A Qualitative Study on the Impact of Cultural Beliefs on Antenatal Care Access in Teaching Hospital Dera Ghazi Khan

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Abstract- Background;For mothers in low-income countries, the World Health Organization proposed in 2002 a focused antenatal care strategy consisting of four visits. Only 46% mothers follow the suggestion, despite the high percentage of women (95%) who see a professional attendant and the implementation of the suggested antenatal strategy. Finding the cultural attitudes influencing women's decisions about prenatal care or pregnancy-related health care was the aim of this study.Methods; In a qualitative study assessing barriers to antenatal care, twenty pregnant mothers and eight health workers from one urban tertiary care facilitiey in Dera Ghazi Khan Punjab Pakistan was enlisted. Face-to-face interviews, audio recordings of the interviews, and a demographic survey were used to gather data between September and December of 2022. Results: Maternal cultural values that were identified included revealing pregnancy, asking village elders for advice, and maintaining marital fidelity. Health professionals reported that because healthcare practitioners frequently shared the same cultural views, they would turn away women who attempted to defy them. Conclusion:Cultural beliefs play an integral role in the decision-making process of antenatal care. Specifically, the belief and practice of when to disclose pregnancy prohibits women from seeking antenatal care in the first trimester.

Index Terms- antenatal care, culture, maternal child health, pregnancy, prenatal care.

I. INTRODUCTION

This article guides Globally, the maternal mortality ratio (MMR) dropped by 38% between 2000 and 2017 (1). The World Health Organization (WHO) defines maternal mortality as dying while pregnant or within 42 days after the pregnancy's end. The length and location of the pregnancy are irrelevant to the cause of death, which could be any ailment aggravated by the pregnancy or its treatment, but not accidental or incidental causes (1). While MMR has declined significantly in recent years, low- and middle-income nations like Afghanistan (638/100,000 livebirths), India (145/100,000 livebirths), Bangladesh (173/100,000 livebirths), and Yemen (164/100,000 livebirths) still have high rates. (3), (4), (5), (6) One of the low-income nations, Pakistan, likewise recorded a high MMR in 2019 of 186 deaths per 100,000 livebirths, up 32% from 140/100,000 livebirths in 2017 (7,8). Particularly impacted were the rural areas, where the MMR was 199 per 100,000 livebirths, while the MMR in urban areas was 158 per 100,000 livebirths (8). For mothers in low-income nations, the World Health Organization recommended in 2002 a concentrated prenatal care approach consisting of four visits (9) The aim of this research was to determine the cultural beliefs that impact women's decisions about prenatal care or pregnancy-related medical treatment, utilizing specific constructs from the theory of planned behavior as a framework for investigation.

According to Ajzen's (2011) theory of planned behavior model, a person's access to and utilization of health care is influenced by their beliefs, values, and social norms. All these domains are included in culture. Culture is defined as "the cumulative deposit of knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, notions of time, roles, spatial relations, concepts of the universe, and material objects, and possessions acquired by a group of people in the course of generations through individual and group striving" by Porter and Samovar (1994)in their book An Introduction to Intercultural Communication. We looked at the relationship between culture and health using Porter and Samovar's (1994) definition of culture. Furthermore, the interview questions were formulated using Ajzen's (2011)

theory of planned behavior, with a focus on the behavioral, normative, and control views of women. According to Porter and Samovar (1994), culture is comprised of the beliefs that fall within the behavioral, normative, and control beliefs components of the theory of planned behavior.

Methods

one tertiary care hospitals in Dera Ghazi Khan in Punjab Pakistan hosted an in-depth qualitative descriptive study utilizing in-depth interviewing. Eight health workers from the study sites—three men and five women—as well as twenty expectant moms were among the participants. To find volunteers, we employed purposive sampling strategies, each research site having a gatekeeper to help. Each hospital's labor and prenatal wards, as well as antenatal clinics, were used to choose study participants. Each interview was performed in the interviewee's preferred language, either Urdu or Saraiki, by the research team, which consisted of the lead author and two research assistants. Every interview had a duration of roughly forty-five minutes and involved a quick demographic questionnaire. Interviews were audio-recorded and transcribed

verbatim by research assistants. Software for qualitative analysis, QSR International Nvivo (10) was used to store and evaluate all of the data and topics. The study subjects, mothers and health workers, were the subjects of data triangulation in order to validate and confirm the beliefs and practices found in the interviews. The study has gained ethics approval from organizations in teaching Hospital D.G.khan.

