



Determinants of Maternal Healthcare Services at Pasni, Gawader

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Abstract

Maternal health is the health of women during pregnancy, childbirth, and postnatal periods. Maternal health is a serious problem all over the World. The factors included in the study were; Education Income level, Women violence, Birth control, Socio-cultural constraints, Child marriage, Awareness, Antenatal care, Pregnancy complication, Inexperienced doctors, Traditional beliefs, and Traditional birth attendants. The universe of the study was Pasni Town, District Gawader. The calculated sample of the study was 131. A convenience sampling technique was used to collect the data. The technique of data collection was an interview schedule that consisted of close-ended, open-ended, and matrix questions. Data were analyzed by applying the independence test of chi-square and phi value to inspect the relationship of bivariate tables. The findings of the study indicated that there were so many barriers, which affected maternal health, sociocultural constraints, perception towards birth control, traditional beliefs, child marriage, domestic violence, traditional birth attendance, lack of education, and low family income

Keywords: *Maternal Health, Socio-cultural Constraints, Antenatal Care, Postnatal Care, Awareness of maternal Health, Birth Control*

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INTRODUCTION

Health is more than just the absence of disease or weakness; it is a state of total physical, mental, and social well-being (WHO, 1946). According to the World Health Organization, maternal health refers to women's health throughout pregnancy, childbirth, and the postpartum period. While many women have positive and fulfilling experiences throughout pregnancy. Infections, unsafe abortions, excessive blood pressure, hemorrhage, and complications in childbirth are among the leading causes of maternal mortality and morbidity (Dar and Afzal, 2016).'

Many women suffer and die carelessly because they lack access to good healthcare and clear useful information about their health. The high maternal mortality rate directs that the health system is weak and poorly operational. A woman's risk of dying or becoming disabled during pregnancy and labor is strongly linked to her social and financial status, the standards and estimation of her way of life, the geographic remoteness of her home, and her social and financial status. The poorer and more undervalued a woman is, the greater the risk of death. More than any other aspect of health, maternal mortality rates reflect disparities between rich and poor countries (WHO, 2008). It is estimated that about 210 million women become pregnant regularly. About 30 million people are causing problems. An additional 515,000 passes on. In addition, 3 million children are stillborn whereas 3 million children die in the first week of their birth and many of these children have varying degrees of disability. These are the challenges that can be avoided (WHO, 2012).

Even though the maternal mortality ratio (MMR) has shown a significant decrease over the past years, the rates remain high in low- & middle-income countries such as Afghanistan 638/100,000 livebirths, India 145/100,000 livebirths, Bangladesh 173/100,000 livebirths, and Yemen 164/100,000 livebirths (Shaheen et al., 2022). Pakistan, being one of the low-income countries, also reported a high maternal mortality ratio (MMR) of 186 deaths per 100,000 live births in 2019, a 32% increase from 2017 (140/100,000 live births) (PMMS, 2019). The maternal mortality ratio (MMR) is nearly 26% higher in rural areas as compared to urban areas due to a major difference in health care services provided to people living in urban areas as compared to those living in distant regions (Hanif et al., 2021). The despaired and inconsistent health care services throughout the country have adversely affected the mothers and their fetuses. According to the latest Pakistan Maternal Mortality Survey; Sindh has 224 maternal deaths per 100,000 as compared to 157 deaths in Punjab, 165 deaths in KP, and 298 maternal deaths in Baluchistan. Azad Jammu & Kashmir has the lowest MMR in the nation with 104 deaths, while Gilgit-Baltistan has an MMR of 157. According to this data, Sindh and Balochistan are in desperate need of improvements and enhanced delivery of services, while the medical services and especially women's access to them may have improved in Punjab and KP, resulting in a fall in the overall maternal mortality rate. The corresponding results of the survey also indicate the differences in health services between urban and rural locations (Pasha, 2022).

Maternal health care like prenatal care, qualified midwives, and postnatal care plays an important role in reducing the maternal mortality rate (Machio, 2008).

