Volume-3

Qualitative Formative Research Findings - Khanewal

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Pakistan Initiative for Mothers and Newborns

The Pakistan Initiative for Mothers and Newborns (PAIMAN) is a five-year United States Agency for International Development (USAID) funded project designed to reduce country's maternal and neonatal mortality by making sure women have access to skilled birth attendants during childbirth and through out the postpartum period. PAIMAN works at national, provincial and district levels to strengthen the capacity of public and private health care providers and improve health care system infrastructure. The PAIMAN Program is jointly implemented by John Snow Inc (JSI), the Johns Hopkins Center for Communication Programs (JHU/CCP), Agha Khan University, Contech International, Greenstar Social Marketing, Population Council and Pakistan Voluntary Health and Nutrition Association (PAVHNA) .

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Study 1:
From Pregnancy to Newborn Care:
Health Seeking, Birth Preparedness/Complication Readiness, Religious and Cultural Practices

Report - Study 1 (Volume 3)
Findings: Khanewal, Punjab

In-depth Interviews (IDIs) with Married Women, Husbands and Family Members

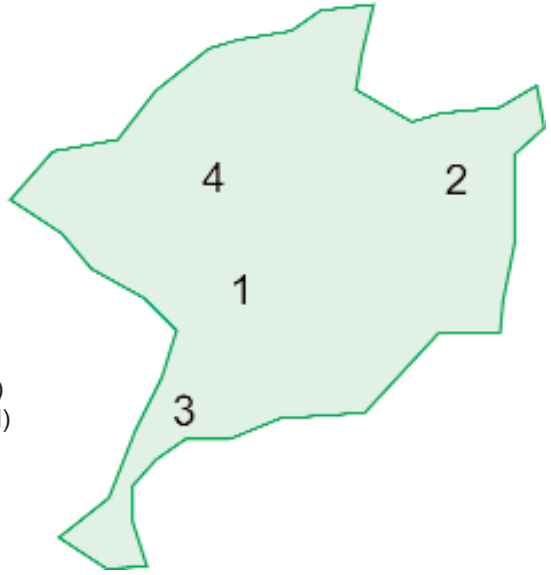
3. Findings - District Khanewal (Punjab)

3.1 District Profile

Khanewal, a district of Punjab province. It is an agriculture area with no significant industry. The population of the district in 1998 was 2,430,000 (52% males and 48% females) with 65% people in rural areas and 35% in urban areas. The population density was 138 persons per square kilometer and an annual growth rate of 2.1%[1]. For admistrative purposes, the district has been divided into 4 Tehsils namely Khanewal, Mian Channu, Kabir Wala and Jahanian.

There is one District Headquarters Hospital (DHQH), 3 Tehsil Headquarters Hospital (THQHs), 4 Rural Health Centers (RHCs), 82 Basic Health Units (BHUs) and 4 Maternal and Child Health Centers (MCHCs).

Figure 3.1: Map of the district with Location of Sampled Areas



Sampled Areas:

1. Shanti Nagar (rural)
2. Chak 136/10-R (rural)
3. Kita Budhana (rural)
4. Jatala Town (urban)

[1] Population Census Report, 1998

3.2 Participants Characteristics

A total of 40 interviews were conducted with the distribution given in Table 3.1.

Table 3.1: Distribution of In-depth Interviews

Area	Number of Interviews					
	Currently Pregnant Women	Women with Live Birth	Husbands		Family Members	
			CP*	LB*	Male	Female
Kita Bhudhana (Rural)	3	3	1	1	0	2
Jatala Town (Urban)	3	3	1	1	0	2
Shanti Nagar (Rural)	3	3	1	1	0	2
Chak 136-10/R	3	3	1	1	1	1
Total 40	12	12	4	4	1	7

Note: CP= currently pregnant, LB= woman with live birth

The ages of participants were: women from 20 to 38 years with the mean of 26.6 years, husbands 27 to 50 years with mean of 35.8 years, and family members 35 to 70 years with mean of 49.3 years. Their living children ranged from 0 to 9; the number of sons ranged from 0 to 6, and the number of daughters ranged from 0 to 9. The age of the youngest child of women participants was 2 to 8 years. The age of the youngest child of the male (husband) and family member participants was 4 months to 4 years and 4 to 20 years respectively.

Several women (15 out of 24) had no schooling, some (8 out of 24) completed grades ranging from 1 to 10, with one woman reported having completed high school (12th grade). In contrast only one-fourth of the husbands interviewed had no schooling while 6 had education from primary to grade 10 level. Three-quarters of the family members had no schooling and 2 had attended school up to the primary level.

The husbands reported working in the following occupations farmer, shopkeeper, carpenter, laborer, mason. Male family members interviewed had no occupations and all the women were housewives.

All the participants spoke Punjabi language.

All of the 10 participants from Shanti Nagar (6 women, 2 husbands and 2 family members) were Christians.

a. Current Maternal Health Seeking Behaviors and the

3.3 Key Factors that Facilitate or Hinder Maternal Health Seeking Practices.

Health seeking behavior and practices of an individual or family is influenced by several factors, such as the felt need, importance given to disease prevention and health promotion during different stages of life, severity of symptoms if ill, whether the condition can be shared with others or not, access to health services, behavior of and confidence in the staff, availability of financial resources, etc. The behaviors recorded in the Khanewal district, and the factors that influence them are presented below.

