigation may be known in order to raise concerns that may be useful to the study. Another important factor which influenced the choice of the qualitative design was the feature of researcher- participant relationship. A typical motivating quality of the qualitative design is its ability to provide plausibility of interpretations. In qualitative research, the investigator does not acquire the information and knowledge in a vacuum, but rather in a context and, in this way, the research findings are a product of various situational factors, making the interpretation of findings in a qualitative investigation more credible (Silverman, 2010). Qualitative researchers may

recognize several nuances of attitudes and behaviors that might escape researchers using other methods. Qualitative research is especially appropriate to the study of those attitudes and behaviors best understood within the natural setting.

4.2.1 Justification of Qualitative Design of Study

Qualitative research tends to be interpretive and seeks to understand a phenomenon in its context in greater depth (Lietz & Zayas, 2010). It seeks to explain the nature of social practices, relationships, and beliefs along with the meaning of human experiences from the participant's point of view (Silverman, 2010; Lietz & Zayas, 2010). Ling (2004) contends that failing to recognize that ways of knowing and research methodology are culture-bound has serious consequences such as marginalization and exclusion of culturally diverse interpretations of reality and human experiences. The choice of the qualitative data collection method was motivated by the rationale that the issues under investigation were too subtle and complicated to be adequately explored by using standard survey techniques (Patton, 2002). It is argued that research should be grounded in the worldviews and cultures of the local people (Ling, 2004, 2007; Smith, 2012). Thus, research methodology as a way of knowing is inextricably linked to culture (Ling, 2004). The positivist approach where the researcher has to distance himself/herself from the data collection process is, however, limited in the focus of this study. Patton (2002) supports the researcher's deep involvement in the research as the research instrument. He maintains that the real worlds are subject to change, and therefore, a qualitative researcher should be present during the changes to record an event after and before the change occurs. The researcher is the tool by which data are gathered. This is an important function of the researcher-participant relationship in qualitative research as it influences research outcomes. This relationship is at the center of in-depth interviews (IDIs) and focuses on group discussions (FGDs), which were the

techniques of data collection in this study. Investigating issues on ethnicity, gender, religion and belief systems requires building a strong rapport between the researcher and the participants to unveil contextual issues. Eisner (1991) contends that a good qualitative study can help us understand a situation that would otherwise be difficult to interpret or confusing.

4.3 Respondents and Key Informants Sampling Procedure

The sampling procedure is an essential aspect of research because the research participants and the data they provide are to contribute to better understanding of issues under investigation as well as the theoretical framework (Tongco, 2007). Therefore, choosing a sampling technique should involve sound judgment about the participants for the research. Purposive sampling is symbolized in most qualitative studies but the method is not sufficiently accounted for in most studies (Tongco, 2007). This technique was very vital because of its ability to cover the population with the samples. This technique was helpful in the selection of the sample and generalization of results on the total population. This was the qualitative type of study. The sampling technique was carefully selected according to the objectives of the study. Qualitative studies (Goode, 2000) are found typically to employ the snowballing method, networking and purposive sampling or selective sampling (Kalton and Anderson, 1986; May 1997; Arber, 2001).

The population of interest consists of married women with at least one child would be the criterion for selecting participants. It is assumed that participants meeting the criterion would be able to provide current information about maternal health issues because they would be in their puberty. Therefore, they would be more likely to recall their last pregnancy, related cultural beliefs and practices as well as traditional medications for reproductive

health care. Second, the Sample consisted of married women of childbearing age (15-49). In this age group, women are more likely to be married and have a child.

Purposive sampling is used mostly in qualitative research studies where members of the groups are selected on the basis of preselected criteria. It depends upon the time and resources available and the research area. Purposive sampling is best to be applied when the research and assessment of aims are linked with evidence gathering (Glinner & Morgan, 2000). Purposive sampling would be applied to recruit the participants for the study. In addition, to avoid one-sided data, the health professionals were interviewed to seek their views on conditions that facilitate or inhibit the utilization of maternal healthcare services. This was to ensure that both the service provider and the clients were interviewed to get balanced data. Snowball sampling was used to reach the various categories of the participants after which a non-proportional quota sampling technique was used to the reach representation of participants based on background characteristics such as age, ethnicity, level of education, occupation and residence. This was to create a room for analysis of interesting background characteristics on issues under investigation because both data triangulation and analysis triangulation produce findings that are trustworthy and dependable (Silverman, 2010; Lietz & Zayas, 2010).

4.3.1 Respondents

In this study main participants of this research consisted of total forty-two (42) married women. All were married women aged 15-49 with at least one child. In this age group, women (a) are actively considering and possibly acting on family limitation; (b) have young children and relatively fresh memories of pregnancies and child-birth; and (c) have

more varied educational experiences than their older counterparts. Women's reproductive health care is a life cycle process.

According to the Government of Pakistan (2017), in Pakistan currently women of reproductive age, that is from 15 to 49 years, 28.5 million that is approximately 48% of the total population of Pakistan. The research participants were selected using a heterogeneous purposive sampling method. Purposive sampling is symbolized in most qualitative studies but the method is not sufficiently accounted for in most studies (Tongco, 2007). The rationale was to provide as much insight as possible into the experiences of women within and outside healthcare facilities during the pregnancy-postpartum period. By this, the main actors in maternal healthcare were women, Thus, the various categories of participants were purposively chosen to provide information on management and treatment of pregnancy-related complications and delivery. According to Lietz and Zayas (2010), the use of purposive sampling technique is distinctive in qualitative study in seeking a specific group of participants who have experienced the issue being studied.

4.3.2 Key Informants

In the various communities, the researcher was introduced to the leadership of the traditional practitioners comprising health professional, traditional birth attendants, old and experienced women, religious/spiritualists and community workers/ consultant. The intentional selection of participants provides basis for collection of rich information related to subject area of the study (Patton, 1990) and maximum variation in research participants (Kielmann et al., 2011). Upon arrival to the research site, researcher was in contact with District Health and Population officer and the official of a local organization working at community level in Jampur. The research project explained to them along with the specific

criterion of research participants. As the village was completely new for researcher, so he met with some cultural consultant and informant in formal and informal way to collect some supporting data, it was helpful for study and all these informants was directly and indirectly linked with present study. Those meeting with informants was necessary/ informative and supporting the IDI and FGD information, especially the information received from the MNCH coordinator, NGOs personnels, regarding the Tehsil health infrastructure and main profile of the area, Dais (TBA) indigenous old women input regarding home remedies and Molvi (religious Practitioner) information supporting the religious belief system at local level. Govt and private doctors share the problems and challenges of RH at local level and at the institutional level health services, information and dissemination system. The lady health supervisor worker provides the detailed MNCH services they are providing at local level and problems facing to then regarding strong local socio-cultural beliefs system and also the role of TBA. The other general meeting during the pilot study and data collection time with the local peoples in all three settings urban, rural and tribal were helpful to understand the local culture, belief system, history, geography and political situation of the study setting. Their detail is as under

4.3.3 Research Assistant

The researcher selected the research assistant from population with health back ground. These ladies had close working relation with Saya foundation NGO network which proved to be beneficial since they could reach the participants for interviews. Some participants refused due to fear of blackmail by journalists despite the issuance of introduction letter.

For field work researcher needed the help of the research assistants for data collection. That's why he selected two research assistants Ms. Tahira Batool (Family welfare worker) and Ms. Fozia (working in an NGO) both of them were experienced in relevant field. Moreover, Sayya Foundation (NGOs) Director Mr. Abdul Satar played a very important role to select the research assistant Ms. Fozia who was working with Sayya Foundation. Ms. Tahria was selected by the recommendation of Ms. Farzana due to her experience as population welfare assistant that was valuable for researcher. She had firsthand information regarding married women and also RH services they helped to identify the research participants. All the potential participants were informed about the purpose of the study with detailed explanation of the informed consent and having them signed it if they are interested to participate in the study. One day training session was organized with these assistants regarding the interview guide, group discussion and data collection. All ToRs were discussed with them. With the guideline of these assistants work plan was designed to conduct field work in the selected union council wise. Ms. Tahira had a liaison with population welfare workers in every union council. She made schedule to conduct interview (time and place) with participants.

Table 4.1: Distribution of Cultural Consultants and key Informants

Characters	**Frequency**
Male Dr (Coordinator) MNCH program Rajanpur District	1
Director (Sayya Foundation)	1
Teacher Govt school Jampur	1
Translator Baloch Language	1
Male Doctor RHC Govt Hurand Trible area	1
Female Dr (BHU Govt)	2
Female Dr Private clinic	1
Lady Health Visitors Govt BHU	2

Table 4.1: continued

Lady Health Supervisor MNCH program	1
Lady health worker MNCH program	2
TBA(Dai) Private	2
Midwifes	2
Indigenous Old ladies (Local RH Remedies Expert)	2
Molvi (Religious Practitioner)	1
Total	**20**

Source: Field Data 2019-2020

4.4 Data Collection Methods

4.4.1 Field Research

The fieldwork of this study was commenced in April 2019 and completed in March 2020, in Tehsil Jampur of Rajanpur district. First step was taken to collect the information of the population with the permission of the Population and Health Department of district Rajanpur. In second step, with the help of concerned departments Lady Health Workers of the health department and Family welfare worker of the Population Department were requested to guide the target population on following ground

They were closely working with the married women regarding RH and Family planning services in the area. They had a complete record register, where they enrolled married couples and also kept a record of RH and family planning services. It was helpful for the researcher to approach easily to the respondents; it also saved time and the community had already a built-in trust in LHWs and FFWs. These service providers and government officials were educating and disseminating the information in the area and they were on board to select the sample size.

For choosing the area of the study, the researcher has a specific purpose in mind to because culture is paradoxical and relative at the same time. Therefore, the researcher selected these geographical area's populations as samples to collect data for research in these areas. The Jampur Sherqi (East) and Ghurbi (West) were the urban setting, Dajal, Hurend and Lundi were the arid and remotest areas of this tehsil near the Tribal setting. Based on data or thematic saturation, the study was conducted 42 IDIs and 5 FGDs in the area.

For data collection research assistant Ms. Tahira played a key role for selection of the study area and consent of the respondent by willing's of male household member on basis of her data. The study area comprising of urban, rural and tribal settings in Tehsil Jampur which have a total of nineteen union councils (UCs) selected areas UCs were in the urban areas. Total (14) fourteen UCs were selected from rural settings and (03) three union councils were selected from the constituted arid area which is adjacent to the tribal union council.

4.4.2 Focus Group Discussion (FGDs)

According to Shafritz and Roberts (1994), FGD is a socially appropriate means for gathering data because the participants are usually keen to discuss issues that are very delicate openly. Therefore, the selection of participants for group discussions was carefully done and guided by the background factors (Shafritz & Roberts, 1994; Patton, 2002).

This research planned to use focus groups in the initial stages to guide the construction of the topics of the individual interviews and to provide a base/guide for selecting participants for more detailed interviews in each sampled community, the study conducted IDIs after FGD sessions. This step was taken to validate the data generated from the FGDs by probing deeply into issues that were not well explained in group interviews.

Two of the FGDs were conducted in the urban setting urban FGD one was conducted in Population welfare field office and one was conducted at one of the participant's homes. Because the municipality area had large number of populations two in the rural area participants of those FGDs belong to the different rural union councils and these FGD were conducted in the local communities and Saya foundation helps out to manage these rural FGDs. One FGD was conducted in tribal area and this was also managed in one participant's home because due to tribal setting, it was not possible to manage at local place. A male member played the role as translator because four out of seven were Baluchi speaking.

The FGDs were also characterized by lively discussions as participants were encouraged by alternating the "difficult" questions with very easy and interesting ones. Also, the responses provided were not judged, and all contributions made were treated with utmost respect, with the view that there is no wrong or right answer. Using their ages, the women were categorized into three main groups for the FGDs i.e., 15-24, 25-34, 35- 44 and 45 and above This was to create age homogeneity during the FGDs to some extent, facilitate group discussions and simplify analysis since the respondents were of similar backgrounds and experiences. All things being equal, women from the ages of 15 to 19 and those aged 35 and above are prone to complications during pregnancy and childbirth whilst 20 years to 34 years are recommended for pregnancy and childbirth (ICRW, 2007). The various age groups should be separated to encourage the younger ones to express their views without fear of being accused of anything by the older ones aside, participants were also grouped according to their localities and ethnicities in order to hold detailed discussions on issues concerning participants from different places of residence and ethnic backgrounds. Interviewing participants from the same places of residence in the FGDs will allow the researcher to analyze access factors such as nature of roads and distance to the facility. Mixing the various

participants from diverse backgrounds also generate misunderstanding on some cultural issues amongst participants from different ethnic backgrounds which would take much time. This explains that cultural or ethnic segregation was to enable cultural factors to flow freely in the course of the interaction. For instance, it avoids the problems associated with dialectical differences (Patton, 2002; Ling, 2004) and ensures smoothness of interaction because of minimized linguistic and conceptual barriers.

4.4.3 In-depth Interview

In IDIs, participants are more confident, more relaxed and are motivated to express their deepest thoughts about research issues (Milena et al., 2008). Moreover, the IDI was used to validate the results of the FGD (Patton, 2002; Lietz & Zayas, 2010). The interview guide is useful in conducting group interviews since it keeps the interactions focused but makes room for individual views and experiences to come up in the course of the interview (Patton, 2002). The use of IDIs and FGDs for investigation in this study was essential by the need to understand why some communities, families and pregnant women exhibit certain behaviors that affect pregnancy outcomes. Also, inner motivations and emotional responses of people to certain socio-cultural features cannot be established without an in-depth exploratory approach (Nwokocha, 2007). Even though FGD and IDI are both interviews, the use of the IDI is to provide privacy and confidentiality to participants so as to allow them to express themselves freely (FHI & USAID, 2011). 14 IDI were conducted from the urban area 8 from Tribal and twenty respondents were interviewed in rural area. All respondents were the married women from age group 15-49 and had at least one child. Some interviews were conducted on paid and in FGD refreshment and tea was served at the end to all the participants. In some interviewees husband and family consent was taken and, in some

interview, household head, the old lady was cited in the interview. The approximately the length of the interviews were one to two hours.

4.4.4 Face to face Interaction

As a moderator and instrument, the researcher created an enabling environment which aroused the interest of the participants to share their views through the use of probes, transitional questions and facilitating interaction amongst participants. By this, the researcher remained reflexive, neutral (Patton, 2002) and focused on issues under study. The researcher presence is also needed to explain to the participants their allowance to opt out or choose not to respond to some issues when considered embarrassing or when they find it uncomfortable to do so. Further, due to linguistic and conceptual in-equivalence of words and terms (Ling, 2004), direct interaction between the researcher and participants is a necessary requirement to explain issues well to generate expected responses, for a high context cultures (Ling, 2004). Field observation is an important part of qualitative research where researcher face to face conducts all the in-depth interviews and focuses on group discussion. This interaction was helpful to understand the culture of the area especially local Sariki language, researcher also participated in local festivities (Mela) in Dajal, religious festivities at shrine Amir Humza and some population welfare walks. This firsthand rich local knowledge is helpful in data analysis and area profile designing.

4.5 Pilot Study

A logical way of testing whether questions produce different answers is to pre-test questions before the main research starts (Amedahe, 2006; Silverman, 2010). A pilot study is required because every side of research design needs clarification, and many features of the design cannot be determined without prior exploratory research (Thabane et al., 2010;

Leon, Davis & Kraemer, 2011). Regardless of its research benefits, most studies ignore pilot studies (Teijlingen et al., 2001; Thabane et al., 2010). Before the actual research, the FGD and IDI guides were tested in a pilot study conducted in the same Tehsil. The communities were chosen for the pilot study with similar features be (Amedahe, 2006), in terms of ethnic, religious and locational factors. The pilot study conducted 10 IDIs one FGD each was conducted to women. The rationale was to check for the possibility of inconsistencies, correct possible mistakes, and identify the language needs of the prospective participants. Before the pilot study, formal consent was sought from the communities for the pilot study and those sampled for the research. This made it possible for the researcher to identify likely issues that needed to address to ensure smooth and successful data collection exercise.

To probe into some potentially neglected aspects of the study design, and to ensure the appropriateness of the interview questions, the participants in the pilot study were involved in a post interview session. This aimed to identify necessary modifications to the research design (Leon et al., 2011). Consequently, the changes were made in the study design. For instance, the study intended for more focus group interviews for the traditional practitioners, but as a result of the pilot study were based on more individual interviews and fewer focus group sessions for them. It was necessary because of the participants were not willing to express their views freely in the group discussions. Those interviewed individually discussed issues at length. The researcher discovered that members did not want to disclose some information about their practices in groups for others to copy them. Therefore, they kept them secret and only disclosed when interviewed individually. To fulfil cross-gender research ethical principles, the study intended to use females (non-relatives) or male/female siblings of the female participants to sit in the individual interviews to avoid suspicions of all forms. However, this method did not work because the participants were neither willing

nor comfortable to share ideas freely in the presence of fellow women or their siblings. In comparing data, it became necessary to consider interviewing without anybody sitting in because those interviewed by the researcher alone, irrespective of the researcher's gender, were more detailed and the women were more comfortable in providing information. Therefore, the interview sessions were conducted solely by the researcher.

The pilot study also led to clarification of the conceptual framework for the study. In analyzing the data from the pilot study, it was established that the women who used the health facilities delayed in professional care seeking within the maternity period, because some cultural beliefs and practices mediated to cause the delays. It was also realized that the same socio-cultural conditions held some women to the traditional practitioners in their respective communities, and they never sought professional care. Besides, some women attempted seeking care from professionals but gave birth on their ways to the facility, while some were delayed in the facilities by the professionals.

4.6 Data Saturation

When the variety level in the data is touching down and nothing new is emerging from data, it means the study has touched the saturation point. It is worth-noting that it is immoral to hire new participant as new contributors to research where there is no use of data. (Mason, 2010; Francis et al., 2010; O'Reilly & Parker, 2013). The whole number of participants was determined during data gathering period (Morse, 1995). The gathering of data ended when data appropriacy was attained to create awareness linked to the results and objectives of the study (Morse, 1995). The total no of participants in the research was forty-two engaged in an in-depth interview and thirty-nine participants was in five group discussions.

The study points out that it is really difficult for researcher to realize when the saturation has been attained. A data collection reviewed speedy extension of field notes and writings out within 24 hours following data collection, and then there was thematic analysis of the data. This analysis touched a level where the same themes were recurring and nothing new was developing from the fresh source of data. The researcher concluded that the theme was sufficient data to ensure that all the study questions were addressed.

4.7 Data Analysis and Presentation

The study was designed to permit the extension of filed notes and transcription of taped audios to be done the next day after every interview session. This also prove to be strategy for additional data collecting as the initial scanning revealed a change of questions in particular conditions. It also enabled the researcher to be in touch with the participants to endure any loss of essential information or simplification. Both the in-depth interview and focus group discussion takes were held in the Urdu language and the relevant local dialects (Sariaki and Punjabi) of the respondent for those who could not understand the Urdu language. The collected data consisted of written text, visual data from captivating occurrences and tape-recorded audio stuff.

The first phase in the analysis started with transferring the taped material into the textual form in the individual language in which it was taped. Those in local languages were transferred in to English for study. This approach was adopted with ethical conscience to prevent distortion of information and guarantee that the identity of the respondent was not linked with data to ensure anonymity. To achieve solid and reliable data for the study, word for word writing and translation were done Non-verbal signals were observed and incorporated. The data were examined based on the evaluation of the result of coding using

ATLAS.ti 9 software and manual coding by the researcher. The program was chosen because of its versatility appropriate for the research. Apart from it, the program made it possible to consolidate massive quantities of documents and keeping track of all notes, comments codes and memos in all disciplines that demand close study and examination of source material that includes words photos, audios etc. Additionally, it gives investigative and conceptual tools which amid to disclose fresh interpretive viewpoints on the content.

To maintain credibility and to guarantee that no critical facts were left out, a manual coding exercise was done and it was compared with outputs of ATLAS.ti.9 program. Thematic analysis was used for analyzing the data. The data which were achieved using a tape recorder during the FGD and IDI session were played to hear again in order to acquire comfortable with the data. There were contrast of terms, remarks, the emphasis of participants and the specificity of rephrase in follow up questions. Similar ideas reported by the subject were recognized categorized and grouped together. Out of each set of linked ideas a unifying notion of under lying topic was developed. Main ideas, words and visual were also found to support the results. Finally emerging similar topics were brought together to come up with significance themes via consultative procedure among writers.

4.8 Data Recording Procedure/ Transcription of Interview

The audio tape was utilized for having data while interviewing, which was linked with note taking to preserve data id audio taping field (Creswell, 2013). The recorded material helped me to listen interviews and FGDs frequently and helped me to confirm that writing of interview was done accurately (Patton, 2002). Research assistant got notes for the interview, one was aiding me in FGD while the other was in an IDI. The notes elaborated a date time places and brief back ground description of interviews. The facial expression and

non-verbal bodily expressions were also incorporated whenever feasible. The participants were briefed about audio taping and they verbalized their comprehensive of the tape recorder and approved for recording. It was shown to verify that all of them understood it. It was made clear to them that the recording would be erased following the end of the study and would not be shared with anyone except researcher and supervisor. It was also guaranteed that the presence of recorder would not hinder their freedom of expression. The risk that the most sensitive things might not be discussed because of recorder, was nevertheless, kept in mind. But it was unavoidable. The taped material was transferred to personal computer of the researcher. All the discussion was recorded and then written out word to word by me. Others of the transcriptions were done during field and same were written down after the conclusion of field work.

4.9 Ethics of the Research

According to La-France and Crazy-Bull (2009), ethical issues are important aspects for studying indigenous populations. Prior to conducting the study, ethical approval was obtained from the Faculty of Social Sciences and Humanities introductory letter obtained from UNIMAS from the office of dean research and data collection permission was sought from community leaders such as municipal/district government, health department and coordinator MNCH program Rajanpur. The purpose of the research was explained to them and formal letters seeking the consent and approval to family head and husband to engage married women in any activity IDI or FGD. This cultural ethical factor was observed in accessing participants for the interviews. The spouses of the women were given the opportunity to be present during the interview session. However, none of them expressed interest in joining their spouses for the interview.

Basically, social research should not cause harm to the people being studied, regardless of whether they volunteer for the study (Babbie, 2010). In line with this, steps were taken by the researcher to ensure that information that would embarrass the participants or endanger their homes, lives, friendships and jobs, was not released to anybody. Babbie (2010), contends that research participants can be harmed in a psychological way as some probing questions can be destructive to a weak self-esteem. The study attached particular importance to the psychological and emotional well-being of the participants and looked for subtlest dangers (Patton, 2002) and guarded against them in the interviewing process and afterwards. During data analysis and discussions, ethical issues were considered in the use of words/terminologies and phrases to describe people, cultures or an ethnic group. According to the American Psychological Association (2012) this should be considered in order not to marginalize or underrate any group or individuals in the society.

The clearest concern in the protection of the participants' interests and well-being is the protection of their identity (Babbie, 2010). Anonymity and confidentiality were also given consideration and observed as principles of research to make participants comfortable and eliminate fears while providing important information. Assurance of anonymity and confidentiality enables participants to establish trust in the researcher and provide relevant information (La-France & Crazy-Bull, 2009).

To ascertain anonymity in the study, the researcher tried to refrain from recording or using names in the exercise. Rather, identification numbers were used for easy access to the participants when the need arose to contact them for further information. Also, in booking appointment for interviewing participants in the first time, only telephone numbers were taken to contact them. To ensure confidentiality, a password system was developed to deny

people other than the researcher access to the tape recordings to ensure that people do not get the information from the field. Also, since the researcher had access to the identities of the participants, he subjected himself to training in the ethical responsibilities of the various ethnic groups and applied them before, during and after the data collection.

4.10 Validity and Reliability

The usage of the rationality of the word and reliability has created controversy among methodologists. There has been difference of opinion between the positivists and the naturalist, even between some of the naturalists themselves. Golafshani (2003) maintains that dependability is a notion to assess quality in the quantitative investigation with the object of explaining. But in qualitative research, the term of "quality" has the objective of developing understanding (Stenbacka, 2001). According to Stenbacka, the difference in aims of assessing quality in qualitative and quantitative research is one of the causes why the concept of reliability is not helpful in qualitative research as it is deceptive in a qualitative study. Additionally, it is maintained that if idea of reliability is employed in qualitative research as a criterion, the outcome is rather that the study is "no good from this view validity and reliability are two changeable that qualitative researcher exert himself when organizing a study, examining data and rating the quality of the study. Healy and Perry (2000) believe that quality of research in certain pattern should be evaluated by the parameters of the pattern. Lincoln and Guba (1985), believe that whilst reliability and validity are necessary criteria for quality in quantitative studies, the term credibility impartiality, compliancy, uniformity or accuracy and appropriateness, movability should be the necessary feature for quality in qualitative research. To Lincoln and Guba, the word "dependability" be utilized in qualitative research for reliability with inquiry audit as one way of boosting dependability in the same line. Seale (1999) links the idea of dependability with the concept of consistency

or reliability in qualitative research. This research was trustworthiness and dependability for validity and reliability correspondingly. In order to eradicate researcher bias to increase the quality of the result of the study and make the research conclusion more trustworthy, many approaches have been advised by qualitative methodologist. For instance, it is maintained that an inquiry audit should be employed to assure the dependability of the qualitative inquiry (Lincoln & Guba, 1985), and that an inquiry audit may be used to check both the method and the output of the study for consistency (Hoepfl, 1997).

Patton (2002) with reference to the researcher's capacity and skill in any qualitative inquiry is also of the view that reliability is result of validity in a study. Guba and Lincoln (1985) claim that guaranteeing credibility is one of the most important principles in creating trustworthiness. to ensure that study results are in conformity with reality, the researcher employed the following measures. As described in the ethical portion of this study.

The researcher established an early awareness of the customs of various ethnic groups to which the participants belong, discussion took place even before the first data collection. The researcher made himself familiar with the cultures of potential participants by review of power resources like textual and audio-visual materials and prior visits to the study communities to create trustworthy relationships, between the researcher and the researched Lincoln and Guba (1985).

In this research, the methodological inadequacies of FGD were taken care of by the individual interviews. Individual's interviews have been recognized as having the ability to verify the findings of FGD in health research (Shafritz & Roberts, 1994). Aside, helpful data were attained from papers to offer a context to and describe the views and behavior of the participants, as well as to verify particular facts that respondents had contributed. Then the

researcher confirmed honesty in the participants responses by making sure that every body contacted was given the choice to reject the participate in the interview. This aimed to verify that the data gathering sessions featured only those who were actually ready to take part. As the ethic of research demand, from the outset of each interview and FGD session, the researchers were urged to be open. The participants were advised that there were no right or incorrect response to the question that would be given. During interview and discussions, the investigator adopted an autonomous position to allow participants to express ideas and speak about their experiences without worry of losing respect to the investigator and other participants during FGD.

The researcher also utilized another method. It was the use of iterative questioning during interviews to discover purposeful lying. This was deployed by employing probes to attain comprehensive data, with the researcher returning to subject previously highlighted by the respondents, via rephrased questions. Where discrepancies showed up, lies were recognized and the questionable data erased. An essential part that was missed out in the investigation is reflexivity. In qualitative research, meaning associated with social events are coined via interaction and are culturally constructed (Ling, 2004, 2007; Smith, 2012). Therefore gender, class, ethnicity and age along with other characteristics vis-a-vis the researcher's background might have an influence. A researcher own sex, age, educational level, and ethnic origin amongst other demographic variables may affect the connection between the researcher and the researched. A proper setting was provided both men and women informants to freely discuss topic without being affected by the researcher's background. The researcher was also careful of his age and degree of education, while interacting with the diverse individuals. The interview method was open to self-searching by assessing any pre-thought notions about problems and about the studies and how they

may impact research choices particularly, the selection and phrasing of questions, interpretations and consciousness as well. The whole process of study was based on reflexivity, free from the self-fulfilling prophesy (Madon et al., 2011) of the researcher. The study ensured that the generation of knowledge mirrored the collaborative endeavors of the researcher and the participants.

4.11 Field Challenges

During the data collection, some challenges were encountered in the study communities. One of such problems was the weather due to climate change. Part of the data collection period coincided with the rainy season which made movement very difficult. Due to the seasonality of rainfall in the study areas and hill torrent in this time comes and flood make difficult for farmers. It was a busy period for farmers, its cotton-picking season, to spend time on interviews. Staying in the community in the period, the researcher noticed that most farmers were not going to their farms off days to cotton picking.

Therefore, arrangements for interview appointments were fixed on days and sometime late in the evenings after they have returned from their farms. Another challenge was reluctance on the part of the people to be participants especially some also entertained the fear that the recordings may be used against them in future and opted for writing instead of voice recording. This delayed the interviewing process especially in the FGDs. However, the researcher's stay in the communities and interacting with the members, involving key members of the communities in the organization members motivated the potential participants to take part and some accepted the use of tape recorders.

Some of the health professionals were not willing to provide data from their institutions for fear of blackmail following the recent activities of investigative journalists

in the country especially the soft form of data. The health professionals suggested choosing study sites for the study. But this was not considered by the researcher on the grounds that they may go to the various communities to meet potential participants and guide them on how to respond to questions. Further, the study found that the traditional practitioners were not responding candidly in FGDs like in interviews. This called for reducing the number of FGDs and increasing IDIs for this category of participants.

Covid 19 was one of biggest challenges. During this time, it was the end time of data collection and start of data analysis. Approximately for six months, nobody was ready to interact with each other and it proved to be a cause of delay in my research activity.

4.12 Conclusion

This chapter presented the design, data collection methods and procedures employed in the study. The use of a culturally appropriate approach, pilot study and the necessary changes made in initial design were also discussed. The challenges experienced in the field and how they were dealt with were also presented. It also discussed how the data were managed and analyzed and presented samples of how coding was done.

The combination of IDI and FGD in the study was equally useful in revealing issues as each of the instruments took care of the weaknesses of the other. As the FGDs generated debates overissues to bring out interesting responses amongst participants, the IDI was able to illicit information that participants were not in the position to give in group interviews. Considering of cultural values in data collection is a rewarding strategy in indigenous research. The adoption of a culturally appropriate approach in this study symbolized appreciation of people's culture, accepting them and accommodating them. The presence of the researcher in the communities and following the cultural ethics of the people eliminated

fear and created good rapport between the researcher and the participants which is a precondition for candid responses. Sticking rigidly to lay down research procedures without being mindful of the culture of a people is a step to generating false responses from research participants. Assessing the needs of indigenous communities in research should be a priority in qualitative studies. Getting exposed to the culture and environment helped the researcher to overcome challenges encountered in the communities. Spending some time with research communities enabled the researcher to be exposed to cultural and ethical principles.

CHAPTER 5

MATERNAL HEALTH BELIEFS/ PRACTICES AND INFLUANCE OF FAMILY DECISION MAKING

5.1 Introduction

This chapter deals with the norms, perceptions, attitudes towards prenatal and postnatal care practices related to maternal health deals. The first objective of the study which is based on the collected primary data from respondents. It addresses the traditional belief system including pregnancy and childbirth that affect the maternal health during and after pregnancy. Moreover, it reveals that these beliefs have a strong impact on both maternal health and health care system. This data would also accumulate the relation between health beliefs and utilization of maternal health care services in the selected area.

The other aspect that was discussed in this chapter is the influence of the family on the mother in terms of gender and decision making. The first section of this chapter is based on traditional beliefs and opinions related to the food and non-food habits of mothers during pregnancy, delivery and the postnatal period. The second section deals with the religious /spiritual ethics on healing through traditional practices (clinical and non-clinical methods) that is especially, based on performing socio-cultural rituals as well as focusing on dominant taboos in the selected study area and the third part focuses on gender health seeking-behavior and the decision-making process.

Table 5.1: Thematic Analysis of Maternal Health Beliefs / Practices

Theme	Category	Sub category	Code
Maternal Health Belief System	Attitude/Perception of the Jampur Families	Family System and Ascendant Influence	Joint family structure, influence of elders, male dominance, mutual consultancy,
		Eating food habits	Higher nutritional intake, proper and adequate nutritional food patterns as precautionary measures
		Food Diet	Cold/ Soft & Warm/ Hard
		Illness and Healing Practices	Allopathic vs Traditional practices, remedies, herbal medicines and self-medication
		Physical Movement and Maternal Beliefs	Cultural beliefs, socio-religious perceptions, internal and external movements
	Religious and Spiritual Beliefs and Practices Regarding Maternal Heal	Mannat	To be pregnant, son preference, health of baby etc., enlightening lamp, food distribution, sacrificing
		Taweez	words, numbers or Quranic verses
		Dam karne	Holy water/food
		Sadqah	Monetary/material, Poor/transgender
		Milad and Wazeefa	Collective/individual, Recitation of verses/ words

Table 5.1: continued

	Rituals Regarding Mother and Newborn	Rituals Regarding Mother	Dress Code, Guad Bhari, Anwal, Nazir Lagna, Chilla, Malish, Dhawna
		Rituals Regarding Newborn	Adhan, Ghutti, Narah, Bandhna, Nazir Lagna, Sathi, Aqeeqah, Jhandh Utarna, Khatna

Source: Field Data 2019-2020

5.2 Attitude/ Perception of the Jampur Families

The family and culture both have significant place in determining culturally appropriate behavior concerning sexual and reproductive health. The family plays a vital role in making decisions and shaping behavior of masses because culturally, family is responsible for the acts of its member in Pakistani society. Pakistan is considered as a poorly ranked country in terms of gender development and inequality index because of the vulnerable condition of females (Siddiqui, 2021). Female health is of much more importance specially in case of maternal health. It is considered to be a fulfilling and positive experience to be a mother throughout the world, but for many women motherhood is associated with illness and suffering that result in poor well-being and even mortality of that women (Chepkorir, 2014). In rural areas of Pakistan, women have strong beliefs in traditional healers as well as spiritual healers. Among the many determinants of maternal health care, that are responsible for access to health facilities, family plays a vital role in provision of information and health services. Before this research lot of researches had been done that highlight the factors affecting maternal and reproductive health of women that ranges from

individual level to household, community or the state. Access to reproductive health services information that would help the youth to make responsible health decisions is further hampered by social norms and cultural taboos against discussing reproductive health issues (Geofrey, T & Kungu, J. N. (2019).

5.2.1 Family System and Ascendant Influence

For analysis of the socio-economic profile of Jampur and respondents, we have to observe structure of ancestral home in selected study area. After analyzing thing, it came to know that there was a joint family and extended joint family. Where living separately is not appreciated. On the contrary, it was thought the children were separated from their parents or uncles etc. due to a property dispute. Extended family system was regarded as a symbol of collective well-being and a blessing. It revealed through study that if a couple stayed in the city as nuclear family setup, with their children, for a job, he would also have to abide by family customs and traditions. Just like his brother, uncles and other family members living in the common courtyard used to do.

There was an aggregative response to the study area as well as in Pakistani culture. In marriages, the consent of the boy or girl was not as important as the control of elders. Other family matters also included the advice of grandparents, on the condition that they were blood kin. It is also obvious from this strong social network what effects it had on women's health This was discussed in the focus group discussion and the majority of respondents agreed that if the mother had to visit a doctor for a checkup at the time of delivery during pregnancy or was to be taken to the hospital, it was also decided with the advice of elders of the family, which hospital or doctor to choose.

It was also observed in the study area the implications of decisions made by older women and men regarding maternal health. This was revealed with reference to the family setup within the respondent's profile. A surprising thing was also found in findings large number of nuclear families especially people living in rural areas used to share the compounds. In that way two to three nuclear families share a courtyard but had their separate kitchens. In IDI one respondent said:

"Inflation is very high. We have a combined house where new rooms are added when needed. But there is a clash on financial issues, so we have decided to have separate kitchens to meet one's needs accordingly. But major decisions are always taken by elders."

(A household educated woman age 35)

It became clear when we came across this aspect that even someone was part of a separate family system, regarding decision making. Children had to accept the decision of their elders. Because research has shown that obedience to elders was seen as a matter of family honor and family tradition. The study also revealed that whenever there was a discussion about food or to following health care in the case of illness, so the collective family thinking came to the fore.

One woman in IDI said:

> *"I belong to the rural area. We moved to city because my husband worked there. Moreover, there was not proper schooling for my children in the village. So, we got out of the joint family system and shifted to the city. My husband made the decision to move to the city after the consulting my in-laws. Some people were in favor of it while the rest of the people thought that the distance between the village and city was not much. Therefore, this journey could be done on a daily basis or arranged a Rickshaw to take the children to the city. In short decision was in our favor. But we celebrate all our festivals for example Eid and all the rituals of joy and sorrow such as marriages or funerals etc., together in the village. Whenever the children get more school holidays, we go to the village to spend those days. The elder in our house still made decision with mutual consent."*
>
> *(A household educated women age 29)*

Another thing was observed in the study as the elders of the house decide and assigned the responsibility according to the occasion. Besides the advice of the elders, the opinion of valuable friends or close family members was also respected and benefitted. These opinions or suggestions could be related to different issues, for example, which doctor or hospital did she visit for a checkup that she did not have any complications at the time of delivery? Which hospital staff was cooperative and competent? Last but not least the expenses and fees of which hospitals or doctors were comparatively less. It could be imagined to what extent our social system and strong family structure affect women's health seeking attitudes.

> *"In an interview a mother told the researcher that both she and her husband were educated and earned a lot to meet their needs. When she was pregnant, she wanted to visit a doctor for an ultra- sound. but her mother-in-law stopped her and suggested to consult a doctor in her family. She was not allowed to take her decisions.".*
>
> *(A working educated woman age 26)*

It was unanimously agreed in FGD with rural women that in our family system when pregnant women had to undergo a checkup whether it was due to pregnancy or delivery pains, it was common psychology of men that this woman was lying and there was no such thing. This delayed the checkup and the women carried their illnesses. If the same thing happened at delivery time, the delivery process would not have been dealt with properly and the woman might be suffered more. it was a general attitude towards women in our society.

> *"A rural woman said "Our biggest problem is of communication gap within a couple where sharing a personal problem with our husbands is socially unacceptable. We share these issues with other female family members who ask men to bring TBA. If a man isn't present then we have to solve the problem by ourselves. A grandmother has become so experienced that if TBA is not available she can handle the delivery herself".*
>
> (A household rural women age 31)

This was also observed during the study in the Jampur area, one or two men from each family had gone abroad to earn money in Dubai or Saudi Arabia. It was the responsibility of parents or brothers of these married peoples to look after the basic needs of their wives and children such as education, health and other necessities of life. Because all the members of the family used to save money and send this person abroad. He did not earn only for his children but for the whole family. The monthly income was sent either to his father or to his elder brother and the whole family was entitled to this income because he went abroad with the mutual consent of the family. So, in those circumstances, they thought the joint family was a blessing. Because in this way they could help and take care of each other. On the other hand, the woman whose husband went out, was completely dependent on others especially in terms of health. An educated working woman at FGD said:

> *"I am married to my cousin who has a job in Dubai. In spite of financial freedom, we aren't free to make our own decisions. My daughter was born in his absence. I am not allowed to leave my government job and live with my husband. Our decisions are made by our grandparents who still consider us children."*
>
> (An educated working woman age 27)

The study proves that the family system in the target population is very strong and culturally influenced by the role of elders and their decision-making. If people went against the role of culture, they would have to face questions in this society from their other relatives and local people. In some way, in matters of mother and child health, all these rituals had to be accepted. During the interview, a question was asked to all the respondents who in their family would decide which doctor or hospital the mother should visit for a checkup. In response, a majority of mothers said it was a collective decision including elders of the house, husband and to some extent the women. Small number said the mother -in-law and

grandparents had decided. From this it could be estimated, what was the role of collective-decision making and grandparents in this society.

5.2.2 Eating Food Habits

Eating food habit is one the most important beliefs. In study area, it was found that the most important aspect of the belief system for them were how a mother used to take care of her health by eating specific food during and before the pregnancy. As far as maternal health was concerned, a healthy life-style and maternal nutrition greatly influence the health of both mother and neonate (Fernández-Gómez, et al., 2020) that is why after conceiving a baby the health care of a mother not remained just an outline matter but turned into an important task in the families. It is the value of nutritional intake during pregnancy that involves researchers to be concerned about the food patterns and adequate amount of nutrition intake assessment and guidance (Chen et al., 2016; Lennox et al., 2017). So, the main point regarding the food intake was which type of diet was suitable for her or which should be avoided during the nine months of pregnancy. According to the findings, diet had a vital role in maternal health one village woman told that:

> *"When a woman becomes pregnant, it is a common notion to start giving her clarified butter from the first month. It is added to both bread and curry. (Tarang) is a beverage that combines ghee, cumin and milk. It is fed in the eighth and ninth months so that it considers malik and butter is a healthy food when mother will be healthy baby can be born easily".*
>
> (Village woman age 28)

Since distant past which is also mentioned by Ali, Azam, & Noor (2004). As the need for nutrients increases during pregnancy as compared to other stages of life so women need higher nutritional requirements (Das, et al., 2017; Nana & Zema, 2018) throughout the pregnancy. Lack of nutritional intake may result in the suffering of mother as well as for

baby that may consist of short term or long-term as well (Shin et al., 2015). A family always wanted healthy children. This was also in the mother's mind that it would increase her value if she gave birth to a healthy baby. In the families, care was taken to ensure baby was born in normal delivery and not abnormal, besides this miscarriage and abortion could be avoided.

One other woman talked about her simple and healthy diet, she side:

> *"I am a village woman I work hard in the fields all day long. During pregnancy time I eat simple food (Sadda Ghiza) bread with milk, butter and Whey (Lassi). I got married at the age of sixteen. Now, I have four children. All babies are born at home I breastfeed my youngest child. I have to take care of my kids to protect the animals (livestock) and to work in fields. Simple and healthy diet ensure the normal delivery and avid the complications"*
>
> (A rural woman age 25)

Further proper and adequate nutritional food patterns may help in the prevention of diseases during pregnancy (Hu, et al., 2019). So, families especially mothers took the different precautionary measures to avoid those fears. If the baby was lost due to the mother's carelessness, then she had to face different negative responses.

5.2.3 Food Diet (Cold/ Soft & Warm/ Hard Food)

To understand belief system of the area, it is important to know about the women of Jampur community about the food diet of pregnant mothers on two basis. There was found the concept of hot and cold food. It was called locally, hard and soft food. One woman told the researcher in FGD*:*

> *''Soft food means it has a cooling effect. The mother should be protected from this, in the start of pregnancy. On the other hand, the hard food having a warm effect creates heat in the body, especially heats up the stomach".*
>
> (A household woman age 43)

Soft or cold food was usually given to women in the prenatal period because, in the first three months of pregnancy, the child had to develop. So, it was considered that such type of food would be useful for mothers. In addition, it also reduced the fear of abortion or miscarriage. On the other hand, hard or warm food was given to mothers during the natal and post-natal period; it might be healed the pain and weakness that evolved as the result of delivery. Warm food was used to provide immediate relief. While collecting the data, it was observed that belief about warm and cold food existed among all the people whether educated or uneducated, living in towns or the countryside. Such type of beliefs about food taboos was also observed in other regions too (Withers et al., 2018). However, it could be said that few people believed more and some less. The fact was that the medicated concept prevailed yet. In IDI a teacher told:

> *"No matter how much we are educated we have to respect traditions. The concept of cold and warm food has same weight. Similarly, a mother needs to be careful about taking hard or soft food during natal and postnatal periods".*
>
> (A woman school teacher age 34)

During the research, it was observed that the women who were interviewed had information related to warm or cold food some were well-informed others were less. The fluctuation of knowledge, as well as practices may be occurred because of differences in age, educational level and life-style of women (Jardí et al., 2019) having different socio-economic backgrounds. According to the opinion of rural women, education made people more aware and the media affected also now what urban people began to abandon the traditions of elders. As studies described that more educated women especially those who are engaged in economic activities as well as older women are more conscious and modified about their health and dietary patterns (Doyle et al., 2016). But the women of Jampur still

believed that soft and hard food definitely affects the health of mother-child and it was important to take care of values and traditions. One mother said:

> *"During the early days of pregnancy mother- in- law or grandmother focus that we should eat a sot food like vegetable, malik, fruit and juices which have cold effect and it protect to the miscarriage and abortion and in the last month near the delivery time should use a hot food like (Trang), beef and egg etc. which help in smooth and easy delivery. This is our common customary practice in our family and culture."*
>
> (Urban educated woman age 27)

It was also clarified how it could be affected regarding the mother child health! Overall, the details obtained from educated and uneducated respondents belonging to rural and urban areas were as follows.

