P-ISSN 2664-0422	Pakistan Social Sciences Review	April-June 2025, Vol. 9, No. 2
O-ISSN 2664-0430	https://doi.org/10.35484/pssr.2025(9-II)37	[486-494]

Pakistan Social Sciences Review
www.pssr.org.pk

RESEARCH PAPER

A Qualitative Analysis of Community Perspectives and Attitudes towards Poor Maternal Health in Rural Punjab Pakistan Sargodha

[1]Dr. Beenish Ijaz Butt*, [2] Dr. Elena Commodari and [3]Valentina Lucia La Rosa

1. Chairperson/Professor, Department of Social Work, University of Sargodha, Punjab, Pakistan.
2. Professor, Department of Educational Sciences, University of Catania, Catania, Italy.
3. Adjunct Faculty, Department of Educational Sciences, University of Catania, Catania, Italy

***Corresponding Author:** beenish.ijaz@uos.edu.pk

ABSTRACT

Maternal health is one of the persistent social problem of Pakistan. Statistical data show high ratio of maternal mortality across the country, especially in the rural areas. Despite the government efforts, the magnitude of the problem could not be minimized in the previous decades. This article aims at investigating the community perspectives and attitudes towards poor maternal health in Rural Sargodha Punjab, Pakistan. Review of literature shows the efforts of Pakistani government together with international partners to decrease maternal mortality but community response seems to be an encompassing responsible factor. The research design of the study followed the qualitative research methodology. Respondents from the selected community were identified during community meetings including married women of reproductive age and male decision-makers. For the purpose of data collection, a loosely structured interview protocol was developed. Data saturation was confirmed though transcriptions of seven focus groups conducted for this purpose. The major themes derived from the collected data were Perception about maternal health seeking knowledge, Role of Decision-makers in care seeking and Cultural Practices and Maternal Health. It is concluded that maternal health is largely influenced by the social structures, cultural practices and lack of decision making power among women. Such influencers determine the health seeking behaviors in rural areas in Pakistan. Educational programs focusing women and their families aiming at improving maternal health in rural areas are recommended for the country to mitigate the high risk of maternal mortality of a common woman.

KEYWORDS Maternal Health, Rural Women, Maternal Mortality, Maternal Morbidity, Maternal Mortality Ratio, Pakistan

Introduction

Maternal health is a national and international concern across the globe. Inclusive of multiple issues, maternal mortality is a top most attention seeking problem in the low income countries. The increased social issue of maternal mortality is still a menace; despite the fact that the disease surveillance was being conducted since decades. MMR stands for the maternal mortality ratio; and is defined as the number of women who die from pregnancy-related complications during the pregnancy period or within 42 days of pregnancy termination per 100,000 live births (World Health Organization, 2023). Multiple causative factors influence the ratio of MMR in different regions across the globe. Multiple diseases like heart or pulmonary diseases, infections and unsafe abortion are among the major complications causing high rate of MMR (Girum & Wasie, 2017). International statistics reveal that

Maternal mortality rate, though decreased world widely, but is highest for low- & middle-income countries which includes Afghanistan (638/100,000 livebirths), India (145/100,000 live

births), Bangladesh (173/100,000 livebirths), and Yemen (164/100,000 livebirths) (World Data Atlas, 2020) including Pakistan.

The MMR in Pakistan has reached 186 deaths per 100,000 livebirths in 2019 as low income country while showing a 32% increase from 2017 i.e. 140/100,000 live births. The rural areas in Pakistan experienced most of the maternal deaths with an MMR rate of 199 per 100,000 live births, while urban area had an MMR of 158 per 100,000 live births (National Institute of Population Studies, 2019). The major contributory factors behind this persistent social problem are poverty, the lack of education and awareness, poor health care facilities and gendered social behaviors which are responsible for high MMR in rural areas. Additionally, coronavirus disease (COVID-19) has given a set back to the entire world economically as well as socially. Evidence on actual COVID-19 occurrence in Pakistan is poorly estimated and the governance system cannot evaluate the community loses especially in rural areas as rural communities were considerably more vulnerable to COVID-19 than urban areas in the developing countries. Under this scenario, the rural communities again shifted on domiciliary birth deliveries, hence increasing the maternal mortality and morbidity.