3.3.1 Recognition of and reaction to pregnancy

In general, the recognition of pregnancy is early by the women, both in urban and rural areas. Majority of the women presume that they are pregnant, if the menses are over due by few days to three weeks, especially if they have one or more associated symptoms such as nausea, vomiting, giddiness, weakness, lethargy, repugnance to smell. Few women diagnosed it mainly on the basis of symptoms, while very few become worried on the appearance of symptoms and sought help from the health care providers, who diagnosed the pregnancy.

Discussing the subject, a woman with a live birth in Shanti Nagar (rural area) gave information about recognition of pregnancy as follows: "(I) was vomiting, felt nausea, and also my menses where overdue by two days, so I came to know (that I was pregnant)" *(Ultian aati theen, dil kharab hota tha, aur is kay alawa mahwari nahi aai, do din upar hui tou pata chal gya).*

About half of the women interviewed sought either diagnosis or confirmation from a health care provider. Most saw a doctor, while a few went to the dai. Interestingly, more women of rural area than urban area got the pregnancy confirmed by the female doctor, some of these through urine test or ultrasound. A currently pregnant woman from Chak 136-10/R (rural) describing this said: "(I) was having palpitations, and menses were overdue by 4 days, therefore got the check up done from the doctor" *(dil mein ghabrahat ho rahi thi, aur char din mahwari kay bhi upar ho gaye to mein ne doctor ko check karwaya).*

Most of the women stated that they shared this news first with their husband with similar pattern in urban and rural areas, indicating that the level of spousal communication is high in this district, both in urban and rural areas. A woman with a live birth in Jatala Town stated: "First of all I told my husband, it is necessary to inform him" *(Sab se pehlay mein ne apnay shohar ko bataya tha, khawand ko batana zaroori hota hay).*

Next, the mother-in-law, other female members of the house, mother, sister, *sotan*[2] were informed. The reasons for informing other family members were mainly to share the happiness and to get family support during pregnancy. Very few also discussed aborting the pregnancy. Few women also informed the LHW their purpose was being either for seeking advice for the pregnancy care or for abortion.
Participants reported varied emotions on learning about their pregnancy. Most of them reported happiness and they had 0 to 9 children.

[2] Sotan: husband's other wife

A husband in Jatala Town (urban area) with 7 living children said: " I am very happy on this pregnancy, because when I got the ultrasound done the doctor told me it is a son, so I felt very happy" *(Is hamal ki mujhey bahut khushi hay, kyunke doctor se ultra sound karwaya tou doctor ne mujhey baita bataya tou mujhey bahut zyada khushi hui).*

A woman with a live birth (on her sixth pregnancy, but with 4 living children) in Kita Budhana (rural area), while expressing her feelings said: "I felt happy as my two daughters have died earlier" *(Mujhey Khushi hui kyunke is se pehlay meri dou betyan foat bhi ho gai theen).*

None of the husbands or family members expressed unhappiness with regards to the pregnancy. However, some women expressed unhappiness on learning about the current or last pregnancy. Among those who expressed unhappiness were women with 0-4 living children. The reasons for unhappiness mentioned by women were: youngest child is too young or too many children. One woman quoted "poverty" as her reason for being unhappy. Another currently pregnant woman in Kita Budhana (rural area) mentioned death of a previous child as the reason and she feared this pregnancy: "One of my child died before this pregnancy, that infant lived for fifteen days. When I learnt about this pregnancy, I became afraid that may God forbid this baby may also not live. Hence, I told my husband that I will get this aborted but he refused" *(Is hamal se pehlay meray aik bacchay ki wafat ho gae thi, wo baccha pandra din zinda raha, jab mujhey is hamal ka maloom hua tou mein dar gae kay khuda na khwasta ye baccha bhi nahi bacchay ga, is liyae mein ne khawand se kaha ke zai karwa deti hun tou us ne mana kar dya).*

Importantly, many of the women who expressed unhappiness also mentioned the desire for abortion (5 out of 8) but could not implement it due to various reasons, such as abortion was believed to be a sin by her, husband, mother-in-law or sister-in-law forbade to do so or the desire to have more sons. One woman mentioned resorting to alternative methods (such as eating forbidden foods) for abortion:

A woman with live birth (second child) in Shanti Nagar (rural area) said: "I did not feel very happy because my child was only one and a half year old. When I learnt about the pregnancy, I started crying. When I told my husband, he brought dried dates for me to eat and abort" *(Mujhey bahut zyada khushi nahi hui, kyunke mear baccha abhi dairh sal ka tha, mujhey hamal ka pata laga tou mein ronay lagi. Khawand ko bataya tou us ne choaray la kar diyae take mein khaon aur hamal zai ho jai).*

From the above, it is clear that:

- Recognition of pregnancy is mostly early and its clinical confirmation is also sought by about half of the woman, both in urban and rural areas.
- Most of the women shared the news of pregnancy first with their husbands indicating that inter-spousal communication is high, which reflects that women do perceive a role of husbands in the process.
- There is also sharing of the news with other family members in hope of getting their favor or support.
- About one-third women reported unhappiness on learning about the pregnancy, and many of them desired abortion indicating a high unmet need for family planning

3.3.2 Health-seeking behavior adopted at home

The participants reported behavioral changes by women and her family on learning about the pregnancy. These are related to food intake, daily routine, rest, etc.

Food intake: About half of the women (several currently pregnant and some of the women with live birth) mentioned that they increased their food intake during pregnancy. Majority of the husbands and very few family members interviewed had similar opinions. This is noticeably high among women in rural areas as compared to urban area as only one urban woman mentioned it. It was stated that this care was mainly initiated by family members followed by husbands or self.

