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Prevailing Government Maternal Health Care System and Challenges Faced by Health Professionals: A Case study in Tehsil Jampur

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ABSTRACT

This research aims to investigate maternal healthcare facilities and the challenges faced by the health professionals in tehsil Jampur. The present study utilized a qualitative approach and collected data from 23 participants through purposive sampling. The population of Tehsil Jampur in the Punjab province of Pakistan predominantly resides in rural areas. The data was collected via in-depth interviews and analyzed using a straightforward thematic analysis methodology. Services provided at primary healthcare units endeavor to met service-provision standards by arranging, LHVs, LHWs, LHS, CMWs, transportation, nutrition etc. but it requires to highlighting the importance of addressing staff absenteeism, inadequate infrastructure, and inconsistent working hours to improve health outcomes. It also reveals that due to multiple deficiencies, the assessment of service quality at facility centers is of utmost importance. The challenges encompass insufficient medicine accessibility, restricted service hours, inconvenient transportation to remote medical facilities, male exclusion as partaker of health program, traditional practices including reliance on TBAs and a scarcity of female healthcare providers influenced by cultural norms pertaining to gender dynamics. The health sector's governance is adversely affected by the frequent fluctuations in government and its system. The health department experiences instability due to the varying strategies, programs, and staff appointments introduced by successive prime ministers.

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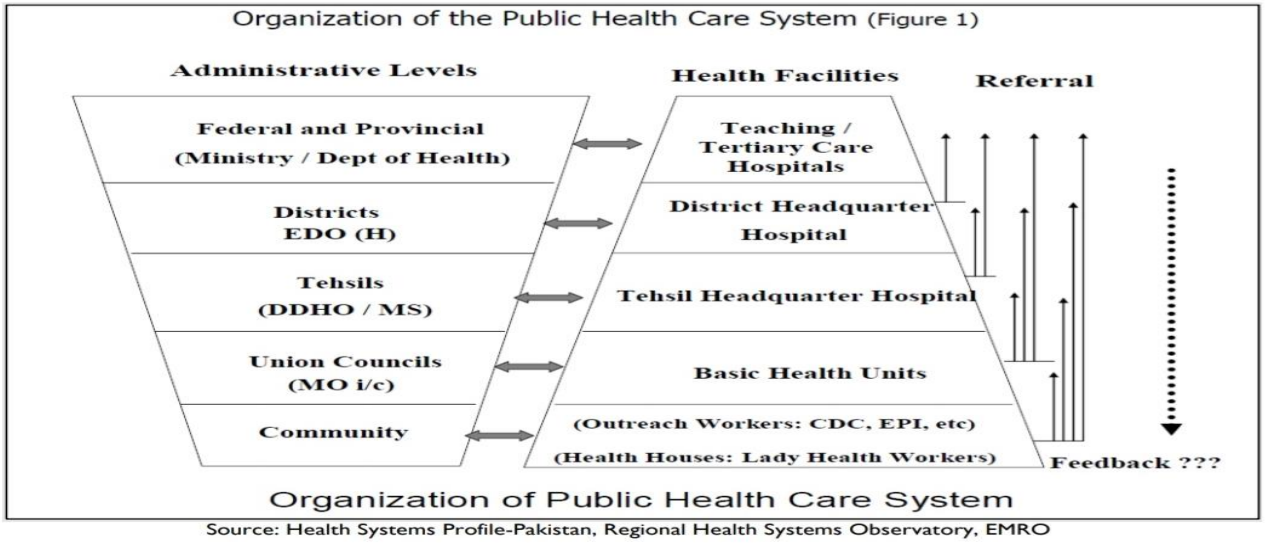
1. Introduction

Providing fundamental healthcare services to the populace is regarded as an essential obligation of the government in every nation. As per the constitutional provisions of Pakistan, the primary responsibility for providing healthcare services to the populace residing within the country lies with the provincial government, except for the federally administered territories (Government of Pakistan, 2013). The district health departments are responsible for engaging in district health planning, budget allocation, quality assurance, and the provision of healthcare services tailored to the specific needs of their respective localities. The healthcare infrastructure in Pakistan comprises both private and public sectors. According to the Pakistan Demographic and Health Survey of 2012, the majority of the country's population, approximately 70%, relies on the private sector to meet their healthcare requirements. This sector operates primarily on a fee-for-service basis and encompasses diverse healthcare providers, ranging from allopathic physicians with formal medical training to spiritual healers. Pakistan's Public Health delivery system comprises three distinct levels of healthcare delivery alongside several parallel national health programs. According to (Hardee & Leahy, 2008), the Primary Health Care (PHC) units comprise Basic Health Units (BHUs) that serve approximately 10,000 individuals, while the

larger Rural Health Centers (RHCs) cater to a population of 30,000 to 45,000 people. The Tehsil Headquarters Hospitals (THQs) offer secondary care services, encompassing acute, ambulatory, and inpatient care. On the other hand, the District Headquarters Hospitals (DHQs) provide both secondary and tertiary healthcare facilities to the district, as stated by the (District Health Authority, Health Contingency Plan of Rajanpur, 2017). In major cities of Pakistan, there are approximately 22 tertiary healthcare facilities that operate as teaching institutions and medical services providers. Maternal and Child Health Centers (MCHCs) play a crucial role within the broader health systems alongside Basic Health Units (BHUs) and Rural Health Centers (RHCs). In collaboration with lady health workers, these centers contribute to the delivery of essential obstetric care through a community outreach program (National Assembly of Pakistan, 2018).