Literature Review

National surveys in Pakistan reveals remarkable differences between rural and urban areas in the country as MMR is found 158 in urban areas while in rural areas MMR is recorded as 199 (Pakistan Maternal Mortality Survey, 2020). Health care system in Pakistan was largely effected by COVID- 19 as there was shortage of medicines, beds, oxygen cylinders and medical staff under both public and private health care sector (Gandhara, 2020). Due to repeated lockdown, economic activities were also restricted which increased non-affordability of the masses, thus making primary to tertiary health care non-approachable. This increased the morbidity and maternal mortality in the country. Although Pakistan has signed Agenda 2030, it lags behind in achieving SDGs. Having highest rate of maternal mortality in South Asia, twenty percent of women die due to maternal complications (Hanif, et al. 2021).

Contributory factors behind the high prevalence of MMR can be seen at medical, economic and social grounds. Medical reasons of high MMR in the country are due to postpartum hemorrhage, puerperal sepsis and eclampsia, infections caused during pregnancy (Rau, 2022). Economically private sector medical facilities are far from the reach of low-income families in far flung areas where public sector tertiary facilities are unavailable. Another major factor is the delays in getting medical facilities and is encompassed by political and cultural constraints. Illiteracy among the masses, gender inequality, restricted mobility, child marriages, poor nutrition are major reason of MMR in Pakistan (Khan, et al, 2009). Further these delays can be seen due to administrative loopholes and embezzlement.

Statistical data reveals that Pakistan has highest maternal mortality rates among South Asian countries. Although the country has signed Agenda 2030, but still lags behind while meeting the desired Sustainable Development Goals (SDGs) (Hanif, et al, 2021). Maternal health complications cause 20% of the deaths among childbearing women, the major causes include the postpartum hemorrhage, blood poisoning or high blood pressure, which is the third commonly found cause of maternal mortality in Pakistan (The Borjon Project, 2022).

The most important factor which affects maternal mortality is the delays in medical care during obstetric complications. It is directly associated with the social life of women and includes family constraints like delays due to ignorance and decision of domiciliary delivery. Secondly, delays are also faced by women due to poor infrastructure and communication way e.g. availability of hospital, ambulance, trained staff & emergency facilities (Ashraf, et al., 2021). Additionally, demographic differences between rural and urban areas of Pakistan reveals that maternal mortality ratio is higher in rural areas as compared to urban areas and is recorded as 26 % higher in rural population. Child birth at home are common and 74% of rural women give birth to their children at home with traditional birth attendants. (World Health Organization, 2015). (National Institute of Population Studies (NIPS), 2020).

Additionally, poverty, is an obvious factor which encircles the pre and post maternal health facilities in rural areas. The underlying fact is the access of women to income, education and hygiene in their areas. Cultural constraints are also responsible for maternal mortality and morbidity in rural areas of Pakistan. Girl child marriages, greater number of child birth, child birth at home, unskilled birth attendants, late access to hospitals and expose them to the risk of mortality.

Government of Pakistan along with international collaborations has made several efforts to reduce maternal mortality rate in the country. It is one of the top most priority of federal and provincial governments to reduce the maternal mortality rate of 70 deaths per 1000,000 live births by the year 2030. The Pakistani government together with international partners made various attempts to decrease maternal mortality. The mission of both federal and provincial governments to decrease maternal mortality from 70 deaths per 1000,000 live births to an improved rate by the year 2030. Punjab being the most populated province of Pakistan, with more than 11 million population (Population Census Pakistan, 2017) has been given commendable attention for maternal healthcare during the last decades (Punjab Economic Report, 2017). Various health reforms have been implemented by the government to improve the maternal health targets.

The above mentioned data reflects the current situation and quality of healthcare with reference to maternal health in Punjab. Significant differences across groups of poor and rich; educated compared to illiterate and rural compared to urban women are observed on the use of maternal health care services. In the last decade, although visible improvements in the utilization of maternal health care services were observed but, MMR was still recorded high due to socio-economic disparities in maternal healthcare availability and utilization. With this reported MMR, neither Punjab nor Pakistan would have met the SDG goal of MMR upto70 per 100,000 live births by the year 2030. On the other side, commitment by the Punjab Government to reduce the maternal mortality to achieve targets of the SDGs, there is availability of 195 hospitals, 314 RHUs, 2,499 BHUs, and 49 MCHs in the province. Health facilities data per 100,000 population of districts reveals that Faisalabad having 2872201 population has 115 beds, 44 medical staff and 342 paramedical staff per 100,000 population. While Sargodha having 3703588 population has 45 beds, 12 medical staff and 114 paramedical staff per 100,000 population (PERI, 2020). According to The World Bank (2019), Sargodha is one of the top five districts of Punjab having high MMR i.e. 132/100,000 live births even in the presence of Government Mian Mola Bakhsh Gynae Hospital (Special government Hospital for maternal health issues). Further Audit Report on the Accounts of District Health Authorities of Sargodha Region (2022) reveals that the Integrated Reproductive Maternal Neonatal Child Heath (IRMNCH) program was unsuccessful in achieving its objectives because the health system lacked enough qualified medical staff along with necessary pharmaceuticals and

