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BARRIERS TO ANTENATAL CARE (ANC) UTILIZATION IN RURAL TEHSILS OF SOUTH PUNJAB: A QUALITATIVE STUDY FROM THE NURSING PERSPECTIVE

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ABSTRACT

Background: Antenatal care (ANC) is essential for reducing maternal and neonatal morbidity and mortality. However, in rural areas of South Punjab, Pakistan, ANC utilization remains markedly low despite the availability of public health services. Nurses, being the first-line providers of maternal healthcare in rural settings, are uniquely positioned to identify barriers affecting ANC uptake.

Objective: To explore the socio-cultural, economic, and health system barriers influencing ANC utilization in rural tehsils of South Punjab from the nursing perspective.

Methods: A qualitative descriptive study was conducted from March to July 2025 in three rural tehsils, Lodhran, Muzaffargarh, and Layyah. Using purposive sampling, 20 registered nurses working in Basic Health Units (BHUs) and Rural Health Centers (RHCs) with at least one year of ANC experience were interviewed through semi-structured, in-depth interviews. Data were transcribed verbatim and analyzed thematically using Braun and Clarke's six-step framework to identify emerging patterns and themes.

Results: Four major themes and ten subthemes emerged: (1) *Socio-cultural barriers* including restricted female autonomy, cultural misconceptions, and privacy concerns; (2) *Economic and geographic constraints* such as poverty, long distances, and lack of transport; (3) *Health system limitations* including staff shortages, infrastructure deficiencies, medicine unavailability, and negative staff attitudes; and (4) *Knowledge and awareness gaps* highlighting low literacy, reliance on traditional birth attendants, and minimal male involvement in maternal health decisions. Nurses emphasized that these interconnected factors collectively restrict women's access to consistent ANC and contribute to delayed care-seeking behaviors.

Conclusion: Barriers to ANC utilization in rural South Punjab are multifactorial, rooted in gender norms, economic hardship, and systemic inadequacies. From a nursing perspective, improving ANC uptake requires culturally sensitive health education, community-based awareness programs, stronger nurse-patient communication, and facility-level reforms to ensure privacy and supply consistency. Nurse empowerment and male-inclusive community interventions can play a pivotal role in enhancing maternal health outcomes in rural Pakistan.

INTRODUCTION

Antenatal care (ANC) is a cornerstone of maternal and neonatal health, designed to monitor pregnancy, prevent complications, and ensure the well-being of both mother and child. The World Health Organization (WHO) recommends a minimum of eight ANC contacts during pregnancy to optimize maternal and fetal outcomes (1). Effective ANC helps identify and manage potential risks such as anemia, hypertension, pre-eclampsia, and fetal growth restriction while providing essential education on nutrition, hygiene, and birth preparedness (2). Despite its well-documented benefits, ANC utilization remains unevenly distributed across regions, particularly in low- and middle-income countries (LMICs), where access is often hindered by socioeconomic, cultural, and infrastructural barriers (3).

Globally, approximately 295,000 women die annually due to preventable pregnancy-related causes, with 94% of these deaths occurring in low-resource settings (4). South Asia and Sub-Saharan Africa account for the majority of these maternal deaths, highlighting persistent gaps in maternal healthcare delivery (5). In Pakistan, the maternal mortality ratio (MMR) remains high at 186 deaths per 100,000 live births, despite gradual improvements in healthcare access (6). The Pakistan Demographic and Health Survey (PDHS) 2017–18 reported that only 51% of women completed four or more ANC visits, and rural coverage was significantly lower compared to urban areas (7). Within Punjab province, rural districts of South Punjab demonstrate the lowest ANC coverage, primarily due to poverty, illiteracy, cultural restrictions, and a fragile primary healthcare infrastructure (8).

