MAPPING MATERNAL HEALTHCARE FACILITIES: EXPLORING BEHAVIORS AND DECISION MAKING ROLES IN HOUSEHOLDS OF TARLAI KALAN (UC-19)

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CERTIFICATE

This is to certify that this thesis entitled: **Mapping maternal healthcare facilities; Exploring Behaviors and Decision-making roles in Households of Tarlai Kalan (UC-19)** submitted by **Mian Ali Kamran Baba** is accepted in its present form by the PIDE School of Social Sciences, Pakistan Institute of Development Economics (PIDE), Islamabad as satisfying the requirements for partial fulfillment of the degree in Master of Philosophy in Development Studies.

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Author's Declaration

I Mian Ali Kamran Baba hereby state that my MPhil thesis titled Mapping Maternal Health Care Facilities; Exploring Behaviours and Decision-making Roles in Households of Tarlai Kalan (UC-19) is my own work and has not been submitted previously by me for taking any degree from Pakistan Institute of Development Economics or anywhere else in the country/world.

At any time if my statement is found to be incorrect even after my Graduation the university has the right to withdraw my MPhil degree.

Date: 15 - April - 2022

Signature of Student

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MIAN ALI KAMRAN BABA

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ABSTRACT

The promotion of health interventions targeted at raising awareness regarding the significance of maternal health at community level holds the potential to improve health outcome and reduce maternal mortality ratios. This study describes and analyzes the maternal health seeking behaviors and service utilization in Tarlai Kalan, a rural area present in the periphery of Islamabad. Attention was drawn to social, cultural and economic factors at individual, household and community levels to understand the causative agents responsible for lack of awareness regarding the significance of maternal health among women and their family members; identified as the key stakeholders. This study also reviewed the private health facilities operating in the area, in terms of access and availability of maternal health services. A qualitative study was designed to trace the perspectives regarding pregnancy and maternal health. Interviews were conducted with three different categories of respondents i.e. married women (12), husbands (8 husbands, and 4 couldn't be interviewed therefore 4 father in laws participated on their behalf), mother in laws (9) and gynecologists (2), making the total sample size to be 35, till saturation point was achieved, and then thematic analysis was done to analyze the collected data. The results of the study concluded that the health services being provided in the research locale, were not up to the standards, as lack of medical equipment was found as a common element of concern. Furthermore, majority of women were not included within the health decision making leading to poor access and low utilization of maternal health services.

Key words: Maternal health, health seeking behavior, decision making, antenatal care

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1. INTRODUCTION

Pakistan faces the burden of maternal mortality on a much larger scale as compared to other countries within Asia. The under 5 mortality rates are 69.3 per 1000 live births (Aleha Aziz, Fabian, Constance, Archana, & Elwyn, 2020). Since, most of the women do not seek professional healthcare during pregnancy it is one of the biggest challenges for the health care system in the country. In countries like Pakistan where, families are interconnected, number of stakeholders are involved in the decision-making process during pregnancy. The mother and childcare are influenced by mothers-in-law and husbands, but in most cases, mothers-in-law play an integral role in determining the level and type of treatment. It is very important to examine the inter-personal relationships within the family and the level of influence associated with decision making process around maternal health care. The findings of the previous studies related to maternal and child health explain that assessing, communicating, and decision making are one of the most important and challenging tasks during the prenatal and antenatal care (Anne, et al., 2007).

World Health Organization maternal, new-born and child health program is playing a pivotal role in improving pre and antennal health. Health care providers have been trained in integrated management of new-born and childhood illness using developed training modules. Emergency obstetric care package developed by WHO[1] Pakistan provides guidelines to health care workers working at first level. WHO Pakistan along with UNFPA[2] and UNICEF[3], received support through Norway-Pakistan partnership initiative for the 10 maternal, new-born and child health programs.

In richly diverse societies like Pakistan where gender roles are very clear and visible, the nature of gender roles and their implication in the modern healthcare is very important. The literature shows that birthing is usually a women affair. Hence, all the decision is to be taken by the older women else than the resources, the rural households depend on the traditional birth attendants (*Dai*) for pre and antenatal care. The women's own decision in pregnancy is relatively less in semi-urban or rural area, the health care beliefs are formulated by traditional practices and

[1] WHO: World Health Organization
[2] UNFPA: United Nation' s Population Fund
[3] UNICEF:United Nation's International Children's Fund

indigenous methods hence the skilled birthing practices and care is less. For issues like these the MNCH Program in Pakistan started incorporating the traditional Birth attendants in the mainstream. The TBAs are reliable and are trusted in the community, husbands and mother-in-law rely on the services provided by them. Under the MNCH Program, the TBAs are trained for safe antenatal care and EmONC[4] practices, to promote safe birthing in the country (Zeenat Sultana, 2017).

The proximity of healthcare and the socio-economic status of the people living in an area determines the care seeking behavior during maternal and child health (Rahat, et al., 2016). In patriarchal societies like Pakistan women are responsible for taking cake of the health of family members of the household. For their own health they are dependent on the male members of the household, in terms of resources and decision. Women's health is dependent upon the socio-economic status of the family and the social, physical, and psychological factors. Level of education and her health belief's system. The health system in Pakistan is a mixture of allopathic and traditional medicines and the choice of care is dependent upon the women's perception and belief about health. The inter-spousal communication and the role of mothers-in-law play a vital role in determining the choice of health services to be opted (Durr-e-Nayab, Health-seeking Behaviour of Women Reporting Symptoms of Reproductive Tract Infections, 2005).

Studies show that women are usually at the receiver's end while learning about pregnancy, mothers-in-law, sisters-in-law are one of the biggest influencers during the health care seeking process. Husbands play an important role usually in terms of providing with resources. Pregnancy and delivery care were meant to be done within family set-ups in cultural societies. Within traditional settings, child deliveries are often done at home without complications, which then dictates young girls mindset regarding giving birth at home and they start perceiving the process much safer as compared to hospitals. Therefore family environment does play a significant role in shaping perspective regarding pregnancy and childbirth. Husbands as the resource providers and to a greater extent mother-in-law play an important role in maternal health care seeking behavior, further limiting women's decision-making autonomy. In the rural context, men usually are the head of a family and take most household decisions. When it comes to the maternal health care, it is dealt with women, and mothers-in-law usually are the first person to take decisions about that.

[4] EmONC: Emergency Obstetric and Neonatal care

Despite this fact, it is also a common practice that many girls give birth at their own parents' house. Girls felt comfortable and expect to be taken good care while giving birth at parents' house rather than at their in-law's house. In such cases, parents are found responsible for influencing the approach towards maternal healthcare according to their own perspective and level of knowledge. The decision of the male members in the parent's house also plays an important role (Asm, et al., 2017)

It is of extreme importance to get information about the factors and the stakeholders that are involved also considering their level of influence on mother's health. This will allow the public health policy makers to address the key areas where steps need to be taken to counsel people regarding improving the decision-making process by keeping mothers in the loop, to avoid unforeseen circumstances and complications afterwards, which are included within the maternal health decision-making process.

There is a prevalence of traditional attitudes among the older generation that may deter women from using maternal health services. Furthermore, the cultural and societal norms that originate from religion and traditional system, equally influences the mind set and thought process of young and old generations within a society. Culture, traditional beliefs, and indigenous techniques play an important role in decision making process. Most of the women in rural or semi-urban settings prefer getting deliveries from traditional birth attendants (Dai).

Decision-making during pregnancy can be ethically complex, the main reason is the involvement of more than one stakeholder and the male dominated society where male members of the family play a major role in determining the healthcare seeking behaviour of women.

It is widely believed that, husbands are the decision makers along with mothers-in-law. But even in that case, mothers-in-law are dependent upon their son's decision in the type and quality of maternal healthcare. Very few women have the right to exercise their own decision-making power for their healthcare needs.

The research aims at adding knowledge to the existing literature of maternal and child health, health facility mapping has been conducted in various capacities in different area of Islamabad, this mapping will focus on Tarlai UC-19. The mapping can be used as a tool in the MNCH program Pakistan for this specific area. Identifying the health facilities will help in provision of better health

services to the mothers and children. The exiting literature on mother and child health explains, that apart from husbands' mothers-in-laws play an important role in decision making related to the choice and type of treatment during prenatal and antenatal stages, incorporating the role of other male members of the household that are fathers-in-law, brothers-in-law, and sons. Their influence on the household decisions and mechanics need incorporation in the health policy narrative. Hence this research will bring in multi-vocal perspective on the subject matter.

1.1.RESEARCH OBJECTIVES:

Following are the research objectives of this research study;

- **To map and assess private health facilities providing MNCH services in the setting of Tarlai Kalan (UC-19), Islamabad**

  The study aims at mapping and assessing the private health facilities within the specific locale which provide facilities, furthermore this objective also addresses the level and quality of services provided in the health facilities located in the selected locale.

- **To explore the women's perspective and perceived role of family members in decision-making and healthcare seeking behaviours during pregnancy and delivery.**

The most important individual during the pregnancy stages is the women itself, it is very important to document her viewpoint regarding the study and how does she feel about the decision-making process as well as the role of various family members that are playing a vital role in determining her health care seeking behaviour. Thus, this objective addresses women perspectives regarding socio-economic status, education and various other factors that play a vital role in her perception building.

- **To explore the perspective of identified family members influencing the decision making and healthcare seeking behaviours of pregnant women.**

The healthcare seeking behaviour of a woman is influenced and dependent on various family members who are not just those involved in decision making but have a supporting role in the whole process as well. Therefore, this objective aims at collecting data and documenting the role of other individuals at household level which are involved in the decision-making process as well as their role as healthcare supporters.

2. Literature Review

The review of literature has been classified into different themes, which are extracted from the literature reviewed for this specific research.

1.2.Masculinity, Culture and its role in Family Planning Decision making

In rural and semi-urban settings family planning decision making is usually credited to the males, especially due to the strong patriarchal practices and the decision power in the hands of male members of the family. The majorly argues that women's role in decision making is strongly affected by the socially determined gender roles and how they affect the family planning practices in the rural settings. The family planning utilization methods are predominantly affected by the strong gender roles within a community. The couples lack the basic communication within themselves to discuss when to have a child. Since, family planning is not accepted by the people of rural community on a larger scale due to the cultural, religious and social believes of the specific community. Large families are given more respect and social prestige within a community. As per the male members of the community, large family sizes will have more say in the community and will ensure that their family name stays. The pre-determined social norms lead to a lower social status of women when it comes to taking decision regarding childbearing, type and quality of care during ante and post-natal care. In a nutshell, the study explores the influence of masculinity and femininity on family planning decision-making. The male and female's identity and the pre-determined identities of both men and women, have a direct influence on child bearing, family size and decision-making related to type and level of care. Due to the cultural beliefs, the ways of expressing their happiness for a male and a female baby are quite different, these ideas and the pressure of giving a male child directly affects the development of femininity and masculinity as individual identities (Geleta, 2018)

A qualitative study which focuses on exploring the explored socio-cultural factors associated with men's involvement with respect to care and support of women throughout their gestational period

and childbirth. The study also explores the influence of men on the decision-making of women in terms of seeking antenatal and delivery care, arranging the conveyance, managing the escort and company to the health facilities, and perspectives of men supporting their wives during the delivery process through their presence.

