



## RESEARCH PAPER

### Socio-Cultural and Financial Considerations of Maternal Mortality: An Evidences from District Bhakkar, Punjab, Pakistan

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PAPER INFO	ABSTRACT
<b>Received:</b> May11, 2021 <b>Accepted:</b> August 30, 2021 <b>Online:</b> September05, 2021	The purpose of this research is to explore the socio-economic and cultural determinants that contributed to maternal mortality in rural areas of District Bhakkar, Pakistan. It was a systematic investigation and analysis of the literature concerning gender equity and socio-economic and cultural determinants to maternal health for females living in Pakistan. The qualitative research design was used and cases of twenty deceased women were investigated while the respondents were their close relatives, husbands, and concerned persons who were sharing their daily life routine. The purposive and snowball sampling techniques were employed for data collection and thematic analysis was used for analyzing this data. The results showed that most of the women were died due to the non-availability of nearby health care facilities, lack of appropriate knowledge regarding maternal health, visit traditional birth attendants, poor economic status, absence of transportation facilities at the time of complication, absence of trained doctors and Para-medical staff at the time of delivery, frequent pregnancies and less birth spacing. The government should provide sufficient resources including health, transport, and education in rural areas. The socio-economic and cultural relief for women is a sensitive issue especially in the decision of childbirth which should be addressed while creating awareness among society.
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## Introduction

Most of the women die due to pregnancy-related complications that may develop during pregnancy and childbirth (WHO, 2019). Maternal health is one of the significant problems of the worldwide health society. Maternal health is a condition of the absolute physically healthy status of a woman in connection to her pregnancy (Jegade, 2010). Maternal mortality is women's death even if expecting or during 42 days of the wind-up of pregnancy, irrespective of the timing and condition of pregnancy, pregnancy-related a few causes or its managing but not from due to the accidental or incidental reasons (WHO, 2004). In Pakistan Maternal mortality ratio (per 100,000 live births) was accounted for at 140 out of 17 (World Bank, 2019). Over 60% of worldwide maternal deaths take place

in the postpartum period characterized by the World Health Organization as the stage starting after the delivery of the placenta and proceeding until 6 weeks (42 days) after delivery (WHO, 2014). Women's reproductive health is a complete state of physical, mental, and social well-being with the reproductive system and its functions and processes (WHO, 2009). International data of health metrics from 2008 to 2016 showed the ratio of maternal death in 82 countries and it varies among developed and developing countries. Programs and Policies targeted to get better maternal health and decrease maternal deaths should reflect on population dynamics, socio-economic control, and health system determinants that impose a major risk for pregnant women or mothers (Girum&Wasie, 2017). Millennium development goal five has to reduce maternal mortality by 75% and improve women's reproductive health between 1990 and 2015 after the commitment 45% sharp decline in maternal mortality ratio was reported globally. Sub-Saharan Africa reached to 50% reduction in maternal mortality ratio during this period. The developing countries were 239 per 100,000 live births whereas 12 per 100,000 live births in developed countries was recorded, globally highlight the maternal health gap (WHO, 2017). Millennium development goals target of 140 set for Pakistan was not achieved last recorded data in 2006-2007 was 276. It will be a worsened situation for Pakistan (Malik & Kayani, 2014). The legislature of Pakistan for accomplishing the sustainable development goals at government and all regional level guideline and coordination had different projects for the decrease of maternal mortality for example; Extended Primary Health, Family Planning, Program of Immunization and Aids Control Program, National Malaria Control Programs, National Tuberculosis Control Program and so forth which are financed by the government, yet their usage is completed at the all levels (Razzaq *et al.*, 2017). The European Region has worthwhile improving maternal health and reduction of maternal mortality rate by adopting the MDGs and after that attainment of SDGs (WHO, 2017). The maternal mortality ratio during 2017 in developing countries was 20 times and Sub-Saharan Africa 45 times more than the developed countries. According to MMR live birth estimation, the 638 women die during pregnancy and childbirth complications in Afghanistan than an America such global differences are not only reflected by the resources but also the attitude towards maternal health (WHO, 2019). Pakistan with 188 million populations is a developing country with a high maternal mortality ratio in South Asia. The most important cause at the back this the social-economic and cultural determinants which may be responsible for missing in the accomplishment of maternal health targets (Pasha *et al.*, 2015).