Excursive intake of fresh fruit juices, Whey (Lassi), butter, milk, yogurt, water and (Tandoor ki Roti) were the components of food that should be used by mothers, at least during the first three months of pregnancy. After the fourth month, the child had fully developed which reduced the tension. Then mother could use all types of food with essential care. It is believed that intake of vermicelli, boiled or cooked in milk or (Atay ka halwa) cooked in desi ghee might be fast in process of delivery. Such type of food curtained abundant amounts of oil. The local belief was that excessive use of oil opened up the uterus and the baby was born easily. It is believed that in the postnatal period, the mother should be given warm food immediately after the birth of the baby. Whether it was winter season or summer, chicken or mutton soup was served. Other than that cumin and ghee bread, meat, Green Gram (Dal Moong), Red Lentils (Dal Masoor), Gourd (Tori), pumpkin and turnips were also served to mothers, considering those as warm food. It was observed that cumin and clarified Butter (Desi ghee) was mostly used in all types of food. "Kehwa" was generally

used locally called (Kahra). The community had a belief that cumin reduced post-delivery pain. Women said:

> *"Today's diseases are intricate. So, we have to use allopathic medicines. Because of this tension a person does not easily recover. On the other hand, we have a tried and tested methods of treatment from elders. Indigenous medicines have cool effect and are not detrimental. The simple home remedies (Desi Totkey) told by our grandmothers also bring relief. Like wise use of Cumin Kehwa is use full and reduce the pot deliver pain, mother use these two to three days."*
>
> (An urban woman age 36)

Apart from that, a list, containing a few food items, came to light that should be never used during prenatal, natal and postnatal periods. The specific food could have put both mother and baby at risk. It could be harmful for the mother's digestive system and it could also affect the baby in the prenatal period. Moreover, if the mother ate that food, the stomach of the baby who was drinking her milk could get upset. The list of food was as following:

Pulses, (Dall China), Spinach (Sagg), beef (Bedda Goshat), Eggplant (Baingan), Cabbage (Gobhi), Okra (Bhindi), Potato (Aalo) and (Pain Bread) the food stuff mentioned above was not allowed to eat, during the nine months of pregnancy, locally. Vegetables like Eggplant, Cabbage and Okra are regarded as flatulent that might disturb the digestive system of the mother. These vegetables could cause gas or constipation so they should not be included in the diet. It was prohibited to drink water immediate one week of delivery.

There was an overall opinion that came up through FGDs and interviews that boiled egg, Kehwa, tea, red chilies and Dal Masoor could not be eaten in the prenatal period but were allowed postnatal. Potatoes could not cause a ventose effect if eaten in baked form instead of curry. The time was set on to use those cold and warm foods during prenatal and postnatal periods. That was cold or soft food should be eaten, at least, in the first three months

and warm or hard food could be used after forty days after delivery. An opinion emerged that economic conditions were not the same for everyone so the intake of food was according to their status. A consensus was there about the mother's complaint of vomiting in the early three months of pregnancy. In that particular situation, she used to choose her diet according to her own wish which could vary. When this phase had ended, she could eat the routine diet. The aggregate opinion related to the post-delivery diet was the mentioned food all used by the rich and the poor foremost eleven days then it was continued according to their social status. The staple food in Pakistan was wheat bread this concept was found that tandoor, bread (Owen cooked) was easily digested while the bread cooked in pan (Taway ki Roti) was hard to digest.

A woman, who was a population instructor and key informant told me about the concept of cold or soft food and warm and hard food. She said:

> *"That she was an educated working woman. She was pregnant and wanted to eat everything she liked. For her doctor's advice was more important than concept of cold and warm told her by elders".*
>
> (A Population assistant woman age 32)

Proceeding this discussion, it became clear that after conceiving the baby, the health of women was unsettled especially in the prenatal period. Most of the women suffered nausea and vomiting due to this, the food was neglected. Generally, the woman began to complain of the smell of a protein diet such as eggs and meat belief system did not allow to eat meat and on the other hand, they also did not like to eat vegetables the result was nothing but weakness. A mother who used to work in an NGO told the researcher,

> *"During the first three months of pregnancy, I used to vomit a lot. The eggs and meat smelled very bad. Rather, my heart wanted to eat Multani mud. My husband and other family members got angry that you eat mud all the time. It will be affected the*

baby negatively. Now I am the mother of three sons and thank God they were born healthy though all three times, I suffered the same conditions"

(An educated working women age 37)

Regarding food, it was observed that women used to eat selected food during pregnancy which caused anemia in them. It directly affects the health of pregnant women (maternal health), along with their expected babies. An IDI anemic mother, who was an uneducated woman as well, described her health condition concerning the pregnancy period:

"I am a house wife. We get married at a very young age. I was married at the age of 16 years. The baby was born a year later. I was already weak, then more happened due to continuous nausea and vomiting. I went to Miss for a medical check-up a couple of times. (The local's community call L.H.V, Miss) but I did not feel well. I wanted to eat wooden charcoal the during first three months of pregnancy. I used to eat secretly from my mother in low. It made me happy. But at the time of delivery, Miss told me that it caused an anemic in my body. The birth of my child was too much difficult and painful for me."

(An uneducated household woman age 25)

Researchers found that educated women could make better decisions about their health and themselves. They had more decision power as compared to those women who were dependent on their husbands. The reason was all their needs were met by their husbands even related to their maternal health. Educated women could decide decently and could take care of her health in a better way. She could maintain her diet, checkup and cleanliness very well as compared to a dependent one. These results have assimilation with previous studies (Alemayehu et al., 2010; Bongaarts, 2010). In IDI A lady working in a local media channel, so had a better awareness level regarding health issues, told that:

"Her husband has another wife too so she has to live on her own. She used to take care of her kids, job and her own health. If though poor health was an issue for women of her area but she insisted that education and awareness could help them to live a better life."

(An educated woman works in media age 35)

When it comes to food, there was common perception in the community that mothers should reduce their food intake during pregnancy to deliver normally. So, to avoid painful delivery in case of highly increased baby weight or big size of the healthier baby head and fear of delivery at the health centers (Gardner et al., 2019) in addition of C-section (Asim et al., 2020) people follow food restrictions to control baby weight and size. It was observed that women should not eat high-protein diets such as eggs, meat etc. A cultural notion had also been found that whatever food a mother eats, benefits her child instead of her. Because of this thinking, mothers often ate less food. illiterate woman, living in the countryside, said in her IDI:

"The elders such as mother-in-law or grandmothers often told me that I ate too much. It will benefit just your child. I the baby is healthier; it will be harder at birth. Because in rural areas, the process of birth at home is preferred and the importance of normal delivery is emphasized. In this way, eating less food weakens the mother and the baby. In this way, not taking care of my health mad me anemic."

(An uneducated rural woman age 29)

For all this, they needed better food which was not available to them. They ate a very simple diet. The village women relied heavily on the TBA for her and her child's health then secondly on her mother-in-law and grandmother. They influenced mothers with their experiences and observations.

“A rural woman said "I got married at an early age. We have simple food with a heavy workload. A woman needs to take care of animals, crops and household tasks. While men spend their time in hotels and markets. A woman has to continue her work during pregnancy even if she's not feeling well."

(An uneducated rural woman age 27)

It became clear through FGD, according to rural mothers they had to bear too much load work (labor work). Their husbands and other members of the family used to treat them like animals. Women told in a bitter tone that animals also had time to rest but they had not. While discussing the birth of children and decision making, a participant said that it was not considered appropriate for men and women to talk about pregnancy. Family planning was also not being taken as well so they had more children.

In FGD a rural woman took things in stride by saying:

“Our husbands in local language (Juwan) treat us like animals from morning to evening. We get tired of working all day long. Rather, pregnancy is the time of rest for us. We are also served with nutritious food. Milk or bread we eat on a full stomach sometimes of we have to go to the city, we also take buy fruits. Therefore, in our life these nine months is a time of relief. That’s why we prefer to have more children”.

(An uneducated rural women age 44)

The role of a TBA is very important in the life of a rural mother. Every effort was made to ensues that the baby was born at home through normal delivery and healthy. When the researcher talked to a lady doctor of BHU about maternal health then the diet of rural women was also discussed. She said that those women especially old ladies had a belief, having a baby was a very difficult process. Thus, the healthier the mother, the easier it would be for the baby to be born. The TBA gave rise to this thinking. The case study of a 28 years old villager women revealed that:

"Lady doctor informed that contrary to common belief having too much fats like ghee or butter makes pregnant women fatty. Once women brought to lady doctor for delivery. They have wasted lot of time already due to the TBA. Doctor asked her relatives for C-Section but they denied. Resultantly, baby was born but could not survive on which her relatives become furious and blamed the doctor for it"

(Key Informant, Medical officer BHU)

In the prenatal period, at home the maternal diet is taken care of. But in the postnatal phase, if delivery (birth process) is taken place in the hospital the role played by relatives matters. It has already been discussed maternal diet that belief system still exists in society without customization of educated and rural and urban. An educated and economically strong mother described in IDI that:

"*She visited a doctor in early days of pregnancy. Then she went to big city (D.G khan) for next checkups she used to eat homemade food after delivery. Her relatives who were living there, sent her homemade soup".*

(An educated woman age 36)

It is obvious now that educated people can afford to consult a doctor about maternal health. They give importance to clinical rules to protect the health of mothers and babies.

5.2.4 Illness and Healing Practice

Illness and healing practice is the part of belief system During probing, the most important code which came to know after food habits was illness. What problems mother had to face before pregnancy, during pregnancy and after delivery? What methods did they use to prevent these diseases? What would they do if got sick to make well again? It was perceived through interviews of different mothers and focus group discussions that two types of focus system existed there. Firstly, they used to adopt allopathic treatment to cure diseases related to maternal health and had firm believe in that. Secondly, the other type of medication was traditional, including home remedies, herbal medicines and self-medication. Both kinds

of treatment went conjointly that was clear through mothers' conversation in FGD that both methods were significant in their own place. There was no clear view of either.

A woman, who lived in the slum area of the city, said:

> *"Today's diseases are intricate. So, we have to use allopathic medicines. Because of this tension, a person does not easily recover. On the other hand, we have tried and tested methods of treatment from elders. Indigenous medicines have a cool effect and are not detrimental. The simple home remedies (Desi Totkey) told by our grandmothers also bring relief. In short, we adopt both methods."*
>
> (An uneducated woman urban area age 36)

Whereas the methods of treatment were divided into two major parts, the diseases a mother suffered during nine months of pregnancy also had two parts firstly clinical illness and secondly non clinical illness. The first one, clinical diseases included biological problems such as abortions, STDs, vaginal discharge, extra bleeding, blood pressure etc. The second one, non-clinical diseases were considered common ailments. For example, tension, anemia, malnutrition, deficiency of iron and vitamin etc. They took as not it a big deal and used to cure it without going to the doctor. Those mothers, who had biological problems, used herbal medicines or home remedies, besides visiting the doctor. Another point was highlighted after several interviews, most of the women had a strong belief that both types of diseases were caused by magic supernatural and demons (Jinaat). They were sure that relatives, even sometimes real sisters used to do sorcery, just because of jealousy. In their opinion, the main reason behind not conceiving and the repeated loss of children was only the supernatural element. Its best cure was a recitation of the Quran Kareem, bringing a talisman from Religious Practitioner (Pir Sahib) and in addition Blow (Phoonk) of Darood. These safety measures were common in practices.

During FGD, rural women told that:

> *"She could not conceive after many years of marriage. Her mother-in-law consulted a Pir who told her that their relative sued black magic against her to restrict her pregnancy. Peer sahib gave an amulet which she had to tie it up with her back. She became pregnant and now had many children''.*
>
> (A primary educated woman age 37)

When the topic of black magic was discussed in Rural area FGD, a woman narrated:

> *"A literate rural wife said "I am the second wife of my husband. I was not feeling well after marriage. My mother suspected that the first wife has cast a spell on me out of jealousy. I didn't believe in it. But my mother consulted a religious practitioner who confirmed it and gave her inhaled water and an amulet for me. I used these things and now I am feeling better."*
>
> (An educated rural Woman age 38)

When forty-two women were asked about their health during the interview that how was their health on that particular day and how were they feeling, many women had no idea about their maternal health. More than 50% were confused. They replied, "Yes, it's all right but sometimes it gets worse." Socio-economic profile of respondent shows that housewives were dependent on the income of their husbands or families. Therefore, reproductive healthcare seeking behaviors of the respondents were also associated with the income of their families or husbands. It was also confirming the assertion that education is a predictor of other variables. As majority of the women were illiterate and house wives, that is why, they were not working outside the home. It means, they did not have even general awareness of self-health and pregnancy related illness not consider serious illness, their health should have been Anemia, fever, headache and malnutrition as were usually not considered diseases. During this study, the researcher asked the mothers another probing question. Among those women, really had serious illnesses. He asked if they had taken those diseases

as a serious matter and what would be the methods of treatment. They replied the same, we had already mentioned both allopathic and herbal remedies. An illiterate rural mother narrated:

> *"Because of the uterus problem (Athra) she could not conceive for ten years after marriage. She consulted many doctors but failed. Then an experienced TBA suggested herbal medicine which she used for a year. Resultantly, she got pregnant and now had four children.*"
>
> (An uneducated woman age 47)

It came into knowledge through FGD and interviews that many mothers were suffering from malnutrition. They were also anemic due to a lack of health food. When socio-economic conditions and respondents' profiles were assessed, it came into light most of the women were residents of rural areas. They had too much labor work. In the area of Jampur, especially at the tribal side, there was lack of clean drinking water. Water was available to those people when hill torrents came into full swing. Therefore, most mothers suffered from anemia and malnutrition.

A young rural mother told in FGD:

> *"We work hard in the fields all day long. The dry bread we get is eaten with milk, butter and Whey (Lassi). I got married at the age of sixteen. I had two abortions. Now, I have four children. I breastfeed my youngest child. I have to take care of my kids to protect the animals (livestock) and work in the fields. I had two checkups at a government hospital during pregnancy. They gave me energy pills which did not help. Everyone eats a simple diet such as bread, milk and spinach etc. God is sovereign."*
>
> (An uneducated young woman age 25)

During research, the women were asked about their age at the time of marriage. The responses were strange 62% answered that thy were married in their teen age. The next question was how long after their first child was born, 60% were conceived a writhing first

year after marriage. Another question was asked to them about the cause of the death of their children, 14% answered that it was an illness. According to them, the main reason behind this illness was the presence of anemia on malnutrition in their mother. It might cause miscarriage which means prevention from conceiving, or abortion in case of conceiving the baby. Mother used to call it weak health. Small number told that their children died because of mishandling and TBA was responsible for that. People could not go to towns due to poverty. Besides this, they needed the help of men to get to the city town who could not accompany them due to cultural compulsions and different assignations and the actual reason behind abortion was carelessness. That's because, sometimes, women did not know in starting two or three months that they were pregnant. As a result, babies were lost due to overwork/ labor work. They few other reasons were walking carelessly going up and down the stairs and jumping over the water course in rural areas.

In FGD, a rural mother emotionally talked about her abortion:

> *"I got married at a young age and lost my first baby while jumping over the water course. My husband did not take proper care of me. Even did not take me to the doctor. In the villages, woman work tirelessly have not proper health care."*
>
> (An uneducated rural woman age 40)

As mentioned above, as a result of mishandling, the big reason for that was home delivery or giving birth to a baby with the help of TBA. An urban woman shared her experience in IDI:

"Their delivery was attended at the clinic of a midwife. In the nick of time, it was found out that the baby was not in a proper position. She injected me with a drip but it did not prove useful. When I pushed, the baby's legs came out. The TBA pulled him hard and his neck got stocked. The delivery was made but the baby died. I could not visit a lady doctor due to poverty. TBA could not handle my case properly my baby died."

(A matriculation woman age 38)

Looking at the geography of remote areas like Jampur, we divide it into three parts: Urban population, Rural Population and Tribal Areas. The researcher met the doctor of the Rural Health Center of Union Council Harand, During the discussion, it came to light that people belonging to tribal areas were very conservative. In such a conservative environment, women are confined to the home for the sake of honor, veil and purity of women (Khan et al., 2020). Their customs were authoritarian. The doctor shared a case study regarding the illness, "TBA culture is very strong in these areas. People believe in what they say because these have been going on for generations. Because of the concept of the veil, they don't get checked up by a male doctor are the reasons for that increase in the cadence of women. Transportation in these areas is also limited."

An informant female doctor said:

"A 32 years old woman was brought to her in a critical condition due to mishandling by TBA. Her baby had already died during delivery. She was referred to Nishter Hospital, Multan where there was no proper care of the patient. Her family decided to shift her to a private hospital but because of extra expenses brought her back to village in a very critical condition. Doctor further told that the concept of pride price exists in this area. People say, "The same amount of money we have to spend on a women's illness, can be used to remarry."

(Medical officer RHC)

The followers of traditional and religious treatment feel it hard to believe and interact with those undergoing allopathic treatment. Which illness did they think well more prevalent regarding maternal health? For supporting data, the researcher met a lady doctor from a private hospital who was mentioned by many mothers in the upper and middle classes have the awareness to some extent. They come for checkups twice or thrice during pregnancy. On the other hand, the people of lower class are mostly illiterate and unaware. They have less information about their health. They are more in number and have a firm belief in TBAs. These people now and then and ask us to inject the drip. They avoid the intake of tablets. They prefer drips for immediate relief. In this way, checkup cost increases. Most people are poor so they rarely go to the doctor to avoid the loss of daily income. Expenditures are high as compared to low income. That's why men do not support women. It's the big obstacle in the way of their health-seeking. But the people who belong to high income families consult me and another doctor out of the city. These people are very few." It seems that poverty with the combination of the social structure of residents produces a mixture of constraints for women's access to health services (Mumtaz et al., 2011). That is why human capital and demographic conditions are considered key of dissimilar behavior and patterns among different economic classes (Agha, 2015). Moreover, the lady doctor described that the people here are strictly bound by rituals and have great impact on TBAs on them. They are against Ultrasounds and C section. According to them the rays of ultrasound are harmful for babies and C-sections are done by doctors to make money. The key informant lady doctor shared a case study:

"A doctor mentioned a case where a lawyer from an educated area brought her daughter to her clinic. She was facing obstructed labor but her family TBA didn't allow the doctor to perform surgery. Resultantly, the baby died for which the family is blaming the doctor. Even educated people avoid seeking proper health care".

(Private practicing Gynecologist)

However, some contradictions exist between both types of treatment. As massage is a common practice (Agus et al., 2012) of TBAs are not appreciated in allopathic treatment. Lady Doctor told that TBAs have made the mothers miserable. Massage that makes their legs swollen and they become fatty after eating Clarified butter (Dasi Ghee) and drinking "Trang" in excess. It creates too much difficulty in delivery."

5.2.5 Physical Movement and Maternal Beliefs

During the study, it was observed that the physical movement of pregnant women was largely dependent on their cultural belief. Including decision making and women's dependency as well as male dominance as a prominent factor. The other aspect was socio-religious, how a pregnant woman's mobility during and after pregnancy was restricted in this society.

In a research setting, interviews and FDG revealed that women's mobility was not completely restricted but to certain rituals. Furthermore, how pregnant women should behave culturally regarding their internal and external movement. Internal movement means that during in early three months of pregnancy how should women behave in daily life such as the ways to walk, getting up, sitting down and sleeping. In addition, for how many days after delivery social mobility was restricted. As for the external movement was concerned it had some rituals on what occasions and in which rituals should pregnant women attend? Additionally, what should be her social movement during day and night. At the same time, women's dependency was also included in the external movement. There was no ritual

involved but she depended on her family for her checkup and at the time of delivery whether she belonged to a rural or urban areas. In additions women were not barred from doing housework, working in the fields during the day of pregnancy and going to the market for basic necessities or to the hospital for their pregnancy checkups. However, the point talked about a lot in FGD was that the first 3 to 4 months a woman needed to be very careful about the movement. Elderly women of the house also said that the woman should be busy with work during the last 1 or 2 months of pregnancy so that the delivery might be easy.

A mother who lived in the city and worked for the government said to her IDI:

> *"After marriage we live in a joint family staying in the upper portion of the house. We have to go up and down stairs several times a day for our daily activities. The kitchen of the house is shared and the meal is prepared together for everyone. During the second month of my first pregnancy, one day I slipped and fell down the stairs. It hurt me badly and I lost my pregnancy. I had to have a DNC. And because of that I had been mentally disturbed. That is why most of the grandparents forbid women to walk on high and low places and advise them to be careful in this condition."*
>
> (An educated woman age 32)

It was also revealed during FGD in rural areas that a strong belief was found in the community. A pregnant woman should not go outside at night whether she lived in the countryside or in the city. Even sleeping alone in the open space at night was also forbidden. This was due to social religious belief that demons used to walk around openly at night especially when it was dark. After sunset, pregnant women should restrict their movement. This could have a (Saya) effect on the woman from the giants etc. and as a result, the child could be lost.

"A woman who was working in an NGO talked about her family that this belief is very strong in our family and we follow it if there is a death in our family the pregnant woman goes but sits away from the dead body and the white thread of the shroud is taken out and put in her ear. After this ritual is performed the woman is protected from these effects of Sayya."

(An educated woman age 27)

Apart from this a few other things came up during the discussions which were not commonly prevailed in society and varied from family to family. Some people used to practice it and some did not but they were mentioned in interviews and FGD. One of them was that a pregnant woman should not meet a woman whose children had been lost due to miscarriage and abortions, or a woman who wore an amulet around her neck. This amulet could affect the pregnant mother and child due to black magic. A pregnant woman had to refrain from meeting an infertile woman during pregnancy. Because the mother of the children was considered the lucky one and the infertile woman was called unlucky. An opinion also emerged that a pregnant woman should not get to a deserted place with perfume etc. And secondly in the nine months of pregnancy one had to be careful to meet a woman who had menstruation. The deserted place was usually inhabited by giants etc. and they were attracted by the fragrance so the pregnant woman had to avoid going out and coming in front of everyone. The concept of the evil eye was also found. A woman should also avoid travelling in the early days of pregnancy because there was a risk of losing the baby in case of a jump.

Similarly, a mixed trend came out with regard to socio cultural belief. In the social mobility of pregnant woman's family members, the husband and mother-in-law played a role, especially concerning decision-making and transportation. During the study when the researcher visited all the union councils, it was observed that the means of communication from village to town and also within the villages were in bad condition. The condition of

road was very bad. In the villages one often had to go through unpaved roads. Assuming the tehsil city area as the center it was spread over at least 80-100 km radius. But due to poor transportation and broken roads the 30 km journey took more than an hour. The situation in the tribal area of transportation was even worse. It was hard to imagine for a woman travelling there alone unless accompanied by a member of the family. Traveling with husband especially a pregnant woman was not part of their culture. In rural and tribal areas, the movement of pregnant woman for health care was too restricted. "During an interview with a tribal woman at Harand rural health center regarding pregnancy check-ups.

> *"She, said at the present movement I have come for treatment of another disease and my son has come with me. The roads are rough and we have come on bikes. During pregnancy, it is arduous to get out of the house. It is our custom that when a woman is pregnant, she does not come in Infront of a 16–17-year-old child who does not belong to her family."*
>
> (An educated tribal woman age 26)

During the interviews with the women, it was revealed in probing that the majority of the women in the villages gave birth to the children at night. Because of the custom the women' normal delivery was handled at home. A rural Mother said in an interview:

> *"I have six children including two daughters and four sons they were born at home and at night. Once mild pain begins, delivery is expected overnight. In rural areas we usually travel on our motor bikes or rickshaws run at certain times of day but there is no traffic at night TBA also makes Tarang for drinking at night which leads to more delivery pains. A mother cannot travel on motor bike at the time of delivery so most babies are born at night."*
>
> (An uneducated woman age 32)

During the FGD in the city, it was discussed that women who lived far away three to four kilometers from the hospitals in the city, did not go to the hospital or clinic at the time of delivery. When taken to a private Hospital lady doctor regarding social mobility, shares the case study of a woman.

> *"She belongs to middle class family, living in the city, she came to me for ultrasound during pregnancy. I asked her "you come to me for a checkup and ultrasound. Where will your delivery process take place?" she replied, our family considers ultrasound also bad. I do it on my own. I will not give birth to my child in the hospital because there is no privacy. In addition, they force to operate. This is false conception about operation has restricted people to avail healthcare facility during delivery. People prefer to have a delivery process at home because of this fear*."
>
> (Key informant medical officer)

Talking to doctors at private and government hospitals it was revealed clearly that culturally women were not allowed to go out during delivery and pregnancy. Moreover, people were afraid of the public and private healthcare system due to the lack of awareness. The fear of the operation was in their brains. They thought if a woman would give birth to a child through surgery, she might not be able to have more children. Having more children was considered good in this community and this woman was considered lucky. More children means earning hands for them. Therefore, a woman's social mobility during pregnancy was restricted in this culture.

5.3 Religious/Spiritual Beliefs and Practices Regarding Maternal Health

Regarding the cultural belief system, it has already been mentioned how mothers believed in internal health seeking, health services and food. It was also observed during the study that there existed a strong factor of religious and spiritual beliefs and practices related to mother and child. The mother in this area, if did not get pregnant, wherever they used clinical and traditional services, they strongly believed in spiritual and religious practices,

according to their own religious beliefs. In addition, this belief was found in every context of prenatal, natal and postnatal care. All the respondents of the related study were Muslim women. However, they belonged to different sects such as Sunni, Deobandi, Ahl-e-Hadith and Shia. Their belief system was in accordance with the beliefs of their sects which appeared through their practices, people from Sunni and Deobandi sects both were followers of Iman Abu Hanifa but there was a difference in their beliefs and practices. People of Ahl-e-Hadith Sect (Aqeedah) were followers of Imams Ahmad bin Hanbal while Shia people had twelve Imams to follow.

Sunni and Deobandi both believed in spiritual Healers (Pir) But Deobandi did not consider it permissible to visit the shrines and to pray there. While Sunnis were in favor of praying and giving alms at the shrines and taking amulets from religious practitioners. Deobandis believed in the use of Quranic verses for insufflating (Dam Kerna). Ahl-e-Hadith was not follower of any religious practice or Sufi of the Shrine. They used to perform their spiritual healing according to Quran and Sunnah. People of the Shite sect had faith in religious practitioners to visit the shrine to pray and use amulets. The religious practitioners and shrines of both Sunnis and Shite were different on the basis of their beliefs. During the interview and FGD, the women of all sects shared their beliefs and practices related to prenatal, natal and postnatal periods. As soon as a mother became pregnant, she began to practice her religious and spiritual beliefs concerning the baby which continued after the birth of child including the care of newborn. Those religious and spiritual beliefs that came up were slike (Mannat) to wish, to pray, (Tawiz) amulets, ((Dam Kerna) insufflate, ((Milad/Wazifa) meditation, and (Sadaqah) charity.

5.3.1 Mannat (Wish)

It is also called (Rakh) in the local language. Issueless women of the area used to have Mannat at the shrine (Dergah) and promised to visit shrine if their Mannat (get pregnant, son preference, health of baby and other issues) was fulfilled, and enlighten the lamp (Día) distribute sweets (Mithai) and Deig (Big pot of rice). They also sacrifice an animal and installing Flag (Alam). They usually visited Khawja Ghulam Fareed Kot Mithan, Hamza Sultan (Jampur) and Sakhi Sarwar D.G Khan and also visited spiritual practitioner (Pirs) in other cities too.

A woman told when interviewed:

> *"I could not conceive even if I got pregnant, I would end up in miscarriage. Then, I visited the shrine of Hamza Sultan Jampur. There I prayed for Mannat that I would enlighten a lamp (Dia) in the shrine after delivery, I laid a sheet there and distributed sweets. In this way, this Peer sahib miracle healed me."*
>
> (An uneducated urban woman age 48)

Another form of Mannat was to worship by sitting in the shrine. A woman talked about it:

> *"I am the follower of Pir Khawja Gullam Fareed. Allah has blessed me with children. I had manat for the birth of each of my children that I would stay at the shrine for nine nights. It means every Thursday I used to offer my prayers in a specific place made for women at the shrine. Started to do that in the seventh month of pregnancy. I did the same of continuous nine Thursdays along with drinking water from a pond in the shrine. That's how God's grace was on me.*
>
> (An uneducated rural woman age 39)

Regarding the concept of (Mannat) a woman said in FGD:

> *"I only had daughters I visited the shrine of Hamza Sultan and prayed there of my son by born, I will wear embroidered shirts till six months and will dress the baby too. These especial shirts are available from the shrine. There the women make it for selling. The women who come there for Mannat purchase these shirts. If they are blessed with sons, they wear the shirts for six months. The color of these shirts should be bright like red and pink etc. These are considered the color of happiness. When*

my Mannat was fulfilled, I wore that shirt for six months. After that, I went to the shrine and gave the Deig".

(Rural woman age 26)

5.3.2 Taweez (Amulet)

It was observed that women in selected study a used amulets to get pregnant, to have safe pregnancy. These amulets were taken from a local Pir Shaib, or from any pious old man or woman. These were strongly believed by the woman of the area. These amulets were worn around the neck, tied by the leg or tied around the waist. These amulets wore written on papers in the form of words, numbers or Quranic verses. Additionally, people wore different colored threads around their necks or in their hands. Those threads could be a combination of seven different colors or usually black, white or green something was red and blue on these threads. According to what came out during the interviews, there were various reasons for using the amulets as a whole. Generally, it is perceived that wearing an amulet can cause healing (Qidwai et al., 2009) Women used amulets to get pregnant, to have safe pregnancy or give birth to a son. Women who failed to conceive used to the insufflate thread around their waists. A thread was also tied around the women's waist to protect the baby and herself from evil eyes during the complete period of pregnancy. The amulet worn around the neck was wrapped in leather cover or silver case and then hung around the neck.

A woman told in IDI that:

"She got pregnant after getting an amulet from the family peer and continuously tied it to her waist till delivery. After delivery she got another amulet for the baby. It is believed that amulet, having Quranic verses can protect its beaver from bad things".

(A primary educated woman age 28)

5.3.3 Dam Kerna (Insufflate)

The locals termed it (Salwat). It was firm belief that Insufflated food had the power of removing the effects of evil eye. It came to know in FGD that it was requested to Moulvi Sahib, Pir Sahib or any pious person of the area to do Dum on the food items and drinking water. Then, eating and drinking these things brought healing. Some women mentioned another remedy to ward off the evil eye. They used to drink Makkah Water which is holy water for the muslims around the world. It was asked to a pilgrim returning from Saudi Arabia to bring that holy water for them. It was also available in the neighboring city in those days. It was the best cure for this purpose. Moreover, some mothers said that dates were effective to conceive and useful for easy delivery. Khaka-e Madina and Khak-e-Karbala were also considered as a source of healing during pregnancy and at the time of delivery.

5.3.4 Sadqah (Charity)

During the interview and FDG, the general opinion of women was that Sadqah /Charity alleviated adversity. This was the firm belief of Muslims but there were found many different ways of giving Sadqah. Some women said that they used to give money case as Sadqah to any poor and needy person or to a Madrasah. In addition, they used to arrange Sadqah especially during the pregnancy or at the time of delivery and a needy person was considered a rightful deserver. A woman said that she used to give her Sadqah to transgender because their prayers were quickly answered. Another opinion was that Sadqah was also used as Mannat that was performed in the form of a black goat or black cock. These were taken to the shrines and given there as Sadqah/Charity. Some used to put a specific amount in the money box of the shrine. A woman said in IDI:

"I belong to the Shiite sect. we donate our family's Sadqah by feeding the people on the 9th and the 10th of Moharam. This method has been going on in our family for years. That's why, we remain safe from all troubles".

(Primary educated woman age 28)

5.3.5 Milad and Wazeefa (Meditation)

Where different ideas about beliefs and practices emerged during interviews, there a mother shared her own experience,

> *"A woman said that she succeeded to get pregnant after following on advice (Wazeefa) Durood e Muqddsa and recited at Tahajjud time, it healed me. After giving birth the child, I distributed a Deig in the area as a charity'.*
>
> (A matriculate woman age 27)

Similarly, another woman described, I am Sunni. We have the tradition that when a woman gets pregnant, we read there the stories of seven ladies. It brings blessings to the home. In addition, we arrange Meelad for her, once or twice, during her pregnancy time period. In Meelad, we start with the recitation of complete Holy Qur'an and then Naat is recited. Remembering Allah and His Holy Prophet (PBUH) bring blessings in everything. During interview and FDG, this opinion came out unanimously that all the women, regardless of their beliefs on sects, used to recite specific Sura has of the Holy Quran during their pregnancies. Surahs were also recited as Dum at the delivery time. Dum wala Pani was provided for the pregnant women to drink for the purpose of healing. So that, mother and baby both might be protected from evil eyes.

5.4 Rituals Regarding Mother and Newborn

The performance of rituals was an indication of their attachment to their own culture regarding mother and newborn, it was observed in the study area that various rituals were performed from conception to forty days after delivery. These rituals were deeply rooted in

that culture. Though a mother had to face many problems from pregnancy to childbirth and beyond. This highlighted the significance of the mother's existence in society. After that, the customs, which were found in the society related to newborn, and how they were practiced culturally and religiously, used to express how much important the newborn was and how his rights were recognized? The researcher has given a deep insider perspective regarding this ritual which has complemented the mother-child health issues in the local culture.

5.4.1 Rituals Regarding Mothers

During research it came out unanimously through interviews and FGD, the rituals which were performed from the conception of mothers to the time of delivery and after that were as follows:

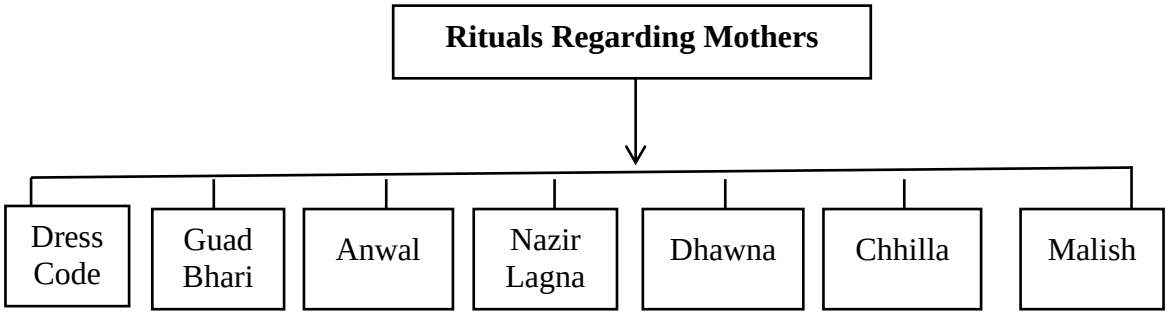


Figure 5.1: Rituals Regarding Mothers

Source: Field data 2019-2020

Dress Code, in a family, when the pregnancy of a woman was confirmed and it began to become obvious after four months, then it was arranged locally that the woman should deviate from their usual clothes and wear loose clothing. The condition of a woman is viewed with respect. It was taken care of especially in joint family point was supported by almost

all mothers. In addition, some miscellaneous things, related to pregnancy, came to light. During this time, along with clothes and their colors, a lot of attention was paid to shoes.

A woman said in an interview:

> *"In our family, a pregnant woman arranges to wear a loose dress. Clothing colors are also taken into account. Black is generally understood as a color of mourning in our family. So, a pregnant mother does not wear black during the complete nine months of pregnancy. White, it's matter of happiness, to get conceive or to give birth to a baby".*
>
> (An educated woman age 35)

It was observed during the discussion that a woman could not carry a high heel in pregnancy. It was prohibited strictly by the elder women of the family because an uneven position could cause abortion. In another interview a Pakhtun woman shared her thought in detail" "In our culture, a mother cannot wear white for forty days after delivery. For forty days there is a fear that the mother's clothes will be damaged due to bleeding and discharge. The marks on the white cloth are clearly visible and it is considered against the dignity of woman. Therefore, care is taken so that the mother does not feel embarrassed."

Guad Bhari (Baby Shower) this also came to the fore unanimously that the ceremony of the baby shower was performed during pregnancy, the woman's parents (Maika) used to come to her house and perform this ritual. Their event was mostly celebrated at the birth of the first child. Some people performed this ritual at the birth of each child and some only for the first time. On that day the woman was dressed in the best clothes. Fruits, dry fruits and baby toys brought by the woman's parents were placed on her lap. A feast was arranged for the guest who came home. The purpose was to express happiness. Usually, after the ceremony, the parents would take the daughter home with them because it was customary for a woman to give birth to her child at her parent's home .However, some families did not

have this ritual. In interviews and FGD, some mothers said that they had this ritual in their families but economic conditions did not allow to celebrate it. But it was a fact that this ritual existed in the area of Jampur.

To Bury the Placenta (Anwal) it was also customary in the community to bury the mother's placenta in the ground after the birth of a child. Contradictory opinions emerged concerning this matter, during the interview. In rural areas, the majority of families still had these traditions. Because they thought that it was the mother's body part so it should not be thrown openly. This was not taken care of at the hospital or clinics. Almost all rural women said that placenta was buried in that particular room where the women gave birth to the babies. Some mothers had a different point of view. They used to perform this process as a ritual. if a male baby was born, the placenta was buried underground after putting it into a clay pot. On the other hand, in the case of the female baby it was poured the running water off or canal so that the placenta stayed cool and the mother could be recovered quickly. The difference between placenta burial for both genders may be associated with the reason explained by (Sharma et al., 2016) that it relates to the child's future health and behavior.

Nazir Lagna (Evil Eye) another ritual existed in the area that after the process of delivery some iron object such as of rod or knife was placed near the mother's head for 40 days so that she might be protected from demons, black magic and the effects of evil eyes. These rituals were commonly found in the area and each family used to perform these according to their religious sects. Usually, it was done for forty days until the women became clean and pure to start the routine work.

All the respondent believed in the effect of evil eyes but they had different opinion for prevention from it. Some women maintained that they used to read Quran verses, (Ayat

ul Kursi), last four Suraha of Quran (Char Qual) and blew on the child. Otherwise, they said process was done by Mosque Imam (Mulvi Sahib) or any elder of the house. Besides this, these mothers did not believe in the use of other remedies. A few women said that they used to put amulet around their neck to be protected from many evil eyes if the evil eye affected someone, then to eliminate the effects by red chilies. Another woman said that they used to take the water from the taps of seven different mosques to feed the mother or child affected by evil eye and it brought relief.

One woman said in an interview:

> *"I get insufflate threads of different colors from my pirni (Lady spiritual Healer) who belongs to Sayed family. Black thread is used to protect from evil eye. Green thread protects the healthy growth of the baby while the white thread is a symbol of (sadqah). I tie these threads to my neck and hands during the nine months of pregnancy and put these around the baby's neck after birth".*
>
> (An uneducated woman age 33)

Dhawna (Bathing) this ritual was locally celebrated in all families. It was purely related to the process of a mother taking bath. Bathing is called Dhawan in the local language. All the people of the area used to celebrate in regarding their social status. A disagreement also arose during the discussion. Some mother's had to say that this ritual was performed after they seven days of delivery, on the other hand, some said that after eleven days. But in fact, the number of respondents who were in the favor of eleven days, was relatively high. A rural mother told:

> *"We celebrated this ritual after eleven days, that day the mother takes bath and wears new clothes. To make (Choori) is still tradition as it was in old days. That particular day we prepare (Choori)" and distribute it among relatives and friends. But now this trend is waning. People prefer to distribute the sweets*."
>
> (An uneducated woman age 35)

Chhilla (40 days Celebration) the (Chhilla) ritual of 40 days was still in practice. A mother told during the interview. It is a ceremony of purification of a new mother. An urban woman said that a woman had to face many restrictions till 40 days after the delivery. She was not allowed to do house chores especially, cooking. She could not touch the Holy book or any other sacred thing because she was considered an impure in those 40 days. It is so because vaginal birth is considered dirty (Sharma et al., 2016) as well as bleeding and vaginal discharge (in some cases) is also an impure condition of women. So, a bath is taken by the mother after almost 40 days of delivery to be purified. But now this custom has also gradually diminished. But according to rural mothers this ritual was still performed in rural areas.

A mother Said in IDI:

> *"We call it the ritual of (Sar Chiuta). After 40 days, the woman takes bath and becomes clean and pure. Then, she restarts her routine work. On that day she wears new clothes. Charity/ Sadqah is arranged. The homemade rice (Diagra) is distributed. A midwife is reserved for mother for these 40 days so some gift such as money or clothes etc are given to her*."
>
> (An uneducated rural woman age 33)

Malish (Oil Bathing) from the last month of pregnancy and after the delivery a TBA was hired to perform the duty of massage (Malish). It included the massage of the legs and abdomen of the mother to release the pain mother had at the time of giving birth to a child. The massage is beneficial to relax muscles after the delivery, (Sharma et al., 2016). Similarly, massage is also given to newborn baby too. It is believed that massage is beneficial as with the smoothing of joints it helps in child's growth and makes them strong enough (Sharma et al., 2016). At the home, mother called a TBA to massage the new mother with mustard oil or olive oil till eleven days after delivery. In the local language this process was

called (Lat Dina) that was, pressing the mother's back on both sides with the help of one's leg. This process reduced the mother's pain and she felt relaxed.

5.4.2 Rituals Regarding Newborn

There were found many local rituals and customs related to the childbirth and care. Regarding the children, the people of area had a religious concept that the son was the blessing of Allah and the daughter was mercy. It was observed in the study that the community had a better opinion now regarding the acceptance of the daughter but the sons were still more important compared to the daughters. The mothers also expressed that the birth of a son increased their importance.

One mother told that:

> *"In our culture, son is preferred to the daughter. Son is considered (Niamat) and daughter (Rehmat). But son preference is important because of he led the name of family and "Waris" of his father property. second if the woman born the baby boy her value and importance enhance on in-laws and she consider Lucky (Khusbkhat)".*
>
> (Rural woman age 39)

Regarding the birth of a child, it also came to light that many cultural and religious rituals and customs were celebrated; some are mentioned as follows by diagram in Figure 5.2.

Adhan, the first-ever task, after the birth of a child, was to recite Azan into the ear of the baby. Babies born in the hospital were thoroughly wiped with a towel and wrapped in a baby blanket. During home delivery the baby was cleared with a cloth bathed in water according to the season, then Azan was recited in his ear. The father or an elder person of the family was given the responsibility of reciting Azan in the baby's ear. The ceremony was arranged in no time.

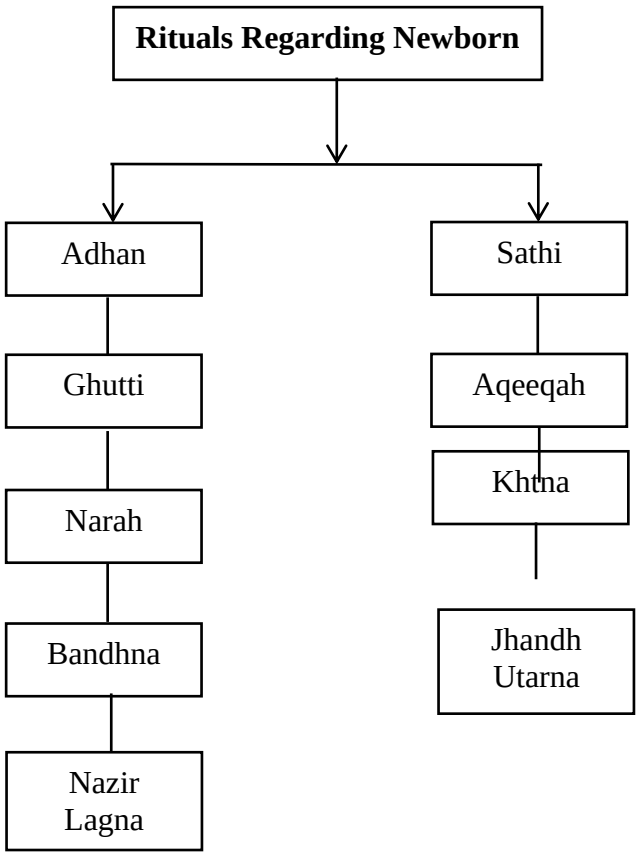


Figure 5.2: Rituals Regarding Newborn

Source: Field data 2019-2020

The Muslim community has a belief that the first right over the child belonged to Allah Who created him. Therefore, it is necessary that the word that the baby first heard after coming into the world should be the name of Allah". The words of Adhan declared the fundamental faith of Muslims constituting on "There is no deity but Allah; Muhammad is the Messenger of Allah" and it is believed that this faith is of crucial importance as the life of Muslim rotates around it (Gatrad & Sheikh, 2001). So that the child realized that he was born in the house of a Muslim.