Research locales for the study included the main referral hospital, six communities and health centers in the western region, and one health region in the Gambia. The respondents for the study were selected using purposive sampling. For conducting the in-depth interviews, 17 pregnant women, 10 midwives, 16 husbands, 2 village health workers and 2 traditional birth attendants were selected. 14 husbands and 14 wives participated in four focus group discussions (FGDs), with seven participants in each group. Two of the FGDs were held in the rural areas, while two of them in the urban areas. All informants ranged between the ages of 21 and 58 years. Data was transcribed and analyzed using a qualitative software opencode-3.4 (Umeå University, Epidemiology and Global health Research Open code). The privacy of the informants' identity was kept intact. Followed by uploading the files to the software, they were read and comprehended carefully, and assigned codes. These codes were further classified into categories, followed by thematic content analysis in order to generate themes and sub-themes for with reference to the findings

The first theme, "*decision making and health seeking behavior*" was further divided into sub themes 'approval of visits,' 'reproductive communication between couples,' 'communication between service providers and antenatal mothers,' and 'obstetric diagnosis - ultrasound scanning.' In this theme, it was found that initiate towards seeking antenatal care was taken by women, but the decision-making power lied with the men, which was often impacted by their conventional cultural, traditional, and religious views. Similarly, women's decision with reference to seeking delivery care was highly influenced by the mother in-laws, mothers, TBAs and the elderly female relatives in the communities. Another reason behind the limited role of women in decision making in this regard was the lack of reproductive communication between them and their husbands, as it was often restricted by individual dispositions and cultural beliefs. The second theme, "*arrangement of transport and transport fares to seek care*," was further categorized into sub-themes, 'transport fares provision and arrangements – rural urban variations,' social programmes – wedding and naming ceremonies, and 'preference of the male child.' In this theme and its sub-themes, it was found out that in most cases in the urban areas, the transport fares were provided by

husbands as means of communication were relatively easier. In contrast to the urban areas, in the rural areas, women reported to have hardly received transport fares from their husbands to access antenatal care, but did get their support for the arrangement of transport to access delivery care. However, keeping in view the preference of the mail child, there were cases where men provided women for antenatal care as well when they were expecting a male child. During the women's visits to antenatal and delivery care, men were usually found to have stayed home. The third finding of the study was "men's escort and company of women to seek antenatal and delivery care," which was further classified into sub-themes, 'companionship to clinics,' 'long waiting time of antenatal and laboratory services,' and 'use of mobile phones.' These sub-themes revealed that men often avoided escorting women, and the reasons behind this behavior included their job responsibilities, multiple antenatal visits, cultural restrictions, long waiting period of antenatal and laboratory services, and large age difference between husbands and their wives (as old men married young girls) which led to discomfort in husbands in escorting their wives to the clinics. In cases of emergency, the use of mobile phones was often reported in order to contact the men for support and meeting the needs. Educated men and foreign nationals like Guineans and Nigerians were found to have escorted their partners to the clinics; however, they were subjected to gossips by the people around them in the clinics. The last theme was "*presence during delivery*," that included 'health service and structural factors,' 'men's involvement non-customary,' and 'cultural and religious beliefs' as sub-themes. Within this theme, it was found out that there were certain factors that restricted the presence of the husbands during the women's delivery process that includes religious and cultural beliefs, limited space in the health facility, compromised privacy of women due to non-cubicle structured wards for labor, and attitude of midwives. A sense of compassion, satisfaction, and feelings of love, support, empathy and sympathy were expressed by the males who got the opportunity to experience their partner's process of delivery (SECKA, 2010).

1.3.Importance of the male inclusivity in decision making during pre-post-natal care

It is very important to enhance the understanding of the role of gender in family planning (FP) while focusing on men and boys; develop a framework that increases the engagement of men as users, agents of change, and supportive partners, and incorporates the transition inequitable gender

dynamics and norms; and create examples of successful interventions of effective males for practitioners so that they may be able to incorporate it into their FP initiatives.

The insight of whys and how's of male engagement in FP leads to the conclusion that it shall be done without compromising the agency and needs of the females in order to generalize the improved health outcomes. Despite the focus of the FP programs having a major inclination towards women, a paradigm shift is needed in order to enhance and increase the commitment of men and boys as supportive partners and users of FP, as well as agents of equitable reproductive health (RH) and FP behaviours. The document emphasizes that it is important to generate an impact on adolescent boys, young men, and those who influence or inspire them (i.e., their parents) in reference to health programming within this new paradigm in order to inculcate a sense of equity, equitable norms, and behaviours that will serve as a resource in their various stages of life. Such programs can also increase the level of engagement of boys and men as individuals, as partners, or in groups and communities. Interventions inclusive of girl/women-centred efforts may be helpful in achieving optimal and sustainable impacts.

The engagement of boys and men as users, supporting partners, and factors of change can also help in accelerating FP goals on a global level by adding new users of contraceptives and sharing the responsibility of family planning with the women. According to the document, it is important that the engagement of men must be carried out keeping in view the needs of women and girls, and while keeping their autonomy and rights safeguarded.

The mobilization of boys and men in FP initiatives may also have positive health and non-health outcomes, exclusive of the target program. The direct impacts of the FP program such as improved couple communication, equitable attitudes toward health, supportive father-child relationships, and healthy decision-making may also pose improved indirect outcomes in other areas of development e.g., reduced gender-based violence (GBV) and improved outcomes of education (USAID, 2018).

1.4. Gender Inequality and family planning decision making

One of the major symptoms of gender inequality around the world is inequality in the work-life divide, which stems out from the general expectations from men to be breadwinners and providers,

who's work tends to be outside the home, and from girls and women to be care providers, who are mainly held responsible for the reproductive aspects of the family life. Two statistics that prove this inequality: according to the World Bank, women averagely earn 22% less than men; and the unequally shared care work. In a nutshell, the rate of men's contribution in the care work is way less than the women's contribution in generating household income, and the wages of women are relatively lesser than that of men against the similar amount of work performed. This document systematically reviews and analyses these trends around the globe, and is divided into the following topics: (a) the changing dynamics of families and the role of men; (b) men, masculinities and families: changing manhood, manhood in crisis, transition to manhood; (c) the trends in engaging men in sexual and reproductive health; (d) and poverty alleviation strategies and men's roles in families.

While shedding light on the changing dynamics of families and the role of men, this document suggests that that while there are persisting patterns of inequality where men do not share the care burden despite struggling with ways of achieving income, there are some evidences in various settings that there may be an increase in the time spent by men in caregiving; however, those activities might not be recognized as care work e.g. accompanying the children to playgrounds or schools, or working overtime to pay their school fee etc. Some studies also show the increasing patterns of marital dissolution due to various purposes, leading to women-headed households. This leads to the lesser involvement of men in the house or with children, specifically in cases where they re-marry and start a new family. However, in some cases, it has been found that post-divorce involvement of fathers with children is greater in cases where proximity and strength of the relationship was stronger prior to divorce, in cases with joint custody, and where fathers tend to live near their children. Other trends that might affect men's involvement in care work and family life include increase in educational attainment and urbanization.

In the second topic, "Men, masculinities and families: changing manhood, manhood in crisis, transition to manhood," it has been discussed that the manhood of a man is generally defined by his ability to contribute in the household financially. This has led to the inclination of men towards the work outside of home. In many settings, this is the foundation of their marriage and family formation. Due to such stereotypes, unemployment in males may lead to a sense of shame and disturbed mental health. However, despite the general resistance shown by men towards women

entering the workforce, some studies suggest that with changing trends, men have started to participate in family and social life in equitable ways while embracing working women as equal partners and generating respect for them contributing financially.

The trends in engaging men in reproductive and sexual health have also been discussed. Statistics reveal that the support of contraceptives use by men for themselves as well as their partners has been improved. The participation of men in family planning is a form of their participation in care work. The efforts that have been put by the national and non-governmental organisations in the engagement of men in reproductive and sexual health have shown modest success. Similar efforts have been made in involving males in maternal health and childbirth by increasing antenatal visits and presence during delivery. These trends have had spill over effects on increase in care work by men, and enhanced acceptance of gender-equitable lifestyles.

Finally, in the fourth topic, "Poverty alleviation strategies and men's roles in families," it has been discussed that joblessness and poverty may bring about a distance between men and their families e.g., in terms of migration for work and generating income. Therefore, in many settings, there are men who value assertions such as women-centred cash transfers as it results in high portions of wage contributions in the household income. Hence, overtime work is reduced at their part as their partners start benefitting from poverty alleviation initiatives such as microfinance initiatives, and they are able to spend more time in care work (Pawlak, 2011).

1.5. Individual and Couple decision making for child bearing and care

A quantitative study in which a model is estimated, specified, tested in order to examine the decision of having a child as a choice jointly made by both the partners. It shows the individual and the mutual influences of both the partners, as well as the strength and significance of these influences on the whole process of decision-making. Therefore, this model helps in representing and explaining the framework within which, the process of decision-making and fertility takes place.

An approach was proposed in order to model the joint influences of both partners in the fertility decision-making process. A trivariate distribution was modelled that comprised of the individual fertility intentions of the male and the female, as well as their joint decision. In order to resolve

the problem of identification in estimation of the relative effects of the individuals (actors), a non-linear multivariate probit model was opted. These parameters helped in understanding the relative importance of the intentions of each of the partners in the decision. Data was analysed through MPLUS. For the estimation of the model, data was used from the panel of intimate relationships and family dynamics.

The results showed that the biographical context of the both partners was quite significant in with respect to their own as well as to their partner's intentions regarding fertility. It was found that the male partners showed greater influence in individual as well as partner effects as compared to their female counterparts. However, the female partners generally showed stronger parameters, and ultimately had developed the power to veto power the final decision of the couple. Hence, which partner has the greater impact in the process of decision-making, remains unclear. Using a dyadic model, the analysis of the decision-making process of couples regarding fertility showed that the individual intention of the male for child bearing was influenced positively by his level of education and weekly working hours. These partner effects also showed significant influence on the intention of the female partner to have a child. Men are expected to have more education and longer working hours as compared to women with respect to the traditional male breadwinner model. In this study, starting a family and extending the family was not distinguished within the analysis. However, it was found that the male partners earn most of the income of the family within the modern fatherhood family model. Therefore, the finding of this study regarding the persistence of the traditional male breadwinner model among couples with children should not be considered evidence for this model still being dominant. One of the most important findings was that the income effect was insignificant (Stein, Willen, & Pavetic, 2014).

