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SYSTEM ANALYSIS OF MODERN MATERNAL AND CHILD HEALTH CARE PRACTICES DURING PREGNANCY

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ABSTRACT

This paper is an investigation of maternal health practices in Jampur, Punjab, Pakistan using anthropological qualitative methods. With the phenomena of globalization, the revolution of Medical Sciences has also reached right up to the developing countries like Pakistan, however there are some issues. The study offers insights into the historical changes in maternal health practices and the increasing awareness of children's developmental milestones. It emphasizes the underprivileged status of peasants and describes the differences in the medical staff focus on city versus rural clients.

In this paper, socio-cultural determinants relevant for women's pregnancy and child rearing practices in Jampur are explored. People tended a decade ago to be unaware of issues concerning maternal health and regarded parental investment into child development as unnecessary as it was a natural event. Though this understanding has improved owing to diverse projects, social networking, and internet, absence of classroom teaching impedes the cause. Money hungry ventures in the development sector and the pharmaceutical capsule industry fleece struggling individuals for profit while it is the center cities that impoverish the villages through budget centers marginalizing them. This paper draws attention to such practices and their consequences with child and maternal health practices in perspective.

Keywords: Antenatal Care, Pregnancies, Exploit, Child Development, Maternal Health, Child Health, Economic

1. INTRODUCTION

Maternal and child healthcare remains an area of huge concern as Pakistan, like many other countries, is amongst those with the highest maternal neonatal morbidity and mortality incidence rates. The they are well rooted from the education gaps, the available health care services as well as poverty that sets in almost every single country. It is common for women to know little about healthy pregnancy practices and advanced maternal and child healthcare is usually beyond

their income (David et al. (2020)). And still, those are the problems, practices' including cultures and traditions and poor health provision increases the burden (Husain et al. (2023)).

According to studies and international consensus on maternal provision practices, antenatal care (ANC) remains a basic requirement in efforts aimed at reducing maternal and neonatal morbidity and mortality. ANC as pointed out by Oladapo (2008), contributes largely in reducing maternal and neonatal mortality in resource constrained environments (Omer et al. (2021)). Similarly studies conducted in countries like Nigeria and Guinea Equatoria also demonstrate that involuntary factors such as poor or no knowledge of ANC services, poor awareness, and poor utilization of these services led to high maternal mortalities in those countries. Significant travelling distance, economic constraints, and sociocultural barriers are major factors hindering most rural women from accessing even the most basic healthcare services. Similarly, further in Pakistan the plight is worse, again, in the rural setting of Pakistan's healthcare situation remains abysmal (Omer et al. (2021)).

Adding to the complexity of the situation are cultural beliefs and practices. For instance, Husain et al. (2023) notes that Pakistani women maintain certain food customs when pregnant and during the postpartum period and use ghee, wheat, and sugar as health-promoting foods due to cultural beliefs. These customs are part of larger cultural traditions. Still, these also reflect some falsehoods that shape maternal health care practices, particularly the interferences caused by socio-cultural notions like that of diets determining the color of a baby or that elders of the family discourage medical supplements because of wrong conception of their safety (Aziz et al. (2020)).

Pakistan's healthcare system has major problems, and so does Pakistan's rural area, which suffers the most from it. Safdar (2002) asserted that there were cultural factors, economic troubles, and a lack of doctors as serious barriers resulting in high maternal and child death rates. Private healthcare is a luxury many women in rural areas cannot purchase, leaving them dependent on already fragile public services. This remains a problem despite initiatives funded by international donors such as NPPI that aimed to enhance services for mothers and their newborns. But, as Ashar (2021) highlighted, "Pakistan is a growing economy which has limited development" in terms of health infrastructure that can cater to the ever-increasing number of people.

This ethnographic study investigates these problems by analyzing maternal health care practices with a maternal health perspective in Pakistan's rural setting. The paper is interested in how cultural attributes, socio-economic circumstances, or poor provision of healthcare affect mothers and children's health. Also, by focusing on the lived experiences of women in such communities, this research establishes how structural and cultural deficit models account for maternal outcomes range within these communities, and their importance in terms of intervention strategies.

