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RESEARCH PAPER

Social Factors Affecting Maternal Mortality in Quetta: A Qualitative Study

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ABSTRACT

The purpose of this study was to investigate the social factors of maternal mortality in Quetta using a qualitative approach. Maternal mortality is a major public health issue worldwide, disproportionately affecting low- and middle-income countries. Maternal mortality rates in Pakistan, notably in Balochistan province, remain dangerously high. Data were gathered via seven in-depth, semi-structured interviews with family members of women who died from maternal causes, as well as twelve key informants such as healthcare practitioners. Participants were chosen using purposive sampling. The data were analyzed thematically to identify recurring patterns and societal factors that influence maternal health outcomes. The analysis revealed five major themes including gender inequality and limited decision-making power among women; early and forced marriages that put adolescent girls at high obstetric risk; poverty and financial inaccessibility that delay or prevent access to skilled care; cultural beliefs and a preference for traditional birth attendants over institutional deliveries and insufficient health infrastructure and geographic barriers. The findings can help to shape community-based programs and maternal health policies that are adapted to Baluchistan's particular socio-cultural setting.

KEYWORDS Social Factors, Maternal Mortality, Gender Inequality, Reproductive Health, Healthcare Access

Introduction

High maternal mortality rates continue to be a major hindrance to public health in low and middle income countries, with South Asia facing the brunt of the problem. As highlighted by WHO (2023), approximately 287,000 women around the world died from preventable pregnancy and child birth associated causes in 2020, most of which occurred in underfunded areas. Regions in South Asia, and specifically Pakistan, are some of the most resource strapped areas which bear the consequences with nearly 186 deaths per 100,000 live births, estimated to have the highest maternal mortality ratio (MMR) in the region (UNICEF, 2023). The provincial Maternal Mortality Ratio (MMR) is about 298 per 100,000 live births, which is about double the national average of 154 and much higher than other provinces like Punjab (157), Khyber Pakhtunkhwa (165), and Sindh (224) NIPS (2019).Maternal mortality is a major public health issue, where structural disparities and societal obstacles limit access to timely and high-quality maternal healthcare services. Although maternal death rates in Pakistan have reduced in recent years, they remain unacceptably high, particularly in marginalised areas such as Balochistan (UNFPA, 2022).

One of the most important things is gender inequality and limited decision-making, which means that women don't have full control over their reproductive and health-related choices. Men in the family habitually choose when and where women can obtain medical care in many South Asian nations, including Pakistan. According to

Naeem et al. (2021), these patriarchal norms make it tougher to find obstetric problems and seek quick medical attention. According to the World Health Organisation (2023), improving maternal health outcomes in patriarchal surroundings requires empowering women and proceeding gender equality. Forced marriages and early marriages are additional long-standing problem. Due to their undeveloped physiology and inadequate access to reproductive health care, teenagers who marry before the age of 18 are more likely to practice obstetric technical hitches like obstructed labour, hemorrhage , and pre-eclampsia (Khan et al., 2022). Maternal health complications are worsened by poverty and economic inaccessibility. Women in the lowermost economic quintile are the least possible to get prenatal assessments or give birth in a medical facility, per the 2019 Pakistan Demographic and Health Survey. Moreover, when services are accessible for free, there may be complications due to unspecified costs, including transportation, prescription drugs, and unendorsed fees. By reducing financial tensions, restricted cash transfer programs significantly improved maternal healthcare consumption in comparable low-income backgrounds, Barrera-Osorio et al. (2020).

Literature Review

Some of the lowest maternal health statistics are found in Balochistan, the largest province in the country by area. According to a study on maternal mortality conducted at Quetta's Bolan Medical Complex Hospital, the main causes of maternal deaths were preeclampsia/eclampsia, sepsis, and obstetrical hemorrhage (Soomro et al., 2023). Maternal mortality rates are considerably impacted by poverty, illiteracy, and a lack of access to quality healthcare. In the Hyderabad region of Sindh, for instance, medical experts described that poverty (41.6%) and family negligence (27.2%) were the leading social factors contributing to maternal mortalities (Khan et al., 2023). Maternal mortality rates are caused by ingrained sociocultural problems, according to recent research. Among the many risks posing a threat to maternal mortality in Balochistan are early marriages, low female literacy, lack of reproductive control, and inadequate health infrastructure (PIDE, 2022). The presence of a tertiary hospital in Quetta does not alleviate the issues as woman continue to give birth in the confines of their home, relying on Traditional Birth Attendants due to the socio-political environment (Kakar et al, 2022).

