



Exploring Perceptions and Experiences about Maternal Health Services: A Community-Level Initiative in Jampur

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ABSTRACT

The aim of the study is to scrutinize the availability and quality of maternal healthcare services by reconnoitering the perceptions and experiences about health facilities, encountered by women residing in tehsil Jampur. The current investigation employed qualitative methodology and obtained data from a sample of 28 participants including both health services seekers and health services providers, by using purposive sampling. The data was gathered through comprehensive interviews and focus group discussions (FGDs). The researcher used deductive thematic analysis methodology to analyze the data. To enhance the validity of information gathered through research, perceptions of both health service-providers as well as health service-seekers was taken encountered. The research emphasizes the significance of addressing unprofessional behavior, transportation deficiencies, insufficient substructure, and erratic working schedules to improve health outcomes. Additionally, service quality evaluation at facility centers is important due to various deficiencies observed at healthcare center. The challenges include limited availability of medicine, limited operating hours of medical services, inadequate transportation options to remote healthcare facilities, and a shortage of female healthcare providers at community level, influenced by cultural norms surrounding gender subtleties. The administration of the health department is adversely affected by the repetitive vacillations in government and its systematic framework. The health department encounters instability due to the diverse strategies, programs, and staff appointments executed by successive prime ministers. Study suggest dire need of sorting out these issues to ensure native's trust on available health facilities and to improve overall health upshots.

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1. Introduction

Pakistan is widely recognised as a country with low rankings in terms of gender development and inequality index due to the precarious situation faced by females. Based on the findings of the United Nations Development Programme (UNDP), this country is positioned at the 100th rank out of 102 countries regarding gender disparities. These disparities are primarily attributed to sensitive inequality based on gender and the limited empowerment of women within the country (M. M. Khan, Zafar, Ali, & Ahmad, 2009). Women in Pakistan experience significant disparities in various aspects of their lives, irrespective of their socio-economic background, age, or geographical location (UNICEF, 2012). They are constrained to exist within a confined realm characterised by stringent religious, socio-cultural, and tribal traditions, perpetuating a sense of subordination and instilling fear among them. According to Bettencourt (2000), women in Pakistan persistently face systematic victimisation by society, the judicial system, and the

government despite numerous human rights conventions and declarations condemning violence against women. Furthermore, he contended that this discrimination arises from socio-cultural underdevelopment and religious interpretation. Rather than being a nation that embraces the concept of religious freedom, individuals tend to prioritise socio-cultural and tribal customs, incorporating them into their daily lives. The subcontinent is inclined to prioritise traditions and customs over religious laws. This phenomenon has been observed to have adverse consequences on Muslim society, particularly concerning gender-related matters (Pakeeza, 2015). According to Bukhari and Ramzan (2013), gender discrimination is primarily ingrained in socio-cultural norms rather than religious teachings. The authors argue that religion is often manipulated for political purposes and financial gain, resulting in a deviation from the authentic practice of Islam. They further contend that cultural factors such as poverty, lack of awareness, employment disparities, and gender-based roles play a more significant role in perpetuating gender discrimination.

Maternal health, a critical component of reproductive health, commences upon women's conception. Maternal mortality arises due to erroneous decision-making during pregnancy, delivery, or postpartum. Compromised maternal health is the primary determinant of mortality and morbidity in developing nations. The health of mothers and infants is indicative of the overall societal well-being. Nevertheless, inadequate nutrition, limited access to healthcare, and the overall consequences of poor health significantly contribute to elevated mortality rates. Persistent high maternal mortality rates continue to pose a significant challenge on a global scale. A maternal mortality rate (MMR) is deemed to be elevated when it reaches or exceeds 300 deaths per 100,000 live births and classified as exceptionally high when it reaches or exceeds 1000 deaths per 100,000 live births. Ensuring adequate care for women during childbirth is a crucial intervention to mitigate the significant burden of maternal mortality. Nevertheless, it is worth noting that in numerous developing nations, such as Bangladesh, women are often responsible for any adverse occurrences of reproductive health (Zahan, 2014). Ensuring the obtainability of reproductive health facilities is a concentration for all nations around the world, as it emphasizes on upgrading the medical services framework concerning maternal health, family planning, and childbearing. In order to effectively address the accessibility and responsiveness of healthcare systems, it is crucial to direct attention towards health-seeking demeanor and the various factors that influence the utilization of healthcare services (World Health Organization, 2014). Essential components of developing evidence-based policies include planning of advocacy campaigns, initiating community-based projects, and convincing partners/stakeholders to put resources into explicit areas that consider information about health promotion, seeking, and utilization, as well as societal factors (Aziz, Raza, & Waqar, 2016).