Ghutti (Tahneek), this ritual was also performed after birth and the baby was given Ghutti before drinking the mother's milk. For this purpose, the request was made to the

baby's father, uncles, aunts or any elder of the family. It was necessary that the person should be caring and loving having good moral character. it is believed that the positive attributes of the person will transmit in the newborn (Gatrad & Sheikh, 2001). Ghutti is given to the baby in different ways. For example, the fingertip dipped in that particular person's saliva was touched to the palate of the baby. Besides this, a few drops of honey were poured into the baby's mouth or some chewed processes of date were also given to the baby. There was a thought behind this ritual that the positive traits of that person would transfer to the baby. There was no difficulty to person these rituals if the baby was born at home in normal delivery. But, on the other hand, all this was hard to perform in hospitals and clinics because they did not give easy access to the baby nursery.

Narah (Umbilical cord), in the area, a belief was found in mothers regarding the umbilical cord. It was considered an important thing because it fed the baby for nine months of pregnancy. So, after cutting, it was dried and placed in a holy place such as a mosque. The thought was that it would have a positive impact on the baby and that would be a noble person. The opinions of mothers were not the same in this regard. Only in a few villages, some mothers mentioned this belief that they usually used to celebrate it as a ritual. A mother living in the city told the researcher:

> *"I am an educated woman and do not believe in such concepts. When my cord is cut, it leaves 4 to 5 inches. Sometimes, when it dries, it is separated from the baby's belly button when my son's cord is dried up and separated, any mother put it in a book. I mean it will have a good effect on the baby and he will be keenly interested in studies".*
>
> *(*An educated woman age 30)

Bandhna (baby Raping), the baby was cleaned and bathed after birth. Then after two or three days, at different times, his oil bathing was started. He often had a lot of hair on his

body. A mixture was prepared that consisted of flour plus mustard oil or olive oil to massage him. After this process, they were bathed and dressed properly. Then his hands and feet were tied lightly with a strip of cloth. It was done by the grandparents, of the baby. Basically, that piece of clothing was called (Bandhna). This process was continued for 2 to 3 months

A mother told the reason for (Bandhna):

> *"After the massage, taking bath and breast feed baby sleeps soundly. While sleeping most children are frightened. Moving hands and feet impair their sleep. After having Bandhna, they enjoy a restful sleep."*
>
> (An educated mother age 29)

Nazir Lagna (Evil Eyes), a collective response of mothers was observed regarding the protection of child from evil eyes. The child should not be exposed in front of a stranger or out sider woman especially, those who wore amulets. This precautionary measure should be taken 3-4 days after the birth. In this way the child could be protected from evil eyes. Other than that, different rituals were also performed. To protect the baby from evil eye, a black spot was marked on his forehead. Some mothers added to this that they use to make the sign of cross under the baby's feet. When the baby stayed beside his mother, an iron or knife was already present there to protect him from demons etc.

One Mother told:

"Initially kept secret in our family and it is not allowed to go outside see the baby. These are precautionary measures taken to be safe against jealousy found in relatives and fear of black magic and demons. Actually early 2-3 week are most important for baby's protection and these evil deeds can put mother and baby on the risk and harmful for baby."

(Rural woman age 37)

Sathi, (Seventh Day's Celebrations), regarding the baby's 7th day celebration, three major rituals came to light through studies that was performed in local community. On the

seventh day of birth, the joy of having a baby was celebrated. It was called “Sathi” in the local language charity was arranged on that day. It was observed through aggregative response whether it was urban or rural, rich or poor, all used to celebrate this ritual at a great scale. The relatives, family friends and neighbors were invited to a feast. They were entertained with meals and sweets. Especially rice was served. Everything was done according to the social status of family. Some well-off people arranged the (Deigs) while the poor cooked the food at home and then distributed it. There were two opinions regarding Sathi: Some women said that the ritual of Sathi was celebrated only for the birth of a male baby. But few mothers had the opinion that it happened in the past but now the people used to express their happiness on the birth of the baby girl too. Actually “Sathi” was the local name of (Aqeeqa) During the research, it was observed that the people who could not afford to slaughter the animals at the seventh day, they just shaved the hair of baby. Actually, the locals had the belief about (Aqeeqah) that was a ritual when animals were sacrificed. This ritual was now less practiced in the area due to poverty.

During the FGD and interview it was observed Sathi and Aqeeqa were seventh day celebrations and objective of these festivities were get-together of family and friends and enjoy the baby birth event One mother explains this ritual, she said:

“Sathi and Aqeeqa are the seventh day celebrations. Sathi is locally considered a cultural festivity and Aqeeqa a religious. The peoples have economic capacity to slaughter animal they shave the hair of baby on that day and gave name to baby. They cooked food or distribute meat in friends and family this consider Aqeeqa. If the peoples could not afford to slaughter the animal, they just shaved the baby hair and cooked some rice and distribute with friends/family, this is called sathi. And this totally depends the socio-economic condition of the peoples”

(An educated urban woman age 38)

Aqeeqah, on the seventh day after baby's birth, animals were sacrificed in the way of Allah to celebrate the event to pay gratitude to Allah Almighty (Gatrad & Sheikh, 2001). For this purpose, usually sheep or goats were slaughtered. The meat was cooked and served in a feast arranged for relatives and family friends. Another option was to distribute the meat in raw form. Both methods were practiced in the area. The local woman told that (Aqeeqah) was mostly celebrated by economically strong people. One opinion was that (Aqeeqah) was a religious obligation. If the newborn was a boy, two animals were sacrificed and in the case of a baby girl only one was considered enough.

Jhandh Utarna (Shaving the Hair), another ritual related to the seventh day was shaving baby's hair along with the sacrifice of animals. It was taken as a matter of purity and impurity. The hair of newborns was considered impure because they have grown in the uterus (Gatrad & Sheikh, 2001) so it was necessary to shave them. The new hair would be pure. The shaved hairs were weighed against silver. Then the calculated amount was given to charity. Besides these rituals which were already mentioned, the newborn was given a proper name on that day. It was taken care of that the name should be a good, meaningful Islamic names such as the names of Allah and prophets.

Khtna (Male Circumcision), it was the most important ritual in the area. The first aggregative response of mother was that in their society it was a common perception that performing this ritual of circumcision the male baby formally became a Muslim because this act was not performed in Christians and Hindus.

The local rural women said that they used to celebrate this ritual on a grand scale and called it mini wedding of a male baby. This trend varied from family to family. In other words, in rural and urban areas, there was a vast difference in the practice. Many mothers

told that now this event was not celebrated with enthusiasm as in the past. If the delivery was handled in the hospital, the circumcising of baby boy was done on the third day of his birth. Some rural women called it ritual. It was performed on the 3rd or the 7th day of baby's birth/ A rural mother told in IDI:

> *"Event of circumcision (Khatna)is celebrated enthusiastically. Beautifully dressed and child receives gifts and money. all the near ones are invited to enjoy especially Jaga where songs are sung till late night".*
>
> (An uneducated woman age 34)

Among these rituals Adhan (Azan), Aqeeqah, Hair Shaving and circumcision are considered as religious rituals. The remaining was taken as part of the culture.

5.5 Decision Making Towards Health Care Seeking

Decision-making power of women is influenced by the patriarchal system where men have greater authority of decision-making simply by virtue of being a man in devloping countries like Pakistan. Pakistan has a strong patriarchal social structure where men are primary power figures and women are subordinate and this structure has genuine ramifications on their life prospects (Ali et al., 2011).

In Pakistan, gender roles are developed by a blend of customary roots and social norms, basically dependent on the ideas of production and reproduction, taken to reflect gender wise attributes of an individual According to Demographic and Health Survey, 2006-07, over half of the women deprived basic education and roughly 30% do acquire some pay. Yet most women in Pakistan are restricted to their homes to do housework for the joint and extended family and are let off from decision-making matters (Rabbani, Qureshi, & Rizvi, 2008).

As a patriarchal society men have dominant position in decision-making as well as in financial side (Omer et al., 2021). The cultural norms and egoistic behavior within patriarchy limitized women authority including decision-making authority. This variation in gender inequalities even in health prospect is not based on solo factor, rather, it has roots in structural formation. Despite the fact that gender discrement happens to both kinds of gender in individual circumstances, women subordination is an entrenched, worldwide pandemic (Hausmann, Tyson, & Zahidi, 2008) Patriarchy, which pre-assumes the prevalent superiority of men over women, brazenly maintains women's reliance and subordination to men in all domains of life thus all the power and authority associated with the family, the general public and the state remain totally in the possession of men (Sultana, 2010). Men have control over society and enjoy full authority in a patriarchal society. Consequently, women were deprived of their primary privileges and prospects as patriarchal norms limit women's freedom of themselves as well as on other socio-economic prospects (Sultana, 2010).

Decision-making power of women is influenced by the patriarchal system where men have a greater authority of decision-making simply by virtue of being a man (Sultana A. M., 2011). Cultural norms and egoistic behavior within patriarchy limited women authority including decision-making authority (Nosheen et al., 2009). This is the second objective of study that shows the influence of the culture of the family on maternal health.

Table 5.2: Thematic Analysis of Decision Making and Maternal Health

Theme	Category	Sub-category	Code
Decision Making and Maternal Health	Influence of family decision making on maternal health	Decision making towards health care seeking/ women's role in decision making	Blend of customary roots and social norms, Patriarchal influence, roles of husbands, family heads, mother-in-law and grandparents Men and elderly authority, women subordination
		Role of Husband in Maternal Health	Exist hierarchically in the family system,
	Traditional Birth Attendant (TBA)'S Role in Decision Making	Culturally accepted faith Based on her Expertise	Consultation of TBAs by family for taking decisions about maternal health of women
	Decision Making and the Role of Traditional and Spiritual Methods	Prenatal and Postnatal Care Decision Making	Home remedies/traditional practices/spiritual healing, reliance on medical storekeeper, educated/non-educated mother
			Home based/healthcare facility, unawareness, dual belief system

Source: Field data: 2019-2020

5.5.1 Influence of Family Decision Making on Maternal Health

When respondents were questioned about health care seeking whether it would be decided just by a husband or a unanimous decision of the couple regarding the maternal health, discussion made it clear that in the process of decision making the roles of husbands, family heads, mother-in-law and grandparents were more obvious and they seemed dominant in this perspective. This would be determined by their decision, regarding the mother's check-up, traditional medicines and home remedies. If the condition of the mother worsened, the family heads decide what to do then.

In FDG, a woman said:

> *"An educated woman explained her problem linked to prenatal checkups because her family considered it bad for a pregnant woman to visit a doctor. Her husband or in-laws decided whether to have a checkup or not and she was not consulted. Her family suggested her to use homemade remedies instead. These remedies proved to be good.*".
>
> (An educated woman age 26)

Findings of the study show that during the maternal period, the mother had to depend entirely on her husband for health care and he mostly valued the decisions of the elders for the house. In this context of health seeking, he seemed to be in a dominating position. Another thing that came to light as a whole was the presence of a strong cultural belief system that consisted of gender discrimination, customs and traditions that greatly affected a woman's health and fitness. As a result, she was unable to make decisions about her health in that local area. That's why the maternal and child health program (MNCH) in their study seemed to be a victim of male domination. The gender imbalance found in society was a big hindrance in the way of the maternal health care system (Hassan et al., 2020). The system of decision-making was badly male dominating so it did not give timely access to health care

of women in addition, decision making was culturally rooted, therefore it caused a delay in health seeking. As a result, the mothers had to use traditional medicines, home remedies and spiritual methods as an alternative system.

It became clear through previous discussions that women's role in the decision-making was very limited. In this case, the joint family system had a huge impact. Along with the decisions of the husband, the decisions of the elders also had to be followed. Women were questioned in the interview concerning the decision-making to what extent were they involved? What was the general attitude towards their health especially maternal health? It makes it even clearer what was the role of women in decision making process? They said that it was up to the family to make the collective decision and mother-in-law had the authority to decide. A smaller number of women narrated that they were their own decision makers as for as their health issues were concerned. Among these women, the majority was educated or were working ladies. In short, they were financially independent. Some young mothers responded that things had changed. Women had more awareness now than before. They could take decisions regarding their health care. But the discussion as a whole made it clear that women still did not have complete liberty to decide. On the other hand, they needed the approval of husbands if they had to go for prenatal or postnatal check-ups. A significant number said that they made collective decisions.

A woman told during the interview:

> *"When I have to go for my check-up, I talk to my husband about it. If he cannot find time due to his busy schedule, I go to the lady doctor with my mother or brother. I get checked up three to four times during pregnancy. If the health of the mother will be good, the child will also be born healthy. But it is our tradition that permission must be obtained from the husband. If the husband is not at home, it is necessary to get permission from the mother-in-law or any elder of the home."*
>
> (An educated urban woman age 29)

Many women answered this question during the FGD, if they had any involvement in decision-making process." Different types of answers came up. Many women said that it was the husband's responsibility to take care of his wife. If he could not manage time due to some assignments, they had to tell their mother-in-law or grandparents. Some women said that their husbands were out of the station for work so they had to go to the doctor with the permission of their elders. Some women disagreed. They were of the point of view that there should have been no restrictions on health issues. According to them, there was a lot of change now women were aware of their health and could make their own decisions. A young mother said in this regard:

> *"She lived with her in-laws who did not interfere in her matters. Her husband lived abroad and she used to take permission from him directly. In household matter family took collective decision. But I decide for myself about my health and the children."*
>
> (Matriculate Woman age 22)

A question was raised in an FGD with rural women what would be their reaction if their husbands forbade them to go out for check-ups. The overall response was that they did not go after what husbands forbade. For them, respect for husbands' decisions took precedence over everything else. According to the culture, a married woman should have obeyed her husband through thick and thin. Her parent also advised her that her husband's decision would be better always. A man looked after the matters outside the house so he could get to know society in a better way. If he said to avoid something, he should be obeyed. A woman told that in FGD:

> *"I have six children and all were born at home. During this time, I did not seek prenatal or postnatal care form any LHV and doctor. Because my husband did not like me going out of the house when I was pregnant. It does not even happen in our homes. We take care at home. And with the help of TBAs all children are born. We use the home remedies. We know that men spend most of the time outside the home.*

They have a good understanding of the outside world. Thy make decisions that are best for us. We consider it a sin to oppose a man's decision"

(An uneducated Rural woman age 47)

It was observed through this FGD that such behavior of men was a normal thing for all those women because they considered it an integral part of customs and traditions. The dominating role of men or joint family was daily routine for them. They did not take it as discrimination against them. It was found that inequality and imbalance existed in society. Women should not exclude from this decision-making process especially, in terms of health rights. In short, if men were given the complete authority of decision making, it turned itself into gender inequality that is considered a static feature of society and enforce by embedded social structures and resulting in the construction of constraints associated with women's autonomy (Ali, et al., 2011; Omer et al., 2021). In the same discussion a woman said:

"If men forbid us to do something, we have no right to protest. Because in our culture man is considered social god. Therefor it is very bad to disobey his orders. That's why women are not included in men's decision making".

(Uneducated rural woman age 37)

Other women proceeded the talk and said that the second marriage of a man was considered normal. The man's two marriages were part of their culture. Women obeyed every command of their husbands because they were afraid that their husbands might remarry if they disobey them. That's why, they used to accept everything their husbands said, even if they did not like it. Another point of view came to light that those who were totally dependent on their husbands, suffered the same problem. If their husbands could not afford their expenses, they also could not decide about their health independently. So, they had to obey their husbands and nothing else. In this way, the traditional belief system of relying on family and adopting traditional treatments became stronger. It means economic

superiority of men and women's dependency on men for the economic purpose led to strengthening power of men in patriarchal system as well as women's subordination and dependent position too. So, it is important for women to be facilitated with education as well as employability and provided opportunities for the sake of economic independence that not only make them empowered and decision-maker but also improve their maternal healthcare service uptake (Hou & Ma, 2013).

5.5.2 Role of Husband in Maternal Health

Pakistani society is male-dominated in terms of decision-making. There is a strong cultural system. In it, the gender's role explains how men and women play their respective roles. In terms of health beliefs, society puts all control in the hands of men. Women are mostly deprived of decision making. They often need the approval of their husbands or head of their families to make decisions about their health. This social inequality affects women's health. They have difficulty accessing health-care services. Male dominance exists hierarchically in the family system and we see its effects in the form of joint family and joint extended family. We find these decisions in different forms in the family system. Some decisions are made by head of the family as a whole in joint family or joint extended family, for example issues of health marriage, property etc. Some decisions are collective and the spouses decide by mutual consent, such as education of children, maternal health and give and take in the family. The nature of some decisions is such that the husband or head of the family makes the decision without consulting, usually related to managerial matters. Some temporary decisions including household chores, labor work and routine matters are attributed to women.

During the study, it was observed that man had a powerful role in household activities. A man had to perform his role in many aspects such as economically politically socially, culturally and spiritually. Besides this, he had the responsibility to take good care of his wife in the prenatal, natal and postnatal periods. During the interview, when mothers were questioned that how much their husbands were supportive in the maternal period. An aggregative response came in front through FGD and interviews. In that culture a man played a supportive role regarding Maternal health care in three ways: firstly, economically, secondly logistically and thirdly through decision making.

Economic and logistic support was the most important aid given by a man relating to the maternal health. Most of the women gave a unanimous statement that their husbands used to pay the expenses of the prenatal, natal and postnatal periods. Medical bills, medicines, expenditures of delivery and fee of TBA, all were paid off by the man. In addition, for visits to hospitals and clinics the expenses of transportation were settled by husband: All the women said that it was the responsibility of the man which he fulfilled. One mother Said IDI:

> *"I am educated and understand the health of mother and baby well. We take care of when the mother needs to be checked up? My husband mostly accompanied me during the check-up. I have three children all three were born in the private hospital of the city. All the expenses such as medicines, fee of doctor, transport etc were borne by my husband. Because it is man's responsibility to provide financial support to his family."*
>
> (An educated woman age 26)

A different point of view also emerged in this group discussion. Some mothers said their husbands did not facilitate them economically, so they had to bear the expenses of delivery themselves. There were various reasons for this. One was that their men did not work to earn. Secondly despite working, their income was very low so they could not meet

the expense of delivery. Those women said that they used to sew and embroider for earning or working women supported their husbands on this occasion. A mother shared her experience:

> *"My husband is a laborer. His income covers household expenses. When the time comes for the baby to be born. I do sew myself to save money and put the committee in the village. This money comes in hands during delivery time."*
>
> (An uneducated rural woman 34)

During the interview, all participants were asked how they managed the money for maternal healthcare, they said that they saved the money and set up a committee in the village. After the confirmation of pregnancy, they started to save the money from expenses so that it might be useful, some said the money was managed by the husband and they also worked hard and saved money by sewing embroidering or laboring etc. A smaller number told that their husbands used to borrow money from someone and it paid back after a certain period of time. It became obvious through this discussion that most of the expenditures were the responsibility of the husband which of course he used to pay. When it comes to the urban population employees met these needs by saving on their salaries. In case of a loan, only the man had to pay. In rural areas, people often used to pay the expenses of delivery by selling the animal, which were contorted by the man.

A discussion was held in FGD and interviews concerning logistics. Which mode of transport was used to visit a clinic or hospitals for medical check-ups. It was revealed that a majority replied personal motorcycle and local transport rickshaw. A smaller number said they used cars for this purpose. Very small number of women said they were used to walk to the hospital. The mode of transport was dependent on the economic condition of user or availability at the spot. A mother told; I ride a motorcycle with my husband for a check-up

during pregnancy. If the husband is not present at home. I can go with my brother-in-law, with the permission of my husband.

It was closely observed during the research that in the particular area, the majority travel on local transport motorcycle rickshaw otherwise on personal motorcycles. It has already been stated that the roads were in bad condition in Jampur. The roads were rough and uneven especially, in rural areas. It was also observed that people used to travel on rented motorcycles from rural areas to the city. The travelling of a pregnant woman on a motorcycle or rickshaw was not out of danger due to rough and uneven roads. It could cause miscarriage in the early three months of pregnancy. Roads in this area were full of danger for a pregnant woman.

In the interview and FGD, all participants were asked a question about who took care of house and kids during their condition of pregnancy. The opinion that came in general those husbands did not cooperate at all in household chores during this period. They did all the housework and took care of the children themself, and for some period mothers-in-law or grandmothers helped them out. Smaller number of women said that their husbands sometimes took care of children. One mother said in an interview, my husbands never helped me with household chores. If I suffer headache or nausea at the start of pregnancy, still I have to do all the housework. My husband is kind enough only to cover our expenses.

On the same note, another mother talked about her husband. He was cooperative to some extent and helped out her sometimes. She said:

“My husband looks after the children for a short time during pregnancy and a few days after delivery. Because it is a hard task for mothers to perform household chores till l7 to 8 days after delivery. My husband prepares the children for school but does not do any kitchen work. For that I have to get help from someone else. I live in the nuclear family so my mother or elder sister help me out.”

(An educated woman age 28)

It was observed during the group discussion that overall opinion of women was their man had to fulfill the responsibilities outside the house therefore they did not help out in household chores especially related to the kitchen. A woman told in an interview that her husband never helped with housework. Another mentioned about that in area of Jampur second marriage was a common practice. A woman shared her case study related to this point in FGD:

“An educated woman said "I am the first wife of my husband who remarried and didn't take care of me or my kids. During my last pregnancy, he visited me in the early months only but then stopped. He knew that I could bear my expenses. Ultimately, I had to call my mother and sister in my critical situation who supported me. She thinks polygamy isn't in favor of wives at all."

(Educated woman age 32)

In a group discussion a woman shared case study of her relative that was totally different from above mentioned lines she told:

“In my family, a relative has been married twice. He keeps both wives in the same house. When such cases occur that as the birth of children or any other compulsion both women help each other. Moreover, they cooperate in household chores as well as child care.”

(An uneducated rural woman age 30)

In FDG, the aggregate response of women made it clear that the duties of men were related to management. He had to do a job for earning. He had to look after the affairs outside the house. If he belonged to rural areas, to work in fields was also his responsibility. It was

thought that if men would be involved in domestic affairs directly during a maternal period, then his other responsibilities would be affected definitely because arranging the money at the time of delivery was the prime responsibility of a man. It was already discussed multiple times that basic household chores were the responsibility of a woman. So, during the time period of pregnancy in case of a joint family other women of home had to support her. If the pregnant women live in a nuclear family, her own mother or mother-in-law would help out. A woman said in IDI:

> *"I do not blame my husband for being not helpful in the pregnancy period because he has to bear the costs of delivery and other-wise matter related to the mother and child- health. So, he just has to do his job. Household chores are done with the help of mother or sister. Men have heavy responsibilities outside the home. They have to work hard to earn money. So, I don't think men should be responsible for housework."*
>
> (Educated woman age 29)

During this study, some educated women shared their point of view that there was nothing wrong with men helping their women for short time but ultimately it was the responsibility of women comparatively since they could do house chores better. Overall, this point came in front that duty was given to someone among the relatives of men or women to assist pregnant women in this period. During pregnancy a young sister or sister-in-law helped out while at the time of delivery and afterward the role of the mother or mother-in-law proved effective and beneficial. And all this was done according to man's decision. Generally, this wheel process was considered an essential part of culture which was happening from the far past. It was taken and followed as a good value in the community.

A woman supported this discussion and said:

> *"Personally, I do not like my husband working in the kitchen and washing the clothes. It is in our culture that mothers or sisters help out in the maternal period. I am in favor of this we must uphold the good traditions of our elders on this occasion. Not that the house chore was given to husband".*

(Rural Woman age 33)

It was observed during the study that the meaning of the maternal healthcare is not limited to the given facilities related to good health and to following religious and social norms but building a healthy environment at house. It can be much better with the cooperation husbands. According to this culture, if a man performs his outdoor responsibilities properly, it is good enough. If help is needed, relatives share the responsibilities. This came as a whole that the way a man participates in various household chores, in the same way, the greater the concern for maternal health, it will be more helpful to improve maternal health.

5.5.3 Traditional Birth Attendant (TBA)'S Role in Decision-Making

It was observed during the study that the role of TBA was significant traditionally regarding the decision-making, especially concerning maternal healthcare. Families consulted TBAs to take the decision about mother's prenatal and postnatal checkups. When would the checkup be done? Where and from whom would it be done etc. It was noticed that in this process usually mothers did not participate, and everything was discussed among husbands, mother-in-law and TBAs. In interviews and FGD, many women said that they did not take prenatal care in the early three months of pregnancy but stayed at home. Attempts were made to minimize contact with other homes. Even going to hospitals or clinics was

feared of the evil eye. During this time period, TBA or mother-in-law took care of pregnant mother.

5.6 Decision-Making and the Role of Traditional and Spiritual Methods

It is customary belief to consult with spiritual healers to ward off evil eye or the influence of evil spirits directed against pregnant women and the elderly of family, very often mother-in-law or any other female takes this responsibility (Omer et al., 2021).

This came out of the discussion that the participants had no interest in that if the mother did not get her check-up done in the early days, she could have medical complications. The participants did not consider this fact at all. Rather they had the point of view the mother could be affected by the evil eye or that might cause miscarriage. Another major aspect of this dual health system was the use of home remedies, herbal medicine and the spiritual belief system. Due to this mother could not avail health services and proper counseling in the early months, resulting in the unawareness of women regarding the basic information about mother-child health. In short, it was noticed that mostly mothers were anemic in the local area. Many mothers did not know how often a mother should be checked up by a doctor during pregnancy. Most of the mothers got checked up once or twice in case of serious problems otherwise relied on home remedies of grandmothers or herbal medicines for TBAs.

A Mother said in IDI:

> *"I had a checkup in the first few months at the approval of my mother-in-law. When I was feeling worse, I used home remedies made by my mother-in-law which heated up my body. It happened to me during the second pregnancy. When I discussed this matter with my mother-in-law she said "this is nothing special. The medicine has some effect." A few days later, I started bleeding. We went to the clinic of a lady*

doctor in an emergency but I aborted meanwhile. Sometimes, herbal indigenous medicine is not compatible with the body so these have the opposite effects."

(An educated woman age 35)

During discussion and interviews, all the respondents were inquired how many women suffered abortions or miscarriages during pregnancy. 48% replied that they had miscarriages especially in the first three months. When mothers were questioned that how many times they got checked up from a doctor or LHV in first three months. 32% answered that they did not get checkup. 8% said that they went for checkup for the first time. 1% told they did second and then a third time too. When they were asked how many women went for checkup after three months 20% said they did so remain 7% confirmed their third checkup. The data supported the first part of the discussion that 67% did not use health care services in their first-time set. A strong belief system existing in the area was the main reason behind this. So, the mother did not consider it suitable to go outside the home during the pregnancy because of the fear of evil eyes or derails.

5.6.1 Prenatal and Postnatal care and Decision Making

The third major reason, regarding gender and decision making, came into light was an overall opinion that the meaning of check-up in a family was considered to confirm the pregnancy of the mother. After the confirmation husband and the other members of the family had a collective discussion including the opinions of mother and TBA. It was decided that further what to do about the mother's health whether a visit to a doctor would be required or not? It also became obvious through discussion that it was not necessary to visit a doctor or LHV for antenatal care and the confirmation of the pregnancy. Rather, some mother said that pregnancy stick was easily available from medical stores for the pregnancy test. Most women confirm their pregnancy through this way.

In FGD, women shared that if they ever felt nausea or headache in the early months of pregnancy, their husband's brought medicine from medical stores without any prescription from a doctor. During the study it was also observed that locally, a few numbers of TBAs were literate. They used allopathic medicines such as injections and drips along with traditional medicines. Medical store owners were also seen colluding with TBAs. The medical store-keepers used to note down the prescriptions of doctors, and memorized the names of few medicines commonly used for pregnancy and delivery. The men of the house used to bring oral medicine themselves. If the mother felt worse, the man working for medical store come and was called to drip her. A mother told in FDG:

> *"We live in a village, located 6-7 kilometers away from the nearest town. My husband used to bring medicine from the medical store when was not feeling well during pregnancy. We never visited LHV or a doctor for checkups. Medicines for minor ailments are easily available from medical stores. The worker owner of the medical store is very sensible. If the drip is to be applied the become to home for it*."
>
> (Uneducated woman age 26)

Another mother said in FGD,

> *"I gave birth to seven children. One of them died. I never visited a doctor or LHV for check-ups. When a woman does not menstruate and her conditions worsens the pregnancy is known. After that, it is confirmed within two months. We take care of ourselves at home. We improve our diet by increasing the intake of milk, yogurt and Lassi. We continue our routine work in this condition. Our men dislike going outside for check-ups."*
>
> (An uneducated mother 47)

The researcher talked to a lady doctor during the study who was working in both government and private sectors. She also confirmed that men did not cooperate with women. The check-up of a pregnant mother was not part of the local culture. Without an antenatal check-up, the pregnancy was not confirmed in the early two months. Due to imbalance and

insufficient diet, most mothers are anemic and therefore got weaker. That was the reason, the fear of miscarriage increased. It was observed during the study that families or mothers, who were under the influence of TBAs and used to follow their decisions regarding maternal health, did not have proper antenatal care. It came to light through data that the mothers who were educated at the primary levels did not take antenatal care until the conditions got critical. In contrast, a small number of women who were more educated a matric, used to get prenatal check-up graduate and post graduate mother 3-4 times visited a lady doctor concerning their antenatal care from the start. But they consisted of just 4% in the total data. The data showed that with the increase in educational level, the tendency of mothers towards health services also increase health information improved their attitude about health seeking. The majority of women did not go for checkups in their second trimester, after the confirmation of pregnancy. It was observed through data that average antenatal visits were one to two.

A mother shared her thoughts regarding the checkup:

> *"Usually, pregnancy is confirmed during the second months. Pregnancy strips are easily available in medical store now a days. These are also used to confirm pregnancy. If a mother feels healthy, she does not go for check-ups. She just improves her diet. In the case of anemia, (Desi Phakki) is used which gives the strength to mothers because it contains dry fruits."*
>
> (Educated urban women age 30)

A woman said in IDI:

> *"Many times, I have caused severe complications for example bleeding in the first three months of pregnancy with indigenous medicine. We use (Tarang) in case of body pains. In case the problem is not solved, we take allopathic."*
>
> (Primary educated rural woman age 37)

As already mentioned, that educational level determines health awareness. It was observed that an educated woman also had to take care of her norms and traditions. If she was the member of a joint family, she had to bear face point. Educated women expressed those things had changed enough. It was not like the use of home remedies or traditional medicines came to an end but an educated woman could manage her health in a better way. It was observed through study that delivery at home was the first choice of the local woman. She had a strong belief in this. The delivery at home was handled by TBAs. In FGD, many women shared that delivering the baby at home was part of their culture. People considered it against honor that delivery occurred at the hospital or a clinic. It became also clear that no residential issue was involved in this factor because a mother who lived just 3 km far away from the city hospital also preferred to give birth to her child at home besides the fact of being educated. Women told during the discussion that the government had given the facility of a free ambulance on-call for the time of delivery through its MNCH program. Yet locals did not use it. They had faith that the presence of ambulance at door step was the symbol of tragedy. They also had a fear in their minds related to the delivery at hospitals that doctors performed surgeries there unnecessarily.

A mother said in IDI:

> *"My family is educated and I have passed matriculation myself. The mother in our family gives birth to the babies at home because in case of going to hospital, doctors do not wait for normal delivery. They instantly switched to surgery which is costly for sure. It also affects the mother's health and causes pain in the stomach and back. Once it is operated normal delivery cannot be possible again."*
>
> (Matriculate woman age 24)

Another woman told in an interview that usually in the case of normal delivery at home, many complications were produced. But, now a days, TBAs can solve the problem by using allopathic injections and drips. As already discussed, due to the existing dual health

system, people had trust in TBAs and many generations had been using their services, rather, they were given the status of mothers locally. Through discussion, it was also observed that men could not guess right about the complication at the time of delivery and pregnancy-related issues. That's why home delivery was interpreted as customs and traditions. It is revealed that unawareness amongst women as well as their families including husbands, about the sensitivity of delivery time complications and continuity of health seeking during pregnancy (Sattar et al., 2019) It also came into light through discussion that the main reason behind the importance of the role of TBA was her continuous presence with mother to serve her for several days. She used to serve the mother in many ways, for example to massage her which gave relief to mother to control her body pains. The protocol which a mother received in delivery at home, was not possible at clinics. One mother said in FGD:

> *"I have four kids. All were born at home easily. My pain history is also very short. It means I suffered just 5-10 minutes of pain. I am an attendant in the Population Department by profession. When I gave birth to my third child, I was present in the office. When labor pains started, I called TBA. When I reached home, she was already present there. After five minutes, I gave birth to my son through normal delivery. Thanks God, I never suffered immense pains and I am at the safe distance from clutters of hospitals."*
>
> (An educated urban woman age 32)

It was also observed during study whether a mother used to go for a postnatal checkup after delivery or not. The doctors and LHVs, had the same reply as it were in ANC. If the delivery occurred at home and no complication happened, PNC was not considered necessary. TBA served the mother for one week. In case of excessive bleeding, TBA treated the mother with desi tips. (Home remedies) cumin seeds were used in bread and ghee. The intake of this food was useful for the speedy recovery of a mother. The women who gave birth to their babies at the clinic of LHV, delivered normally. In case of any complication, they discussed the matter with LHV. Only 4% women were admitted in to the hospital for

delivery. They followed the PNC because they were constantly in touch with their lady doctors during the complete nine months of pregnancy.

In FGD, women agreed at the point that after delivery a mother should pay a visit to day doctor or LHV. In rural areas, mostly male doctors were appointed so the women had to depend on TBAs. If allopathic medicine was required, it could be purchased without any prescription. Some women shared that at BHU level mostly appointed LHVs or midwives were less experienced than TBAs. They often found them consulting TBAs. In interviews and FGD, all the participants were questioned related to decision-making what was their opinion regarding the difference in maternal health care between now and the time of their grand-parents. The women replied that in past, access to health services was less but with the passage of time it became improved. Now it was up to them which system would they like to choose? The sources of communication were also better than before. There was a motorcycle in every home. In addition, local transport was also easily available at day time. In case of emergency, the vehicles could be rented which was not possible before. The education had enhanced the awareness of the people. An ever-present object was local customer, tradition and the belief system. While discussing the role of TBA, the majority of women declared it a blessing for themselves. They said those family TBAs were very sensible and intelligent. The openings of clinics had disturbed them a lot because this new trend attracted people's attention also learned so many new things to cope with situation. When it was probed that would they like to transfer their knowledge gained from grandparents, to the next generation. They agreed overall that home remedies and religious beliefs were a blessing for family structure and baby-care so they would definitely like to share it with the next generation.

5.7 Critical Analysis/ Commentary

The indigenous birthing practices and the associated prohibitions were driven by the cultural and religious beliefs of the people. The study revealed systems of oppression at the house hold and community levels that relate to societal, cultural, religious and moral values. These systems empowered men who used their supremacy over their spouses to hold them to traditional gender expectations. The power that is given to men by the culture facilitated women's oppression and the internalization of oppressive codes by the women themselves which adversely impacted the use of healthcare services.

The observance of prohibitions subjected some pregnant women to purely vegetarian diet and concept of hard and soft food suggested by the elder women of the household. This has serious implications for the health of the woman or her foetus for instance, though some food habits may help check foeto-pelvic disproportion. which usually results in labor dystocia and consequently prolonged labor, they may worsen the anemic status of the pregnant women and affect the growth and development of the foetuses (Sperling et al, 2015). The food habits and taboos created limited choices of food for the pregnant women, which can affect the diet and health of the expectant mother and the foetus. Expectant and lactating mothers are supposed to eat nutritious and balanced diet because the foetus/baby depends on what the mother eats for growth and development. Three Delays Model emphasizes the power of cultural beliefs in influencing healthcare services utilization. The society has created structures in form of walls - making it difficult for women at the agency level to break. This creates inequality in access to healthcare between men and women to the disadvantage of women.

The study observed that in most cases, duality of structure and agency was not functioning because the structural forces were domineering over the agency. However, few empowered women were able to stand against dominant norms. This sustains the call for female education for empowerment to position well to make informed changes in the structural systems for equity to take place for improved access to healthcare services. The prohibitions were not just isolated norms, but located in cultural structures and being enforced by men at familial and the communal levels. Aside, some of these women did not get the opportunity for early screening and treatment of pregnancy-related conditions in illness and healing in maternal health.

The study observed that location of health facilities was not a major concern for skilled care. Some women staying closer to facilities neglected clinical care neither for economic nor transport-related factors. They did not have perceived need to seek clinical care either because they judged themselves strong and healthy or it was in fulfillment of the traditional birthing culture. This is a confirmation that, cultural and social norms restrict women's physical movement and care seeking. Some women neglected clinical services in their critical stages. Meanwhile, it is required of women to seek professional care during these phases regularly and timely (WHO, 2013). This is because the totality of a woman's health in the pregnancy-postpartum continuum functions as a system comprising ANC, SD and PNC (Nwokocha, 2007).

Some other women especially, in rural setting have history of safe delivery at home with the assistance of TBAs or relatives they did not seek PNC until after one week. These women and their husbands perceived institutional delivery and PNC as options for the

weaker and unhealthy women. The women who had perceived need for clinical care were influenced by their predisposing factors.

The quest to conform to the health beliefs around pregnancy and childbirth necessitated home care that was characterized by purification rituals The motherhood interventions which is based on spiritual ritual experiences of the family should be focused on breaking cultural structures that inhibit access to healthcare through key personalities at the household and community levels. For fear of being fed with forbidden foods because they had no control over food prepared in facilities, women ignored facility-based intensive care. They argued that food was allowed to be sent to the facilities for women on admission. Only few mothers who were not in favor of these practices but influenced by the hierarchical structures within houses and could not avoid these practices.

Most of the formally educated women were less concerned about the taboos especially, in their most recent pregnancies. Those staying outside houses were able to express their health needs and concerns timely accessed clinical services. Thus, they were able to translate knowledge into behavior to ensure good health because they stayed alone with their partners and were free from interference. Women who were totally dependent on their husbands for their needs were under total control of their husbands and they only provided when considered necessary. This observation sustains the argument for women's empowerment as a necessary condition for positive maternal outcomes.

The study revealed differences in status between spouses within households which is manifested in both intra-household and inter-household decisions-making, and the status of decisions taken by wives and husbands. Whilst husbands took individual and final decisions, wives could only take tentative decisions subject to approval by men. The

decision-making process which considered women as minors was characterized by marginalization and oppression of women which was not only discriminatory, but also a precondition for inequalities and disparities in access to healthcare. These are major impediments to improvement of maternal health (WHO, 2007).

Women who felt symptoms of various pregnancy-related conditions did not have the mandate to make decisions about their own experiences but had to report to men, most of whom did not have adequate knowledge about pregnancy signs and their implications on women's health. This system of decision-making was observed to be connected to the cultural mandatory role given men to take sole decisions which was regarded as an act of protection for women. The men determined the severity of the women's conditions and decided on the type of care they needed upon going through the family protocols and spiritual consultations. In line with the observations of Qureshi et al. (2016), these processes of decision-making denied women speedy clinical intervention.

The study discovered that disparities for women were further widened by the male-dominant philosophies and practices connected to healthcare decisions and accessibility. This supports the statement by the UNDP (2013) that patriarchal ideologies and practices have been structured to make women vulnerable to illness and deaths. As argued by Sithole (2021) there is an urgent need for elimination of cultural practices that deny women equal access and opportunities to healthcare in these communities to improve women's health in maternity.

Marginalization of women as observed in the decision-making towards care seeking is a precondition for subjecting women to maternal morbidities and mortalities. This is because decision-making is a key component of care seeking and appropriate and timely

decisions lead to positive maternal outcomes. Therefore, neglecting women's minds and voices in determination of the severity of their obstetric conditions and the choice of care or timing of care seeking may amount to adverse implications for the health of both the expectant mother and her unborn baby. It is women who experiences the symptoms of the conditions and can best tell the severity of such complications. Using health beliefs and masculine role to determine women's state of health, type of care needed and the time for care seeking as observed in the study deprived women of expressing their perceived need and knowing their evaluated needs.

The first ANC was for verification for further decision-making. This period is very crucial in maternity because risk factors are normally screened for during this period for treatment and counselling. The blood level of pregnant women needs regular monitoring in the hospital through laboratory tests to save the woman's life. Aside, the unborn baby needs regular clinical monitoring to ensure that is in good state. When women confirm their pregnancy status on the first ANC visits and turn to herbal treatment, their blood levels cannot be determined later in pregnancy. This becomes very risky for those who are anemic because in the event of hemorrhage such women stand the risk of losing their lives. In some cases, the use of TBAs was not related to beliefs but the comfort the women and their families derive from them, and the inadequate knowledge about pregnancy-related complications on the part of the men to make informed decisions towards care seeking. This also calls for health professionals to strengthen their care to women in maternity by accommodating cultural differences when they visit the facility.

In spite of the extended family influence in the study area most formally educated women showed positive attitudes towards clinical care seeking. This maintains the positive

correlation between female education and maternal clinical attendance (Hagman, 2013). Most of these formally educated women were well informed about pregnancy-related complications, nutrition and the need for frequent clinical care. Some were able to stand against food habits which they felt could lead to deficiency of important nutrients. This confirms that literacy skills enable women to perceive and retain health information and adopt health promoting behavior (Asif & Akbar, 2020).

Involving men in maternal healthcare has the potential of improving women's health (Hagman, 2013). Traditional masculine and feminine roles and the beliefs systems of the participants also affected the involvement of husbands in maternal healthcare at the household level. Most husbands did not perform the feminine roles in person at the household levels to assist their spouses who were not fit to play such roles. Whilst those in polygamous marriages used co-wives to perform such duties, the men in monogamous marriages used female relatives. However, both the pregnant women and the non-pregnant rivals preferred female relatives of their husbands for such roles. Some other men did not assign the feminine gender roles to female relatives and co-wives but left them to their pregnant wives to perform irrespective of their conditions. This has adverse impact on the health of the woman especially, those with obstetric complications that do not require them to perform some household chores. Again, visiting the facilities exposes men to education on maternal healthcare which helps them accept the available maternal health programs and make them more accessible to the women as well as increase their commitment in assisting their spouses at the household level.

This section discussed masculine and feminine roles in decision-making for maternal healthcare. The section also examined how the faith systems of the communities informed

decisions towards care seeking as well as the role played by husbands in maternity. Behind poverty, which is the end point factor, there are socio-cultural issues which are normally neglected. Poverty could be economic, social, intellectual, psychological or cultural. Neglecting the fact that, health beliefs are well grounded in some communities and inform their behavior towards healthcare is a step towards failing healthcare programs.

5.8 Conclusion

The study discovered a cultural belief and decision-making practiced by the participants in selected study area which led to healthcare, where expectant and new mothers received care from both health professionals and the traditional practitioners. Irregular and low clinical visits as well as delays were associated with this system of care. It was about to know that what is behavior toward maternal health in traditional Pakistani society. The second one is to elaborate on what is the role of gender in decision-making with responsibilities of men and women regarding maternal health. Moreover, it reveals that how do the norms of society affect the health of mothers and how the belief system of society affects decision-making?

In Pakistan, the extended family system was regarded as a symbol of collective well-being and blessing. In Pakistani culture, in marriages the consent of the boy or girl was not as important as it is in the hands of parents, uncles, aunts and brother. It was also observed in the study area the implications of decisions made by older women and men regarding maternal health. The status of the eldest in the family had more importance, so to obey and accept his advice and respect his decision. As for as maternal health was concerned, a healthy lifestyle and maternal nutrition greatly influence the health of both mother and neonate after

conceiving a baby the health care of a mother has not remained just an outline matter but turned into an important task in the families.

The diet has a vital role in maternal health. The need for nutrients increases during pregnancy as compared to other stages of life so women need higher nutritional requirements throughout the pregnancy. Lack of nutritional intake may result in the suffering of the mother as well as for the baby that may consist on short-term or long-term as well. Soft or cold food was usually given to women in the prenatal period. So, it was considered that such type of food would be useful for the mother in addition, it also reduced the fear of abortion or miscarriage. It is believed that in the postnatal period, the mother should be given warm food immediately after the birth of a baby.

The people belonging to tribal areas were very conservative. In such conservative environment women are confined to homes for the sake of honor, veil and purity of women. Their customs were authoritarian, TBA culture is very strong in these areas. People believe in what they say because these have been going on for generations. Upper and middle classes have awareness to some extent they come for checkup twice or thrice during pregnancy. On the other hand, the people of lower classes are mostly illiterate and unaware they have less information about their health. They are more in number and have a firm belief in TBAs. The concept of the veil and don't get checked-up by the male doctor are the reasons that increases in the cadence of women.

The transportation in these areas is also limited and the social mobility of a pregnant women was largely dependent on her cultural belief including decision-making and women's dependency as well as male dominance as a prominent factor. The other aspect was socio-religious, how a pregnant women's mobility during and after pregnancy was restricted in

this society. Moreover, people were afraid of the public and private health-care system due to lack of awareness. The fear of the operation was in their minds. They thought if a woman would give birth to a child through surgery, she might not be able to have more children.