Punjab's services are delivered through a meticulously planned infrastructure. The health department in the province is comprised of 2,461 basic health units (BHUs), 293 rural health centers (RHCs), 88 tehsil headquarters hospitals (THQs), 34 district headquarters hospitals (DHQs), and 23 teaching/tertiary care hospitals. The provided organizational chart effectively illustrates the structure of the public health care system in Punjab, Pakistan. The administrative structure of the Punjab health department exhibits a well-coordinated and strategically designed government and healthcare system, along with its infrastructure.

Figure 1: **Organization of Public Health Care System**



Source: Health Systems Profile-Pakistan, Regional Health Systems Observatory, EMRO

The primary objective of the integrated reproductive, maternal, and newborn health initiative is to enhance maternal well-being and reduce mortality rates by disseminating knowledge about reproductive health and childcare. It reveals the unwavering commitment of Punjab, Pakistan, to expedite the attainment of health-related objectives (Government of Pakistan, 2013). Cultural and social norms influence social structures and individuals' behavior, rendering them integral to daily interactions (Ministry of Health, 2019). Maternal health is a multifaceted measure for assessing the health status of women globally (Ministry of Health, 2019) as it provides insight into women's overall well-being within a given region (Liljestrand & Sambath, 2012). Pregnancy, childbirth, and the postpartum period are frequently associated with socio-cultural practices, leading to their regulation by social norms (Coast, Jones, Portela, & Lattof, 2014). Individuals' social and clinical behavior can be influenced by cultural and traditional pressures, which may contribute to adverse maternal health outcomes, such as maternal mortality (Kaneoka & Spence, 2020). Pakistani women encounter culturally constructed forms of discrimination (Nasrullah, 2015) that are rooted in their gender (Fikree & Pasha, 2004), and this discrimination can manifest from early childhood or even immediately following birth (Qadir, Khan, Medhin, & Prince, 2011). Despite the passage of the Reproductive Healthcare and Rights Act in 2013 by the Government of Pakistan, which aimed to address health issues such as infertility, fistula, sexually transmitted diseases (STDs), and maternal mortality in rural areas, Pakistani women continue to be deprived of their rights, including the right to life (Qadir et al., 2011).

Maternal mortality is a pressing global concern, particularly in developing regions, where maternal death rates are approximately 216 per 100,000 live births (Ozimek & Kilpatrick, 2018).

According to a report by the World Health Organization (2018), there is a global occurrence of approximately 830 maternal deaths per day, primarily attributed to complications related to pregnancy and childbirth. According to the (World Health Organization, 2015), it is estimated that approximately 303,000 maternal deaths occurred in 2015 during and after the reproductive period. The majority of these deaths, nearly 99%, were reported in developing countries, highlighting the severity of the issue (Kalisa & Malande, 2016; Ozimek & Kilpatrick, 2018; World Health Organization, 2015). This study aims to examine the maternal health care system in Jampur, focusing on programs, policies, medical systems, and socio-cultural factors related to reproductive health. This study aims to comprehensively review the available evidence about the current configuration of the healthcare system in Jampur, specifically in relation to pregnancy, childbirth, and the postpartum period. This study aims to contribute to the existing body of literature on the healthcare system in rural Punjab, Pakistan. This study addresses two research questions: (i) How does the maternal health services mechanism work? (ii) Which type of facilities are provided by health care department in Jampur? The research study also aims to examine the role of health providers in disseminating reproductive health information. This study aims to assess the level of reproductive health service utilization among women and examine the strategies employed by health providers to disseminate reproductive health information within the context of cultural beliefs and practices.

2. Literature Review

2.1. Studies on Reproductive Health Facilities

Providing reproductive health facilities is a global concern for all countries, as it aims to enhance the healthcare system regarding maternal health, family planning, and childbearing. In order to effectively address the accessibility and responsiveness of healthcare systems, it is crucial to prioritize health-seeking behavior and the various factors that influence the utilization of healthcare services (WHO, 2014). (Aziz, 2016) argue that incorporating information about health-promoting behaviors, seeking healthcare, utilization patterns, and societal factors is imperative for designing advocacy campaigns, launching programs, and persuading stakeholders to invest in specific areas. Additionally, this approach aids in the development of evidence-based policies. According to the (World Health Organization, 2006), health services encompass the visible components of a health system, encompassing all activities associated with identifying and managing illnesses and facilitating health promotion, maintenance, and recovery. Service provision refers to integrating various resources, including financial means, personnel, equipment, and pharmaceuticals, which collectively enable the implementation of healthcare interventions.

