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Cultural Challenges Faced By Women in Accessing Maternal Healthcare Services

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Abstract: *Women in Pakistan face numerous cultural challenges in accessing maternal healthcare services. The study aims to see what cultural barriers women face in seeking health care services and decision-making. The objective was to study the challenges, women's autonomy, women's health-seeking behavior, and food taboos, that limit access to women attending healthcare services. Using Exploratory methodology, in-depth interviews were held with 24 such women in Jhang Sayedan Islamabad, in May 2023. Findings suggested that although women do want to receive healthcare services, cultural barriers often make it difficult for such women to access healthcare services and food taboos are sometimes useful, but they sometimes also affect women's health negatively. Other challenges such as lack of knowledge, not having the right to decision-making, limited support, hierarchy, and taboos need to be tackled. Men are crucial in deciding a woman's medical requirements and determining whether they need medical assistance or not.*

Keyword:
Patriarchy
Stigma
Taboos
Gender
Barriers
Maternal Health
Decision Making
Women Autonomy
Health Seeking Behavior

Introduction

The timely utilization of healthcare services to obtain the greatest health outcomes is referred to as access to healthcare. Access to healthcare services for Maternal women is facilitated by factors such as insurance coverage, money, the cost of healthcare services, information, transportation, and communications. However, it is crucial to consider how healthcare services are accessible from a societal perspective. While there are many challenges for women in accessing quality maternal healthcare and support in the communities, these challenges are

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increased by the health behaviours, socio-cultural beliefs and taboos of the community.

In low-income countries, the health-seeking behaviour of women is low. This theory was developed by Edward A. Suchman. This theory explains the health-seeking behaviour of an individual and their behaviour toward health-seeking care. This theory uses some indicators to measure an individual's behaviour for example what is the perceived health status of the women, actions they took when they got ill, the type of action, and medical institution visits and preference of medical institutions. Many articles investigate women's health-seeking behavior by using this theory which explains that in low-income countries women's behavior toward taking health care is very low. The main reason behind maternity death or increased mortality rate is low health-seeking behaviour.

Due to the patriarchal system in Pakistani society, gender-based differences between men and women exist in many areas such as education, health, job opportunities, and control over assets. Many other well-known obstacles prevent women from accessing healthcare, such as limited decision-making authority women, domestic care obligations, not allowing travelling alone, and the preference of the choice of male family members. " Gender-responsive health programming is crucial in this environment. Particularly in nations with poor and middle levels of income, gender plays a significant role in determining health

" (Sheikh & Hatcher, 2004).

Women must take approval from men or the family's dominant male member before making decisions, they do not have this privilege. Men are crucial in deciding a woman's medical requirements. Men determine where and when women should seek medical attention because they make all the decisions and have control over all the resources. The findings of our research uncover that as compared to males, women who are ill report seeking medical attention less frequently. Women's low status makes it difficult for them to identify and express their concerns about health requirements. The decision to spend money on medical care is typically not permitted for women. As a result, women typically cannot obtain emergency medical care. Women have been denied access to basic health knowledge, even though they frequently provide the majority of the care for their families. The dominant value system upholds gender division and confines women to their homes. More than one-fifth of the world's population are women of reproductive age, or women aged 15 to 49, who are frequently subjected to pregnancy and childbearing. 'According to the World Health Organization (Shimizu, 2023), using maternal healthcare services is crucial for identifying pregnant women who are at high risk of sickness and mortality early on (WHO)'. When women choose to engage in the dangerous processes of pregnancy and childbirth, they have a fundamental right to protection. One cannot disregard the 600,000 maternal deaths that result from pregnancy-related complications each year in the world.

Pregnant women and nursing mothers typically consume significantly less food than the average male does in underdeveloped countries. Pregnant women frequently experience iron and protein deficits as a result of cultural practices, such as nutritional taboos, which ensure that they are deprived of necessary nutrients. A more balanced diet helps improve poor health. Numerous factors, such as the availability of natural resources, finances, religious convictions, social standing, and cultural taboos, influence the type of food consumed. These factors limit food intake in one way or another, depriving communities and people of important nutrients and impeding physical and mental growth as a result.