Results

Based on the demographic survey, 90% of the mother respondents were between the ages of 20 and 39, and the majority of them were between the reproductive age range of 18 to 50. Eighty percent of the women had previously given birth, while thirty-three percent did not currently have any living children. When they were in their second trimester or later, 75% of the women first requested Ante Natal Care (ANC). A varied mix of doctors, midwives, and clinical officers made up the sample of health professionals; half of them had less than five years of experience working in the prenatal care industry. The categories for emerging themes pertaining to prenatal care included culture, significant others, enablers, and barriers.

Regarding pregnancy and the use of antenatal care, several themes were found. Few themes, such as declaring pregnancy and ANC visits, were shared by mothers and health workers, despite the majority of themes being identified by maternal interviews. The timing of seeking care, disclosing pregnancy, who to seek care from, counsel or guidance from close friends and family, beliefs regarding the number of prenatal care visits a woman should have during her pregnancy and *pregnancy*-related habits and beliefs been among the major themes.

When to seek care

The third or fourth month of pregnancy is when prenatal care should be sought, according to the mothers who participated in the interviews. Women felt that the third or fourth month was the best time for the first visit because the pregnancy had progressed to a point where one could receive care (identify the fetus, hear the heartbeat), depending on the many treatment options she received at her appointments. One mother referred to the fetus's developing stages when she said that this period was being produced. "You want the child to be mature so they can receive the proper care, but when you just found out you are pregnant, the child is not fully matured." Some women also thought that the nurses would be happy if they sought care after three months.

"An expectant mother ought to see the ANC within the first three months of her pregnancy, and the nurses are pleased to see us at that early stage"(Pregnant Mother #4)

"That marks the beginning of the fetus's development. You can't tell how it's like if it's watery, but the heart begins to form after three months". (Pregnant Mother #12)

Disclosing pregnancy

It is culturally improper, according to mother respondents and health professionals, to disclose a woman's pregnancy before a certain time. It was believed that when a woman's pregnancy was obvious to everyone, which is often during the fourth or fifth month of gestation, which was the best moment to disclose the pregnancy. Women were frequently discouraged from obtaining care throughout the first trimester by this cultural mindset. This cultural concept is based on the notion that telling nonfamily members or distant relatives about one's pregnancy too soon could put the woman at danger of being miscarried due to witchcraft.

"It is true that women should not disclose their pregnancy if it is not readily apparent. It's said that witches will murder your child if you discuss it". (Pregnant Mother #6)

"It's a cultural custom that requires a pregnancy to be declared when it is discovered; if it is not discovered, it need not be disclosed. It could not only be in Dera Ghazi Khan, but it seems that people will do all kinds of weird things to you during a pregnancy, like let it go unnoticed (delaying the delivery of the child) or use witchcraft to make you miscarry. As a result, when a pregnancy is detected, it will be nearly 20 weeks along". (Medical Professional)

From whom to seek care

Women believed there were many different providers from whom a mother could seek care during her pregnancy. However, it was common for mothers to more often seek care from traditional health workers before seeing medical personnel at the hospitals. This practice stems in part from the idea that one does not go to the clinic or hospital unless one is physically ill.

Therefore, pregnant women who need information about pregnancy or to learn about pregnancy-related issues, especially early in the pregnancy, often relied on their elders, traditional birth attendants (TBAs), or other traditional healers. This behavior was due to the belief that nurses, midwives, and doctors at the clinic would not treat them well or would shout at them, so they preferred to reserve hospital/clinic visits for illness.

"Some people choose to receive care and give birth at home with the TBA due to the harsh treatment they received there at times from medical professionals, which created anxiety". (Pregnant Mother #2)

Significant others

Mothers stated that they followed the advice of nurses, midwives, and doctors; nevertheless, important people could disregard the opinion of medical professionals, including spouses, mothers, friends, and spiritual healers. Women stated that their moms, community elders, relatives, and spouses were the primary sources of information regarding pregnancy-related health services. These individuals are crucial in influencing a pregnant woman's choice to seek medical attention. The meeting with elders at the start of one's pregnancy to learn about pregnancy and the need for antenatal care was one of the replies given by maternal participants when asked how important others influence mothers to seek antenatal care. Women said that, in addition to elders, their mothers were the ones who initially taught them about pregnancy.