In Pakistan healthcare problems, especially in rural areas, are viewed as the undisguised exploitive relations that exist between core and periphery areas according to the World-System Theory, Wallerstein, 1974. Urban centers are the core areas that come forward in building the majority of the attention and resources while peripheral areas constitute rural villages that are marginalized (Michael et al. (2020)). The same pattern of the distribution of the services can also be seen in the world settings where the socioeconomic factors put certain regions at a disadvantage to develop the structures in the first place. Such women in rural Pakistan become entrapped in the cords of radicalization of poverty, education

deprivation, and healthcare advancement lot contributing to maternal and child mortality rates being extremely high (Nadeem et al. (2021)).

The interaction between these core-periphery structures in Pakistan necessitates this investigation on maternal healthcare practices and the outcomes in regard to rural areas. Adopting an ethnographic approach, the present research seeks to examine how certain cultural norms, socioeconomic factors and institutional factors of neglect influence maternal healthcare seeking behavior. The results will assist in appraising suitable culturally appropriate cost-effective measures aimed at reversing maternal and child mortality, redressing reproductive health inequities and enhancing fair allocation of resources vertically and horizontally in urban and rural areas.

2. THEORETICAL FRAMEWORK

Immanuel Wallerstein's World-System Theory (1974) is focused on connections between societies. These propositions raised structure with a hierarchy, groups, boundaries, and rules (Ciplet et al. (2022); Touray (2022)). It persists because of conflict where groups struggle at tensions to modify the system for their own purposes. It is like a living body that develops and evolves through time. Some elements remain constant; others develop. The theory tries to address the issue of how core, semi-periphery, and periphery regions relate in terms of power. Core regions put peripheral regions into submission through economic, political and social dominance (Smith & Sarabi (2022))

This theory has been used by Morgan (1987) to examine disease and healthcare in the context of social and economic inequalities (Popay et al. (2021)).Goldfrank (2000) views the world economy as one where markets link regions that need resources and strive for power. Semi-periphery zones work as transition zones between core and periphery (Väyrynen (2021)). Theda (1977) traces it, semi-periphery zones both core and periphery characteristics and maintains the balance of the system (Väyrynen (2021)).

World-System Theory serves as the basis of this research with regard to maternal healthcare usage in the selected geographical area, rural Pakistan as the case. It expands on the previous research, like Mohyuddin's Zandra village research in 2015 that changes from conventional modes of healing and practice to modern forms of medicine and practice with the rise in literacy and economic conditions. In the last three decades, exposure from the media and changing patterns of subsistence to market-oriented economies has led to the incorporation of modern medicine. At the micro level, the research highlights the fact that core-periphery relations operate within the country whereby urban centers are also seen to engage in the exploitation of the rural areas.

2.1. HEALTHCARE EXPLOITATION IN BASTI MEERAN

The Basti Meeran village inequalities in healthcare are proof of how the higher rural villages become self-sufficient, leaving an area for the lower ones to be exploited. The village lacks a singular public or government clinic or hospital as we speak. In case of emergencies, the villagers need to travel fifteen kilometers towards Jampur city, which indicates negligence on part of the government. The bulk of the national expenditure is aimed at urban places, thus providing settlements such as Basti Meeran, healthcare, and educational services as luxuries.

The private clinics that have established themselves in the cities provide services, which are referred to as the 'core within the periphery'. These charge exorbitant fees, thereby forcing people from the impoverished segments in rural areas to sacrifice other essential consultations. This aggravates poverty levels, and keeps the people from enjoying proper health care. In the absence of public health care, expectant women depend on antiquated or spiritual means that are often useless in the context of prenatal care.

2.2. CULTURAL AND SOCIAL BARRIERS

The villagers are more prone to have healthcare issues due to limited education and low awareness about their health problems. With no proper schools, many of the villagers still practice conventional antenatal practices than seeking medical assistance. This is particularly true in matters related to maternal health care issues; cultural practices and ignorance prevents women from receiving necessary health care. A combination of low cost and familiarity makes traditional methods appealing, but they frequently cannot resolve significant health issues, leading to unnecessary harm to mothers and babies.