In general, this is true in the majority of emerging nations, but particularly in Pakistan as a whole. There are many justifications for such

taboos, but they are all based on superstition. Many taboos continue to exist because it is thought that ingesting a certain thing or plant will harm the person. Additionally, female community members in Pakistan are subject to ongoing taboos. Women are disproportionately affected by temporary taboos that only apply at specific points in a person's life. Food is prohibited in the majority of Pakistani societies, especially for expectant mothers. These taboos frequently forbid consuming nutrients that are vital for the expecting woman and fetus.

Basic Statistics

Cultural variations may have an impact on how women view their needs and preferences for healthcare. Ling and Cheung discovered that people's capacity to differentiate between health issues varies across cultures. 'The World Economic Forum's Global Gender Gap Survey places Pakistan 145th overall, second to last'. An estimated 30,000 Pakistani women lose their lives to problems with reproductive health every year. Neonatal and maternal health are closely related (Zahidi, Global Gender Gap Report, 2022).

According to Studies, Women in Pakistan have a lifetime chance of maternal death of 1 in 93. When compared to industrialized countries (Majrooh, 2013), where antenatal care (ANC) utilization is 97%, developing countries use ANC less frequently (65%)'. In established countries, 99% of deliveries are attended by skilled personnel, compared to 53% in developing nations. Only 53% of pregnant women in Punjab have access to ANC treatments from doctors at least once, and only 41% have access to postnatal care. In Pakistan, there are significant differences in the socioeconomic groups' availability of healthcare for mothers and newborns. Women's position and access to healthcare are impacted by poverty, racial, ethnic, cultural, and religious factors. According to research on the use of primary ANC services in Pakistan, a significant portion of poor (46% for ANC) and less educated (33% for ANC) women were not getting any ANC at all or were receiving it less frequently than the WHO- and nationally-recommended schedule.

Objectives

1. To study the cultural challenges, food taboos and restrictions faced by women in accessing maternal healthcare services.
2. To explore the health-seeking behaviour of women in access to health care services.
3. To identify women's autonomy as participation of women in decision-making related to access to healthcare services.

Research Questions

1. What is the health-seeking behaviour of maternal women regarding access to healthcare services?
2. What are the cultural challenges faced by maternal women in accessing healthcare services?
3. What is women's autonomy in making decisions regarding health services utilization?

Review of Literature

(Makuochi, 2021) uses a Health Belief Model to investigate four different aspects of perceived advantages, perceived barriers, perceived threats, and sociocultural aspects that might affect maternal health habits by using Semi-structured interviews conducted with 47 respondents. The findings Explain the connection between the following four health belief factors: i. The difficulty of accessing medical facilities; ii. Long wait periods (queues) at those facilities, iii. Attitudes toward Cesarean Section and iv. Lack of awareness of the effects of poor health choices, poverty, lack of technical abilities, and cultural norms (traditional and religious beliefs).

(Mumtaz & Salway) used the Social Relation theory which was given by Lev Vygotsky (1968) to address maternal health care disparities in Chakwal, Pakistan. The study explores how healthcare systems as social organizations can be used to understand the phenomenon of challenges in access to maternal health care. By using Ethnography in-depth interviews were conducted with 40 respondents, and 8 focus group discussions. The study will offer theoretical developments that will improve comprehension of the class and gender power dynamics, Behind Pakistan's institutions' exclusion of poor women, and Seeks to lessen inequalities in Pakistan's maternal health treatment and Aid in the reduction of societal injustice and accomplishment of MDG No. 5.

investigate the Health-seeking behaviour and utilization of health services in Pakistan. The relationship between factors influencing health-seeking behaviour and usage of health services in Pakistan, including both the public and commercial sectors, is examined using Kroeger's conceptual framework for analyzing health-seeking behaviour. Data was gathered from secondary sources. The results demonstrated the need to comprehend the factors influencing people's decisions to seek medical attention in an increasingly diversified medical system. By adopting more client-centred approaches, more female health workers, and supportive policies, the polarization in the usage of the health system can be reduced.