"The elders advised me to go to ANC for my first pregnancy because of how you currently appear" (Pregnant Mother #10).

"Some spouses forbid them from attending because, as to another woman I heard, "My husband doesn't want me to be coming for antenatal," leaving me with no other option than to stay home". (Pregnant Mother #8)

ANC schedule of visits

Pregnant women used to think that they only needed to visit the clinic when the mother was unwell or had a problem. Consequently, these women did not see the value in following the antenatal monthly visits schedule since they did not see a necessity for frequent clinic visits. Many women also had to suffer lengthy waits in line after traveling great distances to the facility. Women therefore favored delaying visits till later in their gestational age.

"I don't want to keep going back there. We get weary of going there five or six times, so I only want to go there two or three times" (Pregnant Mother #7).

Some women felt there was no need to attend during those months because early ANC visits were a waste of time and little to no care was given. Appointments should ideally be scheduled for later in pregnancy, when the visits will have more meaning. Others decided to delay seeking care until later in their pregnancies and cut back on the number of trips they made to the health facility owing to financial and transportation constraints.

"When you arrive early, you often receive in different treatment and are advised to return at a later time, which makes you regret your early arrival. Maybe you may have received assistance if you had arrived in the fifth or sixth month". (Pregnant Mother #3)

Pregnancy-related practices

There were numerous other cultural ideas about pregnancy that were found, in addition to the customs and beliefs discussed above. According to interviewees, pregnant women were expected to abstain from specific activities and to "carry themselves in a certain way."

"They claim that if you simply wait until your due date to deliver, you can end up staying for a few weeks or months. The same as bidding people farewell". (Pregnant Mother #3)

Discussion

Our findings supported the Ajzen's theoretical constructs, showing that women sought and used care. Women's decisions to seek or resume prenatal treatment were influenced by their attitudes, views about control, and relationships with significant others. For example, women did not go ANC regularly or early because they felt that spiritual healers and TBAs were better qualified to care for them throughout pregnancy. The frequency of visits was lowered by those who felt powerless over their time at ANC. Lastly, women who heard from close friends and family that ANC was unnecessary or that it was necessary later in pregnancy tended to put off seeking care for the first time. Nevertheless, in spite of this, it seems that the cultural values upheld by the mothers and providers had the greatest influence in ANC attendance when compared to the individual constructs.

Health professionals must comprehend the complicated idea of culture in order to practice their profession effectively. Numerous shared cultural experiences occur when a patient seeks care, including their cultural background, the culture of their provider, and the culture of medicine (Bussey-Jones & Genao, 2003). Values, beliefs, traditions, practices, and social standards that are acquired from families and social groups comprise an individual's culture (Bussey-Jones & Genao, 2003). The patient's culture and that of the medical community frequently diverge in terms of socio demographic variables, professional employment, education, and modes of mobility.

Patients may find it challenging to follow the recommendations given by the medical community as a result of such disparities, such as when to present for ANC.Our findings demonstrate how cultural perceptions effect on health care of women during their pregnancy period. Although it is customary in Dera Ghazi Khan for women to reveal their pregnancy only once it becomes apparent, moms may feel differently about when to seek medical attention in rural versus urban areas. Numerous pregnancy-related behaviors or attitudes that we found in our research were founded on non-medical therapies; it was typical for women to seek care from alternative providers, such as herbalists, in order to ensure the health of their unborn child. This was a practice

followed by women who believed that doctors were not prepared to deal with the spiritual risks associated with pregnancy.

To increase Southern Punjab women's use of health care, cultural sensitivity and competency training programs must be developed. As they train new health professionals, the Ministry of Health may wish to address the ideas found in our study and include cultural competency and sensitivity training in their health education courses. It is necessary to create local professional development programs that address the present attitudes held by the medical professionals working in the ANC clinics.

Women in a nation where miscarriages are common and infant survival rates are low put off seeking medical attention until after the pregnancy becomes apparent. Some women, fearful that their unborn child may not survive, wait to name their children until after they are born. Thus, working along with traditional health providers like herbalists, TBAs, and spiritual healers may show to be a successful strategy for addressing the issue of culture and health. The government may reach more people and encourage greater use of health services by encouraging cooperation between traditional and medical staff. This will benefit all Punjab.

In conclusion, additional research is required in developing nations where there is a shortage of healthcare professionals and a strong demand for their services.

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