The study emphasizes that the oppression that is experienced in the core-periphery relationship on a global level exists in Pakistan as well. Most resources are channeled to cities while most parts of the rural regions like Basti Meeran are ignored. Even in the periphery class, the elite are a part of this oppression by making money from private health care systems and not providing low-cost options for the low-income earners. This structural injustice pushes already vulnerable people into worse situations, where they lack the healthcare and education that they require to improve their situation.

The circumstances of antenatal patient practices in villages is greatly influenced by the unfair provision of healthcare services. This is because many women do not have access to modern facilities and instead resort to traditional medicine and spiritual healers. In the case when they try to use modern health care, substantial costs and poor-quality services from public institutions are the obstacles. For instance, better services are provided in private clinics, however, most villagers opt not to go there since they are expensive and cut back on other necessities of life.

The study, in addition, maintains that when there is sub-optimal maternal care, it is due to not just systemic exclusion but even the way society regards women and the decisions they make pertaining to their health care. For example, men from the family or older relatives tend to decide if women are allowed to go for any modern health care which again means that critical time is lost for seeking treatment. Poor infrastructure, together with such barriers, create a vicious interrelated loop of ill health and poverty in rural areas.

The research shows that there is systemic neglect and oppression mostly in rural areas when it comes to maternal health issues. Residents of Basti Meeran are affected by several such structural inequities: poor availability of health facilities, dependency on kahologie, the cost of attending private clinics, and non-availability of a government education and health care system. These issues are typical of the global patterns of World-System Theory where urban areas act as core and exploit the villagers in the periphery, resulting in perpetual poverty and exclusion.

3. ETHNOGRAPHIC METHODOLOGY

The research applies qualitative ethnographic research methodology aimed at investigating maternal and child healthcare practices in Jampur. The tools of data

collection included participant observation, focus group discussions, and 35 individual interviews. The respondents were chosen using purposive sampling method on the basis of prior experiences regarding the provision of services in pregnancy, child development and overall healthcare.

Jampur was selected as the area for the study because it records high levels of maternal and child mortality due to low education, low levels of awareness and poor health facilities. The town comprises of people from different social classes and all these classes have different attitudes and approaches towards the health care of mothers and children. This diversity enabled the researcher to consider the effects of socio-economic conditions on the healthcare practices of the people.

The study was carried out in three months. Paticipatory observation contributed the researcher`s comprehension of people's way of life and cultural practices. Focus group discussions offered community common views and problems that existed in the community, whereas, in-depth interviews revealed individual's perspectives. All these methods combined provided a clear picture of the challenges surrounding maternal health issues in Jampur and child healthcare.

3.1. DATA ANALYSIS

The data were treated using thematic analysis method. For instance, interviews and discussions were transcribed and sorted thematically, covering issues such as hearth culture, factors impeding healthcare access, and health disparities across different social strata. Also, notes from observations were included so as to contextualize the results. The analysis established that people's healthcare seek behaviors are determined by a combination of factors, namely education, income level, and socio-cultural beliefs. Also, ilustrated how the gap in provision of healthcare facilities fuels high maternal and child morbidity and mortality. This analysis therefore assisted in pinpointing the major health problems that the people of jampur face as well as providing an insight into their health care practices.

4. RESULT AND DISCUSSIONS

This research focuses on the different maternal health practices being implemented in rural areas of Pakistan, and the cultural factors affecting attitudes and practices towards antenatal care. Women participated in interviews whereby they narrated how they used traditional, spiritual and modern medicine systems during their periods of pregnancy. The lives of mothers provide the sociospatial context in which mothers' experiences of motherhood are embedded and, in turn, affect the provision of health care services.

4.1. TRADITIONAL PRACTICES IN ANTENATAL CARE

In the first trimester of pregnancy, women living in the rural areas seek traditional treatment as well as spiritual healing onset. Such practices usually start as cultural norms in the lives of women and are passed and endorsement or guidance is done by the older women of the house. According to one of the respondents Amna, she remembers the first nine months pregnancy as something very new to her. Then her mother-in-law and her mother gave her home therapies including aloo imli and choran when she felt nausea and vomiting which were helpful up to a certain extent. Such dependence on indigenous knowledge is common practice among many rural dwellers who have been raised in such environments and therefore tend to inherit the same forms of healthcare systems.

