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Socio-Cultural Causes of the Increasing Rate of Maternal Mortality in District Lodhran, Pakistan

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Abstract *This qualitative study conducted at District Lodhran, Punjab, Pakistan adopted a constructivist approach with an aim to investigate the social-cultural factors accelerating maternal mortality. The primary data was collected through in-depth interviews from 40 family members of deceased mothers and four focus group discussions, and the information for the secondary data pertaining to the victims of maternal death recorded in District Lodhran for the year 2016-17 was collected from the Health Department. The study concluded that there are various social and cultural practices, i.e. the practice of early marriages, repeated pregnancies with the wish of having a male child, treatment and living of pregnant women in the joint family system, and son's preferences are the causative factors behind maternal mortality. The study recommends inculcation of awareness, especially among gestating women, regarding maternal health and associated factors, besides civil society's measures for improvement and the government's special attention towards the issue.*

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Introduction

Maternal mortality is related to one's reproductive fitness, which was defined by Cairo as "a condition of complete mental, physical and social well-being and not merely the absence of disease or infirmity, in all matters related to the generative system and its roles and practices" (Urquia et al., 2015). According to this definition, reproductive health is related with individuals' preferences for safe sexual life, which enables them to reproduce and also make critical decisions about how and when to give birth (Glassier et al., 2006; African Union Commission, 2006). Maternal mortality can be defined by the 10th Amendment of the International Statistical Classification of Diseases (ICD-10) and the World Health Organization (WHO) as "the death of a woman while pregnant or within forty- two days of cessation of pregnancy regardless of the period and the site of the gestation, from any cause connected to or serious by the pregnancy or its managing but not from unintentional or attendant causes" (WHO, 2004; Ronsmans and Graham, 2006).

Maternal mortality was used as an example of an event that is more prevalent in underdeveloped nations (WHO, 2014) due to its widespread negligence (Shole, 2017). As per the WHO (2014), over 800 maternal deaths occur each day, with 99 percent occurring in underdeveloped nations. Maternal mortality has been observed to be higher in rural areas than in urban areas. Consequently, the issue has been more closely tied to poverty and localities with limited access to health care, particularly maternal care.

According to the United Nations Development Program (UNDP), in 2000, the estimated number of maternal deaths was recorded as 529,000 at a global level. Of the total maternal deaths, 95% deaths were reported in Africa and Asia. According to the WHO, in 2010, a total of 827000 mothers were testified dead due to the absence of proper motherly health

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carefulness facilities and poverty in developing countries. In 2013, the maternal mortality figures were found high as 289000 maternal deaths took place at the global level (WHO, 2013).

Factors Affecting Maternal Mortality

Maternal deaths were a problem in developing nations that drew world attention in1990s through the MDGs. The issue, however, continues in underdeveloped countries, and recent initiatives have taken the form of the Sustainable Development Goals (SDGs). To eliminate or significantly reduce maternal mortality, a better understanding of the underlying causes is required. Several variables have been found in the studies that add to the severity of the problem, particularly in developing nations. These variables, which fall into the following categories: social, cultural, and economic, have exacerbated the situation, and any improvement in resolving these issues could result in an improvement in maternal mortality reduction. The following sub-sections will explore the aforementioned factors affecting maternal mortality one by one:

Social Factors

Several explanations for maternal mortality have been found and explored in the developing world's literature under the umbrella of social determinants. Kaur and Purayil (2018) examined the socioeconomic concerns surrounding maternal deaths in rural India on a global scale. The findings indicated that the key societal factors contributing to maternal mortality were male child desires, home birth norms, successful home deliveries, and a lack of information regarding family planning. All of these cases could be avoided through personal, family, institutional, and policy-level efforts; thus, implementing relevant programs might help minimize maternal mortality.

According to Adgoy (2018), a review study found several possible socioeconomic factors affecting the issue of maternal mortality. Early marriages, repeated deliveries, marital status, age, gender equality, literacy, and materials and other resources were all included among the social factors. All of these factors played a key role in large-scale maternal mortality. Other researchers, such as Adjiwanou et al. (2018), have found that the same socioeconomic determinants, such as marital status and illiteracy, worsen the problem of maternal mortality in developing nations.

Cultural Factors

Cultural factors also contribute to the high rate of maternal mortality, especially in low-income countries that have certain types of inter-country cultural values. Culture differences, which considerably raise maternal death rates, were more severe in rural areas than in urban areas. However, cultural barriers have also been observed in urban slums, where residents maintained a greater adherence to their old cultural traditions (Adgoy, 2018).

