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CULTURAL NORMS AND THEIR EFFECTS ON THE THREE DELAYS IN PREGNANCY: A QUALITATIVE STUDY IN RURAL SINDH, PAKISTAN

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Abstract

Maternal mortality remains a criticall public health issue in low-resource settings, particularly in South Asia. This study aims to investigate how cultural norms and social structures influence the three phases of delay decision to seek care, reaching a healthcare facility, and receiving appropriate care during pregnancy and childbirth in the village of Haji Ameer Ali Shah, District Naushero Feroze, Sindh. Using a qualitative approach, 25 pregnant women were interviewed to uncover cultural beliefs, mobility restrictions, and family dynamics that contribute to delays in maternal healthcare. The study highlights how patriarchal structures, religious misconceptions, and lack of autonomy impede timely care. Findings will inform culturally sensitive strategies to reduce maternal mortality through community engagement, male involvement, and culturally competent healthcare delivery.

INTRODUCTION

Maternal mortality is a pressing global health concern, especially in developing countries where access to timely and quality healthcare remains limited. Pakistan, ranked among countries with the highest maternal mortality ratios, faces a particularly severe challenge in its rural regions. While much of the existing focus has been on improving clinical care and infrastructure, there is growing recognition that socio-cultural barriers—rooted in gender norms, traditional beliefs, and religious perceptions—play a decisive role in shaping maternal health outcomes. In rural areas of Sindh, such as Haji Ameer Ali Shah village in District Naushero Feroze, women's health behaviors are strongly influenced by family power hierarchies, male dominated decision-making, and restrictions on female autonomy and mobility. These factors delay or altogether prevent access to antenatal care, skilled birth attendance, and emergency obstetric services. To systematically understand these challenges, this study applies the Three Delays Model (Thaddeus & Maine, 1994), which categorizes delays in maternal healthcare into three critical stages:

the delay in deciding to seek care, (2) the delay in reaching an appropriate facility, and (3) the delay in receiving quality care. Although this framework has been widely used globally, it has been underutilized in Pakistan's rural and culturally conservative settings, where women's voices are often unheard in healthcare decision-making. This research investigates how cultural norms shape each delay in the maternal care

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pathway, based on qualitative data collected from women of reproductive age. The findings aim to provide contextualized insights that can inform community-level interventions and policy reforms to improve maternal health outcomes in similar settings. Rationale / Problem Statement Although maternal mortality is a recognized public health issue in Pakistan, existing interventions often fail to account for local cultural contexts that deeply affect women's ability to access timely care. In rural Sindh, where communities are governed by strong patriarchal systems, traditional customs, and limited autonomy for women, maternal health outcomes remain poor despite the availability of services. Women in areas like Haji Ameer Ali Shah frequently depend on the approval of husbands or mothers-in-law to seek medical attention—even in emergencies. Cultural taboos prevent women from traveling alone, while religious misconceptions discourage the use of family planning. These realities lead to dangerous delays that can result in life-threatening complications. The Three Delays Model provides a structure for analyzing these issues, but few studies in Pakistan have applied it specifically to rural Sindh with a focus on cultural norms. This research addresses that gap by examining how these norms influence all three delays during pregnancy and childbirth. By doing so, it aims to generate evidence that can guide culturally sensitive, community-based interventions to improve maternal health outcomes in similar low-resource settings. Aims The primary aim of this research is to explore and analyze how cultural norms, values, and traditional beliefs influence maternal health outcomes through their impact on the Three Delays Model in pregnancy and childbirth. This study is especially focused on identifying areas where cultural practices either contribute to or hinder timely access to maternal healthcare services. Broader Goals: 1. Understand the role of cultural norms in shaping maternal health-seeking behaviors. 2. Examine how cultural expectations and social structures contribute to each of the three delays. 3. Identify specific cultural barriers that prevent women from receiving timely and appropriate maternal care in rural or patriarchal settings. 4. Provide insight into cultural practices that may serve as facilitators or protective factors. 5. Suggest culturally sensitive improvements in maternal health strategies for policymakers, healthcare providers, and community leaders. Objectives To achieve the aims, the study sets the following specific objectives:

Delay I – Decision to Seek Care:

• Explore how cultural beliefs and practices contribute to delays in decision-making. • Investigate the influence of family hierarchy, gender norms, and stigma around pregnancy complications. • Assess the role of male decision-making power and community elders in healthcare choices.