The significance of female health, particularly concerning maternal health, cannot be overstated. Motherhood is widely regarded as a rewarding and optimistic undertaking on a global scale. However, it is essential to acknowledge that for numerous women, the experience of motherhood is intertwined with ailments and distress, leading to compromised physical and mental well-being and, in severe cases, even mortality (Chepkorir, 2014). One of the critical factors influencing access to maternal health care is the role of the family in providing information and health services. Numerous studies have underscored the significant impact of familial factors on women's reproductive health. According to the study conducted by Shaikh and Hatcher (2004), it was determined that the ability of women to access health services is hindered by restrictions placed on their autonomy in decision-making within the context of their marital household. According to their assertion, the determination to seek healthcare is contingent upon allocating household resources, a responsibility typically held by the male figure who subsequently determines the timing and location for the woman to access healthcare services. In addition, cultural norms often dictate that women adhere to the authority of their husbands or mothers-in-law, as this is perceived as a display of respect. Consequently, this may lead to an exaggerated influence on family members, particularly in the case of adolescents (Upadhyay, Liabsuetrakul, Shrestha, & Pradhan, 2014). Adolescents are commonly perceived as being less knowledgeable, lacking experience, and displaying immaturity, thus necessitating increased guidance and supervision compared to adults.

This study aims to investigate the maternal health care system in Jampur, with a specific focus on the various programs, policies, medical systems, and socio-cultural factors associated with reproductive health. The objective of this study is to conduct a comprehensive review of the existing evidence about the present structure of the healthcare system in Jampur, with a specific focus on pregnancy, childbirth, and the postpartum period. The primary objective of this study

is to make a scholarly contribution to the current body of literature concerning the healthcare system in rural Punjab, Pakistan. This study aims to investigate two primary research inquiries: (i) What are the perspectives and experiences of women concerning maternal health services? (ii) What do women face the potential complications of inadequate health facilities in the Jampur region? The study also seeks to investigate the involvement of healthcare professionals in the distribution of maternal health information.

2. Literature Review

2.1. Health Services

As mentioned by the World Health Organization (2016), the term "Health services" encompasses the visible functions within a health system, covering all services related to disease identification and management, as well as the promotion, maintenance, and restoration of well-being. Service provision involves the integration of diverse resources like financial assets, human resources, apparatus, and medications, which collectively support the delivery of healthcare intercessions. Through a number of initiatives and programmes including the public and private health sectors, the nation is working to provide reproductive and maternal health services (Shaikh & Hatcher, 2004). With the help of the commercial sector, namely the Family Planning Association of Pakistan, the first five-year Plan (1955–1960) included maternity health (MH) and reproductive health (RH) services. The principal aim of the second five-year Plan (1960–1965) was to slow down the pace of population increase and improve the availability of family planning (FP) services via government health channels. It was observed, although, that during this time these services had not yet matured enough to implement family planning programmes successfully (A. Khan, 1996). Until the third five-year Plan was put into effect, there was no particular, sufficient framework for family planning (FP) at the national level (Bhatti, 2014). This Plan created a unique service delivery system with dais (birth attendants), physicians, health visitors (HVs), retailers, and pharmacists, and it devoted a chapter to FP. Implementing the IEC (Information, Education, and Communication) and IUD (Intrauterine Device) programmes was another important endeavour included in the third plan. In order to refocus the supply method, the Continuous Motivation System (1970–1973) introduced a client-based structure in which male and female employees were appointed at the union council (UC) level. Rather of concentrating only on IUDs, the Contraceptive Inundation Scheme (1974–1977) sought to provide condoms, tablets, and sterilization, thus following a supply-oriented approach.