There exists a strong factor of religious and spiritual beliefs and practices related to mother and child. The women in the area, if did not get pregnant, was considered to be unlucky. They used clinical and traditional services, they strongly believed in spiritual and religious practices, according to their own religious beliefs. In addition, this belief was found in every context of prenatal, natal and postnatal care all are Muslim women.

CHAPTER 6

INDIGENOUS REMEDIES AS AN ESTABLISHED WAY OF MATERNAL HEALTH

6.1 Introduction

This chapter discusses the indigenous method and traditional practices related to health which addresses the research objective that is find out the indigenous remedies and practices in socio- cultural setting. It has been tried to find out how many types of health-care practices are found in traditional society regarding Maternal Healthcare. The data obtained discusses the role of the family regarding the use of home remedies for maternal health care and how is the usefulness of these methods recognized locally after that, prevailing the local concepts are discussed which cover the detail about the services of traditional (TBA) and religious practitioners.

6.2 Efficacy of Traditional and Herbal Medicine as Indigenous Remedies

Most research on medicinal herbs is conducted in areas of the world where the use of medicinal herbs is mainstream, particularly in Asia and Europe (Barrett, 2001). Depending on the cultural or ethnic groups engaging with traditional health practices, the term traditional medicine (TM) or complementary and alternative medicine (CAM) is used, albeit interchangeably (Shewamene et al., 2017). Traditional medicine is commonly used in developing countries e.g. Pakistan. The World Medicines Situation 2011 report estimates that between 70 and 95% of the population in developing countries use traditional medicine (Shewamene et al., 2017; Hernandez et al., 2011). In Africa, more than 80% of the population use TM (Shewamene et al., 2017). The sources of information on traditional medicine were from families, relatives, friends, traditional birth attendants and local herb

sellers/herbalists (Sabe, 2019) This study found that women did not usually seek treatment for physical health and mental health problems during the prenatal period in the study area. Many factors are contributing in delay of ANC that include attitude toward pregnancy, inefficient medical facilities spousal involvement and gaps in in promotions (Taylor et al., 2017). Spontaneous pregnancies, multi-parity, religion and social variables lead to the low usage of antenatal care benefits in low wage settings. Similarly, some studies show that parents are reluctant to seek mental health issues (Mahejabin et al., 2015). Even, 78% of parents sought 'no care' for their preterm newborn (Shah et al., 2014). On the other hand, they women do not seek medication for any mental health disorders during the prenatal period of women (Dennis & Chung Lee, 2006).

Globally, sales of herbs have sharply been increasing, and herbal medicines (HM) are increasingly used to prevent and treat various illnesses (Dennis & Chung-Lee, 2006). The prevalence of HM use in pregnancy has been reported in various countries, including Iran (67%) (Dabaghian et al., 2012), Jordan (60%) (Amasha & Jarrah, 2012), the United Kingdom (58%) (Holst et al., 2011), Iraq (54%) (Hwang et al., 2016), Italy (48%) (Lapi et al., 2010), Norway (40%) (Nordeng et al.,2011), Palestine (40%) (Jaradat & Adawi, 2013), and Australia (34%) (Frawley et al., 2013).

The popularity of HM among pregnant women is mainly because of the common belief that herbs are natural and free of any adverse effects that are usually associated with conventional drugs in indigenous communities (Ernst, 2002). Additionally, herbs contain biologically active ingredients that have a potential to mediate pharmacological actions; thus, HM may produce adverse effects (Marcus & Snodgrass, 2005). However, due to a lack of information regarding the efficacy and safety of HM use in pregnancy at household level.

The pregnant women have very little knowledge about the efficacy and safety of using these medicines in the study area. It is not confined to use medicinal plants/herbs or relying on spiritual etiologies but also includes sacred-profane constructs and hot-cold like dichotomies that influence the cultural practices and may be, sometime, become harmful for both mother and new born.

Later, another report suggested that women using licorice and chamomile during pregnancy had a higher incidence of threatening miscarriage and preterm labor, and newborns of herbal medicine users were smaller for their gestational age (Cuzzolin et al., 2010). Moreover, in high income countries such as the USA, the UK and Australia, healthcare providers and consumers can report the side effects of drugs, including HM, to the government authorities by filling out a prescribed form (Hazell et al., 2013). Herbal Medicine is commonly used throughout the world. It was found that 70% of the women used at least one herbal product during their last pregnancy. The difference in the prevalence of HM use could be explained by several factors such as culture, socio-demographic factors, and use of health care services (Ahmed et al., 2018). One study reported that TM was frequently used to get back in shape after delivery, facilitate childbirth, increase breast milk secretion and reduce pain during pregnancy (Elkhoudri et al., 2016). Use of alternative medicine for maternity-related health complaints is common (Johnson et al., 2016).

Other determinants included user's belief that traditional medicine was more effective than western medicine, as well as better accessibility and lower cost of traditional medicine (Shewamene et al., 2017). Other reasons for TM use included general-wellbeing during pregnancy, promotion of fetal growth, spiritual cleansing, to protect the pregnancy

against evil influence, having a male baby, induction of labor, assisting childbirth, and as dietary supplements (Mugomeri et al., 2015).

Table 6.1: Thematic Analysis of Indigenous Remedies and an Established Ways of Maternal Health

Theme	Category	Sub-category	Code
Indigenous Remedies and Established ways of Maternal Health	Indigenous Traditional Care System	Family Role	Responsibility of female head of the family, pre-natal, natal and post-natal care
		Role of Traditional Birth Attendant (TBA) as Herbalist	Stakeholder/consultation, methods of treatment
		Role of Spiritual/Religious Healer	Practitioner/healer, Pir/Pirni, methods of healing

Source: Field data: 2019-2020

6.3 Indigenous Traditional Care System

The role of the traditional practitioner was discussed in detail under this heading. What would they used to do for maternal health care locally, away from modern health care facilities? Which processes were adopted for prenatal, natal and postnatal care? How the diseases were diagnosed locally? How was its proper medicine prescribed? Also how to treat any problem or complication with traditional methods? Three types of traditional

practitioners emerged from the data is as family role (Home Remedies), TBA role (Herbalist) and spiritualist Role (Religious Healer).

In this regard, the family role and the role of TBAs is almost the same. In both cases, mostly herbs were used for cure. But locally, the methods adopted by the family were called home remedies. One mother told that:

> "*TBAs still have strong influence in the area especially in the rural area. People also follow their pieces of advice. I have two kids. I visited the doctor for checkup in both pregnancies. But we cannot avoid our mothers and mother-in-law in our homes. They give us green tea to cure the nausea and vomiting did it has no side effects"*
>
> (A school teacher age 32)

Different spices and herbs at house were used for this purpose. Medicines used by TBAs were made herbs brought from the market. Additionally, medicines for local herbal companies were also used nowadays. At sometimes, the role of religious and spiritual healers was of a different kind. It was dissimilar from herbal treatment by performing various types of rituals.

As a as the traditional practices were concerned, the efficacy of herbal medicines was under question on big question mark. Because homemade medicines prepared by TBAs were not tested in laboratories. On the other hand, the data showed that the local belief in these herbal medicines was very strong. People thought that these herbal medicines or home-made remedies were transferred from generation to generation as a traditional pathway so they were authentic without any test from laboratory.

6.3.1 Family Role

Regarding the maternal-health care, the most important person responsible for providing initial services and care to a mother was female head of the family, a mother or a mother-in-law. The general opinion of society about the elderly women of the house was that they had extensive testing experience. Therefore, their views regarding the health of the mother and child were considered to be paramount. They could guess on the base of their experience by observing the appearance of women and the changes in her routine, that she was expiating. A mother said IDI:

> *First time when I got pregnant my mother-in-law easily guessed that I was pregnant by my pale complexion, feeling weakness in my daily routine and liking and disliking different food items. Additionally, another major sign is vomiting and menstruation does not come".*
>
> (An educated woman age 28)

Once the pregnancy was confirmed the use of home remedies was started these tips were used according to the nature of each mother. Through interviews and FGD, a chart of home remedies, used locally was compiled with the help of aggregative response. The use of herbal medicines during prenatal natal and postnatal care. There are different types and the opinion about the effectiveness of these remedies written in this Table.

Table 6.2: Home Remedies

S. No	Remedy	Ingredients, indigenous name	Ingredients English name	Usage and effectiveness
PRENATAL CARE				
1	Kahwa	1.Saunf+ Elaichi+ Pani+ Shakar 2.Pudina+Elaichi+ Pani+ Shakar 3.Adrak+Elaichi+ Pani+ Shakar	1. Fennel seeds+ green cardamom+ plan water+ sugar 2. Mint leaves+ Green cardamom+ water+ sugar 3.Ginger+ Green Cardamom+ water+ Sugar	All these three types of Kahwa used early 2-3 month of pregnancy, when women feel Nausea or Vomiting. its pay relief to women in that such condition and are effective in vomiting and nausea.
2	Araq	Saunf ka Pani	Fennel Water	Use and effective in Gas Trouble. Feel some heaviness in the stomach, sometimes use in a malik
3	Murabba	Hareer+ Shakar	Chebulic Myrobalan+ sugar	Its effect considers cold and women used in pregnancy, to avoid constipation and have normalized the stomach condition

Table 6.2: continued

4	Gulkand	Gullab ki Patina+ Shakar	Rose Patel+ sugar	Gullkand is a very good antioxidant 1-2 tea-spoon helps to reduce acidity and stomach heat. women use in pregnancy avoid constipation and acidity. it also uses for refresher and healthiness. Women use this with cup of malik and in natural form.
5	Surodha	Doodh+ Choti Eliachi+ Desi Ghee+ Shakar or Gorh	Boiled Malik+ small Green Cardamom+ Clarified butter+ Brown sugar	This type of drink used once or twice a week in the last month of pregnancy. It considers effective in easy delivery
NATAL CARE				
6	Trang	Desi Ghee+ Zeera+ Eliachi+ Gorh	Clarified Butter+ Cumin + small cardamom+ brown sugar	This drink is used when the Labor pain started its effective to fasten the pain
7	Oubli Seviyan	Seviyan+ Desi Ghee+ Shakar	Boiled Vermicelli+ clarified Butter+ brown sugar	This remedy is used when the labor time is prolonged. it's made effective to easy delivery
8	Peeli Tiki wala Doodh	Gram Doodh+ Andha ki Zirddi + Shahad	Boiled Malik+ egg Yuk+ Hony	This drink is used soon after delivery as effective in pain relief

Table 6.2: continued

POSTNATAL CARE				
9	Yakhni	Murghi ya Bakray ka Goshet+ Lehsun+ kali Mirch+ Numak	Chicken or Muton meet+ Galic+ Black Paper+ Salat	This soup is used regularly by 7-11 days after delivery its effective to restore the energy of women especially in summer weather it works more effective and protect from cold.
10	Halwa	Gandam ka Ata + desi ghee+ Shakar+ Eliachi	Grain Floor + clarified butter + Brown Sugar+ Cardamom	It considers very soothing in postnatal is period. this food easily digested. and protect the digestive system and provide relief in early recovery
11	Badam wala Doodh	Doodh+ Badam+ Shakar	Boiled Cow Malik+ Almand+ Sugar	Women use this drink in case if loose motion it's also effective in pain relief.
12	Ghutti	Gared Nali (Amaltas) + Paneer+ Sanuf+ Pani	Cassia Fistula+ Cheese+ fennel+ water	All these ingredients put in some water 1-2 days when they mix up, smash them and use it some drops to newborn. its effective to clear the chest and stomach of a baby, in summer sue only its water and in winter whole matter could be used.

Table 6.2: continued

13	Tail, Surma	Sersoon ka Tail + Surma	Mustard oil + Coal Stone (galena)	Mixed the oil and Coal put on the umbilical cord of the baby it protects the infection of the cord

Source: Field Data 2019-2020

In the prenatal period, which began immediately after the pregnancy was confirmed, the women's health was not stable. This included nausea and poor appetite and this time period was called in the local language (Arohay). In additions, various foods were used to make up for vitamin and iron deficiencies. Depending on the nature of the women different remedies were used in the early 2-3 months.

One mother said IDI:

> *"In the early months of pregnancy, I feel very unwell. This phase sometimes lasts for more than six months. Meanwhile, our elderly women give us (Kehwa). This drink is made by boiling mint in water. Sweetness can also add in it according to taste. We drink it time from time in little quantity. That's the way we feel better."*
>
> (Educated woman age 28)

The same things were mentioned by a mother in FGD, For the first two to three months we drink fennel ginger (Kehwa) in addition to the mint. It relieves nausea but it depends on the nature of the woman what she wishes to eat at what time." A mother talked about the use of home remedies during the prenatal period and sometimes they used them against their will. She said:

"I am a school teacher being an educated person; I know well that in the starting months, we have to take good care of our diet to avoid the deficiency of vitamins and irons. But it is a fact that we cannot escape our traditional system. When I get unwell, my mother must give me fennel or mint (Kehwa). I feel much relieved after drinking it."

(An educated school teacher age 28)

Other than that, an aggregative response about fennel water came up. The woman's health swung during the prenatal time period. Usually, pregnant women complain of gas trouble caused by improper diet. The fennel water was used as the best cure for this problem. A mother said in FGD:

"To have fennel water at home is a routine matter especially, in pregnancy period. Sometimes we use a mixture of fennel water and cardamom. It enhances effectiveness. The effect of cardamom is considered as clod usually."

(Educated woman age 26)

During the interview a grandmother talked about home remedies, she said:

"Our certified recipes have been around for years. Our grandmother and mothers told us and now we tell our children. Today is the modern age, but the status of these remedies is still recognized. They were just Lile popups today. The ingredients used in these prescriptions are all very useful and they have no side effects."

(Key Informant Grandmother age 60)

The interviews and FGD revealed a consensus that during the pregnancy, the intake of milk and ghee was increased as a better diet, especially in rural area. As well as home remedies were also considered. Other things came up to the light that these remedies were in common practice in rural areas, where deliveries were held at homes. It was advised to pregnant women, during the last two months of pregnancy, to keep themself busy in-house chores. In addition, (Sarodha) was used once or twice a week till delivery. This facilitated the delivery process. A rural woman told:

"I have four children all were born at home. It was my routine throughout the whole nine month of pregnancy period to use (Sarodha). It is a mixture of milk ghee and Cardamom. It is good for health as well as it prevents from constipation and makes the delivery easy".

(An uneducated woman age 38)

The point also came up in this discussion that regarding prenatal care women used (Panjeer) or almond milk according to their health and financial status. It gave them strength by improving health. The natal care time period consisted of three stages including labor point delivery time and immediately after the delivery. Different home remedies were used during this time period. During the Group discussion, one mother said:

"When labor pain starts in natal time, we used to drink Tarang. It contains desi Ghee clarified butter cardamoms, almonds and (Gurr). If there are false are pains, they disappear after drinking it. If they are labor pains, they become faster. This way the delivery process is completed quickly".

(Rural woman age 43)

Another woman told in this discussion:

"We have very testified home remedy which we used after the delivery time. We have not trust on the allopathic medicine it has side effect. we give a mixture of milk and egg yolk to the mother, immediately after the delivery. It gives quick relief to the woman in post-delivery pains. This Desi Totka we use from generation to generation"

(Rural woman age 39)

One more woman went on to say:

"If we have some complication during the delivery time i.e. Mother have problem to pushing baby and not delivering properly due to labor pain was not increasing. Then, our family has a certified remedy for this. We feed the woman with boiled vermicelli with des ghee. This way increases the labor pain and the delivery is instantaneous."

(Rural woman age 35)

The postnatal period lasted from the time of delivery to forty days later. During this time home remedies for the mother, as well as new born baby was started. Through interviews and FGD held in different rural and urban areas, contrasting responses came up. Women were forbidden from working in the kitchen for forty days. It was commonly practiced in the rural areas and in the urban areas. On the other hand, women took bath after seven or eleven days and started to do housework. Regarding the home remedies, it came into the light about postnatal care that in case of normal delivery, for seven to eleven days, special care was taken of the women's diet. Home remedies were used according to the season. The woman was given soup for two to three days after delivery so that she might be relieved of pains. If there were pains or infection in the abdomen, the (Kahrah), was given to drink. It was the boiled mixture of fennel, cardamom and milk.

One mother shared her experiences:

> *"I eat flour halwa made in desi ghee along with other food, for a week after delivery. It is easily digested and it restores health in no time. I eat bread which is usually baked in the oven. Cumin is also added to it so that the bread is easily digested."*
>
> (Rural woman age 42)

Regarding the child's care, home remedies were also used in the postnatal time period. But there was a difference of opinions between urban and rural areas as newborn baby care was concerned. The response of rural mothers in this regard was that baby should be given (Ghutti) or Gird Nalli after birth so that his abdomen might be cleaned up. That is, if any dirt got into the baby's stomach at birth it would be excreted through the stool in this way. Some mothers said that they used to boil Eucalyptus leaves in milk to clean the baby's stomach. In addition, a rural mother said that after cutting the baby's Umbilical cord, applying Surma or mustard oil on it would heal the wound. Such home remedies were

applied usually in rural areas. On the other hand, urban mothers told that (Ghutti) was no longer a tradition. When a baby was breastfed, his stomach was cleansed. Moreover, they did not agree with coating the Surma and oil on Umbilical cord to heal it up. However, during the discussion, it was agreed that to prevent the baby from gas trouble a (Phaki) was given to the baby which was called Sehat. It was the mixture of dried cheese and cardamom.

In FGD an urban mother shared remedies related to the breast milk:

> *"These remedies are used in our family. If the mother's milk is less, the cumin and desi Ghee are added to the bread and fed it to the mother. This is how breast milk increases. It is a very useful and effective remedies."*
>
> (Educated mother age 36)

6.3.2 Role of Traditional Birth Attendant (TBA) as Herbalist

A Traditional Birth Attendant (TBA) is considered a member of the family in Pakistani society. In the traditional health care-system, a TBA used to play her role as a key stakeholder. She played her role alone as well as in consultation with the elderly women of the families. TBAs are preferred for various reasons including, being readily available in the community, offering individualized care to mothers unlike in the healthcare facility, and that they provide herbal medicine believed to quicken the labor process. TBAs do this by massaging the mother's womb, which enables them to tell the birth date. In addition, the fact that TBAs are pay- in- kind, makes the whole process affordable for men (Lane & Garrod , 2016) (Cheptum et al., 2017).

Because these TBAs had been playing their role for generations. She was like a medical professional at a local level. It was her duty to checkup the woman, to examine her general condition then to check the position of a baby in case of pregnancy etc. On the

contrary, family TBAs began to play their part even before the pregnancy of the women. If two or three years passed since the marriage and pregnancy would not have taken place, they started to perform their duty. Each family initially consulted a TBA. Infertility, irregularity or absence of menstruation to conceive miscarriage or licorice were the diseases handled by the consultation with TBA at a local level. This was done on the advice of a TBA that which type of medical care was needed for a mother. All this was done verbally without using any instrument. She listened intently to the situation and then examined mother's abdomen. After that she would give her advice to solve the problem and whether any health professional is needed.

So TBAs also used both methods for treatment, their herbal treatments along with allopathic medicines. They used some herbal medicines manufactured by local companies. But most of the time, they prepared medicines by themselves with the help of natural herbs which were easily available from local Pansar Stores. These natural herbals were used in powdered form after grinding or as an (Arq) were consumed. According to TBAs, these natural herbs were very effective for reproductive system of women specially to activate it and for ended up infection. A TBA said:

> *"We don't do all this on our own. When we are called by family or husband, so we adopt the treatment according to their wishes. We told them about the required herbal medicines. When the family is busy then we prepare it. We share all the necessary treatment information with the family. After that with their advice, this method of treatment is applied".*
>
> (Key informant)

During the study in addition to the target respondents, TBA, health workers and medical professionals were also met. The majority of the population was also come to light through data that most deliveries were held at homes. With help of TBAs, there was a

detailed discussion, about maternal health and herbal medicines, with four different TBAs belonging to various areas of the target population. As a result, a chart was created, listing those herbal medicines which were used by TBAs locally. That chart is given below.

Table 6.3: Traditional Birth Attendant (TBA) Remedies

S.No	Remedy	Ingredients Indigenous name	Ingredients English name	Usage and effectiveness
PRENATAL CARE				
1	Trang	1.Gulab ke Phool+ Zeera+ Moti Eliachi+ Mesrey+ Desi Ghee+ Pani 2.Kapass ke Phool+ Zeera+ Moti Eliachi+ Shakar+ Pani 3.Chowaray+ Moti Eliachi+ Gerey+ Desi Ghee+ Gur+ Pani	1.Dry or fresh Rose petals+ Cumin + black cardamom+ sugar loaf+ clarified Butter+ water 2. dry or fresh cotton flowers+ cumin+ Black Cardamom +Sugar + water 3.. Dry Dates+ Black Cardamom+ dry coconut +clarified butter+ brown sugar+ water	All three types of drink are useful in infertility, all ingredients are boiled in water to make syrup and then one cup is used first three days of menses. The same action could repeat for three months. It is considered very effective in the removal of infertility

Table 6.3: continued

2	Phaki (Athra)	Sufeed Mussly+ Chandi work+ Choti Eilachi+ SInghra Pouder+ Tabashir+ Suchey Mooti	Chlorophytum borivilianum+ silver Leaf +Green cardamom+ Chestnut +Bans lochan +Pearl	Mix all these herbs and make a powder and use this powder one spoon with glass of water or milk. It is effective in pregnancy sustaining and protecting against Miscarriage
3	Safoof	Pak Supari	PaK Supari	It's a registered herbal medicine. Hamdard company. It is used one tea spoon daily with a cup of milk. It is effective in Vaginal discharge and leucorrhea during pregnancy. this herbal medicine helps to sustain pregnancy
4	Phaki (Likoria)	Kuchey Chawal+ Badam+ Eliachi+Zeera+Shakar+ Butter+ Pani	Uncooked rice + Almonds+ green Cardamom+Cumin+ Brown sugar+ Butter+ Water	soak rice in water for a day then add all herbs and make a powder. one spoon of this powder is mixed with small pieces of butter and used once in the early morning. it is considered very effective in Leucorrhea during pregnancy

Table 6.3: continued

5	Char Araq	Araq Suanf+ Araq Gulab+ AraqMakao+ Araq Gaozban	Fennel water+ Rose water+ Atropine water+ Gaozban Water	Mix all four water and take one cup daily for one-month early in the morning Effective in the irregular menstrual cycle of women
6	Churan	1.Suanf+ Ajwian+ Shisha Numak+ Kala Numak 2.Tabasheer+ Eliachi +Sunaf+ Mesrey	1.Fennel seed+ carom seed+ Sea Salt+ Black Salt Bans lochan+ green cardamom + Fennel seed + sugar Loaf	Grind the herbs of Both type of formulas and make a powder. This is very effective in stomach problems, nausea and vomiting during pregnancy
7	Shurbat	Shurbat Khatooni	Syrup Khatooni	Registered herbal company syrup women used for their Abnormal period
8	Castrol	Doodh + Castrol	Boiled Milk +Castrol	Mixture of both the liquid could be used and effective in constipation
9	Phaki	Akhroot+ Badam+ Char Maghz+ Kamar Kas+ Pesta+ desi Ghee+ Doodh	Walnuts + Almonds+ four Maghz seed+ Butea Frondosa+ Pistachio+ Clarified butter+ Milk	Grind all the herbs and fried in clarified butter. Used this powder with glass of milk once in day. During pregnancy women use for good health. this is effective in the removal of general weakness

Table 6.3: continued

NATAL CARE				
10	Trang	Dar Chine+ Suanf+ Desi Ghee+ Gur	Cinnamon+ Fennel seed+ Clarified Butter+ brown Sugar	This drink Fastens the labor pain
11	Doodh Wali Seviyan	Doodh+ Seviyan+ Shakar+ Eliachi	Milk+ vermicelli+ sugar+ Cardamom	During the delivery time it could be eaten helpful to make Easy delivery
12	Bhap Lina	Pani Ki Bhap	Plan water steam	Delivery time woman get vapor, it helps to open the uterus and make easy delivery
13	Halwa	Ata+ Desi Ghee+ Shakar+Eliachi	Grain Floor+ clarified butter+ brown sugar+ cardamom	Soon after delivery this Halwa helps in Pain relief
POSTNATAL CARE				
14	Dhooni Dena	Hermal +Kola Ki Aag	Wild Rue+ Coal Fire	After delivery if women have some vaginal and urine track infection, the smoke of Wiled rue gives relief and works as antiseptic
15	Phaki	Maghz+ Kamar Kas+ Akhroot+ Badam	Maghz seed+ Butea Frondosa+ walnut+ Almond	After delivery women feel weak this Phaki is Healthy food and improve the health of the women

Table 6.3: continued

16	Ghutti	Hamdard Gutti	Hamdard Ghutti	Soon after the birth of the baby Used some drops of this ghutti Clean the babys stomach
17	Namik wal Pani	Numak + Pani	Salt+ plan water	use this saltish boiled water soon after the birth of baby. Use some drops could help to clear the stomach of the baby
18	Zeera Wali Roti	Gundam Ata+ Zeera+ Desi Ghee	Grain floor+ Cumin + desi ghee	Make a bread in traditional Oven (Tanur), women almost eat this bread for 40 days. This is considerd very digestive and due to the use of cumin in bread it is helpful to increase the breast milk of the mother

Table 6.3: continued

19	Malish	Zetoon or Sursoon ka Tail	Olive oil or Mastered oil	Body Massage of these oils and specially baily and legs massages women get relief in pain

Source: Field Data 2019-2020

The particular chart consisted of all those herbs, their usage and effectiveness which were used by TBAs for infertility, miscarriages, prenatal, natal and post-natal care. A TBA said:

> *"I have a certified effective prescription recipe. If a woman is not getting pregnant, she is given syrup to drink in the first three days of menstruation. That syrup is prepared by boiling the walnuts, dried dates, coconut, cardamom and Gurr, in the water. After drinking it the woman gets conceived. Among three ingredients, not a single one has side effects."*
>
> (Key informant/Dai)

The TBAs usually prepared their prescription according to the demands of the family. Sometimes due to a strong belief system many families were contented with the same presentation. One woman said in an interview:

> *"I got licorice during pregnancy. I was afraid of miscarriage. In our family, it is not considered good to visit the doctor and take allopathic medicines during pregnancy. I consulted my family TBA. She bought me an indigenous medicine from the market. I used that medicine in milk and I was relieved*".
>
> (Urban woman age 29)

During the discussion, TBA told that:

> *"I have a very effective prescription. Women who have frequent miscarriages, if they use it, their diseases of are vanished. I have successfully treated many women with the help of this prescription. A powder is made by mixing a few herbs. It is beneficial to take a spoon full of this powder with milk daily. Women who use it during pregnancy are protected from miscarriages."*
>
> (Key informant)

The role of TBAs was important in past than present. People are opting for other health professional. The untrained TBAs lack of proper health facilities, commoner's preference to solve even critical situations at home, have worsened the whole scenario. Once TBAs were trained but the training program was terminated. One TBA told that:

> *"In this program with the help of pictorial booklets, the TBAs were explained about cleaning procedure, to cutting the umbilical cord and making sure the delivery at home in hygienic environment. The TBAs were told to stay in touch with the hospitals. But this program was terminated after some times."*
>
> (Private hospital midwife)

It was obvious through discussion that there had been at least one benefit from the program and that was coordination began among TBAs, LHVs and different hospitals. Now, if the case became complicated the TBAs would advise the conceded family to go to the nearest government or private hospital. But it was up to the family to decide whether or not to get a doctor's visit for a check-up. After that coordination, maternal health care got better. During the discussion with TBAs, some other important information regarding prenatal care also came to light. In addition, some such herbal prescriptions were shared which were prescribed to the mothers in case of various reasons and diseases during the pregnancy. It included the use of (Choran) in case of nausea or gas, the use of (Phuki) to restore mother's strength after pregnancy and to treat constipation with (Gulqand) or castor oil etc. The details of all these herbal prescriptions are given in the chart. The main role of a TBA in the natal

period was to perform the delivery process. It was a very important and sensitive stage, where TBAs had to use the experience to the fullest. At local level, they were usually supported by family mothers or grandmothers at this stage. In the case of home delivery, the process was held untraditional way by laying the pregnant women upright. One TBA said:

> *"Usually, I handle the process of delivery on a clean sheet made of palm leaves at the local level. The surrounding environment is kept clean. I do this after washing my hands thoroughly with soap."*
>
> (Key informant)

When FGD discussed these issues, the overall response was that a room was usually set aside for home delivery. Its environment was made neat and clean. In rural areas, usually, a mat made of palm leaves was used for this purpose and room temperature was set according to the weather. In winter season, it was kept warm with the help of a heater and fans were arranged in the summer. Additionally, a cloth was placed on that special mat. The baby was cleaned after birth and wrapped in a suitable cloth. Overall, it also turned out that the time of giving birth to a baby was very critical for the woman. So, she was helped out and backed up, emotionally and psychologically by the TBA and the aged women of her family. From labor pains to the birth process, they were constantly helping the TBAs as well as the mother. When a TBA discussed prolonging labor, she said:

> *"If the delivery process takes too long, we continue to change the women's position. We give a mixture to drink mad of cinnamon, fennel Gurr and desi ghee, to speed up the labor pains. This speed up the pain and makes delivery easier."*
>
> (Key informant/Dai)

During the discussion, the TBAs also spoke on the subject that how they took care of the mother's health during the process of delivery. It became clear through interview and discussions that usually in rural areas, TBAs handled the delivery process without gloves

and sterilization. It was said by both TBAs and mothers, that hands were simply washed with soap. In addition, the TBAs did not use any tools, rather they did all the work with their hands. A TBA informed that:

> *"I have spent my whole life in this field. I have never used gloves yet because I cannot feel comfortable to use gloves. I wash my hands only with soap and then use clean towel or piece of cloth. The baby and mother have never had an infection nor any illness problem. If we care about ourself and protect the clean environment we save the mother and baby form infection".*

(Key informant/Dai)

Information from TBAs revealed that they used to do all the work without gloves such as inside examining the birth process, cutting the umbilical cord etc. As already mentioned above that a program was commenced for the training of TBAs. The TBAs were taught in it how to cut and tie up the umbilical cord. Earlier, they used a knife or sharp-edged wooden piece to cut the cord. But they used blades for this purpose now adays. After that it was old. After delivery, the woman was wiped clean with a towel and then shifted from the mat to bed and she was given hot/warm food as a pain reliever, for example, egg yolk in warm milk, hot (Kehwa), tea or boiled egg etc. A mother told IDI:

> *"In our family, the mother's body is thoroughly cleansed after delivery and transferred to bed from the mat. Usually, a plastic sheet is laid on the bed for eleven days and the lower abdomen is covered properly. The white bed sheet is not used. The mother's head is well-wrapped to be safe from the wind. The baby is also warped in cloth after leaning according to the season."*

(Educated rural woman age 33)

Despite its short comings, the role of TBAs has been crucial in our maternal health system. They helped mother's psychologically and emotionally along with providing health care. They are easily available and economically affordable. They also provide postnatal services and visit the mother and baby for eleven or forty days. Mother said:

"*TBA responsibilities include room cleaning after the delivery, burial of placenta and massage is the mother because in this way the unnecessary contents of her stomach come out and this is usually done for seven to eleven days."*

(Educated urban woman age 31)

A TBA discussed the use of herbal medicines during postnatal period. She used to clean the mother's lower abdomen after the process of delivery with mixed hot water. In addition, for a day or two at first the mother would complaint, of a burning sensation in the union. To protect against this urinary tract, Mura's is usually considered an antibiotic which was useful to cure this problem. One TBA said, referring to the newborn that in the early days, they baby was cleaned on the daily basis. (Ghutti) was given immediately after birth. Now adays, the child was given (Hamdard Ghutti) available in the market. In additions fennel cheese or Gird Nalli was added to water to cleanse the baby stomach.

During interviews and FGD, the overall view of mothers regarding postnatal care was that they used to support the role of TBA related to home delivery. In the early days, the mother was very weak and had pain in her body. When TBA massaged her, she felt relieved. One mother said:

"I always prefer delivery at home. First of all, it maintains privacy and secondly, the TBA is very helpful to me and the baby. Because in the early days, I feel very weak and hygiene also needs to be taken care of. The TBA can do this job better than any hospital.

(Educated woman age 26)

Most of the mothers said that TBA continuously used to serve them for seven to eleven days. After eleven days the woman would take a bath and her wounds had healed also. By then the bleeding was under control. Even the TBA could be called in if needed. In case of any problem, she used to make herbal medicine which brought relief. Usually, for

eleven days, the woman was fed with warm hot energizing diet including soup halwa and cumin bread. The use of cumin seed was considered beneficial to increase breast milk to fulfill baby requirement. A mother told researcher during the discussion:

> *"After the baby is born the mother's health deteriorated. The baby also needs milk. For this our family TBA makes a (Phaki), which gives strength to the mother. That (Phaki) contains almonds, walnuts, four nuts and Kamar Kash. It includes almost all dry fruits. It is ground and made into a powder form usually used for one to two months to restore a woman's strength."*
>
> (Rural woman age 35)

During this postnatal period, the TBAs tried to comfort the woman as much as possible and provided relief in her pain so that her health might be restored and she could restart her routine work. During the interview a village woman said:

> *"I slept alone at night during the pregnancy in the open yard of my house. My husband was not at home for some work. Then I saw something moving like a shadow which made me scared and I suffered mental stress for a long time which led to the loss of my baby. So, I asked (Pir Sahib) for prayers and took the amulet and tied it around my neck which ended my fear."*
>
> (Uneducated woman age 43)

In postnatal time, strict measures were taken regarding the movement of women in a particular area. There was a general response in the interview and FGD that a woman was not allowed to go out of the house for forty days after giving birth, which was called (Chila) in the local language. There were two different opinions about this. Some women said that it lasted for 7 to 11 days. After 11 days the woman could socially mobilize. Others said that agreed on forty days. Those who supported eleven-days said that after eleven-days the woman would take a bath and be cleansed, so she could meet other people. There were no restrictions on her movement. But the other group believed that regarding her postnatal care, the woman became completely healed up after forty days. The woman used to bleed for 40

days for which she was not considered cleansed. However, it was agreed that the woman could neither touch the kitchen and cook inside her house for forty days nor she go to the cooking place. But some educated mothers disagreed with them, the people who lived in a nuclear family could not have attendants for more than two weeks. In the end all the mothers had to take care of themselves, house chores, and cooking.

TBA refers to traditional birth attendants who have significant place in traditional health system. They have been the main human resource for women throughout the history as they provide the social and cultural support during pregnancy with the provision of tasks including health knowledge, care management and home visits at door-step, referrals and last but not least outreach and case findings. People feel satisfied with TBAs because of their efforts which range from assisting women at the time of delivery, provision of guidance on nutrition during pregnancy and lactation, counseling women throughout the pregnancy till childbirth, guiding their natural family planning strategies, to providing psychological support to women (Adatara et al., 2018). So, it is important to discuss their role in the provision of maternal health facilities.

The issue of maternal illness was discussed with two local TBAs and two midwife who was basically a TBA she studied up to primary classes. She was trained in maternal health for a few weeks by a government institute. Sometimes she used to refer the cases to LHVs or lady doctors in the area and received her share. This linkage between TBAs and health facility providers not only reduces maternal risks (Adatara et al., 2018) but at the same time it encourages a woman to utilize and function the essential obstetric care provided by the health facility (Bergström & Goodburn, 2001). The researcher met a grandmother in Jampur city who was experienced enough. She knew a lot about home remedies and had the

experience to handling the normal delivery to some extent. During the discussion a TBA told, “In this area, mothers do not eat properly balanced diet because of poverty. Besides this, they suffer many biological problems for which they cannot conceive. In addition, women also have leucorrhea. Sometimes, they have bleeding during the first three months of pregnancy. Pregnant women also have problem of constipation and hemorrhoids the mothers have become weakened due to too much bleeding after delivery giving birth to the baby. We have solutions to all these problems such as miscarriages, leucorrhea, piles and bleeding during pregnancy.” Both TBAs and midwives explained, “We use allopathic and herbal medicines along with home remedies. Now a days, the pregnant women do not wait too long so we use injections and drips. In case of non–pregnancy “Tarang” is fed which is definitely helpful”.

Additionally, a powdered medicine (Phaki), (Sharbat-e-Khatooni) of Hamdard and Qarshi Dawa Khana and Pak Supari are very useful for leucorrhea. Our work has been going on for generations. These allopathic medicines are now widely available. These drugs have also harmful effects. The injections and drips are used for quick delivery.” When the researcher asked,” Why do you do so much DNCs? The TBAs and LHVs avoided further discussion on this subject. They replied briefly:

> “*We do not abort immorally if they want to have an abortion at their husband’s will, we have a cure. We give two pills for oral intake and two more to put in mothers’ uterus which absorbs automatically and DNC held. To this day, we have never killed any mother.”*
>
> (Key informant/Dai)

While talking about traditional practices of maternal care, evidence describes that massage is deep rooted in TBA culture and very often practiced from prenatal period to the time of delivery (Agus et al., 2012; Gogoi, 2021). Talking to the midwives about massage,

they said, the position of the baby in the mothers' womb is checked through massage in the last month of pregnancy. Massage straightens the baby's position. The leg massage of the mother reduced the pain, after giving birth to the child. It depends on the woman whether she likes this method or not. To reduce and eliminate pain, cumin seed is the best thing. If a woman drinks it in the milk or eats in Bread (Roti) her pains subside. The cumin seed is also useful if breast milk is not enough for babies to drink. It is emphasized by health concerning organizations and research that training and linkages of TBAs with formal health center is very important and need of the time because it not only increases the abilities and knowledge of TBAs but also enables them to get greater community acceptance by consumer satisfaction (that is the result of greater skills and knowledge) as well as helps in the provision of broader health-care facilities that may decrease maternal complications and mortality ratio (Islam & Malik, 2001; Fatmi et al., 2005; Jokhio et al., 2005; Sibley & Sipe, 2006). About the training of TBAs doctor told "They participated in a three days training program managed and organized by the government. The type of former midwives is no longer available. We took better care of mother and child and our cleanliness as well. A blade or a pair of scissors is used to cut down the umbilical cord of newborns. LHVs also use our tips. We are linked with LHVs and lady doctors of private clinics." The LHV of BHU endorsed the lady doctor and said that most of the problems were the same as mentioned by the lady doctor. According to her, the "MNCH Program by government has produced awareness in this area. Now local women visit us at least twice or thrice times. We check their weight and blood pressure. Health workers inject them with vaccine. We use sterilized instruments in hospitals and use gloves during the process of delivery that is not done by TBAs." She further told, "Mothers get checked up from hospitals but prefer to give birth at homes with help of TBAs because of strong culture and traditions. It can be said that

TBAs remain the most acceptable resource especially in rural settings because of their full-time availability and accessibility (Islam & Malik, 2001). Spending their entire life in specific community and offering their services have made people trust and listen to them in addition to their seniority level based on their entire life serving experience (Fatmi et al.,2005).

When talked to a grandmother, she told:

> "*We use different simple home remedies that give relief to mothers in ordinary illnesses. For example, the use of (Kehwa) is common to cure nausea and vomiting. A mixture of cumin seed, mint leaves and sugar also works effectively."*
>
> (Key informant)

It is advised to mothers to take precautionary measures during the period of pregnancy. For example, to avoid sleeping one side and walking slowly, massage, after giving birth to the baby and intake of (Kehwa) and soup etc. The religious minded people act according to them believes such as recitation of Quran, consulting peer sahib and to beg at tombs etc.

6.3.3 Role of Spiritual/Religious Healer

In the local health care system, spiritual/Religious Healers played a significant role. Actually, this role was not that of a practitioner, but of a healer. It was clear from the data obtained that this role was closely linked to the local belief system. The nature of this character was dissimilar from that of TBA, but a mentor. The main part on spiritual healing, was the shrine than the characters of Peer sahib or (Pirni) who used to cure human sufferings by healing up through some rituals and sacrifices. Those rituals were performed in form of Mannat or amulet locally. Many studies found that the religious beliefs and practice of family

influence care-seeking. Almost similar findings were found from a study that showed women sought seek faith-based medication from 'local religious leaders 'along with formal Healthcare services (Qureshi et al., 2016).

A woman used to practice the 'Mannat' for safe pregnancy, easy delivery and a healthy baby. For this purpose, she with her husband or family used to go to their living peer or to visit a shrine and expressed their devotion in different ways, according to their belief. This will be explained later how a woman used to follow her Peer or (Pirni) for the sake of infertility, and the maternal care. The other major role was the religious healer. Usually, it was a local old person or the Imam of a mosque. People also dealt with them according to their belief system. These people did not directly involve with health care but they were running their own system parallel to the existing health systems. The locals considered their role for superior to traditional health system and institutional health care. This type of treatment was called spiritual healing. Talking about this system in an interview, one mother said:

> *"Whether the medicine is indigenous/traditional or allopathic, it is a temporary treatment. The cure given by (Pir Sahib) or through the shrine is spiritual therapy. Its effect is long lasting and there is also a reward. So, we avail spiritual healing as well as worldly treatment. It is indeed a blessing for us and our babies",*
>
> (Rural Woman age 39)

According to the FGD and interviews, the treatment that women used for maternal health and with the help of things they used to do their spiritual healing, a chart of those particular details had been compiled with the description of their effectiveness. It is given as follows.

Table 6.4: Spiritual and Religious Remedies

S. No	Remedy	Ingredients indigenous name	Ingredients English name	Usage and effective ness
PRENATAL CARE				
1	Mannat	Darbar per Mannat (Rakh)	Seeking for mercy or wish on the shrine	In Mannat role of shrine is important, in case of infertility, normal pregnancy and for healthy child and sometime baby boy. Women visit the shrine and wish that their desires, when desire come true, they make their promise to God
2	Dum Kerna	1. Jism per Dum kerna 2. Khajoor Dum Kerna 3. Pani Dum Kerna 4. Shakar Dam Kerna 5. Namak Dum Kerna	1. Below or breaths hard on the body 2. Blow on Dates 3. Blow on water 4. Blow on Sugar 5. Blow on salt	Religious practitioner read Some Quranic verse and blew on these items as per direction of the spiritual and religious healer women eat and drink in different times. All these used for fertility, safe pregnancy. Belief is its effectiveness.

Table 6.4: continued

3		Khak Ya Matti	1. Khak Madina 2. Khak Kerbala 3. Darbar ki Matti	1.Hard piece of dust of Madina 2.Hard piece of dust of Kerbala 3..Hard piece of dust of shrine	Women use this Dust (khak) with water for a safe pregnancy. They beliefs that Khak is from a pious place, it has an effect
4		Tail ke Malish	Dia ka Tail	Lamp blown with mastered oil	On shrine peoples blew a lamp with mastered oil, pregnant women ues this oil on her body and massage her baily for safe delivery
5		Pak Pani	Chashma ka Pani	Water Pound on shrine	One of the shrines is of Baba Freed in area where water pond for ablution, peoples put money and women drink water of this pond their belief is this water is “Shifa” its use in pregnancy is useful.

Table 6.4: continued

	NATAL CARE				
6		Tawize	Dhaga + kaghz per	Amulet in kind of (Threed + piece of paper)	Spiritual practitioner blew on thread or put some verses or numeric on piece of paper during the delivery time women put it on her Thing or waist it helpful in easy delivery
7		Booti	Mariyam Booti	Mariyam Flower	Reconstitute in water and taken internally for colds. Is considered in labor pain and child-birth. This is found in Saudi Arabia
	POSTNATAL CARE				
8		Pak Pani	Aab-E- Zum Zum	Maka water	Muslim belief is, Maka water is a “Shifa” women and new born drink this water for safety and healthiness

Table 6.4: continued

9	Mannat Dina	Rakh Puri Kerna	Performance of Mannat	During and after the postnatal care women perform their Mannat, in kind of food, animal sacrifice, Money, chadar on shrine etc
10	Shahad	Makhi	Honey	Muslim belief is Honey is Shifa, women and new born use Honey.in postnatal care women use this in different kind in boil water and in green tea. People give a Ghutti of Honey to new born

Source: Field Data 2019-2020

During another FGD and interviews, one more aggregative response came into knowledge The people, who had a strong belief in (Pirs/Pirnis) and the role of shrines, are told that human were sinful creatures. When a woman could not conceive, had a miscarriage after pregnancy or had abnormal babies, it was thought that God was angry. That is why they used to visit the shrine of their Peer for Mannat and requested the for dua. Because they thought that their Peers were true followers of Allah so they were able to solve their problems. If the wishes of these people were fulfilled, they would come to the shrine and completed their Mannat. In FGD, a women shared her experience:

> *"I was not conceiving baby. I went to the shrine of my Peer (Hamza Sultan) and practiced a Mannat there. I prayed that if I had children, I would sacrifice an animal.*

In addition, I kept massaging my body with the oil from a (Dia) burning at the shrine. I brought soil from the shrine and mixed it with drinking water, then used it. Peers are good servants of God and everything in the shrine is holy. I went there until my baby was born. I used to go there with the permission of my husband and family. When God gave me children, I went there to complete my Mannat".