The country is implementing various projects and programs involving public and private health sectors to deliver reproductive health (RH) services (Shaikh & Hatcher, 2004). The private sector facilitated the initial inclusion of reproductive health services in the first five-year plan (1955-1960), specifically the Family Planning Association of Pakistan. During the second five-year plan (1960-1965), the primary objective was to reduce the population growth rate and enhance the availability of family planning (FP) services through government health channels. However, it was noted that these services were not yet fully developed to effectively implement family planning measures during that period (Khan, 1996). The absence of a specific and adequate framework for family planning (FP) at the national level persisted until the implementation of the third five-year Plan (Bhatti, 2014). This plan dedicated a chapter to FP and established a distinct service delivery system involving dais (birth attendants), doctors, health visitors (HVs), shopkeepers, and chemists. The third plan also incorporated the implementation of the IEC (Information, Education, and Communication) and IUD (Intrauterine Device) programs as significant initiatives. The Continuous Motivation System (1970-1973) was designed to shift the focus of the supply approach towards a client-centered structure, wherein male and female workers were assigned at the union council (UC) level. The Contraceptive Inundation Scheme (1974-77) aimed to distribute condoms, pills, sterilization methods, and intrauterine devices (IUDs), as part of a supply-oriented approach. The implementation of programs faced constraints in terms of politics, administration, and logistics, which hindered the ability to receive support from international organizations in both technical and financial aspects (Robinson, 2007).

One constraint that hinders the effectiveness of FP programs is insufficient coverage, particularly in rural regions. In the early 1990s, it was found that the proportion of the population

effectively covered by services was merely 20%. Among this percentage, only 5% were provided services in rural areas, while urban areas had access to 50% of the available facilities (Carton & Agha, 2012; Hardee & Leahy, 2008). The Lady Health Workers (LHW) program was established in the mid-1990s to provide assistance and empowerment to women who faced restrictions on their mobility. Implementing this measure led to an increase in the use of family planning methods. However, there were contrasting views regarding the utilization of antenatal visits and hospital deliveries. According to (Mumtaz & Salway, 2005) and the Ministry of Health (2004), a significant number of women (80%) experienced the presence of untrained birth attendants during childbirth. Additionally, only approximately half of all mothers received adequate antenatal care and services, as reported by (UNFPA, 2005), the (Population Council 2003), and the Pakistan Integrated Household Survey (2002). The IEC program experienced various shortcomings, such as inadequate components that failed to effectively promote awareness of contraception or generate demand for it prior to the 1990s (Farooq, 2007).

2.2. Recent Studies on LHVs and LHWs

The presence of female health staff, such as Lady Health Visitors (LHVs) and Lady Health Workers (LHWs), is not adequately prioritized in health facilities, particularly in rural areas (Siddiqi, Haq, Ghaffar, Akhtar, & Mahaini, 2004); this lack of emphasis is linked to concerns regarding safety and security (Ali et al., 2000). The use of ineffective communication methods, such as posters and leaflets, by the IEC (Information, Education, and Communication) was found unsuitable for illiterate individuals (Robinson, 2007). Consequently, these methods failed to effectively engage and persuade people to adopt the recommended techniques, leading to concerns about their safety. Numerous initiatives about family planning (FP) have been implemented since 1955 by the Ministry of Population Welfare and the National Trust for Population Welfare (NAPTOW). NAPTOW, established in 1994 by the Government of Pakistan (GOP), aimed to facilitate collaboration between the government, donors, and civil society organizations. However, these endeavors have proven inadequate due to their limited focus. According to (Seltzer, 2002), the National Family Planning Program, like other programs initiated between 1960 and 1970, was primarily motivated by concerns surrounding population growth and its potential impact on economic, social, and national development rather than focusing on providing reproductive health services. Mustafa and Qasmi (2017) examine the issue of women's rights in Pakistan from both an Islamic and legislative standpoint. They discover a significant disparity between theoretical frameworks and the actual implementation of policies about women’s status.

During 2007-2008, the Federal government implemented measures to enhance the availability of reproductive, maternal, newborn, and child health (RMNCH) services. These initiatives encompassed the establishment of Community midwives to ensure safe deliveries, providing necessary resources to 30% of basic health units (BHUs), and the improvement of two Rural Health Centers in each district. In addition, ambulance services are provided to all District and Tehsil Headquarter hospitals. In a similar vein, provinces strive to enhance the quality of reproductive, maternal, newborn, and child health (RMNCH) services through the implementation of adaptable performance contracts, provision of brief anesthesia and cesarean section training for women, as well as compulsory rotation of newly graduated medical professionals to rural regions. According to (El-Saharty et al., 2014), the grass root coverage plans implemented by the Prime Minister's program for family planning and primary health care in 1993 have contributed significantly to the international recognition of these programs. (Ali & Gavino, 2008) conducted a study in Pakistan and discovered that the issues of staff absenteeism, inadequate infrastructure, and inconsistent working hours require significant attention to enhance health status. Implementing adequate checks and balances, coupled with stable governance, is necessary to mitigate the provision of 24/7 essential services that pose risks and cause deprivation to numerous lives. The frequent changes in government and their corresponding systems have a detrimental impact on the governance of the health sector and each prime minister introduces distinct strategies, initiates various programs, and appoints personnel, leading to instability within the health department (Abbasi, 1999).