Evans (2012) conducted review of research on the problem of cultural barriers leading to maternal mortality and identified a variety of cultural factors. It was mentioned that women's behavior during the pregnancy stage is highly influenced by their customs, behaviors, attitudes, and values. Women's behavioral impact raised the probability of maternal mortality during childbearing as a result of the aforementioned cultural barriers. In addition, Adetoro (2011) found that in Nigeria, certain cultural factors like cultural values, polygamy, request for consent to visit health organizations, and cultural values that a female in labor must endure woe, which aggravates the problem of maternal mortality in the country. The aforementioned cultural factors served as barriers to address the issue of maternal deaths. In Nigeria, the women were dependent on the household head for the assessment regarding their access to health care facilities due to the prevailing cultural practices (Federal Ministry of Health [FMOH] and UNICEF, 2008). Adgoy (2018) also pointed out that in Africa, women were subject to various cultural barriers, which did not only limit their entree to health care facilities but also the decision of seeking health behavior. Moreover, the delay in seeking health care also contributed to the prevailing high rates of maternal deaths in the state. Pakistan, being a developing country, also has certain cultural practices, which result in higher rates of maternal deaths (Kassebaum et al., 2014). Literature has identified certain cultural practices that have direct and indirect effects on the issue to some extent. The traditional culture and practices compel women to depend upon men regarding their reproductive health life increasing the risk of maternal mortality (Yasir et al., 2012). According

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to Begum et al. (2003), in Pakistan, various cultural factors such as male supremacy or patriarchy, the interpretation of females as inferior, a typical family structure where women are discouraged from discussing health care, and men approval and companionship for doctor's visits are the primary cultural factors contributing to the prevailing problem of maternal deaths. Similarly, Shah et al. (2014) discovered that 35percent of females had an induced abortion during their first trimester of pregnancy as a result of established cultural customs prohibiting women from seeking and accessing health care services without their male partners. Additionally, society's caste-based system restricts women's access to health care resources.

Objectives of the Study

The present study aimed at investigating the social-cultural factors accelerating maternal mortality in the target population. The study also examined the role of governmental and non-governmental organizations as well local reproductive health service providers in the sampled area.

Methodology

This study adopted a constructivist approach with an aim to dig out the social reality of the situation being faced by gestated women that lead towards their maternal mortality. The universe of this study is District Lodhran, Punjab, Pakistan. For this research, the primary data was obtained from the family members of the deceased mothers in District Lodhran; and the information for the secondary data pertaining to the victims of maternal death recorded in District Lodhran for the year 2016-17 was collected from the Health Department in the same area. For this purpose, data were collected purposively through in-depth interviews from 40 family members of deceased mothers and four focus group discussions. The collected data was analyzed through the process of thematic analysis.

Results and Discussion

THEME 1: Social Factors Accelerating Maternal Mortality

On the basis of analysis of In-depth interviews and FGDs, various social factors emerged which contribute to accelerating maternal mortality. Most of the participants were of the view that along with medical or biological causes, there are social causes that contribute to a large number of maternal mortalities in the area. These factors include early marriage, a large number of pregnancies and birth spacing.

Early Marriage

It was noted in the discussion that the practice of early marriage was conceived as one of the reasons behind maternal mortality. It was found that early marriage of females is common practice in the study area. The majority of the participants shared that early age females are favoured for marriages, and older age females are not accepted for marriage. Therefore, the family does not wait till specific age to tie the knot of their girls rather agrees to give the hands of their daughter in marriage at in early age. In this regard, one of the participants, named Kamran, narrated that

"Early age marriages are very common in the area. Most of the girls do not attend school after primary education, and their marriages are arranged in their teenage. In the local areas, girls are considered economic burden and parents think that daughters cannot earn like son and support family; therefore, they opt marriage as the best option for girls".

Likewise, another participant, Nadeem told that

"In our society, it is seen a high moral value and duty of parents to arrange the marriage of their daughters early. Those parents are considered to be lucky who finds a match for their daughter at an early age. Honor is also important to factor in this regard. As girls are not allowed to choose the life partner of their choice, so parents prefer early marriage before any such incident happens and girl shows interest in somebody".