medical devices. Providing enough nutrition and supplements enables a reduction in maternal mortality. The data also reveals that maternal health services in Sargodha are encompassed by disparities among poor and rich as well as in the urban and rural population. This situation has even worsen after pandemic COVID-19. This article aims at investigating the community perspectives and attitudes towards poor maternal health in Rural Sargodha Punjab, Pakistan.

Material and Methods

In order to explain the said objective, the research design of the study followed the qualitative research methodology. To have a deeper insight of community perspectives and attitudes towards poor maternal health in rural Sargodha, Village 103 SB, Tehsil Sargodha, Sargodha was selected as a geographical universe. Respondents from the selected community were identified during community meetings including married women of reproductive age and male decision-makers. For the purpose of data collection, a loosely structured interview protocol was developed. The interview protocol was developed by following the available literature review and informal discussions with a gynecologist, community women and community key informants. The questions of interview protocol consisted of community attitudes and perspectives regarding care seeking in maternal health and decision-making power. Data collection procedure was conducted between January- July 2024, as a part of a post-doctoral project. Data collection was followed by purposive sampling and was done by conducting focus group discussions with selected respondents. Purpose of the research was explained and a prior consent of the respondents was obtained. All focus groups were conducted in regional languages to facilitate the participants. Data saturation was confirmed though transcriptions of seven focus groups conducted for this purpose. After this, similar ideas and themes were generated from data. Data transcribing, storing and analysis was carried out by following the procedure as explained by Creswell (2013) to present the major themes.

Results and Discussion

Theme- I- Perception about maternal health seeking knowledge

In rural Punjab, understanding community attitudes towards healthcare access and utilization is essential for addressing poor maternal health outcomes. When the groups were asked about their perception of women health, they were of the view that prenatal and antenatal care is required at the time of emergency only and stated that,

Women in our village are healthy. They do not suffer from complex diseases. They are also healthy during pregnancy and a healthy person do not need doctors. As pregnancy is not a disease, women should work during this period normally as our previous generations used to do it.

Some other were of the view that,

Women do not need health checkups during pregnancy. It is only in vogue in urban areas that women go to doctors frequently during pregnancy. It is waste of money and time. Sometimes it increases the risks. Many people who go to doctors, do not have normal delivery and they have to face C-section. So we do not prefer to go for checkup.

We have natural environment in village and it is favorable for child and mother so we do not prefer pre-natal and ante-natal checkups.

After child birth, we care about mother as family. We give her good food and rest. Sometimes women have pain and excessive bleeding but it is cured with rest and natural food and remedies we take after child birth.

We have experienced traditional health care providers who look after us and do not charge much like doctors and they provide at door services. So we are satisfied with those services. A few women need hospital who are not handled by them at the time of delivery. Some women die during this time but we accept it as God's will because their life time has completed and we accept it with patience.

Other opined that

Women also face headache or weakness and excessive bleeding during pregnancy then they have to visit doctor during pregnancy as it is a danger sign. Some other women also included that when they face high blood pressure it also dangerous and need checkup but they don't go to doctor and self-medicate them.

Perception about maternal health seeking knowledge of the rural group seems that they are unaware of the prenatal and antenatal complications. They have their own understanding of maternal health and its associated complications.

Theme- II- Role of Decision-makers in care seeking

The majority of respondents gave similar response that decision making power for seeking health care lies in the hands of their head of the family and they cannot go to seek medical advice or care by themselves. They were of the view that

Our mother in-law is the decision maker for child delivery and she decides that child will be delivered at home with the help of traditional birth attendant or needs hospital care.