2.3. Reproductive Health in Cultural Context

Pakistan ranks fifth globally in terms of population. According to (Sheikh et al., 2016), the maternal mortality ratio in Pakistan stands at 276 deaths per 100,000 live births. The recent publication titled 'Pakistan Maternal Mortality Survey 2019', conducted by the National Institute of Population Studies (NIPS) and funded by USAID, highlights significant demographic disparities

in the maternal mortality ratio. Specifically, the survey reveals that maternal mortality is approximately 26% higher in rural areas than urban areas. According to the Pakistan Maternal Mortality Survey (2019), the maternal mortality rate (MMR) in urban regions of Pakistan is 158, whereas in rural regions, it is 199, indicating a difference of 41 deaths per 100,000 live births. The cultural beliefs in Pakistan contribute to the construction of traditional gender roles for women concerning childbearing activities that lead to a lack of empowerment in making reproductive health decisions and negatively impact the overall health status of women (Jejeebhoy & Sathar, 2001; Sathar, Crook, Callum, & Kazi, 1988). According to (Kaneoka & Spence, 2020), there is an association between shyness and discussions about pregnancy and reproductive health. Pakistan is characterized by a patriarchal social structure deeply ingrained within a multifaceted family system (Dar, 2013). The preference for a joint family system, characterized by a complex structure, highlights the significant role of the family in decision-making. Consequently, women's autonomy as independent decision-makers is not accurately represented, as the family's opinions influence their choices. Target orientation is an enduring process that needs strengthen integration among socio-cultural setup and launched program and require steadily monitoring and evaluation. Available literature review document different maternal and child health care programs and their cultural contextualization. However, this work contributes to assess the prevailing government maternal healthcare system and challenges faced by health professionals in a marginalized community.

3. Materials and Methods

This study aims to examine the healthcare system in the rural area of Jampur, Punjab. Population of the study include primary healthcare facilities of Rajanpur district. The district has subpar infrastructure, according to the Multiple Indicator Cluster Survey (MICS) report from 2011. In line with this, literacy and health services are inadequate, especially for women. Bordering with Baluchistan province, makes the sociocultural fabric distinctive by providing rural-tribal traditions. Thus, marginalization and distinct socio-cultural fabric of agro-tribal setting opens the door to observe the influence of rural-tribal traditions and customs on healthcare system of primary healthcare facilities of the selected locale. This study employed a qualitative methodology because he topics under investigation were too nuanced and intricate to be fully analyzed through conventional survey method. The study involved 23 selected participants comprised on male and female health professionals who served as key informants and cultural consultants by using purposive sampling techniques.

Table 1: Demography of Participants

Categories	Participants	Designation	Frequency
Stakeholder	Director	Sayya Foundation	1
	Male Doctor	Coordinator MNCH program Rajanpur District	1
Medical Staff	Male Doctor	Govt RHC Hurand Trible area	1
	Female Doctor (Govt)	BHU	2
	Female Doctor	Private Clinic	1
Para-medical staff	Lady Health Visitors	BHU	5
	Lady Health Supervisor	MNCH program	1
	Lady Health Worker	MNCH program	3
	Mid wife	MNCH program	1
Local Practitioners	TBA (*DAI*)	Private	4
	Indigenous Old ladies	Local RH Remedies Expert	3
TOTAL			23

Source: Field Survey

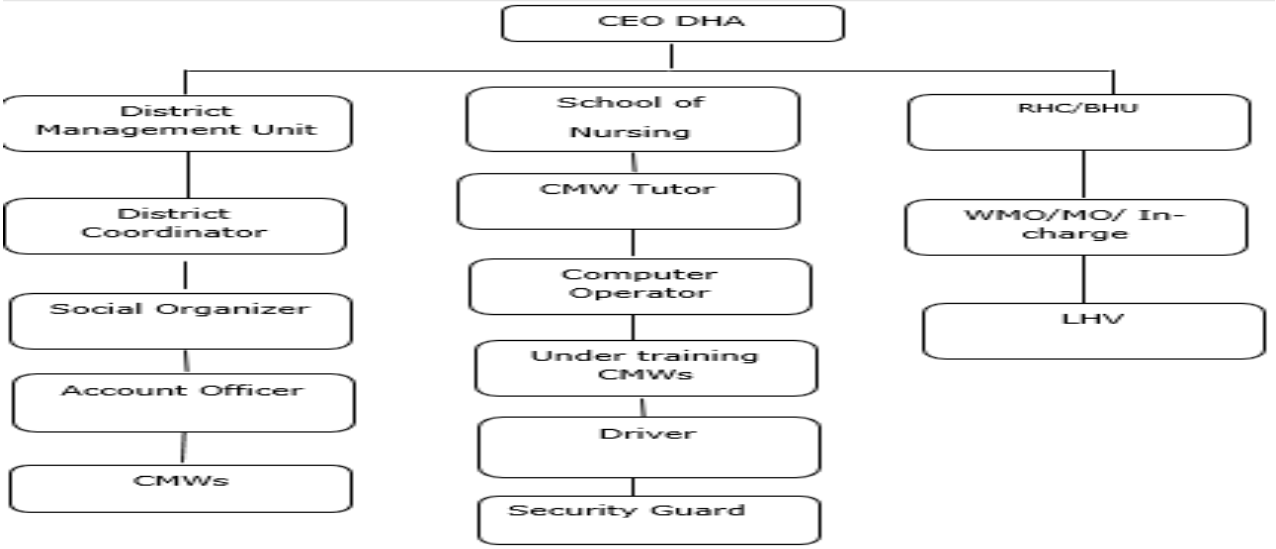
The data was gathered through in-depth interviews and analyzed through a simple thematic analysis approach. The researcher employed an immersion method to obtain primary data from community members by residing within the community and engaging in firsthand observation. In addition, this method is employed to observe the participants' verbal and non-verbal communication cues, including their ideas, opinions, behavioral characteristics, and body language. Two focus group discussions were conducted, with a participation of 7 to 8 individuals per session, all focusing on a single topic. Field notes were primarily employed to document essential information and activities within the research site for retention and recall.