(Mulenga, 2018) explain cultural taboos and customs around pregnancy and childbirth in 3 different regions. Various taboos and customs discovered by rural placement activities were carried out where a total number of 68 nursing students were placed in 14 rural health facilities. The findings show that Pregnancy and childbirth are surrounded by a variety of taboos and customs, some of which are advantageous to the mother and child's health while others are harmful.

(Ugwa, 2016) investigate some of the taboos and dietary customs among expecting mothers receiving antenatal care. The data was collected by 220 pregnant women who were interviewed using a structured questionnaire, which revealed numerous sociodemographic data, cultural dietary practices, social taboos, and a 24-hour meal recall in General Hospital in *Dawakin* Kudu LGA, Kano, Nigeria. The findings showed that 100% (200/20) of the women agree that eating more during pregnancy will help ensure the health of the unborn child. 53% of the time, their husbands provided for them, with support from the community being less common. Age, parity, and support from the husband and community were statistically associated with the women's nutritional practices and taboos.

(Navabi, shamsi, khorsandi, & zamanian, 2020) used the Theory of Planned Behavior (Ajzen,1985) to identify and comprehend how an individual's and the environment's variables affect behaviour and culture. In this study, Data was collected from 100 pregnant women by random sampling technique in the Health Centre of Iran. Data was collected using questionnaires and interviews. The results of this research, which focused on perceived behaviour for maternal health, can help guide and make suggestions for the design of educational programs for expectant mothers. Communication about behavioural transformation is essential. The theory of planned behaviour constructs can be used to check how pregnant women will treat their newborns.

investigates maternal knowledge and food restriction and taboos and how women adopt prevention strategies during pregnancy. Using the descriptive methodology, consecutive sampling techniques are used. A total of 121 pregnant women participated in this study. The restriction they have in food is a rich carbohydrate diet, protein, and beverages. Cultural and religious beliefs also influence food restrictions. Restriction of nutritious food during

pregnancy is a matter of concern as this may lead to maternal mortality because of nutrition loss during pregnancy.

Materials and Methods

Locale

My locale of study is *Jhang Sayedan Islamabad*. I chose this place for my study because Islamabad City is a place where people from almost all cultures live there.

Justification of Locale

Jhang Sayedan is a small area with very few streets. People of different socio-economic statuses and cultures lived here. So, by researching this region I'll get to know how different ethnic groups of women seek care during and after pregnancy. However, the main reason for selecting this locale is that there is not a single maternal public health facility available in *Jhang Sayedan* that accepts only 1 single room and 1 female doctor. Women who go through from maternity period will face a lot of issues because of the lack of health facilities. Besides, we know that maternal health care services are a major issue globally. Many countries try to deal with this issue but still, the maternal mortality rate is high. Islamabad is a big city with a lot of opportunities still faces issues in delivering and accessing health care services.

Sample

The Sample size of 24 married women of reproductive age is primarily chosen for in-depth interviews based on their reproductive histories, childbirth experiences, or fertility decision-making processes. In-depth interviews were conducted until the point of saturation. The inclusion criteria selected for the study were, Experience with antenatal and postnatal care, recently going through a maternity period, volunteering, and understanding of Urdu. The sample size was chosen because of the topic sensitivity and limited respondents in the area. It is preferable to use open-ended questions to elicit a holistic account from the respondents of all the cultural obstacles, taboos, or other factors they believed to have increased or decreased their ability to obtain medical care. Interviews with women who belonged to the following groups are done in the local language: i). Various socioeconomic groups reflect households from the lower and middle classes, ii). both nuclear and joint family, iii). recent mothers, fertile women, women who have reproductive diseases, as well as more outspoken and information-willing women.