With respect to antenatal care practices, belief in spiritual healing was also included in these practices. As the first port of the call for women in rural areas, midwives administered some measures but prayers were their main weapon and little medicine was used. Such practices tended to be within the reach of many families since the practice did not require the use of much money and cost effective. But sometimes these methods were not enough for many women to treat complicated conditions which led to the late arrival of women to seek care from professionals.

4.2. OBSTACLES IN ADDRESSING MODERN HEALTH CAR

The accounts of women shed light to the fact that there are prominent barriers in accessing modern antenatal care service women's accounts during their first pregnancy. Such is the experience of Amna during her first pregnancy. Because of intense headaches and swelling, her family went to the local hospital. The provision of the public healthcare system was lacking which included cramped providers and substandard treatment. As a result, Amna's family sought alternative solutions such as a homeopathic practitioner. Unfortunately, even the purposed low cost treatment of Amna's homeopath was unhelpful and caused Amna's condition to deteriorate further.

These problems were made worse by insufficient resources and the absence of institutions offering health services. Both Amna and her husband were wage laborers hence the couple's economic status did not allow them to attend a private practice regularly. They had no reasonable alternative but to attend the local midwives and traditional healers, for that limited knowledge could not invoke fear for severe complications. This embodies disordered healthcare seeking behavior that exhibit the economic and social conditions of the rural people especially women.

4.3. THE INFLUENCE OF SOCIETAL EXPECTATIONS AND GENDER INEQUALITY

There are cultural practices that affect the antenatal care practices in rural areas. Women, for example, are socialized to place the management of the family unit in front of their own well-being. For instance, during pregnancy, Amna's mother-in-law, found her sweeping and hand washing laundry as she in ecstasy that such work would make delivery easier. Even more absurd was the insistence on avoiding beef, pulses, and sour foods, which had to do with the culture and not medicine.

In a patriarchal setting, women's ability to access health facilities is further curbed. Almost all the time it is the men of most households or the older women who are responsible for making the decisions. In regard to Asma, Amna's mother-in-law with regard to her healthcare, was active during Amna's first pregnancy and controlled the entire process of consultation with the cross-delivery midwives and a homeopathic nurse rather than a medical doctor. Such norms however lead to avoidable delays in seeking important medical help, more so where the chances of complications are high.

4.4. LOSS AND AWARENESS: THE NEW ERA OF MODERN ANC

The first two pregnancies of Amna ended in the death of the children as there were problems related to the health services. Such experiences became a turning

point for her and her family that made them embrace modern methods of ANC. Amna, on the other hand, was encouraged by her sibling and this prompted her to visit a private gynecologist during her third pregnancy. This change was in terms of the change of attending traditional caregivers to the modern medical facility practitioners as a result of the occurrence of untoward events several times in the past.

Amna professed that her gynecologist was a really great doctor with whom she got connected immediately. The doctor made thorough examinations, prescribed proper diet, and conducted regular follow-ups to check the growth and all fetal developments. The pre-requisites for the successful delivery were met, and Amna gave birth to a healthy male child. The priorities of amna's family were therefore shifted and maternal health was given the topmost position contending for other priorities.

4.5. THE SOCIAL HIERARCHIES IN THE UTILIZATION OF ANTENATAL HEALTHCARE

The implementation of modern ANC techniques also differed between socio-economic classes. People from educated and economically sound homes were more inclined towards the allopathic form of treatment due to the preventive advantages gained. Such families viewed the adoption of new forms of treatment with a better chance of improved maternal and infant health. Beginning with economically weak households first, due to the unaffordability of resources that were necessary, these families resorted to traditional ways, which in reality were less productive.

For Amna and other women in similar settings, the shift to the contemporary health care system was not an individual choice rather it was due to the constant failure of the conventional forms. It has been shown that the financial and emotional burdens associated with losses due to pregnancies moved the families to seek maternal health as one of their most preferred needs.