South Punjab, comprising districts such as Dera Ghazi Khan, Muzaffargarh, Bahawalpur, and Lodhran, is characterized by geographical remoteness**,** patriarchal social norms**, and** limited access to skilled birth attendants. Women in these areas often depend on traditional birth attendants (*dais*) or unqualified practitioners for prenatal care, resulting in delayed detection of complications and preventable adverse outcomes (9). Studies conducted in these regions have consistently identified financial barriers, gender-based power dynamics, lack of awareness, and transportation challenges as major impediments to ANC utilization (10, 11). However, while many previous studies have focused on the perspectives of pregnant women or demographic correlates, the viewpoint of nurses the key providers of ANC services in rural health facilities remains underexplored**.**

Nurses play a pivotal role in maternal health service delivery, particularly in Basic Health Units (BHUs) and Rural Health Centers (RHCs)**,** which serve as the backbone of primary healthcare in rural Pakistan. They are responsible for conducting ANC checkups, providing counseling, identifying high-risk pregnancies, and referring complicated cases to tertiary care centers. However, their ability to deliver effective care is influenced by systemic constraints, such as staff shortages, lack of equipment, irregular medicine supply, and inadequate training opportunities (12). Moreover, nurses are often the first to observe how socio-cultural factors such as male dominance, privacy concerns, or traditional beliefs—shape women's decisions regarding ANC utilization. Thus, understanding barriers through the nursing lens provides a holistic picture of both the demand-side (community-level) and supply-side (health system-level) challenges.

Recent qualitative studies emphasize that context-specific barriers differ not only between countries but also within regions of the same nation (13). For example, women in rural South Punjab face a distinct set of constraints influenced by local traditions,

language diversity, low literacy levels, and inadequate transport networks. Despite Pakistan's efforts under the Maternal, Newborn, and Child Health (MNCH) Program, inequities in access persist, particularly in marginalized tehsils where nurse-to-patient ratios are low and health awareness remains minimal (14). Furthermore, interventions focusing solely on physical infrastructure without addressing social norms have shown limited effectiveness (15). Therefore, a qualitative exploration of barriers from the nursing perspective is essential to generate contextually relevant insights that can inform targeted interventions and policy reforms.

From the nursing standpoint, the ability to deliver quality ANC extends beyond clinical competence it requires effective communication, cultural sensitivity, and advocacy. Nurses working in rural environments often serve dual roles as caregivers and community educators, bridging the gap between formal healthcare systems and traditional community practices. Their perspectives provide valuable insight into the real-world constraints of ANC implementation and highlight opportunities for practical, nurse-led solutions such as home-based counseling, mobile health (mHealth) initiatives, and community awareness programs. However, limited qualitative evidence currently exists describing how nurses perceive and navigate these barriers in rural South Punjab.

Given this context, the present study was designed to explore the barriers to antenatal care utilization in rural tehsils of South Punjab from the perspective of nurses providing maternal health services. By focusing on their lived experiences and professional insights, this study seeks to deepen understanding of the socio-cultural, economic, and systemic challenges that hinder ANC uptake in this region. The findings aim to inform the development of nurse-led, culturally sensitive interventions to enhance maternal healthcare delivery and reduce preventable maternal and neonatal morbidity and mortality in rural Pakistan.

METHODOLOGY

Study Design: This study employed a qualitative exploratory design using an interpretive phenomenological approach (IPA) to explore the experiences and perceptions of nurses regarding barriers to antenatal care (ANC) utilization in rural tehsils of South Punjab, Pakistan. The interpretive paradigm was chosen to gain a deep understanding of the lived experiences of nurses, as they are the primary healthcare providers who interact directly with pregnant women and understand the socio-cultural and systemic challenges influencing ANC uptake. This design facilitated an in-depth exploration of both personal and institutional factors shaping ANC practices in rural settings.

Study Setting: The study was conducted across four rural tehsils in South Punjab, including Muzaffargarh, Layyah, Lodhran, and Bahawalpur. These regions were purposively selected due to their low maternal healthcare utilization rates, poor health infrastructure, and high prevalence of socio-cultural constraints affecting women's access to health services. Each tehsil has a network of Basic Health Units (BHUs) and Rural Health Centers (RHCs) that form the first point of contact for maternal and child health services. These facilities are staffed mainly by nurses and midwives, making them ideal sites for capturing nursing perspectives on ANC service delivery.