Methodology

The methodology of the study is Explanatory. Explanatory methodology is used when we have limited information and explore why something occurs. This methodology is used when you explain why and how the particular thing happened and how we can tackle the situation in future. In my research, I explore what are the cultural challenges that prevent and stop women from adopting appropriate health care and why they don't have access to health care services. What are the underlying challenges and how do they tackle the situation?

Method

The method of Purposive Sampling was used. According to Kothari (2004), purposeful sampling is a technique whereby researchers select a person or a group as the sample based on their goals and objectives. The information was gathered using field notes, which were then entered into Microsoft Word and subjected to thematic analysis.

Tools

Tools for data collection will include an In-depth Interview Guide. The tool covered the 3 sections:

1. Demographic information of the respondents such as age, education, locality, occupation, family structure, etc.
2. Health-seeking behaviour of the women such as perceived health status of women, taking action when ill, medical institution preference, who they consult, and attending ANC services.
3. Cultural challenges, community norms, and food restrictions and taboos.
4. Women's autonomy in decision-making.

Detailed Study Plan (DSP)

The socio-economic survey's beginning phase of fieldwork involves gathering baseline demographic data. Secondly, a thorough interview will be conducted, consisting of questions on family/household dynamics, community norms, cultural factors, healthcare systems, challenges, patterns of interaction and roles of various family members, the authority and contribution of women in household decision-making, the type and extent of power dynamics at home, etc.

Data Management and Analysis

This research will be purely explanatory and qualitative in nature due to the reason that it will focus on explaining the health-seeking behaviour of women, Cultural challenges, community norms, and food taboos faced by women in accessing healthcare services and Women's autonomy in decision-making. The research tool was developed in English. Then convert to the local language Urdu. Urdu and Punjabi languages are used in the fieldwork. Then the interviews are converted into English with the help of an AI translator app. Data for demographic information and health-seeking behaviour of the women will be quantitative while the rest of the data will be qualitative in the form of words, clues, and body gestures. Quantitative data such as demographic information were analyzed under Excel software whereas qualitative data will be dealt with under Thematic Analysis.

Table 1

Data Management and Analysis

Method	Tools	Data Type	Mode of Collection
Base Line Survey	Demographic information	Quantitative	Direct
Observation	Participant Observation	Qualitative	Direct observation by the researcher
Interviewing	Interview Guide	Qualitative	Conducting of interviews by the researcher

Results and Discussion

A sample of 24 respondents was obtained and interviewed, relevant to the topic: Cultural challenges faced by women in accessing health care services.

Demographic Information

Basic demographic information of the respondents is given below:

Table 2

Demographic Information of the Respondents'		
Responses	Frequency	Percentage
Age distribution of the respondents		
20-25	6	25%
26-30	11	45.83%
31-35	4	16.67%
36-40	3	12.50%
Education of the respondents		
Illiterate	2	8.33%
Primary	1	4.17%
Secondary	9	37.50%
Intermediate	2	8.33%
Bachelor	10	41.60%
Locality of the respondents		
Urban	18	75%
Rural	2	8.33%
Semi-Urban	4	16.67%
Household Income of the respondents		
1k-10k	7	29.17%
11k-20k	6	25%
21k-30k	5	20.83%
31k-40k	6	25%
Socioeconomic status of the respondents'		
Lower Class	17	70.80%
Middle Class	7	29.20%
House ownership of the respondents		
Own	17	70.80%
Rented	7	29.20%
Family structure		
Nuclear	11	45.83%
Joint	12	50%
Extended	1	4.17%
Number of Bread Earners		
One 1	11	45.84%
Two 2	8	33.33%
Three 3	3	12.50%
Four 4	2	8.33%
Number of Dependents		
1-5	12	50%
6-10	11	45.80%
11-15	1	4.20%

Table 1 shows the demographic information of the respondents such as age, education, income, family structure, number of bread earners, socioeconomic status, and number of dependents. Out of 24 respondents, 25% of women are between 20 and 25 years which constitutes about 6 respondents, 45.8% of respondents' age lies between 26-30, 6% of respondents' age is 31-35, and 12.5% of respondents' age lie between 36-40. The respondents were also categorized based on their education. In this regard, the highest proportion of the respondents 41.67% studied till their Bachelor's. Out of 24 respondents, 9 respondents were studied till the secondary level. Out of 24 respondents, 8.33% were illiterate, 8.33% studied till intermediate, and 4.17% studied till primary. Out of 24 respondents, 75% of respondents belonged to Urban areas, 8.33% of respondents belonged to rural areas and 19.7% of respondents belonged to semi-urban areas.