Participants also pointed out that why early marriages are preferred, such as widely held beliefs that young girls are beautiful and can stay healthy and fit for a long time in comparison to old age girl who is assumed to have faded their beauty very soon. Another reason for early marriage is the tendency of local people to have more children. The young girl would have the long-term capacity to give birth to babies as most of the families prefer to have more children except the highly educated families who prefer

the small family size. Some of the participants highlighted that daughters are considered less productive, and as a burden on the family; that is why their marriage is arranged as early as they find a mate for them. Some of the participants were of the view that early marriage is considered a religious obligation and a means for abstinence from sins and worldly indulgence. They were of the view that it protects young girls and boys from the extra marital relationship. It could be said that there is a lack of knowledge and misperception of such Islamic conjunctions. The health and protection of women are also important. It shows the lack of health awareness regarding reproductive health and its impact on women health. Another important factor identified by a few participants was the personal situation and economic well being of the male spouse; if parents get a chance to tie the knot of their daughters with a wealthy person, they do not wait to consider other factors such as age. One of the participants shared the story of his family and said that:

"In our family, our elders arranged the marriage of two girls because of the wealth factor. The boys were wealthy, and they had huge land sizes. They give the hands of young girls in marriage in which one died in her first delivery. The other girl is fine, but who knows what she has faced while giving birth to her first child".

Most of the participants were of the view that that early marriages lead to pregnancy complications. They pointed out that a young women body is not capable of bearing a child smoothly. Young women are often anaemic and weak. Their body is not ready to bear a child for nine months and then deliver it without complications. It is known that teenage pregnancies carry a high risk of mortality (Girum & Wasie, 2017). In line with this, other studies also reported that the prevalence of early marriage has a significant relationship with maternal mortality (Alvarez et al., 2009; Granja et al., 2001). This could be due to the fact that at early age, the females pelvic is not capable of carrying a fetus, posing a higher risk for obstructed labour, and thus, its consequences may be maternal death in the worst scenario.

In discussion, participants shared various stories of cases of early marriages in which the death of women occurred during the first pregnancy. Moreover, it was noted that in most of the cases of maternal mortality, the deceased was married during teenage while in a few cases, the age of the mother was twenty-five or above. Therefore, it could be said that early marriage is strongly linked with maternal mortality. This supports the findings of Egmond et al. (2004), who reported that in developing countries where the rate of maternal mortality is higher, the average age of marriage for a female is below 18 years. Similarly, Wydra (2013) has noted that in India, the early marriage of a female is one of the factors related to maternal mortality. Further, WHO (2019) also noted that in developing countries, the early marriage issue is very common, and when such teenage girls (10-14) become pregnant, they have a high risk of complication as a result of their pregnancies in comparison to other women. Recent research indicates that early marriage may have negative repercussions not only for young females but also for the babies they give birth to (Santhya, 2011). Young women experience high rates of unwanted pregnancy, miscarriage, premature delivery, low birth weight babies, and foetal and maternal death, which are closely connected with early marriage (Sabbe et al., 2013). Hence, it can be inferred that not only early marriage is the cause, but there are associated societal factors that influence early marriage decision, for example, the desire of having more children, the economic well being of males, low status of women and consideration of women as a burden on the family. These factors influence the early marriage decision of a family for a girl while then leading to pregnancy complications and impact a woman maternal health. Therefore, addressing such associated factors are vital for an impactful change to influence the early decisions of the families regarding the marriage of a girl.

A large Number of Pregnancies

Another factor under the social factors contributing to maternal mortality in the study area is women with a large number of pregnancies. Most of the participants were of the view that large family size and joint family system is common in the area. People prefer to have more babies. This could be because people have more free time to spend at home and less alternative of leisure time. Moreover, some participants pointed out that a large family is considered a symbol of strength in the area, which is why people compete with each other to have more babies. However, educated

participants and those from urban localities had opposite views. They pointed out that in urban areas, people cannot afford the large size of family and they do not compete for children. However, the desire for male children still exists due to the male dominancy and patriarchal structure of society. The educated participants, urbanites and health professionals were of the opinion that families with having a lower level of educational background had a higher number of pregnancies or number of children. The other reason behind this, as reported by most of the participants during interviews and also quoted in the focus group discussion, was that in these communities, a lower number of pregnancies are considered as a weakness in terms of marital relationships as well as a symbol of weak or lake of masculine characteristics of maleness. One of the participants named Ibrar quoted this situation in the following words.