Another study tends to determine the level of the involvement of males in family planning decision making. It also assesses the knowledge of men, their attitude, and ways of practicing modern contraceptive methods. The research also limelight's the extent of communication regarding family planning decision making among the couples, and explores the correlates of the opinion of the men with regards to their role in family planning decision making.

The study was conducted in Southwest Nigeria, in a place called Ile-Ife in the Osun State, which is the headquarters of Ife Central Local Government Area. The design of the study was descriptive and cross-sectional, and was based on both, quantitative and qualitative methods. 402 males in

their reproductive age (15-59 years) were selected from 402 households using a multistage sampling technique. This involved initial random sampling of 40 out of the 400 enumeration areas (EAs) in the area, which was followed by systematic random sampling as one eligible male from one household was selected randomly at first, followed by every other K^{th} household for each EA household listing until the recruitment of 10 eligible males in the EA, apart from two EAs, from which 11 men were recruited. Family planning providers were also selected for participating in the study. In order to collect the details regarding the socio-demographic characteristics of the respondents, their level of knowledge and awareness regarding family planning methods, and their utilization of the modern contraceptives, a structured household questionnaire was drafted.

Information about the role of men in communication about contraceptive choice and decision making, child spacing, and family size was also attained. In-depth Interviews (IDIs) were conducted with 8 family planning providers (2 males and 6 females). The quantitative data was analyzed through SPSS.

The themes generated from the findings were as follows: Awareness of family planning methods; Men's attitude and practice about self/spousal use of family planning; Spousal communication about family planning decision making; Correlates of men's opinions about their roles in family planning decision making; Family size; Adoption of family planning; and Family planning providers' perceptions of men's attendance at family planning clinics. The results showed that 80% of the males had a history of contraception uses, while 56% of them were present users. The level of reproductive communication and discussion about family planning was quite poor among the couples. The socio-demographic correlates of the opinion of men comprised of marriage type, educational attainment, religion and occupation ($p<0.05$). It was deduced from the findings of the study that males had a poor extent of involvement in family planning decision making, and they had a low support for the family planning services (Macellina, et al., 2014)

2.1. THEORETICAL FRAMEWORK

The conceptual or theoretical framework adopted for this study is "Socio-ecological model of health" (CDC, 2007). The model was used for analysis of the data in the later stages. In countries like Pakistan, where the use of skilled-birth services in relatively low, the study aimed at exploring

the role of male members of the household that not just includes husband but father-in-law, brother-in-law and son.

The Socio-Ecological Model is a theory-based framework for understanding, exploring, and addressing the social determinants of health at many levels. The Social-Ecological Model encourages us to move beyond a focus on individual behaviour and toward an understanding of the wide range of factors that influence health outcomes. This Model/framework is a complex interplay of multiple levels of a social system and interactions between individuals and environment within this system. The SEM thus adequately facilitated the exploration of women' experiences, integrating their intrapersonal, partner-related, family, community and socio-cultural contexts to produce one behavioural outcome regarding maternal health care-seeking behaviour.

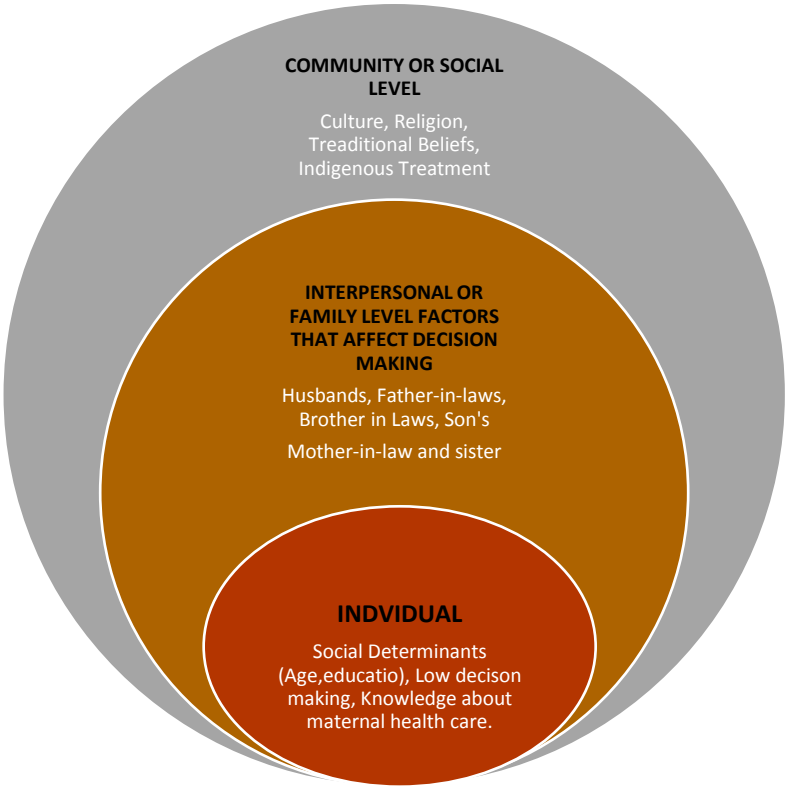


Fig 4.1. Socio-Ecological Model of Health

3. **RESEARCH METHODOLOGY**

Research methodology is the pathway through which researchers conduct their research. It shows the process through which the researchers define their research problem and objectives, and then present their result from the data obtained during the study period. It comprises of concepts such as theoretical models, research paradigms, and quantitative or qualitative techniques for the data collection process.

3.1.**RESEARCH DESIGN**

Research design for any empirical research is a plan thorough which a specific hypothesis is tested, and questions related to a specific research are answered. The research design of this study was chosen to be exploratory as it will help in further exploring the concept of decision making and healthcare seeking behaviour among women and key family members, during the pre- and post-natal period.

3.2.**RESEARCH STRATEGY**

Qualitative research techniques were used for addressing the objectives of this study, and for mapping and assessing the health facilities providing MNCH services in the research locale. Qualitative research method was used for in-depth analysis of women and key family members' perspectives and approach towards maternal health seeking process and for identifying the different actors involved in health decision making.

3.3.**METHODS OF DATA COLLECTION**

Data for assessment of functionality of healthcare facilities was collected using observations. The observational questions was targeted at understanding the availability and absence of healthcare services and equipment within the two identified private clinics located in Tarlai. On the other hand, qualitative data was collected using in-depth interviews and focus group discussions. The inductive method approach was used to understand the role of family members in decision making and healthcare seeking behaviour. In the first step; in-depth interviews were conducted with 12 married women who have recently given birth to a child. Their experiences and perceptions were documented and the key family members influencing i) decision making and, ii) healthcare seeking

behaviour were identified through these interviews. Furthermore, two focus-group discussions were conducted with the identified key family members i.e. mother in laws and husbands who play a crucial role in the two dimensions being explored, therefore there were 8 husbands and 4 father-in-laws, as some husbands were not available, within the first FGD and 9 mother in laws in the second FGD, again 12 respondents were expected to take part but only 9 of them became part of this study. Finally, two gynaecologists from the identified private clinics of the target locale were interviewed to incorporate the health service provider perspective.

3.3.1. Semi-Structured Interviews

A semi-structured interview is a one-to-one interview conducted with a respondent, in accordance with a specifically designed interview guide or questionnaire. The data from married women was collected through semi-structured informal interviews. The data was collected by using Vignettes. Vignettes are short stories about a hypothetical person, presented to participants during qualitative research (e.g., within an interview or group discussion) or quantitative research, to gather information about their own set of beliefs. Keeping in view the cultural setting, the topic is sensitive in nature and respondents, it was quite natural for women to hesitate on answering questions related to their pregnancy or reproductive health. For that, vignettes were used as a tool during in-depth interviews to glean information regarding decision making and pre-, post-natal care of women, to reduce the element of reluctance.

Considering the sensitivity of the topic, the researcher hired a female research assistant. The assistant was a Master Graduate in Global Health Policy from London School of Economics, and was already trained regarding the data collection on sensitive topics like these. With the help of a well-qualified assistant the researcher was able to conduct the semi structured interviews with the women. The assistant collected the data and assisted the researcher during the Focused grouped discussions as well.

3.3.2. Focus group discussions

A focus group discussion involves gathering people from similar backgrounds or experiences together to discuss a specific topic of interest. It is a form of qualitative research where questions are asked about their perception’s attitudes, beliefs, opinion, or ideas. Focus group discussions were conducted with key family members identified by the women who play major role in decision

making and healthcare seeking behaviour. One focus group discussion was done with 9 mothers in laws, while one was planned to be done with 12 husbands, but it was done with 8 husbands and 4 father in laws, who were there on behalf of the 4 unavailable husbands. Similar to in-depth interviews, vignettes were also used in focus group discussions to ensure that members are able to express themselves more freely without any pressure of sharing their personal life details.

3.3.3. Data Analysis

Thematic Analysis is a process that involves searching for themes that are categories identified by the analyst from the collected data. The raw data was transcribed, and coded. Thematic analysis was used to analyse the data, and the data collected was incorporated in the already available themes drafted as per the interview guide. New themes were added in accordance with the tabulation of the relevant data. The data from the private health facilities is being presented through the indicator of availability of health services.

3.4. SAMPLING

The respondents were selected through purposive sampling technique. Purposive sampling was chosen instead of other sampling techniques because in accordance with the theme and nature of this research, purposive sampling suited best to reach the targeted sample within a time and cost-effective manner. This research was tracking new mothers who have recently given birth and therefore they were identified through the gynecologists, making purposive sampling the appropriate sampling technique instead of snow ball or other sampling methods.

The mothers who have recently given birth (age of child up to 6 months) were included in the study. These mothers were purposely selected from the mapped facilities. A total number of 35 participants were interviewed through various data collection techniques. The sampled women were 12 in number, and the FGDs were conducted with the Mother-in-laws of the same women, due to unavailability of 3 mother in laws only 9 of them were a part of the FGDs. The same is for the Husbands, 8 husbands out of 12 were a part of the FGD. 2 out of 12 husbands were working abroad and the other two were unavailable. For mapping, the researcher used the technique of social mapping in which extensive visits of locale were made. All the sub-locales were mapped

from where private healthcare units were identified which are of significance for maternal healthcare. UDC-4 also extended support in mapping healthcare units.