4. Result and Discussion

4.1. Health Care System of IRMNCH Programs

The integrated reproductive, maternal, and newborn health program pursue intentions to enhance maternal well-being and reduce mortality rates by raising women's awareness of reproductive health and childcare-related concerns. It demonstrates the Punjab government's unwavering commitment to expeditiously attaining health-related objectives (Government of Pakistan, 2013). The program additionally facilitates the ongoing initiative aimed at tackling malnutrition and enhancing the availability of Maternal, Newborn, and Child Health (MNCH) services. This program addresses the health and nutritional concerns within the context of economic growth. All such efforts aim to target the enhancement and management of primary, secondary, and tertiary healthcare and financial reforms. Additionally, improved governance, emphasizing attaining quality standards, essential service packages, support effectiveness, service structure, scope, and accessibility of affordable medication are some other traits of the program (Requejo et al., 2015). For the purpose, a proper structure is organized to run the whole program systematically, which is as follows:

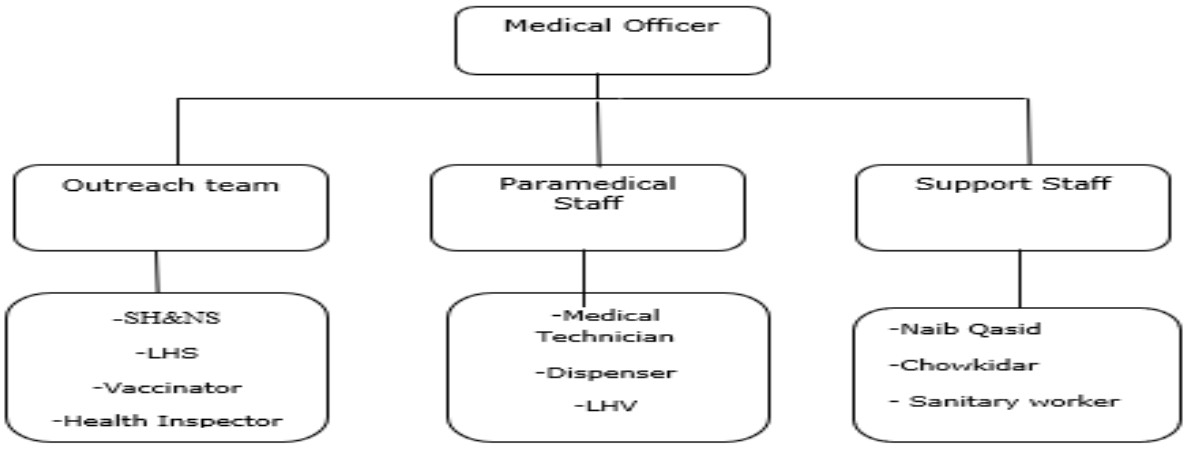
Figure 2: Organogram of the district MNCHH program



Source: Health Department Punjab

Furthermore, to ensure the provision of health services accessible for all, efforts are made for the arrangement of certified and adequate staff.

Fig 3: Organogram of Health Services Providers at Union Council Level



Source: Health Department Punjab

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The MNCH District coordinator in Rajanpur explained the MNCH program and services at the Broder and district levels. The government offers two types of services within this framework: community-based and facility-based. The IRMNCH Program is crucial in delivering health services within the community-based setting, specifically focusing on providing essential

healthcare facilities. The MNCH and nutrition program facilitates community-based services by training and deploying Lady Health Workers and Community Midwives. The researcher met the district coordinator MNCH program he said:

"Role of health provider is important to look after the pregnant mother and refer them to government health centers and hospitals where the medical officer and lady health visitors and midwives are available to mothers and newborns. Normal delivery takes place at BHU and RHCs and for C-sections referred to tehsil or district hospitals. He also said that we have a strong monitoring follow-up system in this program."
(Health Key Informant)

4.2. Role of Lady Health Workers

In 1994, the National Program for Family Planning and Primary Health Care was implemented nationwide to deliver healthcare services to both rural and urban slum areas. This initiative involved recruiting 44,700 lady health workers and 1800 lady health supervisors. The program aimed to achieve a coverage rate of 70% in the region, with a particular emphasis on extending services to rural areas (Omer, 2019). The responsibilities of LHWs encompass home visits, provision of guidance on maternal and infant health concerns, reproductive health counseling, immunization services, and family planning assistance. The Lady Health Workers (LHWs) are supervised by the Lady Health Supervisors (LHS). LHWs guide pregnant mothers regarding the timely recognition of warning signs and the importance of preparing for childbirth. Additionally, they attend to the healthcare needs of children, encompassing immunization, vaccination, and screening.(Perry, Crigler, & Hodgins, 2013) highlights the significant contributions made by individuals in targeted campaigns to raise awareness about the importance of breastfeeding and nutrition.