(Uneducated urban woman age 47)

Taking this further, another woman said in IDI:

"My Pir Sahib is from Kot Mithan. I used to get pregnant and had an abortion after two to three months. I sought treatment from doctors but to no avail. After that I went to Baba Farid's shrine, prayed for myself and drank water from a spring there. I brought that water with me and drank it at home. The lamp (Dia) was also lit every Thursday. In this way Allah did mercy and I became pregnant. There was healing in the spring water of shrine. People also threw offerings in it".

(Rural woman Age 39)

It was revealed from data, as for as prenatal care was concerned that the majority of women used to go to the shrine for Mannat to cure their infertility. Moreover, spiritual practices included, for the purpose to heal the problems of abortions, miscarriages abnormalities of babies and to prefer the son as a child. People used to treat these diseases according to their beliefs by using (Khak-e-Madina, Khak-e-Karbala) or dust of the shrine, Dua of pir (Dum Wala Pani), oil from lamp of shrine, tie a thread or amulet, given by Peer, around their waist etc. The second circle consisted of people who did not visit shrines. They had belief that they used (Dum Wala Pani) during pregnancy time. It was requested to any pious elder man or to imam masjid sahib to do Dum on salt, sugar or water and then given to the pregnant woman. Some women said that they used to recite Surah Yasin and Surah Rehman or Surah Yousaf, then blew on the drinking water. By taking this (Dum Wala Pani), they were healed. A consensus had emerged that the whole process was aimed at keeping the baby spiritually safe and facilitating delivery. The spiritual/religious healer used to play key role in natal care as in prenatal. During the natal period, mother was not in the direct

contact with spiritualists. In spite of that, her husband or any other member of the family contacted with spiritual/religious healer and requested for amulets, (Dum Waal Pani) or dua/prayer to handle the hardships of delivery. A mother said FGD,

> *"My Bibi (Pirni) is Syed Zadi. She is a pious lady indeed. She gives Dum Wala Pani to the mother for delivery time. In addition, she has a flower (Marriyam Booti) brought from Saudi Arabia. At the time of delivery, that flower is soaked in water. As it increases in size by sucking the water, the process of delivery becomes easy. This process is performed by different people in the locality".*
>
> *(*Rural woman age 41)

One more point became clear through discussion that peers also explained the specific method and precautions for tying the amulets. In addition, special arrangements were made for drinking Dum Wala Pani and prayers. The elders of the house were told (Wazifah) for the time of delivery. The role of TBAs and grandmothers was very important at this stage, because they were overseeing the whole process and providing their services. Usually, they had to follow the methods advised by Peers.

Opinions were also expressed regarding prolonged delivery. Some women said that Mannat was also performed on this occasion. Money was given to the poor in the form of Sadqah/charity or an animal was sacrificed. In this way the difficulty was removed. Before slaughtering the animal for (Sadqah), Pir's hand was touched. It was obvious from this strong belief system that people preferred spiritual aspect even in such a critical situation. However, in case of complications, medical facilities were adopted so that the lives of mother and child could be protected. Nevertheless, it was clear that the belief system was a major obstacle to the pregnancy delay. Medical and traditional remedies for maternal and child health were adopted during the postnatal period but spiritual character encouraged families to think that this was the right time to offer Mannat. Those rituals were performed in the form of intaking

Dum Wala Pani, Dum Wali Shakkar mixed in halwa and tying amulet around the mother's neck. All of these things were repeated exactly in the same way as in prenatal and natal periods.

During this postnatal period, the first offering was sent to spiritual healer (Bibi Sahiba, Pir Sahib or Molvi Sahib) in the form of money or sweets. It was considered a symbol of gratitude for performing their spiritual role. When the mother became able to continue her routine work after eleven or forty days, the families visited the shrine to complete their Mannat. It might be in the form of Deig or the sacrifice of an animal. It was thought that if Mannat was not performed in time, it could be harmful for mother and child. During the interview, a mother shared her experience:

> *"I had no son among the children. I aimed for a Mannat at the shrine of Hamza Sultan that it I had a son, I would come here and sacrifice an animal or would donate a chadar. God heard my prayer and accepted my Mannat. Forty days later, my husband was too late to fulfill this Mannat due to some business. My son cried a lot in those days. I asked my husband to offer the Mannat without more delay. Then we offered it at the shrine so that Pee Sahib might not be angry".*
>
> (Uneducated rural woman age 36)

All discussions during the interviews and FGD revealed that whether it was an institutional health care system or traditional, the spiritual/religious system had a dominant role, rather it was considered far superior locally. The thought was that their system was a source of peace for the soul. That was the reason, people always preferred the advice of their Peer in spite of critical situations during prenatal, natal and postnatal periods. During the interview a village woman said:

> *"I slept alone at night during the pregnancy in the open yard of my house. My husband was not at home for some work. Then I saw something moving like a shadow, which made me scared and I suffered mental stress for a long time which*

led to the loss of my baby. So, I asked Pir Sahib for prayers and took the amulet and tied it around my neck which ended my fear."

(Rural woman age 36)

In the end all mothers take care of themselves do, house chores, and cooking. Another strong belief exists in the community. It was revealed through discussion that a pregnant woman should not go to some one's death even in case of the demise of a close relative. Because it was said that the shadow of the dead body on a pregnant woman would stop the growth of the child. It was said locally that the baby would dry up in the mother's womb. Regarding this belief, there was a difference of opinion in the FGD that if the woman who was pregnant and one of her close relatives had died, she should have gone and sat away from the dead body so that she could be protected from the effect of "Sayya." The treatment for that effect was also told that if a woman took a thread from the shroud of the dead and tied it in her ear then the effects would vanish.

6.4 Critical Analysis/ Commentary

In regions of the world where the use of therapeutic plants is common, the majority of research is carried out on the use of herbs, botanical composition, ethno-medical and in specific case ehtno-gynaecological use of herbs (Rahman, 2014) but in this work, indigenous remedies means established customary and traditional ways of curing a health issue including the medical application of traditional knowledge, skills and practices that evolved over many centuries within the folk beliefs of communities, mainly in indigenous peoples. As the study is concerned with women maternal health and its relevant practices, so the focus was on the specific health caring practices, remedies, knowledge related to the maternal health of women. The work has association with (Ahmed, Leghari, Shahid, & Ahmad, 2021; Mudonhi1 & Nunu, 2021) who reported that culture has an impact on women's

maternal health too. Cultural beliefs and practices that include self-medicine, utilization of home cures and counseling with traditional and spiritual healers.

The results of this study indicated that different variables related to customary practices affected the utilization of maternal health care. Compared to their peers, mothers who keep to customary practices were less inclined to utilize maternal health care. Our results are consistent with that reporting consciousness toward pregnancy, spousal contribution, inefficient healthcare facility and gaps in promotion of healthcare programs (Taylor et al., 2017) unconstrained pregnancies, religion and social factors lead to the low use of antenatal consideration benefits in low pay settings. Additionally, a few examinations show that guardians are hesitant to look for psychological wellness issues (Mahejabin et al., 2015).

It was observed that the main contributors of women health-seeking practices are family, TBAs and spiritual healers. People rely on family and TBAs as they are considered most reliable and loyal. But health care needs something more than only loyalty and reliability. Family and TBA both have direct role in the use of indigenous remedies as both directly involve in the process on the behalf of self and other women's experiences. This situation may become alarming for the health of pregnant women as these experiences with absence of enough knowledge about herbal and other indigenous remedies may harm their health. One ingredient or recipe which relieves the problem of a women may not necessarily be good for other one as each female has variety of biological nature, problem, deficiencies and health status. So, it should be taken under consideration before using a remedy.

To get escape from threatening situation, one must consult with one's specialist having proper information about herbs as well as its effect on health-related issues. TBAs,

which were the only source of health providing practices also use the remedies without any kind of laboratory test and knowledge of composition and nutrients of herbs/ingredients used in remedies. Similarly, they took examination by their hands only which may not provide good understanding in case of any complexity. Less understanding about health issues in contrast of improper remedy may risk the health of mother as well as baby. For example, vomiting and absence of menstruation are considered sign of pregnancy, but it may be due to any other problem. Similarly, Kahwa and some other remedies may harm women. The study supports that most renowned home-grown item during pregnancy is green tea yet its overconsumption might have brought about high caffeine content, intrusion of tea polyphenols with iron absorption and fetal ductus arteriosus constriction when used in late pregnancy (Belica, Ćetković, Milić, & Milošević, 2017).

The health system has to face problems because of the TBA density. The Ministry of Health is working to provide better alternates in the form of LHVs, LHWs and midwives, but the community's preferences maintain TBAs available to the public. The non-qualified TBA’s dearth of legitimate health facility, community's preferences to address even critical situation at home, have deteriorated the entire situation. To overcome the scenario, TBAs training program was launched but soon finished. When the case became convoluted the TBAs would encourage the yielded family to go the closest government or confidential emergency clinic. However, it ultimately depended on the family to choose whether or not to get a specialist's visit for an examination. Our findings align with those presented by a study in Indonesia (Aryastami & Mubasyiroh, 2021). TBAs assist the mother throughout the mother's birth in order to counsel, encourage and aid the mother. In addition, the TBA offers the mother more comprehensive treatments such as body massages throughout pregnancy

and newborn ceremonials following birth. A study conducted by Gogoi (2021) support our result by providing tackling techniques of dealing resuscitation problem practiced by TBAs.

It was observed that people rely on spiritual healers for many kinds of maternal health issues, but these healers have no direct influence as compared to family and TBAs. In fact, family and TBAs are the influencing factors of consulting with these healers. Because of having strong belief on religious activities, people visit religious leaders, folk, spiritual healers and seek mental satisfaction. Results indicate that different type of religious healing practices involve holy water, verses recitation, amulet, Mannat etc. Findings are associated with a study (Mudonhi, Nunu, Sibanda, & Khumalo, 2021) reported that mythological beliefs of people give them satisfaction and peace so they use religious practices like holy water for the completion of same pregnancy. Religious sect differences influence these types of activities. However, being a Muslim, it is believed that there are many verses known as "verses of cure" as also reported by (Anwar, Green, Norris, & Bukhari, 2015) that help in treatment of different illness and give relief to the victim. This is typically signifying cultural influence on reproduction which may interact with biological or genetic conditions of the woman and negatively impact her health. The neglect of medical services by some women was not necessarily for the sake of their health, but for avoiding misfortunes or curses in their babies or future generation from the spiritual world. This concurs with previous findings that Pakistani women submit to traditional beliefs and practices as an act of respect for their culture.

6.5 Conclusion

Established routine of using herbal medicine without getting them tested and following elder women's advices without questioning, are major characteristics of commonly observed attitudes though difference of opinion emerged between rural and urban areas regarding child and newborn care. On the other hand, the local belief in these drugs (herbal medicines) is very strong people think that these herbal medicines or home remedies have been transferred from generation to generation as a traditional pathway so they are authentic without any test from the laboratory.

The difference in the prevalence of HM use can be explained by several factors such as culture, socio-demographic factors, and use of health care services. Because of socio-Cultural traditions, herbal medicine is commonly used and thought to be free of any side effects. Other aspect of women health is also ignored for the same reasons. Since pregnant women has easy access to the Traditional Birth Attendant, so she became a family member in Pakistani society. She used both herbal and allopathic medicines as per the demand of the family. She also played a crucial role in postnatal care where a mother of newborn baby needed a psychological as well as emotional support.

In the local health care system, spiritual/Religious Healers play a significant role. Actually, this role is not that of a practitioner, but of a healer. This role is closely linked to the local belief system. In this background use of amulet or performing of Mannat appeared to be a visible trend among the women whereas their proper diet or treatment to biological problems was almost nonexistent.

CHAPTER 7

COMMUNITY EXPERIENCES AND PERCEPTION TOWARDS PREVAILING HEALTH CARE SERVICES

7.1 Introduction

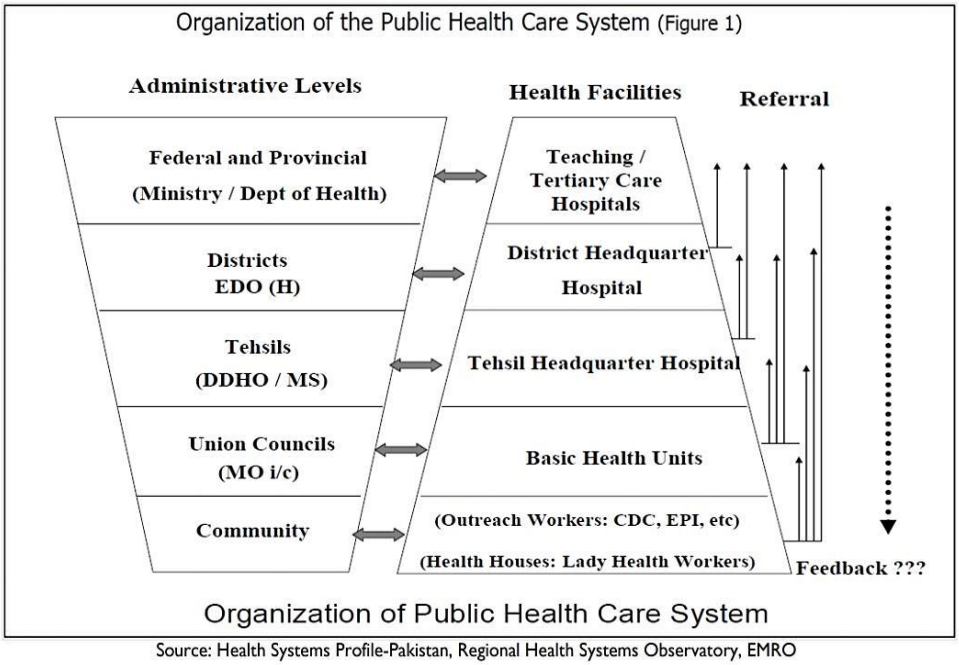
This chapter is based on collected primary and secondary information about existing health care system in Pakistan and the perception of the community regarding Maternal Health Services in Jampur. All collected information of this chapter is gained from the key informant and participant from the study area. In this chapter, the firstly task was to get the information available maternal health facilities in selected study area and the second one to uncover what extent of access women have to these locally available facilities. The third one is to see the perception of community related to reproductive health provided by the government in study area. It is very important to know about these research questions to get acquainted with the maternal health care system of the government sector which covers the aspects, mechanism of their services, the role of services providers and the perceptions of health services. Because in any country, providing basic health care services to its citizens is one of the basic duties of the government. According to the constitution of Pakistan, the provincial government is mainly responsible for the health of the population living in country except in the federally administered territories (Government of Pakistan, 2013) [GOP] The provincial governments are responsible for implementing targets defined in the National Health Policy while the Ministry of Health (MoH) at Federal level is responsible for developing national policies. The district health departments are responsible for district health planning, budgeting, quality assurance and provision of delivering healthcare services based on their local needs. Health systems in Pakistan consist of private and public services. The private sector caters to the health needs of almost 70% of the population of the country,

principally a fee- for- service system and includes a broad range of health providers from trained allopathic physicians (Pakistan Demographic and Health Survey, 2012) [PDHS].

7.2 Mechanism of Health System in Pakistan

The Public Health delivery system of Pakistan comprises three distinct levels of health care delivery system and meanwhile it consists of various parallel national health programs. The Primary Health Care (PHC) units consist of Basic Health Units (BHUs) which cover around 10,000 people and large Rural Health Centers (RHCs) cover around 30000-45000 people (Hardee & Leahy, 2008). At the Tehsil Headquarters Hospitals (THQs) secondary care is provided which includes acute, ambulatory and inpatient care while at the District Headquarters Hospitals (DHQs) secondary and tertiary health care facilities are made available to the district (District Health Authority, 2017) [DHA]. The third one in the major cities of Pakistan around 22 tertiary healthcare facilities are working presently and that are also serving as teaching institutions. Maternal and Child Health Centers (MCHCs) are also an important part of the health systems and together with BHUs and RHCs provides essential obstetric care through lady health workers by way of the community outreach program (National Assembly of Pakistan, 2018) [NAP].

The services for Punjab are provided through a well-designed infrastructure. Health department across the province is divided into 2,461 Basic Health Unites (BHUs), 293 Rural Health Centers (RHCs), 88 Tehsil Headquarter Hospitals (THQs),34 District Headquarter Hospitals (DHQs) and 23 Teaching/ tertiary care Hospitals. Following organizational chart portrays the clear picture of public health care system in Punjab Pakistan. Administrative hierarchy of the Punjab health department also shows the well-organized and planned government and health system and infrastructure.



Source: Health Systems Profile-Pakistan, Regional Health Systems Observatory, EMRO

Figure 7.1: Organization of Public Health Care System

Administrative Organogram Punjab

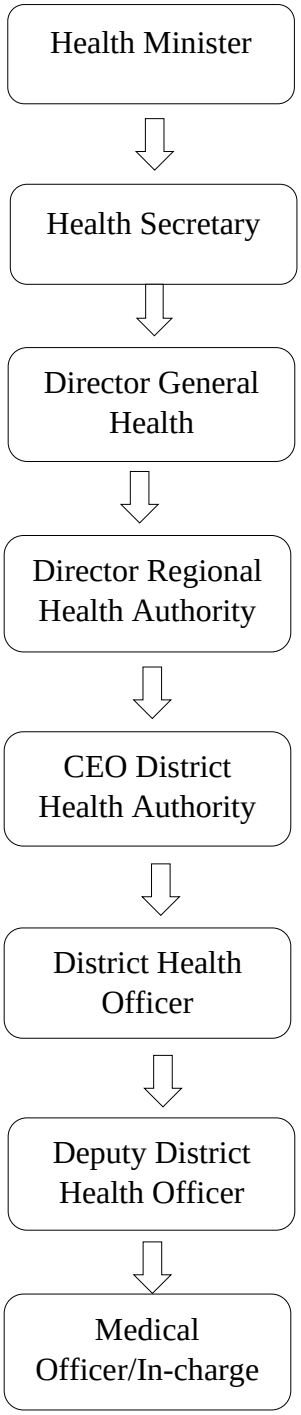


Figure 7.2: Administrative Organogram Punjab

Source: Health Dept Punjab

7.3 Integrated Reproductive Maternal Newborn, Child Health and Nutrition (IRMNCH&N) Programs Important Features

The unified reproductive, maternal and newborn health program aims to improve maternal health and lower of mortality rates by making women aware of issues linked with the reproductive health and childcare. It reveals the governments firm dedication to achieve health-related goals in a faster way in Punjab (GOP, 2013).

The program also supports ongoing initiative to address the malnutrition and increases accessibility to MNCH services. The program focuses on issues linked with health and nutritional goals set in the economic growth framework including the upgrading and administration of primary, secondary and tertiary health care and financial reforms, improvements linked with governance, with a focus on achieving quality standard, necessary services package, Support efficacy, service structure, rang and ability to achieve affordable medicine (Requejo et al., 2015).

This study also reveals both types of health facilities in selected study area such as Institutional health services along with traditional medication. In other words, a dual faith system was practiced in the community Firstly, women gaining the clinical services such as ultrasound, TT vaccine, tablets of iron with vitamin. Secondly, they are using the herbal medicines as we as home remedies.

For supporting secondary data, the researcher visits in government hospitals including BHUs, RHCs and arranged the meetings with District management, MNCH program coordinator, medical officers, lady health supervisors, workers LHVs and Midwives as well as meet with private hospitals doctors. There was a discussion with doctors who were serving in government to take their opinions about discharging duties and how

they are providing the maternal health services to the mother. Moreover, discussion was made on the socio-cultural environment and the health seeking behavior of the client. In addition, response of Lady Health Workers, LHVs and Midwifes, also be obtained concerning with the health-related problems that they are facing in field. The other important aspect related to research questions was also discussed that is related to women health seeking behavior especially related to the pregnancy because at the grass rout level they were disseminating the MNCH information's and services for community.

The MNCH District coordinator Rajanpur explained the MNCH program and services at the broader level and the service imparted at the district level. He told that two types of services were provided by the government under this umbrella; one is Community Based Services and second was a Facility Based Services. In service that is under the community based, role of IRMNCH Program is to provide of health facilities. The MNCH and nutrition program offers community-based services through the development of lady Health Workers and Community Midwifes.

The National Program for Family Planning and Primary Health Care was started throughout the country in 1994 aiming to provide healthcare services to rural and urban slum areas through the appointment of 44,700 lady health worker and 1800 lady health supervisor, with 70% coverage in the region and greater coverage in rural areas (Omer, 2019). The services by LHWs include visiting household, counseling on health-related issues of both mothers and infants, reproductive health, immunization and family planning. The LHWs are overseen by LHS. LHWs also guide pregnant mothers about early identification of danger signs and birth preparedness, they also take care of children that include immunization,

vaccination, screening. They play very crucial roles in specific campaigns to increase awareness about breast feeding nutrition etc. (Perry et al., 2013).

District coordinator MNCH Rajanpur explain about the role of Lady heath worker in the area he said:

> *An (MNCH) has been running in the district for the last ten years. Its main focus is on maternal and child health. Lady health workers go from door to door informing people about maternal health and vaccinations. There is no male involvement in this program. If this point is focused and they are educated through this program, then local behavior regarding the maternal health can be changed. Beside this, in this way, the gender gap existing in the society may be reduced. If this is done, rapid and effective better result can be emerged in society regarding maternal health*".
>
> (Health key informant)

Lady health supervisor further explain the role of health worker she said:

> *"MNCH Program of government has produced awareness in this area. Now local women visit us at least two or three times. We check their weight and blood pressure. Health workers inject them Its vaccine. We use sterilize instruments in hospitals and use the gloves during the process of delivery that is not done by TBAs."*
>
> (LHS, key informant)

The community Midwifes program was launched in 2007 under the National MNCH Program. It aimed to ensure availability of trained birth attendants to the mothers from rural areas. Young matriculate girls are selected and then trained for two years and appointed at their residential areas. Services provided by them include conduction of deliveries at the midwifery homes by community CMWs, antenatal care and family planning. Every CMW covers a population of 5,000to 10,000 individuals (Mubeen et al., 2019).

Lady health visitor elaborate the role and work of the trained midwife at the government RHCs and BHUs, she told that:

"In the government sector midwives are fully trained. They took better care of mother and child and our cleanliness as well. A blade or a pair of scissors is used to cut down the umbilical cord of new born. LHVs also support them. We are linked with lady doctors if have some emergency we refer the client to them at Tehsil and district hospital.

(LHV key informant)

BHU Lady doctor told the cultural constraint which they have faced during their duties:

"Women living in local villages are banned by the local customs. Their work load is too heavy. They work all day in the field with pregnancy. Due to the frequent visit of our health worker, they hardly come to the hospital check-ups, once or twice in pregnancy even though the delivery at the hospital is free. On the other hand, their husband does not cooperate with them."

(Health key informant)

The facility-based services are available at all Basic Health Units, (BHUs) Rural Health Centers, (RHCs) Tehsil Head Quarter Hospitals (THQs) and District Head Quarter Hospitals (DHQs). The DHQs provide services related to immunization and nutrition whole week at 24 hours (24/7) i.e., Basic EmONC Services. This program was initiated 2010 with aimed to offer round the clock basic EmONC in seven flood affected districts. In the beginning it was finalized by UNICEF and UNFPA for 90 health facilities (Abou Zahr, 2007). Then funded 150 BHUs for twenty-four-hour services. These number increased to 550 in 2015 and now 803 BHUs from all districts are offering 24-hour services. The services provided by these BHUs include antenatal care general examination, obstetric examination, basic diagnostic tests and delivery services. They also provide services including newborn care, helping baby's breath, cord-care by using chlorhexidine, breast feeding issues, pneumonia, diarrhea treatment, skin care and child immunization according to the EPI schedule.

The Nutation related program also started for community, this program was initiated in 2010 in the seven flood affected districts in 2010 and financed by UNICEF and WHO. Since malnutrition proved to be a major issue in Pakistan, to expand the scope of this service to all BHUs, DHQs and teaching hospitals. The range of services includes supply of treatment services by LHWs and LHVs using medicines such as iron, folic acid tablet, multi-micronutrient sachets and zinc for diarrhea cases (WHO, 2017).

The lady doctor of BHU Kot Tahir informed us in detail about MNCH Program immunization and nutrition she told that:

> *"Ten years ago, a project of model district had started launched in Rajanpur district related to mother child health. Whereby different BHUs were converted into models. Those model BHUs included Kot Tahir. A lady doctor informed about medication, we have folic acid pills, multi vitamins and TT vaccine for pregnant mothers. There is a complete program of healthcare. We go from door to door finding mothers diet charts but due to poverty they do not follow it."*
>
> (BHU Lady doctor)

Overall, the male and female doctors of government said:

> *"The biggest challenges we have to face is our limited resources. We have limited stock of medicines so we have to prescribe most medicines. Another challenge is the role played by TBAs, Quacks and peer culture. The TBAs has formed a front against us. In the beginning, the health workers were not allowed to enter in the homes by local's people in the area."*
>
> **(**Health key informant)

The project of rural ambulance service1034 was launched on 22nd May, 2017. Since LHWs play the role of a strong connection between the people and health facilities, so this program aimed to strengthen the linkage. It also aimed to decrease the risk of delays in case of emergencies. Now 220 ambulances are available for it (Omer et al., 2021). The program gives pick and drop services to pregnant women and complicated pneumonia / diarrhea cases

from their homes to nearest functional basic EmONE. A total number of 477 ambulances would be on road by 2018, call response centers (helpline 1034) were established to monitor the movement of ambulances. The ambulances service was immediate provided on the call by LHWs and LHVs to CRCs. The receiver locates the address of the patient and informs the nearest available ambulance. The automated SMS is created and sent to driver describing all the necessary details an automated SMS that include name and contact number of the driver -15 seconds are set to be call response time whereas the average time for reaching the patient is 45 minutes (Farooq, 2007).

District coordinator MNCH explained about the free ambulance service available in district and fear of the community, he said:

> *"Under this program, LHV stays on duty in hospitals for 24 hours. When the delivery time approaches, the ambulance picks up the pregnant mother on just a phone call and drops back at home for free of cost but peoples don't avail their service of ambulance. They take ambulance as a symbol of fear. They use to think only the dead bodies are brought in the ambulance."*
>
> (Health key informant)

Organogram of the district MNCH program

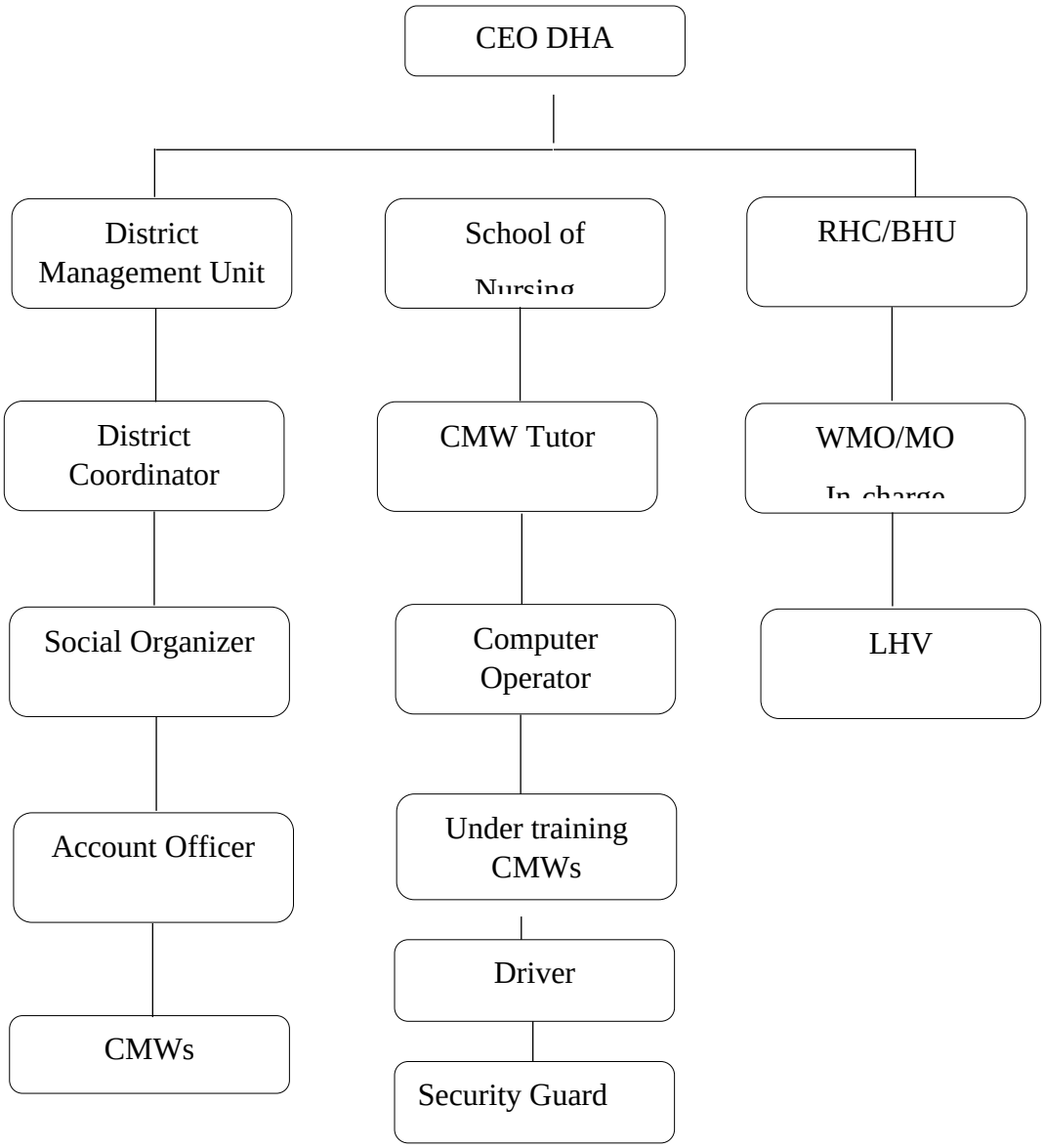


Figure 7.3: Organogram of MNCH Program

Source: Health Dept Punjab

At the Tehsil Jampur level data was received from the district coordinator MNCH program Rajanpur showed that out of 19 union councils the program is running in 15 Union Councils of Tehsil Jampur other 4 union councils are covered by THQ and RHCs. Every Union Council has 15000-30000 population and some has 50,000. one the Tehsil Headquarters (THQ) Hospital, 03 rural health centers and 11 basic health centers were performing their duties to serve and cover the total population of the study area (DHA, 2017). MNCH program in all 19 union councils, Lady Health Supervisor and Lady Health Worker performing their duties to register the married couples, provide the maternal health services and awareness to the women. Except this, these health workers are providing the services of immunization polio campaigns and family planning services also (Government of the Punjab Planning, 2011) [GOPP]. The ambulance service is also available in the area. Researcher met the district coordinator MNCH program he said:

> *"Role of health is important to look after the pregnant mother and refer to them govt health centers and hospitals where the medical officer and lady health visitors and midwives are available to mothers and newborns. Normal delivery takes place at BHU and RHCs and for C-section referred to tehsil or district hospitals. He also said that we have strong monitoring follow up system in this program."*
>
> (Health Key Informant)

Table 7.1: IRMNCH program staff and health centers at Tehsil Jampur District Rajanpur

S. No	Name of Health Center	Union Council	No of Lady Health Worker (LHW)
1	Tehsil Head Quarter Hospital (THQ)	Jampur Sharqi	32
2	Rural Health Center (RHC)	Muhammad Pur	28
3	Rural Health Center (RHC)	Harrand/ Tibi Lundan	10
4	Rural Health Center (RHC)	Dajal	23
5	Basic Health Unit (BHU)	Kotla Dewan	19
6	Basic Health Unit (BHU)	Kotla Mughlan	18
7	Basic Health Unit (BHU)	Kot Tahir	19
8	Basic Health Unit (BHU)	Haji Pur	14
9	Basic Health Unit (BHU)	Saleem Abad	25
10	Basic Health Unit (BHU)	Tatar Wala	28
11	Basic Health Unit (BHU)	Basti Rindan	19
12	Basic Health Unit (BHU)	Salam Pur/Wah Lashari	15
13	Basic Health Unit (BHU)	Bukhara	19
14	Basic Health Unit (BHU)	Burray Wala	18
15	Basic Health Unit (BHU)	Tal Shumali	14

Source: District health department Rajanpur 2019-2020

Organogram of Health Services Providers at Union Council Level

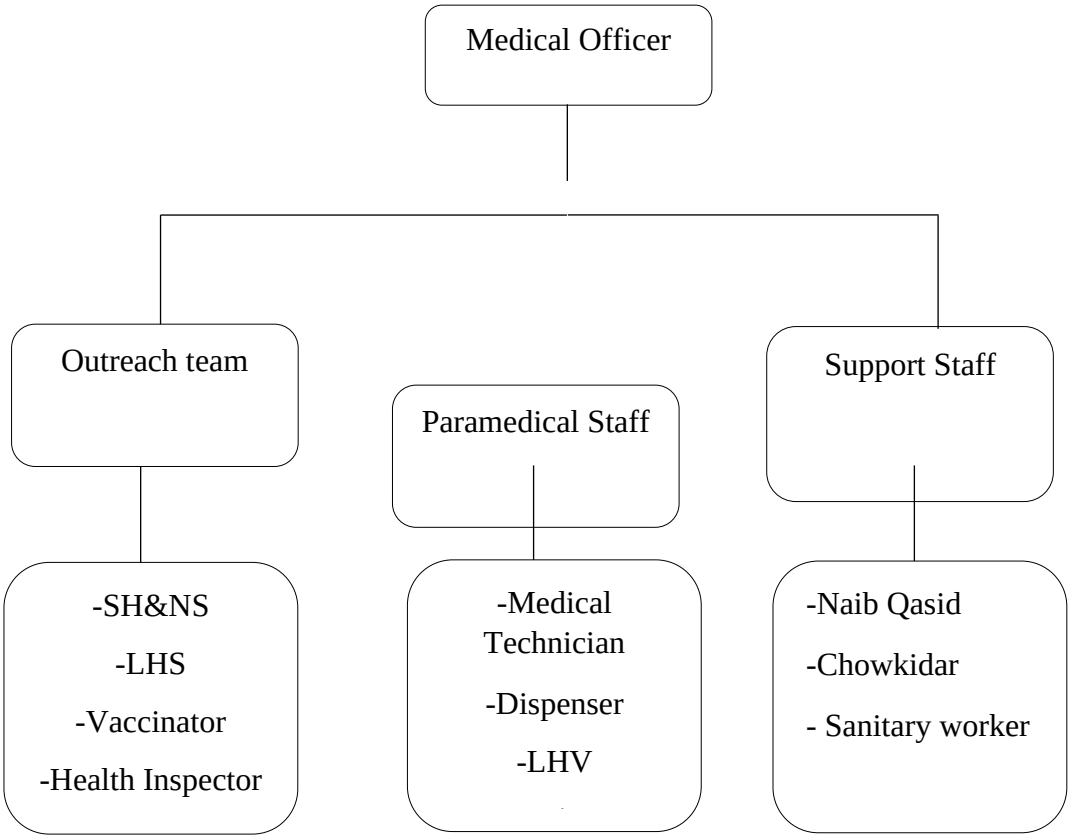


Figure 7.4: Organogram of Health Services Providers at Union Council Level

Source: Health Dept Punjab

7.4 Provision and Reception of Community about MH Services

It is essential to know about this objective so that we can get balanced data and deeper insight concerning the health services provided in the area. In addition, the client's demand can be traced to the kind of problems they have to face for access to health services. Basically, the demand side means the point of view of pregnant women and their families. Both primary and secondary data are relied upon for balanced discussions. Primary data was

collected through women interviews, focus group discussion and meeting with health professionals. while the secondary data was derived Punjab health department, district health department and IRMNCH program office and annual health and statistic reports. The facts identified from this discussion and data analysis address the point of view of both service providers as well as service users. They are as follows: financial constraints, lack of professionalism, lack of facilitation (equipment, medicine, staff and infrastructure), lack of transportation and lack of clinical turnout.

Table 7.2: Thematic Analysis of prevailing Health care System and Community Perceptions

Theme	Category	Sub-Category	Code
Prevailing Health Care System and Community Perceptions	Provision and Reception of Community about RH Services	Financial Constraints	• Low wagers community
		Lack of Professionalism	• Arrogant behavior of (para)medical staff • Unavailability of staff • Burden of extra work
		Lack of Facilities	• Shortage of health equipment and medicines • Absence of professional health staff • Lack of resources

Table 7.1: continued

		Transportation Network	• Rough roads • Insufficient ambulance service
		Poor Clinical Turnout	• Traditional belief system and practices • Absense of staff • Female house chores

Source: Field Data 2019-2020

7.4.1 Financial Constraints

The main factor identified from the data was a financial constraint. The health services in the area were lacking due to the inadequate funds to run the health care services. The difficult procedure is the main reason for procurement and delay in the acquisition of medical supplies for the smooth running of regular health activities. A medical officer of Basic Health unit said:

> *"Purchase of all medicines and equipment is under a centralized system, means the Punjab health department purchases everything itself. The chain of supply systems is quite complex. Hospital sends a requisition to district administration then it is forwarded to the provincial department, after completing legal procedures, procurement and purchase are completed. This way there is a lot of delay and hospitals cannot buy medicine themselves."*
>
> (Health key informant)

It was observed after discussion with doctors of different BHU, RHC and Tehsil Headquarters Hospitals of the area and they agreed collectively on many issues i.e., difficult bureaucratic procedures due to which clinical supplies are delayed and provision of effective health facilities may not be possible. Besides that, departmental hindrances were also found such as failure to pay bills on time also delays in clinical services. All of these were the major hurdles to driving smooth health-care services. The problem was raised by the health sector, that BHU and RHC did not have many facilities for maternal and child health. Doctors usually prescribe medicine and lab test which they had to do in private laboratories and medical stores. Due to the non-availability of health insurance cards or policies in Punjab, this financial burden had to be borne by the client herself. The poor health policy was responsible for this situation. A rural woman told IDI:

> *"My husband is a daily wage laborer. Our economic situation is not good. When I got to the hospital for a checkup. there is usually no medicine or test facility. That is why, I have to buy medicine from the private medical stores. We have to go to town for the test. we do not have enough money to get better treatment."*
>
> (Uneducated woman 27)

It was observed during the analysis that the poor health policy and bureaucratic intervention cause the delay in procurement. Failure of the health policy and poor health services also create distrust and demotivation of clients in the government health system. Due to the poor maternal health services, Pakistan was declared one of the poorest regions, performing against SDG target of improving maternal and child health. (Govt of Pakistan, 2017)

7.4.2 Lack of Professionalism

At the local level, people were well aware of the fact that local hospitals lacked medicines and other facilities, but what came to light after the clients' interviews and FGDs was the attitude of doctors and other medical staff. According to the aggregative response, going to government hospitals for check-ups whether it was BHU or district hospital, was considered a waste of time. The majority of women said that the doctor did not check-up properly. If they wanted to know about their diseases, they would not get a satisfactory answer. On the other hand, the behavior of the lady health visitor LHVs and midwives was also very inappropriate. Many women said that they did not go to the hospital for prenatal care and delivery because of this insulting behavior of health professionals. If a woman had a problem during pregnancy, she would be carelessly attended by staff in government hospitals. If they had not taken the ANC due to any compulsion, she would have been humiliated on the bases of old reports or previous history. Some women said that only reference-based people were treated well in government hospitals and the poor and illiterate people treated badly.

One woman said in FGD:

> *"In fact, home delivery is the best. There are some non-good jobs in hospital and clinics. It is our custom to burying the placenta and mostly in hospitals and clinic it is thrown away and concept of privacy more regarded at home. TBA takes proper care at home and family support is also available which is not possible in the hospital. There we are only humiliated."*
>
> (Urban educated woman age 29)

According to some women, the behavior of LHVs and Midwives was unbearable, even with the facilities of a government hospital. Despite the patient's emergency, the staff did not show any urgency. When the question was asked to doctors of BHU, RHC and Tehsil

Hospital, what was the reason that a large number of women did not trust the government hospitals and resented the attitude of the doctors and paramedic staff, different points of view came from doctor's side. The first Tehsil hospital doctor said that government hospitals were over-burdened. Patients had their own personal suffering besides the illness and they wanted to discuss it with doctor. In outdoor checkup we have not much time to address their personal stories. That's why they thought that doctor did not give them proper attention. Another Doctor said that the main reason was the lack of medicine and some other health facilities in government hospitals. Moreover, at the grass root means BHU level, the biggest hurdle in health care and especially in the MNCH program was the role of the health worker. Lady health workers were incompetent and non-professional. The majority of them was less educated and appointed on the political basis. In addition, they lacked the training and skill. That's why they could not mobilize the women properly. Furthermore, their counseling power was weak enough. As a result, women's trust in government hospitals could not be established. In this situation the role of TBA would become strong. In fact, it was the job of the lady health worker to register a pregnant woman and make a diet plan for her. Due to their limited knowledge and poor information, women did not pay attention to what they said. A gap was found in maternal health care due to the lack of training and proper capacity building of lady health worker.

The Doctor added that:

> *"Most women in rural areas are illiterate. On the one hand there is lack of counseling from lady health workers. Therefore, they do not understand the information given regarding maternal health care. They do not care of their diet due to poverty which leads to complications*"
>
> (Medical officer BHU)

It reveals after group discussion and interviews (women and health professionals) who failed to convey information properly they could not fulfill their responsibilities as mostly did their duties in the polio vaccine campaign. Mother's illiteracy was also a hindrance but the response of the literate mothers was quite different. They knew and understood better the importance of clinical services, ANC, delivery time and postnatal care. It was clearly observed during the study that the major challenge related to healthcare services was the behavior of the service providers. Their behavior kept the participants away from clinical services and maternal health care.

7.4.3 Lack of Facilities

There was a severe lack of facilities in the study area such as the absence of sufficient medicine and professional health staff and shortage of health equipment. Resultantly, people's confidence in the government hospitals was low, especially in rural areas. There were 11 BHU 3 HRC and one Tehsil Hospital in the study area. About 90% of the population depended on these BHUs and RHCs. As for the professional health staff was concerned, there was one doctor, one LHV and only one dispenser at a BHU. Besides this, a midwife and watchman were also included in the staff. Usually, a BHU would cover a population of 10,000 but the population of Tehsil Jampur was 700,000. Thus, BHU covers about thirty to forty thousand people. Only one doctor (medical officer) was not enough to cover such a large number of people who had to handle general patients along with pregnant women at the same time.

In MNCH program the non-professional staff at the union council level was one Lady health supervisor LHS and lady health workers LHWs. Their only responsibility was to mobilize and counsel. They had to raise awareness about maternal and child health in the

community. As for prenatal, natal and postnatal care services were concerned only the doctor and LHV was present there. In the emergency and C -section the cases were referred to the Tehsil and District hospitals. The BHU only had normal delivery facilities. Under the MNCH program, LHVs were on duty 24 hours a day but due to a lack of proper facilities, very few women used to come there. Those inadequate facilities included poor infrastructure and lack of space etc. Most of the BHUs were without a boundary wall, that's why due to the lack of privacy at the time of delivery, people avoided going there. Because of a male doctor, the clientage of pregnant women was very limited. In the presence of a lady doctor, the clientage of women was seen to be better. Culturally in the case of women, people used to avoid the male doctor. at the BHU level. There was a nonresident doctor who was only available during the day-time. A mother told:

> *"There is a male doctor in a government BHU. He is also present during the day. In case of pregnancy, only LHV is available usually, she is not professional and skilled. In addition, there is an insufficiency of facilities. in case of emergency, we have to go to a big hospital. That's why we do not go to govt hospital for delivery. TBA handle the case better."*
>
> (Rural woman age 39)

The situation was the same at RHC. Both male and female doctors were available there but only during the day time. It became obvious through discussions that professionals usually refused their posting in rural areas because they had to face many problems there as well as general public had. Especially female staff used to suffer the problems related to accommodation, communication and transportation etc. A local LHV of the government hospital said:

> *"Due to the unavailability of the provisions in these BHUs and RHCs doctor, especially lady doctor from outside get transferred in no time. therefore, locals rarely visit here. Mostly dispensers and LHV, handle the patients and pregnant women.*

That's the reason, people avoid coming here for checkup and prefer to visit private doctors"

(Health key informant)

They found that due to the lack of staff, women did not trust the local health system. That's why majority of the women look demotivated. Another major reason for the lack of provision was unavailability of lab equipment. The BHU and RHCs did not have ultrasound facility. Only the weight and blood pressure could be checked. However, limited lab tests were possible at RHC as blood and urine etc. Local people did not trust government hospitals due to equipment malfunctions and shortage of medicine. During the discussions the doctor further told if normal delivery at the hospital become complicated the oxygen cylinder were not available at the BHU level. A BHU doctor told:

"We have a limited amount of equipment regarding maternal health sterilizers are most needed. they are used to sterilize other equipment's. In case of damage, it is very difficult to repair or replace them because all equipment and medicine are purchased at the provincial level. That's why, there is a lot of difficulty in health care of women due to the lack of these medical equipment".