The study's methodological framework and sample size is summarized in the following table:

UDCs	Research Methods	Research Instruments	Sampling	Approach and Tool of Analysis	Number of Respondents
UDC 1: **Sampled Women**	Unstructured Interviews (narrative interviews)	Vignettes/Narrative guides	Purposive sampling	**Approach**: Thematic analysis **Tool**: Framework analysis	**12**
UDC 2: **Mother-in-laws**	Focus Group Discussions (FGDs)	Vignettes/protocol for FGDs	Purposive sampling	**Approach**: Thematic analysis **Tool**: Framework analysis	**09**
UDC 3: **Husbands & Father-in-laws**	Focus Group Discussions (FGDs)	Vignettes/protocol for FGDs	Purposive sampling	**Approach**: Thematic analysis **Tool**: Framework analysis	**08 (Husbands)** **04** **(Father in Laws)**
UDC 4: **Gynaecologist**	Unstructured Interviews (narrative interviews)	Narrative guide/protocol for narrative interviews	Purposive sampling	**Approach:** Thematic analysis **Tool:** Framework analysis	**2**

3.5. RESEARCH LOCALE

The study was conducted in Tarlai Kalan. Tarlai Kalan (UC-19) is a semi-urban setting of more than 100,000 inhabitants, it is almost 10kilometers from the main city. The setting is a predominantly low and lower middle-class settlement with many immigrants from other parts of Pakistan. The crude birth rate is around 40 per 1000 and families have 4-8 children. Families are typically based on traditional gender roles (Centre, 2021). Among poor sections of the population, multiple adversities including malnutrition, irregular income, and low literacy are common.

Fig. 3.1. The geographical map of Tarlai Kalan, Islamabad

Source: Google Maps

3.6. SIGNIFICANCE OF RESEARCH

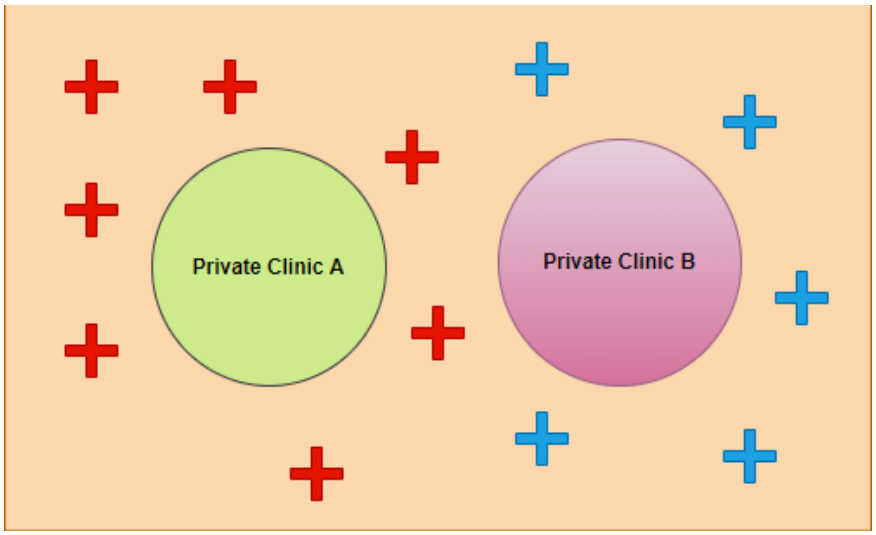
Decision making in any capacity, in a culture like that of Pakistan is predominately credited to males. The social setup of Pakistan is extremely religious and culturally bound and culture plays an important role, in decision making process and choice, type and use of reproductive health entities. In joint family systems, each and every individual of family is involved in the decision making regarding health services during pre-post and antenatal period. Hence, it is very important to incorporate each of them while designing reproductive health care initiatives. This research will help the policy makers, in understanding the role of different family members during maternal health decision making and how different family members contribute in determining the health seeking behaviour of a woman, and looks forward to add knowledge to the existing literature, viz a viz acting as a tool for aiding in health policy making.

4. RESULTS

4.1. Mapping the service and equipment ability in private health facilities

Two private health facilities, Private clinic A and Private clinic B were identified in the research locale premises. Both of the facilities were visited to collected data regarding the availability of maternal health services equipment and relevant infrastructure. Private clinic A was found to be functioning at a better capacity of health service provision, as compared to the Private clinic B. Consequently, more respondents were found to be availing services from the Private clinic A. The following table enlists the health service provision capability of both private clinics, in terms of availability of relevant equipment and infrastructure.

No.	Maternal health service equipment	Private clinic A	Private clinic B
1.	Labour Room	✓	✓
2.	Delivery table	✓	✗
3.	Sterilization Equipment	✓	✗
4.	Medical equipment for delivery	✓	✓
5.	Operation theatre	✗	✗
6.	Baby beds	✗	✓
7.	Healthcare staff	✓	✓
8.	Oxygen cylinders	✗	✗
9.	Blood pressure machine	✗	✓
10.	In-patient ward	✗	✗
11.	Ultrasound machine	✓	✓
12.	Patient monitor	✓	✗
13.	Body thermometer	✗	✓
14.	Proper light source	✓	✓
15.	Clean water supply	✓	✓



Key for color coding
Peach color= Research locale i.e. Tarlai Kalan
Red color= Patients seeking maternal healthcare from Clinic A
Blue color= Patients seeking maternal healthcare from clinic B
Green= Private clinic A
Purple= Private clinic B

Gynecologist Perspective

While visiting the private clinics located around the locale i.e. Tarlai, two gynecologists were interviewed to analyze their perspective regarding patient behavior and attitudes towards maternal healthcare. The primary data collected from the doctors pointed out three key issues in terms of determining barriers to healthcare provision on the patient's end. One of the primary issues was identified to be the irregular visits of patients to the clinic. It was found that many of the female patients, dealing with pregnancy, did not come to all their scheduled appointments. Some women tend to come for a few visits and then stop coming altogether, while some women continued to

visit the doctor but missed many of the appointments in between sessions. With further probing, it was figured out that women missed their appointments because of different reasons. While analyzing the doctor's perspective, one reasons which was highlighted explicitly indicated the financial barrier on the patients end. Private healthcare clinics are generally more expensive than public hospitals. Therefore, for people living in rural setups, earning wages on a day to day routine to meet both ends meet, it becomes pretty difficult to set aside money for private clinic appointments. And, apart from paying for the appointments, money is also needed to get the medicines from the clinic. Due to these financial constraints, it was remarked as a trend among patients to miss their antenatal visits, by both the gynecologists.

Another issue that was identified as a gap in health service provision was that of family issues and influence. According to the gynecologist perception, when they dealt with women coming to their clinic, it was often expressed by the patients that their families do not support the idea of them coming to the clinic. Therefore, the women patients also hesitated in coming to the clinics in accordance with the schedule. Furthermore, one of the gynecologist expressed her concern over women not taking their medications, even when those medicines are carefully prescribed to them, for their health and their child's healthy growth.

> *"Hum patients ko iron tablets likh kar detay hain, magar next visit pr jab un se puchtay hain k dawai le rahi ho ya nahi, to aurten keh deti hain k wo dawai lena bhul gaye ya un ki saas ne unhen mana kar dia tha"*

> *"We prescribe iron tablets to our patients, but when we ask about taking medicine when they visit again, they usually say that they forgot taking the medicines or that their mother in laws asked them not to take the medicine"*

Lastly, the gynecologists indicated that even when they ask the female patients to bring their husbands for the appointments, the husbands never come. Most of the husbands dropped their wives to the clinic, but they never come to see the doctor. It was found that the husbands showed this type of reluctance because of the taboo culture that has been created around the matters of reproductive health and pregnancy. Within a rural household, women alone cannot take decisions regarding her maternal healthcare needs due to traditional family setup, therefore support from

husbands is inevitable in improving the health seeking behaviors of mothers. Therefore, it was highlighted through gynecologist perspective that the absence of husbands in antenatal visits leads to lower understanding of complications of pregnancy at the household level, poor postnatal care, lack of awareness regarding the nutritional requirements for pregnant and breastfeeding mothers etc. The men involvement in maternity care was pointed out as a very significant element for reducing maternal and child mortality, and appropriately dealing with postpartum health complications.

4.2. Women perspective regarding maternal health at individual level

4.2.1. Age and experience

The first sub-theme studies the impact of the factor of age on awareness and understanding about maternal health, do's and don'ts of pregnancy and other relevant health needs during the time period of pregnancy. In terms of primary data analysis, a visible dichotomy between young/new mothers and old mothers who have already given birth at least once or twice, can be observed. It was found that mothers above the age of 30, who have given birth multiple times were more aware and resourceful in terms of knowledge when it comes to handling the process of pregnancy due to their experience with childbirth.

"Maray iss toon pehlay vee bachy ny, iss astay mikki pta iss ny baray ich. Aey nikkian ki naa pta hona itna"

Before this, I had other kids as well. That is why I know about this; the younger girls are less aware of that.

"Hun itni umar hoye rayee, hu inn sb ny baray ich pta lagi reya. Aapon apna khayal rakhi kinanay aan. Sass ya khawand toon puchay bagher"

I have aged now; I know about all of this now. I can take care of myself without asking my husband or mother-in-law.

While, on the other side, young/new mothers, aged less than 30 years were found to be less aware of the process and complications related to pregnancy and maternal healthcare essentials. Therefore, due to the fact that it was their first time dealing with pregnancy, which implies no experience, they were not very familiar with the guidelines in terms of maintaining maternal healthcare standards on an individual level. They were found to be more reliant on their elder's advice, more specifically, instructions from their mother in laws.

"Mera pehla bacha hai tou jo ammi ny sikhaya wohe krty hen, saas bhe smjha daite hain sath sath. Iss ki paidaish pr tou mujhe samajh e nahe araee thee. Sb Saas aur meri nand ny kia tha"

This is my first child, we do as we were told by our mother. Along with this mother-in-law guide as well. I knew nothing when he was born. My mother-in-law and sister-in-law did everything.

"Mikki pta seya thora both, maari pehn ny bachay thaye. Lekin jiss taim apna hoya ty firr jera sb akhnay sy ohe krny seyan. Aapon samajh ney si ashni"

I knew a little bit, due to my sister's kids. But when I had a baby, I used to do what I was asked. I did not know anything myself

4.2.2. Education

When it comes to the level of education, the literacy rates show a visible difference between the ratio of educated men and women in Pakistan. According to the latest statistics, male literacy rate is around 70%, while the female literacy rate is much lower i.e. 48%. The sub-theme of education has a direct relationship with the level of knowledge regarding maternal and child healthcare needs. It was found that the educated women, among the respondents, were more aware of the process and dangers associated with pregnancy and maternal care.

"Men primary school men parhati hoon, BA kia hua hai, Mery hissab sy parhi likhi aurton ko isska zada pta hota hai. Meri nand ann parh hai usay men btati hun inn cheezon k baray men"

I teach in a primary school; I have done my BA. I think educated women are more aware of this. My sister-in-law is uneducated and I tell her about all of this.

"Jiss tarah aap keh rahe, jo aurten parhi likhi hoti hain unhen zada pta hota hai inn sb ky baray men. Unhen pta hota hai k konsy haspatal jana hai aur kahan sy ilaj krvana hai. Wohh doctor k pass bhe har mahenay check-up kelye jaati hain. Mera pehla bacha hua hai, aur men hr mahenay doctor k pass jati thee, yeh mujhe khud sath lai kr jatay thy. Taqat ki dawaian bhe khatay hen sath sath, kyun k bachon men iron ki kami hojati hai, Islye yeh sb both zruri hota hai. Agr aurat ko khud pta ho tau who bohth sy cheezen krlaite hai"

Like you said, those women who are educated know more about this, they know which hospital to go and where to get the treatment from. They go to the gynecologist as well for her monthly antenatal visits. I just gave birth to a baby, and my husband used to take me for my antenatal visits, himself. I used to take energy boosters, as the fetus may get iron deficient. That is why it is very important. If the women know about this herself, she can do a lot of things.