Maternal healthcare use in Balochistan is very poor. Balochistan is a militancy stuck province which is having maternal mortality rate due to the absence of health services, tribal culture, less economic status, lack of awareness about pregnancy care, and no security for medical officials. Most females' lose their life during pregnancy because of the complexity of their cases, the non-availability of trained doctors, no facilities that provide emergency complications, and there are no facilities for female maternal health care (Achakzai, 2014). In Balochistan, the pace of females' development is very low. Particularly in the rural areas of Balochistan, the contribution of women in socio-economic activities is largely ignored. An extensive gender gap in every aspect of life can be seen throughout Balochistan and this gap is larger in the health sector. Deterioration of health, decreased life expectancy, increased mortality, and premature death is the main indicators of poor health in women. The maternal mortality ratio in Balochistan (600 per 100,000 live births) is higher than the national figure. Life expectancy at birth (54 years) is also lower than other health parameters. This is due to poverty, low social status, low literacy rates, and poor access to medical facilities (Achakzai, 2014). Providing and planning medical services in Balochistan has always been difficult for healthcare managers due to the difficult and harsh terrain and the inaccessible and dispersed population (Ahmed, et.al, 2012).

In Pasni there are no good maternal health facilities at the hospital. Many females lose their life in pregnancy or childbirth due to complications of their cases and the non-availability of trained doctors. In emergency cases they suggest them to go another city which is difficult to reach early so women lose their life or child on the way in emergency cases they even don't have transport facilities and people in the community are very poor, so they also cannot afford the huge amount of transport and delivery. People in the community don't have good nutrition; there is non-availability of notorious food. Women visit traditional birth attendants (Dai) because no good maternal health facilities at the hospital and a large no of pregnant women die during pregnancy, due to the non-availability of health facilities at the hospital and trained doctors, level of nutrition in the community, illiteracy, poverty and no awareness among maternal health care.

Based on the above discussion, it is clear therefore that there is poor maternal health care service in Pasni which could be having an adverse effect on women's maternal mortality and morbidity. This study analyzes the profile of maternal healthcare service and the situation of women's maternal health in Pasni town of district Gwadar.

Objectives of the Study

- To explore the women's educational level and correlate with maternal health.
- To identify the socio-cultural constraints regarding maternal health in the community.
- To explore awareness of women about their maternal health.
- To identify the antenatal and postnatal healthcare services.
- To suggest remedial measures for better maternal health in the community.

LITERATURE REVIEW

Asim et al., (2021) revealed individual, sociocultural, and structural-level barriers that inhibit women from seeking maternal and newborn care. Individual barriers included mistrust towards public health facilities and inadequate symptom recognition. The three identified sociocultural barriers were aversion to biomedical interventions, gendered imbalances in decision-making, and women's restricted mobility. The structural barriers included ineffective referral systems and prohibitively expensive transportation services. Increasing the coverage of healthcare services without addressing the multifaceted barriers that influence service utilization will not reduce the burden of maternal and neonatal mortality. Malik et al., (2022) found that 54.5% of the population under study was health compromised due to poverty or low socioeconomic status. 61.8% of the population specified improper diet as a health issue that was the major reason behind their abortion/miscarriage/preterm labor. 57.2% of pregnant women were not satisfied with their diet plan. 48.6% of the population faced psychological issues during the gestation period and 59.3% of the population faced a financial crisis during pregnancy. According to Ahmed & Hydar (2017), Maternal healthcare-seeking behavior in Pakistani cities was very much associated with socio-economic status. Education can improve knowledge about maternal health care and the females whose age group was less were more aware of maternal healthcare. However, distance failure, female knowledge about pregnancy complications, spouse education, and a number of the child hurt seeking maternal healthcare. Rehman et.al (2017) found that utilization of maternal healthcare in Khanewal, Punjab was associated with less financial status most of them were engaged in labor farming and financial cost in both sectors were high due to which they cannot approach maternal health. The healthcare determinants were exuberate poverty of households. Faiz et.al (2016) research demonstrated that women in the study area District Faisalabad were facing difficulties in utilization of maternal health care services, which were caused by these all factors such as lack of education, age of marriage, socio-demographic and cultural barriers, family type, attitudes towards healthcare facilities. The study revealed that limitations of healing facilities like socio-demographic and cultural barriers, transportation, lack of knowledge about maternal health services, complications hemorrhage, infections, unsafe abortion, financial problems, poor infrastructure, traditional beliefs, lack of women's autonomy, non-cooperative behavior of staff these all factors have been restricted them to utilize maternal care services. Pandey & Singh (2015) explored that utilization of maternal care in India was unequally distributed between rich and poor, uneducated women cannot approach maternal healthcare due to no awareness regarding the benefits of maternal health. Education not only increased awareness but also utilization of maternal health. Birth orders increased and utilization of maternal health decreased. Sarfraz et.al (2015) found that antenatal and delivery care is associated with a lack of knowledge, most do not aware of the dangerous signs of pregnancy. Women had strong beliefs about taweez, and dhaga. They used these all from faith healers for protection from evil eyes, and curses, and for normal delivery. Which affect women's antenatal care (ANC) such to social and financial barriers, traditional birth attendants, distance, and cost. Abbasi & Younus (2015) explored in Pakistan the maternal mortality ratio was increasing the most