2.1. Socio-economically embedded hindrances

Instead of seeking support from international entities in terms of technical and financial aspects, the prevailing obstacles of political, administrative, and logistical nature have impeded the successful implementation of the initiatives (Robinson, 2007). One of the limitations that impedes the efficacy of family planning programs is inadequate coverage, especially in rural regions. According to an approximation from the early 1990s, it was observed that only 20% of the population was effectively covered by services. Within this percentage, a mere 5% of individuals received services in rural areas, while urban areas had access to 50% of the available facilities (Carton & Agha, 2012; Hardee & Leahy, 2008). The Lady Health Workers (LHW) scheme was established in the mid-1990s with the aim of providing support and empowerment to women encountering mobility constraints. This endeavor aimed to reach out to women in their residences and cater to their healthcare requirements. Implementing this measure resulted in an increased utilization of family planning services. Nevertheless, there were divergent opinions regarding the utilization of antenatal visits and hospital deliveries as discussed by Mumtaz and Salway (2005). Approximately 80% of women were attended by traditional birth attendants, and nearly half of all mothers received antenatal care and services (Federal Bureau of Statistics, 2002; Population Council, 2003; UNFPA, 2005). The Information, Education, and Communication (IEC) program demonstrated several deficiencies, including inconsistent components that failed to effectively raise awareness about contraception or create a demand for it before the 1990s (Farooqui, Sheikh, & Shah, 1993).

In contrast to prevailing expectations, the dependence on females had a detrimental impact on women's maternal health. According to Dar (2013), the likelihood of seeking medical assistance at least three times during the pregnancy is influenced by the marital status of the household head's wife and factors related to maternal and reproductive health. By leveraging their familial position, older women assert their authority and provide instructions and advice that may primarily concern economic matters. However, their limited experience and knowledge

ultimately prove to be inadequate. In a study conducted by Atieno (2007) in Kenya, the author examines the impact of family involvement on the sexual and reproductive health of adolescents. The findings indicate that families possess insufficient knowledge regarding adolescent sexuality and reproductive health matters, primarily due to socio-cultural, religious, economic, and educational limitations. The study further asserts that the available information is limited, rendering it insufficient to achieve satisfactory outcomes. Moreover, relying solely on this information may potentially result in complications and health-related concerns.

Contrary to the discussion above, women who hold positions of authority and possess empowerment within their families tend to avail themselves of superior healthcare services. In their study conducted in Nigeria, Fawole and Adeoye (2015) examined the relationship between women's status within the household and their utilization of maternal healthcare services. The researchers examined the correlation between women's autonomy in financial resources and empowerment and its impact on utilizing maternal healthcare services. The study conducted an analysis revealing that women who possess economic autonomy and independence are more likely to prioritize their health than financially dependent women. The study additionally demonstrates that women who possessed knowledge regarding healthcare and held negative attitudes towards physical violence exhibited a higher level of utilization and satisfaction with reproductive healthcare services than their counterparts. Pakistani women have to follow the socio-cultural norms in all spheres of life including their reproductive health. The motive of this study is to bring forth a wide-ranging review of the evidence concerning the most widely recognized customary practices in a neglected region Jampur and its influence on women's reproductive health in selected area. However, this study is specifically concerned with the perceptions and experiences of both health-seekers as well as health-providers to make the cultural scenario more understandable.

3. Methodology

This study determines to analyze the available healthcare system related to maternal health in the rural region of Jampur, Punjab. This study comprised on quality-based research approach and performed data collection from a sample of 28 selected participants comprised on 20 health-seekers and 08 health professionals (including male and female both) through purposive sampling techniques. The research incorporated the involvement of health professionals who played the roles of key informants and cultural consultants. Native Health Visitors (LHVs) and health workers (LHWs) are integral participants in the research study domain due to their resident status. The in-depth interview method and focus group discussions was used for data collection and subsequently analyzed using a deductive thematic analysis approach. The researcher utilized an immersion methodology to acquire primary data from community members by residing within the community and engaging in direct observation. The utilization of interview guides and focus group discussions facilitates the acquisition of data via direct interpersonal communication. Furthermore, this methodology examines the participants' non-verbal communication cues in addition to verbal perceptions, encompassing their thoughts, viewpoints, behavioral traits, and non-verbal gestures. Two group discussions of duration almost 3 hours were carried out, with participation ranging from 6 to 8 individuals (health seekers) per session and all of them centered on a singular relevant issue. Field notes were utilized to record crucial data, actions and observations inside the research area for preservation and recollection. A diverse array of methodologies were utilized to acquire significant financial resources and gather data of exceptional quality.

4. Result and Discussion

Understanding the maternal healthcare services available to women is crucial for obtaining comprehensive and in-depth information regarding health services within a region. Furthermore, the clients' demands can be attributed to their challenges in accessing health services. The demand side refers to the perspective of pregnant women and their families. Balanced discussions often rely on both primary and secondary data sources. Primary data collection was facilitated through interviews conducted with women and focus group discussions and meetings held with health professionals. The secondary data utilized in this study was obtained from various sources, including the Punjab Health Department, the district health department, and the IRMNCH program office, as well as annual health and statistical reports. The facts derived from this discourse and subsequent data analysis encompass the perspectives of both service providers and service recipients. The identified factors include financial limitations, insufficient professionalism, inadequate provision of resources (equipment, medicine, staff, and

infrastructure), limited transportation options, and low clinical attendance rates. On the basis of the findings, the researcher extracted relevant themes that were discussed in different sections.