Additionally, The Global Health Observatory (WHO, 2023) indicates that the 'three delays model' to care delays in seeking help, reaching the healthcare facility, and receiving the appropriate medical attention exists in both rural and urban poor areas in Balochistan. These delays as noted by Yasmin et al. (2021) are a result of social determinants such as the patriarchal head of household, transport, economic dependency, and available health services. Another study stated that early marriage and adolescent pregnancies increase mothers' health concerns. According to research, females who marry before the age of 18 are much more likely to have pregnancy and delivery difficulties such as obstructed labor, hypertensive disorders, and postpartum hemorrhage (UNFPA, 2024). Efforts to reduce maternal mortality in Pakistan have included the deployment of community midwives (CMWs) to offer skilled birth attendance, especially in underserved rural regions. However, issues like insufficient integration into the larger healthcare system, a lack of professional support, and appropriate training hinder these efforts (UN Women, 2023; Rahim & Baloch, 2023).
This study aims to investigate the social facets of maternal mortality in Quetta through a qualitative approach. In order to examine how sociocultural, economic, and gender connections impact maternal health in the area, the study specifically focuses on women and the community's healthcare providers.

The study aims to design maternal health care initiatives that are suitable within the local context to help curb the rising cases of maternal mortality in Quetta and other similar areas.

Despite global advances in maternal healthcare, maternal mortality remains disturbingly high in low-resource areas like Balochistan, notably in the capital city of Quetta. While clinical reasons such as hemorrhage, eclampsia, and sepsis are widely known, the underlying social determinants such as poverty, gender inequality, early marriage, low education, and cultural barriers are frequently disregarded in both study and policy responses. In Quetta, a substantial number of maternal deaths are caused not just by medical difficulties but also by delayed care-seeking behaviors, limited mobility of women, a lack of information, and a lack of qualified healthcare practitioners in marginalized groups.

Material and Methods

The study surveyed the socioeconomic factors affecting maternal mortality in Quetta, Balochistan, utilizing a qualitative research methodology. In order to capture the cultural customs, lived experiences and community-level influences that quantitative methods can overlook, a qualitative method was deemed suitable. The objective of the study was to provide comprehensive and contextual information from the viewpoints of women who work as healthcare providers.

Study Area

Balochistan's capital, Quetta, is home to a various population that includes Pashtuns, Hazaras, Baloch and Brahuis, making it a appropriate location to examine the relationship between socio-cultural norms healthcare access and maternal health outcomes. The study was conducted in Quetta, which has a diverse population of urban, peri-urban and semi-urban residents. A civil hospital was selected for focus group discussions to collect information from healthcare providers, and seven families of deceased mothers were picked from different ethnic backgrounds.

Sampling Size

Total Nineteen participants were took part in the study, including twelve healthcare providers and seven families of women who had died due to issues during pregnancy. Moreover, to get complete data, focus groups discussion and purposive sampling were employed. Participants had to have lived in Quetta for at least three years and agreed to give their information in order to be eligible.

Data Collection Methods

Semi-structured and in-depth interviews were utilized to collect the information. Depending on the participant's option, interviews took place in Brahui, Urdu, or Pashtu and lasted between thirty and sixty minutes. In order to examine the cultural beliefs and practices related to childbirth and pregnancy, decision-making and gender dynamics in maternal health, hurdles to accessing healthcare services, and individual and community experiences with maternal healthcare, the interview guide used open-ended questions. Moreover, with the participants' consent, audio recordings of the interviews were made, and inclusive field notes were achieved.