(Male health informant)

Another doctor said:

"We are facing a big challenge in the government hospital which is the lack of resources due to limited budget. If the equipment in the hospital is damaged or not available, in that case doctor or LHV is also just like TBA who handles the delivery without necessary equipment."

(Female health informant)

It became obvious through FGDs and interviews that there was severe shortage of professional health staff, especially in the rural areas. The MNCH program mainly focused on awareness but the client demand was for better services not only the diet plan but needed a balance diet from this program which was badly needed in this area. In addition, the

majority of women had a point of view that there was a shortage of medicine and equipment. Even after waiting for a long time neither medicines were available nor tests could be done. Some women said that their men did not come to the govt hospital with them because it was a waste of time. There was one doctor and the long line of patients waiting. The absence of proper infrastructure was also noticed. There was no sufficient seating for the patients and their families. Due to limited and small space the checkup and privacy were a big problem for pregnant women. All these aspects of improper health facilities were responsible for the demotivation of women from the government healthcare services.

7.4.4 Transportation Network

Means and mode of transport was significant problem in the study area. The road network was ruined. Tehsil Jampur was located within a radius of 80-100 km. Only the Tehsil hospital and one RHC were situated on main Indus Road. Whereas two RHCs and all BHUs were on the link road. In addition, the road leading to other hospitals were in very bad condition. Almost the entire Tehsil was visited during data collection. To go to RHC Dajal and Hurand from main city, one had to travel on a damaged and broken road. The journey of sixty KM took two hours approximately. Eleven BHUs were under different union councils which were purely rural areas, located away from the main road. There roads were either rough and uneven or unmetalled. During seasonal flooding, the tribal area was completely cut off from the rest. As a result, access to healthcare becomes limited. During the visit of RHC Harand, a health worker described:

> *"Imagine that the local population becomes cut off from the main road during the rainy season (Moon soon). No ride can reach the hospital from the road except the main road. In this situation, pregnant women consider it safe to have a delivery at home. Due to this reason MMR is more in this area as compared to other areas."*
>
> (Female health informant)

In the rural areas the local mode of transport was Rickshaw and Motorcycle. Rickshaw would also stop running after evening. Then in case of an emergency motorcycle was the available means of only transport. In view of all this, it became clear that due to the lack of transportation, rural women were forced to rely on TBA and consider it better to deliver the baby at home. During the discussion with the district coordinator of the IRMNCH program, he informed the researcher that fifteen ambulances 1034 were available throughout the district under this program which was accessible 24 hours a day on call for delivery. They provided pick and drop service to women from home to hospital and then back to home after delivery. One ambulance was provided to three or four BHUs due to overcrowding/ population this facility was available throughout the district but locals were reluctant to use ambulance 1034 because of their belief system. According to them, the ambulance service was not available on time. In addition, the ambulance was considered a sign of emergency and thus generated fears. The locals did not trust it and considered its use as ominous at the time of delivery. Ambulance 1034 was not culturally accepted. The response of the public regarding ambulance service in case of shifting of pregnant women from home to MNCH center are not good. The reason may be due to psychological and social fear of something bad has happened.

As for as maternal health services were concerned, ambulance 1034 was considered as an ineffective system in rural areas. People mostly preferred their own conveyance at the time of delivery. In urban areas most people used Rickshaw. There were few people who used their own cars or rented a car at the time of delivery. Usually, Rickshaws and motor bikes were used for ANC and PNC.

7.4.5 Poor Clinical Turnout

It was observed in the study that women did not get their checkups done on time during the prenatal, natal and postnatal periods. 67% of women had their ANC checkup done only the once. Postnatal care was nonexistent only 4% of women used to go to clinics for postnatal care. It came to light through FGD that most of the women preferred delivery at home for fear of C-Section. Some women mentioned that they did not go for checkups during the early 3-4 months of pregnancy because of their belief system. An LHV said:

> *"Majority of the local women do not come to the clinic during the early four months of pregnancy because they believe in superstitions. Some women do not go out of the house even for delivery and postnatal care for forty days"*

(Female health informant)

Besides that, it was also observed that poor clinical attendance of women was also due to the use of herbal medicine and traditional remedies. The data shows that beliefs, taboos and rituals were a major obstacle to maternal and child health. Because of this, they did not avail a maternal health care service. There was another reason, the attitude of the health professional staff was responsible for their irregular attendance. This was made clear in interviews with rural women.

A woman shared her experience:

> *"A government hospitals staff attendance is a big issue for us. I leave all my daily chores and go to the hospital for a check-up. Going there, it is found out that the doctor has not come or LHV is on leave that how my whole day is wasted."*

(Rural woman age 26)

In the same way, it was also observed that women used to practice both traditional health care methods as well as clinical services. This was another reason for the poor clinical turnout.

During a discussion with lady doctor Abida Faiz of a private hospital, it came to light that three major illnesses related to maternal health were found in that particular area is as hyper-tension, anemia and blood Pressure. The main reason standing behind these illnesses was actually the problems such as iron deficiency, imbalanced diet and lack of clean drinking water, she explained further: “Local men used their women as a useful tool. Women of rural and tribal areas have to bear too much load of work. I divide those people into three groups who come to me for medical checkups firstly upper class second divided into middle and last in Lower class.

During the study, overall, it turned out in FGD and interviews that man and woman were assigned different roles to perform. It was the duty of a woman to stay at home for cooking, washing, cleaning, milking etc. These were not the responsibilities of man. A woman told:

> *“In our culture, men and women have different responsibilities. If a man does what a woman is responsible for, he is called a female disciple. There is nothing wrong with that but society does not accept this. Domestic work is considered against the dignity of a man”.*
>
> (Rural woman age 37)

During the discussion, it was also probed that in the community what responsibilities did men and women have? According to the overall response received, house chores such as cooking, cleaning, working in fields, milking animals cutting fodder etc. were the duties of women. While the responsibilities of men were working outside the home, to do job,

ploughing the fields, payment of utility bills and children's fees, house rent etc. In addition, selling and buying of crops, animals and property were also the duties of men. In short, the men's responsibilities were of managerial nature. "Even with a normal fever, the pregnant woman should get her checkup done. The mothers should take precautions in taking vitamins etc. in the first three months of pregnancy. PV assessment is most important. Nowadays, lady doctors don't do PV assessment of pregnant women. We can examine only the external pelvis through ultrasound. PV assessment is necessary for internal examination." The male and female doctors of government RHC and BHU responded that the services of ultrasound, blood test, ambulance service and free normal delivery were available 24 hours at RHC with the constant duty of LHV. While at BHU, a checkup of blood pressure, tablets of folic acids, free normal delivery 24 hours of LHV and facility of the ambulance was also available.

The male and female doctors had an opinion regarding the ill health that the majority of mothers were anemic due to imbalanced diets. The most common illnesses found in pregnant women were hyper-tension and blood pressure. The root causes of that illness were poverty, unawareness and an extra load of work on women. These factors were also concentrated as the hurdles of health seeking (Price & Hawkins, 2007; Riang'a, Nangulu, & Broerse, 2018).

7.5 Critical Analysis/ Commentary

The health seeking behavior affects reproductive health as it reflects one's concern about health. So, the assortment and selection of RH services largely rely on the perception of people towards available RH services. People strongly prefer private facilities for the availability of 24 hours' services and doctors as well as better equipment. At the time of the decision for seeking health facilities people focus on gender of HC provider (as many

females are restricted not to visit government facilities because of the presence of male staff), the quality of services at a medical center in addition of financial expenditure (Hatcher et al., 2014). Perception about provided quality of services at the facility centers is an important factor at selection of facility as such perception influenced the opinions of people. Anwar et al. (2012) described that a low amount of people (especially from rural areas) relies upon and use public facilities in Pakistan because of poor facilities like unavailability of medicines, restricted hours for service availability, long distance of medical centers with poor transportation and lack of female health providers as culture confined male-female relations. Such type of perceptions and health seeking-behavior is universal in the areas where available public health services are poor and unreliable (Batchelor et al., 2015). According to (Gurol-Urganci et al., 2017) the concept of "Health services are visible functions of any health system including all services related to the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. Service provision is the inputs such as money; staff, equipment and drugs are combined to allow the delivery of health interventions."

The country Pakistan is trying to provide RH services through different projects and programs comprised of public and private health sectors. Even RH services provision was included in the first five-year Plan (1955-1960) through the private sector like the Family Planning Association of Pakistan. (Sathar & Zaidi, (2012). Instead of getting support from international organizations from a technical and financial perspective, continuous political, administrative and logistics issues became constraints for the implementation of the programs. Inadequate coverage of FP programs especially in rural areas is one of those constraints. According to an estimate in the early 1990s, the ratio of the effectively covered population was only 20% among which only 5% were facilitated in rural areas whereas 50%

of facilities were available in urban areas (Carton & Agha, 2012). In mid 1990s, Lady Health Workers (LHW) program was initiated to facilitate and empower women at the doorstep who were prohibited from women's mobility. This step resulted in uptake of FP. However antenatal visits and hospital deliveries still showed a different perspective (Ahmad, 2012) as 80% of women suffered from unskilled birth attendants and about half of total mothers received antenatal care and services (UNFPA, 2005; Population Council, 2003; Pakistan integrated household Survey, 2002). IEC program also had many spurts including inconsistent components that were insufficient for awareness about contraception or creating its demand as well before the 1990s (Nasir, 2013). Despite emphasis on female health staff i.e., LHVs and LHWs, health facilities especially in rural areas are under-strength (Siddiqi et al., 2004) somewhat associated with safety and security issues. Inappropriate methods of communication, such as IEC focused on posters and leaflets that were inapt for illiterate respondents (Robinson and Ross, 2007) could not satisfy and pursue people for adopting these techniques and thus arose the issue of their safety in their minds.

In 2007-2008, the federal government took initiatives to increase the accessibility of reproductive, maternal, newborn and child health (RMNCH) services that include introduction of Community midwives for safe delivery, Equipping 30% of basic health units (BHUs) and up gradation of two Rural Health Centers in every district. Further, all District and Tehsil Headquarter hospitals are supported by ambulance services. These programs gained an international reputation due to their grass root coverage plans (Prime Minister's program for family planning & primary health care, 1993). In a study conducted in Pakistan, Ahmad et al. (2020) found that absenteeism of staff, poor infrastructure and inconsistent working hour needs serious concern for improving health status. It needs proper checks and balances along with stable governance to reduce the provision of around-the-clock essential

services that endangered and deprived many lives. Instability of government in the form of frequent changes in government as well as their system adversely influences the governance of health sector as each prime minister adopt a different strategy, launches different programs and appoints their own staff that resulting in instability of the health department.

7.6 Conclusion

Health services are visible functions of any health system including all services related to the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. Service provision is the inputs such as money; staff, equipment and drugs combined to allow the delivery of health interventions. The Public Health delivery system is based on three distinct levels of health care delivery system and consists of various national health programs. Primary Health Care (PHC) units consist of Basic Health Units (BHUs).

At the Tehsil Headquarters Hospitals (THQs) secondary care is provided which includes acute, ambulatory and inpatient care while at the District Headquarter Hospitals (DHQs) secondary and tertiary healthcare facilities are made available to the district. Maternal and Child Health Centers (MCHCs) are also an important part of the health systems and together with BHUs and RHCs provides essential obstetric care through lady health workers by way of the community outreach program. MNCH services in Punjab are provided under the umbrella of the Integrated Reproductive Maternal Newborn, Child Health and Nutrition (IRMNCH) Program. The main objective of this program is to improve the maternal health and decrease mortality rate by educating women regarding reproductive health.

The quality of services at the facility center is an important factor in selection of facility as such perception influenced the opinions of people. A smaller number of people (especially in rural areas) relies on and use public facilities in Pakistan because of poor facilities like unavailability of medicines, restricted hours for service availability, long distance of medical centers with poor transportation and lack of female health providers as culture confined male-female relations. Such type of perceptions and health-seeking behavior is universal in the areas where available public health services are poor and unreliable. Inadequate coverage of family planning (FP) programs especially in rural areas is one of those constraints.

Moreover, the absenteeism of staff, poor infrastructure and inconsistent working hours need serious concern for improving the health status. It needs proper checks and balances along with stable governance to reduce the provision of around-the-clock essential services that endangered and deprived many lives. Instability of the government in the form of frequent changes in government as well as their system adversely influences the governance of the health sector as each prime minister adopts a different strategy, launches different programs and appoints own staff that results in instability of health department.

CHAPTER 8

CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

This study was focused on the social and cultural contexts of how the structure of the society and social relationships assign men and women different positions, which exposes women to damaging health conditions during pregnancy and childbirth. The study also considered the delivery and utilization of maternal healthcare services from the clients, healthcare professionals and traditional practitioners to the balanced conclusions. The study developed a model as a framework for viewing maternal healthcare services utilization by using Three Delay Model. This Three Delay Model uniquely emphasizes the inter-connectedness of the stages of maternity as well as the importance of the role of the key actors in maternal healthcare. This study highlighted the need for well-trained and qualified female HC providers for women and male HC providers at established health facilities, for ensuring the access, affordibality, availibality of services and involvement.

In rural areas of Pakistan, women have strong beliefs in traditional healers as well as spiritual healers. It is also believed that due to a large number of patients, the doctor doesn't give proper time to each patient to explain the ways of care, and maintenance of her health. This results in low rate of use of professional modern RH services among rural women. A study conducted in rural Sindh reveals that antenatal care (ANC) is perceived to be taken at the time of any severe conditions. So, they visit a doctor when they suffer from vertigo, high blood pressure, excessive bleeding, seizures and weakness because these dangerous symptoms show complication of pregnancy (Qureshi et al., 2016). This study reveals that

people perceive emergencies at the time of child birth and in that case women access health facilities.

8.2 Key Findings

In this concluding chapter, the key findings of the study, the contribution of this research to new knowledge, and the implications of the findings for healthcare practices, education and policy development as well as recommendations for policy consideration are highlighted. By using a qualitative design, this study adopted culturally appropriate approaches to answer the research question: What, if any, socio-cultural structures and conditions associated with pregnancy and childbirth influence utilization of maternal healthcare services in Southern Punjab? Guided by Three Delays Model, this study explored the experiences of women and their spouses in the three inter-connected stages of maternity. The study also included herbalists, spiritualists as well as healthcare professionals. The findings provided insights for the researcher to analyze the stages of the maternal healthcare system comprising the prenatal, intrapartum and postnatal stages.

These behavioral codes were spiritually inclined and the observance of these norms was a means of maintaining traditional values and beliefs such as protecting the lives of women and their babies from evil forces and showing reverence to family, community and the spiritual world to avoid misfortunes or death. The study also discovered beliefs which manifested in the blend of traditional practices with either spiritual or clinical that led to dualism of care and over-reliance on traditional medicine and home delivery. The dual care seeking attitudes that emphasized the need to observe traditional patriarchal norms and practices resulted in poor clinical attendance for prenatal, intra-partum and postpartum care. The ideology and arrangement of the traditional housing and the extended family systems

influenced the order of care seeking within households which formed the basic unit of decision-making through structured patriarchal systems based on worldviews and health beliefs.

An important observation was that both roles were not separate activities but were carried out concurrently. This sustains the observation that medical conditions during pregnancy have spiritual explanations in traditional setting. The various stages of indigenous maternity care were associated with the use of herbal products, rituals and sacrifices. Parallel with existing literature that puts the TBAs at the center of traditional care, this study observed both the spiritual and medical roles of the TBAs as conditioned and limited by the traditional gender roles. Their primary role was assisting at delivery, which is a traditional gender space and they only gave treatment upon instructions from male members of the family. It was consistent with existing studies (Ahmad et al., 2021).

This study found that women had low status and occupied a weaker position within households and the larger society. Just as Nwokocha observed, society used gender as a means to create low status and discrimination against women which facilitated inequalities and poor health-seeking behavior for women. The decision-making process was male-dominated with strong male supremacy which facilitated discrimination, oppression and marginalization against women. Similar to the observation of Matoane (2015), at the individual level, the low status of women remains an important hindrance to maternal healthcare services utilization. Whilst male dominance in decision-making was regarded as a cultural mandate and an act of protection for women, women could only make tentative decisions about their own health subject to men's approval.

This sustains the observation that adherence to and respect for culture subject women to victimization of traditional gender norms because decision-making power is in the hands of men who control resources and spiritual matters. Neglect in the traditional setting was the fact that a positive maternal outcome is a function of the joint commitment of men and women in all aspects of maternal healthcare including decision-making. Another issue that raised concerns for the women and spouses was lack of professionalism exhibited by the care givers. Any abusive behavior put up by professionals toward clients either covertly or overtly is a source of demotivation for future use of the facility. This is because the experiences of women in their previous pregnancies either motivate them or discourage them to continue seeking care from the facility (Story et al., 2012).

In terms of roads and transport, the care provider was much concerned about both means and network but the care-seekers in all rural communities including those with first class roads identified means of transport as a major concern. Transport is a crucial component of healthcare system. Hence the improvement of health infrastructure and development of human resources must go alongside the improvement of the transportation system to attract both care-seekers and care givers.

To sum up, this study observes cultural beliefs and practices, lower status/position of women, abuse of power by healthcare professionals and administrators as well as incomprehensive formulation and implementation of maternal healthcare policies as major impediments to maternal healthcare. Again, poor facility and road infrastructure also accounted for the poor delivery and utilization of clinical services. From conception to the post-delivery period, three main categories of factors from the socio-cultural environment, influence maternal healthcare services utilization: the family/household structures and

conditions comprising gender, cultural norms and beliefs, background of couples and housing system; institutional structures and conditions such as the traditional institutions, the health institutions and the political institutions; and community resources and environmental factors such as leadership ideologies, the transportation system, and the availability or location of health facilities and personnel. The management and treatment of obstetric complications, the delivery process and the post-delivery practices were guided by the worldviews and health beliefs of the communities. Despite the comprehensive strategies designed in the population policy to deal with the traditional institutions as stakeholders and partners in promoting maternal health, acceptance of modern healthcare services remains a challenge at the household level.

Decision-making is an important ingredient in healthcare services utilization. However, this has not received adequate attention in the implementation of maternal healthcare policies which are usually skewed toward the provision of facilities, professionals and transportation system. In all the communities, the study discovered male dominance in decision-making as an act of protection and a cultural mandate. Traditionally, women had no space in decision-making, not even about their own health. This male supremacy which marginalizes women who experience the symptoms and severity of pregnancy-related conditions, positions men to make decisions for women regarding the timing for care-seeking and the type of care to receive.

However, in intra-household decision-making which was typical of the study area, each household within the compound house was represented by a man and decisions finalized by the family heads. Joint decisions taken at the intra-household level involved only the spouses and were finalized by husbands. Exclusion of women in decision-making

concerning their health is a precondition for wrong decisions on timing for care-seeking and the type of care required because most of the men who took decisions did not have adequate knowledge about pregnancy and related complications. They could not also determine the severity of women's complications to make informed decisions. Since women are the objects of both decisions and obstetric conditions, and are the only people at the household level who can feel and judge the extent of severity of their conditions, patriarchal gender norms should give way to women's autonomy in making decisions about their own health. This is because a wrongly taken decision leads to the wrongful choice of care and negative maternal outcomes.

Another issue connected to household decision-making was the consultation of spiritualists by the family heads or husbands before reaching a final decision based on dual-faith beliefs. The ability of these few women to make informed decisions was also due to the fact that they had attained an appreciable level of education with adequate knowledge about reproductive health. They were married to men who were even higher than them in terms of education and understood their actions. The level of education and exposure of these men helped them to stand dominant against traditional gender norms.

Maternal healthcare in the traditional setting was governed by indigenous knowledge and cosmic order based on their beliefs through dietary and behavioral taboos around human reproduction. Care provider in the pregnancy-postpartum continuum was characterized by the use of herbal medicines alongside rituals and sacrifices. Maternity care was entrusted into the hands of TBAs who diagnosed the women, and prepared, prescribed and administered medicines. Treatment and management of pregnancy and related conditions were associated with injection and ingestion of herbal concoctions into the women. These

concoctions were not subjected to laboratory investigation and clinical trials but according to the clients and the TBA, they were effective. In spite of the poor hygienic conditions observed and the inappropriate methods adopted in care-provider which exposed women to health risks, the TBA services were very helpful especially, to the communities without facilities and motorable roads. Women relied fully on the TBAs especially for delivery in rainy seasons when some communities were completely cut off from clinical services by floods. The policy of training traditional midwives is a good intervention in itself but lacks comprehensive implementation and sustenance. The TBAs interviewed were untrained and had no access to professional guidance on assistance, whilst the few trained ones also complained of a lack of materials for assistance at delivery.

Just like the households, the health institutions were composed of structured systems that hindered the effective delivery and utilization of healthcare services. Though few highly educated women mentioned that they were treated well in the facilities in their last clinical attendances, most of the women had issues with non-satisfactory behaviors from the service providers which was a major push factor. The clients enjoyed receiving care from professionals who applied the common humanity principle in care provider. Enduring the pains associated with pregnancy and childbirth requires sympathy, empathy and encouragement from care-provider. When denied, compromised, care-seekers look for alternative care sources and this leaves an indelible memory as a demotivation for future facility-based care.

The professionals neglected cultural attachment in dealing with clients who were adherent to cultural methods of birthing. Cultural tolerance is required for professionals to understand the culture of the people and help them modify the harmful parts to improve

women's health during maternity. Healthcare providers need intensive in-service training on the culture of the people they deal with because culture is relative. The provision of healthcare services appeared to be parallel to the cultural norms of indigenous people and this served as a push factor within facilities. However, with the modification of culture and integration of health-promoting cultural practices into the modern healthcare system, utilization would increase for improved maternal health to be realized. Understanding the cultural beliefs and practices of a people is a step towards improving access to care because this forms the basis of health education and the development of strategies to influence clinical services' acceptance and utilization.

8.2.1 Conclusion of the Key Finding

This study explored maternal healthcare from the socio-cultural perspectives by examining the social and cultural conditions within households, communities and health facilities that influence utilization of maternal healthcare services. The study focused on how health beliefs around maternity as well as how household decision-making determines healthcare services utilization. The study described that Postpartum hemorrhage is one of the major reasons for maternal deaths followed by eclampsia, obstructed labor and puerperal sepsis in Pakistan (Khan et al., 2009). The deaths caused by indirect causes (infectious diseases like cancer or hepatitis) are only 13% (Khan et al., 2009). Studies determined that the age of women is directly related to maternal death. The females aged from 10 to 14 were five times more likely to die than the women aged 20 to 24 years (ICRW, 2007). The countries where women die because of pregnancy-related problems and having ages below 20 and above 40 have high MMR per 100,000 live births. The reason behind of maternal death is mostly delay in taking care during complications related to obstetric. These delays can be divided into three categories including delays because of some traditions of home

care and deliveries, lack of communication and transportation of women to the hospitals and non-trained staff in hospitals of non-availability of equipment. Inadequately skilled birth attendance is another dilemma of Pakistan that has resulted in continuing maternal mortality in remote areas (Agha, 2015). Further determinants of maternal as well as maternal mortality include poverty, cultural constraints (inequality, oppression, consulting male doctor, purdah), early marriages, lack of transportation, delay in decisions, less access to medical facilities and illiteracy (Khan et al., 2020). People did not consider it necessary to seek routine ANC in the absence of an ailment. However, those who were interested in seeking antenatal care were not satisfied with the services provided at public sector facilities, forcing clients to seek expensive private sector services. The expense of medicines and transport, long distance from private sector facilities, and inadequate transport facilities were frequently cited as barriers by the majority who were interested to seek care (Memon, Zaidi, & Riaz, 2016).

Herbal Medicine is commonly used all around the world. It was found that the majority of the women used at least one herbal product during their last pregnancy. The popularity of HM among pregnant women is mainly because of the common belief that herbs are natural and free of any adverse effects that are usually associated with conventional drugs in indigenous communities. The family role and the role of TBAs were almost the someone who used to overlap each other. In both cases, mostly the herbs were used for cure. But locally, the methods adopted by the family were called home remedies. The role of religious/ spiritual healers was of a different kind. It was dissimilar from herbal treatment by performing various types of rituals. The general opinion of society about the elderly women of the house was that they had extensive testing experience.

8.3 Contribution to Knowledge

Both empirically and theoretically, this study has contributed to the body of knowledge on utilization of maternal healthcare services by filling the existing research gaps, adding to existing literature and introducing a new conceptual model and a proposition of a theory on maternal healthcare services utilization. Firstly, the study provides insights into the role played by the various categories of traditional practitioners and the power imbalances between the TBAs and their male counterparts in traditional medical practice. The present study fills the gap in the literature on the gender aspect of the traditional medical practice that limits the power of the TBAs to the instructions of men who indirectly use the TBAs to practice indigenous birthing culture. This research discovered strong gender forces behind the role of TBAs. That is, their role was traditionally gendered and facilitated by men for the purpose of fulfilling their cultural demands. Whilst previous studies have featured mainly the TBAs in home birthing (Senah, 2003), in this study, it was observed that the TBAs were just acting on instructions of the husbands and family.

Secondly, one important observation made in the existing literature was analyzing the various stages of maternity without emphasizing their inter-connectedness. Though the study was not directly guided by the system's approach, the research attached equal importance to the inter-relationship of the stages of maternity by considering ANC, delivery and PNC as inter-connected parts of the maternal healthcare system. Also, the blend of the structure and agency theory and the Three Delays Model identified systems and structures especially, within households that hampered women's clinical services utilization at the agency level throughout the maternal stages. Moreover, rather than the extended family system as reported in previous studies (Senah, 2003) the hierarchical structures in houses

facilitated the observance of prohibitions around pregnancy and childbirth that obstructed women's utilization of healthcare services.

Thirdly, in light of the findings, this study developed the systemic structural model for viewing maternal healthcare services utilization. The model explains that the ability of a woman (agency) to effectively utilize maternal healthcare services is hampered by collective socio-cultural systems in hierarchical structures within the family, the traditional, health and the political institutions that hold women to the norms of the systems. This model views maternal healthcare as a system of inter-connected stages of antenatal care, delivery care (DC) and postnatal care. Suggesting that, analyzing one stage will not produce the actual health status of women in maternity but only the individual stage and a different response is generated when it is analyzed as a system (Nwokocha, 2007). The model considers both direct and indirect causes of maternal mortality and morbidity as equally important conditions that should be given the necessary attention in each of the stages. According to Systemic Structural Model for Viewing Maternal Healthcare Services Utilization. three main categories of factors influence maternal healthcare services utilization: the family/household structures and conditions comprising gender, cultural norms and beliefs, background of couples and housing system; institutional structures and conditions such as the traditional institutions, the health institutions and the political institutions; and community resources and environmental factors such as leadership ideologies, the transportation system, and availability and location of health facilities and personnel. The model also presents strategies to produce behavior changes to promote maternal healthcare at the familial, communal and institutional levels.

Fifthly, more importantly, the study argues that given the power imbalances between men and women and the supremacy of structural forces over the agency, the provision of health infrastructure and personnel without structurally transformative strategies at present time might not meet the desired outcome so far as these conditions remain functional. However, with time and with increased access to secondary education and above, especially, for women, women's empowerment will take its course with cultural modification or modernization and traditional norms and beliefs will give way to modern and scientific methods of healthcare. This will result in access to health information, healthcare and positive maternal outcomes. A critical look at the maternal healthcare policies indicates that they are sound and comprehensive, but there is more to be implementation.

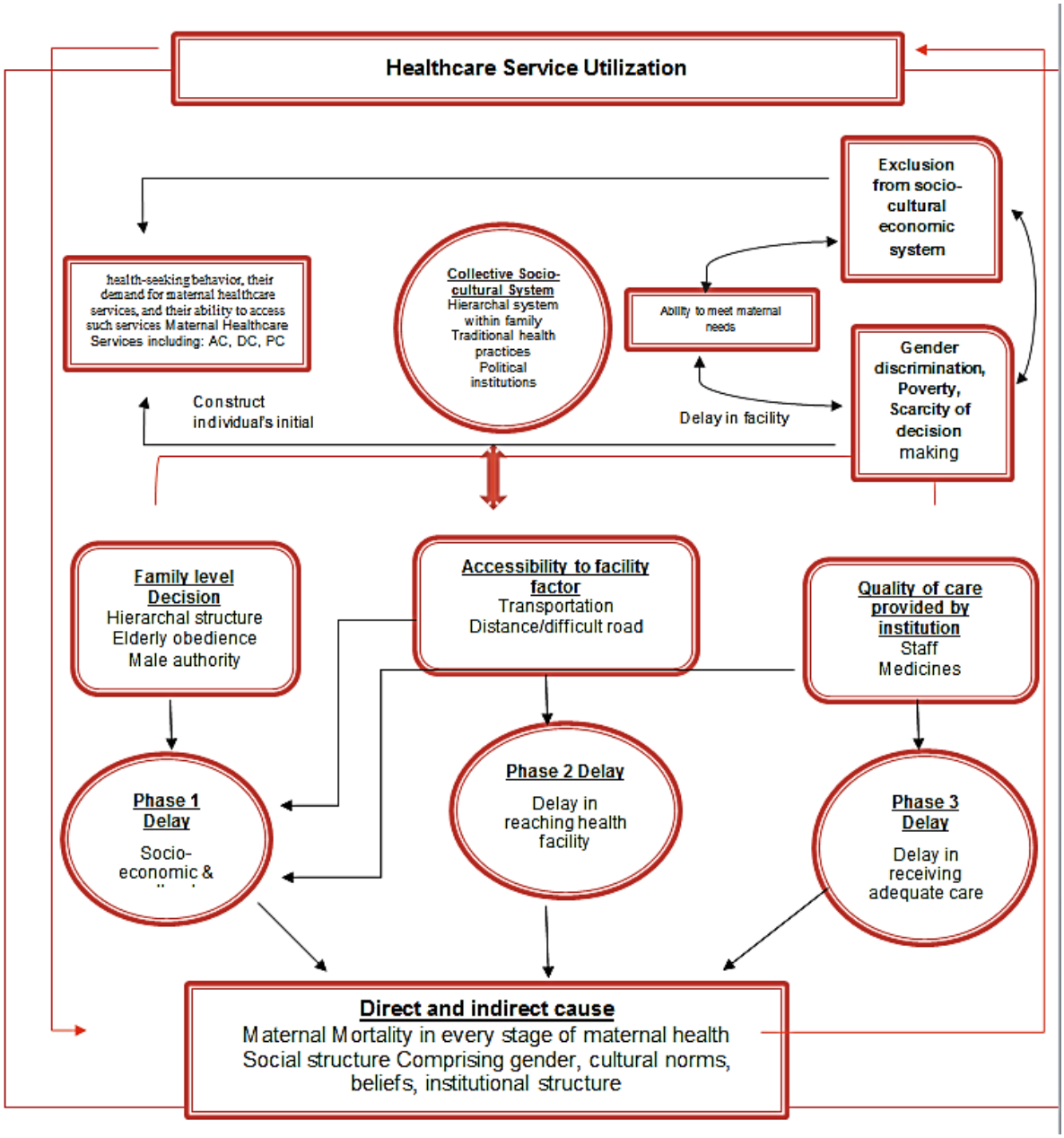


Figure 8.1: Healthcare Service Utilization Model

8.4 Limitations of the Study

The maternal healthcare encompasses the healthcare dimensions of family planning, preconception, prenatal, delivery and postnatal care (WHO, 2013). The study has some of the limitations due to the time factor and resource constraints, the study was limited to maternal health. Further, special population women with Infertility, abortion, STIs and Family Planning and women with disabilities who constitute an important segment of the population were not covered in this study to discover the challenges they faced during pregnancy and childbirth. The use of purposive and snowball sampling methods for allocating the participants in the study means we have a limited number of samples because of the sampling technique that does not allow the generalization of study results on large scale population. While conducting FGD, there was some limitation as the groups were based on the time suitability of available participants. The participants with a similar background might have occurred which might have inhibited the occurrence of varied views in the discussion. Furthermore, as the women of the selected community seemed to be busy in their daily household chores, this might have excluded the other possible participants in the discussion. Moreover, here in this study researcher visits to locate and interviews from key informants only from four (04) Government and one (01) private hospital in the selected study area which can be expanded further. Only accessible and feasible areas were selected geographically. This case study was focused on one Tehsil and some tribal areas due to the security reason of the researcher. It can further be expanded in future at the district or Provincial level if the economic resources are available and security be ensured.

8.5 Recommendations/Outcomes of Research

The outcome of this study has implications for healthcare practices, education as well as policy development. As a result, some recommendations have been made to relevant health organizations, agencies and individual stakeholders for the improvement of maternal and neonatal health in the study communities and in similar settings from the participants and researcher.

- Since the Lady Health Worker (LHW) works in collaboration, educating them together would improve their practices and access to clinical care through prompt referrals. Regular provision of educative programs for the LHWs on the implications of their practices for maternal, fetal and neonatal health as well as the need for clinical care will help them detach beliefs from healthcare. Aside from these programs, a warm rapport would be established between the LHWs and health professionals. If the healthcare system could capacity build the LHWs with their counseling skills, train them to handle basic health issues and timely referrals in deprived communities, it would produce better maternal outcomes.
- The traditional medicines used by the TBAs and traditionally families were not subjected to laboratory investigations and clinical trials. Following this, the study recommends to relevant organizations and agencies like the WHO, international NGOs, the primary health care system of Punjab, Pakistan and the District Health Service collaborate to educate the LHWs, TBAs and women as well as their spouses on the dangers involved in using non-certified drugs. Moreover, there is need to restrict the role of medical store-keepers and they should be banned to sell unprescribed medicine. Traditional practitioners should be given the opportunity to access laboratories at minimal cost with the standards authority. This would ensure

that the herbal medicines given to women or babies are wholesome and meet the standards of WHO.

- It is observed in the study area the gender responsiveness aspect is not comprehensively implemented. Active male participation would make men understand the predicaments and concerns of women and consider the need to give women autonomy over their own health. This would in turn give women the opportunity for making independent and informed decisions by promptly seeking healthcare from professionals. Since men remain the perpetrators of the cultural beliefs and practices with supremacy, their involvement will gradually break down the walls of culture that mediate to delay or deny women access to professional care which will subsequently empower women due to the tribal culture. To this end, the modernization of healthcare will take its roots as women would be empowered to be active agents of change. This would remove gender inequalities and strengthen the women for effective utilization of health services because men will become active partners and perform their role as companions of female rather than only financers in modern maternal healthcare.
- Many people in the informal sector, mostly, the rural inhabitants are not the part of any health programs or policies. Therefore, this practice as observed in the study will not encourage people to participate or engage on any program. The available social mobilization unit should actively work in collaboration with all the stake holder who is working in the various health system. Moreover, monitoring will build facilities to promptly deal with complaints and suggestions. Any structure related to the difficulties and bureaucratic procedures involved in delays procurement of medicine and equipment and artificial shortages of medical supplies should be handled strictly.

- The study also recommends to the WHO, NGOs, the Punjab Health Department and their international and local partners to redesign the health promotion programs towards strengthening both facility-based and community-based health promotion maternal health programs. At the community levels, and efforts should be made to educate community members including men and adolescents on maternal complications to help them recognize problems and make timely decisions towards health-seeking. This is necessary because under severe obstetric pain, women may not be in the right position to make informed decisions. Inevitably, people around them make decisions for them. Therefore, they must have adequate knowledge about pregnancy, childbirth and healthcare to make informed decisions for women. To improve the poor clinical attendance observed in the study, people should be educated about the risk involved in the dualism of care and the need for timely and regular clinical attendance. Interventions should be strategically directed to home care and facility-based care rather than only concentrating on facility-based clients and service providers.
- Some of the TBAs had adequate knowledge about pregnancy and childbirth but they were limited in their abilities to make referrals because of their gender. Their efforts and suggestions for referrals were subject to approval by the husbands and family heads, who were already reliant on spiritualists or herbalists. Aside, the relationship between the TBAs and professionals was not cordial. Some of the women and the TBAs themselves reported having received harsh words from some professionals for reporting to TBA care or forgiving care and making referrals late respectively. Irrespective of their background and the deficiencies in their activities, the TBAs' efforts in rural healthcare should be recognized, appreciated and accorded the desired

respect by men and health professionals. Measures should be taken to establish warm relationships between the TBAs who function as liaisons and the professionals to promote timely referrals especially, in rural communities. Strategies should be devised to allow TBAs perform their roles free from the interference of husbands and in-laws with the commitment of community leaders through community healthcare promotion programs.

- This study recommends the provision of a culturally sensitive training program for the health professionals in collaboration with the tribal leaders and Tehsil Union councils UCs (Urban, Rural) in the study area and other settings of similar characteristics to make them aware of the cultural diversity. This will help the professionals understand, appreciate and accommodate the cultures, and in turn, position them to contain any culturally influenced behaviors put up by clients within the facilities. Understanding the culture of people is a necessary precondition for changing them for an improved healthcare system.
- The poor transportation system in the form of poor roads and lack of transport with uneven distribution of facilities and health professionals mean that women would continue to seek the services of the health care system. To avoid the delays associated with transport, the tehsils and UCs should work in collaboration with the NGOs Service to improve upon the ambulatory system in the areas. The road network should also be improved by the concerned departments they should also dedicate some of the public transport buses to deprived communities for easy access.
- The health facilities especially, the MNCHs program need to be resourced with qualified personnel and equipment. Apart from qualified midwives, the most of BHU and RHC lacked basic materials like sterilizers and gloves to assist during delivery.

These conditions did not motivate women to use the facilities in the Government sector. Resourcing the BHUs and RHCs with human and material resources will put the facilities in the best position to handle cases effectively at their level. To increase utilization of maternal healthcare services, it is important to bring the TBAs closer to LHWs, LHVs and medical officers to boost the confidence and trust of the community members in clinical services.

- The delivery process by the TBAs was observed to be liable to exposing women and their babies as well as the TBAs to infections. There is a need to strengthen the TBAs training program and resource them with gloves and sterilizers to be used during delivery in the absence of professionals. Voluntary counselling and screening services on infections should be carried out by Govt health services program and their international as well as local partners for the TBAs to know their statuses before they are allowed to offer their services.
- The inter-connectedness of education, employment and empowerment make it a heading along with others in the same way. This study considers education as the most powerful tool for improvement of maternal healthcare. Education has the tendency of exposing women and their spouses to health information, making them able to stand against dominant gender norms at both familial and communal levels and take informed decisions. Since reproduction is a function of sexual activities between men and women, the promotion of female education should be "carefully" used as women-specific approach. Equally, education of men is crucial for the understanding health issues, breaking traditional gender walls, modifying culture and making them actively involved roles regarded as feminine space, especially during pregnancy.

- The study recommends the adoption of gender responsive and gender mainstreaming policies and programs by the stakeholders like WHO, Punjab Health department and relevant agencies and NGOs in the provision of maternal healthcare with active engagement of men. Approaches of these policies should be culturally sensitive and structurally transformative on the woman at the community level to empower women for autonomy in all spheres of life for an improved healthcare system.
- The thesis further recommends that studies in indigenous communities should not follow a uniform approach, instead, the methods need to be adapted to the local cultural way of interaction and communication. Culturally sensitive research builds strong rapport between the researcher and the research participants, in addition to the elimination of fears and suspicions by the latter. Apart from the motivation of participants to provide candid responses, culturally sensitive research would also enable the researcher to observe cultural and ethical principles peculiar to the study setting including cross-gender ethics, which are necessary conditions for reflexivity in data collection and analysis.

8.5.1 Policy Recommendations

In this section, the researcher conducted a systematic review and synthesis of policy documents related to women health care specifically and family planning in general. This review of the documents not only provides systematic evidence for a policymaking process and informs decision-makers about various ethical and legal issues surrounding this but also analyzes the implications of a particular policy on maternal health care practice.

An estimated 400,000 infant and 16,500 maternal deaths occur annually in Pakistan. These translate into an infant mortality rate and maternal mortality ratio that should be

unacceptable to any state. Disease states including communicable diseases and reproductive health (RH) problems, which are largely preventable account for over 50% of the disease burden. The overall MCH/FP policy is well directed. MCH/FP has been a priority in all policies; resource allocation, although unacceptably low, has substantially been increased during the last decade; and there is a progressive shift from MCH to the reproductive health (RH) agenda. Areas in need of improvement include greater use of evidence as a basis for policy; increased priority to nutrition programs, measures to reduce neonatal and prenatal mortality, provision of emergency obstetric care, availability of skilled birth attendants, and a clear policy on integrated management of childhood illnesses. Enhanced planning capacity, development of a balanced human resource, improved governance to reduce staff absenteeism and frequent transfers, and a greater role of the private sector in the provision of services are some organizational aspects that need the governments' consideration.

There are several lessons to be learnt:

1 Ministries of Health need sustained stewardship and well-documented evidence to protect cuts in resource allocation;

2 Frequent policy announcement sends inappropriate signals to managers and weakens on-going implementation;

3 MCH/FP policies unless informed by evidence and participation of interest groups are unlikely to address gaps in programs;

4 Distributional and equity objectives of MCH/FP be addressed while setting overall national goals;

5 Institutional capacity is a vital ingredient in translating MCH/FP policies into effective services. The suggested strategic directions emphasize,

> among others, the need for a comprehensive MCH/FP framework; strengthened stewardship in ministry of health, cost-effective strategies to address the gaps identified and doubling of the public sector resource allocation to MCH/FP over the next 5 years. The ability to ensure delivery of quality health services remains the biggest challenge in the Pakistani health

The suggested strategic directions emphasize, among others, the need for a comprehensive MCH/FP framework; strengthened stewardship in Ministry of Health, cost-effective strategies to address the gaps identified and doubling of the public sector resource allocation to MCH/FP over the next 5 years. The ability to ensure delivery of quality health services remains the biggest challenge in the Pakistani health sector. Unless sound policies are backed by well-functioning programs, they are likely to become a victim of poor implementation.

Urgent action is needed to improve the state of MNCH through concerted, direct efforts, rather than expecting economic growth or poverty alleviation alone as the principal vehicles for main change. All provinces of Pakistan need to substantially increase funding for MNCH and nutrition, with the requisite multi-partisan support for sustainability. Pakistan's current health spending is mere 0.6% of the GDP. It is critical that investments in health and education and other social sectors increase substantially over the next few years. Although health has been devolved to the provinces as a principal responsibility, inflation has eroded the corresponding increase in resources and support of primary health care programs. Much of the existing expenditure within the health sector is also limited to tertiary hospitals and, although primary care is supported through the lady health workers (LHW)

program there has been limited investment is strengthening district level health services, especially the Rural Health Centres and Basic Health Units. This must change from the current reliance on external assistance for these sectors to much more sustained and enhanced national and provincial funding for such efforts. Pakistan must target a significant increase in MNCH investments over the next 5 years.

Primary care services in rural areas of Pakistan are critically dependent upon the LHW program and the relatively recent initiative to produce more community midwives. The community midwifery program was developed as a consequence of the demand for provision of skilled care in poor rural populations with limited referral facilities. The recent, most formal evaluation of the LHW program and a number of informal reports post-devolution have identified several areas of weakness and opportunities for further enhancement of LHW skills and effective linkages with the People's Primary Healthcare Initiative program which manages the basic health units. Effective coverage has now become a serious issue given that there are managerial inefficiencies and between 30–50% of the population in several rural districts, especially the poorest and most remote areas, are without LHW cover. Similarly, although the community midwifery program was launched, it is unclear exactly how this has led to their retention and utility in these areas. There is a need for integrated services with linkages to vaccinators and other staff within the health system, as well as focusing the work of the LHWs on their core MNCH efforts as opposed to an increasing repertoire of services including non-communicable diseases and non-health sector activities.

This is a key barrier towards the promotion of care seeking in public sector facilities and is dependent upon a range of issues, including human resources, infrastructure,

transportation, and communication. Establishing a linked referral chain for MNCH within the health system is dependent upon functioning facilities with provision of respectful care.