4.1. Financial Constraints

The primary determinant identified from the data was a financial limitation. The provision of health services in the region was deficient due to insufficient funding allocated for the operation of healthcare services. As (Government of Pakistan, 2017); Robinson (2007) mentioned that successful execution of the programs is hindered by political, administrative, and logistical obstacles. The challenging process is the primary factor contributing to the procurement and delay in acquiring medical supplies, which hinders the efficient execution of routine healthcare operations. After engaging in discussions with doctors from various healthcare facilities, including BHU, RHC, and Tehsil Headquarters Hospitals in the area, it was noted that they expressed collective concerns regarding several issues. These issues primarily revolved around challenging bureaucratic procedures that often result in delays in the procurement of clinical supplies, consequently hindering the provision of effective healthcare services. Additionally, departmental obstacles were identified, such as the failure to settle bills timely and delays in the delivery of clinical services.

Table 1: Perceptions and experiences of health-seekers and health providers about Financial constrains

Financial Problems at	Types	Consequences
Health Providers Level	Challenging	
	Bureaucratic procedures	delays in the procurement of clinical supplies
	Departmental obstacle	failure to settle bills timely and delays in the delivery of clinical services
Health Seekers Level	absence of health insurance cards/policies	financial burden had to be borne by the client herself
	poor economic condition	shortage of health seeking

Source: Research Work Data

These obstacles constituted significant challenges in the provision of seamless healthcare services. The health sector brought attention to the issue that BHU (Basic Health Unit) and RHC (Rural Health Centre) lacked adequate maternal and child healthcare facilities. Physicians typically prescribe medication and laboratory tests, which are subsequently conducted at private laboratories and medical establishments. The absence of health insurance cards or policies in Punjab necessitated the client to bear the financial burden. This situation can be attributed to the inadequacy of the health policy. A rural woman discuss further in the financial constraints matter:

"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 age 27)

The delay in procurement was attributed to the poor health policy and bureaucratic intervention, as observed during the analysis. The lack of effectiveness in health policy implementation and the provision of inadequate health services contribute to the erosion of trust and demotivation among clients within the government health system. Pakistan has been designated as one of the regions with inadequate maternal health services, leading to its classification as one of the poorest areas in terms of meeting the Sustainable Development Goal (SDG) target of enhancing maternal and child health (Govt of Pakistan, 2017).

4.2. Lack of Professionalism

At the community level, there was widespread recognition of the inadequate availability of medications and other resources in local hospitals. However, through conducting interviews with clients and engaging in focus group discussions (FGDs), it became evident that the attitudes of doctors and other medical personnel were also significant factors to consider. Based on the aggregative response, seeking medical checkups at government hospitals, regardless of whether at BHU or a district hospital, was considered an inefficient use of time. Most female respondents reported that the physician did not conduct a thorough examination. If individuals were seeking information regarding their medical conditions, they would not receive a response that meets their expectations. Conversely, the conduct exhibited by the lady health visitors (LHVs) and midwives was deemed highly inappropriate. Numerous women reported refraining from seeking prenatal care and delivering at healthcare facilities due to the derogatory conduct exhibited by healthcare practitioners. When a woman encounters complications during pregnancy, it has been observed that the level of care provided by staff in government hospitals may be characterized by a lack of attentiveness and diligence. Without any external pressure or coercion, had she chosen not to join the ANC, she would have faced potential humiliation based on records or historical context. According to certain female individuals, individuals with references or connections receive favorable treatment within government hospitals. At the same time, those who are impoverished and lack formal education are subjected to substandard care.