Data Analysis

To ensure validity and preserve the original context of the participants' declarations, the audio recordings of the interviews were transcribed verbatim. Moreover, for a more complete analysis, the transcripts were later translated into English. Thematic analysis, which followed Braun and Clarke's (2006) six-phase paradigm, was utilized to interpret the data. This began with familiarization, where researchers read the transcriptions multiple times to have an inclusive understanding of the subject matter. In the second stage, significant portions were labelled and identified in order to create primary codes. These codes were scrutinized for patterns in order to provide probable themes in the third stage. The themes were studied in the fourth phase to make sure they perfectly reflected both the coded data and the complete dataset. The fifth step was to describe and name each subject so that their essence could be easily captured. Finally, the sixth phase was to generate the report, in which ideas were united into a cohesive description to answer the research questions. The NVivo 12 program was used to help with data organizing, efficient coding, and theme visualization. To ensure the findings' credibility and trustworthiness, emergent themes were validated using cross-group triangulation, and, where possible, member checking was performed by returning to select participants to confirm the accuracy of interpretations.

Ethical Considerations

The Balochistan Health Department's Research Ethics Committee provided ethical permission. All participants provided written and verbal informed consent before data collection began. The use of pseudonyms and the secure storage of all data in password-protected files maintained confidentiality and anonymity. Participants were advised of their right to withdraw at any time with no penalty.

Results and Discussion

Gender Inequality and Restricted Decision-Making

Gender inequality has become a significant factor affecting maternal health outcomes. Participants stated that women in Quetta commonly lack autonomy in making decisions about their own health, particularly during pregnancy and childbirth. In most situations, the husband or the family's elder male members made the key decisions. This limited access to timely maternal care and contributed to delays in seeking medical attention, especially in emergencies. One participant, a sister of a deceased mother, stated that "*her sister complained of pain throughout pregnancy, but her husband dismissed it as usual. She fainted before he took her to the hospital".* Another participant discussed how "*women are expected to remain silent*" and how cultural norms promote male dominance in health-related decisions. They need permission to leave or call a doctor, even if they are near death. Our system is this. These opinions were expressed by medical professionals, who noted that many women arrive at the hospital too late because they are awaiting financial aid or clearance from their male guardians. In addition to delaying care, a lack of agency prevents women from advocating for their own health and identifying warning signs throughout pregnancy. This subject focuses on how the region's avoidable maternal death rate is directly caused by ingrained gender norms and power disparities.

Lady Health Worker stated "*Husbands here don't allow their wives to go for regular check-ups unless it's an emergency*." This limited autonomy frequently results in delayed

or no access to expert maternal care, which contributes directly to problems and unnecessary fatalities.

Early and Forced Marriages

Participants consistently identified early and forced marriages as major factors in maternal death in Quetta. Many young females are married in their mid-teens, frequently against their will, and become pregnant shortly thereafter. These girls are physically and emotionally unprepared for childbirth, which raises the risk of difficulties and death. The mother-in-law of a deceased adolescent mother stated, "*She was only 16 when she got married." We assumed she would learn over time. But during her second pregnancy, she bled excessively, and we were unable to save her.*"

One member stated that their niece struggled with self-care, let alone caring for a baby. She sobbed a lot during labour, but the elders said that it is typical for young females. "*She died before we got to the hospital.*" According to healthcare experts, adolescent moms regularly encounter life-threatening diseases such as obstructed labour, eclampsia, and postpartum haemorrhage. Furthermore, many young brides lack the expertise and courage to address health concerns or seek care. The normalisation of early marriage, which is entrenched in cultural traditions and economic pressures, continues to expose young girls to avoidable maternal risks, emphasising the need for education, advocacy, and policy reform.

Poverty and Financial Inaccessibility

Poverty was recognised as a major underlying factor contributing to maternal mortality in Quetta. The majority of participants noted how financial constraints hampered or impeded access to high-quality maternity healthcare. Families frequently couldn't afford private hospitals, medications, or even transportation to medical institutions. As a result, many women either gave birth at home without professional help or were taken to hospitals only when difficulties worsened.