District coordinator MNCH Rajanpur explained about the role of Lady health worker in the area he said:

An (MNCH) has been running in the district for the last ten years. Its main focus is on maternal and child health. Lady health workers go from door to door informing people about maternal health and vaccinations."(Health key informant)

Lady health supervisor further explains the role of the health worker she said:

"MNCH Program of government has produced awareness in this area. Now local women visit us at least two or three times. We check their weight and blood pressure. Health workers inject them with Its vaccine. We use sterilized instruments in hospitals and use gloves during the process of delivery that is not done by TBAs." (LHS, key informant)

4.3. Role of Midwives

The inception of the community midwives program took place in 2007 as part of the National MNCH Program. The objective was to guarantee access to skilled birth attendants for mothers residing in rural regions. Adolescent female students were carefully chosen for enrollment and subsequently undergo a two-year training program before being assigned to positions within their respective residential regions. The services offered by this organization encompass facilitating deliveries at midwifery residences by community-based skilled birth attendants, as well as providing antenatal care, normal deliveries, postnatal care and family planning services.

Lady health visitor elaborated on the role and work of the trained midwife at the government RHCs and BHUs, she said:

"In the government sector midwives are fully trained and they take better care of mother and child and our cleanliness as well. A blade or a pair of scissors is used to cut down the umbilical cord of a newborn. LHVs also assist them. We are linked with lady doctors if have some emergency we refer the client to them at Tehsil and district hospitals. (LHV key informant)

BHU Lady Doctor told the cultural constraint which they have faced during their duties:

"Women living in local villages are banned by the local customs. Their workload is too heavy. They work all day in the fields even during pregnancy. Due to the frequent visit of our health workers, they hardly come to the hospital check-ups, once or twice in pregnancy even though the delivery at the hospital is free. On the other hand, their husband does not cooperate with them." (Health key informant)

Facility-based services can be accessed at Basic Health Units (BHUs), Rural Health Centers (RHCs), Tehsil Head Quarter Hospitals (THQs), and District Head Quarter Hospitals (DHQs). A program was established in 2010 by the District Health Quarters (DHQs) to offer round-the-clock (24/7) access to Basic Emergency Obstetric and Newborn Care (EmONC) services, including immunization and nutrition support. The initial agreement for providing services at 90 health facilities was reached by UNICEF and UNFPA . Almost 150 Basic Health Units (BHUs) were funded to offer round-the-clock services that later increased from 550 in 2015 to 803, encompassing all districts. The services these Basic Health Units (BHUs) offer include general examination, antenatal care, history taking, obstetric examination, basic diagnostic tests (including urine (for pregnancy and proteinuria), blood (for Blood Glucose levels, Hemoglobin levels, Hepatitis screening and HIV screening)), and delivery services (Basic EmONC). In addition, they offer a range of services encompassing newborn care, assistance with infant respiration, chlorhexidine-based cord care, management of breastfeeding challenges, treatment of pneumonia and diarrhea, skincare, and adherence to the child immunization schedule as outlined by the Expanded Program on Immunization (EPI).

Table 2: Assessment of Basic Health Units (BHUs) services in study area

BHUs Services	Categories	Availability	Acceptability	Accessibility
Maternal Health Services	Antenatal care	Reported	Not reported	To some extent
	general examination	Reported	Reported	Reported
	obstetric examination	Including ultrasound	Not reported	Reported
	basic diagnostic test	Blood, urine	Reported	Reported
	Transportation	Ambulance Service	Not reported	To some extent
	Medicines, nutritional supplements	Not Reported	Not Reported	Not Reported
	delivery services	Labor room	Not Reported	Reported
New born Services	Primary health services	Not Reported	Not Reported	Not Reported
	Management of Breastfeeding	To some extent (instructions/awareness)	Not Reported	Not Reported
	Treatment of pneumonia and diarrhea	Reported	To some extent	To some extent
	Skincare	Not reported	To some extent	Not reported
	Child immunization	Reported	Reported	Reported

Source: Field notes data

4.4. Nutritional Program

The Nutation program, launched in 2010 and funded by UNICEF and WHO, was implemented in seven flood-affected districts. It aimed to benefit the community. Given the significant prevalence of malnutrition in Pakistan, it is imperative to extend the provision of this service to encompass all Basic Health Units (BHUs), District Headquarter Hospitals (DHQs), and teaching hospitals. The services offered encompass the provision of treatment services by LHWs and LHVs, utilizing medications such as iron folic acid tablets, multi-micronutrient sachets, and zinc for cases of diarrhea (World Health Organization, 2017). The lady doctor of BHU Kot Tahir informed us in detail about MNCH Program immunization and nutrition she told that:

"Ten years ago, a project of the model district had started launched in Rajanpur district related to mother-child health. Whereby different BHUs were converted into models. Those model BHUs included Kot Tahir. A lady doctor informed us about medication, we have folic acid pills, multivitamins, and TT vaccine for pregnant mothers. There is a complete program of healthcare. We go from door to door finding mothers' diet charts but due to poverty they do not follow it." (BHU Lady Doctor)

4.5. Transportation Service

The rural ambulance service project, was initiated on May 22, 2017. The objective of this program was to enhance the connection between individuals and healthcare facilities by

leveraging the pivotal role of LHWs in addition to mitigate the potential for delays in unforeseen circumstances. The program provides transportation services for pregnant women and individuals with complicated pneumonia or diarrhea cases, facilitating their transfer from their residences to the nearest operational basic EmONE facility. In order to effectively track the ambulances' movements, call response centers, accessible via helpline 1034, have been established. The ambulances were promptly available on call by Lady Health Workers (LHWs) and Lady Health Visitors (LHVs) to Community Resource Centers (CRCs) upon receiving the call. The recipient identifies the patient's address and notifies the closest ambulance. An automated SMS is generated and transmitted to the driver, providing a comprehensive account of all pertinent information. According to (Farooq, 2007), an automated SMS is sent to provide the driver's name and contact number. The call response time is 15 seconds, while the average time taken to reach the patient is reported to be 45 minutes.

District coordinator MNCH explained about the free ambulance service available in the district and the fear of the community, he said:

"Under this program, LHV stays on duty in hospitals for 24 hours. When the delivery time approaches, the ambulance picks up the pregnant mother on just a phone call and drops her back at home for free of cost but people don't avail their service of ambulance. They take an ambulance as a symbol of fear. They used to think only the dead bodies are brought in the ambulance." (Health key informant)

4.6. Challenges Faced by Health Professionals

It is imperative to gather feedback from female healthcare professionals, including Lady Health Visitors (LHVs) and Midwives, regarding the challenges they encounter while working in healthcare. This significant aspect of the discussion pertained to research inquiries concerning women's health-seeking behavior, particularly during pregnancy. At the grassroots level, efforts were being made to disseminate information and provide maternal, newborn, and child health (MNCH) services to the community. So, it is important to list down those challenges which work as constraints of health service provision.

4.6.1. Societal Hindrances

According to the data obtained from the district coordinator of the Maternal, Newborn, and Child Health (MNCH) program in Rajanpur, it has been observed that the program is operational in 15 out of the 19 union councils at the Tehsil Jampur level. The Tehsil Headquarter (THQ) and Rural Health Centers (RHCs) serve the remaining four union councils. From the perspective of a medical officer:

"The country is endeavoring to deliver reproductive health services through various projects and programs involving both the public and private health sectors. The provision of reproductive health services was also encompassed. The implementation of programs was hindered by ongoing political, administrative, and logistical challenges, despite the availability of technical and financial support from international organizations."
(Health key informant)

4.6.2. Work Load

As reported by DHA (2017), the study area was served by a Tehsil Headquarters (THQ) Hospital, three rural health centers, and eleven basic health centers to provide healthcare services and reach the entire population. Each Union Council typically has a population ranging from 15,000 to 30,000, although there are instances where the population may reach up to 50,000. According to (Mubeen, Jan, Sheikh, Lakhani, & Badar, 2019), each CMW encompasses a population of 5,000 to 10,000 individuals. The MNCH program is being implemented across all 19 union councils, with Lady Health Supervisors and Lady Health Workers diligently fulfilling their responsibilities of registering married couples, delivering maternal health services, and raising awareness among women. In addition, health workers deliver immunization polio campaigns and family planning services (Government of the Punjab Planning & Development Department Bureau of Statistics, 2011). All situation mentioned above reflect overloading of work.

4.6.3. Traditional Practices

Identified health seeking practices ranges from institutional health services to traditional medication in the selected study area. The community practiced a dual faith system, in essence. Initially, it is essential to note that women increasingly access clinical services encompassing various interventions, including ultrasound examinations, tetanus toxoid (TT) vaccinations, and iron and vitamin tablets. Additionally, they employ herbal medicines and home remedies for maintenance of their health. Following reviews were received by another key informant as:

"People firmly believe on herbal medicines and home remedies because they have had experienced them in past. So, before visiting the health facility they prefer to use these traditional practices, which may cause harm for them." (Health key informant)

During the deliberation of seeking healthcare services, individuals placed considerable emphasis on the gender of the healthcare provider, as there exists a cultural constraint for females to refrain from visiting government facilities due to the presence of male staff.