"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)

As per the accounts of certain women, the conduct exhibited by LHVs (Lady Health Visitors) and Midwives was deemed intolerable despite the presence of government hospital amenities. Despite the patient's critical condition, the medical personnel displayed a lack of promptness or urgency in their response. When the question above was posed to medical professionals affiliated with BHU, RHC, and Tehsil Hospital, various perspectives were expressed by doctors regarding the underlying reasons behind the substantial lack of trust exhibited by a significant number of women towards government hospitals, as well as their resentment towards the attitudes of doctors and paramedic staff. According to the initial statement made by the doctor at the Tehsil hospital, it was observed that government hospitals are experiencing a significant strain due to excessive workload. Patients experienced individualized suffering besides their illness and wanted to discuss their struggles with their healthcare provider. During the outdoor checkup, limited time is available to attend to individuals' narratives. This led them to believe that the doctor had not provided them with adequate attention. According to another medical professional, the primary factor contributing to the issue is the inadequate availability of medication and other essential healthcare resources within government-operated hospitals. Furthermore, at the grassroots level, specifically at the Banaras Hindu University (BHU), the primary obstacle in the healthcare field, particularly in the Maternal, Newborn, and Child Health (MNCH) program, pertained to the involvement of healthcare workers. A lack of competence and professionalism characterized the performance of lady health workers. The majority of individuals possessed lower levels of education and were appointed to positions based on political affiliations. Furthermore, their deficiency in training and expertise hindered their ability to mobilize the female population effectively. Moreover, their counselling capacity was notably inadequate.

In the MNCH program, the nonprofessional personnel at the union council level consisted of one Lady Health Supervisor (LHS) and several Lady Health Workers (LHWs). The sole duty assigned to them entailed the mobilization and provision of guidance. The imperative was to enhance community awareness regarding maternal and child health. In terms of prenatal, natal, and postnatal care services, only the doctor and LHV were observed. The cases of emergency and C-section were referred to the Tehsil and District hospitals. The Basic Health Unit (BHU) solely offered conventional delivery services. Within the Maternal, Newborn, and Child Health (MNCH) program framework, Lady Health Visitors (LHVs) were assigned round-the-clock responsibilities. However, the limited availability of adequate facilities resulted in a low utilization rate among women seeking care at these centers. The insufficient facilities encompassed substandard infrastructure and limited space, among other deficiencies. Many Basic Health Units

(BHUs) lacked a boundary wall, resulting in a dearth of privacy during the delivery process and subsequently deterring individuals from seeking care at these facilities.

Table 2: Perceptions and experiences of health-seekers and health providers about lack of professionalism

Lack of Professionalism at 7	Types	Consequences
Health- seekers level	local hospitals lacked medicines and other facilities	<ul style="list-style-type: none"> feeling of wastage of time lack of satisfaction and trust
	attitude of doctors and other medical staff	<ul style="list-style-type: none"> improper checkup Unsatisfactory disease descriptions Humiliated and insulting behavior of LHVs and midwives
	Over burden	<ul style="list-style-type: none"> No time for discussing patients' irrelevant issues
Health-Providers level	lack of medicine and some other health facilities	<ul style="list-style-type: none"> constrain of medical facilities provision
	behavior of LHVs and midwives	<ul style="list-style-type: none"> incompetent and nonprofessional behavior weak counseling power less educated and lacked the training and skills

Source: Research work Data

Consequently, the establishment of trust among women towards government hospitals was not achieved. In this particular scenario, the influence of TBA would be significantly amplified. Indeed, the female health worker's responsibility entailed enrolling a pregnant individual and devising a dietary regimen for her. Women's lack of knowledge and inadequate access to information resulted in their disregard for the content of their discourse. A deficiency in maternal health care has been identified due to inadequate training and insufficient capacity building of lady health workers. In this response of the doctor said that:

"Most women in rural areas are illiterate. on the one hand there is lack of counseling from lady health worker and on the other hand illiterate mothers. 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)

The findings indicate that individuals unable to effectively communicate information during the polio vaccine campaign, as evidenced by group discussions and interviews with women and health professionals, could not fulfil their responsibilities satisfactorily. The illiteracy among mothers posed an additional obstacle. However, the literate mothers exhibited contrasting reactions. The individuals possessed a heightened awareness and comprehension regarding the significance of clinical services, antenatal care, timely delivery as well as postnatal care. The study highlighted a prominent issue in healthcare services, namely service providers' conduct. The participants' behavior deterred them from seeking clinical services and maternal health care.

4.3. Lack of health facilities

The study area exhibited a notable deficiency in essential facilities, including an inadequate medicine supply and a scarcity of qualified healthcare personnel. Additionally, there was a shortage of necessary health equipment. Consequently, there was a notable lack of public trust in government-operated healthcare facilities, particularly in rural regions. Regarding the composition of the professional healthcare personnel, it was observed that a single doctor, one Licensed Health Visitor (LHV), and only one dispenser were present at the Basic Health Unit

(BHU). In addition, the staff was comprised of a midwife and a watchman. Typically, a Basic Health Unit (BHU) is designed to cater to approximately 10,000 individuals. However, in the case of Tehsil Jampur, the population exceeded this estimate, reaching approximately 700,000 residents. Therefore, BHU encompasses a population of approximately 30,000 to 40,000 individuals. The presence of a solitary medical officer proved insufficient to attend to the extensive population, necessitating the simultaneous management of both general patients and pregnant women.