Additionally, it was noticed during data analysis, that the uneducated mothers did not think that being educated is important for better understanding of maternal health. According to their perspective, childbirth is more of a natural process which does not require any external guidance or assistance. It was found that the uneducated mothers solely relied on the help of traditional birth attendants from their community, because of the perception that dealing with the complications of pregnancies is traditional birth attendant's job, and mother themselves do not need to worry about these things.

"Maarian 2 bachian ny, iss vaari puttar hoya. Maaray teenon bachy daaye paida karaye. Assan ik vaari vee nae gae doctor kol. Parhi likhi Kurian vee osay tarah bachay paida karnian jiss tarah assan karnay aan. Koe faraq na aeya"

I have two daughters, now I am blessed with a baby boy. All of my deliveries were done by the traditional birth attendant. I didn't go to the doctor even once. Educated girls give the birth, the same way like we do, there is not difference"

Furthermore, it was found that there was a certain negative sentiment against the perspective that educated women become better mothers. Majority of the respondents were of the view that education has nothing to do with the process of childbirth. These responses depicted the rural-urban dichotomy which is very much prevalent in Pakistan; the urban women are generally more educated than rural women because of more access to educational opportunities. But, rural women are not bothered by their less access to education and they definitely did not view education, as already mentioned, a precursor for maternal care and childbirth.

"Ajkal neyan kurian bothian parhi gashnian, ty vada operation karae kinian. Assan ki jerra sikhaya gya assan oya e karnay aan. Waday hasptaalan ich kharcha vee zada hona ty maslay vee honay bachian ki"

Our girls get a lot of knowledge about this, and they go for C-section. We do as we were told. There are a lot of expenses in big hospitals, and the young girls face complications as well.

4.2.3. Access

Having awareness and knowledge regarding the significance of maternal health is not enough on its own, as the factor of access plays a major role in health seeking behavior. This sub-theme addresses the relationship between access to health facilities and maternal healthcare behavior among rural woman. It was found that almost half of the respondents were inclined towards getting admitted and availing facilities from the nearby city, Islamabad. The reason was found to be quite explicit, as due to the rural urban divide in Pakistan, more health facilities are available within big cities as compared to suburbs of cities and rural areas. In remote areas, the means of transport are scarce, as proper roads and transport infrastructure is majorly absent within most of the rural areas. As for our given locale, the area is located within the periphery of Islamabad, so people having personal vehicles have the opportunity to reach out to hospitals within Islamabad in case of any medical emergency. But, looking into the primary data, more than half of the respondents do not have their own personal vehicle, therefore access to hospitals in Islamabad becomes an issue.

"Hum tau Islamabad k qareeb men e hain, yahan tou qareeb haspatal bhe hain. Agr emergency hojae tou baray hasptal jaaskty hen. Lekin jo log gaon men rehtay hain unky lyay masla hoskta hai"

We live in the peripheries of Islamabad, there are hospitals near as well. In case of emergency, we can go to big hospitals as well. But people who live in village have issues

Some of the respondents, who do not have access to transport to visit hospitals in Islamabad, were found to be more inclined towards the private clinics present in Tarlai. Therefore, it can be stated that even if the target population is well aware of significance of maternal health and how big cities are more capable of dealing with pregnancy cases and deliveries, due to restricted access to hospitals, families become more inclined towards any nearby clinics for anti-natal visits and deliveries. Furthermore, while analyzing women's perspective on the level of services provided in nearby health facilities, it was found that most of the respondents, who preferred visiting the private clinic in their area were satisfied with their local doctors and the level of treatment they are getting at those clinics.

"Maari koshish honni k men private clinic ich e jullan. Doctor boon khayal rakhni assan naa. Cooperate vee karni assan ny naal. Unhan maaray khawand ki vee smjhaya boht vaari. Assan ki odhron e dawaian vee labbi gashian, clinic boon acha vaa. Men ty delivery vee odhron karasan"

I try to go the private clinic; the doctor takes care of us and cooperates as well. She has also guided my husband. We also get medicine from there. The clinic is really good, I will get my delivery done from that clinic.

4.2.4. Source of information regarding maternal healthcare

This sub-theme enlists the potential source of information, regarding maternal health and childbirth, for the respondents of this study. As already established through previous sub-themes, lack of awareness regarding the complexity of maternal health was found very common among the respondents. When dealing with a pregnancy, women need to be aware and informed regarding the complications in terms of pregnancy cycle and stages, for instance knowledge about physiological restrictions during different stages of pregnancy etc. Through primary data analysis,

it was found that the mothers included in this study never had proper guidance on maternal health except the knowledge they received from their mothers and mother-in-law.

"Assan nee sass assan ki smjhani see, nalay maari ammi vee asan ki isny bara yech daseya seya. Ajkal neeyan Kurian, tai saara kij internet apor taki kiniyana, fir uss aapor aamal karni tai apny aastay maslay banaye kinninyan"

Our mother-in-law used to guide us, my other also guided me about this. Girls nowadays, use internet in this matter, and make complications for themselves.

4.3. Maternal health perspective at household level

For this theme, data was exclusively collected from women's husbands and their mother in laws to understand the effect of pregnancy and its various dynamics at the household level. Out of 12, 8 husbands were present while data was collected from father in laws on behalf of the 4 absent husbands.

4.3.1. Healthcare seeking behavior

For most of the cases, it was found that husbands were the primary agents responsible for aiding their wives, in terms of finance and access/transport, which clearly depicted the healthcare seeking behavior of the fathers. The study results depict that the husbands were found to be very responsible and sensible regarding the complexity of pregnancy and the significance of maternal healthcare for dealing with the dangers of complicated pregnancy cases. It was found that taking women to doctors was primarily the responsibility of husbands. But, in the absence of husbands, father in laws and brother in laws take the responsibility of taking women to clinics, in cases of emergency or for any pre-scheduled appointments.

"Mery 2 bachay hain, aik beta aur aik beti. Meri sanitary ki dukan hai main road pr. Doctor k pass kabhe khud le jata tha kabhe dewar lai jata tha lekin paisay mein hi daita tha"

I have two kids, a son and a daughter. I run a sanitary store. Sometimes I take my wife to the doctor and sometimes my brother does, but I always pay for the clinic charges.

Furthermore, it was found that some of the respondents (husbands) relied upon suggestions and recommendations from their friends and other people in their social circle rather than discussing such matters with their family members. After probing, the reason was discovered to be the traditional mindset of men, which restricts their ability to talk about maternal matters, as such matters are considered to be discussed and decided among women of the family, within traditional rural households. But, at the same time it was noticed that due to a patriarchal brought-up, some of the respondents were often asked to take the responsibility and decisions on their own which implies the reason for relying upon friends and acquaintances who previously have had experience with certain doctors or a healthcare facility.

"Jee men gahr walon sy iss baray men baat nahe krta hun, jo dost yaar hen baal bachay daar unsy mashwara kr laita hun haspataal k baaray men"

I don't talk to my family about this, I usually take advice regarding the hospital from my friends who have kids.

While on the other side, a different pattern was noticed among the other respondents. Interestingly, some of the respondents were more inclined towards giving the decision making power within the hands of their mothers or their wives as they felt they do not understand these maternal matters with enough clarity.

"Assan ny kaar ich iss tarah ny mamlay maari ammi taknay ny, kus haptalay ich julna ya kitni vaari julna o sb kij maari walida krny ny. Ortan ki botaa pata hona inn any baary ich. Mikki paisay na aakhnay men bs daye chorna"

My mother deals with all these things in our home. Which hospital, and how many visits all of these are foreseen by my mother. Women know more about these things. They just ask me for finances and I give that

Such differences within a set of respondents imply the subjective nature of health seeking behaviors and decisions making process. Every household has its own unique dynamics, which further gets translated into different nature of decision making in terms of maternal healthcare. It is but obvious that one criteria fits all, can never be utilized to define the overall patterns of maternal health seeking attitudes at household level.

As mentioned above, 4 husbands could not be interviewed because of their busy routine, therefore father in laws were included instead of them, and therefore this sub-theme also analyzes the availability of support system for women in the absence of their husbands. It was found that primarily father in laws were responsible for taking women to hospital or clinic when required in the absence of husbands. But, on instances where even father in law is not available, then the responsibility is directed towards brother in laws. It was noted that the father in laws never mentioned the possibility of including the father or brother of the women, which reflects one of the household dynamics of rural areas, where after marriage the affairs of a woman are supposed to be handled by her in laws.

"Unj tai maara putor e kharna jee mari nooh ki, magor kaday o masroof hona tai main uski kharna hasptal aapun"

Usually, my son takes his wife to the doctor but if he is busy, I take her to the hospital myself.

"Agr mara puttor masroof hovay ty maara nikka puttor apni phabi ki kharna haspatal. Men ty naa itna turri sakna jee tabeat vee khrab rehni maari"

If my son is busy my younger son, takes her bhabi to the doctor. I can't go as I am not well nowadays.

4.3.2. Healthcare decision making

This sub-theme identifies and analyses the decision making actors within a rural household. Several different patterns were identified when analyzing the decision making dynamics. For

instance, in some households such decisions were primarily taken by the men due to the patriarchal mode of family setting. While, other cases reflected women and mother in laws influencing the decision making process. Decisions, revolving around anti-natal visits, healthcare facilities, preference towards a certain healthcare professional or a clinic etc were focused under this theme. Interestingly, only two of the respondents expressed that they shared the decision making tasks with their wives, instead of any other family member. This low trend of involving women (mothers) in decision making is caused by the reluctance of husbands to discuss maternal healthcare needs.

"Jiss tarah men aur meri biwi hai, hum mil kr faisal krty hen k konsay hapataal jana hai aur kitni baar jana hai. Uski dawaian wgera sbka khayal main khud rakhta hun"

Like me and my wife, we decide ourselves regarding the choice of hospital and number of antenatal visits. I personally take care of her medicines and all"

Majority of the respondents (husbands) were found to be the main decision making actors regarding maternity care. And it was found that they took decisions on the basis of their own knowledge or after taking guidance from their male friends and relatives. For instance, when it came to choosing a healthcare facility for his wife, one of the respondents clearly stated that he decided to go visit a clinic where one of his friends worked, therefore familiarity with the staff of a healthcare unit was found to be one of the major factors when taking decision regarding the appropriate healthcare facility.

"Mera aik dost hai, who dispenser hai aik lady doctor k clinic men. Main hamesha apni biwi ko wahan e lai kr jata hun. Ilaj bhe acha hojata hai aur reiyayat bhe miljati hai"

One of my friends is a helper/dispenser at a lady doctor's clinic. I take my wife to her clinic, we get a good treatment with concession as well.