According to the brother of a deceased mother, "*the cost of hiring a car to transport her to the hospital exceeded 3,000 rupees due to their remote location. We believed we could handle it at home. Money could not be organised in time.*"

Another participant said "*She wanted a checkup, but we couldn't afford it*," Private hospitals are too costly and government hospitals are congested. She fainted and we just took her. Healthcare practitioners verified that many maternal fatalities might be averted if families sought prompt care, but poverty rendered even the most basic services unavailable. A lack of resources and a lack of support are two common burdens faced by women from low-income households. This topic illustrates how maternal survival is significantly hampered by economic limitations, insufficient public health coverage, and remote location.

Cultural Beliefs and Preference for Traditional Birth Attendants

Participants cited deep-rooted cultural beliefs and a significant preference for traditional birth attendants (TBAs) as primary reasons for maternal death. TBAs, occasionally known as "dais", are trusted more than medically experienced experts in certain cases due to their expertise, cost, and long-standing cultural acceptance. However, these attendants frequently lack the requisite abilities to handle problems, resulting in avoidable maternal deaths.

According to a participant who was a cousin of a mother who had passed away, "*an elderly dai who had delivered all babies in their family attended her*." However, she had no idea what to do when things went wrong. Before taking her to the hospital, we wasted time.

One participant said "In our village, people think hospital deliveries bring bad luck and are only for emergencies". Therefore, unless they are dying, women give birth at home.

Because they trust TBAs and are afraid of or distrustful of traditional healthcare institutions, many families delay hospital visits until the condition is critical, according to healthcare providers. This topic highlights the serious health risks to mothers posed by cultural conventions and childbirth misunderstandings. Better outcomes depend on addressing these biases through community-based education and the polite integration of qualified midwives.

Inadequate Health Infrastructure and Geographic Barriers

Participants' stories frequently mentioned the lack of adequate local healthcare facilities and geographic restrictions that prevent prompt access to maternity care. Emergency obstetric services, qualified staff, and suitable medical facilities are lacking in many remote towns surrounding Quetta. Critical delays often result from long distances, bad road conditions, and a shortage of transportation, which increases the risk of maternal death.

The mother of a deceased mother shared her experience that "*Quetta is more than two hours distant from where we live*". At night, the nearby clinic was locked, and the ambulance never showed up. It was too late, but we had to make our own car arrangements.
Another relative stated that when they got to the hospital, no doctors were available. We must wait, they said. "*My sister expired before someone could come to check on her*".

Discussion

According to the study's findings, maternal mortality in Quetta, Balochistan, is caused by a complex network of socioeconomic influences. Widespread gender inequality is one of the most important of them, as it confines women's autonomy in healthcare decision-making. Participants repeatedly stated that the main decisions about maternity care were made by male family members, especially fathers-in-law and husbands. Delays in attaining prompt medical attention are caused by this dynamic, mainly in obstetric situations. The abovementioned results align with previous studies conducted in other South Asian settings and rural Pakistan, where patriarchal social norms have been acknowledged as a significant barrier to the utilization of maternal health services (Naeem et al., 2021; WHO, 2023).

The rate of early and forced marriages was another important issue brought up. In Quetta, a lot of women get married when still in their teens, which leads to early pregnancies before their bodies are ready for motherhood. Problems from these early pregnancies frequently include severe hemorrhage, pre-eclampsia, and obstructed labor, all of which are known to be roots of maternal death. This result is in line with previous studies that revealed a strong association between increased maternal mortality in Pakistan's neglected districts and adolescent pregnancies. (Khan et al., 2022).

One major obstacle to mothers' survival is poverty. Numerous families said they couldn't pay for private clinic prices, essential medications, or transportation. Many people were discouraged from seeking treatment, even in official clinics, due to the demand for informal payments and unseen charges. These results are in line with the socioeconomic gaps discovered by the 2019 Pakistan Demographic and Health Survey, which publicized that women in the lowest income quintile are much less likely than their richer counterparts to get emergency or prenatal care. Similar results have been seen in other low-income surroundings where the use of maternal health treatments has upgraded as a result of financial involvements such as conditional cash transfers (Barrera-Osorio et al., 2020).