4.6.4. Scarce Resources

In spite of the availability of technical and financial support from both government and international organizations, limited availability of resources was observed as a big hindrance of securing the target of MNCH. The majority of BHU and RHC lacked essential supplies like sterilizers and gloves to aid in childbirth in addition to qualified midwives. Women were not encouraged to use the facilities in the government sector by these circumstances some hindrances are political, administrative, and logistical challenge. Overall, the male and female doctors of the government said:

"The biggest challenge we have to face is our limited resources. We have limited stock of medicines so we have to prescribe most medicines". (Health key informant)

Reasons of procurement and delay in acquisition of medical supplies are Inadequate funding and complicated procedure. A medical officer of BHU reported that:

"All equipment and medications are purchased through a centralized system (Punjab's health department). Hospital sends requisition to district administration, which then forwards it to provincial department, where procurement and purchase are completed after all legal requirements have been met. As a result, there is a significant delay and the hospital cannot purchase the medication." (Health key Informant)

4.6.5. Role of TBAs

Many individuals working in the informal sector, primarily rural residents, still do not fully comprehend or participate in any health policies or programs. As a result, the practice as it was observed in the study won't motivate anyone to take part in or enroll in any program. Rather they prefer to go to traditional practitioners.

"Another challenge is the role played by TBAs, Quacks, and peer culture. The TBAs have formed a front against us. In the beginning, the health workers were not allowed to enter the homes by local's people in the area." (Health key informant)

In this regard lady health supervisor said that:

"People are habitual of traditional practices for years, and these practices fulfill their satisfactions. So, for technical and complicated issues like ultrasound examinations, tetanus toxoid (TT) vaccinations they visit health centers otherwise consult with TBA." (Lady Health Supervisor)

4.6.6. Male Exclusion

The cultural, social, familial, economic, and political contexts of a woman's life are entwined with her conceptions of and actions regarding reproductive health (Fatmi & Avan, 2002; Khan, Zafar, Ali, & Ahmad, 2009; Munir & Mohyuddin, 2015; Singh, Rai, Alagarajan, & Singh, 2012) and men have the control on all such phenomenon and work as an obstacle in utilization of available health services. So, it is important to involve men in the process of MNCH program to ensure targeted goals. As male doctor pointed that:

"*There is no male involvement in this program. If this point is focused and the man are educated through this program then local behavior regarding maternal health can be changed beside this, in this way, the gender gap existing in the society may be reduced. If this is done, rapid and effective better results can emerge in society regarding maternal health".*
(director MNCH program)

5. Conclusion

The impact of health-seeking behavior on reproductive health is manifested through its reflection of an individual's level of concern for their overall well-being. The provision and availability of reproductive health (RH) services are fundamentally contingent upon individuals' subjective perceptions of the range and options of RH services. There is a notable inclination among individuals to favor private establishments due to the provision of round-the-clock services, medical professionals, and superior medical apparatus. Furthermore, the perceived quality of services at a medical center and the associated financial costs were also considered. Due to various deficiencies, the perception of service quality at facility centers is a crucial consideration. These include inadequate availability of medicines, limited-service hours, inconvenient transportation to distant medical centers, and a lack of female health providers, which is influenced by cultural norms surrounding male-female relationships. This phenomenon is observed in regions characterized by inadequate and unreliable provision of public health services, leading to corresponding patterns of perception and health-seeking behavior. Lady Health Workers (LHW) program was initiated to facilitate and empower women at the doorstep who were prohibited from women's mobility. This step resulted in the uptake of FP however antenatal visits and hospital deliveries still showed a different perspective of women suffering from unskilled birth attendants and about half of the total mothers received antenatal care and services IEC program also had many supports including inconsistent components that were insufficient for awareness about contraception or creating its demand as well In 2007-2008, the federal government took initiatives to increase the accessibility of reproductive, maternal, newborn and child health (RMNCH) services that include the introduction of Community midwives for safe delivery, Equipping 30% of basic health units (BHUs) and up gradation of two Rural Health Centers in every district. In addition, ambulance services are provided to all District and Tehsil Headquarter hospitals. These programs have achieved global recognition due to their extensive grassroots reach. The study revealed that addressing staff absenteeism, inadequate infrastructure, and inconsistent working hours is crucial for enhancing health outcomes. Implementing adequate checks and balances, coupled with stable governance, is necessary to mitigate the provision of 24/7 essential services that pose risks and lead to the deprivation of numerous lives. The frequent changes in government and its system negatively impact the health sector's governance. Each prime minister introduces different strategies, programs, and staff appointments, leading to instability in the health department.

5.1. Policy Recommendation

- The MNCHs program needs to be resourced the health facilities with skilled personnel and equipment. The BHU and RHC will be in the best possible position to manage cases at their level if they are provided with the necessary people and material resources. Bring the TBAs closer to LHWs, LHVs, and medical officers to raise community members' confidence and trust in clinical services. This will increase the use of maternal healthcare services.
- The study also urges the WHO, NGOs, the Punjab Health Department, and their international and domestic partners to redesign health promotion programs to strengthen facility-based and community-based maternal health promotion programs. Interventions should be strategically directed to home care and facility-based care rather than only concentrating on facility-based clients and service.
- The study recommends that stakeholders like WHO, Punjab Health Department, and relevant agencies and NGOs adopt gender responsive and gender mainstreaming policies and program in the provision of maternal healthcare with active engagement of men. These policies' approaches should be sensitive to cultural differences and structurally transformative for women in the community in order to provide women greater autonomy in all facets of life and enhance the healthcare system.

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