significant factors were poverty, low economic status, female literacy, awareness and knowledge, early marriage, nutritional food, poor reproductive healthcare, and broken roads due to which cannot reach to hospital on time in emergency cases. These entire factors maternal mortality rate ratio in Pakistan. Mirza et al (2014) study revealed that female clients were not satisfied with maternal health services in the study area. Maternal health indicators were very poor in the study area of the city district Government of Lahore. The management of hospitals and healthcare was very poor, no good transportation system in rural areas. Most clients were illiterate and had low-income levels which were very insufficient to reach maternal healthcare. The study explored that clients were not satisfied with the cleanliness of the waiting area, and comfort, also not satisfied with the examination time provided by the lady health visitor (LHV) and there has not been any privacy during the examination. Service facilities regarding healthcare were neglected majority of respondents were deprived of basic determinants requirements and services. Mahmud & Bashir (2012) explored that utilization of maternal healthcare practices was associated with education women who got more education got better knowledge about maternal health, and the women whose education was higher used high healthcare practices, and wealth has been a strong impact on maternal healthcare practices. Poor families do not have good maternal health care services. Gaffar et.al (2015) explored that maternal healthcare in rural areas of Balochistan was very low due to illiteracy and poor family income, early marriage, more no of children, and women who experienced spouse violence had less access to maternal health. Khan, et.al (2009) explored that maternal mortality rate was associated with low economic status, women empowerment, poor nutrition, lack of skills, untrained staff, and traditional birth attendants. The major cause of death among pregnant women is the reproductive age of women. Haq & Arshad (2007) found that maternal healthcare services were associated with traditional birth attendants, low economic status, and tetanus immunization as the barriers to maternal healthcare. Balochistan was the most vulnerable province in all aspects. Tetanus immunization was spread all over the country which was improved but in Balochistan, it does not improve across the different economic statuses. Hassan (2007) found that in Dhaka Bangladesh patients were satisfied with maternal and child health, satisfied with all accessibilities of the hospital such as transport, cost, and source of information, and available services such as physical examination, privacy, and lab technician were satisfied.

METHODOLOGY

The present research was studied through a quantitative approach and the researcher used an explanatory type of research in which the research mainly set out the theoretical framework by using a deductive approach. However, this has been studied on the principle of social survey research. Thus, the present study in which the universe of the research was selected was Pasani, a small town of District Gawader, and units of the research were the married member of the households of Pasni. The researcher took the total household numbers from the website of the Pakistan Bureau of Statistics. Then the researcher used Roasoft sample size calculator and got the sample of 131HH out of the total population which was 8400HH. Thus, after getting the sample size the researcher collected the data from the sample by

using the convenience sampling technique. The tool for the collection of data was a questionnaire that contained 30 questions of open-ended, close-ended, and matrix questions. Data were analyzed through SPSS. Uni-variate tables were used to know the frequencies and bivariate tables were used to know the relationship between the variables by applying the chi-square test of independence. A Phi value test was conducted for the significance of the relationship among the variables.

Findings of the Sample Tables

Table No.1 depicts that the majority of the respondents i.e. 31.0% ages were 26-30 years. 22.1% of the respondents' ages were 36 or more than that years, 14.5% of the respondents' ages were 21-25 years and 4.6% of the respondents' ages were 16-20 years in the community. However, the researchers found that majority of the respondents i.e. 41.2% monthly family income was 15000-20000. 33.6% of the respondent's family income was 20000-25000, and 14.5% of the respondent's family income was 25000-30000 while 10.7% of the respondent's family income was 10000-20000. According to the qualification and educational status of the respondents, it found that 55.7% were illiterate and the rest of them were educated. The family status and nature of the respondents were joint family systems and 47.3% of family members were 7-10, 42.2% of the respondent's family members were 3-6 and 10.7% of the respondent's family members were 11-14 in the community. However, it was found that traditional foods were used particularly during pregnancy 42.7% used rice and fish. 21.3% used Mish-mash, 17.5% used rice & dal, 10.6% used fish fry and 7.6% Nan sheer in the local community. Traditional foods after delivery used specifically by the respondents were Soji, Safa-e-roghan, Sesirk, Dhalag, and Madar in the local community. Researchers explored that majority of the respondents i.e. 48.9% have 5-8 children, 42.7% of respondents have 1-4 children and 8.4% of respondents have 9-12 children. The choices regarding the pregnancies of the respondents were 74.8% agreed, 14.5% disagreed and 10.7% did not have any idea of their pregnancy at the time.