The vicious cycle of uncontrolled population growth and poor MNCH outcomes and nutrition in Pakistan needs urgent attention. The devolution of health and family planning to the provinces has created opportunities for integration; breaking down silos between hitherto parallel initiatives, such as the MNCH, expanded program on immunization, and malaria and nutrition programs, is challenging and it is unclear if the federal ministry for health services and regulation will integrate national oversight of this. It is naive to imagine that gains in MNCH and nutrition can be achieved by intervening within the health sector alone.

There is also the urgent need to tackle social determinants affecting MNCH in Pakistan, which relate to fundamental issues of the status of women, their education and empowerment, the built environment, and water, sanitation, and hygiene. Given the critical role of maternal education in improving child survival and maternal health, there is an urgent need for these investments. Integrating health and development messages in linking MNCH to other sectors, such as education, prevention of child marriage, and gender empowerment, are a key task for the federal ministry in tandem with the provinces. Further, enhanced efforts to address maternal and child undernutrition with a focus on adolescent girls are needed given the critical need to address food insecurity and undernutrition. Notwithstanding the importance of nutrition-sensitive interventions, the role of the health sector in enabling the implementation of nutrition-specific interventions is critical; this is especially true for integrating maternal nutrition and breastfeeding support strategies, ensuring that major causes of micronutrient deficiencies are addressed, and that nutrition prevention and promotion is integrated within the primary care programs.

One of the key limitations for action is the lack of accurate and timely information. Pakistan has long depended upon expensive and time-consuming cross-sectional surveys for assessment of progress and to-date key information on important issues of direct causes of mortality and morbidity are not available at the provincial level. There is a need for strengthening of district information systems, such as the District Health Information Software, and the creation of sentinel information systems for important areas related to MNCH by age group and gender. There is a corresponding need for a national multi-stakeholder body for oversight of MNCH and nutrition in addition to the important role of the Federal Ministry for Health Services and Regulation.

8.6 Conclusion

The financial issues, socio-cultural barriers, lack of maternal health services including delays in approaching maternal care facilities are some of the major reasons behind maternal deaths in study area. The male's supremacy and the role of TBA including the methods and substances used, have been extensively discussed. In Pakistan parents sought for children's wellness, however, much apprehension is for sons as daughters suffer from malnutrition, less attention and exclusion from family resources even girls were breast feeding for shorter period than boys.

The study also examined why more than half of the births in Asia are delivered outside the health facilities the reasons behind this were not isolated but structured within the household in hierarchical layers where women were viewed as minors and recipients. The study suggested ways to empower women by implementing gender responsive strategies. Highly religious females may feel it less important to seek assistance for pregnancy since they rely heavily on their husband's support.

Herbal medicines are widely used and appreciated. In-terms of the role of traditional practitioners, they took the form of medical and spiritual involving diagnosis, preparations and administration of herbal medicines along with allopathic medicine. Pakistani women deeply trust in their ethno- cultural religiosity. Some influences factors of family planning practices including education, social norms, gender roles desired family size, contraceptives use along with/ as well as absence of institutional support.

REFERENCES

Abbas, Z., Khan, S. M., Alam, J., Khan, S. W., & Abbasi, A. M. (2017). Medicinal plants used by inhabitants of the Shigar Valley, Baltisstan region of Karakorum range-Pakistan. *Journal of Ethnobiology and Ethnomedicine*, *13*, 1-15.

Abel, T., & Frohlich, L. K. (2012). Capitals and capabilities: Linking structure and agency to reduce health inequalities. *Social Science and Medicine*, *74*(2), 236-244.

Adatara, P., Afaya, A., Baku, E. A., Salia, S. M., & Asempah, A. (2018). Perspective of traditional birth attendants on their experiences and roles in maternal health care in rural areas of northern ghana. *International Journal of Reproductive Medicine, 2018*.

Adelson, E. M. (2014). *Sexual health and psychological well-being of unmarried adolescent females living in an urban slum in India* (Doctoral dissertation, Tulane University School of Science and Engineering).

Agha, S. (2015). A profile of women at the highest risk of maternal death in Pakistan. *Health Policy and Planning*, *30*(7), 830-836.

Agha, S., & Carton, T. W. (2011). Determinants of institutional delivery in rural Jhang, Pakistan. *International Journal for Equity in Health*, *10*(1), 1-12.

Agus, Y., Horiuchi, S., & Porter, S. E. (2012). Rural Indonesia Women's Traditional Beliefs about Antenatal Care. *BMC Research Notes*, *5*(1), 589.

Ahmad, A. M. (2012). *Primary antenatal health care services, maternal health and birth outcomes in rural Pakistan*. University of Melbourne, School of Population Health.

Ahmad, M., Raziq, M. M., Rehman, W. U., & Allen, M. M. (2020). High-performance work practices and organizational performance in Pakistan. *International Journal of Manpower*, *41*(3), 318-338.

Ahmed, F. (2019). Understanding food insecurity experiences, dietary perceptions and practices in the households facing hunger and malnutrition in Rajanpur District, Punjab Pakistan. *Pakistan Perspectives*, *24*(2).

Ahmed, F., Leghar, I. U., Shahid, M., & Ahmad, M. (2021). Newborn care practices: locals' analytical models, and Newborn care practices: locals' analytical models, and potential medical risks in South-Punjab Pakistan. *Rawal Medical Journal*, *46*(2), 442-446.

Ahmed, F., Leghari, I. U., Alam, M. B., & Shahid, M. (2019). Sociocultural construction of the ritual and practice of ghutti (pre-lacteal): An ethnographic study in Rajanpur, Punjab Pakistan. *Annals of King Edward Medical University*, *25*(4).

Alemayehu, T., Haider, J., & Habte, D. (2010). Determinants of Adolescent Fertility in Ethiopia. *Ethiopia Journal of Health Development*, *24*(1), 30-38.

Ali, M., Bhatti, M. A., & Kuroiwa, C. (2008). Challenges in Access to and Utilization of Reproductive Health Care in Pakistan. *Journal of Ayub Medical College Abbottaba*, *20*(4), 3-7.

Ali, N. S., Azam, S. I., & Noor, R. (2004). Womens' beliefs and practices regarding food restrictions during pregnancy and lactation: a hospital based study. *Journal of Ayub Medical College Abbottabad:JAMC*, *16*(3), 29-31.

Ali, T. S., Krantz, G., Gul, R., Asad, N., Johansson, E., & Mogren, I. (2011). Gender roles and their influence on life prospects for women in urban Karachi, Pakistan: a qualitative study. *Global Health Action, 4*(0), 7448.

Amasha, H., & Jarrah, S. (2012). The use of home remedies by pregnant mothers as a treatment of pregnancy related complaints: An exploratory study. *Medical Journal Cairo University*, *80*(1), 673-80.

American Psychological Association (2012). *Guidelines for ethical conduct in behavioral projects involving human participants by high school students*. Council of Representatives, USA: APA. Retrieved from: http://www.apa.org/sciece/leadership/research/ethical-conduct-humans.aspx 19th July, 2015.

Andersen, R., & Newman, J. F. (2005). Societal and individual determinants of medical care utilization in the United States. *The Milbank Quarterly, 83*(4), 1-28.

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*(1), 1-10.

Anon. (2006). Media Crucial to AIDS Fight. *AIDS Patient Care and STDs, 20*(9), 662.

Anwar, M., Green, J. A., Norris, P., & Bukhari, N. I. (2015). Self-medication, home remedies, and spiritual healing: common responses to everyday symptoms in Pakistan. *Health Psychology and Behavioral Medicine, 3*(1), 281-295.

Anwar, M., Green, J., & Norris, P. (2012). Health-Seeking Behaviour in Pakistan: A Narrative Review of the Existing Literature. *Public Health, 126*(6), 507-517.

Anwar, S. M., Khan, A. A., & Sardar, Q. (2022). Educational Disparity among Families living in Balochistan (Pakistan) on the Basis of Gender. *Journal of Management Practices, Humanities and Social Sciences*, *6*(3), 74-80.

Ariyo, O., Ozodiegwu, I. D., & Doctor, H. V. (2017). The influence of the social and cultural environment on maternal mortality in Nigeria: Evidence from the 2013 demographic and health survey. *PloS One*, *12*(12), e0190285.

Aryastami, N. K., & Mubasyiroh, R. (2021). Traditional practices influencing the use of maternal health care services in Indonesia. *Plos One*, *16*(9), e0257032.

Asif, A. M., & Akbar, M. (2020). Inequalities in child health care in Pakistan: measurement and decomposition analysis of maternal educational impact. *Public Health*, *183*, 94-101.Asim, M., Ahmed, Z. H., Nichols, A. R., Rickman, R., Neiterman, E., Mahmood, A., & Widen, E. M. (2022). What stops us from eating: a qualitative investigation of dietary barriers during pregnancy in Punjab, Pakistan. *Public Health Nutrition*, *25*(3), 760-769. doi:10.1017/S1368980021001737

Ayres, A. (2009). *Speaking like a state: Language and nationalism in Pakistan*. Cambridge University Press.

Aziz, M. A., Khan, H. A., Ullah, H., Adnan, M., Hashem, A., & Abd_Allah, E. F. (2018). Traditional phytomedicines for gynecological problems used by tribalcommunities of Mohmand Agency near the Pak-Afghan border area. *Brazilian Journal of Pharmacognosy*, *28*(4), 503-511.

Babbie, E. (2010). *The basics of social research.*, (13th Edition), Belmont, USA: Wandsworth.

Barrett, B., & Kieffer, D. (2001). Medicinal plants, science, and health care. *Journal of Herbs, Spices & Medicinal Plants*, *8*(2-3), 1-36.

Barus, V. R. (2013, April 30). *Socio-economic inequalities in access to maternal health care in India: Challenges f or policy*. World Health Organization. www.whoint/global_ health_ histories/ seminars/ presentation 52a.pdf.

Batchelor, S., Waldman, L., Bloom, G., Rasheed, S., Scott, N., Ahmed, T., & Sharmin, T. (2015). Understanding health information seeking from an actor-centric perspective. *International Journal of Environmental Research and Public Health*, *12*(7), 8103-8124.

Beebe, K. R., Gay, C. L., Richoux, S. E., & Lee, K. A. (2017). Symptom experience in late pregnancy. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *46*(4), 508-520.

Belica, A. L., Ćetković, N. B., Milić, N. B., & Milošević, N. P. (2017). Herbal Therapy in Pregnancy - What to Expect When You Expect? *Natural Product Communications, 12*(12), 1957-1969

Bhattacharya, S. (2014). Status of Women in Pakistan. *Journal of the Research Society of Pakistan, 51*(1), 179-211.

Bongaarts, J. (2010). The Causes of Educational Differences in Fertility in Sub-Saharan Africa. *Vienna Yearbook of Population Research, 8*, 31-50.

Brown, E., Gul, X., Abbas, A., Nasar, A., & Balal, A. (2017). Men's perceptions of child-bearing and fertility control in Pakistan: insights from a PEER project. *Culture, Health & Sexuality, 19*(11), 1225-1238.

Bruno, L. O., Simoes, R. S., de Jesus Simoes, M., Girão, M. J. B. C., & Grundmann, O. (2018). Pregnancy and herbal medicines: an unnecessary risk for women's health - A narrative review. *Phytotherapy Research, 32*(5), 796-810.

Bukhari, F. Y., & Ramzan, M. (2013). Gender Discrimination: A Myth or Truth Women Status in Pakistan. *IOSR Journal of Business and Management (IOSR-JBM), 8*(2), 88-97.

Bureau of Statistics, Planning and Development Department, Government of the Punjab. (2016) "Punjab Development Statistics 2016: Available at http://aidsdatahub.org/ sites/ default/ les/ publication/Punjab_ Development_ Statistics_2016. pdf; page 43-44; (Accessed: 28 April 2018)

Bureau of Statistics. Bureau of Statistics ... Planning & Development Board (P&D), Government of the Punjab. Powered by: Punjab Information Technology Board.

Buser, J. M., August, E., Rana, G. K., Gray, R., Tengera, O., Jacobson-Davies, F. E., & Smith, Y. R. (2023). Scoping review of qualitative studies investigating reproductive health knowledge, attitudes, and practices among men and women across Rwanda. *Plos One, 18*(3), e0283833.

Carton, T. W., & Agha, S. (2012). Changes in Contraceptive Use and Method Mix in Pakistan: 1990-91 to 2006-07. *Health Policy and Planning, 27*(2), 166-174.

Central Intelligence Agency. (2022, December 13). *The World Factbook.* Center of Intelligence agency [CIA]. https://www.cia.gov/the-world-factbook/countries/pakistan

Cesare, M. D., Bhatti, Z., Soofi, S. B., Fortunato, L., Ezzati, M., & Bhutta, Z. A. (2015). Geographical and Socioeconomic Inequalities in Women and Children's Nutritional Status in Pakistan in 2011: An Analysis of Data from a Nationally Representative Survey. *Lancet Glob Health, 3*(4), 229-239.

Chen, X., Zhao, D., Mao, X., Xia, Y., Baker, P. N., & Zhang, H. (2016). Maternal Dietary Patterns and Pregnancy Outcome. *Nutrients, 8*(6), 351.

Chepkorir, J. (2014). *Determinants of maternal healthcare utilization in rural Kenya* (Doctoral dissertation, University of Nairobi).

Cheptum, J. J., Gitonga, M. M., Mutua, E. M., Mukui, S. J., Ndambuki, J. M., & Koima, W. J. (2017). Perception about traditional birth attendants by men and women of reproductive age in rural Migori County, Kenya. *International Journal of Africa Nursing Sciences, 7*, 55-61.

Choudhury, N., Moran, A. C., Alam, M. A., Ahsan, K. Z., Rashid, S. F., Streatfield, P. K., (2012). Beliefs and Practices during Pregnancy and Childbirth in Urban Slums of Dhaka, Bangladesh. *BMC Public Health, 12*(1), 1-6.

Coast, E., Jones, E., Portela, A., & Lattof, S. R. (2014). Maternity care services and culture: a systematic global mapping of interventions. *PloS One, 9*(9), e108130.

Combs Thorsen, V., Sundby, J., & Malata, L. (2012). Piecing together the maternal death puzzle through narratives: The three delays model revisited. *PLoS One*, *7*(12), e52090.

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*: Sage publications.

Cukarso, S. N. A., & Herbawani, C. K. (2020). Traditional beliefs and practices among pregnant women in Javanese communities: a systematic review. *J Public Heal Res Community Health Development*, *4*(1), 71-80.

Culhane-Pera, K. A., Sriphetcharawut, S., Thawsirichuchai, R., Yangyuenkun, W., & Kunstadter, P. (2015). Afraid of delivering at the hospital or afraid of delivering at home: a qualitative study of Thai Hmong families' decision-making about maternity services. *Maternal and Child Health Journal*, *19*(11), 2384-2392.

Cuzzolin, L., Francini-Pesenti, F., Verlato, G., Joppi, M., Baldelli, P., & Benoni, G. (2010). Use of herbal products among 392 Italian pregnant women: focus on pregnancy outcome. *Pharmacoepidemiology and Drug Safety*, *19*(11), 1151-1158.

Das, J. K., Salam, R. A., Thornburg, K. L., Prentice, A. M., Campisi, S., Lassi, Z. S., . . . Bhutta, Z. A. (2017). Nutrition in adolescents: physiology, metabolism, and nutritional needs. *Annals of the New York Academy of Sciences*, *1393*(1), 21-33.

Dayal, M. (2013). *Unraveling the web of maternal mortality: Addressing the interaction of structural violence and maternal mortality in modern India.* [Bachelor Thesis,

University of North Carolina] Global Studies. https://globalstudies.unc.edu/wp-content/uploads/sites/224/2013/11/Dayal-Mitali-Unraveling-the-web.pdf

Dennis, C. L., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *Birth, 33*(4), 323-331.

Disaster Management Authority. (2017). "Provincial Disaster Response Plan, 2017"; available at https://pdma.punjab.gov.pk/system/ les/Punjab%20Disaster%20 Response%20Plan%202017.pdf#overlay-context=documents, Page 06-12. (Accessed 20 Nov 2017)

District Health Authority, Rajanpur (2017). "Health Contingency Plan of Rajanpur, 2017"; Slide 04 Received October 2017.

Doyle, I.-M., Borrmann, B., Grosser, A., Razum, O., & Spallek, J. (2016). Determinants of dietary patterns and diet quality during pregnancy: a systematic review with narrative synthesis. *Public Health Nutrition, 20*(6), 1009-1028.

Elkhoudri, N., Baali, A., & Amor, H. (2016). Maternal morbidity and the use of medicinal herbs in the city of Marrakech, Morocco. *Indian Journal of Traditional Knowledge, 15*(1), 79-85.

El-Saharty, S., Ohno, N., Sarker, I., Secci, F., Haq, I. U., & Kashif, A. (2014). *Pakistan: Maternal and Reproductive Health at Glance.* World Bank. Health, Nutrition and Population Global Practice (HNPGP) Knowledge Brief.

Ernst, E. (2002). Herbal medicinal products during pregnancy: are they safe? *BJOG: An International Journal of Obstetrics & Gynaecology*, *109*(3), 227-235.

Family Health International & United States Agency for International Development. (2011). *Qualitative Research Methods: A data collector's field guide*. In Mark, N., Woodsong, C., MacQueen, M. K., Guest, G., & Namey, E. (Eds). FHI & USAID

Farooq, M. (2007). Remote Patient Monitoring System with Focus on Antenatal Care for Rural Population.

Fathalla, M. F. (2011). Human Rights Aspects of Safe Motherhood. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *20*(3), 409-419.

Fawole, A. O., Okunlola, M. A., & Adekunle, A. O. (2008). Clients' perceptions of the quality of antenatal care. *Journal of the National Medical Association*, *100*(9), 1052-1058.

Ferdous, N., Kabir, R., Khan, H. T., & Chowdhury, M. R. (2017). Exploring the Relationship of Domestic Violence on Health Seeking Behavior and Empowerment of Women in Pakistan. *Epidemiology Biostatistics and Public Health, 14*(1).

Fernández-Gómez, E., Luque-Vara, T., Moya-Fernández, P. J., López-Olivares, M., Gallardo-Vigil, M. Á., & Enrique-Mirón, C. (2020). Factors Influencing Dietary Patterns during Pregnancy in a Culturally Diverse Society. *Nutrients, 12*(11), 3242.

Frawley, J., Adams, J., Sibbritt, D., Steel, A., Broom, A., & Gallois, C. (2013). Prevalence and determinants of complementary and alternative medicine use during pregnancy: results from a nationally representative sample of Australian pregnant

women. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, *53*(4), 347-352.

Friese, S. (2011). Using ATLAS.ti for Analyzing the financial crisis data. *Qualitative Social Research, 12*(1), 312-331.

Frohlich, K. L., & Potvin, L. (2008). Transcending the known in public health practice: The inequality paradox; the population approach and vulnerable populations. *American Journal of Public Health, 98*(2), 216-221.

Gardner, H., Green , K., Gardner, A., & Geddes, D. (2019). Maternal and Infant Health in Abu Dhabi: Insights from Key Informant Interviews. *International journal of Environmental Research and Public Health, 16*(17), 3053. doi:10.3390/ijerph16173053

Gatrad, A. R., & Sheikh, A. (2001). Muslim birth customs. *Archives of Disease in Childhood-Fetal and Neonatal Edition*, *84*(1), F6-F8.

Geofrey, T., & Kungu, J. N. (2019). Socio-Cultural Determinants Influencing Adolescent Sexual and Reproductive Health in Bomet East Sub-County, Kenya.

Germov, J. (2014). *Imagining health problems as social issues*. ANZ: Oxford University Press.

Ghimire, S. (2019). Women's Empowerment and Its Impact on Reproductive Health Outcomes: Evidence from Nepal.

Gogoi, P., & Nath, N. (2021). Indigenous knowledge of ethnomedicinal plants by the Assamese community in Dibrugarh District, Assam, India. *Journal of Threatened Taxa*, *13*(5), 18297-18312.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, *8*(4), 597-607.

Government of Pakistan. (2013, March 12). Pakistan *Passes the Reproductive Healthcare and Rights Act 2013.* Retrieved from The Canadian Association of Parliamentarians on Population and Development: https://cappd.ca/node/80

Government of Pakistan. (2017). *Census Report*. Islamabad.

Government of the Punjab Planning & Development Department Bureau of Statistics. (2011). Multiple Indicator Cluster Survey (MICS) Punjab. Rajanpur.

Gray, C., Crawford, G., Maycock, B., & Lobo, R. (2021). Socioecological Factors Influencing Sexual Health Experiences and Health Outcomes of Migrant Asian Women Living in 'Western' High-Income Countries: A Systematic Review. *International Journal of Environmental Research and Public Health, 18*(5), 2469.

Gurol-Urganci, I., Campbell, F., & Black, N. (2017). *EBOOK: Understanding Health Services*. McGraw-Hill education (UK).

Hanif, M., Khalid, S., Rasul, A., & Mahmood, K. (2021). Maternal mortality in rural areas of Pakistan: challenges and prospects. *Rural Health*, *27*, 1040-1047.

Harrison, K. A. (1985). Childbearing, health and social priorities. A survey of 22,774 consecutive hospital births in Zaria, Northern Nigeria. *British Journal of Obstetrics and Gynaecology*, *92*(15), 1–119.

Hassan, S. N., Memon, E., Shahab, M., & Mumtaz, S. (2020). Utilization of maternal healthcare services in women experiencing spousal violence in Pakistan: A comparative analysis of 2012-13 and 2017-18 Pakistan Demographic Health Surveys. *PLoS ONE, 15*(9). doi.org/ 10.1371/ journal.pone.0239722

Hatcher, P., Shaikh, S., Fazli, H., Zaidi, S., & Riaz, A. (2014). Provider cost analysis supports results-based contracting out of maternal and newborn health services: an evidence-based policy perspective. *BMC Health Services Research, 14*(1), 1-8.

Hazell, L., Cornelius, V., Hannaford, P., Shakir, S., & Avery, A. (2013). Yellow card study collaboration how do patients contribute to signal detection? A retrospective analysis of spontaneous reporting of adverse drug reactions in the UK's yellow card scheme. *Drug Saf*, *36*(3), 199-206.

Healy, M., & Perry, C. (2000). Comprehensive criteria to judge validity and reliability of qualitative research within the realism paradigm. *Qualitative Market Research: An International Journal, 3*(3), 118-126.

Hira, S.K., Bhat, G.J., Chikamata, D.M., Nkowane, B., Tembo, G., Perine, P.L., Meheus, A., & Hodzic, A. (2002). Gender does Matter: Framing Risks Sexual Behaviors Among Coroation Adolescents. *Časopiszaknjiževnostikulturu, idruštvenapitanja*, *67*(13), 273-286.

Hoepfl, M.C. (1997). Choosing qualitative research: A primer for technology education researchers. *Journal of Technology Education, 9*(1), 122-141.

Holst, L., Wright, D., Haavik, S., & Nordeng, H. (2011). Safety and efficacy of herbal remedies in obstetrics—review and clinical implications. *Midwifery*, *27*(1), 80-86.

Hou, X., & Ma, N. (2013). The effect of women's decision-making power on maternal health services uptake: evidence from Pakistan. *Health Policy and Planning, 28*(2), 176-184.

Hwang, J. H., Kim, Y. R., Ahmed, M., Choi, S., Al-Hammadi, N. Q., Widad, N. M., & Han, D. (2016). Use of complementary and alternative medicine in pregnancy: a cross-sectional survey on Iraqi women. *BMC Complementary and Alternative Medicine, 16*(1), 1-7.

International Center for Research on Women. (2010). *Targeting poverty and gender inequality to improve maternal health*. In Paruzzolo S., Mehra, R, Kes, A., & Ashbaugh, C. (Eds). ICRW. Washington, DC: Witter Ventures.

International Center for Research on Women. (2014). *Improving the lives of married adolescent girls in Amhara, Ethiopia*: A Summary of Evidence. Documents (4). In Edmeades, J., Hays, R., & Gaynair, G.(Eds.). Washington. DC: Gap Incorporate.

International Council for Research on Women (ICRW). (2007). New Insights on Preventing Child Marriage: A Global Analysis of Factors and Programs. Retrieved August 02, 2018 from http://www.icrw.org/files/publications/New-Insights-on-Preventing Child Marriage.

Ismail, M., Ahmad, I., Khan, M. S., Ullah, S., Malik, M. I., Muhammad, K., & Jan, A. A. (2018). 19. Seroprevalence of Brucella abortus in cattle and buffaloes in district Rajanpur, Punjab, Pakistan. *Pure and Applied Biology (PAB)*, *7*(2), 556-564.

Jafarey, S. N., (2002). Maternal Mortality in Pakistan-Compilation of Available Data. *Journal of Pakistan Medical Association*, *52*(12), 539-544.

Jaradat, N., & Adawi, D. (2013). Use of herbal medicines during pregnancy in a group of Palestinian women. *Journal of Ethnopharmacology*, *150*(1), 79-84.

Johnson, P. J., Kozhimannil, K. B., Jou, J., Ghildayal, N., & Rockwood, T. H. (2016). Complementary and alternative medicine use among women of reproductive age in the United States. *Women's Health Issues*, *26*(1), 40-47.

Jones, M. R., & Karsten, H. (2008). Giddens's Structuration Theory and Information Systems Research. *Management Information Systems Quarterly*, *32*(1), 127-157.

Kalisa, R., & Malande, O. O. (2016). Birth preparedness, complication readiness and male partner involvement for obstetric emergencies in rural Rwanda. *The Pan African Medical Journal*, *25*(91).

Kaneoka, M., & Spence, W. (2020). The cultural context of sexual and reproductive health support: an exploration of sexual and reproductive health literacy among female Asylum Seekers and Refugees in Glasgow. *International Journal of Migration, Health and Social Care*, *16*(1), 46-64.

Khan, M. M., Zafar, M. I., Ali, T., & Ahmad, A. (2009). Effect of Socio-Economic, Cultural and Demographic Factors on Woman Reproductive Health. *Pakistan Journal of Agricultural Sciences, 46*(4), 308-314.

Khan, S., Haider, S. I., & Bakhsh, R. (2020). Socio-Economic and Cultural Determinants of Maternal and Neonatal Mortality in Pakistan. *Global Regional Review, 5*(1), 1-7. doi::10.31703/grr.2020(V-I).01

Khan, Y. P., Bhutta, S. Z., Munim, S., & Bhutta, Z. A. (2009). Maternal Health and Survival in Pakistan: Issues and Options. *Journal of Obstetrics and Gynaecology Canada, 31*(10), 920-929.

Kidwai, S., & Almugahed, N. (2021). *Sexual and Reproductive Health and Rights Policy, Birmingham*. Islamic Relief Worldwide.

Kort, W., & Gharbi, J. E. (2013). Structuration theory amid negative and positive criticism. *International Journal of Business and Social Research, 3*(5), 92-104

Kumar, M., Rawat, S., Nagar, B., Kumar, A., Pala, N. A., Bhat, J. A., . . . Kunwar, R. (2021). Implementation of the Use of Ethnomedicinal Plants for Curing Diseases in the Indian Himalayas and Its Role in Sustainability of Livelihoods and Socioeconomic Development. *International Journal of Environmental Research and Public Health, 18*(4), 1509.

La France, J. L., & Crazy Bull, C. (2009). *Researching ourselves back to life*: Taking control of the research agenda in Indian Country. Los Angeles: Sage Publications.

Lapi, F., Vannacci, A., Moschini, M., Cipollini, F., Morsuillo, M., Gallo, E., & Mugelli, A. (2010). Use, attitudes and knowledge of complementary and alternative drugs (CADs) among pregnant women: a preliminary survey in Tuscany. *Evidence-Based Complementary and Alternative Medicine*, *7*(4), 477-486.

Lennox, J., Petrucka, P., & Bassendowski, S. (2017). Eating practices during pregnancy: perceptions of select Maasai women in Northern Tanzania. *Global Health Research and Policy, 2*(9), 1-9.

Lietz, C., & Zayas, E. L. (2010). Evaluating qualitative research for social work practitioners. *Advances in Social Work, 11*(2), 188-202.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Ling, H. K. (2004). The search from within. Research issues in relation to developing culturally appropriate social work practice. *International Social Work, 47*(3), 335-344.

Ling, H. K. (2007). Indigenising social work: Research and practice in Sarawak. Strategic Information and Research Development Centre. Selangor, Malaysia: Petaling Jaya.

Lucy, O., Alice, O., & Lucy, O. (2015). Socio-Cultural Factors Influencing Access to Reproductive Health Service Information among the Youth in Korogocho Slum of Nairobi, Kenya. *Research on Humanities and Social Sciences, 5*(14), 153-163.

Madon, S., Willard, J., Guyll, M., & Scherr, K. C. (2011). Self-fulfilling prophecies: Mechanisms, power, and links to social problems. *Social and Personality Psychology Compass*, *5*(8), 578-590.

Mahejabin, F., Parveen, S., & Begum, R. (2015). Disease pattern and health seeking behaviour of slum dwellers in Dhaka city. *International Journal of Medical and Health Research*, *1*(2), 4-8.

Marcus, D. M., & Snodgrass, W. R. (2005). Do no harm: avoidance of herbal medicines during pregnancy. *Obstetrics & Gynecology*, *105*(5), 1119-1122.

Marmot, M., Allen, J., & Goldblatt, P. (2010). A social movement, based on evidence, to reduce inequalities in health. *Social Science & Medicine*, *71*(7), 1254-1258.

Matoane, T. E. B. O. G. O. (2015). *Women in local government decision making and leadership positions: an analysis of the gender dynamics in the Nkangala District Municipality, Mpumalanga Province, South Africa* (Doctoral dissertation, University of Limpopo).

Mcnojia, S. Z., Saleem, S., Feroz, A., Khan, K. S., Naqvi, F., Tikmani, S. S., & Goldenberg, G. I. (2020). Exploring Women and traditional birth attendants' perceptions and experiences of stillbirths in district Thatta, Sindh, Pakistan: a qualitative study. *Reproductive Health*, *17*(1), 1-11.

Memon, Z., Zaidi, S., & Riaz, A. (2016). Residual Barriers for Utilization of Maternal and Child Health Services: Community Perceptions From Rural Pakistan. *Global Journal of Health Science*, *8*(7), 47-57.

Ministry of health, Indonesia. (2019). *The Role of Culture in Maternal Healthcare Utilization.* Kementerian Kesehatan Republik Indonesia: Badan Litbangkes.

Ministry of Health, Pakistan. (2004). *Progress on Agenda for Health Sector Reforms.* Islamabad: Ministry of Health.

Mudonhi , N., Nunu, W. N., Sibanda, N., & Khumalo, N. (2021). Exploring traditional medicine utilisation during antenatal care among women in Bulilima District of Plumtree in Zimbabwe. *Scientifc Reports, 11*(1), 1-9.

Mudonhi1, N., & Nunu, W. N. (2021). Traditional Practitioners and Nurses' Perspectives on Traditional Medicine Utilisation During Antenatal Care in Matabeleland South Province, Zimbabwe. *Health Services Insights, 14*, 1-10.

Mugomeri, E., Chatanga, P., Seliane, K., & Maibvise, C. (2015). Identifying promoters and reasons for medicinal herb usage during pregnancy in Maseru, Lesotho. *Africa Journal of Nursing and Midwifery, 17*(1), 4-16.

Muldoon, K. A., Galway, L. P., Nakajima, M., Kanters, S., & Hogg, R. S., Bendavid, E., & Mill, E. J. (2011). Health System Determinants of Infant, Child and Maternal Mortality: A Cross-sectional Study of UN Member Countries. *Global Health, 7*(42).

Mumtaz, Z., Salway, S., Shanner, L., AfshanBhatti, A., & Laing, L. (2011). Maternal deaths in Pakistan: intersection of gender, caste, and social exclusion. *BMC International Health and Human Rights, 11*(S4).

Munir, S., & Mohyuddin, A. (2015). Social and Cultural causes of Female Reproductive Health Issues in Tribal Area Koh-Sulman Dera Gahzi Khan, Pakistan. *Indian Journal of Health & Wellbeing, 6*(9), 854-858.

Nana, A., & Zema, T. (2018). Dietary practices and associated factors during pregnancy in northwestern Ethiopia. *BMC Pregnancy and Childbirth, 18*(183).

Nasir, J. A. (2013). *Fertility transition in Pakistan: neglected dimensions and policy implications* (Doctoral dissertation, University of Southampton).

Nasrullah, M. (2015). *Child Marriage And Its Impact On Maternal And Child Health In Pakistan.* [Unpublished master's thesis]. University of Bielefeld, Germany.

Nasrullah, M., & Bhatti, J. A. (2012). Gender Inequalities and Poor Health Outcomes in Pakistan: A Need of Priority for the National Health Research Agenda. *Journal of the College of Physicians and Surgeons Pakistan, 22*(5), 273-274.

Nasrullah, M., Zakar, R., & Krämer, A. (2013). Effect of child marriage on use of maternal health care services in Pakistan. *Obstetrics & Gynecology, 122*(3), 517-524.

National Assembly of Pakistan. (2018). *Reproductive and Healthcare Rights Act 2013*. Retrieved from. July 24, 2018, https://www.prb.org/wp-content/uploads/2018/05/

National Disaster Management Authority. (2009). "District Disaster Risk Management Plan, 2009"; available at http://www.ndma.gov. pk/plans/ District%2 0DRM% 20Plan% 20% 20 Rajanpur.pdf; Page 18-19. (Accessed 20 Nov 2017)

National Implementation Strategy & Action plan 2016-2020. (2019). Pakistan Maternal Mortality Survey. National Institute of Population Studies by (NIPS) Islamabad.

National Institute of Population Studies (NIPS) [Pakistan], and Macro International Inc. 2008. *Pakistan Demographic and Health Survey 2006-07.* Islamabad, Pakistan: National Institute of Population Studies and Macro International.

Ndidi, E., & Oseremen, I. (2010). Reasons Given by Pregnant Women for Late Initiation of Antenatal Care in the Niger Delta, Nigeria. *Ghana medical journal, 44*(2), 47-51.

NIPS. (2010). *Pakistan Demographic and Health Survey (PDHS).* Islamabad: National Institute of Population Studies Islamabad, Pakistan.

NIPS. (2019). *Pakistan Demographic and Health Survey (PDHS).* Islamabad: National Institute of Population Studies Islamabad, Pakistan.

Nordeng, H., Bayne, K., Havnen, G. C., & Paulsen, B. S. (2011). Use of herbal drugs during pregnancy among 600 Norwegian women in relation to concurrent use of conventional drugs and pregnancy outcome. *Complementary Therapies in Clinical Practice, 17*(3), 147-151.

Nosheen, F., Ali, T., Ahmad, M., Anwar, H. N., Ahmad, M., & Iqbal, A. (2009). Assessing Gender Role in Decision Making Regarding Socioeconomic Activities in Rural Punjab. *Pakistan Journal of Agricultural Sciences, 46*(1), 73-77.

Nwokocha, E. E. (2007). Maternal crises and the role of African men. The case of a Nigerian community. *African Population Studies, 22*(1), 39– 62.

Obasi, Z. E. (2013). *A Review of the Barriers and Socio-Cultural Factors Influencing the Access to Maternal Health Care Services in Nigeria* [Master's thesis, Helsinki

Metropolia University of Applied Sciences]. Metropolia Ammattikorkeakoulu. https://urn.fi/URN:NBN:fi:amk-2013122622111

Omer, S. (2019). The Social and Cultural Factors of Maternal Mortality in the Context of Three Delays: The perspective of Lady Health Workers of South Punjab, Pakistan. *Pakistan Vision, 20*(1), 1-8.

Omer, S., Zakar, R., Zakar, M. Z., & Fischer, F. (2021). The infuence of social and cultural practices on maternal mortality: a qualitative study from South Punjab, Pakistan. *Reprod Health, 18*(1), 1-12.

Ope-Babadede, O. O. (2021). Factors Contributing to Increased Utilization of Traditional Birth Attendants Among Pregnant Women in Illah Community of Oshimili North Local Government Area, Delta State. *Euro Global Contemporary Studies Journal*, *1*, 27-37.

Ozimek, J. A., & Kilpatrick, S. J. (2018). Maternal mortality in the twenty-first century. *Obstetrics and Gynecology Clinics*, *45*(2), 175-186.

Pakeeza, S. (2015). Domestic Violence Laws and Practices in Pakistan. *Vfast Transactions on Education and Social Sciences, 6*(1), 17-20.

Pakistan Bureau of Statistics, Islamabad. (2017). “District and Tehsil level population summary with region breakup”; available http://www.pbscensus.gov.pk/sites/default/ les/bwpsr/ punjab/ Rajanpur_Summary.pdf

Pakistan Bureau of Statistics. (2017). “Population of Punjab Census 2017; available at http://www.pakinformation.com/ population/punjab.html (Accessed: 28 April 2018)

Pakistan Demographic and Health Survey. (2012). National Institute of Population Studies (NIPS), Islamabad, Labor force participation rate (LFPR) in 2018-2019 Pakistan Bureau of Statistics Pakistan

Pakistan Demographic and Health Survey 2006-07. (n.d) National Institute of Population Studies (NIPS), Islamabad.

Patel, P. K., & Patel, M. K. (2012). Ethnogynaecological Uses of Plants from Gujarat, India. *Bangladesh Journal of Plant Taxonomy, 19*(1), 93-94.

Perry, H., Crigler, L., & Hodgins, S. L. (2013). Developing and strengthening community health worker programs at scale: a reference guide for program managers and policy makers. *Dhaka, Bangladesh: University Press Ltd*.

Pillai, V. K., & Maleku, A. (2015). Reproductive health and social development in developing countries: changes and interrelationships. *The British Journal of Social Work*, *45*(3), 842-860.

Planning Commission, Ministry for Planning, Development & Reform Pakistan. (n.d). *Pakistan 2025 One Nation-One Vision.* https://www.pc.gov.pk/uploads/vision2025/ Pakistan-Vision-2025.pdf

Porteous, T., Wyke, S., Hanaford, P., & Bond, C. (2015). Self-care behaviour for minor symptoms: can Andersen's behavioural model of health services use help us to understand it? *International Journal of Pharmacy Practice, 23(*1), 27-35.

Punjab Population Policy. (2016). Population Welfare Department; Government of Punjab 5 http:// www. pbscensus. gov. pk/sites/default/files/ Files/ PAKISTAN.pdf 6 National Health Vision; 2016 – 2025, Pakistan.

Qadir, F., Khan, M. M., Medhin, G., & Prince, M. (2011). Male Gender Preference, Female Gender Disadvantage as Risk Factors for Psychological Morbidity in Pakistani Women of Childbearing Age - A Life Course Perspective. *BMC Public Health, 11*(1), 745-758.

Qazlbash, S. K., Zubair, M., Manzoor, S. A., ul Haq, A., & Baloch, M. S. (2021). Socioeconomic determinants of climate change adaptations in the flood-prone rural community of Indus Basin, Pakistan. *Environmental Development, 37*, 100603.

Qidwai, W., Tabassum, R., Hanif, R., & Khan, F. H. (2009). Belief in Prayers and its Role in Healing among Family Practice Patients visiting a Teaching Hospital In Karachi, Pakistan. *Pakistan Journal of Medical Sciences, 25*(2), 182-189.

Quresh, R. N., Sheikh, S., Khowaja, A. R., Hoodbhoy, Z., Zaidi, S., Sawchuck, D., & Dadeslzen, P. V. (2016). Health Care Seeking Behaviours in Pregnancy in Rural Sindh, Pakistan: A Qualitative Study. *Reproductive Health, 13*(34), 75-81.

Rabbani, F., Qureshi, F., & Rizvi, N. (2008). Perspectives on domestic violence: case study from Karachi, Pakistan. *Eastern Mediterranean Health Journal, 14*(2), 415-426.

Raffiee, M., & Mirzaee, A. H. (2014). The relationship between structure and agency in communicative action theory. *Bulletin of Environment, Pharmacology and Life Sciences, 3*(11), 141-149.

Rahman, A. H. M. M., Gulsan, J. E., Alam, M. S., Ahmad, S., Naderuzzaman, A. T. M., Islam, A. K. M. R. (2012). An Ethnobotanical Portrait of A Village: Koikuri, Dinajpur with Reference to Medicinal Plants. *International Journal of Bioscience, 2*(7), 1-10.

Rahman, A. M. (2014). Ethno-Gynecological Study of Traditional Medicinal Plants Used by Santals of Joypurhat District, Bangladesh. *Biomedicine and Biotechnology, 2*(1), 10-13.

Rai, R. K., Tulchinsky, T. H. (2012). Addressing the Sluggish Progress in Reducing Maternal Mortality in India. *Asia-Pacific Journal of Public Health, 27*(2), 1161-1169.

Rajanpur District Administration. (2017). "Flood Contingency Plan District Rajanpur, 2017"; Page: 4

Rashid, N. (2016). Giving the silent majority a stronger voice? Initiatives to empower Muslim women as part of the UK's 'War on Terror'. In *New Racial Landscapes* (pp. 13-28). Routledge.

Rebhan, P. D. (2008). *Health care utilisation: Understanding and applying theories and models of health care seeking behaviour.* Case Western Reserve University.

Reimer-Kirkham, S., Sharma, S., Pesut, B., Sawatzky, R., Meyerhoff, H., & Cochrane, M. (2012). Sacred spaces in public places: Religious and spiritual plurality in health care. *Nursing Inquiry*, *19*(3), 202-212.

Requejo, J. H., Bryce, J., Barros, A. J., Berman, P., Bhutta, Z., Chopra, M., & Victora, C. G. (2015). Countdown to 2015 and beyond: fulfilling the health agenda for women and children. *The Lancet*, *385*(9966), 466-476.

Rizvi, N., Khan, K. S., & Shaikh, B. T. (2014). Gender: Shaping Personality, Lives and Health of Women in Pakistan. *BMC Women's Health*, *14*(1), 53-60.

Rizvi, N., S Khan, K., & Shaikh, B. T. (2014). Gender: shaping personality, lives and health of women in Pakistan. *BMC Women's Health, 14*, 1-8.

Roberts, J., Sealy, D., Marshak, H. H., Manda-Taylor, L., Gleason, P., & Mataya, R. (2015). The Patient Provider Relationship and Antenatal Care uptake at Two Referral Hospitals in Malawi: A Qualitative Study. *Malawi Medical Journal, 27*(4), 145-150.

Robeyns, I. (2005). The capability approach: A theoretical survey. *Journal of Human Development, 6*(1), 93-114.

Robinson, W. C., & Ross, J. A. (2007). Family Planning Programs and Policies in Bangladesh and Pakistan. In W. C.Robinson, & J. A. Ross (Eds.), *The Global Family Planning Revolution: Three Decades of Population Policies and Programs* (pp. 325-339). Washington, D.C.: World Bank.

Rosenfield, A., & Maine, D. (1985). Maternal mortality: A neglected tragedy. Where is the M in the MCH? *The Lancet, 34*(2), 83–85.

Roudsari, R. L., Zakerihamidi, M., & Khoei, E. M. (2015). Socio-cultural beliefs, values and traditions regarding women's preferred mode of birth in the North of Iran. *International Journal of Community-based Nursing and Midwifery*, *3*(3), 165.

Ruger, J. P. (2010). Health capability. Conceptualization and operationalization. *American Journal of Public Health, 100*(1), 41-49.

Sabe, Z. (2019). *Traditional and complementary medicine use by African migrant women in Australia: the interface between cultural health practices and Western medicine*. [PhD thesis, University of Western Sydney].

Saeed, S. (2022). Bee Diversity of Pakistan. In *Biodiversity, Conservation and Sustainability in Asia: Volume 2: Prospects and Challenges in South and Middle Asia* (pp. 487-519). Cham: Springer International Publishing.

Saleem, T., Sajjad, N., Fatima, S., Habib, N., Ali, S. R., & Qadir, M. (2011). Intrauterine growth retardation-small events, big consequences. *Italian Journal of Pediatrics*, *37*(1), 1-4.

Sarfraz, M., Tariq, S., Hamid, S., & Iqbal, N. (2015). Social and Societal Barriers in Utilization of Maternal Health Care Services in Rural Punjab, Pakistan. *Journal of Ayub Medical College, 27*(4), 843-849.

Sathar, Z., & Zaidi, B. (2012). Pakistan *in Asia & The Pacific*, 199.

Sattar-Jenkins, A. (2019). *Motherhood and the absence of maternal support: an exploration amongst Asian women* (Doctoral dissertation, Middlesex University/Metanoia Institute).

Schwab, K., Crotti, R., Geiger, T., & Ratcheva, V. World Economic Forum. (2019). Global gender gap report 2020 insight report. In *World Economic Forum. http://reports. weforum. org/global-gender-gap-report-2020/dataexplorer*.