The socio-economic background of the respondents was also included to check the impact of status, occupation, and household income. Out of 24 respondents, 70.8% of respondents belong to the lower class and their husbands' occupations are labour, cooking, Shopkeeper, mechanic, factory working, etc. 3 respondents are widows or divorced who earn themselves. One of them has their own parlor, another one is a maid and the third one is doing oriflamme work. 28.9% of respondents belong to middle-class families and their husbands' occupations were university officers, Stamp sealers, etc. Out of which, the monthly income of 29% of respondents' households is from 1k-10k, 25% of respondents' household income is 11k-20k, 20% of respondents' household income is 21k-30k, and 25% of respondents' household income ranges from 31k-40k.

Out of 24 respondents, 70% of respondents lived in their own houses and 30% lived in rented homes. Most of the respondents who lived in their own houses have a joint family type. 50% of the respondents lived in a joint family, 1% lived in an extended family structure and 49% lived in a nuclear family. I also focus on the bread earners and the number of dependents in the family. Out of 24, 45% of respondents only have 1 bread earner who runs their whole family, 33.3% have 2 bread earners, 12% have 3 bread earners and 8.3% have 4 bread earners. Out of 24 respondents, 50% of respondents' bread earners take care of 1-5 members, 45% of respondents' bread earners take care of 6-10 family members and 4.2% of dependents range from 11-15.

The rest of the interview was conducted in an in-depth interview. The following themes emerged after data collection and analysis:

Table 3

Thematic Analysis		
S. No	Theme	Description
1	Health-Seeking Behavior of Women	Perceived health status of women Don't take action when got ill False beliefs regarding medicine use Don't follow the prescription of the doctor
2	Cultural Challenges	Challenges in accessing the Nearest health facility Challenges in adopting adequate Maternal health care Cultural Beliefs and practices during pregnancy Role of the health sector in disrupting health services

Thematic Analysis		
S. No	Theme	Description
3	Food Taboos, Restrictions and Practices	Homemade aid during pregnancy Food restriction during pregnancy. Desi food practices during pregnancy
4	Women Autonomy	Patriarchal society Take permission from family members Don't decide on her own

Theme 1: Health Seeking Behavior of the Women

According to the study, the perceived health status of the women is very low. Health-seeking behaviour is a theory which explains the behaviour of individuals towards health care, how they act, and what healthcare institute they prefer. The study shows that by using the health-seeking behavior theory indicators the perceived health status of majority respondents is fair.

Out of 24 respondents, approximately 85% of the respondents act when they get ill and use some type of action. The type of action they take is visited to the medical institution and 37.5% use only home medicines, remedies, and traditional healing practices and 45% said that they use both types of treatments. As one of the respondents said:

"I take both types of action. But always preferred to take medicine from home and use traditional practices if didn't heal then go to the hospital"

Another respondent said:

" I didn't visit any medical centre if I got ill. I always use medicines from home given by my mother in law"

The majority of the respondents preferred to visit public hospitals, some preferred to visit private clinics and few preferred to visit health centres and dispensaries. Hence this shows that the majority of participants had a low level of health-seeking behavior. This study shows that care-seeking behaviour is needed to improve so that we control the maternal mortality rate in Pakistan and improve health utilization.

Didn't Adopt the Recommended Health behaviour by the Health Professionals

The majority of the women adopted the recommended health behaviour by the doctors but only during pregnancy except for medicines they didn't take proper recommended medicines during pregnancy. Only a few respondents follow the recommended health behaviour after childbirth. But still, the majority of the women thought that if they didn't follow the recommended behaviour it could cause risk. However, they didn't follow the recommendations because of the cultural and community beliefs and taboos about pregnancy and maternal health.