Table 3: Perceptions and experiences of health-seekers and health providers about lack of health facilities

Lack of health facilities	Types	Consequences
BHU level	Professional Staff	<ul style="list-style-type: none"> 1 doctor, (may be only male) 1 LHV & 1 dispenser at a BHU whereas population to be cover is about 30,000-40,000 prenatal, natal and postnatal care services provider include 1 doctor and LHV
	Nonprofessional staff	<ul style="list-style-type: none"> 1 Lady health supervisor LHS and lady health workers LHWs
	poor infrastructure	<ul style="list-style-type: none"> unavailability of emergency and C –section Reffered to THQ or DHQ No boundary walls Lack of privacy at the time of delivery
RHU level	Professional Staff	<ul style="list-style-type: none"> Availbale only during day time Lack of trust on local health system
	Lack of necessary equipment	<ul style="list-style-type: none"> no ultrasound facility unavailability of lab equipment equipment malfunctions Medicine shortage/unavailability

Source: Research Work Data

The presence of a male physician resulted in a significantly restricted clientele of pregnant women. The presence of a female physician was observed to positively impact the clientele of women. Historically, there has been a tendency for individuals to refrain from seeking medical assistance from male physicians regarding women, at the level of Basic Health Units (BHU). A doctor who was not a resident and could only be accessed during daylight hours was present. 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." (Rural woman age 39)

The circumstances were identical at RHC. Both male and female physicians were present at the facility, albeit exclusively during daylight hours. It became evident through deliberations that professionals commonly declined their assignments in rural areas due to the numerous challenges they encountered, which were also experienced by the general public. Female staff members, in particular, have historically encountered challenges with accommodation, communication, and transportation, among other issues. 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)

The researchers discovered that a dearth of personnel within the local health system resulted in a lack of confidence among women, leading to a prevailing sense of demotivation among the majority of female individuals. The unavailability of laboratory equipment contributed significantly to the insufficient provision. The Basic Health Units (BHU) and Rural Health Centres (RHCs) were not equipped with ultrasound facilities. The only parameters that could be assessed were the individual's weight and blood pressure. However, the laboratory tests that could be conducted at RHC were limited to blood and urine analyses, among others. The lack of trust in government hospitals among the local population stems from issues such as equipment

malfunctions and a scarcity of medication. During the discussions, the doctor provided additional information regarding the unavailability of oxygen cylinders at the BHU level if a normal delivery at the hospital becomes complicated. 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)

According to a female respondent: “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 35)

The focus group discussions (FGDs) and interviews revealed a significant scarcity of skilled healthcare personnel, particularly in rural regions. The MNCH program's primary emphasis was raising awareness, while the prevailing demand from clients was for improved services. In addition to the diet plan, the program provided a much-needed balanced diet in this region. Furthermore, many women believed that medical supplies and equipment were scarce. Despite an extended waiting period, neither the medications nor the necessary tests were accessible. Several women reported that their male partners did not accompany them to the government hospital, citing it as a futile use of time. In the medical facility, a solitary physician was attended by a lengthy queue of patients patiently awaiting their consultation. The lack of adequate infrastructure was also observed. Insufficient seating was available for both patients and their families. The issue of limited and confined space has posed significant challenges regarding checkup procedures and privacy for pregnant women. The various inadequacies in health facilities contributed to the discouragement experienced by women in seeking government healthcare services. In short, it is necessary to ensure sufficient services to achieve the targeted health outcomes. In other case insufficient services or coverage may appear as hindrance of health seeking process (Carton & Agha, 2012; Hardee & Leahy, 2008).

4.4 Transportation Network

The study area experienced a notable issue concerning the mean and mode of transportation. The road infrastructure suffered significant damage. Tehsil Jampur was situated within a geographical range of approximately 80-100 kilometers. On the main Indus Road, only the Tehsil hospital and one Rural Health Centre (RHC) were situated. At the same time, two Rural Health Centers (RHCs) and all Basic Health Units (BHUs) were located along the link road.