The most commonly reported food items of increased intake mentioned by all groups were milk and fruit, while a few mentioned *Desi ghee*[3]. None mentioned increase in meat/beef, eggs, pulses and *roti*[4]. Rarely mentioned items were dried fruits, butter, vegetables, *suji*[5], *panjiri*[6] *giri*[7], *kamarkas*[8]. The reason commonly mentioned for the increased intake of the preferred items was that they provide strength.

Table 3.2: Preferred Foods During Pregnancy

Foods	Preferred Foods by Number of Participants																		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Fruit	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
Milk	■	■	■	■	■	■	■	■	■	■	■								
Desi ghee	■	■	■	■	■														
Rice	■	■																	
Vegetables	■	■																	
Juice	■	■																	
Choori[9]	■																		
Dry Fruit	■																		
Meat	■																		

Apples, bananas and oranges were the most commonly consumed fruits, while a few participants also mentioned eating grapes, melons, guavas, or other seasonal fruits. However, the frequency of intake of fruits is not specified by many. The increased intake of milk was reported to be on a daily basis. This increase was reported more frequently by women in rural areas, which ranged from 200 ml to one liter per day.

A woman with live birth from Shanti Nagar (urban area) expressed this increased intake as: "(I) changed my intake, for example (I) used to take either one banana or apple, and about half liter milk in a day, (I) would drink quarter liter in the morning and quarter in the evening" *(tabdeele ki khanay*

[3] Desi Ghee: clarified butter
[4] Roti: Jesus bread/flat bread made from wheat
[5] Suji: Semolina
[6] Panjiri: a sweet food made with whole wheat, clarified butter, nuts and herbs
[7] Giri: coconut pieces
[8] Kamarkas: a herb
[9] Choori: roti soaked in clarified butter

mein fruit maslan. Kaila aur saib mein din mein aik zaroor leyti thi, aur doodh bhi din mein adha kilo, aik pao subah aur aik pao sham ko piti thi).

A husband in Kita Budhana (rural area) mentioned about the increased food intake in the following words: "Did not make any change in the first month, as she would vomit on eating anything, then the diet was improved from third/fourth month. (I) gave her milk and she used to drink up to half liter. Apple and other fruits were given every second or third day" *(Pehlay mahinay tou koi tabdili nahi ki thi kyunke wo jo bhi khati thi ulti aa jati thi, phir teesray chothay mahinay mein khoraak achi kar di thi, doodh dya tha, adha kilo tak pee layte thi, saib waghera har doosray teesray din daitay hain).*

One-fourth of women and very few family members reported **decreased intake** of food during pregnancy, while none of the husband mentioned it. The reasons quoted were nausea or lack of desire to have food. Also, another one-fourth of women and husbands and most family members mentioned that there was **no change** in food intake. However, no specific reason for not changing their diet was given except by one woman, who expressed that her diet was good even before the pregnancy hence she did not felt the need to increase it.

Only some (one-third) women and husbands did not mention any **forbidden foods** during pregnancy, while the remaining specified foods that were forbidden to maintain health of the mother or the fetus. The forbidden foods, predominantly mentioned were *garam foods*[10]. These included fish, eggs, meat/beef, dry fruit, *lassi*[11], *ghee*, fried items like *pakora*[12] *and samosa*[13], sour and spicy items *(achar, chutney*[14]*)*. The reasons given were that *garam* (hot) foods can cause abortion. Other forbidden items mentioned rarely were vegetables that can produce "gas" inside the body (brinjal, spinach, carrot, radish, cauliflower, potato, *karaila, sund*), rice, pulses, anis seed, tea, sweets, orange, Japanese fruit, lemon.

A woman with a live birth in Jatala Town (urban area) explaining forbidden foods said: "Garam foods are prohibited as they could lead to bleeding and blood clots during pregnancy. Hot things include egg, meat/beef, dried dates" *(garam cheezain mana kartay hain kay kisi bhi waqt hamal mein khoon aa sakta hay, khoon kay lothray aatay hain, garam cheezon mein anda, ghosht aur choaray ho saktay hain).*

A husband in Shanti Nagar (rural area) described other forbidden items and said: "*Garam foods* like spinach, mustard leaves and brinjal should not be eaten. These can cause miscarriage" *(garam cheezain palak, saag, aur baingan na khai, is se hamal gir sakta hay).*

A mother-in-law in Jatala Town (urban area) specified forbidden timings also and said: "(she) cannot eat radish and carrot in the evening, (these) can cause abdominal pain" *(sham kay waqt moli, gajjar nahi kha sakti, dard pait mein ho sakta hay).*

[10] Garam Foods: foods that are considered to have hot effects inside the body
[11] Lassi: yoghurt based drink
[12] Pakora: Vegetable fritters deep fried in chickpea batter
[13] Samosa: Potato or meat fritter wrapped in dough and deep fried
[14] Achar, Chutney: Pickles

Table 3.3: Forbidden Foods During Pregnancy

Foods	Preferred Foods by Number of Participants																		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Dry fruits	■	■	■	■	■	■	■	■	■										
Eggs	■	■	■	■	■	■	■	■											
Meat	■	■	■	■															
Pickle	■	■	■	■															
Fish	■	■	■																
Spinach	■	■	■																
Ghee/fried items	■	■	■																
Carrot	■	■																	
Radish	■	■																	
Potato	■	■																	
Banana	■	■																	
Mango	■	■																	
Rice	■	■																	
Brinjal	■																		
Cauliflower	■																		
Bitter gourd	■																		
Lemon	■																		
Pulses	■																		
Hot roti	■																		
Sund[15]	■																		
Sweets	■																		
Anis seed	■																		
Tea	■																		
Orange	■																		
Japanese fruit	■																		

Daily routine: Several of the women participants (14 out of 24) reported that they decreased their daily work routine. Interestingly, more rural women decreased their daily work as compared to urban women. The timing of decreased work varied with only a few individuals reporting that they decreased workload from the first trimester. The work decreased varied from individual to individual, but mostly reduction was in strenuous work such as lifting of animal fodder, water buckets, sweeping floors, washing clothes, etc. A few mentioned that they kept a maid to support them.