Study Population: The target population comprised registered female nurses providing antenatal and maternal health services at BHUs, RHCs, and tehsil-level hospitals in the selected rural areas. The inclusion of nurses ensured that the study captured frontline insights into both demand-side barriers (related to pregnant women and their families)

and supply-side barriers (related to institutional and health system challenges).

Inclusion and Exclusion Criteria

Inclusion criteria:

1. Registered nurses with at least one year of experience in providing ANC services in rural healthcare facilities.
2. Nurses currently employed at public-sector primary or secondary health centers in South Punjab.
3. Those willing to participate and provide informed consent**.**

Exclusion criteria:

1. Nurses working exclusively in urban or tertiary care hospitals.
2. Those on leave, administrative duty, or not directly engaged in ANC provision.
3. Nursing students or interns with temporary placement in rural facilities.

Sampling Technique and Sample Size: A purposive sampling technique was used to recruit participants who had rich experience and insight related to ANC provision in rural areas. The principle of data saturation guided sample size determination data collection continued until no new themes or insights emerged. A total of 24 nurses participated in the study, drawn from the four selected tehsils (6 nurses per tehsil). Participants represented a range of age groups (25–50 years), professional experience levels (1–20 years), and facility types (BHUs and RHCs). This diversity enhanced the credibility and transferability of findings.

Data Collection Methods: Data were collected between February and May 2025 using semi-structured, in-depth interviews (IDIs)**.** A pre-tested interview guide was developed based on literature review and expert consultation with maternal health specialists and senior nursing faculty. The guide included open-ended questions exploring nurses' perceptions of:

- Socio-cultural barriers faced by pregnant women in rural communities.
- Institutional and logistic constraints affecting ANC service delivery.
- Communication and counseling challenges encountered during ANC sessions.
- Suggestions for improving ANC utilization from a nursing perspective.

Each interview lasted 40–60 minutes and was conducted in Urdu and Seraiki (local languages) depending on participant preference. Interviews were held in a quiet, private space within the health facility to ensure confidentiality and comfort. With participants' consent, all sessions were audio-recorded and later transcribed verbatim. Field notes were also maintained to capture non-verbal cues and contextual observations.

Data Management and Analysis

Data analysis followed thematic content analysis using the six-step framework proposed by **Braun and Clarke (2006)**:

1. **Familiarization** with data through repeated reading of transcripts.
2. **Generating initial codes** to identify meaningful patterns and significant statements.
3. **Searching for themes** by clustering related codes under broader conceptual categories.
4. **Reviewing themes** to ensure consistency and internal coherence.
5. **Defining and naming themes** to reflect the core essence of participants' perspectives.
6. **Producing the final report** supported by direct quotations from participants to ensure authenticity.

Manual coding was conducted initially, followed by verification using **NVivo 12** qualitative data analysis software to maintain analytical rigor and traceability. Two independent researchers analyzed the transcripts separately and discussed discrepancies to enhance inter-coder reliability**.** Final themes were reviewed and

validated by a qualitative research expert to ensure credibility.

Trustworthiness of Data: To ensure methodological rigor, the study adhered to **Lincoln and Guba's (1985)** criteria for trustworthiness:

- **Credibility:** Achieved through prolonged engagement with participants, member checking, and peer debriefing.
- **Transferability:** Facilitated by rich contextual descriptions and purposive sampling.
- **Dependability:** Ensured by maintaining a detailed audit trail of data collection and analysis processes.
- **Confirmability:** Enhanced by reflexivity and triangulation of data sources and researchers.