Keeping in view the above critical situation, the present study is designed to explore the socio-economic conditions of the respondents as well as to understand the socio-economic and cultural determinants of maternal mortality which become the cause of the death of females.

### **Literature Review**

Zulema and Julian (2011) however around about 15,000 ladies died every year in Latin America and the Caribbean for pregnancy-related causes. Socio-economic determinants, health services, illiteracy, region, the financial status of women, maternal equality, age, the environment of the house, and prenatal care were associations with maternal mortality. Kaphle *et al.*, (2013) found that Nepalese ladies, their families, and the vast majority of their locale obviously esteem their childbirth customs and related

religious thinking and they significantly shape ladies perspectives on security and chance during pregnancy and childbirth, affecting how birth and new maternity fit into day by day life. Mumtaz *et al.*, (2014) there was a need to end the imperceptibility of the low-status group in Pakistani human services strategy. They recommended that specialized upgrades in maternal health care, social insurance administrations ought to be upheld to counter social and financial minimization so progress can be made toward Millennium Development Goal five in Pakistan. Fawole *et al.*, (2015) in Sub-Saharan Africa some socio-cultural determinants like illiteracy, the socio-cultural status of women, unemployment and lack of decision-making power about their health and high fertility, son preferences, physical violence and abuse, cultural beliefs, lack of transportation services causes behind the high maternal mortality. Fleming *et al.*, (2017) stated that the obstacles that prevent the excellence of maternal health services should be explored and addressed to lower the death toll during pregnancy. Ariyo *et al.*, (2017) found with the help of multilevel logistic regression analysis that there was a relationship between socio-cultural factors and maternal mortality. Women's education, region, and religion were linked with maternal mortality. The other causes were the absence of data on family arranging, sexual orientation issues, delay in choosing to look for health services, lack of decision-making power for their health causes in which fifty present death happen from Sub-Saharan African countries. Kildia *et al.*, (2018) females face many complications that affect their health during pregnancy and childbirth due to their socio-cultural status, illiteracy, lack of decision making power, inaccessibility of transportation, unaffordable health care services, and negligence of medical staff are the obstructions that contribute to unavailability of health facilities to the mothers. The lack of decision-making power is the major factor that worsens the condition in rural areas that influence maternity. Omer (2019) stated that Pakistan is among those nations of existence where vast quantities of maternal mortality cases are accounted for. In Dera Ghazi Khan, social-cultural reasons were the primary explanations for the greater part of the maternal mortality in South Punjab. It was uncovered that the poor framework of towns, absence of health facilities at closest wellbeing places including essential wellbeing units, Tehsil and area clinic and the dissatisfactory job of specialists at gynecology ward were the other contributory variables of maternal mortality. This investigation has adopted a theoretical framework that integrates interrelated theoretical points of view. According to Equity theory by Adams (1965), it is to create systems where resources can be comparatively divided between the individuals. Gender equity theory clarifies that how individuals react to socio-economic and cultural strain by manipulating the system to their apparent compensation and obviously, only women are suffering from maternal mortality, especially in rural areas. Socio-economic inequalities play a role in strategy making to decrease these disparities proficiently (Khange *et al.*,2008).

### **Material and Methods**

The qualitative research design was used and cases of twenty deceased women were investigated through the data collected from their close relatives, husbands, and other concerned persons. In-depth interviews were conducted while investigating each selected case of maternal death in Bhakkar. Bhakkar is a region in the province of Punjab, Pakistan, large portion of the region's territory lies in the ruined plain of the Thal desert. The purposive and snowball sampling technique was employed for data collection and

thematic analysis was applied. Seven emerging themes/thematic analyses were given related to maternal mortality.