A woman with live birth in Kita Budhana (rural area) explaining the rest said: "I stopped working when I became pregnant and kept a maid for working, I did not do any work" *(Jab mujhey hamal hua tou mein ney kam waghera chore dya, aur kam kay liyae mai rakh li, aur mein koi kam waghera nahi karti thi).*

Another woman with live birth in 136/10-R (rural area) describing a decrease in her work load said: "I stopped doing some of the household work like sweeping instead did light work that I could do while sitting like dish washing and cooking, (I) avoided strenuous work, for example did not carry fodder for buffaloes because that could cause miscarriage " *(Kam mein ne kuch chore diyae thay, jharo nahi deyti thi, halka phuka kam karti thi, baithnay walay kam*

[15] Sund: A paste of dried ginger

karti thi, bartan dhona, handi roti bana leyti thi, wazni kam nahi karti thi, bhainson ka chara waghera nahi uthati thi, kyunke in kamo mein baccha zai honay ka khadsha hota hay).

All husbands and some of family members (3 out of 8) reported that the work-load has been/was decreased during pregnancy. A husband in Shanti Nagar (rural area) said: "Stopped (her) from doing all heavy work such as lifting of water buckets, decreased lifting of animal fodder, and (also) decreased work that involved prolonged sitting such as cooking food, sweeping, etc. Increased (her) rest period by 2-3 hours"*(Saray bhari kam rok diyae thay maslan pani ki balti uthana, janwaron ka chara uthana wagera kam kardiya tha, zyada baith-nay wali cheezain kam kar di theen yani handi pakana, jharo lagana wagera. Aram mein do se teen ghantay barha dya tha)'"*

From the information presented above, it can be concluded that:

- Some positive changes in life style of pregnant women were reported by all groups of participants.
- Half of them reported increase in food intake but not in sufficient quantity as mainly increase in intake of milk and fruits were mentioned. Rural women had more increase food intake than urban women.
- Several healthy food items, especially those rich in proteins are forbidden during this period, especially those considered to have "hot" effects and can cause miscarriage.
- About one-fourth women decreased their intake of food due to pregnancy associated symptoms such as nausea and vomiting.
- Several women were also able to decrease their routine work, especially heavy work and again more participants in the rural areas mentioned this.

One possible explanation for the lower levels of reported positive behaviors in the urban area is that the people in the sampled area were very poor.

3.3.3 Perceptions of required health services in pregnancy, delivery, and postpartum

Pregnancy: Most of the participants (33 out of 40) believed that check up should be done during normal pregnancy. Majority of them reported a preference for skilled providers namely the doctor/hospital, while few suggested seeking health services from LHV, LHW or Dai. The various purposes identified for seeking health services included: check up of the status and position of the fetus, weight and blood pressure of the mother, identification of any abnormality in the mother or fetus, prescriptions or tablets for "strength" and tetanus toxoid vaccinations.

A woman with live birth in Jatala Town expressed: " (the pregnant woman) should get the check ups done to know the status of fetus, blood pressure should also be checked and ultrasound should be done to know the position of the fetus" *(check waghera karatay rehna chahiyae taki pata chal sake kay bacchay ki kya halat hay. Blood pressue waghera bhi check karana chahiyae, ultrasound karwa lena chahiyae take pata chalay kay baccha kis rukh ka hay).*

A husband in Shanti Nagar (rural area) stated: "Antenatal check up should be done from a doctor every month so that he could advise about the proper diet" *(Hamal ka check up karana chahiyae aur doctor se har mahinay karana chahiyae takay doctor khoraak kay baray mein sahi cheezain bata sakein).*

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The frequency of visits for check up was suggested by few and it ranged from every week to every month.

A currently pregnant woman in 136-/R (rural area) supporting regular check up stated: "*(She) should go to hospital (and) get check up done every month, get weight checked, take medicines that are prescribed" (haspatal jana chahiyae, har mahinay check up karwao, wazan karwao, jo dawaiyan wo batain, wo khao).*

Only some participants (13 out of 40) mentioned about the need for getting tetanus toxoid (TT) injections during pregnancy that is far below the optimal level.

A woman with live birth from Shanti Nagar (rural area) stressing on importance of vaccination said: "Vaccinations should also be done, three injections are given [during pregnancy] that should be taken" *(Hifazati teekay bhi lagwanay chahiyan, teen teekay lagtay hain wo zaroor lagwanay chahiyan"*

Delivery: About half of the women (12 out of 24) stated that the services of dai should be sought for delivery, while the other half preferred hospitals/doctor as the first choice. Very interestingly, more urban women preferred dai than rural women (again the low socio-economic status of the urban sample might account for this).

A currently pregnant woman in Jatala Town (urban area) favoring deliveries by dai and said: "Consult the dai and get the delivery conducted by her at home. If she says that it could not be conducted at home, then think about other options" *(dai se mashwara huna chahiyae, aur ghar pe hi paidaish dai kay sath karni chahiyae, agar dai kahe kay ghar par nahi ho sakti to phir kuch aur sochna chahiyae).* Statements like these indicates a lack of complication readiness and points out the delay that is likely to occur due to no prior planning for rushing the women to appropriate place in case of an emergency.