As Respondent Said:

"During 1st pregnancy, my doctor advised me to do exercises but I didn't follow due to which last month I faced a lot of complications and went through C-section during 2nd pregnancy, I followed the instructions and had a normal delivery."

Another respondent said:

"Yes, it's risky for the baby's health and to survive a bad time period. When I visited the doctor she advised me to eat Pomegranate because I am an anaemic patient, so I followed if I didn't follow it might affect my children's health"

Another said:

"Yes, it's risky because only through diet we can't maintain our nutrition like calcium, potassium, and vitamins which is also necessary for the child's health. So, a doctor's prescription is necessary to take. I didn't follow the instructions at the start due to which I can't maintain the balance between body temperature due to which my baby and I suffer from pneumonia."

Similarly, 54.17% thought that it might cause health issues for both mother and child health. Some of the respondents had a miscarriage just because they didn't follow the recommended health behaviour.

As the respondents said:

"My bp shoots during the 7^{h} month of pregnancy due to which my baby died."

Another respondent mentioned:

"It's risky for both mother and child health. I didn't follow the proper instructions due to which my first miscarriage happened"

False Beliefs Regarding Medicine Use

The majority of the women didn't follow the medicines or instructions recommended by their doctors. They thought that excessive medicines could lead to miscarriages and affect the child and mother's health.

One of the respondents said:

"It might be risky to not follow the doctor's recommendation and medicines but what can I do? The medicine gave me a lot of medicine which is not suitable for me. So, I just didn't take the medicines"

The other said:

"I didn't follow doctors because when I use medicines my stomach upsets, so I stopped"

One of them said that:

"I only used folic acid and calcium medicines. I don't take the rest of the medicines because I thought that the food we eat is enough for the good health of baby and mother"

Some of the respondents know that it's risky to not take medicines but still didn't follow the doctor's recommendation. As one of the respondents said:

"I had a lot of health issues and done a few surgeries such as nose surgery my doctor advised me to take few medicines, but I didn't take medicines because during pregnancy taking more medicines is not good for both health"

Theme 2: Cultural Challenges and Community Norms

Women face a lot of cultural challenges in accessing maternal care services. They didn't visit the hospital for several reasons such as

Knowledge and Perception of Health Care Services

According to a study, approximately 16.% of the women attend ANC twice a month, 66.67% attend the ANC monthly while 16.7% attend ANC less than twice in the whole pregnancy period.

One of the respondents said:

"I didn't attend ANC during pregnancy. I only visit twice first when I know that I am pregnant and then before a few days of delivery. Because I don't face any issues, so I think it's not important to visit the hospital monthly"

Another respondent said:

"Yes, I have BP issues due to which I had 3 miscarriages just because I didn't follow all the instructions strictly."

After childbirth, only 20% of the respondents visit for postnatal care services. As one of the respondents said:

"I have twin babies, but I didn't visit the hospital for PNC. I don't want to visit the hospital again"

Another respondent said:

"After childbirth, I only visit the hospital 1 time to open my stitches"

Geographical Distance: doesn't have Proper Maternal Health care Facility Near

Respondents didn't visit the nearest facility because the nearest facility doesn't have good doctors every other street had 1 or 2 clinics which are not for maternity health care. Secondly, the facilities that they have near the area don't have proper services, and a lot of health care costs, especially in C-Section.

One of the respondents said:

"Transport issues are the main reason, economic issues, we don't have proper counselling, if there is an emergency to visit a hospital we face a lot of difficulties. We don't have a transport system as all women wait for the local bus which is not available all the time, especially at night."

Another respondent said:

"We don't have any vehicles due to which I have problems coming and going and also have to wait in the hospital for hours and no proper counselling."

Difficulties they Confront that Prevent them from Adopting Maternal Health Care

The respondents mentioned that there are a lot of difficulties that prevent them from adopting maternal health care. First of all, waiting for long hours in the hospital is the major reason they didn't go to the health care centres.