### Results and Discussion

The following seven themes were emerged after data collection and analysis. Table 1 presents the themes as well as the description of these themes that was considered in this study.

**Table 1**  
**Major themes and Description**

No.	Themes	Description
1	<b>Effects of Economic Status</b>	<ul style="list-style-type: none"> <li>• Treatment from unskilled birth specialist because of lack of money</li> <li>• Non-affordability of clinics</li> <li>• Over work load during pregnancy due to lack of money</li> <li>• Weakness due to unavailability of sufficient food</li> <li>• No means of transportation for emergency</li> </ul>
2	<b>Effects of Education Status</b>	<ul style="list-style-type: none"> <li>• Illiterate pregnant women didn't know but antenatal care and maternal health complications</li> <li>• Ignorance regarding their maternal health care</li> <li>• Unaware of hygienic practices</li> <li>• Absence of proper information and awareness</li> </ul>
3	<b>Health Seeking Behaviors of Rural Women</b>	<ul style="list-style-type: none"> <li>• Lack of proper visits to doctor</li> <li>• Shy to visit male doctor even in case of emergency</li> <li>• Superstitious beliefs regarding medicine use</li> <li>• Misguided judgment and misconception</li> <li>• Don't follow the prescription of the doctor</li> </ul>
4	<b>High Fertility / Male Child Preferences</b>	<ul style="list-style-type: none"> <li>• Frequent pregnancies in short time</li> <li>• No use of any family planning method</li> <li>• Gender disparity/Desire of male child</li> </ul>
5	<b>Role of Quackery and Traditional Birth Attendant</b>	<ul style="list-style-type: none"> <li>• Unawareness of risks of quackery</li> <li>• they rely on assistant of doctor</li> <li>• Uses of traditionally home medics to deliver baby easily</li> <li>• Lack of money</li> <li>• Traditional system of family/village birth attendant</li> </ul>
6	<b>Cultural beliefs</b>	<ul style="list-style-type: none"> <li>• Early age/child marriages</li> <li>• Unnecessary to treat anemia, high blood pressure etc.</li> <li>• Overlook the unsatisfactory condition of woman to bear more children</li> <li>• Joint family structure is not supportive in her clinical treatment</li> <li>• Belief that baby will be active and delivery could be easy is the women do hard work tasks in last days of pregnancy</li> </ul>
7	<b>Provision and Access to</b>	<ul style="list-style-type: none"> <li>• Delay in accommodating emergency cases</li> <li>• Poor performance of government medical clinics</li> </ul>

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**Maternal  
Health Care  
Services**

- Careless behavior of emergency panel toward emergency cases and hospital's staff
  - long distance to the health facility
  - inaccessibility of qualified paramedical staff at the time in rural/slum
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**Theme 1: Effect of Economic Status**

The economic status of the family has a greater effect on the maternal health of pregnant females. The present research explored that most of the deceased women were belonging to low-income or poor families in which they cannot afford the appropriate health care facilities. Maternal health required proper diet, supplements, and vitamins but their poor financial status did not allow them to get the nourishment as per their requirement. Another cause of maternal death in rural areas that have no access to health care services due to their low economic status also affected her choice to select health care services for delivery. Poor financial situation constrained the pregnant ladies to settle on the TBAs because of the adaptable timetable of the installment. The comparable outcomes were likewise found by Walton *et al.*, (2013) in their investigation directed in Bangladesh. They recognized that poverty is a reason for maternal death. Pregnant ladies have no access to medicinal services because of poverty. Taguchi *et al.*, (2003) Indicated that low socio-economic establishment and the accessibility of antenatal care affect maternal mortality in Surabaya, Indonesia.