Furthermore, the main road leading to alternative medical facilities deteriorated significantly. Data collection encompassed a substantial area of the Tehsil. In order to reach RHC of Dajal and Hurand from the central city, it was necessary to traverse a road that exhibited signs of deterioration and disrepair. The journey of sixty KM took approximately two hours. There were a total of eleven Basic Health Units (BHUs) that were situated within distinct union councils. These union councils were primarily characterized by their rural nature and remote positioning, situated far from the main road. The condition of the roads varied between being rough and uneven or lacking a paved surface. During seasonal flooding, the tribal area experienced complete isolation from surrounding regions. Consequently, the availability of healthcare services becomes restricted. During the visit of RHC Hurand, 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 compared to other areas.” (Female health informant)

In rural regions, the primary means of transportation for the local population consisted of rickshaws and motorcycles. The transportation of rickshaws was also ceased in the evening hours as well. In an emergency, the sole available mode of transportation was a motorbike. Given the circumstances above, it became evident that the absence of transportation options compelled women residing in rural areas to depend on traditional birth attendants (TBA) and perceive home delivery as a preferable alternative. During the conversation with the district coordinator of the

Integrated Reproductive, Maternal, Newborn, and Child Health (IRMNCH) program, the researcher was apprised of the presence of fifteen ambulances designated for this program. These ambulances are operational round the clock and can be summoned anytime to facilitate deliveries. The organization offered transport services for women, facilitating their journey from their residence to the hospital for childbirth and subsequently returning them to their homes post-delivery. Due to the high population and overcrowding, a single ambulance was allocated to serve three or four Basic Health Units (BHUs) within the district. However, despite the availability of this facility throughout the district, residents exhibited hesitancy in utilizing ambulance 1034 due to their adherence to specific belief systems. As per their account, the prompt arrival of the ambulance service was not forthcoming.

Furthermore, the presence of an ambulance was regarded as a symbol of an urgent situation, eliciting apprehension. The local residents harboured a lack of trust towards it and regarded its utilisation as foreboding during its arrival. The cultural acceptance of Ambulance 1034 was lacking. The public's response to the ambulance service for transporting pregnant women from their homes to the Maternal, Newborn, and Child Health (MNCH) centre is unsatisfactory. The underlying cause may be attributed to psychological and social apprehension stemming from an adverse event.

Regarding maternal health services, ambulance 1034 was deemed inefficient in rural regions. The majority of individuals preferred utilizing their means of transportation during the delivery process. In urban areas, the predominant mode of transportation utilized by a significant portion of the population is the rickshaw. During delivery, a few individuals opted to utilize their personal vehicles or engage in car rentals. Traditionally, rickshaws and motorbikes have been employed for antenatal care (ANC) and postnatal care (PNC) services.

4.4. Poor Clinical Turnout

The study revealed a notable trend wherein women delay scheduling and attending prenatal, natal, and postnatal checkups. According to the studies majority of the women are attended by TBAs whereas half of women acknowledged antenatal care (Federal Bureau of Statistics, 2002; Population Council, 2003; UNFPA, 2005). Our findings reflect that merely 67% women received a single antenatal care (ANC) checkup. Postnatal care provision was severely lacking, as evidenced by a mere 4% of women seeking medical attention at clinics for postnatal care. The findings of the focus group discussion (FGD) revealed that many women preferred home delivery due to concerns regarding the possibility of undergoing a caesarean section (C-section). Several women reported refraining from attending prenatal checkups during the initial trimester of their pregnancy due to their belief systems. An LHV said:

"Majority of the local women do not visit 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)

In addition, it was noted that inadequate clinical attendance among women can be attributed to the utilization of herbal medicine and traditional remedies. The data indicates that cultural beliefs, taboos, and rituals pose significant barriers on mother and child health, resulting in limited access to maternal healthcare services. Furthermore, the manner of healthcare professional treatment was identified as a causative factor to the irregular attendance of women, as revealed through interviews conducted 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 checkup. 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)

Similarly, it was noted that women historically utilized traditional healthcare practices and clinical services. This factor contributed to the low attendance rate in the clinical setting. During a conversation with Dr. Abida Faiz, a female medical professional affiliated with a private healthcare institution, it was revealed that three prominent maternal health conditions prevalent in the region above include hypertension, anemia, and high blood pressure. The primary factor contributing to these illnesses was attributed to issues such as iron deficiency, an imbalanced diet, and inadequate access to clean drinking water. She stated, "Local men utilized women to fulfil their objectives." Women residing in rural and tribal regions are burdened with an excessive

workload. Thus, embedded conflicting interpretations and perceptions concerning antenatal visits and hospital deliveries utilization influence the health-seeking behavior of people (Mumtaz & Salway, 2005).