Some other opined that,

Our father in-law is the decision maker of each matter of the house and they do not allow to spend on medical facilities of hospital as they are of the view that when we will go to government hospital even, it will cost for transport and other facilities.

Most of them replied that

Our husband is the decision maker and he decides whether we should take health care from a professional or not. When traditional birth attendant refuse to take our case at child birth delivery, then our husband decide whether we have to go to hospital or not.

Actually a pregnant women cannot decide from whom, when or why to take medical advice or checkup. Usually it is decided by the husband and his family jointly. They take the decision of place keeping in view the birth attendant advice, economic affordability and clan pressure. In the rural culture, women need to ask and grant permission of the head of the family to seek maternal health care when it is required. They are not independent to make decision and their mobility to hospitals is restricted by the decision makers of the family.

Theme- III- Cultural Practices and Maternal Health

Women also have to follow the certain cultural practices for living a common life which ultimately effects on seeking maternal health in the rural areas. When asked about

their cultural practices with regard to women life and status, the community groups were of the view that,

There is no need of girls' education and we do not prefer their high education as they are the home makers and they have to do the house chores throughout their life span. Their literacy is enough till reading and writing Urdu (national language).

Some other stated that

We do not prefer to give higher education to our daughters. It is limited to village school as we have to marry them soon. We cannot afford to keep them at our house after teenage as we will not find their mates in our clan if they will get more education and will be over age.

Many of them were of the view that

As our women are not well educated and do not have external world exposure, so the decision to avail a healthcare facility is decided by the husband or head of the family. Sometimes it is not based on women's health condition but on the availability of transport as well as the availability of our economic resources. We mostly rely on our local birth attendants as they are cheaper and accessible. They use herbal medications which do not have side effects for mother and child. We know about the health facilities and government hospitals but we do not avail that as child birth at home is our tradition since centuries.

Regardless of government efforts, Pakistan is still lagging behind than the other countries in achieving gender equality in health, education, and economic participation for women. Women are still subjected to different forms of discrimination and have little or no say on personal or family matters. Still women are vulnerable to poor reproductive and general health. There are certain social and cultural practices, such as seclusion, dependency on a head of the family, and other social restrictions like their independent mobility which keep them away from having proper medical care during childbirth.

Conclusion

Maternal health is largely influenced by the social structures, cultural practices and lack of decision making power among women. Such influencers determine the health seeking behaviors in rural areas in different low income countries, Pakistan is one of them. The persistent high ratio of maternal mortality is still alarming in the country. There is widespread gender disparity in the social structure of the rural areas of the country which is another reason for MMR. Additionally, women lack decision making autonomy in these areas; bringing high health risk for them.

The root cause of this persistent social problem also lies in these cultural practices which are main hurdle in seeking maternal care. Wide spread illiteracy and poverty in the country are still not addressed by the different successive governments. Poor family structure is in the web of daily wages which restrict them to go for even government hospitals. Their illiteracy restrict them to rely on state policy and they are comfortable with the cheaper local remedies. Despite the state interventions, the health seeking behaviors of the families in the rural areas are still backward.

On the other side of the coin, government check and balance in the health sector rural areas is also weak. Here is scarcity of doctors, nurses and paramedical staff as well as of medicines and equipment. This also brings delays in the timely decision and

treatment of women during child birth; hence increases MMR in the rural areas of the country.

Recommendations

Maternal mortality can be reduced by addressing the poor economic and social status of rural women. Strong strategies are required to raise the women status in their communities through higher education and economic empowerment. Educational programs focusing women and their families aiming at improving maternal health in rural areas are need of the country to mitigate the high risk of maternal mortality of a common woman. Active involvement of different stakeholders like NGOs, public-private partnership and community can play a vital role to eliminate this persistent social problem from the rural areas of the country.

References

Ashraf, N., Sarwar, S., & Bibi, N. (2021). Determinants of maternal mortality in Pakistan. *Pakistan Journal of Medical & Health Sciences*, 15(3), 613-615.

Creswell, J. W. (2013). *Qualitative inquiry and research design: choosing among five approaches (2nd Ed.)*. Thousand Oaks, CA: Sage.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research (2nd Ed.).* Thousand Oaks, CA: Sage.

Girum T & Wasie A. (2017). Correlates of maternal mortality in developing countries: an ecological study in 82 countries. *Maternal Health Neonatal Perinatology*. 3(1), 1-6**.**

Government of Pakistan. (2022). *Audit report on the accounts of district health authorities of Sargodha region audit year 2021-22.* Islamabad: Auditor General of Pakistan.