Most woman and husbands who preferred dai as the first choice stated that in case she cannot handle then either the doctor should be called home or the woman should be taken to a doctor or hospital. The reluctance to seek care outside of the home setting is evident from the response that even in an emergency situation it is better to call a doctor at home rather than directly moving towards a hospital. A woman with live birth in Jatala Town expressed this: "Delivery should be conducted by dai at home but incase of any complication, a doctor should be called" *(zichgi ghar mein dai se karwani chahiyae liken agar koi masla ho jai to doctor ko bula lena chahiyae)*

Several husbands and very few family members preferred skilled provider (doctor, LHV, nurse) for the delivery. A husband in 136-10/R mentioned: "Women should get their delivery done from an experienced LHV" (Aurton ko delivery tajrabakar LHV se karvani chahiyae). This position was reversed with regards to using the Dai for delivery, when very few husbands and many relatives showed faith in the services provided by dai. As expressed by a husband in Kita Budhana (rural area): "(We) will give whatever dai will prescribe during delivery, for example injections are given, but if the woman (in labor) has enough strength (to push), she should not be given facilitation" *(zichgi kay doran jo dai batai gi wo hi dain gay, maslan teekay waghera lagatay hain, agar aurat kay pas apni taqat zyada hay tou us waqt koi sahulat nahi deni*

chahiyae).

One mother-in-law from Kita Budhana suggested a spiritual service for facilitating delivery, and stated: "At the time of delivery, (woman) takes good diet, injections for strength. We have a man here who gives *gur*[16] with *dum*[17] to facilitate in delivery, we call that *chotkaray ka gur*[18] *(gur that gets rid of the fetus)" (baccahy ki paidaish kai waqt khanay penay ki achi cheezan letey hain, taqat kay teekay waghera leti hain aur yahan aik Bhai ghar mein gur par dum kar ke daita hay, is se bacchay ki paidaish jaldi hoti hay, use chotkaray ka gur kehtay hain).*

Postpartum: Except very few, all participants believed that there is no need to seek any health services from skilled providers during the postpartum period. Only few participants from both rural and urban areas mentioned that doctor's help should be sought if there is any complication. Almost half of the women mentioned that the services of dai are needed for conducting massage in the postpartum period, and this opinion was also supported by some family members. Many women and men emphasized having good diet and rest in this period, while very few mentioned cleanliness.

Inference drawn from above is that:

- Encouragingly, many of the participants believed that there is need for seeking skilled health care for normal pregnancy, and majority of them expressed need for check up by a doctor.
- The perception regarding the need for TT vaccination is low
- Despite the belief that normal pregnancy check-ups should be done via skilled providers including doctors. With regards to delivery services, half of the women and a majority of the family members favored services from the dai. Among the different groups of participants only husbands remained more in favor of skilled providers during delivery.
- In order to receive timely and appropriate care it is important that the key decision makers agree on when and from whom to seek care. In this regards the divergence of opinions among family members and husbands is relevant keeping their important role in decision making in mind.
- Almost all participants believed that there is no need for seeking health care in case of a normal postpartum period.

3.3.4 Availability of services to women and their utilization

In Pregnancy: In rural and urban areas, the commonly available health services for pregnant women within their community are those provided by LHWs and Dai and by few paramedics like dispensers and LHVs. These are given in Table 3.4.

LHWs were available in all areas, and many women, family members and husbands reported utilizing their services for antenatal care (ANC). This included availing advice for diet, etc. and supplements like iron and vitamins. A few also mentioned receiving TT injections from them.

[16] Gur: raw sugar
[17] Dum: verses from Holy Quran are read and then the breath air is blown over the individual or water, which is then used for drinking
[18] Chotkaray ka gur: gur that gets rid of the fetus

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Table 3.4: Services Available in the Community for Maternal Care

Jatala Town (urban)	Kita Budhana (rural)	Chak 136-10/R (rural)	Shanti Nagar (rural)
● dai ● LHW ● *Buzurg*[19] *	● dai ● LHW ● Private Clinic ● *Moulvi*[20]	● dai ● LHW ● BHU ● Private Clinics with male and female doctors ● Chemists	● dai ● LHW ● Visiting doctors ● *Hakim*[21] ● Priest of the Church

**buzurg's* (elderly pious man) prayers are sought for having a son.

A currently pregnant woman in Shanti Nagar (rural area) praised the services of LHWs in the following words: "LHW is here, she gives us all kinds of medicines and good advises" *(yahan LHW hay, ye hamein har qism ki dawaiyan dey kar jati hay aur achay mashwaray deiti hay).*

A husband in Jatala Town also appreciated the work of LHWs and said: " In our area LHW is present for (giving services to) pregnant women, she visits us at home and gives advice" *(hamaray ilaqay mein hamla aurton kay liyae LHW mojood hay. LHW gharon mein aati hay aur mashwaray deyti hay).*

Some participants reported utilizing the services of the dai during pregnancy for assessing the month of pregnancy, check up and treating problems.

A woman with live birth in Chak 136-10/R said: "Here most of the people are poor who get the check up done for pregnancy from dai" *(Yahan zyada tar gharib log hain jo hamal ka check up bhi dai se karatay hain).*

Male paramedics are utilized for treatment of minor ailments during pregnancy and also TT vaccination.

The utilization of BHU services for pregnancy was mentioned rarely.

Delivery: In both urban and rural areas, dai was mentioned as the main available service provider for delivery.