5. Conclusion

In conclusion, this study identifies cultural biases and practices, women's status/position, healthcare professionals' and administrators' abuse of power, as well as the lack of comprehensiveness of maternal health policies above and beyond health facility as major barriers to maternal health outcomes. Challenging and time-consuming bureaucratic procedures for financial arrangements of health facility along with departmental delays in the delivery of clinical services due to failure in settling bills reflect some financial constraints of health-providers. Situation become worsen as health-seekers too have poor economic condition and had truancy of health insurance card/policies which keep them away from health seeking. Poor facilities and road infrastructure contributed to poor delivery and use of clinical services as well. People's perceptions are impacted by the level of services they get at the facility center; thus, this is a crucial consideration when choosing a facility. In Pakistan, fewer people rely on and use public facilities, particularly in rural areas. This is due to inadequate facilities such as limited hours for service availability, unavailability of medicines, long travel times between medical centers, and a dearth of female health providers due to culturally restricted male-female relations. In places where there are inadequate and inconsistent public health care, these kind of thinking and behavior are prevalent.

The health institutions were structured in ways that prevented the efficient provision and use of healthcare services. Although only a small number of highly educated women reported that they were well-treated in the facilities during their last clinical visits, the majority of women reported issues with non-compliant behavior from the service providers as a major push factor. Clients liked receiving care from professionals that applied the principle of common humanity in their care providers. Pregnancy and childbirth are painful experiences that require sympathy, empathy and support from care-providers. When care-seekers are denied or compromised, they seek alternative care sources and leave an indelible impression as a motivator for future facility-based care. Furthermore, in order to improve the state of health, there is a need of substantial consideration given to staff absenteeism, inadequate infrastructure, and irregular working hours. Reduced provision of vital services around-the-clock that endangers and deprives countless lives requires strong checks and balances and stable administration.

Further, implementing community-level initiatives in Tehsil Jampur has resulted in notable advancements in enhancing maternal health outcomes through identifying and resolving obstacles pertaining to accessibility, awareness, and education. Although certain women voiced their discontent regarding the level of care provided, community-based initiatives hold promise in addressing this disparity through the implementation of comprehensive measures such as sufficient training for healthcare professionals, provision of well-equipped facilities, and adherence to proper hygiene standards. Considering cultural and social factors impeding women's access to maternal health services is paramount.

5.1. Policy Recommendations

1. Since lady health workers (LHWs) collaborate with one another, training them together will enhance their methods and increase patients' access to clinical treatment through timely referrals. The LHWs will be able to separate beliefs from healthcare with the regular provision of educational programs on the effects of their practices on maternal, fetal, and neonatal health as well as the necessity of clinical treatment. In addition, these programs would foster a friendly relationship between LHWs and medical experts. Better maternal outcomes would result from the healthcare system's ability to equip LHWs with counselling skills, teach them to manage basic health conditions, and provide prompt referrals in underprivileged communities.
2. Community-based interventions must incorporate strategies to mitigate stigma and foster awareness regarding the significance of accessing healthcare services throughout pregnancy and childbirth. The efficacy of these endeavors hinges upon the cooperation among diverse stakeholders, encompassing governmental health agencies, non-governmental organizations, and community members at the local level. Maintaining these initiatives' sustainability through ongoing support and funding is crucial. However,

additional research is necessary to evaluate these initiatives' enduring effects and pinpoint areas that still necessitate enhancements. In summary, the case study's findings indicate that community-level interventions in Tehsil Jampur have yielded favorable outcomes in providing maternal health services.

3. Enhancing maternal health outcomes for women in this region can be achieved by fostering collaborative initiatives that tackle access, quality of care, awareness, and cultural barriers. The MNCHs program, in particular, requires the health facilities to have access to trained staff and equipment. Many healthcare centers were be deficient in having basic stuff like gloves, sterilizers and kits to assist during delivery procedure, on top of skilled midwives. females were not urged to utilize the government sector's health centers because of these circumstances. Equipping the BHUs and RHCs with both human and material resources will enable the facilities to accomplish cases at their level with optimal effectiveness. Increasing native community's certainty and confidence in clinical administrations through the TBAs' propinquity to LHV, LHWs, and clinical officials is crucial for increasing the utility of maternal healthcare services.
4. This study, likewise, proposes that the Punjab Health Department with collaboration of non-government established organizations, the WHO and its international and local cronies should update and reformat health promotive projects to support the reinforcement of facility-based as well as community-based maternal health projects and policies. This will help community members to recognize issues and make timely decisions to seek medical attention.

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