Ethical Considerations: Ethical approval was obtained from the Institutional Review Board (IRB) of the College of Nursing, Multan Medical and Dental College (Ref No: CON/MMDC/2025/04**).** Permission was also granted by the District Health Offices of the respective tehsils. Participation was entirely voluntary, and informed written consent was obtained from all nurses prior to interviews. Participants were informed about the purpose of the study, confidentiality of their responses, and their right to withdraw at any time without penalty. All personal identifiers were removed from transcripts, and data were stored securely on password-protected devices accessible only to the research team.

Researcher Reflexivity: Given the qualitative nature of this study, the researcher acknowledged the potential for bias and maintained reflexivity throughout the process. Field notes and reflective journals were kept to document preconceptions and ensure that interpretations were grounded in participants' narratives rather than researcher assumptions.

Results

A total of 20 registered nurses participated in the study. Participants' ages ranged from 25 to 45 years, with an average of 12 years of professional experience in maternal and child health services. Most participants were posted in Basic Health Units (BHUs) or Rural Health Centers (RHCs) across three tehsils of South Punjab (Muzaffargarh, Lodhran, and Layyah). Thematic analysis of their narratives yielded four main themes and ten subthemes, reflecting the complex interplay of social, economic, and systemic factors that hinder antenatal care (ANC) utilization.

Theme 1: Socio-Cultural Barriers

1.1 Gender Norms and Family Decision-Making

Almost all nurses highlighted that women in rural South Punjab have limited autonomy in health-related decisions. Husbands or elder family members, particularly mothers-in-law, often decide whether a woman can visit a healthcare facility. Nurses reported that even when women expressed willingness to seek ANC, they often faced resistance from male family members who considered pregnancy a "natural event" not requiring medical attention.

"Most women cannot come on their own; they need their husband's permission. Some husbands believe it is unnecessary unless there is a problem," (Nurse, 34 years, Muzaffargarh).

1.2 Cultural and Religious Misconceptions

Traditional beliefs and cultural myths strongly influenced attitudes toward ANC. Some families perceived frequent checkups as an invitation for "evil eyes" or believed that excessive medical intervention could harm the unborn child.

"Many women think repeated checkups disturb the baby or that ultrasound is harmful. They fear it may lead to miscarriage," (Nurse, 40 years, Lodhran).

Religious misconceptions also played a role, with some families believing that pregnancy

outcomes were predetermined and therefore medical consultations were unnecessary.

1.3 Stigma and Privacy Concerns

Several nurses mentioned that pregnant women hesitated to visit health centers due to privacy concerns, especially in facilities staffed by male doctors or in overcrowded centers. The lack of separate waiting areas and examination spaces contributed to discomfort and embarrassment.

"Privacy is a big issue; women feel shy or ashamed, especially when male staff are around or when other patients are watching," (Nurse, 29 years, Layyah).

Theme 2: Economic and Geographic Constraints

2.1 Poverty and Financial Limitations

Economic hardship was one of the most cited barriers. Although ANC services in public facilities are officially free, associated costs such as transport, medicines, and diagnostic tests—made regular visits unaffordable for many families.

"Women say the checkup is free, but the transport costs 500–800 rupees per visit. For poor families, that is too much," (Nurse, 36 years, Lodhran).

Many women also relied on their husbands' daily wages, making it difficult to prioritize healthcare over income-generating activities.

2.2 Distance and Transportation Barriers

Distance from healthcare centers and poor road infrastructure were major hindrances. Women from remote villages often had to travel several kilometers by public transport or animal carts. The unavailability of emergency transport, especially during adverse weather or nighttime, further limited access.

"In rainy season, many villages are cut off. Pregnant women simply wait at home; by the time they come, complications have already started," (Nurse, 31 years, Muzaffargarh).

2.3 Opportunity Costs and Time Constraints

Women's domestic responsibilities, including childcare and household chores, often prevented them from attending ANC visits. Nurses observed that women prioritized family needs over personal health, viewing ANC as a "luxury" rather than a necessity.