**Theme 2: Effect of Education Status**

In rural areas the majority of the women were illiterate and they were not fully aware of health care practices during pregnancy. Illiteracy is a risky aspect among pregnant women for their deaths during pregnancy. The absence of knowledge regarding reproductive health, family planning, and maternal health care is a higher risk of maternal mortality in rural areas. Illiterate women cannot get decision-making power regarding their lives, do not recognize their self-image, and cannot improve their social status. They were easily impressed by and influence of advertisements by unskilled and unqualified healthcare providers and also added their lives in suffering. Literacy greatly affects the lives of the maternal potency of ladies. The greater part of the ladies who passed on was discovered uneducated and couldn't realize the varied wellbeing aspects and self-care. Even, few of the respondents stated that "if we were educated, we can take care of ourselves better than now". The comparative outcomes were additionally found by Combs Thorsen *et al.*, (2012) stated that lack of education was firmly connected with the maternal death ratio, in the region of Lilongwe, Malawi. Lack of education among females and absence of perceiving signs, side effects, and seriousness of the circumstance is a dangerous factor for their death during pregnancy. McAlister & Baskett (2006) explored the effect of female proficiency rate and consolidated enrolment in educational projects as moderate indicators of maternal mortality rates. A strategic venture to improve personal satisfaction through female education will have the best effect on maternal mortality decrease.

**Theme 3: Health Seeking Behaviors of Rural Women**

Health-seeking behavior of women found a prominent aspect in their maternal death and they believe that in hospitals/healthcare providers and physicians use the operation as unnecessary treatment/ surgical processes to get more money that concept in rural areas showed the determinant that becomes the cause of maternal death. In rural areas, most of the people felt shame to abort their women in public health care centers or hospitals for treatment/delivery until they felt severe condition but that was too late to reach on time. During pregnancy, the health-seeking behavior of women in rural areas is a major cause of maternal deaths as they did not bother to take care of themselves while they preferred to take care of their family especially male members of the family. The greater part of the persons didn't prefer to visit the health facility or doctor for antenatal, natal, and postnatal necessary exams until the mother felt cut-off issue in Uganda. A comparative investigation is discovered which was directed in the countryside by Armstrong (2011). It was concluded that deliveries with TBAs at home can create high risks for pregnant women because of the reasons that they don't approach the health facilities.

#### **Theme 4: High Fertility / Male Child Preferences**

In Pakistan, females are expected continuously to give birth to baby boys even her healthiness was at risk, complications of maternal health and childbirth take her to the eventual death. In most of the cases of the researcher found that frequent pregnancy/desire of son in a shorter period cause of depression, anemia, and high blood pressure during pregnancy increased the risk of health complications i.e. risk for ruptured fetus and Post-partum hemorrhage. Milazzo (2018) found that having a first-conceived baby girl prompts affluence practices medicinally known to spoil ladies' staying power and seriousness of anemia. Women tend to have more children to have a son, which was a very serious risk to their health especially in rural areas in India. The results are as similar as in our study. Kaur *et al.*, (2018) found that early marriage, frequent pregnancies, and unsafe abortion causes more extensive maternal deaths due to more pregnancies mean more chances of mortality of ladies in Chandigarh, India.

#### **Theme 5: Role of Quackery and Traditional Birth Attendant**

In rural areas, unqualified/untrained quacks are hired for medical health care and the delivery of pregnant women. Most of the reason for maternal death was found the delivery from a traditional birth attendant or treated by unqualified/untrained quacks. Quacks and TBA do not have sound knowledge and standard practice of medical science and maternal health complications but only know about some fast relief treatments. In rural areas, women are not allowed to go outside for modern medication for their treatment/ compulsory checkups until they felt a severe condition. They can have access to modern medication if their family/husband takes them or else quacks are not available in the community. In Ethiopia, maternal mortality can be reduced through mass education and training of TBAs by professionals' skilled persons and sustained behavioral change of women in rural areas (Gurara *et al.*, 2019). In another study, Kumari *et al.*, (2019) found that almost 50% of maternal deaths were because of cases/delivery delays. Visit unskilled and untrained person, anemia and hemorrhage were discovered the main immediate and circuitous obstetric reason, individually.