Table NO.1 Characteristics of the respondents N=131

Response Options	Frequency	Percentage
Age of the Respondents		
16-20	6	4.6
21-25	19	14.5
26-30	41	31.3
31-35	36	27.5
36+	29	22.1
Family income		
10000-15000	14	10.7
15000-20000	54	41.2
20000-25000	44	33.6

25000-30000	19	14.5
Educational status		
Matric	17	13.0
Intermediate	16	12.2
Bachelor	15	11.5
Master	10	7.6
Illiterate	73	55.7
Family Members		
3-6	55	42.0
7-10	62	47.3
11-14	14	10.7
Traditional Foods During Pregnancy		
Rice & fish	56	42.7
Mish-mash	28	21.3
Rice & Dal	23	17.5
Fish fry	14	10.6
Nan sheer	10	7.6
Traditional Foods after Delivery		
Soji	45	34.5
Dhalag	15	11.4
Sesirk	25	19.0
Madar	11	8.3
Safa-e-roghan	35	26.7
No of children		
1-4	56	42.7
5-8	64	48.9
9-12	11	8.4
Choice of Pregnancy		
Agree	98	74.8
Disagree	19	14.5
No idea	14	10.7
Antenatal Care		
Doctors	11	8.4
Dai	71	54.2

Customary practices as taweez dhaga	49	37.4
Maternal Health in Community		
High	55	42.0
Moderate	46	35.1
Low	30	22.9
Delivery		
Doctors	2	1.5
Traditional Methods	119	90.8
Hakim	10	7.6
The decision of Delivery Place		
Themselves	19	14.5
Husband	55	42.0
In-Laws	57	43.5
The decision about Maternal Health		
Themselves	15	11.4
Husband	61	46.6
In-Laws	55	42.0
Socio-cultural Practices		
High	48	36.6
Moderate	57	43.5
Low	26	19.8
Condition of Maternal Health Care		
Good	45	34.4
Bad	86	65.6
Age of Girls' Marriage in Local Community		
16-19	60	45.8
20-24	69	52.7
25-30	2	1.5
Age of Marriage		
16-19	48	36.6
20-24	56	42.7
25-30	27	20.6
Opinions about Early Marriage		
Agree	90	68.7

Disagree	41	31.3
Violence against Women		
Physical	58	44.3
Verbal	73	55.7
Reasons for Travelling for Maternal Health		
No Skill birth attendant	4	3.1
Drugs unavailability	10	7.6
No emergency	52	39.7
Inexperienced doctors	65	49.6
Awareness About Maternal Health		
High	39	29.8
Moderate	68	51.9
Low	24	18.3
Perception regarding Birth Control		
High	69	52.7
Moderate	31	23.7
Low	31	23.7

It was explored that the method of antenatal care of the respondents 54.2% received traditional methods, 37.4% of the respondents received antenatal care through customary practices such as taweez, dhaga, and 8.4% of the respondents received their antenatal care through medical doctors. The maternal healthcare services satisfaction level of respondents was 42.0% highly agreed, 35.1% moderately agreed and 22.9% low-level agreement was shown about their maternal health in the community. Moreover, the researchers found that the majority of the respondents i.e. 90.8% gave birth to their children through traditional methods and others gave birth to their children through hakim doctors. The decision of delivery place was taken by in-laws 43.5%, husbands 42.0% and 14.5% of the respondents' delivery place was decided by themselves in the community. And the majority of the respondents i.e. 46.6% of maternal healthcare decision was taken by their husbands, 42.0% of the respondents' maternal healthcare decision was taken by in-laws and 11.4% of the respondents' maternal healthcare decisions was taken by themselves. As per the socio-cultural constraints of the community concerned regarding maternal health, it was explored that 43.6% told a moderate level of socio-cultural constraints, 36.6% told a high level of socio-cultural constraints and 19.8% told that there is a low level of socio-cultural constraints. The condition of women's maternal health was shown well by 56.6% and 34.4% told that the situation of women regarding maternal health is bad. The researchers further explored that 45.8% of the respondents told that the ages of girl marriages are between 20-24 years, 45.8% told that between 16-19 years, and 1.5% between 25-30years in the community. Whereas, 42.7% got married at the age of 20-24years. 36.6% of respondents got married at the age of 16-19years and 20.6% of the respondents got married at the ages of 25-30 years

