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Signalling, status and inequities in maternal healthcare use in Punjab, Pakistan☆

Zubia Mumtaz[a,*], Adrienne Levay[a], Afshan Bhatti[b], Sarah Salway[c]

[a] School of Public Health, University of Alberta, 3-309 Edmonton Clinic Health Academy, 11405 – 87 Ave, Edmonton, AB T6G 1C9, Canada
[b] Real Medicine Foundation Pakistan # 70, Nazimuddin Road, F-7/4 Islamabad, Pakistan
[c] School of Health and Related Research, University of Sheffield, Regent Court, 30 Regent Street, Sheffield, S1 4DA, UK

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ABSTRACT

Despite rising uptake of maternal healthcare in Pakistan, inequities persist. To-date, attempts to explain and address these differentials have focused predominantly on increasing awareness, geographic and financial accessibility. However, in a context where 70% of healthcare is private sector provided, it becomes pertinent to consider the value associated with this good. This study examined patterns of maternal healthcare use across socioeconomic groups within a rural community, and the meanings and values attached to this behaviour, to provide new insight into the causes of persistent inequity. A 10-month qualitative study was conducted in rural Punjab, Pakistan in 2010/11. Data were generated using 94 in-depth interviews, 11 focus group discussions and 134 observational sessions. Twenty-one pregnant women were followed longitudinally as case studies. The village was comprised of distinct social groups organised within a caste-based hierarchy. Complex patterns of maternal healthcare use were found, linked not only to material resources but also to the apparent social status associated with particular consumption patterns. The highest social group primarily used free public sector services; their social position ensuring receipt of acceptable care. The richer members of the middle social group used a local private midwife and actively constructed this behaviour as a symbol of wealth and status. Poorer members of this group felt pressure to use the aforementioned midwife despite the associated financial burden. The lowest social group lacked financial resources to use private sector services and opted instead to avoid use altogether and, in cases of complications, use public services. Han, Nunes, and Dreze's (2010) model of status consumption offers insight into these unexpected usage patterns. Privatization of healthcare within highly hierarchical societies may be susceptible to status consumption, resulting in unforeseen patterns of use and persistent inequities. To-date these influences have not been widely recognised, but they deserve greater scrutiny by researchers and policy-makers given the persistence of the private sector.

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Introduction

Pakistan is one of six countries contributing to over half of all maternal deaths worldwide (Hogan et al., 2010). In its efforts to meet the targets of Millennium Development Goal 5 (MDG5), the government has focused on improving the delivery of both facility-based and domiciliary maternal healthcare by strengthening district health services' technical and managerial skills and creation of demand. It is assumed these will lead to the provision of optimal quality of care (Government of Pakistan, 2006). Consequently, some improvement in service availability and levels of use has occurred, particularly antenatal care usage, which doubled from 32% to 61% between 1995/6 and 2006/7 (DHS, 2008).

However, as services are becoming more available, inequities in use between the rich and poor are also increasing (DHS, 1992, 2008; Mahmood, 2010). The 2006/7 Demographic and Health Survey found that 92% of women in the highest wealth quintile reported seeking ANC compared to 37% of women in lowest quintile; 74% of women in the highest wealth quintile delivered in a health facility compared to just 12% of women in the lowest quintile (DHS, 2008).

Inequities between the rich and poor in maternal healthcare usage are well documented across the global south and a large body of research seeks to understand and address the underlying factors that restrict uptake of services (Amin, Shah, & Becker, 2010; Aremu,

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* Corresponding author. Tel.: +1 780 492 7709.
E-mail addresses: zubia_mumtaz@yahoo.com, zubia.mumtaz@ualberta.ca (Z. Mumtaz), adrienne.levay@ualberta.ca (A. Levay), s.salway@sheffield.ac.uk (S. Salway).

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Lawoko, & Dalal, 2011; Barros et al., 2012; Thind, Mohani, Banerjee, & Hagigi, 2008). To-date, this work has focused predominantly on supply-side factors, particularly increased geographical accessibility and quality of services (Thind et al., 2008), and some demand-side factors, including, levels of awareness and knowledge and ability to pay (Amin et al., 2010; Aremu et al., 2011).

While this work has provided useful insight and direction to policy and practice interventions, it appears to paint a partial picture of the factors that shape and constrain maternal healthcare use. This incomplete understanding is suggested by the disappointing and unanticipated outcomes of some interventional approaches aimed at addressing these obstacles. For instance in Pakistan, a 10-district maternal healthcare intervention that focused on improving service quality and creating demand, reported an increase in facility deliveries across the districts from 62% to 74% among the highest wealth quintile but no improvement among the lowest wealth quintile (18 to 17%) (Mahmood, 2010). Furthermore, the National Maternal, Newborn, and Child Health (MNCH) program has aimed to improve service delivery in the public sector, assuming it will be used by the poor. However, national data shows that 84% of women who sought delivery care from the public sector were non-poor (Mahmood & Bashir, 2012).