Seale, C. (1999). Quality in qualitative research. *Qualitative Inquiry, 5*(4), 465-478.

Sen, A. (1999). *Development as freedom.* New York: Random Books.

Sen, A. (2001). *Development as freedom*. New York: Oxford University Press.

Senah, K. (2003). Maternal mortality in Ghana: The other side. Research review. *Socio-cultural Dimensions of Reproductive Health and Human Development, 19*(1), 47–56.

Shah, R., Mullany, L. C., Darmstadt, G. L., Talukder, R. R., Rahman, S. M., Mannan, I., & Baqui, A. H. (2014). Determinants and pattern of care seeking for preterm newborns in a rural Bangladeshi cohort. *BMC Health Services Research, 14*(1), 1-12.

Shah, S. A., & Amjad, S. (2011). Cultural Diversity In Pakistan: National Vs Provincial. *Mediterranean Journal of Social Sciences, 2*(2), 1-14.

Sharma, S., Teijlingen, E. v., Hundley, V., Angell, C., & Simkhada, P. (2016). Dirty and 40 days in the wilderness: Eliciting childbirth and postnatal cultural practices and beliefs in Nepal. *BMC Pregnancy and Childbirth, 16*(147).

Sheikh, S., Qureshi, R. N., Khowaja, A., Salam, R., Vidler, M., Sawchuck, D., . . . CLIP Working Group. (2016). Health care provider knowledge and routine management

of pre-eclampsia in Pakistan. *Reproductive Health, 13(Suppl 2)*(104), 107-113. doi: 10.1186/s12978-016-0215-z

Shewamene, Z., Dune, T., & Smith, C. A. (2017). The use of traditional medicine in maternity care among African women in Africa and the diaspora: a systematic review. *BMC Complementary and Alternative Medicine, 17*(382).

Shin , D., Lee , K. W., & Song, W. O. (2015). Dietary Patterns during Pregnancy Are Associated with Risk of Gestational Diabetes Mellitus. *Nutrients, 7*(11), 9369-9382.

Siddiqui, S., Farah, N., & Malik, N. (2021). Cultural Values about Gender Inequalities and their Implications for Women's Health in Rural Punjab, Pakistan. *Pakistan Journal of Social Research, 3*(3), 44-53.

Silalahi, M., Khairiah, A., & Nisyawati, N. (2020). Ethnomedicinal plants and practices related to pregnancy, childbirth, and postpartum healthcare of Minangkabau ethnic group, West Sumatra, Indonesia. *Biodiversitas Journal of Biological Diversity*, *21*(10). 4597-4605.

Silverman, D. (2010). *Doing qualitative research.* Third edition. London, U. K: SAGE.

Singh, P. K., Rai, R. K., Alagarajan, M., & Singh, L. (2012). Determinants of Maternity Care Services Utilization among Married Adolescents in Rural India. *PLoS ONE, 7*(2).

Sithole, L. (2021). Women's right to access family planning and maternal health care services in Hwange rural district, Zimbabwe: challenges and opportunities.

Sperling, J. D., Dahlke, J. D., Huber, W. J., & Sibai, B. M.. (2015). The Role of Headache in The Classification and Management of Hypertensive Disorders in Pregnancy. *Obstetrics & Gynecology*, *126*(2), 297–302.

Stenbacka, C. (2001). Qualitative research requires quality concepts of its own. *Management Decision*, *39*(7), 551-556.

Stevens, G. A., Finucane, M. M., Paciorek, C. J., Flaxman, S. R., White, R. A., Donne, A. J., & Ezzati, M. (2012). Trends in Mild, Moderate, and Severe Stunting and Underweight, and Progress towards MDG 1 in 141 Developing Countries: A Systematic Analysis of Population Representative Data. *Lancet, 380,* 824-834.

Story, W. T., Burgard, S. A., Lori, J. R., Taleh, F., Ali, N. A., & Haque, D. E. (2012). Husband's involvement in delivery care utilisation in rural Bangladesh: A Qualitative study. *BMC Pregnancy and Childbirth*, *35*(3), 150-161.

Sully, E. A., Biddlecom, A., Darroch, J. E., Riley, T., Ashford, L. S., Lince-Deroche, N., Firestein, L., & Murro, R. (2020). Adding it up: investing in sexual and reproductive health 2019.

Sultana, A. (2010). Patriarchy and Women's Subordination: A Theoretical Analysis. *The Arts Faculty Journal*, *4*, 1-18.

Sultana, A. M. (2011). Factors effect on women autonomy and decision-making power within the household in rural communities. *Journal of Applied Sciences Research*, *7*(1), 18-22.

Syed, U., Khadka, N., Khan, A., Wall, S. (2008). Care-Seeking Practices in South Asia: Using Formative Research to Design Program Interventions to Save Newborn Lives. *Journal of Perinatology*. *28*(2), 9–13.

Syraya, S., & Jamaludin, S. (2014). Postpartum Food Restriction of Rural Malay Women. *Asian Journal of Humanities and Social Sciences, 2*(4), 32-41.

Tarafder, T., & Sultan, P. (2014). Reproductive Health Beliefs And Their Consequences: A Case Study on Rural Indigenous Women in Bangladesh. *Australasian Journal of Regional Studies, 2*(2), 351-374.

Tarar, M. A., Akhtar, S., Zafar, M. I., & Muhammad, S. (2015). Reproductive Health; Perceptions, Attitudes And Practices Among Young Females In Faisalabad District, Pakistan. *The Professional Medical Journal, 22*(1), 81-99.

Taylor, L. M., Sealy, D. A., & Roberts , J. (2017). Factors Associated with Delayed Antenatal Care Attendance in Malawi: Results from a Qualitative Study. *Medical Journal of Zambia, 44*(1), 17-25

Thaddeus, S., & Maine, D. (1994). Too far to walk. Maternal mortality in context. *Social Science and Medicine, 38*(8), 1071-1091.

Tuladhar, H., &Dhakal, N. (2012). Impact of Antenatal Care on Maternal and Perinatal Outcome: A Study at Nepal Medical College Teaching Hospital. *Nepal Journal of Obstetrics and Gynaecology, 6(2),* 37-43.

UN. (1995). *Report of the International Conference on Population and Development, Cairo, 5- 13 September 1994.* New York: UN.

UNDP. (2014). *Human Development Report, The Real Wealth of the Nations: Pathways to Human Development*. New York: UNDP.

UNFPA (2004). *Investing in People: National Progress in Implementing the ICPD Programme of Action, 1994-2004. UNFPA, New York*. Retrieved July 13, 2018, from http://www.unfpa.org/icpd

UNFPA (2005). *State of the World Population 2005*. Retrieved July 23, 2018 from https://www.unfpa.org/publications/state-world-population-2005

United Nations Development Programme. (2007). *Towards a more inclusive society.* Ghana Human Development Report. Accra: Combert Impressions.

United Nations Development Programme. (2011). Discussion paper. *A social determinants approach to maternal health. roles for development actor*s. 19th October, 2011, UNDP

United Nations Development Programme. (2020). *2019 Annual Report Gender Equality Strategy 2018-2021*. New York, USA: United Nations Development Program.

United Nations. (1995). *Report of the International Conference on Population and Development, Cairo, 5- 13 September 1994.* New York: UN.

Upadhyay, P., Liabsuetrakul, T., Shrestha, A. B., & Pradhan, N. (2014). Influence of family Members on Utilization of Maternal Health Care Services among Teen and Adult Pregnant Women in Kathmandu, Nepal: A Cross Sectional Study. *Reproductive Health, 11*(1), 92-103.

Vallely, L.M., Homiehombo, P., Kelly-Hanku, A., Vallely, A., Homer, C.S.E., & Whittaker, A., (2015). Childbirth in A Rural Highlands Community in Papua New Guinea: A Descriptive Study. *Midwifery*, *31*(3), 380–387.

WHO Guidelines Approved by the Guidelines Review Committee. (2016). *WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience. Geneva: World Health Organization. Copyright*. Geneva**:** World Health Organization.

Withers, M., Kharazmi, N., Lim, E., (2018). Traditional Beliefs and Practices in Pregnancy, Childbirth and Postpartum: A Review of the Evidence from Asian Countries. *Midwifery*, *56*, 158-170.

World Bank. (2014, April 03). *Reproductive Health and the World Bank Group: The Facts*. Washington, D. C: World Bank Groups.

World Bank. (2019). *World Development Indicators 2019.* Washington D.C: World Bank.

World Economic Forum. (2020). *Global Gender Gap Report 2020, Geneva*. reports.weforum.org/global-gender-gap-report-2020/data explorer.

World Economic Forum. (2020). *Global Gender Gap Report 2020.* Geneva, Switzerland: World Economic Forum.

World Health Organization. (1986). Maternal mortality: helping women off the road to death. *WHO Chronicle, 40*, 175–183.

World Health Organization. (2013). *World health report 2013*: Research for universal coverage. Geneva: WHO Press.

World Health Organization. (2013). *Family Planning Fact Sheet*. Retrieved July 28, 2018 from http://www.who.int/mediacentre/factsheets/fs351/en/

World Health Organization. (2002). *The world health report 2002: reducing risks, promoting healthy life*. World Health Organization.

World Health Organization. (2006). Integrating Sexual and Reproductive Health-Care Services. *Policy brief: Implementing the Global Reproductive Health Strategy,*1- 3.

World Health Organization. (2015). *State of inequality: reproductive maternal newborn and child health: interactive visualization of health data*. World Health Organization.

World Health Organization. (2017). *Maternal health: fact sheet on Sustainable Development Goals (SDGs): health targets* (No. WHO/EURO: 2017-2363-42118-58039). World Health Organization. Regional Office for Europe.

World Health Organization. (2017). World health statistics 2017: monitoring health for the SDGs, sustainable development goals. World Health Organization https: //apps. who. int/iris/handle/10665/255336. License: CC BY-NC-SA 3.0 IGO United Nations Population Fund (2019) Annual report https://www.unfpa.org › annual-report-2019

Zahan, N. (2014). Factors Influencing Women's Reproductive Health. *ABC Journal of Advanced Research, 3*(2), 38-46.

APPENDICES

Appendix I

Informed Consent for Participants

Influencing of Cultural Factors in Women Maternal Health Care: A Case Study in Tehsil Jampur, District Rajanpur of Punjab, Pakistan

I am Altaf Ghani. As a student of PhD at University of Malaysia SARAWAK Malaysia. I am currently conducting a study "Influencing of Cultural Factors in Women Maternal Health Care" for my thesis. I have chosen your village as specific area for this study. I want to conduct interviews with selected married Women in your village. I would like to interview of you, if you and your family have not any objection. If you agree, the interview will take place at your home at a time which is convenient for you. The interview will include questions about your experiences, opinions and decisions on matters related to your reproductive health and socio-cultural factors influencing maternal health care system.

Your participation for this study and all information given will be kept confidential. If you agree for recording, the interview recordings will be kept in a secure place and will not be accessible to others. Your participation in this study is voluntary. If you did not to participate or withdraw at any stage of the interview there will be no penalty.

Although I am conducting this study as a part of my degree, I also intend to inform policy makers in Pakistan and Government of Punjab, and therefore your participation would not only benefit my project but also the government policies on reproductive health of women.

Thank you,

Appendix II

Interview Guide

Influencing of Cultural Factors in Women Maternal Health Care: A Case Study in Tehsil Jampur, District Rajanpur of Punjab, Pakistan

Section A- Demographic Information

Name: _____ Husband Name: _____

Contact Number: _____ (Please state) UC: _____

S. No	Questions	Responses
A-1	Age	_____ or (Date of Birth: ___/___/____)
A-2	Occupation	1. Housewife 2. Govt. Employee 3. Private Job 4. Farmer 5. Other _____
A-3	Area of residence	1. Urban 2. Rural
A-4	Family Type	1. Joint Extended 2. Extended 3. Nuclear

A-5	Ethnicity	1. Saraiki 2. Punjabi 3. Balochi 4. Pashtun 5. Sindhi 6. Others :_____ (please state)
A-6	Marital Status	1. Married 2. Widowed 3. Divorced 4. Separated 5. Other : _____ (please state)
A-7	Religion	1. Muslim 2. Non-Muslim
A-8	Qualification	1. Illiterate 2. Primary School 3. Middle School 4. Secondary School 5. Higher Secondary School 6. Higher Education 7. Others : _____ (please state)

Section B: Health Status and Experiences

S. No	Questions	Responses
B-1	How many times have you been pregnant?	
B-2	How do you get to know that you are pregnant?	Probe for signs of pregnancy
B-3	Did you experience any complications in your last pregnancy?	Find out the nature of complications, whether complications were reported to professionals or treated with alternative medicine and why.
B-4	If yes, what measures did you take to manage them?	
B-5	In your last pregnancy did you seek medical care?	(Probe for timing and number of visits)
B-6	If yes, at what stage?	
B-7	Do you have children?	1 Yes 2 No
B-8	If yes, how many living children you have?	
B-9	Is there any abortion or pregnancy loss in past	1 Yes 2 No
B-10	If yes, what was the major reason	
B-11	What do you think who is responsible for the delay of some women in seeking health care services?	
B-12	Where did you receive treatment for the above complication?	

Section C: Healthcare Service and Information system

S. No	Questions	Responses
C-1	Is there any health facility or services available in your area/UC?	1 Yes 2 No
C-2	If yes, then what types of services are available?	Probe 1. Government Hospital/Health clinics 2. MCH Clinic 3. LHV's clinic 4. TBA 5. Private Hospitals 6. Homeopathic clinics 7. Herbals
C-3	Which services woman regularly choose to go for maternal health?	
C-4	How many times you visit for these services during pregnancy?	_____ First Trimester _____ Second Trimester _____ Third Trimester _____ Total Visits Don't know
C-5	How do you travel and how long does it take time?	
C-6	Which mode of transport do you choose?	

C-7	What types of services are given in government centers for a pregnant woman? (Multiple responses)	1. Blood pressure 2. CT scan 3. Ultra Sound 4. TT Vaccination 5. Other… Specify
C-8	What types of services are given in non-government centers for a pregnant woman?	1. Blood pressure 2. CT scan 3. Ultra Sound 4. TT Vaccination 5. Other… Specify
C-9	Do you satisfy the quality of the Govt health care services and facilities?	
C-10	Do the Lady Health Workers visit in your area?	1 Yes 2 No
C-11	If yes, then what type of maternal healthcare services they provide?	1. Give satisfactory information/ advise 2. Reproductive health services 3. Counseling 4. Treatment 5. Other _____ (specify)
C-12	How do you arrange money to avail maternal healthcare services in your area?	

C-13	Have you experienced home delivery before?	Probe Who assisted you at delivery? are there other women in this community who have had home deliveries
C-14	If yes, why didn't you give birth in a health facility?	
C-15	How would you describe your experiences in home delivery?	
C-16	Have you ever given birth in a health facility?	
C-17	If yes, can you share your experiences?	
C-18	Did you seek treatment after home delivery?	
C-19	If yes, when and where? If no, why and how did you treat yourself?	

Section: Maternal Health Beliefs and Practices

S. No	Questions	Responses
D-1	What was your age at the time of marriage?	Completed Years
D-2	How old was you when you had your first child?	Completed Years
D-3	Any of your child died after birth? Note: Don't include still births	1. Yes _____ Number 2. No
D-4	If yes, what caused the death of children after birth?	Specify
D-5	Have you ever experienced miscarriage/still birth/premature delivery?	(Probe for clinical attendance/alternative care before and after).
D-6	If yes, how many times? At what stage in pregnancy did that happen?	
D-7	Do you have traditional birth attendants/ herbalists/spiritualists who give treatment to pregnant women in this community or in a nearby community?	

D-8	If yes, did you use them services in your last pregnancy?	
D-9	If no why?	Probe further
D-10	What are the reasons of pregnant women's illness?	Probe: Biological malfunctioning, Witchcraft, sorcery or Mystical forces, carelessness, malnutrition, work load
D-11	What should people do to protect them from illness? (Multiple responses may encourage)	Probe: visit doctor, Hakeem, Spiritual Healers, Home remedies etc.
D-10	In your culture, what is dirty / impure regarding pregnancy and how these impurities affect pregnant women?	
D-11	Who in the community or in the family defend these traditions?	Probe: husbands, other women, TBAs, religious leaders, culture etc.
D-12	In which situations (fertility, birth, newborn initiation) do women require the intervention? Please describe the kind of support requested	religious/ spiritual leaders
D-13	In which occasions (before delivery, and after delivery,) do women require the intervention/help from? Please describe the kind of support requested	religious/ spiritual leaders
D-14	Is the information given by reproductive health service providers similar to your beliefs regarding maternal health?	1. Yes 2. No
D-15	What type of rituals are performed when women get pregnant and baby born?	Probe: (*Godh bharai)*, Charity (*Sadqa*) etc.
D-16	What are the routine cultural practices for postnatal care?	Probe: confinement restrictions, Taboos

D-17	Are there any ceremonies that a woman needs to do after she has given birth?	1. traditional 2. religious rituals
D-18	Do you think these are only cultural/Religious perceptions?	1. Yes 2. No
D-19	Do you prefer a baby girl or a baby boy? Give reasons?	
D-20	Do you have specific beliefs, taboos, norms around pregnancy and childbirth?	(Probe for beliefs around, pregnancy, delivery, and post-delivery & the implications in each case).
D-21	If yes, what are some of the views and health beliefs	
D-22	Do you have prescribed food for pregnant women?	(Probe for food habits and implications). In your last pregnancy, did you observe?
D-22	If yes, what food are pregnant women allowed/not allowed to eat?	
D-23	What is your opinion on these views and health believes	

Section E: Health Beliefs and Family Decision making

S. No	Questions	Responses
E-1	During pregnancy, do wife and husband prefer to talk about pregnancy, usually?	1. Yes 2. No
E-2	Who are normally allowed to witness/assist women during childbirth in this community?	
E-3	Whom do you prefer to witness/assist your delivery and why?	
E-4	Do you need approval of your husband before choosing where and when to seek care?	(Probe for who decides e.g father or mother of husband/self)
E-5	If yes, in the absence of your husband what do you do?	
E-6	Have you ever experienced an instance where your husband prevented you/disagreed with you from/in seeking health care?	(Probe for type of prescribed source of care).
E-7	If yes, what was the reason? Did he prescribe a different source of care for you?	
E-8	If yes/no, what did you do?	
E-9	Are you allowed to make your own decision about your health during pregnancy and childbirth?	
E-10	If no, would you prefer that women be allowed to make their own choice of care?	
E-11	If yes, why?	
E-12	What role does your husband play during your pregnancy and childbirth?	(Probe, helping in household chores, payment of bills, accompanying her to clinic

E-13	What role did your husband play in managing the complication?	(Probe for involvement of spouse in the action taken).
E-14	Does your husband accompany you for ante-natal checkup?	1. Yes 2. No
E-15	If no, then who goes with you?	
E-16	Who decides how many children you have	
E-17	Do your maternal health-seeking behavior is same as your elder women?	
E-18	If it is change then what are the differences in the health-seeking behavior of your elders and yours?	
E-19	Who in the family, usually takes decisions about whether to follow traditional practices?	Probe Mother-in-law Husband Grandmother TBA_____

Section F: Indigenes Methods Regarding Maternal Health

S. No	Questions	Responses
F-1	Do you seek treatment for physical health problems during the pre and postnatal period	
F-2	If yes then who suggest you,	Probe, Family, TBA, Pir group and any other
F-3	Does your family use herbal medicine to prevent and treat various other Illness.	
F-4	Do you think that herbal medicine used in pregnancy because of common belief that herbs are natural and free of any adverse effect	
F-5	Have you use at least one herbal product during your last pregnancy	
F-6	Do you believe that traditional medicine is more effective than western medicine?	Probe Because of (better accessibility, lower cost, any other) If yes? Why?
F-7	How illness was diagnoses locally for maternal health care?	
F-8	Which type of Remedies is used in pregnancy in your family?	
F-9	Do you think traditional medicine also used for treatment by performing various type of rituals?	
F-10	Homemade remedies made by TBAs, family and Pir that are transferred from generation to generation.	
F-11	Do you think that herbal medicine or home remedies are authentic without any test form laboratory?	
F-12	Do you think that these home remedies are in common practice where delivers hold at home?	

F-13	In your family child care home remedies also used on postnatal time period as the newborn baby care is concerned?	
F-14	In your family TBAs are preferred for various preseasons?	Prob, availability in community, offering individual care to mothers, provide herbal medicine,
F-15	Do you experience that usually TBAs prepared, prescription according to the demand of the family?	
F-16	Do you promote traditional values regarding maternal health that you have learned from your elders?	

Thank you,

Appendix III

Focus Group Discussion Guide

Influencing of Cultural Factors in Women Maternal Health Care: A Case Study in Tehsil Jampur, District Rajanpur of Punjab, Pakistan

Section A- Demographic Information

Respondent	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Age									
Occupation									
Residence									
Family Type									
Ethnicity									
Marital Status									
Religion									
Qualification									
Place of interview									
Date of interview									

Section B: Health Status and experiences

- How many times have you been pregnant?
- How do you get to know that you are pregnant? (Probe for signs of pregnancy).
- Did you experience any complications in your last pregnancy? If yes, what measures did you take to manage them? (Find out the nature of complications, whether

complications were reported to professionals or treated with alternative medicine and why).

- In your last pregnancy did you seek medical care? if yes, at what stage? (Probe for timing and number of visits)
- Do you have children
- If yes how many living children you have?
- Is there any abortion or pregnancy loss?
- If yes what was the major reason
- What do you think could be responsible for the delay of some women in seeking health care services?
- Where did you receive treatment for the above complication?

Section C: Health care Service and Information system

- Is there any health facility or services available in your area/UC
- If yes, then what types of services are available? (Probe Government Hospital/Health clinics MCH Clinic., LHV's clinic, TBA, Private Hospitals, Homeopathic clinics, Herbals)
- Which services people in your community regularly choose to go to Maternal healthcare for?
- How many times they visit for these services during pregnancy?
- How do you travel and how long does it take?
- Which mode of transport do you choose?

- What types of services are given in government centers for a pregnant woman? Probe
- What types of services are given in non-government centers for a pregnant woman?
- Do you satisfy the quality of the Govt health care services and facilities?
- Do the Lady Health Workers visit in your area?
- If yes, then what type of maternal healthcare services they provide?
- How do you arrange money to avail maternal healthcare services in your area?
- Have you experienced home delivery before? If yes, why didn't you give birth in a health facility? Who assisted you at delivery? Are there other women in this community who have had home deliveries?
- How would you describe your experiences in home delivery?
- Have you ever given birth in a health facility? If yes, can you share your experiences with me?
- Did you seek treatment after home delivery? If yes, when and where? If no, why and how did you treat yourself?

Section D: Maternal Health Beliefs and Practices

- What was your age at the time of marriage?
- How old were you when you had your first child?
- Any of your child died after birth? Note: Don’t include still births
- Have you ever experienced miscarriage/still birth/premature delivery? If yes, how many times? At what stage in pregnancy did that happen? (Probe for clinical attendance/alternative care before and after).

- Do you have traditional birth attendants/herbalists/spiritualists who give treatment to pregnant women in this community or in a nearby community? If yes, did you use their services in your last pregnancy? If no why? Probe further
- What are the reasons of pregnant women's illness?
- What should people do to protect them from illness? (Multiple responses may encourage)
- In your culture, what is dirty / impure regarding pregnancy and how these impurities affect pregnant women?
- Who in the community or in the family defend these traditions?
- In which situations (fertility, birth, newborn initiation) do women require the intervention/help from? Please describe the kind of support requested
- Is the information given by reproductive health service providers similar to your beliefs regarding maternal health?
- In which occasions (before delivery, and after delivery,) do women require the intervention/help from? Please describe the kind of support requested
- What type of rituals are performed when women get pregnant and baby born?
- What are the routine cultural practices for postnatal care? Probe
- Are there any ceremonies that a woman needs to do after she has given birth?
- Does your community prefer a baby girl or a baby boy? Give reasons?
- In this community do you have beliefs, taboos, norms around pregnancy and childbirth? If yes, what are some of the worldviews and health beliefs? (Probe for beliefs around, pregnancy, delivery, and post-delivery & the implications in each case).

- Do you have prescribed food for pregnant women? If yes, what food are pregnant women allowed/not allowed to eat? (Probe for food taboos and implications). In your last pregnancy, did you observe these taboos?
- What is your opinion on these worldviews and health believes?

Section E: Health Beliefs and Family Decision making

- During pregnancy, do wife and husband prefer to talk about pregnancy, usually?
- Who are normally allowed to witness/assist women during childbirth in this community? Whom do you prefer to witness/assist your delivery and why?
- Do you need approval of your husband before choosing where and when to seek care? If yes, in the absence of your husband what do you do? Probe
- Have you ever experienced an instance where your husband prevented you/disagreed with you from/in seeking health care? If yes, what was the reason? Did he prescribe a different source of care for you? If yes/no, what did you do?
- Are you allowed to make your own decision about your health during pregnancy and childbirth? If no, would you prefer that women be allowed to make their own choice of care? If yes, why?
- What role does your husband play during your pregnancy and childbirth?
- What role did your husband play in managing the complication?
- Does your husband accompany you for ante-natal checkup? If no, then who goes with you?
- Who decides how many children to have?

- Do your maternal health seeking-behavior is same as your elder women? If it is change then what are the differences in the health-seeking behavior of your elders and yours?
- Who in the family, usually takes decisions about whether to follow traditional practices?

Section F: Indigenes Methods Regarding Maternal Health

- Do you seek treatment for physical health problems during the pre and postnatal period?
- Does your family use herbal medicine to prevent and treat various other Illness.
- Do you think that herbal medicine id used in pregnancy because of common belief that herbs are natural and free of any adverse effect.
- Have you use at least one herbal product during your last pregnancy.
- Do you think that traditional medicine is more effective than western medicine?
- How illness was diagnoses locally for maternal health care?
- Which type of Remedies is used in pregnancy in your family?
- Do you think traditional medicine also used for treatment by performing various type of rituals?
- Homemade remedies made by TBAs or family that were transferred from generation to generation.
- Do you think that herbal medicine or home remedies are authentic without any test form laboratory?

- Prenatal period after the pregnancy your health was stable?
- Do you think that these home remedies were in common practice where delivers hold at home?
- In your family child care home remedies also used on postnatal time period as the newborn baby care is concerned?
- In your family TBAs are preferred for various preseasons?
- Do you experience that usually TBAs prepared, prescription according to the demand of the family?
- Do you promote traditional values regarding maternal health that you have learned from your elders?

Thank You,

Appendix IV

Key informants / Cultural Consultant Guide

Section A: Health Professional and Health Worker (Perception & Reception) Health care system

- What is the staff arrangement/ organogram of the institution? (Within the institution who is accountable to whom)

- How long have you been working at this health centre? What are the health services provided here?
- What is the average number of patients per day/per month that come for check-ups?
- How much fees are taken from the patients coming for treating maternal health?

  for each visit, for regular diagnosis and for complicated medical procedure

- Is there any issue in this health centre that cause you dissatisfied? – (Prompt: salary, incentives, infrastructure, work pattern, work load, overall quality of service, Trainings and refresher courses etc.)
- What role do you play to help women during the prenatal-postnatal period? (Prompt: preparation towards birth, support during delivery and treatment after birth).
- How do you handle complications during pregnancy, delivery and post-delivery stages?
- How many women have you treated in pregnancy or assisted them at delivery?

- How do you solve the situation when you run out of funds or medicines or equipment before the next funding?
- How many women per week come here for receiving maternal health care?
- How many Health service providers are there?
- For what types of complication of the women come to seek health care? – (Prompt: pregnancy, delivery or post-partum care, miscarriage or abortion)
- On average how long they have to wait for receiving health care?
- Can you give me the detail of logistic support (equipment for treating severe complication)?
- Do you think the women coming for treating maternal health can freely discuss their health problems with you? If no then why?
- How do pregnant women behave with you while seeking reproductive health care?
- What type of problems do you face while dealing with women who comes for seeking reproductive health care?
- Are there TBAs/herbalists/spiritualists in this community who treat women during pregnancy or assist during delivery? If yes, do women in the community use their services?
- What do you think are the reasons why some women deliver at home and seek help of traditional practitioners?
- Would you say that some women/families may decide not to do traditional practices during pregnancy and childbirth? If yes, what are the reasons?
- Do you have beliefs, taboos, norms around pregnancy and childbirth? If yes, what are some of the reproductive health beliefs?

- Do you have challenges with the communities regarding utilization of maternal health care services because of traditional beliefs? If yes, could you share with me?

Section B: Traditional Birth Attendant (TBA/ Dai) Role in Health care services

- What is your professional qualification? (Probe, traditional skill, midwife training etc.
- In which sector do you work as a reproductive health care provider? (Prompt: public hospital, private clinic, local health complex, traditional healer or other)
- How many women have you treated in pregnancy or assisted them at delivery?
- How long have you been working as TBA (Dai) and nature of relationship with local families?
- What role do you play to help women during the prenatal-postnatal period? (Prompt: preparation towards birth, support during delivery and treatment after birth).
- How do you handle complications during pregnancy, delivery and post-delivery stages?
- What is the average number of patients per day/per month that come for check-ups?
- How much fee is taken from the patients coming for treating maternal health/ Deliveries?
- What type of problems do you face while dealing with women who comes for seeking reproductive health care?
- What is the nature of relationship between you and Health practitioners/govt health worker? (Doctor, LHV and Lady health worker)?

- Do you have beliefs, taboos, norms around pregnancy and childbirth? If yes, what are some of the reproductive health beliefs? (Probe food, spiritual/ religious healing and decision making).
- How you traditionally treat the illness (prenatal, natal and postnatal) of women and new-born (probe, herbal medicine, Traditional Remedies, (Malish) etc?
- How you traditionally involve/ influence in healthcare and decision making with in family (probe mother in-laws' husband)?

Section C: Family (Old Woman) Perception Regarding Maternal Healthcare

- In your point of view what are the reasons of pregnant women's illness? And what people should do to protect them from illness? (Prompt: Biological malfunctioning, Witchcraft, sorcery or Mystical forces)
- Can you tell me about anything that women must, or must not do, according to your culture/traditions, during pregnancy, birth and in the days after birth? (Prompt: Are there some particular foods that women must eat, or cannot eat? And home remedies)
- Are there any traditional or religious rituals or ceremonies that a woman needs to do after she has given birth? (Prompt: Sixth day celebration (*Ghutti*, *Haqeeqa*, First Haircut (*Jhand lahawrha)*, Forty day celebration (*Chilah*), Keeping Knife with mother and child)
- Do your maternal health-seeking behavior is same as your elder women? If it is changed then what are the differences in the health seeking behavior of your elders and yours?
- Who in the family, usually takes decisions about whether to follow traditional practices? About how many and when to have children? Other decisions in the home?

- Is the information given by reproductive health service providers similar to your beliefs regarding maternal health?
- What type of special care is provided to the mother after the birth of the baby? Who provides this care? How often? (Prompt: Any foods she must eat, or that she is not allowed to eat, Body massage (*Maalish wali*), Maintenance of hot temperature etc.)
- Who decides whether a woman should deliver her baby at home or at a clinic/ hospital? If at home then who assists with the delivery? (Prompt: Husband, Midwives/ LHV/LHW/TBA, grandmother, Mother-in-law etc.)

Thank you

Appendix V

Respondent Demographic Profile

During the fieldwork, information was collected regarding the socio-demographic characteristics of the respondents. The characteristics were: age, education, occupation, monthly income, family type, ethnicity, marital status, location, religion (sect), traveling mode and decision-making about services. Previous studies (Fatmi et al., 2002; Khan et al., 2009; Singh et al., 2012; Munir & Mohyuddin, 2015) show that woman's reproductive health beliefs are practices are interwoven with the cultural, social, familial and economic as well as political contexts of her life. Here some important characteristics age education and occupations are mentioned others were covered in the finding's chapters. After relating all the aspects to reproductive health and women, this research will be conducted in Jampur, Rajanpur district is located in Southern Punjab, which is a province of Pakistan.

Keeping in view the poor reproductive health status in Jampur, a study is designed to identify the influence of cultural factors affecting women's reproductive health through studying their ethnomedicinal practices. The purpose of this study is to provide a comprehensive review of the evidence regarding the most common traditional practices in Jampur relating to pregnancy, childbirth, and the postpartum period. This study will provide an explanation of the prevailing practices and beliefs in Pakistani rural cultures. This study will examine a broad range of beliefs by geographic concentration.

4.3.1 Age of the Respondents

In order to summarize the data, five group intervals of ages were made. The ages of the respondents were between 15 to 49 years and fell into the following age group intervals.

Table 4.1: Regarding Respondents s' Age

Age	**Frequency**	**Percentage**
15-24	05	10
25 -34	21	50
35-44	13	34
45 and above	3	06

Source: Field Data 2019-2020

The majority of the respondents in Jampur (50%) were within the age group of 25-34 years who were interviewed. Those within the age range of 45 years and above had the least number of respondents (6%). The age distribution of the respondents clearly shows that most of the women continue childbearing until their early 40s. It is also so, because the higher the age, the greater the complications that women face during pregnancy.

4.3.2 Respondents by Educational Level

The main concern here was to determine that what is the highest level of education obtained by women and what is the relationship between the attainment of education and maternal health care beliefs. Whether with the attainment of education's the traditional

maternal healthcare practices are changed or remained the same? Table 4.2 shows the distribution of respondents according to their level of education.

Table 4.2: Regarding Respondents s, Education

Qualification	**Frequency**	**Percentage**
Illiterate	17	40.48
Primary School	11	26.19
Middle School	02	4.76
Secondary School	05	11.90
College Certificate	01	2.38
Higher Education	06	14.29

Source: Field Data 2019-2020

Education of women was also found to have an influence on the reproductive health seeking-behavior of the respondents. The level of education also influences the views of women about their health in general. The sample of the study shows that many of the women had not gone to school. As can be seen in table 4.2 that most of the women (40.48%) were illiterate in the studied area. While other respondents had achieved education to some extent. The primary economic activities of the respondents were focused on here. These included all income-generating economic activities in which participants were engaged most of their time. These activities are shown in the table below.

4.3.3 Respondent by Occupation

Table 4.3: Regarding Respondents Occupation

Occupation	Frequency	Percentage
Housewife	21	50.00
Government Employee	08	19.05
Self-employed	05	11.90
Daily wages	03	7.14
Private Job	01	2.38
Farmer	04	9.52

Source: Field Data 2019-2020

4.3.4 Respondents by Family Type

The family role is a significant variable that influences health-seeking behavior especially in regard to reproductive health. It is already discussed in reviewed literature that Shaikh & Hatcher (2004) said that access of women to healthcare services is actually limited by restrictions on their decision-making independence with their husband's house (family) The Table 4.7 shows the distribution of respondents' family type.

Table 4.4: Regarding Respondent's Family Types

Family Type	Frequency	Percentage
Joint family	14	33.33
Extended family	08	19.05
Nuclear family	20	47.62

Source: Field Data 2019-2020

Table 4.4. elaborates the majority 47.62% of the respondents were living in a nuclear family, where they were living with their husbands and children. One of the respondents told that, the reason behind living in a nuclear family is poverty because her husband has not enough income to share with other family members. Another respondent said that although they are living in the nuclear family their decisions are made with the consent of the whole family because three brothers lived in the same bounderywall but their kitchens are separate. In nuclear families, as far as, reproductive health is concerned majority of the respondents told that, husbands take decisions regarding reproductive healthcare seeking behavior, following traditional practices about when to have children and even other decisions in the home. The women who were living in extended or joint extended families responded that their mothers or mothers-in-law and grand-parents take decisions regarding the reproductive health of the female. Although there were also women who had rejected the view of family influence and they were independent to take their own decision regarding reproductive health.

4.3.5 Respondents by Their Location of Residence

Location of residence is also a major determinant that influences the reproductive healthcare- seeking behavior of women.

Table 4.5: Regarding Respondent's Location of Residence

Location	**Frequency**	**Percentage**
Urban	14	33
Rural	23	55
Tribal	05	12

Source: Field Data 2019-2020

It can be seen in the table that 55 women from rural areas and 33 women from urban areas were interviewed and 12 % were from the Tribal area. As it was discussed in the reviewed literature that beliefs and practices regarding reproductive health-care seeking behavior are less likely to be practiced by women living in urban settings (Chien et al., 2006; Liu et al., 2006; Fadzil et al., 2015), and similar cases were seen in the research locale to some extent, that women of rural areas were more likely to follow traditional reproductive healthcare practices. Although women followed traditional practices, they also prefer western medicines and prescriptions. As one of the respondents told that "*god ta dawai keni bhar skdi… oo ta sadda peer hi bharesi*". She said that western medicines cannot vanish infertility rather saints can do so.

Appendix VI

Glossary

Aab-E- Zum zum	Maka water
Aalo	Potato
Adhan	Purpose of the Azan is to Muslims baby first heard after coming into the world should be the name of Allah".
Adrak	Ginger
Ajwian	Carom seed
Akhroot	Walnuts
Alam	Flag
Andha ki Zirddi	Egg youk
Anwal	Placenta
Aqeedah	Sect
Aqeeqa /Jhandh Utarna	Sacrifice animal and shaving the hair of baby
Araq Gaozban	Gaozban water
Araq Gulab	Rose water
Araq Suanf	Fennel water
Araq	Extract of something /syrup
Araq Makao	Atropine water
Arohay	Women Condition of Nausea and poor Appetite (early month of pregnancy)
Ata	Floor
Atay ka Halwa	Wheat halwa
Athra	Miscarriage
Badam	Almand
Baingan	Eggplant
Bakra	Goat
Bandhna	Baby to tie/wraping
Banjh Pun	Infertility
Bedda Goshat	Beef

Bhindi	Okra
Bibi	Elder sister/ Pious lady
Booti	Flower
Chandi work	Silver leaf
Char Araq Four	Different tape of extract (water) of herbs
Char Maghz	Four Maghz Seed
Char Qual	4 Surahs of the Holy Quran(Surah al-Kafirun, Surah a al-Ikhlas, Surah al-Falaq, and Surah al-Nas)
Chaye	Tea
Cheshma	Water pound
Chilla	***40-day Period of Confinement after Childbirth***
Choti Eilachi	Green cardamom
Choti	Small
Choori	Small pieces of bread, sugar and clarified butter
Chowaray	Dry dates
Churan	Churan is a powder made by grinding several spices, it's helpful for healing acidity, indigestion and flatulence
Dai	Traditional birth attendant
Dal Masoor	Red lentils
Dal Mong	Green gram beans
Dall China	Pulses,
Dam Kerna /Salwat	(Insuffilate)
Dar Chine	Cinnamon
Darbar	Shrine
Deig	Big pot of rice
Desi Ghee	Clarified butter
Desi Totkey	Home remedies/ ips
Dhaga	Thread
Dhawna	Bathing
Dhooni Dena	Sterilize/Fumigate
Dhoti	Unstitched Garment worn by men and women in

	some rural areas of Punjab
Diva/Día	Lamp
Doodh	Milk
Dua	Pray
Dum wala Pani	Insufflate on water
Eliachi	Cardamom
Gandam	Grain/Wheat
Garam Ghiza	Hot/Hard food
Gared Nali /Amaltas	Cassia fistula
Gaud Bhrai	Baby shower
Gerey	Coconut
Ghutti	Tahneek
Ghutti	Baby supplemented with honey, water etc after birth
Gobhi	Cabbage
Goshet	Meat
Gram Doodh	Boild malik
Gulab ke Phool	Rose flower
Gulkand	Cooked rose patel with sugar
Gullab ki Patina	Rose Patel
Gurh	Brown Sugar (Hard form)
Halwa	Paste of Grain Floor, clarified butter, sugar and cardamom
Hareer	Chebulic myrobalan
Hermal	Wild rue
Humal	Pregnancy
Jism per dam kerna	Below on body
Jowan	Husband
Kaghz	Paper
Kahwa /Kahra	Green tea
Kala Jadoo	Black majic
Kala Numak	Black salt
Kali Mirch	Black paper

Kamar Kas	Butea frondosa
Kapass ke Phool	Cotton flowers
Khajoor Dam kerna	Below on dates
Khatna	Male circumcision
Khak Shifa	Dust have healing power
Koh-e- Sulaiman	Mountain of Sulaiman
Kola Ki Aag	Coal fire
Kuchey Chawal	Uncooked rice
Lassi	Whey (Drink made from Yogurt)
Lehsun	Garlic
Luat Dina	Massage with leg
Madrasa	Islamic School/ Institution
Makhi	Honey
Maika	Woman parents
Malish	Massage/Oil bathing
Mannat	Wish
Matti	Hard piece of dust
Mesrey	Sugar loaf
Milad	Birthday celebration of Prophet Muhammad (PBUH)
Mithai	Sweets
Moharam	1st Islamic month
Molvi	An Imam/Religious Practitioner
Moti Eliachi	Black cardamom
Murabba	A kind of sweet fruit preserve
Murghi	Hen
Namak Dam Kerna	Below on salt
Narah	Umbilical cord
Naram Ghiza)	Soft food
Nazir Lagna	Evil eye
Niamat	Blessing
Numak	Salat
Oubli Seviyan	(Boiled Vermicelli+ clarified Butter+ brown sugar

Pak Pani	Holy water
Paneer	Cheese
Pani Dume kerna	Below on water
Pani ki Bhap	Water steam
Pani	Water
Panjeer/Panjeeri	A Traditional dessert ingredients are smolina sugar, dry fruit, Ghee (gives a ton of energy and stamina and helps Combat Postpartum Fatigue, Aches and Pains)
Pashoo	Newborn
Peeli Tiki	Egg yuk
Pesta	Pistachio
Phaki	Po***wdery substance made of dried herbs***
Pir	Saint / Spiritual leader
Pirni	Lady saint/Lady spirtual healer
Pudina	Mint
Rakh	Mannat (Wish)
Rehmat	Mercy
Roti	Bread
Sadqah	Charity
Sada Gheeza	Simple food
Safoof	Fine powdery foodstuff
Sagg	Spinach
Sahib	Man in a position/Authority
Sahib/ Sahiba	Respectable person
Salwar	Loose trousers
Salwat	Insufflate
Sanuf	Fennel seed
Sathi,	Baby seventh day's celebrations
Sar Chiuta	Take bath
Saunf ka Pani	Fennel water
Saya	Effect of evil (djinn or anglicized)
Sayyed Zaadi	Syed woman/Girl

Seviyan	Vermicelli
Shadi	Marriage
Shahad	Honey
Shakar Dam kerna	Below on sugar
Shakar	Brown sugar
Shisha Numak	Sea salt
Shurbat	Sweet drink
Singhra Pouder	Chestnut
Suchey Mooti	Pearl sron
Sufeed Mussly	Chlorophytum borivilianum
Sufi	Saint
Surkh Mirch	Read chili
Surma	Kohl stone /(galena)
Surodha	Drink made by (Boiled Malik+ small Green Cardamom+ Clarified butter+ Brown sugar)
Sursoon ka Tail	Mastered oil
Tabashir	Bans lochan
Tahajjud	Night prayer/Prayer offered to God after Isha prayer
Tail	Oil
Tandoor	Clay oven
Tandoo ki Roti	Bread made in clay oven
Tawa	Griddle
Taweez	Amulet
Turi	Sponge gurad
Tarang	Drink made by (Clarified Butter, Cumin, small cardamom and brown sugar
Watta Satta	Exchange marriages
Wazeefa	Meditation
Yakhni	Soup of chicken or muton meet with Galic, black paper and salad
Zeera	Cumin
Zetoon ka tail	Olive oil

Appendix VII

Pictural Image of Study site. Deehat (Rural Area) daily life sports, dwelling and bazar


























Shrine in study area

Pictural images of Shahar (City Area)





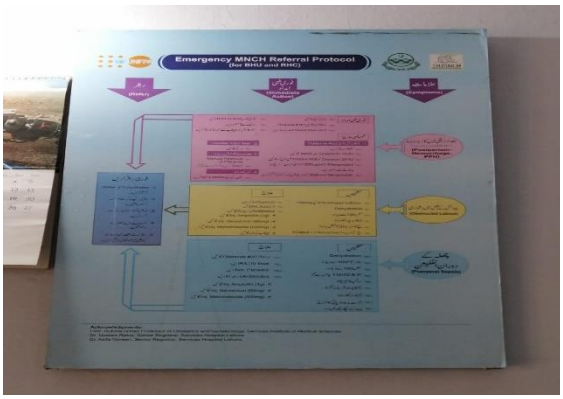








Pictorial image of Key informants' meeting /Health, Population and of Education departments



















Traditional Old women of study area