in the community. It was found that the majority of the respondents i.e. 68.7% agreed that early marriage affects maternal health while 31.3% of the respondents disagreed. Besides this, 55.7% of the respondents faced verbal violence and 44.3% faced physical violence in the community. The majority of the respondents i.e. 49.6% traveled to another city for maternal health due to inexperienced doctors. 39.7% of respondents traveled due to no emergency, while 7.6% traveled due to drug unavailability and 3.1% of the respondents traveled due to no skilled birth attendant in the community. Awareness about maternal health among the respondents was 51.9% moderate, 29.8% high, and 18.3% low. Thus, the perception of birth control is high level in the community among the respondents as 52.7%, 23.7% moderate level perception and 23.7% had a low level of perception of the community.

DISCUSSION

Table No.2 shows that the calculated value of χ^2 (18.5) at the degree of freedom 4 and level of significance 0.05 is greater than the table value of χ^2 (9.488). Thus, the null hypothesis is rejected and the alternative is accepted. It means that there is a relationship between maternal health in the community and the education of women in the community. Hence, the phi value is 0.001 shows that there is a strong significant relationship between both variables.

Table No.2: Contingency Table showing the relationship between Women's Education & Maternal Health in the community

Education of Women	Maternal Health in the community			Total
	High	Moderate	Low	
Illiterate	41 (30.6)	21 (25.6)	11 (16.7)	73
Matric/Intermediate	7 (13.9)	12 (11.6)	14 (7.56)	33
Bachelor/Master	7 (10.5)	13 (8.78)	5 (5.73)	25
Total	55	46	30	131
Chi-Square Value= 18.5, Table Value of Chi-Square= 9.488 & Phi Value=0.001				

Table No.3 shows that the calculated value of χ^2 (14.2) at the degree of freedom 2 and level of significance 0.05 is greater than the table value of χ^2 (5.991). Thus, the null hypothesis is rejected and the alternative is accepted. It means that there is a relationship between maternal health in the community and family income. Hence, the phi value is 0.001 shows that there is a strong significant relationship between both variables.

Table No.3: Contingency Table showing the relationship between Family Income & Maternal Health in the community

Family Income	Maternal Health in the community			Total
	High	Moderate	Low	
10,000-20,000	39 (28.5)	19 (23.9)	10 (15.6)	68
20,001-30,000	16 (26.5)	27 (22.1)	20 (14.4)	63
Total	55	46	30	131
Chi-Square Value= 14.2, Table Value of Chi-Square= 5.991 & Phi Value=0.001				

Table No.4 shows that the calculated value of χ^2 (0.376) at the degree of freedom 2 and level of significance 0.05 is lesser than the table value of χ^2 (5.991). Thus, the null hypothesis is accepted and the alternative is rejected. It means that there is no relationship between maternal health in the community and violence against women. Hence, the phi value is 0.892 shows that there is a less significant relationship between both variables.

Table No.4: Contingency Table showing the relationship between Violence against women & Maternal Health in the community

Violence against women	Maternal Health in the community			Total
	High	Moderate	Low	
Physical	26 (24.4)	19 (20.4)	13 (13.3)	58
Verbal	29 (30.6)	27 (25.6)	17 (16.7)	73
Total	55	46	30	131
Chi-Square Value= 0.376, Table Value of Chi-Square= 5.991 & Phi Value=0.829				

Table No.5 shows that the calculated value of chi-square is 1.672 at the degree of freedom=4 and the value of the level of significance is 0.05 which is lesser than the table value of chi-square which is 9.488. Thus, the null hypothesis is accepted and

the alternative is rejected. It means that there is no relationship between maternal health in the community and the perception of birth control. Hence, the phi value is 0.796 shows that there is a less significant relationship between both variables.

Table No.5: Contingency Table showing the relationship between perceptions about Birth Control & Maternal Health in the community

Perceptions about Birth Control	Maternal Health in the community			Total
	High	Moderate	Low	
Agree	31 (29.0)	25 (24.2)	13 (15.8)	69
Disagree	11 (13.0)	11 (10.9)	9 (7.1)	31
No Idea	13 (13.0)	10 (10.9)	8 (7.1)	31
Total	55	46	30	131
Chi-Square Value= 1.672, Table Value of Chi-Square= 9.488 & Phi Value=0.796				

Table No.6 shows that the calculated value of χ^2 (9.93) at the degree of freedom 4 and level of significance 0.05 is greater than the table value of χ^2 (9.488). Thus, the null hypothesis is rejected and the alternative is accepted. It means that there is a relationship between maternal health in the community and socio-cultural constraints. Hence, the phi value is 0.042 shows that there is a less significant relationship between both variables.