Delay II – Reaching the Health Facility:

• Identify how mobility restrictions, stigma in traveling alone, and lack of awareness delay access. • Explore how obligations or cultural restrictions hinder transportation to health facilities.

Delay III – Receiving Quality Care:

• Understand if cultural disconnects with healthcare workers affect the quality or timeliness of care. • Assess if modesty or shame prevents women from sharing vital information at facilities. To analyze the knowledge and attitudes of women and their families about pregnancy risks and healthcare options: • Identify gaps in maternal health education and community- based communication.

To provide culturally grounded recommendations that address:

• Awareness programs tailored to local customs and • languages. • Engaging male partners and community elders in maternal • health education. • Designing interventions that respect cultural values while • promoting timely and effective care-seeking behaviors. To suggest community-level and policy-level reforms based on identified cultural gaps, such as: • Strengthening culturally competent healthcare services. • Training healthcare providers in respectful maternity care. • Integrating traditional birth attendants into formal referral • systems where applicable. Research Questions Based on the objectives, here are the key research questions: 1. How do cultural beliefs and traditional practices influence the decision to seek maternal care (Delay I) in rural Sindh? 2. What cultural barriers affect women's ability to reach health facilities (Delay II) in the study area? 3. To what extent do cultural values impact the quality

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and timeliness of care received at health facilities (Delay III)? 4. How do family structures, including the roles of husbands and mothers-in-law, influence maternal health decisions? 5. What are the prevailing community attitudes toward family planning, birth spacing, and modern maternal health services? 6. What culturally appropriate strategies can be suggested to reduce maternal delays and improve outcomes in such rural settings? Literature Review Maternal mortality continues to be a significant global health concern, particularly in low- and middle-income countries (LMICs). While medical causes such as hemorrhage, infection, and obstructed labor are well documented, growing attention is being paid to the social, cultural, and systemic factors that influence maternal health outcomes. In many rural settings, deeply rooted cultural norms and gender dynamics act as critical barriers to timely and adequate care. A widely accepted conceptual framework for analyzing the non-medical causes of maternal deaths is the Three Delays Model, introduced by Thaddeus and Maine (1994).

This model identifies three types of delays that contribute to maternal mortality:

1. Delay in deciding to seek care 2. Delay in reaching an appropriate healthcare facility 3. Delay in receiving adequate care at the facility Each of these delays is shaped by a unique interplay of cultural beliefs, economic conditions, gender roles, health system weaknesses, and societal expectations. The following review explores the role of cultural norms across all three delays, focusing on evidence from Pakistan and similar LMIC contexts.

1. Cultural Norms and the First Delay:

Deciding to Seek Care One of the most pervasive challenges in maternal health is the delay in the decision to seek care, which is often influenced by gender norms, power hierarchies, and family decision making structures. In many traditional societies, including rural Pakistan, pregnancy is viewed as a natural process that does not require medical intervention unless complications become severe (Gabrysch & Campbell, 2009). Women's autonomy in healthcare decisions is typically limited. In patriarchal societies, men or elder women (such as mothers-in-law) usually make key healthcare decisions on behalf of women, often underestimating the severity of symptoms (Mumtaz & Salway, 2007).

Evidence from research:

• Ganle et al. (2016) found that in rural Ghana, childbirth was seen as a test of endurance, leading many women to avoid hospitals and opt for home births. • Naviwala (2016) reported that in Pakistan, women often require permission from husbands or in-laws to leave home, even during emergencies, leading to critical delays. • In Ethiopia, Tura et al. (2014) revealed that women often prefer traditional birth attendants (TBAs) over formal providers due to cultural familiarity and perceived trustworthiness. These findings highlight how cultural perceptions of motherhood and societal roles limit timely decision-making and increase maternal risk.

2. Cultural Norms and the Second Delay:

Reaching a Health Facility Even when the decision to seek care is made, the journey to a facility is often delayed by restrictions on women's mobility and social stigma surrounding travel. In conservative communities, women are often not allowed to travel alone, particularly in the presence of male service providers (Ahmed et al., 2019). Honor-based traditions also influence mobility, where visiting a hospital for childbirth may be seen as shameful or unnecessary (Ali et al., 2018). These norms not only restrict physical access but also influence transportation availability and travel behavior.