Cultural norms and traditions make the problem worse. Traditional birth attendants (TBAs) are still utilized by many families in place of competent professionals. Although TBAs are respected members of the community, they usually lack the medical knowledge and abilities needed to handle problems. Participants voiced concerns about modesty and the availability of female doctors, as well as a strong feeling that home birth is a safer and more "natural" choice. These views are in line with studies done in Afghanistan and Balochistan that demonstrate how sociocultural attitudes significantly influence maternal health practices (Abbasi et al., 2020). One way to bridge the gap between modern medicine and traditional that may be culturally acceptable is to participate TBAs into formal health organizations through training and monitoring. Lastly, the study found that maternal mortality is largely caused by geographic isolation and insufficient health infrastructure. Participants from rural locations peri-urban discussed the long drive to the nearby medical Centre, the challenging roads, and the inadequate options for transportation. The dearth of nearby hospitals, especially those with female doctors on staff, was a major problem. These issues are constant with UNFPA (2022) reports that demonstrate the serious neglect of healthcare services in Balochistan. Improving emergency referral networks, deploying trained midwives to distant areas, and funding provincial medical institutions are all necessary to lesser maternal mortality.

The overall results of the study provide support for the need for inclusive, multi-sectoral interventions that emphasis on the social determinants structural of maternal health. It is essential to pursue, economic support networks, community education, legal reforms, and healthcare system strengthening all at the same time. Even while this study provides insightful information, it only looks at Quetta; future research should conduct at other districts and employ a diversity of approaches to increase generalizability.

Conclusion

In Quetta, Balochistan, one of Pakistan's most maltreated districts, this study determined the complicated and interconnected social factors that influence maternal mortality. According to the findings, maternal mortality in this background is not solely due to clinical problems but is deeply rooted in cultural, broader social, institutional issues. Maternal mortality is mostly caused by a number of factors, including illiteracy, early poverty, and forced marriages, and women’s limited mobility, a lack of decision-making autonomy, insufficient transportation infrastructure, and limited access to competent healthcare providers. Delays in identifying danger signs during pregnancy, obtaining suitable medical attention, and receiving timely and adequate treatment after being admitted to a medical facility are often triggered by these social factors. Maternal health initiatives like the practice of community midwives have been put into place, but there are still substantial issues with their integration into the official healthcare system,

lack of training, and lack of self-assurance in their skills. Additionally, women's access to life-saving care is hindered by the gender norms that favor patriarchy over female health decisions as well as the occurrence of traditional birth attendants in rural and peri-urban areas.

The study highlights that medical measures alone won't be sufficient to reduce maternal mortality in Quetta. Strong social policies intended at empowering women, raising community awareness, and addressing deeply rooted gender inequities must be joint with improvements in healthcare quality and accessibility in a broad, multi-sectoral strategy. Policymakers need to be aware of how dangerous it is to remove these social obstacles through community engagement initiatives, investments in girls' education, better infrastructure, and comprehensive health policies. To put it briefly, maternal mortality in Quetta is a disaster that could have been avoided and is a reflection of greater social injustices. Important insights into the lived certainties of women and healthcare professionals are provided by this study, which may consequently be utilized to create interventions that are both culturally suitable and long-lasting. To ensure safer pregnancies and deliveries for all women in Balochistan and beyond, collaboration between the government, local communities' medical experts and civil society is essential.