Table No.6: Contingency Table showing the relationship between Socio-cultural Constraints & Maternal Health in the community

Socio-cultural constraints	Maternal Health in the community			Total
	High	Moderate	Low	
High	27 (20.2)	10 (19.6)	11 (11.0)	48
Moderate	19 (23.9)	27 (20.0)	11 (13.1)	57
Low	9 (10.9)	9 (9.13)	8 (5.95)	26
Total	55	46	30	131
Chi-Square Value= 9.93, Table Value of Chi-Square= 9.488 & Phi Value=0.042				

Table No.7 shows that the calculated value of χ^2 (9.082) at the degree of freedom 2 and level of significance 0.05 is bigger than the critical value of χ^2 (5.991). Thus, the null hypothesis was rejected and the alternative was accepted. It means that there is a relationship between maternal health in the community and opinions about child marriage in the community. Hence, the phi value is 0.011 shows that there is a less significant relationship between both variables.

Table No.7: Contingency Table Showing Relationship Between opinions about Child Marriage & Maternal Health in the community

Opinions about child marriage	Maternal Health in the community			Total
	High	Moderate	Low	
Agree	43 (37.8)	24 (31.6)	23 (20.6)	90
Disagree	12 (17.2)	22 (14.4)	7 (9.4)	41
Total	55	46	30	131
Chi-Square Value= 9.028, Table Value of Chi-Square= 5.991 & Phi Value=0.011				

Table No.8 shows that the calculated value of χ^2 (18.1) at the degree of freedom 4 and level of significance 0.05 is larger than the critical value of χ^2 (9.488). Thus, the null hypothesis was rejected and the alternative was accepted. It means that there is a relationship between maternal health in the community and awareness regarding maternal healthcare in the community. Hence, the phi value is 0.001 shows that there is a greater significant relationship between the both variables

Table No.8: Contingency Table Showing Relationship between Awareness about maternal healthcare & Maternal Health in the community

Awareness about maternal health care	Maternal Health in the community			Total
	High	Moderate	Low	
High	27 (16.4)	7 (13.7)	5 (8.93)	39
Moderate	19 (28.5)	31 (23.9)	18 (15.6)	68
Low	9 (10.1)	8 (8.43)	7 (5.50)	24
Total	55	46	30	131
Chi-Square Value= 18.1, Table Value of Chi-Square= 9.488 & Phi Value=0.001				

CONCLUSION

Thus, the researcher explored various factors which affected maternal health because the women did not utilize maternal health care services. There are so many barriers, which effected maternal health: socio-cultural barriers, traditional birth attendance, customary practices such as taweez dhaga, lack of knowledge regarding maternal health, awareness about antenatal care, perception towards birth control, traditional beliefs, age of marriage, domestic violence, no emergency and non-availability of drugs, untrained doctors, limitation facilities, lack of education and low family income.

The study explored that women's education is an important factor for maternal health and well-being. Because it enables women to know and become aware of maternal healthcare services. But the majority of the women were found illiterate or had a low level of education in the present study. Besides this, the research found that sociocultural obstacles are the hurdles in the way for women to receive maternal healthcare services. And mostly women deliver their babies through traditional methods. Besides this, poverty is another obstacle because people cannot afford the

services of maternal health.

Recommendation of the study

Based on the present research, the following suggestion and recommendations are suggested for the improvement and betterment of maternal healthcare in the community. Education must be compulsory for all women and a special emphasis on maternal health should be included in the text box of secondary-level classes. Provision of maternal healthcare services in the BHUs and hiring of female doctors at each BHUs. Special Training of midwives and nurses at the BHUs with modern methods and techniques. Non-governmental and semi-governmental organizations with the local government and health department must run campaigns on the awareness of maternal health at the community level. Implementation of early marriage law at the micro level by the government ought to be done. Sociocultural constraints should be discouraged with the help of community elders by conducting special sessions for married women on maternal health. Civil society organizations, educationists, and health care professionals should provide better maternal health, and more skilled birth attendants should be trained, to provide 24-hour health care and facilitate timely referral in case of emergency.

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