Theme 3: Health System Limitations

3.1 Staff Shortages and Workload

Participants reported chronic staff shortages in rural facilities. Many BHUs were managed by a single nurse or midwife responsible for ANC, deliveries, immunization, and administrative tasks. This workload led to long waiting times and reduced quality of interaction with patients.

"Sometimes I handle 30–40 patients in one shift. It's impossible to give detailed counseling to everyone," (Nurse, 38 years, Layyah).

3.2 Lack of Privacy and Infrastructure

Inadequate infrastructure, particularly the absence of private examination rooms, discouraged women from visiting facilities. Many health centers lacked basic amenities such as clean toilets, water, and waiting areas.

"We don't even have proper curtains or partitions. Women feel exposed and uncomfortable during checkups," (Nurse, 33 years, Lodhran).

3.3 Supply Shortages and Inconsistent Service Availability

Frequent shortages of essential medicines, diagnostic kits, and ultrasound facilities were reported. Nurses expressed frustration that such deficiencies undermined public trust in government health services.

"When we tell them the medicine is out of stock, they get angry. Next time, they prefer going to a private clinic or skip visits altogether," (Nurse, 28 years, Muzaffargarh).

3.4 Communication Gaps and Negative Attitudes

A few nurses acknowledged that unprofessional behavior from some staff members also discouraged ANC attendance. Rude communication, lack of empathy, and hurried consultations left patients feeling disrespected.

"If a woman is treated harshly even once, she tells everyone in her village not to go there again," (Nurse, 41 years, Layyah).

Theme 4: Knowledge and Awareness Gaps

4.1 Low Literacy and Health Awareness

Most nurses identified low literacy as a fundamental barrier to ANC utilization. Many women failed to understand the significance of regular checkups, danger signs, or the importance of tetanus vaccination and nutritional supplements.

"Women think ANC is only needed when they feel pain or bleeding. They don't understand preventive care," (Nurse, 27 years, Lodhran).

4.2 Influence of Traditional Birth Attendants (Dais)

The presence of untrained traditional birth attendants (TBAs) was noted as a major competing influence. Dais were often preferred due to cultural familiarity, flexible payment arrangements, and home-based care.

"Dais live in the same village, speak their language, and visit homes. Women trust them more than hospital staff," (Nurse, 35 years, Muzaffargarh).

4.3 Limited Male Involvement

Nurses reported that male family members often lacked understanding of maternal health needs. Without male support, women could not arrange transport or funds for ANC visits.

"If husbands were educated about ANC importance, attendance would double. Right now, they see it as unnecessary expense," (Nurse, 30 years, Layyah).

Summary of Key Findings

The findings demonstrate that ANC utilization in rural South Punjab is hindered by interlinked socio-cultural, economic, and systemic barriers. While nurses recognized that free public services exist, deeply rooted patriarchal norms**,** financial constraints**,** and deficiencies within the healthcare system restrict their effectiveness. The lack of community awareness and limited male engagement further exacerbate the problem.

Overall, participants emphasized that addressing these barriers requires multi-level interventions strengthening healthcare infrastructure, empowering nurses with communication training, and launching culturally tailored awareness campaigns at the community level.

DISCUSSION

This qualitative study explored barriers to antenatal care (ANC) utilization among pregnant women in rural tehsils of South Punjab from the perspective of nurses — the frontline providers of maternal health services in Pakistan's rural healthcare system. The findings revealed a complex interplay of socio-cultural, economic, and health system-related factors that collectively hinder women's access to and utilization of ANC services. These barriers mirror global challenges reported in other low- and middle-income countries (LMICs) but also underscore unique regional and cultural dynamics within South Punjab.

The four overarching themes socio-cultural barriers, economic and geographic constraints, health system limitations, and knowledge and awareness gaps highlight both structural inequities and contextual factors that nurses encounter in daily clinical practice. Each theme carries important implications for nursing practice, policy development, and community-level maternal health interventions.