"Specifically, males felt ashamed if their wives did not conceive within the first few months after marriage. Sometimes a woman is weak or of young age and could not bear early pregnancy, but societal pressure compels the man for repeated conception, which cause health issue for the woman. In this community, we have examples of maternal mortality cases that had 6 times pregnancy despite ill health and lack of proper nutrition".

In line with the above narration, many participants reported the link of large family size with an early marriage that lead to teenage pregnancies as it was said: "early age marriage is also a common practice, which results in teenage pregnancies and this situation is meagre in family with large size where the girl has to offer services to the family". Most of the female relatives of the deceased mothers quoted that women domestic work is so heavy that women could not bear the pregnancy and may result in miscarriage multiple times. They were of the opinion that when repeated pregnancy is coupled with household burden, it definitely results in miscarriage, which badly impacts a women health and causes complication for her in future pregnancies. In the same vein, a lady health worker said, "young age and domestic workload contribute to pregnancy complications and could result in maternal mortality". Similarly, the focus group participants were also of the view that repeated pregnancy and the desire of having a large family size is affecting women maternal health and putting them at risk of mortality. It reveals that not only a large number of pregnancies but also the age factor along with household burden on pregnant women negatively impact women maternal health. These views of the participants are in consonance with the results reported by Ali et al. (2014), who stated that several socioeconomic factors, such as women's age and family size, had a significant role in maternal mortality. Women of childbearing age face a greater risk of maternal mortality than women of reproductive age. Similarly, huge household sizes, low socioeconomic position, and women from poor homes also suffer significantly more from poor reproductive health status. Similarly, according to WHO (2019), people in poor countries have a greater rate of pregnancy than women in industrialized nations, and their overall rates of mortality due to pregnancy are higher. In rich countries, a woman's lifetime risk of mortality — the likelihood that a 15-year-old woman will die from the maternal cause – is 1 in 3700, compared to 1 in 160 in underdeveloped countries.

Some of the participants, mostly the health workers, were of the view that there should be a proper gap between pregnancies. If a woman does not bear a conception, the male should properly treat her instead of repetitive attempts for conception. This could be because of their health knowledge as being health practitioners. It could be said that having proper health education is positively related to women good maternal health. In this regard, a lady health worker, namely Naima, reported that

"I have observed some cases in which families have shown less interest in the health of their woman but more interested in having a baby. I noted that some people even do not know what is maternal health and what kind of care is required. They are not aware of the pain a woman bears by having a baby for nine months and the complications of pregnancy. They do not know that what a repeated pregnancy causes to a woman."

Focus group participants were of the view that this higher rate of pregnancies when coupled with other maternal health issues and iron deficiency increases the chances of maternal mortality. Some female relatives of the deceased mother reported that they have observed that in some cases where a number of mothers who died had more than 6 times pregnancies with a limited interval between those pregnancies. It is very common practice in the area to bear as many children as possible. One of the reasons

behind this, counted by health professionals, is the lack of family planning awareness. As, some health workers noted that when they ask people about their repeated pregnancies, they were found unaware of the negative consequences of it. Some participants in the focus group reported that women sometimes couldn't discuss contraceptives due to shame. As discussion on the sexual issue by women raises questions on their character. To be of good character, a woman must have a low level of awareness and discussion on sex-related topics. However, educated participants were found to disagree that a woman cannot discuss sex-related topics with a male. It means that education results in more confidence in women to talk about their bodies and health-related issues with their male partners. Further, more children are considered as more strength and more hands to earn eventually. Therefore, for a struggle to have more children, especially male children, men demand the women bear another pregnancy with a limited gap. Women with having the capacity to birth more children are also considered mighty, lucky and respectful in the eyes of the family and society. However, lady health workers and urbanite participants had the opposite view. They think that women with a small number of children and their proper look after and education as the strength of women. It means that in an urban setting, a small number of children but their education are considered important for a family. This supports the findings of Ali et al. (2014), who noted that repeated pregnancies play a role in the increasing rate of motherly mortality, especially in the rural areas where children and especially sons are associated with more power. Owing to the repeated pregnancies with low health status and with low health care services access, maternal mortality became high among these women. Similarly, Shah et al. (2009) and Yasir et al. (2009) have reported that poverty is then more rampant in the rural regions and, thus, lower health status and especially of females' low procreative health is interrelated to poverty in the rural regions. Women among poverty-stricken rural households preferred more children and had high fertility rates and births. Among them, less number of their deliveries was attended by skilled professionals, which served as the primary factor in increased mortality rates in the nation. However, in urban societies, the situation differed; as some of the participants reported above, they brought their women to standard hospitals for deliveries. This could be the reason for high education, the trend of nuclear families in the urban society and awareness and availability of health facilities.