This backdrop suggests the need for more careful exploration of the social, economic and cultural contexts within which maternal healthcare seeking behaviour is situated. Early anthropological work has usefully described the gender context (Winkvist & Akhtar, 2000) as well as the existing social structures (Mohmand & Ghazdar, 2007) in Pakistan in general. Further, some studies have sought to illuminate the ways in which these structures and processes shape and constrain access to healthcare, with useful recent contributions addressing women's gendered position within households, limited decision-making authority (Bhatti & Jeffery, 2012; Mumtaz & Salway, 2009), and issues of social accessibility (Mumtaz & Salway, 2005). The present paper adds to this important body of work by pursuing a line of enquiry that has to-date received little attention within the maternal healthcare literature; namely the meaning and value attached to maternal healthcare consumption.

Much of the research on maternal healthcare use in the global south assumes that use of such services is fundamentally linked to their inherent utility in relation to enhancing the health of the mother and/or unborn child. Though not all studies are explicit about their theoretical underpinnings, these approaches tend to align with psychological models of healthcare utilization that foreground the interplay of perceived threats to health and benefits of (or need for) particular health behaviours on the one hand with the obstacles (or disincentives) to such behaviour on the other hand, for instance the Health Belief Model (Rosenstock, Stretcher, & Becker, 1988) or Andersen and Newman's health-seeking model (Andersen & Newman, 2005).

Such models have been widely applied within health services research, but can be critiqued for their failure to consider the possibility that healthcare behaviours and services may be adopted – at least in part – for reasons other than their perceived health-enhancing effect.

The consumption of goods and services for reasons other than their direct utility, particularly for their symbolic meaning, has been widely documented within economic and sociological literature (Richins, 2011; Witt, 2010). Further, the links between consumption, social position and status distinctions have long been the subject of empirical observation and theoretical debate (Aydin, 2006; Bourdieu, 1984). Heterogeneity in use of goods or services is a common feature of consumption. While some suggest that this fragmentation reflects individual taste and style (Pakulsky & Waters, 1996), others argue that fragmentation appears along socio economic lines (Aydin, 2006; Manza & Brooks, 1998) and serves to maintain social distance between hierarchically structured groups.

In general terms, the growing commodification of healthcare is widely recognized (Henderson & Petersen, 2002; Pelligrino, 1999) and its potential to encourage unnecessary or even harmful patterns of healthcare use has been documented in varied contexts. For example in Vietnam, ultrasounds in pregnancy have become a highly profitable service, with some women reporting having gone for one or more ultrasounds per month (Gammeltoft & Nguyen, 2007). Furthermore, patterns of healthcare consumption that suggest motivational factors beyond inherent health-enhancing utility have been noted in some settings. For instance, a recent commentary in the United States suggests that use of midwives by the wealthy elite in Manhattan has become a status symbol, as well as being associated with a more natural birth experience (Pergament, 2012). The potential relevance of status signalling processes to understanding patterns of maternal healthcare utilization clearly deserves greater attention.

An exploration of the patterns and meanings of maternal healthcare consumption is particularly pertinent to Pakistan. Privatization of the health sector has been aggressively pursued in Pakistan since the 1990s as part of its structural adjustment program (World Bank, 1998). Consequently, as of 2005, 74% of the total health expenditure was from the private sector (World Health Organization, 2013). Evidence also suggests that private sector services are perceived to be superior to public sector care (Irfan & Ijaz, 2011). In addition, Pakistan is recognized as a highly unequal society with ideologies and social processes acting in consort to perpetuate rigid gender and socio economic hierarchies (Easterly, 2001; Mumtaz, Salway, Shanner, Bhatti, & Laing, 2011). Furthermore, although there have been significant public sector investments in improving maternal healthcare services, concerns remain regarding low uptake among the poorer sections of the population (Mahmood, 2010). The present study sought to provide new insight into the factors shaping maternal healthcare utilization by examining in detail the patterns of use across socioeconomic groups within one community, and the meanings and values attached to this behaviour.

Methods

The findings presented in this paper form part of a larger study aimed at developing a detailed understanding of the influence of caste and gender hierarchies on maternal health. A ten month study (May 2010–February 2011) was conducted in Ganji village; district Chakwal, northern Punjab. Given that no one village can represent an entire country, Ganji (population 1229) was selected because it was socio economically heterogeneous. District Chakwal is relatively well-developed and can be considered representative of conditions in Northern Punjab. Land-holdings are small compared to southern Punjab. Consequently men seek work beyond the village, commonly in the military and related industry. Poverty levels are therefore somewhat lower compared to southern Punjab. A critical ethnographic approach was used (Geertz, 2000; Wainwright, 1997). Four inter-related phases of data generation were involved: (1) Familiarization and rapport building (four social mapping exercises, home visits and a demographic survey of all village households. The survey collected basic socio-demographic data of all the village residents and included education, occupation, caste, landownership and maternal health services use in the preceding five years); (2) Exploration of social norms, everyday practices and their relation to childbearing (observations and informal interviews, mapping of behaviours and decision-making processes for 18 pregnant women, in-depth interviews with 34 young women, 27 older women, 20 young men, and 13 older men). These methods also enabled us to document behaviours and decision-making processes around seeking maternal healthcare as

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