As the respondent said:

"Sometimes I didn't make an appointment with the doctor, so I had to wait for a very long time in the hospital which is frustrating for me"

Secondly, health care costs, especially in C-Section, are unbearable. There were a lot of other difficulties they faced such as transport issues, low household income, don't have a proper care system.

As the 10th respondent said

"During checkup my experience was good but after the C-section ty didn't pay attention to the patient. The NIH experience was the worst. They admitted me for 3 months because my child died in the 7th month they admitted me and wait for 3 months"

Another respondent said that:

"My experience is very bad because my baby after delivery needs oxygen and has some breathing problems, but the hospital doesn't have ventilation for children. Then in an emergency, we take a baby to the other hospital, don't have a good nursery for children"

Cultural Beliefs and Practices of the Community

The study shows that there are a lot of cultural beliefs that women follow during pregnancy. They don't have permission to attend funerals, stay at home especially if she had twin babies, avoid travelling, avoid going outside, and don't carry weight.

Respondents said:

"I remember in our neighborhood a 2-month-old baby died but my in-laws didn't allow me to attend the funeral of the child. Don't announce pregnancy and gender (Nazar)."

Another respondent said:

"Yes, during pregnancy I apply zaitoon oil and massage all over my body. It's good for my health as my mother-in-law advised me to do this."

Another respondent said:

"Don't carry weight which I didn't follow. I believe that doing work makes pregnancy easy and more chances of normal delivery."

One of the respondent's mother-in-law advised her:

"My Mother-in-law advised me to consume more protein, and in my community, I noticed women didn't take medicines properly because they thought it might affect the child's health."

Role of the Health Sector in Disrupting Health Services

The health sector plays an important role in encouraging and discouraging women to attend proper maternal healthcare services. However, their negative experiences discourage the women from attending the ANC and PNC. Firstly, they don't have any nearby facilities for maternal health care. According to the data, 67% of the women travel 20 minutes for checkups during pregnancy. Public and private sectors also impact health-seeking behaviour. Most of the women who belong to the lower class can't afford expensive treatments, so they visit public health centres. However, some of them had faced miscarriages because of inadequate health services, poor functionality, and not paying attention to the patient.

As one respondent said:

"Health care cost, and lack of family support because they thought that rather than wasting money I should take medicine from home "

The health sector doesn't listen to the patient carefully. The women who visited the private hospital also faced issues because they thought that the private sector charges a lot of money to attend health care services. But they treat them well.

The respondent said:

"It is difficult to access the nearest health facility because nowadays every other street has a clinic so it's hard to find a good doctor, and with good functional services."

Another respondent said:

"I attended ANC from RIHS but at the time of delivery, my doctor told me that I had a C-section but me and my husband think that the baby can be normal. So, then we decided to go to PIMS."

Theme 3: Food Taboos, Restrictions, and Desi Food Practices during Pregnancy

Food Restrictions during Pregnancy

Women don't allow specific foods during pregnancy such as Avoiding baadi food, Hot meals in the first three months, avoiding salt, etc. As the respondent said:

I avoided spices, baadi things, rice, meat, lenticels, potatoes, cabbage, and cauliflower.

Another said:

"I eat food according to taseer like in the starting months I didn't take hot things. My mother-in-law told me to avoid hot things, for example, don't eat eggs, or cheese."

Desi Food Taken during Pregnancy

Few women mentioned they follow specific foods during pregnancy especially the food rich in proteins. Such as consuming *Panjiri*, Suji halwa, and green leafy foods.

As the respondent said:

"Avoid hot and cold meals, taseer effects, eat more green leafy vegetables, consume Panjiri was taken with milk each night".

Another respondent said:

"During the whole pregnancy, my mother-in-law made specific Suji halwa for me and also advised me to consume Panjiri at night with milk"

Recommended Food Pattern

Women take food according to the *taseer* effect. One of the respondents told me about the Toxo test that is conducted in her village. According to the test result the women eat foods.