4.3.3. Gender reveal

This sub-theme discusses the attitudes and preferences towards knowing the gender of the baby before birth, and the aftermath of gender reveal within rural households. The son preference is a very common dynamic in the cultural setting of Pakistan, in both rural and urban areas. Because

of the male dominated nature of the society, women are explicitly and implicitly pressurized to bear sons instead of daughters. Gender bias can be traced in almost all fields of everyday life, and especially mothers face the pressure in the name of family expectations regarding giving birth to sons. Although, this phenomenon of gender bias within children is very common yet it is not considered an immoral practice, given the patriarchal mindsets of individuals.

Most of the respondents (husbands) were of the view that they are never interested in knowing the gender of the baby, because of their religious perspective.

"Bachay Allah ki dain hotay hen jee, meny tau kabhe koshish nahe ki k paidaish sy pehly pta chalay k larka hai yeh larki. Jo bhe ho sehat mand ho bus"

Babies are God's blessing; I have never tried to know before birth if it is a boy or a girl. Irrespective of the gender, health is important

On the other hand, majority of the respondents (Mother in laws) were found to be interested in knowing the gender of the baby, but they did not express the reason as their preference for a grandson, given the prevalent son preference notion, instead they expressed that gender reveal before birth is significant for making appropriate arrangements for the arrival of the baby. But, at the same time one of the respondents depicted the existence of discriminatory practices and behaviors towards mothers after the gender reveal.

"Ptta lagi gachay tai, assan hoye gashna. Maari vaddi nooh ny tame ich vee asan doctor kolon puchi kinanay siyan. Munday niyan maawan nian hor khurakan dainiyan honiyan ty Kurian nian hor honiyan. Nallay fir tayari vee tai karni honi na"

If the gender is revealed, it becomes really easy. At the time of my elder daughter in law, we asked the doctor before regarding the gender of the baby. When a girl is pregnant with a boy, she has to take different foods as compare to when she carries a baby girl. Also, we have to prepare for the baby accordingly

4.4. Maternal health perspective at community level

This theme discusses and analyses the perspectives and practices around maternal health and childcare at the community level. For this theme, primary data was extracted from women (mothers) and mother in laws, as female perspective is more dominant at the community and cultural level in terms of pregnancy and maternity care.

4.4.1. Cultural beliefs

Cultural beliefs are often given a lot of importance when it comes to traditional system of healthcare. Being a developing country, Pakistan is not equipped with modern healthcare facilities at the rural level. Therefore, the traditional method and treatments of healing are still prevalent in majority of the rural settings. The data analyses revealed that apart from the choice of treatments, the cultural beliefs also influence the choice of healthcare attendants. For instance, it was found that the traditional birth attendants "Dai" are trusted significantly when it comes to seeking healthcare advice for maternal cases, and also that many of the respondents expressed that they always reach out to the traditional birth attendants to help with the process of delivery and maternal care post-pregnancy.

"Assan nee khandani daaye apor assan ki zada bharosa eya. Maaray saaray bachay uss paida karaye, main tai na gae aan kaday doctor any kol"

We believe in our traditional birth attendant more. She has helped me in delivering all my babies. I have never been to the doctor for this purpose

Numerous other cultural beliefs around pregnancy and maternal health were revealed as well. For instance, it was noticed that the respondents were more inclined towards normal delivery process instead of an operation and they connected the possibility of getting a C-section operation with going to hospital. In the light of cultural beliefs, this stereotype was found to be quite prevalent that the doctors in hospitals complicate the pregnancy and delivery with C-section operations, and endanger the lives of mothers and their newborns.

"Hasptaal men delivery karana sunanay men boht acha lagta hai, lkein hum ny yehe dekha hai k jo orten hasptaal jati hai wohh normal ki jagah bara operation kara kr aajati hain"

It seems very nice, going to the hospital for delivery but we have seen that women who go to the hospitals get their c-section done instead of a normal delivery.

"Jee 3 saal pehly, humari aik cousin foat hogae thee, jb who haspataal gae thee delivery karany. Tab sy hum sb tau darr gae aur ab haspataal koe nahe jaata"

3 years ago, one of our cousins died, when she went to the hospital for delivery. We got cared after that and now, no one goes to the hospital for delivery purposes"

Another significant factor, which was identified in terms of cultural expectations was that of shame. It was found that many of the respondents, both mothers and mother in laws, had the perspective that a strong woman needs no external help from a doctor during the delivery process. This preconceived notion has generated an element of hesitancy and shame for those women who do want to get their delivery done under the supervision of professional healthcare staff, but the cultural expectations force them to mold their healthcare choices, so that they can stay accepted within the women circles at the community level.

"Assan nee taraf ty saari Kurian, karay apor e bachay paida karniyan. Aurat aapun itni mazboot honi k uski kusay ni madad nee zrurt na honi. Assan ny garan ich ty saurian karaya appor e bachay paida karnian"

In our side, all the women deliver their babies at home. Women at strong enough, and they don't need any help from anyone in this regard. In our village all the women deliver their babies at home.

4.4.2. Indigenous setup

This sub-theme follows and traces the perspective of rural women regarding their own indigenous healthcare system and the modern medical healthcare facilities, and their preferences between the

two systems. As already mentioned in the above theme, traditional healers are quite popular and influential in rural communities given the lack of access to modern healthcare facilities in villages. Most of the respondents mentioned having contact with traditional healers of their community, whose medicines they have been using for many years. Due to the factor of time, a certain element of trust is naturally built between women and traditional healers in rural settings. And, healthcare seeking behavior is all built upon the element of confidence and trust on health providers. It was found that, in many cases pregnant women were asked to take medications from both the clinic doctors and traditional healers, while in a few cases, mother in laws influenced their daughter in laws to take medications from the traditional healer only.

"Maari sass mikki doctor neeyan dawaian kinan to mana kari soreya seya. Unhan ny mutabaq, hakeemay neeyan dawaian zada asor karniyan"

My mother-in-law stopped me from taking the doctor medicines. According to her, the traditional healer's medicines were more effective

Women have been giving birth since forever, hence several indigenous practices have always been associated with the process of pregnancy and maternity care. One of the respondents (mother in law) stated some specific indigenous practices that were common in their household for pregnant

"Doctor neeyan dawaian naa kai karsan, main apni nooh ki khali paid adrak daine aan usny naal hamal ech jera dil kacha honna o behtr hoye gashnas. Fir raati doodh ech haldi vee baaye tai daine aan. Naalay kadi kadi arandi naa tail ve daine aans doodh ich baaye tai"

We don't need doctor's medicines; I give ginger to my daughter-in-law for any nausea or vomit feeling in the morning. Along with this I give her tamarind and milk in the night. Sometimes I also give her castor oil mixed in milk

The concept of witchcraft evil eyes were also found to be quite prevalent among the respondents. Such practices are common in rural settings due to the lack of awareness and fear of supernatural entities. Therefore, it was noticed that these practices are considered a serious threat to pregnant

women and certain indigenous practices are observed in order to ensure that the pregnancy stays safe from any attempt of witchcraft.

"Mai apni nooh nee roz nazor laani aan. Usnay kamray ich mirchan nee thooni vee daine aan, kuray nazor na lagi gachais. Uss miki do potay ditay. Ik pehlay seya aik hun hoyyas"

On daily basis I protect my daughter in law from evil eye. I also give chili flake smoke in her room to protect her from evil eye. She has given me two grandsons, one before and one now.

4.4.3. Family Traditions

This sub-theme discusses the deeply enrooted relation between family traditions and its effects on pregnancy. It was found that when a woman is pregnant, it is seen as a family matter rather than an individual matter. Therefore, pregnancy related decisions often gets influenced by family perspectives and traditions, especially in rural setting where joint family system is still intact as compared to the urban areas, where the trend of nuclear families is increasing significantly. Furthermore, it was found that many of the major decisions, such as the choice of healthcare provider and location of delivery etc. are taken as a joint family decision, without considering the pregnant women's perspective and choice. The respondents (Mother in laws) were noticed to be quite vocal when discussing their family traditions in terms of pregnancy, which clearly depicted their lack of interest in knowing the perspective of their daughter in laws regarding their maternal healthcare needs.

"Assan ny garan na aieye system aa, hakeemay kol julnay aan ya daaye aapon aaye gashni madad vee usni kari sornay aan. Doctoran nai kol kon julay, paisa vee barbad hona tai taime vee"

This is the system of our village, we go to the traditional healers or the traditional birth attendant comes here self, and we help her as well. Why go to the doctor, it is a wastage of money and time.

"Khandany naa rawaj aa assan na, k beshak ortan doctoran kol checkup asstay jaaniyan, magor bacha karay appor e paida karni aan"

It is our family tradition that even if the women go to the doctor's for checkup but the baby is delivered at home.

4.5. Case Studies

Case study #1

Respondent A, aged 24, a newly wed woman, went through pregnancy for the first time a few months ago was interviewed as the subject matter for this case study. It was found that she had studied only until matric, in a school located in Tarlai, and has lived all her life there. She was married at the age of 23 years old, to one of his male cousins. Respondent A's perception of maternal health was found to be quite basic. She viewed the whole process of pregnancy as an inevitable for all women, because she had seen women getting married and giving birth to children as a routine matter. She did not thought of maternal healthcare as something very significant. Upon further probing, it was found that she was not aware of the fact that various complications of pregnancy can be dealt with, with the help of proper medications, vitamins and anti-natal visits. It was quite explicit, that she had a very traditional mindset, in terms of pregnancy and childbirth. When asked about maternal health education and information, she expressed that she is aware of everything her mother in law has told her, because her mother in law is her primary source of guidance regarding these delicate matters. It was an interesting key point, that the respondent only stated the name of her mother in law and not her own mother, which clearly depicts the lack of communication between mothers and daughters in our society regarding these matters, especially the taboo concepts are not discussed at all, within the households at rural level, due to the element of shame and tradition. Furthermore, Respondent A expressed that the decisions related to pregnancy and childbirth are taken by her mother in law only, excluding the male perspective i.e. of husband. It was further noted that the respondent had a very friendly relationship with her in laws, which is contrary to the mainstream culture perception which dictates that married women are often mistreated on several occasions by their in laws. The respondent used to visit a nearby clinic with her mother in law every month but upon asking about her visits and medications in detail, she was found to be quite confused. This indicated her low level of interest regarding her previous anti-natal visits. The dynamic that emerged from this case study was of a leader-follower protocol, where mother in law was calling all the shots while the respondent followed her silently without any element of discomfort or mistrust. This kind of behavior can be connected to the fact

that the respondent was very young in age, not educated after matric, and definitely not mature enough to understand the potential complexities of pregnancy in terms of all different stages, as she did not pay proper attention to her own healthcare needs.