THEME-II Cultural Factor accelerating Maternal Mortality

Cultural factors are strongly related to the health behavior of a person in the study area. The culture of the area negatively affects women lives and their health, especially maternal health. There are various factors, which impede women from getting access to quality health services and timely treatment. Overall, the culture of the area supports patriarchy and pushes women to subordinate positions. Patriarchy is the main reason behind the poor maternal health of women.

Joint Family as a Patriarchal System of Residence

The culturally joint family system is prevailing in the area. During the discussion with the participants, it was analyzed that most of the deceased mothers were part of a joint family system with 3 or more three generations living in one compound having separate kitchens. In this regard, some participants pointed out certain nuclear family and their health behavior and maternal health, including access to health care services. They compared maternal health in the nuclear and joint families and were of the view that women get much better care and health access in nuclear families in comparison to joint families. Hence it could be said that the family system is strongly associated with the maternal health of women. Further, participants shared some problems of the joint family, such as there is one bathroom in the family shared by all members of the family and a single entrance to the house and children of many families playing in the same house resulting in overcrowdedness and creating dirt inside the house. One of the participants named Ruqaya outlined this situation as

When many females are living in the same place, inside one roof, husbands do not take care of pregnant wives openly. Culturally it is considered weird. Women discuss pregnancy-related issues among themselves and not with their male counterparts. This combined system affects the care behaviors of males towards their

pregnant wives due to cultural limits and cultural rigidity.

In discussion about the joint family system, it was noted that some female relatives of the deceased mother were found in support of the joint family system, arguing that there are other members of the family who are available for the help and support of a pregnant wife. They share the household burden of the pregnant mother. While the educated participants and health professionals were of the view that norms in a joint family system make it difficult for a woman to make her decision. Decisions are taken by in-laws, which sometimes are not in favour of pregnant women. Some female lady health workers pointed out to intrafamilial jealousy between women living and sharing the common house and resource, which sometimes push the pregnant woman into a miserable situation. She shared her story that "when I was pregnant, my mother in law always objected on my treatment and care by saying that I was getting special treatment from my husband. In laws even said that your husband did not treat us like he treated you". So it could be said that things in joint family are based on normative standards of the society, which expects different things that might not be possible for every kind of situation. Moreover, traditional societies are facing a cultural lag as with modern technology and faculties in the market are there for people, but their norms and values and expectations within the joint family framework do not allow a woman or her husband to take out of the context decision. Moreover, about half of the participants were of the view that there are relationship issues of the women with in-laws in the joint family system. When these relationships are bad, the family is not in favour to provide better health care. Wives of different brothers have competition with each other, which results in jealousy, and they do not want the other to have good health care. Moreover, the husband, due to family pressure, also cannot speak for his wife health openly. This also affects marital relationships. They further explained that in nuclear families, such issues are uncommon, and their husband taking good care of his wife. This result is in line with the study conducted in India by Allendorf (2010), which reported that women in nuclear families have better marital relationships and are more likely to use antenatal care and deliver in a health facility. The study further showed that only joint families with better relationships with their in-law's women are more likely to use antenatal care.

Most of the participants reported that males consider the pregnancy and its related issues are totally in the domain of joint family. They feel shy in publically discussing their wives pregnancy complications. They prefer that elderly females of the family would take care of these problems and complications. Some of the participants reported domestic violence with pregnant women in joint families, which devastates maternal health too. This support the findings of Ellsberte et al. (2008), who reported that women who are subjected to domestic abuse are considerably more likely to report poor self-reported health, suicidal tendencies, and other health issues. Likewise, Allendorf (2010) reported that violence and negative interaction within the family harm women's health. Women experiences of abuse at the hands of husbands and in-laws increase the chances of maternal deaths in low-income countries. A study conducted by Saikia and Singh (2009) investigated the influence of the type of family on maternal health services. They used binary logistic regression to predict the influence of family type on maternal health services. The type of family is classified as nuclear, joint with in-laws or joint without in-laws. Other variables included in the study are age, the number of babies, occupational status, women's education, religious practice, caste, and living standards, media coverage, women's independence, and the presence of others during the interview. The findings clearly indicate that household type is highly linked with the utilization of the aforementioned maternal health-promoting services. Women in nuclear families are more likely to use these services than women in joint families. Hence, it could be deduced that participants also noted that the type of family has a relationship with maternal mortality. The more use of maternal health services by nuclear families indicates less risk of maternal mortality.