As Afshan Bangash mentioned

"In our village, every woman takes a toxo test, and according to the result of the toxo test, she follows the food eating pattern. I also took the test my test became positive and the range is 180

so they advised me not to eat meat, yogurt, and milk the things which are high in protein"

Theme 4: Women's Autonomy in Decision-Making

When it comes to pregnancy and postpartum care, nutrition, and daily activities, gender role norms in Pakistan are predominantly male-dominated and restrict the autonomy of women. These expectations could put the mother at even greater risk for complications during labour or after delivery. Pakistani women are traditionally expected to rely largely on their husbands and mother-in-law for guidance on matters such as diet, healthcare, finances, and daily activities. Only 29% of women were able to decide to seek health care. While the rest of the respondents must get permission from the other family members. Decisions were made either by husbands or by mothers-in-law. Even if she had to decide in an emergency they must take permission from her husband, mother-in-law, father-in-law, other caretaker, and the dominant person of the family.

As the respondent said:

"Usually my husband and khala make decisions. Because he runs the house and we must get permission from our mother-in-law."

Even the widow and the divorced must get permission from their family member to visit any health facility or at least must tell their family member. As one respondent mentioned:

"I am divorced, most of the decisions are made by my father because he was the head of the house"

One of them said:

"No, my family makes decisions to seek care Because my husband advised me to consult with my family before making any decision."

Another respondent said:

"My Mother in Law because my husband lives in Saudi Arabia, so she looks after all the things"

Conclusion

This study revealed that women faced a lot of issues in accessing maternal healthcare services not only at the personal level but also at interpersonal, community and health sectors. The patriarchal system of society limited women's empowerment in choosing and attending health care services. The women also face nutritional challenges because they follow the cultural food practices and don't take specific foods which might lead to low nutrition in the body which is not good for themselves and their baby. There are many difficulties they encounter in adopting adequate healthcare behaviour. They face transport issues, health care costs, low household income, lack of family support, and poor functional services of the health sectors and medical institutions. The majority of women had a low level of health-seeking behaviour. The women face challenges in the health sector. Some of them had multiple miscarriages because of poor health care services and didn't have proper equipment and services. Some had miscarriages because they didn't take the health professional recommendation properly. They follow the cultural beliefs and practices due to which they face issues during and after pregnancy. So, it's necessary to make sure women's empowerment, and health sectors need to be improved, and the government needs to take interventions to reduce healthcare costs. Proper care counselling education is provided to the women. This study shows that the behaviour of women towards accessing maternal health is needed to improve health health-seeking behaviour of the women so that we control the maternal mortality rate in Pakistan and improve health utilization. According to this study, women's access to skilled maternal health services was limited by their beliefs, their ignorance of maternal and reproductive health, their lack of autonomy in making decisions, the influence of family members particularly mothers-in-law and

husbands as well as the lack of access to and availability of adolescent-friendly health facilities. Women need to be empowered through education and employment to strengthen their decision-making autonomy in accessing care, as having greater decision-making independence is linked to more ANC visits and skilled care during delivery. Teenagers' access to care should be improved in remote areas, and more providers would help to reduce wait times and improve maternity care availability. Healthcare staff should be educated to overcome stereotypes to improve maternity services.

Recommendations

1. Raise awareness of the advantages of ANC and PNC.
2. Target male family members as well as females while conducting awareness campaigns.
3. To address negative attitudes and a lack of enthusiasm towards family planning, it is crucial to involve the secondary target audience in behavioural change initiatives.
4. Both the husband and the mother-in-law should be involved in behavioural modification efforts.
5. It is necessary to increase the accessibility of hospitals that provide services for maternal health, especially in distant locations where hospitals are not present.
6. To dispel cultural and religious myths, women must be empowered through education and employment, as well as by involving communal, religious, and political partners.

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Ethical Consideration

Participants were informed about the study and only those who wanted to participate were included. The recordings were made after the respondent's permission. Those who were allowed pictures were taken. Those who did not allow photographs were not taken.

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