Evidence from research:

• Bartlett et al. (2005) noted in Afghanistan that women could not travel without a male escort, leading to dangerous delays during complications. • Umar et al. (2020) documented in northern Nigeria that cultural pressures to maintain modesty discouraged many women from delivering in hospitals. • UNFPA reports from Pakistan emphasize that even when facilities are nearby, social practices such as purdah and the lack of female-friendly transport options delay care access. These cultural barriers highlight the gendered constraints women face in accessing essential maternal health services, particularly in emergencies.

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3. Cultural Norms and the Third Delay:

Receiving Adequate and Respectful Care The third delay occurs within health facilities and is often shaped by the interaction between service providers and patients. A lack of cultural competence among healthcare workers, along with discriminatory attitudes and insensitivity to traditional values, can lead to mistrust and mistreatment. Women may avoid institutional care due to fear of humiliation, especially in cases involving early pregnancy complications, abortions, or out-of-wedlock pregnancies—all of which carry social stigma (Bohren et al., 2015). Additionally, the presence of male doctors in facilities is a major deterrent for women from conservative families (Miller & Smith, 2017).

Evidence from research:

• Jeffery & Jeffery (1993) observed in India that women from marginalized castes or economic groups faced mistreatment in healthcare settings. • Bohren et al. (2015), in a global review, found that fear of abuse or denial of care strongly influences women's decisions to avoid institutional delivery. • Sathar & Zaidi (2009) reported that in Pakistan, the lack of culturally sensitive care alienated many traditional women, leading them to rely on TBAs instead of formal providers. These findings underscore that facility-level experiences are deeply influenced by sociocultural mismatches between patients and providers. The Three Delays Model remains a vital framework for understanding the complex web of cultural, social, and systemic barriers that hinder access to maternal healthcare. Cultural norms—whether related to family power structures, religious beliefs, or gendered expecta ons—cut across all three delays. Addressing these delays requires more than just improving infrastructure; it demands a culturally informed, gender-sensi ve approach that engages communi es, empowers women, and trains healthcare providers in respec ul maternity care. To effectively reduce maternal mortality in rural Pakistan, particularly in Sindh, maternal health strategies must be developed with a nuanced understanding of the local cultural landscape. Only then can interventions be both accepted and effective.

Methodology Study Design:

This was a descriptive, cross-sectional qualitative study. Data were collected through in depth interviews with pregnant women and recent mothers, focusing on factors that contribute to the Three Delays in maternal care. Study Site: The research was conducted in Village Haji Ameer Ali Shah, located in District Naushero Feroze, Sindh, a region lacking basic healthcare facilities. Study Population: 25 pregnant women of reproductive age (15–49 years) participated in the study. Data Collection Technique and Procedure: Data collection was conducted through semi-structured interviews using open-ended questions. Interview guides were developed in consultation with Lady Health Workers (LHWs) to ensure cultural sensitivity and effective communication in the local language (Sindhi). Participants were approached through door-to-door visits and gave informed consent. Sampling Technique: Cluster sampling was used for selecting the area and participants.

Data Compilation and Analysis:

Responses were recorded manually and analyzed using thematic analysis. This approach allowed flexibility in exploring emerging themes. Descriptive statistics were used to summarize demographic data such as age, number of children, and tribal affiliations. Discussion The findings of this study reaffirm the notion that maternal healthcare-seeking behaviors are deeply embedded within socio-cultural contexts, particularly in rural regions like Haji Ameer Ali Shah village in District Naushero Feroze, Sindh. Among the three delays identified in the Thaddeus and Maine model, the first delay — the decision to seek care — emerged as the most significant in contributing to poor maternal health outcomes. The qualitative data reveals that this delay is shaped by multiple, intersecting factors including patriarchal family structures, economic dependency, cultural beliefs, and religious interpretations. Women in the study reported that decision-making power lies primarily with husbands or mothers-in-law. In many cases, even in the presence of complications, pregnant women were unable to seek care without explicit permission. This reflects a lack of autonomy and highlights the dominance of gendered power dynamics in rural households. Another prominent barrier was the