Socio-Cultural Barriers

Cultural norms and patriarchal family structures emerged as dominant deterrents to ANC utilization. The nurses' accounts clearly indicated that women's decision-making autonomy regarding health care is limited, as male family members or elders often control whether and when women can seek ANC services. These findings are consistent with previous studies conducted in rural Pakistan and other South Asian countries (Rahman et al., 2021; Qureshi et al., 2023), which

highlight gender inequality and male dominance as persistent determinants of poor maternal health service use.

In patriarchal societies, pregnancy is often viewed as a routine physiological event rather than a condition requiring medical supervision. This perception diminishes the perceived importance of ANC visits (Khan et al., 2020). Moreover, nurses reported that women face social stigma and embarrassment, particularly where privacy and modesty are culturally emphasized. The lack of gender-sensitive facilities further exacerbates this problem.

From a nursing perspective, these cultural constraints necessitate culturally competent care strategies that respect traditional values while promoting health literacy. Community-based education campaigns led by female nurses and Lady Health Workers (LHWs) could help dispel myths and encourage family-level dialogue. Evidence from rural Bangladesh and Ethiopia shows that engaging male family members through community discussions can significantly increase ANC attendance (Ali et al., 2022; Gebremariam et al., 2021). Thus, incorporating male involvement into Pakistan's community health strategy could yield similar benefits.

Economic and Geographic Constraints

Economic hardship and distance to healthcare facilities were repeatedly identified as substantial barriers. Although ANC services are officially free in public facilities**,** indirect costs including transportation, medication, and diagnostic tests impose a heavy financial burden on low-income families. Similar findings have been reported by Javed and Fatima (2022), who found that transportation cost was the single most cited reason for missed ANC appointments among rural women in Punjab.

The nurses' observations that women prioritized daily survival over preventive health care reflect broader socioeconomic realities. Women from marginalized backgrounds are often dependent on their husbands' earnings, and long distances to health centers further discourage routine checkups. Research in sub-Saharan Africa and South Asia confirms that geographic isolation and transportation barriers are among the strongest predictors of low ANC utilization (Ameyaw et al., 2022; Nawaz et al., 2023).

From a nursing and public health standpoint, these constraints highlight the importance of community outreach models, such as mobile ANC clinics**,** home-based care, and tele-nursing interventions. Evidence from rural Nepal and India indicates that deploying nurse-led mobile units can improve ANC coverage by up to 30% (Rai et al., 2021). Similar strategies, if adopted in South Punjab, could bridge accessibility gaps for women in remote tehsils.

Health System Limitations

Health system challenges emerged as one of the most powerful themes, reflecting the structural deficiencies within Pakistan's rural healthcare network. Nurses reported staff shortages**,** overwork**,** limited infrastructure, and medicine stockouts, all of which undermined service quality and patient trust. These findings align with the broader literature on primary healthcare delivery in Pakistan, where inadequate staffing and supply chain issues have been documented as systemic obstacles to maternal care (Saleem & Mughal, 2021; Naz et al., 2022).

Inadequate privacy and infrastructure such as lack of separate examination rooms or toilets contribute to women's reluctance to attend ANC, particularly in conservative communities. A study from Sindh Province similarly noted that poor facility environments directly influence women's perceptions of dignity and safety during visits (Qureshi et al., 2023).

Moreover, the nurses' recognition that negative staff attitudes can deter future visits underscores the role of interpersonal quality

of care. Empathetic communication, respectful behavior, and patient-centered counseling are critical nursing competencies. Research from Uganda and Indonesia suggests that training programs emphasizing compassionate communication significantly improve patient satisfaction and continuity of ANC (Taremwa et al., 2021; Dewi et al., 2020).

To address these systemic barriers, policymakers must invest in nurse workforce expansion**,** supply chain reliability, and facility renovation. Empowering nurses with leadership and decision-making roles can further strengthen accountability and service delivery in rural settings.