4.6. GENDER BASED INEQUALITIES IN MATERNAL HEALTH

The narratives also emphasised the gender-based inequalities manifested in the practice of maternal healthcare. Most caregivers were women and they received no acknowledgment. Amna’s account depicted the plight of women who were forced into the pregnancy without many instructions and attempts to support them from the society. The pressure to provide male children also increased the pressure on women to go through pain and stress as well.

In instances where women failed to deliver a baby as a result of pregnancy loss, the blame rested on such women which were further blatant demonstrations of patriarchy. One of the respondents regretted not having attended school and being educated since her late presentation seeking medicine may have averted her three miscarriages. This desire of her spouse to make antenatal care a center of her policy has progressed due to their tragedies but more particularly due to the realization of healthcare.

4.7. THE BLEND OF OLD AND NEW TRADITIONS

Even as more respondents adopted modern ANC practices, traditional practices still persisted. Many women employed a mixture of modern treatment and home remedies – a practice that is not uncommon in antenatal care. For instance, Amna kept taking Gachi during her third pregnancy even when she was receiving medical

attention from her gynecologist. This intermixing of practices indicates the going of culture even after modern medicine is being accepted.

Older women in the community frequently encouraged them to use traditional medicines and perceiving pregnancy as a normal event which does not need much medical care. But the younger ones, particularly the ones with history of complications were more ready to adopt the newer practices. This generational gap highlights the changing perception regarding maternal healthcare in rural communities.

4.8. THE ROLE OF SUPPORT SYSTEMS

Amna's experiences with receiving ANC have also been shaped by the support of her families, i.e. her husband and brother assisted her in adapting to modern care. Their support was not only for financial assistance but also went against the patriarchal custom of women attending to health issues in most cases. Such a transformation in male's attitude provides hope for the larger transformation of society as family's perspective with regards to maternal health changes.

Women, who for one reason or the other did have strong support systems, have a tougher time and go through more hurdles to access and use quality care services. Seeking assistance from mid wives and traditional healers was more of a compulsion than choice for many because they lacked financial resources and means of transportation to healthcare facilities. Since the problems come in more or less strong degrees, there is an obvious need for community-based measures to deal with the adverse situations.

4.9. CULTURAL CELEBRATIONS AND SOME COMMON AFTER-BIRTH CUSTOMS

Childbearing customs also influenced women's maternal health practices. Amna said her relatives sang festive souther, and the family prayed and feasted to mark the childbirth. These rituals more enhanced the status and importance of childbearing especially the male child.

Like other postpartum practices, there were restrictions about food and there were also special foods that were 'clean' such as choori and desi chooza. These were found to be in keeping with the expectations of the community to help the mother to convalesce. It was however observed that some of these traditions even though beneficial in some way, were often not consistent with medical advice and thus stressed on the importance of holistic health education.

5. DISCUSSIONS

The gap in maternal healthcare is well acknowledged in the literature in countries such as Pakistan where systemic weaknesses manifest as high maternal and neonatal mortality. Oladapo (2008) cites antenatal care (ANC) services as one of the most effective measures aimed at decreasing maternal and neonatal mortality. On the other hand, absences of the ANC services, and lack of knowledge and awareness have been noted to undermine pregnancy outcomes. In the same manner, Safdar (2002) and Ashar (2021) contend that there is a great demand for better maternal health policies and their associated infrastructure, particularly in the rural areas where healthcare services are limited and women are not in a position to effectively utilize such services.

Women at rural areas of Pakistan have to cope with a lot including poverty, cultural factors and lack of healthcare options which undermine their ability to access modern maternal healthcare. Hussain (2021) looks at the role of cultural patterns, and notes that pregnancy is conducted using old traditions of diet and myths. Although culturally accepted foods such as butter, wheat, and protein-rich items are common during pregnancy and might be beneficial for some mothers, harmful misconceptions such as not taking any supplements and avoiding specific foods for certain skin tones prevent the elderly women from using modern healthcare facilities. Such cultural practices on mothers, which in most cases are provided by elderly women, are evident of cultural impediments to an effective usage of necessary maternal health services.