Case Study #2

Respondent B, aged 29 years old, a mother of one child, was interviewed as the subject matter for this second case study. It was found that she had completed her education till B.A, and she taught at a girl village school for a while, before her marriage. She got married late, due to some family situation, she lost her father when she was 23, and that is why she started working to support her family financially. After three years, she got married at the age of 26 and had her first child, a boy when she turned 28. When her baby was only a year old, she became pregnant again with her second child. Upon probing upon this matter, it was found that despite the fact that she is an educated individual who understands her rights within a marriage, her husband did not ask for her perspective when taking decision regarding the second child. It was found that her husband is not educated and owns a shop near their house. When probed regarding her perspective about maternal healthcare, she was quite enlightened about the matter. The respondent expressed that she understood the dangers and complexities associated with the time period of pregnancy and that she does all she can to take of herself and the baby. The respondent explained how she used to frequently visit the private clinic, and never missed any of her checkups. Furthermore, the respondent had access to internet through her mobile phone which helped her keeping updated with the issues of pregnancy and how to tackle them properly. As mentioned already, it was noted that her husband was the one to take decisions regarding conceiving the baby, but the respondent had freedom regarding health seeking decisions and other related medical practices. The respondent had less communication with her mother in law, as according to her perspective, her mother in law was not very much interested in affairs related to her pregnancy. She expressed that just because she is educated and she used to earn, these things are held against her within the family and she often feels misjudged. Anyhow, it was found that she relied on her elder cousin-sister for support and guidance rather than other family members. It was quite interesting to note that within a rural setup, it is considered odd to be aware of your healthcare needs, especially for mothers.

Analysis

The most important theme identified from these case studies was the direct relationship between the level of education and level of awareness. It was found that level of education significantly influences and shapes the perception regarding maternal health. And, low level of literacy contributes to the low knowledge about reproductive health. Furthermore, it was found that the low level of ignorance and lack of awareness is generated out of the cultural norms and traditional way of health seeking attitudes within rural areas, like Tarlai itself. Maternal health awareness programs can help with the low level of knowledge by educating women regarding their bodies, the different phases of pregnancy, the complexities of pregnancies and the significance of antenatal and postnatal maternal healthcare services

The case study analyses clearly depicts that even when rural women are well aware of their maternal health needs, they are often subjected to shaming and misjudgment, as due to the traditional norms and cultural hierarchy, the word of elders is considered to be the only correct thing when it comes to matters related to maternity and childbirth. Educated women are looked down upon, and their decisions are questioned and criticized. Therefore, the traditional system does not allow women to think independently without being misjudged. These outdated perceptions are contributing to the creation of obstacles for women to avail health services. Under such circumstances, women feel forced to change their health choices because of their family members and societal norms.

Another identified theme is lack of communication and conversation about maternal health at household levels. Due to the cultural setup, pregnancy and reproductive health are dealt as taboo subjects, which enforces the individuals within a community to not discuss or share their perceptions about such topics within a public space. The element of shame and secrecy has been attached to the whole process of pregnancy, which makes it difficult for young mothers to understand the complexities and dangers associated with pregnancy. The case study analysis reflects that in various households, even mothers and daughters do not communicate about reproductive and maternal health. Cultural views of pregnancy makes it impossible for the men to ever engage in such conversations within public. Therefore, significant gap in communication was traced at both household and community level regarding pregnancy and maternal care.

5. Discussion

Given the fast pace of development in the field of medical sciences, the analysis of the past decade depicts that the service provision quality of maternal health services have been improved quite significantly, by shifting the focus towards nutritional requirements, pre-partum and post-partum facilities along with appropriate medical care services. These interventions have improved the overall health indicators for maternal health in many countries across the globe, however due to the prominent economic divide between Global North and Global South, a huge percentage of female population in the developing countries, still faces critical complications during pre-partum and post-partum stages, leading to mother and child mortality.

Provision of access to maternal healthcare is inevitable for enhancing the overall indicators of women's health. However, in most of the developing countries the quality of maternal health services is not up to the standards, and also the underutilization of services is also quite common.

The present research aimed at identifying and evaluating the women and key family members' perspectives regarding the process, experiences and their expectations with respect to pregnancy and post-birth phase, while exploring the general trend towards access and utilization of maternal health services in the selected locale i.e. Tarlai Kalan. Such research analysis is significant in terms of designing appropriate health interventions, therefore researches should embody and express the perspectives of women as they are the principal stakeholders, utilizing the maternal and child healthcare; thus incorporating the women's perspectives, experiences and expectations regarding maternal health can potentially assist in designing more accessible health interventions, resulting into improving the service delivery and provision of services within the rural areas of Pakistan.

This research study mainly revolved around mapping the availability of health services in the selected locale of Tarlai Kalan, and exploring the behavior patterns responsible for decision making regarding maternal health within rural settings. The main research objectives were further divided into relevant themes and sub-themes through thematic analysis on the basis of the collected primary data. This study aimed to provide an in-depth qualitative analysis into the underlying causative agents for prevalent and persistent ratios of maternal and child mortalities in rural setups of Pakistan. This study highlighted numerous key barriers which hinder the health seeking process

for women in the selected research locale i.e. Tarlai. For instance, this research study revealed that the factors of age, education and experience with childbirth etc. plays a vital role in shaping the thought process and health seeking behavior of mothers. Therefore the lack of awareness regarding the importance of antenatal care acts as a major causative factor for the less ratio of women seeking maternal healthcare services.

Furthermore, this research indicated that women and the health decision makers at household level are usually not much aware of the significance of routine antenatal checkups for avoiding complications in pregnancy and reducing the danger of still-birth, maternal mortality and miscarriage. This perspective was found to be quite prevalent that pregnancy is a normal process and it is forcefully converted into a complicated matter by involving the doctors. These results are found to be consistent with existing research literature, for instance, Mumtaz et al conducted a study to analyze the women perspective regarding the importance of antenatal care, and it was found that majority of rural women from Punjab held this view that mothers have been giving birth since the beginning of time, making it a very natural matter which does not require medical care or attention (Mumtaz & Salway, 2007). Another study, which discussed the health seeking behavior of women, reflected that according to rural women medical intervention can cause complications in pregnancy because medical care is not required to intervene in a naturally occurring process, and that is why they prefer to not seek maternal care via hospitals and clinics (Durr-e-Nayab, 2005).

Also, this study depicted that financial constraints act as barrier for accessing antenatal and maternal health services. Financial resources are required to travel to hospitals or clinics, getting appointments at private clinics, and buying medicines. All this expenditure creates a financial constraint for families within rural setups, making it difficult for them to access antenatal care. These study results are also consistent with previous research studies. Sheikh et al, through their research study conducted in Northern Punjab, indicated that financial costs is one of the major determinants for decision making regarding the choice of health care facility and which services to access (Shaikh, Haran, & Hatcher, 2008). Similarly, several of the findings of this research were found to be coherent with the study results of already existing research literature, indicating the reliability and accuracy of this study.

The present study utilized the socio-ecological model of health as its theoretical framework. The socio-ecological models were initially designed to analyse and understand the nature of interactions and relationship between individual and environmental factors. This model approach is utilized for the purpose of bridging the gap areas between theory and practice, focusing on small population settings. The socio-ecological model of health theorises the concept of health at different levels, while emphasizing those factors which influence and affect health service delivery and access.

The results of this study were found to be consistent with the theoretical framework i.e. Socio-ecological model of health. According to the model, the traits of an individual constitute the first level i.e. Individual level. Therefore, on this level, the characteristics of an individual, for instance age, education, level of knowledge, experience, economic status etc. are analysed to understand the influence of these key factors upon the perceptions and behaviours towards the health seeking behaviour.

The findings of this study analysed the various factors of age, education, access, level of knowledge and source of information to determine the causative factors and social determinants responsible for low knowledge and awareness among women regarding the significance of maternal healthcare services. Both the model and the study results accurately highlighted the low decision making opportunities, being attributed to the women which gets translated into a significant gap between services needed and services accessed, in terms of maternal healthcare. Therefore, it was found that health outcomes are affected by multiple layers of factors, and they all collectively determine an individual's access and ability to achieve better health.

When analysing the maternal health decision making processes, it became quite evident through the study findings that individuals do not think and act in isolation, but through consultation and in accordance with their community beliefs. Therefore, the theoretical framework proved quite useful in understanding the nature of interactions at household level, between the family members regarding the maternal health seeking behaviour. According to the model, the family member's perception and attitudes towards maternal and child health affects the decisions making process significantly. The study results were found to be aligned with the theoretical framework. While analysing the theme of maternal health perceptions at household level, the key family members were identified which were found to be influencing the health decision making, which were

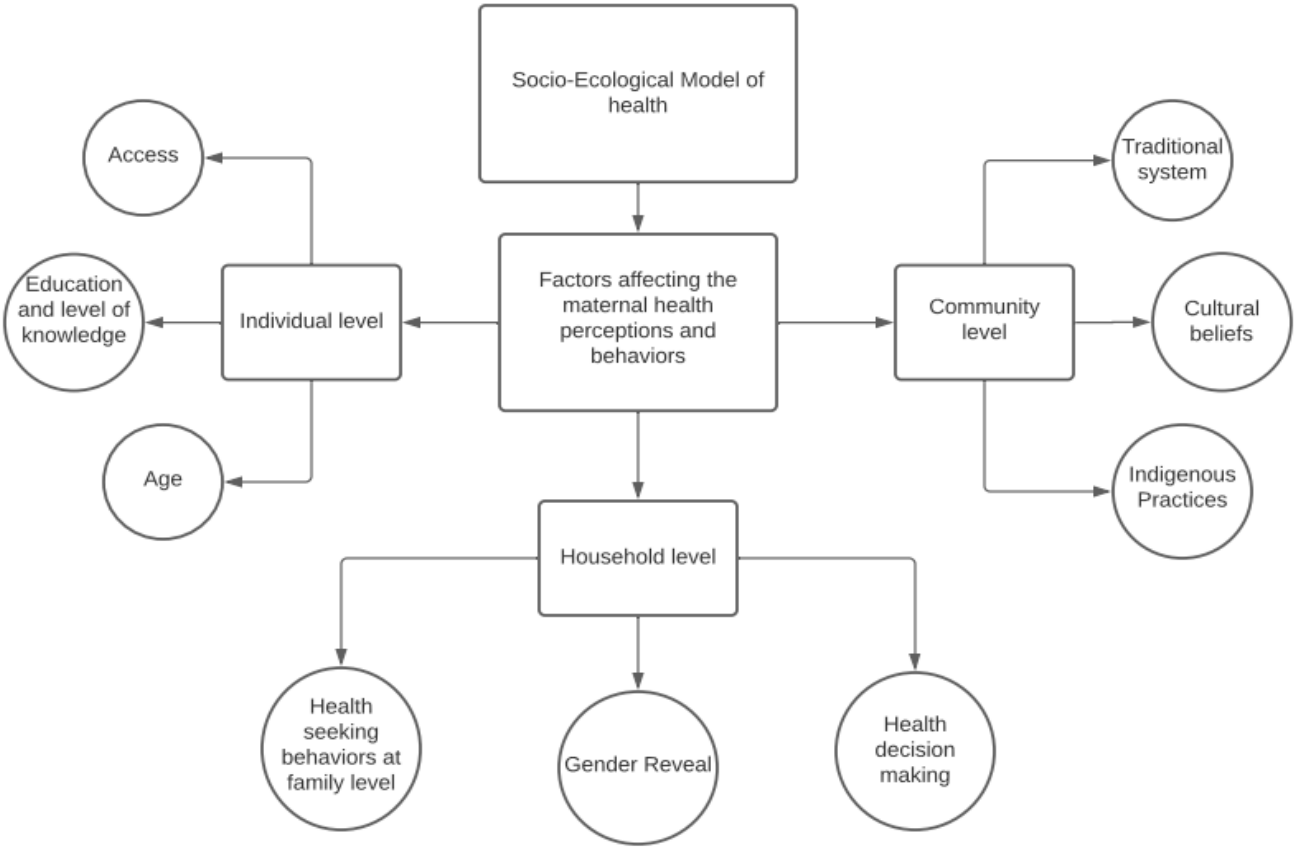
husbands, mother in laws and father in laws. The perspectives of these key family members have been analysed separately to determine their level of contribution in decision making process. It was found that the women's health seeking behaviour is determined by their husband's choices and more, importantly the financial status. Therefore, the decision of utilizing maternal health services from the private health facilities, was primarily taken by husbands and mother in laws in most of the cases, analysed under this research study. Furthermore, the level of education of family members were also noted to be a determinant for decision making.