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restriction on women's mobility, particularly during obstetric emergencies. Cultural norms dictate that a woman must not leave the home unaccompanied, even for medical reasons. Traveling alone, especially for childbirth or reproductive health issues, was considered dishonorable and shameful, leading to critical delays. This cultural expectation contributes to a dangerous "wait and see" approach, often resulting in women reaching healthcare facilities only when complications have worsened. A recurring theme in the interviews was the lack of access to and use of family planning services. Decisions related to family size were largely in the hands of husbands and elder family members. Many participants associated contraceptive use with religious disapproval, and some viewed it as a conspiracy against Muslims. The desire for male children further exacerbated this issue, leading to closely spaced pregnancies and increased maternal risk. These findings align with existing literature from Pakistan and other low-income countries, where patriarchal norms and traditional beliefs often override biomedical advice. Moreover, cultural taboos surrounding reproductive health result in women delaying care or concealing important medical information from healthcare providers due to modesty or shame. In sum, this study highlights the complex interplay between culture, gender, and health seeking behavior in rural Sindh. Any attempt to reduce maternal mortality in such contexts must consider not only infrastructural and clinical factors but also the deeply rooted socio cultural systems that dictate behavior. Limitations While this study offers valuable insights into the cultural determinants of maternal delays in a rural Pakistani context, it is important to acknowledge its limitations:

1. Geographic Limitation:
The research was conducted in a single village — Haji Ameer Ali Shah, District Naushero Feroze — which may limit the generalizability of findings to other rural areas of Pakistan. 2. Sample Size and Scope: Although the sample size of 25 participants is appropriate for qualitative research, a larger and more diverse participant pool could have offered broader insights, especially across different tribal, ethnic, or socio-economic backgrounds. 3. Reliance on Self-Reported Data: Data collection was based on in-depth interviews. Participants' responses may have been influenced by social desirability bias or cultural hesitance, particularly when discussing sensitive issues like family planning, gender roles, or religious views.

4. Exclusion of Non-Verbal Cues:
As the analysis was based solely on verbal responses, non-verbal expressions, emotional cues, and body language — which are often crucial in qualitative research — were not included in the thematic analysis.

5. Lack of Triangulation:
The study primarily relied on interviews. Additional qualitative tools such as focus group discussions or direct observations could have enhanced the depth and triangulation of data. Despite these limitations, the study provides a context-rich understanding of the sociocultural barriers affecting maternal healthcare access. It contributes to the evidence base needed to design culturally sensitive and community-informed maternal health interventions in rural Pakistan. Expected Outcomes and Implications This study is expected to yield a nuanced understanding of how cultural norms, gender roles, and religious beliefs contribute to maternal healthcare delays in rural Sindh, particularly in the context of the Three Delays Model. By documenting the lived experiences of women in Haji Ameer Ali Shah village, District Naushero Feroze, the research aims to generate culturally grounded insights that can shape both practice and policy. Expected Outcomes:

1. Identification of Cultural Determinants:
The study will identify specific cultural and social norms—such as male-dominated decision-making, restrictions on women's mobility, and family planning misconceptions—that contribute to the three delays in maternal healthcare access.

2. Recognition of Delay I as the Most Critical:
It is anticipated that the first delay— the delay in deciding to seek care—will emerge as the most influential in determining maternal outcomes, primarily due to socio-cultural restrictions.

3. Documentation of Gender and Power Dynamics:
The study will provide evidence of how patriarchal

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family structures and religious interpretations limit women's autonomy and access to timely healthcare.

4. Insights into Family Planning Barriers:
The findings are expected to reveal strong opposition to contraceptive use, influenced by cultural and religious beliefs, as well as son preference, leading to high maternal health risks. 5. Culturally Responsive Themes for Intervention: Emerging themes from the qualitative data will serve as the foundation for designing culturally acceptable, community-based strategies to address the maternal health crisis. Implications for Policy and Practice: • Public Health Interventions: The study will offer actionable insights for NGOs, government health departments, and maternal health initiatives to tailor interventions that respect local traditions while promoting women's health.

• **Community Engagement Strategies:**
Findings will support the development of community education campaigns that involve not only women but also men, elders, and religious leaders, enhancing the social acceptability of maternal health services.

• **Health System Reform:**
The study will reinforce the need for culturally competent healthcare delivery, including the availability of female providers, respectful care practices, and integration of traditional birth attendants (TBAs) into referral systems.

• **Advocacy and Awareness:**
The research can be used to advocate for maternal health policies that address cultural barriers, improve transportation systems for rural women, and integrate local beliefs into health messaging.

• **Academic Contribution:**
The study will contribute to the academic literature on the Three Delays Model by providing localized evidence from a rural Pakistani setting, which can inform future qualitative research and comparative studies.

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