Besides the dai, in two rural areas the services of nurses or LHV were being acquired for delivery. In Shanti Nagar nurses from Civil Hospital Khanewal comes to conduct deliveries at home, while in Chak 136-10/R, few mentioned utilizing the services of LHV.

Postpartum: Several participants, both in urban and rural areas, mentioned the availability of the services of the dai for postpartum period. A Dai is mainly sought for conducting massage, and providing advice for care at home in this period.
Very few also mentioned the dai's role in conducting household chores and

[19] Buzurg: elderly pious man
[20] Moulvi: Imam of the mosque
[21] Hakim: A physician using herbal remedies

taking care of the child.

A currently pregnant woman in Jatala Town described the services of dai as follows: "Dai is available during postpartum period (and) we call her, she tells us if there is any problem, we follow her advice and do whatever she says"*(Chillay mein dai hay, usey ko bula laytein hain, koi masla ho tou bhi wohi batati hay, ham ne usey kay mashwaray se chalna hota hay, jo wo kehti hay ham wahi karte hain).*

A woman with live birth in Chak 136-10/R (rural area) said: "Dai should visit during postpartum for massage, household work and to bath the newborn" *(Chillay kay doran dai aani chahiyae jo dabai aur malish karay, ghar ka kam karay aur bacchay nehlai).* Very few mentioned that LHWs are available in the area that can provide treatment, if required. Their advocacy for breastfeeding was also mentioned, though in rare cases.

Participants in all areas stated that **services outside the community** are accessible in Kabirwala (half hour by transport), Mian Chunnu (15 minutes), Jahanian (15 minutes) and main city of Khanewal (15 minutes) for pregnancy care, delivery and postpartum care. These included Civil Hospital, 3 THQHs, private female doctors, nurses, LHVs, dais and *hakim*. Participants mentioned that services in these facilities are good and they are availed according to the need and affordability.

Few mentioned that these are used even for normal pregnancy and delivery, while others mentioned that help from outside community is only sought in cases of complications.

The specific reasons mentioned for utilizing the services outside community are:

- Insufficient facilities within community
- Easy accessibility
- Better quality of care
- All types of facilities are available
- Free services in some facilities

A woman with live birth in Jatala Town described some of these reasons and said: "Government hospital is present outside the community, several private clinics exist, nurses are there, dais are there, all facilities exist and several women utilize them, (they are) easily accessible (and) not very far, transport is easily available" *(Ilaqay se bahar sarkari haspatal hay, bahut saray private clinic maujood hain, nursay hain ,daiyan hain, sari hi sahulatain hain aur bahut sari aurtain unko istamal bhi karti hain, aasani se pahonch mein hain, bahut zyada dour nahin hain, gari waghera mil jati hain)*

Another woman with live birth from Kita Budhana, giving other reasons said: "Here, people mostly go to Government hospital in Kabirwala, where operations are also performed, correct medicines are given, care is taken of the patient, the very best doctors are available, and whatever is required is given there" *(Log yahan kay zyada kabirwalay mein sarkari civil haspatal jatay hain, wahan par operation bhi kartay hain, sahi dawaiyan bhi daitay hain, khyal bhi rakhtay hain mareez ka, achay se achay doctor bhi hain, aur jis cheez ki zarorat ho wahi daite hain)*

A husband in Shanti Nagar praised the quality of care outside community in

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following words: "There are several (male) doctors and lady doctors in Khanewal, medical stores and hakims are also present. Preference is given to them as their service provision is very good, they provide complete information" *(Khanewal mein kafi doctor aur lady doctors maujood hain, medical store aur daise hakim bhi maujood hay. Inko ahmiyat is leay deti hain kay inke karkardigi bahut achi hay, sehat kay baray mein har cheez puri batatay hain)* A currently pregnant woman in Chak 136-10/R said: "People go outside (the community) mostly because there is no lady doctor here" *(Log zyada bahar is leay jatay hain kyunke yahan lady doctor nahi hay)*

Despite the positive reasons for seeking services outside of their community mentioned by several participants, there were others who reported that not all people utilize health services outside the community.

The major reason for not accessing services outside the community was poverty, while very few also mentioned other reasons such as family members do not allow one to go outside the community, or they felt that they have necessary services in their community and hence do not need to seek services outside of the community

In brief:

- Health services available to rural and urban women within their community for pregnancy care are mainly by LHWs. Some also reported utilizing dais, LHVs and dispensers. The use of LHWs and LHVs for pregnancy care points to the utilization of the formal health system during pregnancy. This could in turn serve as an entry point for programs designed to improve demand for MNH services.
- Very few also acquire special prayers from *buzurg, Moulvi*[22] or priests. This reliance on alternative and traditional forms of help and treatment is important as a means to focus attention on maternal health for example to use these systems as an entry point for messages or alternatively as a juxtaposition for trained and skilled services.
- Interestingly, despite the reliance on providers belonging to the formal health sector for pregnancy care, when it comes to delivery, the dai is considered as the main available provider and is most commonly utilized. The role of the dai extends from delivery to providing various medical and non-medical types of assistance in the postpartum period. Given this active and important role that the dai plays it is probably important to design interventions that utilize the services of the dai in appropriate ways rather than try to undercut her presence in the community.
- Participants presented a fairly positive picture related to the availability of services outside their community. This positive picture related both to the various types of services available as well as the quality of care available. The utilization of services outside the community however was restricted to those who can afford these services or in emergency situations. These findings are pertinent for messages that seek to promote local services.