**Theme 6: Cultural Beliefs**

The sixth theme that emerged in the findings of this study was that in rural areas some cultural beliefs and customs also act as obstacles for many women who try to avail the available health facilities. Early age marriage was a very common cultural practice in rural areas and it became the cause of the high rate of pregnancy in the short period and no use of any family planning method creates anemia and weakness/ruptured of the fetus that increased the risk of maternal death. In rural areas, women share the burden of the family/husband by working along with them in the fields and did all household responsibilities even the day of delivery are likely to suffer from maternal complications and are also at a higher risk of maternal death due to their belief system that baby would be born active, healthy and delivery could be easy also by hard-working in last days of pregnancy. Muoghalu (2010) gave the comparative outcomes about financial, cultural food restrictions, cultural beliefs, and gender o relations on maternal mortality and dietary pattern of ladies during pregnancy in Nigeria. Evans (2013) also found that cultural values, customs, beliefs, and practices significantly impact ladies' ways of living during the prenatal period and now and again increase the probability of maternal death during delivery.

**Theme 7: Provision and Access to Maternal Health Care Services**

It is found that some cases which delayed in the access to the health services became the main aspect of maternal death due to unavailability of means of transportation, absence of husband/male member at the time of delivery, lack of money, a long distance from health facilities or social restrictions on females to move alone outside the community. The careless behavior of the medical staff was also the reason. Mannava *et al.*,(2015) found that ladies with complex pregnancies got inadequate poor care because of the absence of multidisciplinary care and weak administration for those ladies including major risk throughout pregnancy. It was found that unsatisfactory care was also found in the medical clinics, patients were referred without given emergency support, lack of facilities and lack of qualified persons and the females died in the way to reach the basic health care facility.

**Conclusion**

The maternal mortality in southern Punjab has greatly been affected by the socio-economic and cultural factors as it has been demonstrated. Though socio-economic and cultural factors are majorly responsible for the deaths of females but in some cases, it cannot be the single factor which can be the reason for maternal deaths. Although, poverty is a major factor that leads to compromise in making selection for appropriate traditional birth attendant. Poverty also forces a pregnant lady to do hard work during the third trimester of pregnancy. It may also cause delay in choosing are reaching an appropriate health facility. Women may also suffer due to lack of knowledge about contraceptives and reproductive health which causes high fertility and unsafe abortions and heavy workload during pregnancy. Secondly, social status of women is also a leading concern to their health as it is responsible for forced marriages, exchange marriages and child hood marriages. The evidence from the study identified some critical aspects of maternal health complications in the countryside, there are poor planning, lack of infrastructure and

comfort, increasing poverty and unhealthy outcomes and the targets of the MDGs and the SDGs were not properly achieved. Obstacles in the provision of health care services are categorized into two. One is quackery and the other in unavailability of trained staff in private hospitals. In the first case, the usually affected group is the rural women who fall deceased to unqualified assistants and fraud hospitals. In the second case untrained staff becomes physicians in the absence of professional doctors thus risking the life of pregnant ladies. Some family customs and traditions also propel mothers to deaths. Another major factor that affects maternal deaths that is found in all the health care providing sectors is inappropriate conduct and unprofessional attitude of the staff. These factors are responsible for high mortality rate in Tehsil Darya Khan District Bhakkar, Pakistan. In the light of the present research, it is recommended to create awareness regarding birth spacing, family planning and maternal health complications. Strict laws must be introduced in the society to make sure the implementation of standardize medical protocols. Education and especially basic health education should be compulsory for women. Female labor force participation should encourage so that they can get economic benefits as well as they can be independent. Enhance the skills of community midwives who are specialized in providing maternal and reproductive health services, community health workers can play a pivotal role. In this way government can reduce the number of traditional birth attendants.



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