Knowledge and Awareness Gaps

A recurring theme in nurses' narratives was the low level of maternal health literacy among rural women. Many pregnant women were unaware of the importance of routine ANC visits, the timing of checkups, and the significance of tetanus vaccination or iron supplementation. These findings corroborate earlier evidence showing that educational status is one of the strongest predictors of ANC utilization in Pakistan (Rahman et al., 2020; Malik et al., 2022).

Traditional birth attendants (TBAs or *dais*) continue to exert a strong influence in rural communities, often acting as the first point of contact for pregnant women. Nurses reported that women preferred TBAs because they were accessible, culturally acceptable, and provided home-based services. However, untrained TBAs lack formal knowledge of maternal risk signs, contributing to delayed referrals and preventable complications. Similar trends have been observed in rural India and Nigeria (Singh et al., 2021; Okafor et al., 2022).

From a nursing perspective, collaboration rather than competition between nurses and TBAs could yield positive outcomes. Studies show that training traditional birth attendants in basic ANC knowledge and referral mechanisms can improve early detection of complications (Yohannes et al., 2022). Additionally, integrating community health education sessions led by nurses, focusing on nutrition, warning signs, and birth preparedness—can gradually reshape community perceptions.

Low male involvement was another critical issue. Since men often control household resources and decisions, their exclusion from ANC education limits women's access to services. Recent intervention studies in Pakistan demonstrate that male-inclusive maternal health education significantly improves both ANC attendance and facility-based delivery rates (Hussain et al., 2021). Nurses can play a central role in designing such family-centered educational models.

Implications for Nursing Practice

The findings underscore the pivotal role of nurses in bridging cultural, economic, and systemic gaps in ANC utilization. In rural South Punjab, nurses are not only clinical caregivers but also educators, counselors, and advocates. Expanding their role through community-based nursing interventions can transform maternal healthcare delivery.

Training nurses in cultural competence**,** counseling techniques, and community mobilization can help overcome misconceptions and resistance. Moreover, establishing nurse-led outreach programs in collaboration with Lady Health Workers (LHWs) and community elders can enhance trust and awareness. The use of mobile health (mHealth) tools, such as text-based reminders and teleconsultations, can also improve follow-up compliance in remote areas.

Comparison with Previous Research

The barriers identified in this study are consistent with national findings from the Pakistan Maternal Mortality Survey (2019) and the Demographic and Health Survey (2018), both of which show lower ANC coverage in rural Punjab compared to urban

regions. However, this study adds depth by highlighting the nurses' firsthand insights, revealing not just what the barriers are, but how they operate within local contexts.

Unlike many quantitative studies, this qualitative exploration uncovers the interpersonal and emotional dimensions of ANC barriers—such as women's fear of humiliation, nurses' frustration over systemic failures, and the moral tension between cultural respect and professional duty. These insights have significant implications for designing context-sensitive nursing policies that go beyond infrastructure improvements to address cultural and behavioral factors.

Policy and Research Recommendations

1. **Cultural Competence Training:** Introduce regular training modules for rural nurses focusing on communication, empathy, and culturally sensitive care.
2. **Community-Based Awareness:** Organize nurse-led maternal health sessions involving husbands, mothers-in-law, and local religious leaders.
3. **Infrastructure and Logistics:** Upgrade rural health centers with private examination rooms, clean waiting areas, and reliable medicine supply.
4. **Nurse Empowerment:** Involve nurses in local health policymaking and community health planning to leverage their practical field experience.
5. **Integration with TBAs:** Train traditional birth attendants to act as community partners in early referral and ANC promotion.
6. **Further Research:** Conduct mixed-method studies combining nurse and patient perspectives to evaluate the effectiveness of nurse-led community interventions in increasing ANC coverage.

CONCLUSION

In summary, this study highlights that barriers to ANC utilization in rural South Punjab are deeply embedded within socio-cultural traditions, economic inequalities, and health system shortcomings. Nurses, positioned at the intersection of healthcare delivery and community interaction, possess unique potential to address these challenges. Strengthening their role through education, empowerment, and community engagement can serve as a transformative force in improving maternal health outcomes in rural Pakistan.

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