3.3.5 Health seeking from skilled providers during current/last pregnancy, last delivery and last postpartum

Participants were asked to report their personal experiences of seeking care beyond the level of dai during pregnancy, delivery and postpartum.

[22] Moulvi: Imam of the mosque

Most women participants of rural area (15 out of 18) and some (2 out of 6) participants of urban area reported seeking **antenatal care** from a LHW or female doctor or a hospital during current or last pregnancy. Only few mentioned that they sought care for some complications during this period.

More husbands (three-quarter) reported that their wives attended a doctor or LHV or LHW for ANC. These visits ranged from only one to fortnightly check ups.

A husband from Shanti Nagar said:" Got a check-up from the doctor in the last pregnancy to check for gestational diabetes, normal fetus position, and to ascertain any abnormality in the ultrasound, went (to the doctor) to get all this information" *(pechlay hamal mein doctor se check karaya tha kay inko sugar tou nahi hay, baccha terah seedha tou nahi hay, ultrasound mein koi paraishani tou nahi hay, ye sarey maloomat lenay kay liyae gaye thay)*

According to woman participants, some (8 out of 24) **deliveries** were conducted by skilled providers such as by nurse, doctor or in hospital, mostly for women from rural areas; and among these about half of these deliveries were of complicated cases.

Only a few husbands and family members reported deliveries by LHVs or hospital.

A currently pregnant woman from Chak 136-10/R said: "My family members and I believe that dais spoil the cases that is why we do not call dais, poor people get the cases done by dais" *(mein ya meray khandan walay ye kehtay hain kay daiyan case kharab kar deiti hain tou ham nahi bulatay daiyun ko, gharib log tou yahin daiyun se case karwa laytay hain).*

Few (about one-fourth) participants reported seeking services from skilled providers for **postpartum** care and all were for complications such as for high fever, abdominal pain, infection of stitches, etc.

Those who sought services from dai, preferred her care as:

- People do not have money to pay other providers
- Expenditures are far less when care is sought from dai as compared to other providers
- It is customary to use the services of dai for delivery
- Family members do not like delivery to be conducted outside the home
- Deliveries outside the community are not perceived well by others
- Doctors performs operations unnecessarily, while dai handles such cases more appropriately
- They had faith in the dai's competence
- She conducts deliveries at home which is logistically convenient

A husband in Jatala Town (urban area), while indicating that poor cannot afford even the minimal charges in government hospitals said: " There are difficulties in going to the government hospital as lot of money is required, too much expenses occur, it is good (to have delivery) at home, it is difficult for poor to go to hospital, (I) have just left it to God" *(Sarkari haspatal jatay huay mushkil hoti hay aur paisa bahut lagta hay, kharcha bahut zyada ho jata hay, apnay ghar sahi reh jata hay, gharibon kay liyae mushkil hay haspatalon tak jana, Allah pe chora hua hay)*

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A currently pregnant woman in Jatala Town (urban area), while describing her confidence in dai said: "We believe in elder (women) who are wise or in dai, where expenses are less and we have faith (in them)" *(Hum baron par jo syanay hotay hain un par yaqeen rakhtay hain ya pjir dai par, jahan kharcha bhi kum ho aur apna yaqeen bhi ho).*

A mother-in-law in Kita Budhana said: "Most of the people get delivery done by dai, the reason being that we do not like to have publicity (of the delivery) by going to the doctors *(zyada tar log daiyun se zichgi karatay hain, is ki wajah ye hay kay hum log pasand nahi kartay kay doctoron kay pas ja kar mashoori karein)*

In brief:

- Many women from rural area and some of urban areas are seeking care for ANC from providers beyond the dai, such as LHW, LHV, doctor
- Contrary to seeking skilled care during pregnancy only one-third deliveries were conducted by skilled providers such as LHV, nurse or doctor
- No care is sought from skilled providers for during normal postpartum
- Care from doctors/hospitals is mostly sought in complications of pregnancy, delivery and postpartum.
- Some providers, even public sector hospitals are perceived as being too expensive by some.

3.3.6 Knowledge about maternal life threatening complications

Pregnancy: About 1 to 3 life-threatening complications were identified by almost all of the women participants. Very few mentioned more than 3 conditions.

A currently pregnant woman from Kita Budhana said: "Bleeding, fever, high or low blood pressure, threatens the life of (an expectant) mother" *(khoon zyada aa jai, bukhar ho jai, blood pressure high low ho jai to is tarah ma ki jan ko khatra hota hai)*

All husbands mentioned 2 to 3 conditions, while family members mentioned 1 to 3 conditions. The number of participants who mentioned different conditions in each group is mentioned in Table 3.5.

Bleeding was the most common mentioned condition.

Delivery: Only one woman said that she did not know of any life threatening complications during delivery. Others mentioned 1 to 3 conditions, and the most common were **retained placenta** and **prolonged labor**.

Among husbands, few (2 out of 8) did not know any condition, while others mentioned 1 to 3 perceived complications.