Furthermore, the study results also analysed the effects of gender reveal of the baby at household level and how it affects the health seeking behaviours and choices. The phenomenon of 'son preference' is quite common within the cultural setup, therefore it was indicated that in some cases, gender reveal led to poor access to health for women. Thus, the theoretical model and study results remain aligned as the key family members are found responsible for making health choices on behalf of women/mothers regarding their pre and post pregnancy health needs.

The third level of the model focused upon the influence of community over the health decision making process. Different elements of culture, religion, family traditions and indigenous treatment methods etc. were analysed through the study findings. It was determined that these elements significantly shape the community narratives and perspectives regarding the maternal healthcare. The cultural setting of an area acts as the foundation for determining the life style choices of individuals at community level. Every cultural setting has its own set of health system in the form of traditional health seeking through indigenous methods. The traditional setups were found to be quite significant in terms of maternal health in this study, as it was found that a number of indigenous practices were quite common at community level. Family traditions and cultural beliefs were also found to be influencing the maternal health seeking process. Therefore, the theoretical model's representation of community was found comparable in terms of study findings depicting community approach and perceptions affecting the utilization of maternal healthcare services.

The socio-ecological model was found to be broad in scope when incorporated in this research study because of its multiple levels. Therefore, the model assisted in analysing health perspectives and behaviours at three different levels i.e. individual, household and community level. And, the study findings depicted the significance of utilization of such models, because it was found through study results that health interventions need to be introduced in a way that they target and address

a broad range of health perceptions, because improving and promoting better health practices at community level cannot be practically done without taking the other factors into account, which



shape and affect the perspectives and determine the actions and behaviours of a community as a whole. On the basis of the theoretical framework and study results, following model was derived.

This model demonstrates the direct connectivity between the maternal health decision making process and factors affecting this process at individual, household and community level. The above-given model defines different elements that are at play at different levels and as a result, collectively influencing the health seeking behaviours of communities. When designing health interventions for maternal health within rural settings, this model provides significant insights and can assist in carefully incorporating all the key factors within the policy framework, so that all these causative agents which influence and shape the decision making process, can be addressed via policy interventions, leading to improved indicators of health, better health seeking behaviours and better health outcomes.

5.1. LIMITATIONS

This research study has had its fair share of limitations, just like any research study. Firstly, due to the taboo nature of this study's research subject i.e. reproductive health and pregnancy, and the cultural association of shame with such topics, the researcher could not interview the women respondents himself. The researcher had to hire a female research assistant for the purpose of conducting interviews with women. But, even when the female research assistant was conducting interviews, due to the sensitivity of the topic, women were reluctant and hesitant to talk about their pregnancy, as the matters of pregnancy are never a topic of discussion within the cultural setting of Pakistan. Also, women were there with either their family members or mother in laws, which further discouraged them to express their perspectives vocally, due to fear of judgement. Secondly, with the respondents, it was generally difficult and tricky to discuss maternal matters, but it was extremely hard to reach out to 'Pathan' women, due to their reserved nature and language barriers. The research assistant had a very tough time, reaching out to the women of Pathan families, and even then most of them declined to become part of this study. Thirdly, during the interviews and data collection process, although women were trying to answer the questions that were being asked, yet they were struggling with providing reasons for their answers due to the element of shame. For instance, while describing indigenous practices, some respondents enlisted the practices but when asked regarding the purpose of those practices, they could not answer properly. Lastly, there were travel and time restrictions for both researcher and research assistant, given the fact that the researcher had a full-time job and the research assistant could not travel alone to the locale.

5.2. POLICY RECOMMENDATIONS

This study highly recommends the involvement of men within the future maternal healthcare frameworks. And, mother in laws should also be included within such frameworks, as this study depicts the important position of mother in laws within rural households, and their role in making healthcare decisions. Furthermore, it is suggested that maternal health awareness campaigns should be launched on a broader scale within the rural areas to involve the whole community through maternal health sensitization programs and by creating discussion forums for women to discuss issues related to their reproductive health and maternity needs, in a safe space. The concept

of shame can only be detached from reproductive health and pregnancy, when individuals are made aware, informed and sensitized regarding the significance of the maternal healthcare. For reducing maternal and child mortality figures, it is inevitable to design maternal healthcare interventions which targets and involves all members of a household. Furthermore, it is suggested that adequate maternal health support system should be in place, at both rural and urban levels, for improving the quality of prenatal and postnatal services for women. Maternal health interventions should be promoted within rural settings to combat the high levels of maternal and infant mortality.

6. CONCLUSION

The aim of this study was to explore the perceptions of women and household members regarding the significance of maternal health, and to investigate the factors which play key role in the construction of behavior patterns and health seeking practices at individual, household and community levels. This study also reviewed the private health facilities operating in the area, in terms of access and availability of maternal health services. The qualitative research design was used to trace the perspectives regarding pregnancy and maternal health.

The study revealed that maternal health outcomes are affected by multiple layers of factors i.e. age, education, experience etc. and they all collectively determine the women's access and ability to achieve better health, at individual level. By examining the inter-personal relationships within the family at household level, the study depicted that maternal health decisions are influenced by mothers-in-law and husbands, but in most cases, mothers-in-law play an integral role in determining the level and type of treatment. Additionally, this study highlighted the influence of cultural practices and traditional health system over maternal health seeking behaviours at community level comprehensively. Therefore, this research contributes by creating an understanding of the perceptions and mind-set of women regarding maternal health, and the role of different family members during maternal health decision making and how different family members contribute in determining the health seeking behaviour of a woman within a rural setup, therefore adding knowledge to the existing research literature, and also acting as a tool for aiding health policy making, for designing more inclusive and improved maternal health interventions.

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Appendix A

QUESTIONNAIRE FOR WOMEN

1. Name: _____
2. Age: _____
3. Years of Marriage: _____
4. Number of children: _____
5. Education: _____

Is this your first baby?

An educated woman, wife of a sole breadwinner of the family, and the decision maker, eldest son, the women just conceived.

What do you think she feels about it?

Probes:

- Who will be the major decision maker for choice of health care facility (Public or Private)?
- Who is she relying for taking care of her for her antenatal visits?
- In case of emergency who do you think is going to take that woman to the nearest health facility?
- Will the woman's level of education play any role in the choice of healthcare facility?
- What factors do you think play a major role in determining the choice and type of healthcare for that woman?
- Will this change if the son is youngest or a middle sibling?

What will happen if the husband is unemployed or doesn't earn that much to take care of the family?

Probes:

- Who will bear the expenses of antenatal visits, medication etc.?
- Do you think in that case they will rely more on public health facilities?
- Will they rely on Traditional Birth attendants (Dai) in this case, or any other person from the family will help in providing financial assistance?

What happens if the Husband is abroad and she is living with her in-laws, recently married, and just conceived? Who will be the main decision maker?

- Mother-in-law/sister-in-law, woman's mother/woman's sister?

- Do you think the gender of the baby determines, the level of care for the mother? If yes, how?
- Do you think your brother-in-law or father-in-law will provide logistic support in this case?
- Who is responsible for the choice of health care, in that case?

Appendix B

FGD- Mother-in-laws

- Total Number of Participants: ____
- Gender: Female

A mother-in-Law got to know that her daughter-in-law is pregnant, what would be her role in all the process.

What would be her general perception regarding maternal/reproductive health of women?

What would be maternal health care decision making and Health care seeking behavior for her?

- Child Bearing (Family Pressure etc.)
- Choice of Health care.
- Antenatal Visits

Do you think Gender plays an important role in determining the level and quality of health care?

If you were a mother-in-law, how would you support your daughter-in-law during her ante or post-natal period?

What do mother in laws usually prefer getting their daughters-in-law delivered from a traditional birth attendant or a hospital?

Do you think it is important for women to go to a health facility for her antenatal visits?

- Family Traditions

What is the type of indigenous believes/practices adopted by mothers-in-law for their daughter-in-law's during antenatal or postnatal period?

- Do you believe in evil eye, do you think it affects the baby or the mother?
- Do you think herbal medicines are more effective than the one prescribed by the doctor? If yes, please explain?
- Please explain some of the indigenous practices.
- How do cultural or religious believes affect the healthcare seeking behavior of women?

Appendix C

FGD-Husbands and Other male members (Father-in-law & Brother-in-law)

- Total Number of Participants: ____
- Gender: Male

FOR HUSBANDS:

What is the general perception regarding maternal/reproductive health of women?

- Shame associated while discussing about this.
- As a social taboo.

How Normal is it to discuss about all these things, whom do you discuss this with?

What is maternal health care decision making and Health cate seeking behaviour for you?

- Child Bearing (Family Pressure etc.)
- Choice of Health care.
- Antenatal Visits
- Financial Constraints.

What is Maternal Healthcare support for you?

- Perception regarding Father-in-laws and brothers-in-law as a support during antenatal/postnatal period.

Do you think the gender of the baby also determines the level and quality of healthcare?

- Do you prefer knowing the gender of the baby before birth, what is your perception about gender reveal?

Communal Level?

- Family Traditions during maternal health and your involvement?
- What does religion say about all of this, and how does that impact individual believes?

FOR OTHER MALE MEMBERS:

How do you take maternal health?

Do you think that other than husbands, other male members play a role in determining the level and quality of care during maternal health?

What is your level of support for your daughter/Sister-in-law?

- Financial
- Logistics