Government of Punjab. (2020). *Regional and Heterogeneous Perspective of Maternal Healthcare Services: Tracking the Inequalities in Punjab*. Lahore: Punjab Economic Research Institute.

Hanif, M., Khalid, S., Rasul, A. & Mahmood, K. (2021). Maternal mortality in rural areas of Pakistan: challenges and prospects. *Rural Health, 1-14*. Retrieved from https://doi.org/ 10.5772/INTECHOPEN.96934.

Hanif, S., Khalid, S., Rasul, A. & Mahmood, K. (2021). Maternal mortality in rural areas of Pakistan: challenges and prospects. In *Rural Health* (pp. 1-14). Retrieved from https://doi.org/ 10.5772/INTECHOPEN.96934.

Hills M, Mullett J, Carroll S. (2007). Community-based participatory action research: transforming multidisciplinary practice in primary health care. *Rev Panam Salud Publica*. 21(2-3):125–35.

Hoodbhoy Z, Sheikh SS, Qureshi R, Memon J, Raza F, Kinshella MLW, Bone JN, Vidler M, Sharma S, Payne BA, Magee LA, von Dadelszen P, & Bhutta ZA. (2021). Role of community engagement in maternal health in rural Pakistan: findings from the CLIP randomized trial. *Journal of Global Health*, 11(04045), 1-9.

Ihsan, A., Ali, F., Khan, Y. Z. & Adil, S. (2024). A spatial analysis of maternal health care in Punjab, Pakistan. *Journal of Population Therapeutics & Clinical Pharmacology,* 31(4), 1424-1440.

Kakar, , A. H. & Siddique, A. (2020). Pakistan Faces Unprecedented Healthcare Crisis amid Mounting Coronavirus Infections (rferl.org). *Gandhara.* Retrieved from https://gandhara.rferl.org/a/pakistan-faces-unprecedented-healthcare-crisis-amid-mounting-coronavirus-infections/30679490.html

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.

National Institute of Population Studies (NIPS) [Pakistan] and ICF. (2020). *Pakistan Maternal Mortality Survey 2019: Key Indicators Report.* Islamabad, Pakistan, and Rockville, Maryland, USA: NIPS and ICF.

Pakistan Bureau of Statistics. (2018). *Final Results Census-2017.* Islamabad: PBS.

Payne, M. (2014). *Modern social work theory.* London: Palgrave Macmillan.

Punjab Economic Research Institute. (2017). *Punjab Economic Report*. Lahore: PERI.

Punjab Economic Research Institute. (2020). *Regional and Heterogeneous Perspective of Maternal Healthcare Services: Tracking the Inequalities in Punjab*. Lahore: Government of Punjab.

Punjab Health Sector Reforms Programme (PHSRP). (2012). *Draft Strategy 2012–2020 Health Sector of Punjab*. Government of the Punjab.

Rau, A. (2025). Maternal mortality in Pakistan. *The Borgen Project*. Retrieved from https://borgenproject.org /maternal-mortality-pakistan/.

Rehman, A., Adnan, M., Mahmood, H. & Humayun, A. (2017). Maternal Health Care Expenditure among Women in Rural Areas of Pakistan. *Annals of King Edward Medical University*: 23 (2), 245-249.

Salim, S; Kalsoom, S & Humayun, A. (2016). Weaning Practices and Perceptions of Mothers Residing in Urban Slums of Lahore, *Pakistan: A Focus Group Design*. 22 (4), 313-320.

Shanmugasundaram, L. (2021). The impact of COVID-19 on poverty in Pakistan *The Borgen Project*. Retrieved from https://borge nproject.org/the-impact-of-covid-19-on-poverty-in-pakistan/.

World Health Organization. (2015). *Trends in maternal mortality: 1990 to 2015 estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division*. Switzerland: World Health Organization.

World Health Organization. (2022). *UN Report: Global hunger numbers rose to as many as 828 million in 2021.* Retrieved from https://www.who.int/news/item/06-07-2022-un-report--global-hunger-numbers-rose-to-as-many-as-828-million-in-2021.

World Health Organization. 2023. *Maternal mortality*. Retrieved from https://www.who.int/news-room/fact-sheets/detail/matern al-mortality.