Recommendations

To successfully reduce maternal mortality in Quetta, a multi-faceted approach is essential. Promoting women's autonomy through gender equality initiatives and education can enable them to make knowledgeable healthcare decisions. Preventing forced and early marriages by enforcing legal agendas and increasing community awareness is critical to protect maternal health. Health infrastructure in underserved areas must be supported by equipping facilities and deploying trained female healthcare employees. Emergency transport and referral systems should be amended to ensure timely access to care during obstetric emergencies. Incorporating and training traditional birth attendants (TBAs) can bridge the gap between community practices and formal healthcare services. Financial obstacles must be addressed through maternal health receipts or conditional cash transfers while eradicating informal payments in public facilities. Raising community awareness about pregnancy hitches and the significance of skilled birth attendance through culturally suitable health campaigns is vital. Strengthening maternal health data systems and ensuring truthful reporting will support evidence-based planning. Cooperative efforts across sectors such as education, health and social welfare are essential to address the root causes of maternal mortality. Finally, escalating mixed-methods and qualitative research to other districts of Balochistan will help design targeted and region-specific interventions.

References

Abbasi, N., Khan, M., & Javed, F. (2020). Sociocultural influences on maternal health practices: A study from Balochistan and bordering Afghan regions. *Journal of Development and Social Sciences*, *1*(2), 45–55.

Bano, N., Hussain, M., & Alam, K. (2023). Evaluating the three delays in maternal deaths in Pakistan: A retrospective review. *Pakistan Journal of Medical Sciences*, *39*(1), 55–61.

Barrera-Osorio, F., Bertrand, M., Linden, L., & Perez-Calle, F. (2020). Conditional cash transfers in education and health: Evidence from low-income countries. *Journal of Economic Perspectives*, *34*(3), 119–140.

Government of Pakistan. (2021). *Pakistan Maternal Health Strategy: 2021–2025*. Ministry of National Health Services.

Kakar, S., Baloch, N., & Ahmed, M. (2022). Barriers to maternal health services in Quetta: A qualitative study. *Balochistan Journal of Public Health*, *3*(1), 18–27.

Khan, F., Shaikh, R., & Jaffar, S. (2023). Social barriers in maternal health: A case study of Hyderabad District. *iRASD Journal of Social Sciences*, *2*(1), 44–52.

Khan, S., Ahmed, T., & Gul, R. (2022). Impact of early marriages on maternal health in rural Pakistan: A cross-sectional study. *Asian Journal of Public Health*, *8*(1), 27–34.

Naeem, A., Bashir, S., & Khawar, H. (2021). Gender norms and maternal healthcare in South Asia: Evidence from Pakistan. *International Journal of Gender Studies*, *14*(4), 101–115.

Pakistan Bureau of Statistics. (2019). *Pakistan Demographic and Health Survey (PDHS) 2017–18*. National Institute of Population Studies.

PIDE. (2022). *Social determinants of maternal mortality in Pakistan: A regional analysis*. Pakistan Institute of Development Economics.

Rahim, M., & Baloch, T. (2023). Effectiveness and limitations of community midwives in rural Balochistan. *Journal of Development and Social Sciences*, *4*(2), 30–38.

Soomro, N., Bibi, A., & Kakar, M. (2023). Maternal mortality trends at Bolan Medical Complex Hospital: A clinical audit. *Journal of the Society of Obstetricians and Gynaecologists of Pakistan*, *13*(1), 20–26.

UN Women. (2023). *Maternal health in Pakistan: Challenges and policy priorities*. United Nations Entity for Gender Equality and the Empowerment of Women. https://www.unwomen.org

UNFPA. (2022). *State of maternal health in Balochistan*. United Nations Population Fund Pakistan. https://pakistan.unfpa.org

UNFPA. (2024). *Adolescent pregnancy and maternal health risks: Country report – Pakistan*. United Nations Population Fund.

UNICEF. (2023). *Maternal mortality data portal: Pakistan*. United Nations Children's Fund. https://data.unicef.org

World Health Organization. (2023). *Improving maternal health outcomes through gender equality*. World Health Organization. https://www.who.int/publications/gender-maternal-health-2023

World Health Organization. (2023). *Trends in maternal mortality: 2000 to 2020*. World Health Organization. https://www.who.int/publications/i/item/9789240068759

Yasmin, R., Shah, Z., & Khan, A. (2021). The role of cultural and gender norms in maternal health seeking in Balochistan. *Journal of Health and Social Sciences*, *6*(2), 125–134.