Jimoh (2003) takes it a step further by studying how women from far-off remote villages ecologically and economically encounter barriers in accessing ANC services. From the study, it is apparent that women's understanding of the advantages of ANC services is however limited due to costs and distances. This is prevalent in the rural sectors in Pakistan's healthcare system, where the private practitioners are allegedly expensive and the government hospitals are poorly equipped. Safdar (2002) states that high mortality rates due to pregnancy complications continue to be the reality when people lack basic healthcare facilities or education.

From the lens of World-System Theory (Wallerstein (1974)), health inequalities mentioned above are experienced because of the core-periphery structure. Most attention and resources have been directed towards cities (core), leaving the countryside (periphery) impoverished and neglected. Ashar (2021) characterizes Pakistan as a one where 'growth without development is the order of the day' due to increase in birth rates when people are already poor with inadequate means of subsistence. This is the outcome world over; where the periphery exists, that core zones are developed at the expense of. Hence in maternal healthcare, the periphery women are defined as the rural women who hardly have any attention and are economically marginalized.

The research brings to light that mothers' health issues in the context of Pakistan cannot be viewed in isolation as medical but need to be linked with social, economic and cultural systems. The rural areas are plagued with lack of accessible and affordable healthcare facilities, coupled with cultural myths and low educational achievement, which poses great risk to safe motherhood. Foreign funded projects like the Norway-Pakistan Partnership Initiative (NPPI) have sought to ameliorate these, systemic neglect remains a bottleneck to sustained improvements of maternal healthcare.

To solve these issues, there is a demand for holistic approaches that combine the provision of western health care technologies with the application of culturally appropriate educational strategies. The healthcare system should give premium to rural growth, enhance the provision of maternal health services that are affordable and equitable and circumvent the societal norms intended to influence women's choices. Using the framework of World-System Theory, there is need to move resources and attention from densely populated urban areas to rural areas to help diminish the disparities that lead to high maternal and neonatal mortality. It is only though such systematic changes that lasting improvements in maternal healthcare will be realised.

6. CONCLUSION

As the last comments of the work show, antenatal care is sufficiently provided in the cities while in the case of villages and remote areas is not. It is apparent that urban areas being the central core take advantage of the remote circumference. It was observed that, the people were illiterate and poorly paid workers. They do not have adequate knowledge concerning pregnancy matters. However, young women were encouraging accepting modern healthcare practices. Some of them were poor economically and so they were some who could not adhere to the modern ANC. Most of them were unable to adhere to modern Antenatal care as their economic conditions were poor and most had never heard of antenatal care. For the elder segment of the population, ANC was considered as a normal and spiritual event and for many elderly women pregnancy problems could be solved by spiritual approach and home remedies. But, for the educated and well-to-do members of the community, modern ANC concept, essentially in terms of attitude, knowledge and practice was the prerogative of Allopathic practitioners.

They held the view that pregnancy-related illnesses can be handled by contemporary treatment and medicating as well as proper nutrition and the right diets for women. But it was clear from the 35 responses of the respondents of the study that within the whole community, the post-self-medication and home remedy was the stage at which the conventional treatment of antenatal care was adopted. Older generation stood in support of antenatal care but they viewed this with the understanding that it should only be administered in cases where there are alarming health concerns for the mother and the baby during the state of pregnancy.

Wallerstein provided an explanation under world system theory that rich nations do not just grow but they also take advantage of the weaker nations. Villages are like important periphery cores of major cities. Villages collectively qualify for the largest share of nearly all health and educational resources earmarked by the national planning authorities. Villages are providing low cost work force and raw materials for developing cities to boost their income level.

7. RECOMMENDATIONS

The government should be proactive in initiating workshops targeting newly nuclear couple families to counter the scarcity of knowledge concerning prenatal and antenatal relations. Majority of Midwives as well as nurses would be effective in stepping in to increase the local population's participation.

Governments should ensure provision of adequate healthcare services in government owned health institutions in remote villages or rural settings.

Policies should be developed by Government for the purposes of raising awareness among rural populations.

CONFLICT OF INTERESTS

None.

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