Son's Preference

Son's preference is very common in patriarchal and poverty-driven societies. In such a society, sons are considered as strength and breadwinners for the family. The study area has a similar socio-economic pattern. Most of the rural population lives in a state of poverty with

extensive patriarchal patterns. Therefore, most of the participants pointed out that son preference over a daughter is indirectly associated with maternal mortality. Most of the participants were of the view that when a girl is born in the family at first birth, then the woman is forced to have another pregnancy shortly in order to have a male child. If she fails again to give birth to a male child, she is supposed to have another pregnancy in a short period of time. This short period of time and repeated pregnancy have a negative effect on women health and result in maternal mortality. Some of the participants pointed out that son preference leads towards repeated pregnancies, as sometimes when girls are born, the family put pressure on women to produce more and more in desire to have a male baby. One of the study participants, Hakeem narrated as

"Male child is preferred over female kids. If anybody has only girls then couple will keep reproducing in a hope of a son. Some deceased mothers had five to six daughters, but they were again pregnant in order to have a male child. It is a very common practice in the area. Females are often scolded and insulted for not having a male baby. There is intense pressure from husband, in-laws and society on a woman to give birth to a son".

This not only affects women physically but also has a psychological effect on them. Women who cannot give birth to male children have an inferior status in the eyes of family and thus suffer from tension and anxiety, which lower her hope for a good life. Further, it was noted that gender discrimination is very common in study area. In Lodhra district female are already discriminated in terms of education and health. As the society is pure patriarch, male are given more preferences in every walk of like. Therefore, this further deteriorates their health conditions and increases the risk of maternal mortality. In Pakistan, male dominancy is one of dominant causes of son preference, which risks women maternal health (Atif et al., 2016). Moreover, in the context of the study area, sons are considered as supporters and earners for the family in comparison to girls. Some of the participants viewed that parents think that they will need support once they become old and a son can only provide this kind of support as the girl is considered to be a member of another family. Based on such dependency on male children, they always desire for a male child.

It was also observed during discussions that, in some cases desire for a son become the cause of multiple pregnancies. Social pressure from the family members on the mother to produce the son is the common cause of multiple pregnancies, which cause severe complications during pregnancy. This supported the findings of Mallizo (2014), who reported that in South and East Asia, son preference is common, as illustrated by sex-selection procedures including differential stopping and sex-selective abortion. The time interval between pregnancies may be short as long as no sons have been born. Decreased birth spacing places a greater burden on the mother's body, increasing the chance of illness for both mother and child. Additionally, there is increased competition for parental care and resources among siblings. Likewise, Mallizo (2018) concluded 3 main conclusions from her research: first, women who have a first-born girl have a lower chance to survive; second, having a first-born girl results in fertility behaviours that are medically known to harm women's survival; and third, having a first-born girl results in fertility behaviours that are known to harm women's survival. There is evidence that a first-born girl has an effect on the likelihood and severity of anaemia in the mother. Additionally, these consequences are worsened significantly with each subsequent female birth.

Some of the participants reported cases of domestic violence with women unable to reproduce male children. They were of the view that women are supposed to produce a male child, and if they fail, it makes their lives miserable. They are treated badly by their families. They also lose their values and dignity in the eyes of society. As in the socio-cultural setting of the area, women who do not produce male babies are less valued and considered an ill fate for the family. This is in consonance with the findings of Mallizo (2018) who found that in Indian society, severe physical domestic violence increased significantly soon after the birth of a first daughter in comparison to those women who give birth to a male child. Women with first-born daughters have higher fertility; tend to space births less hence higher risk of dying because of maternal depletion.

Conclusion and Recommendations

The study concluded that there are various social and cultural practices that influence the risk of

maternal mortality in the area. These social practices include the practice of early marriages and repeated pregnancies with the wish of having a male child, which negatively affects women maternal health causing maternal mortality. Similarly, cultural practices such as the treatment and living of pregnant women in the joint family system and the normative preference of male babies are the causative factors behind maternal mortality. The study recommends inculcation of awareness especially among gestating women regarding maternal health and associated factors, beside civil society's measures for improvement and government's special attention towards the issue.

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