A husband in Shanti Nagar said: "There is danger of getting infection in case of excessive bleeding during delivery, abnormal position of the fetus and filth like dirty blood remains inside the mother" *(delivery mein khoon zyada se zyada zai ho jai, baccha terah hay, agar ma kay undar gandagi rah jai, yani ganda khoon undar reh jai tou is se infection honay ka khatra ho sakta hay)*

Table 3.5: Knowledge of Life Threatening Conditions During Pregnancy Among Different Groups of Participants

Conditions	Woman (24)	Husbands (8)	Family Members (8)	Total Participants (40)
Bleeding	12	1	4	17
High/Low blood pressure	7	0	1	8
Malpresentation	3	1	2	6
Deficiency of blood	3	2	0	5
Weakness	4	0	1	5
Miscarriage	1	3	1	5
No movement of fetus	4	0	1	5
Vomiting	4	0	0	4
Giddiness	4	0	0	4
Lower abdominal pain	3	0	1	4
Bursting of water bag	2	1	0	3
Sadness/sorrow	1	1	1	3
Fever	3	0	0	3
High sugar level	2	0	0	2
Insufficient diet/vitamins	0	2	0	2
Fits	1	0	1	2
Overdue delivery	1	0	0	1
Foul smelling discharge	1	0	0	1
Heart problem	1	0	0	1
Numbness of hands and feet	1	0	0	1
Jaundice	1	0	0	1
Don't know	0	1	0	1
No complications	1	1	0	2
No response	1	0	0	1

In the group of family members, all participants were aware of 1 to 3 conditions. Details of conditions mentioned by each group are given in Table 3.6.

Postpartum: The conditions mentioned by women ranged from 1 to 3 and the leading condition mentioned by several women (13 out of 18) was **bleeding**.

In contrast, half of the husbands did not mention any life threatening complications, while the other half mentioned 1 to 2 such signs. such as excessive bleeding, *thand lagna* (having effects of low whether temperature), fever and weakness.

All the family members mentioned 1 to 2 life-threatening complications in the postpartum period. Details of the conditions mentioned by each group of participant are given in Table 3.7.

A woman with live birth in Shanti Nagar said: "A woman can be in danger during postpartum period, if she bleeds excessively or if affected by winds that leads to body ache" *(Chiley men aurat ko agar khoon ziada aa jaye ya agar aurat ko hawa lag jaeye to purey jism men darden shoru ho jatee hen, to aurat ko khatra*

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ho sakta hey)

It could be concluded that:

- Knowledge of life threatening obstetric complications is limited
- Though varied signs were mentioned by participants the knowledge of individual participants was very low.
- Bleeding is the predominantly recognized sign for pregnancy and postpartum, while retained placenta for delivery.
- Postpartum appears to be an often neglected area. On the one hand fewer participants reported the need for skilled care during the postpartum and at the same time fewer individuals recalled danger signs during the postpartum period.

3.3.6 Actions taken during obstetric emergency

The trend for seeking emergency care during pregnancy, delivery and postpartum is very similar, hence dealt together.

Many women (18 out of 24) mentioned seeking medical care from skilled provider as the first choice during an obstetric emergency. Several participants mentioned that the woman is taken to a doctor while few stated that they are

Table 3.6: Knowledge of Life Threatening Conditions During Delivery Among Different Groups of Participants

Conditions	Woman (24)	Husbands (8)	Family Members (8)	Total Participants (40)
Retained Placenta	14	1	2	17
Prolonged labor	10	2	2	14
High/low blood pressure	7	1	1	9
Bleeding	6	0	1	7
Mal presentation	4	1	1	6
Obstructed labor	3	0	2	5
Dead fetus	2	0	1	3
No labor pain	0	0	2	2
Deficiency of blood	0	1	0	1
Weakness	1	0	0	1
Thand[23]	1	0	0	1
Retained blood clots	0	1	0	1
Early bursting of water bag	0	1	0	1
No response	0	3	1	4
Don't know	1	0	1	2

[23] Thand: effects of cold

Table 3.7: Knowledge of Life Threatening Conditions During Postpartum Among Different Groups of Participants

Conditions	Woman (24)	Husbands (8)	Family Members (8)	Total Participants (40)
Bleeding	13	1	4	18
Thand	5	2	0	7
High/low blood pressure	3	0	1	4
Weakness	1	1	2	4
High Fever	2	1	0	3
Excessive pains	0	0	2	2
Deficiency of blood	2	0	0	2
Lower abdominal pain	2	0	0	2
Infection in stitches	1	0	0	1
Heavy work	0	0	1	1
Body ache	0	0	1	1
Severe headache	0	0	1	1
No complications	1	1	1	3
No response	3	0	0	3
Don't know	0	3	0	3

taken to a hospital.
Rarely a dai was stated to be consulted first for an obstetric complication. Recitation of the Holy Quran was also mentioned by a woman in case of such an emergency.

Despite the mention of not seeking care from a dai during an emergency, there is a high possibility that an emergency situation plays out quite differently. Given the overwhelming reliance on the dai for regular care and the lack of planning for emergencies, the dai in all likelihood plays a crucial role in the health seeking behaviors of women and their families in case of emergencies.

For example: a woman with live birth in Kita Budhana said: "Dai does not allow the family to take the (woman) somewhere else and says that delivery will take place soon but when the woman is about to die, (we) call a vehicle and take her to the hospital" *(Agar bohat masla ho jaye to dai to ley kar naheen janey detee kion ke who kehtee hey bus abhee ho jaye ga, magar jab aurat marney walee ho jaye to sawaree kara ker haspatal ley jatey hen)*

In contrast, almost all husbands mentioned that in obstetric emergency the woman is taken either to a doctor or hospital as a first priority, with slightly more in favor of doctor than going to a hospital. Rarely, consulting dai, LHV and hakim was also stated in case of emergency. Very similar response was given by the family members interviewed.

In brief:

- In emergency help is reportedly mainly sought from the doctors and it is important to note that doctor, not necessarily hospital is the first choice for many participants.
- Despite the mention that dais are not consulted it is likely that they do

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play a crucial role in decision making regarding health seeking behaviors in an emergency by sheer virtue of the fact that they are often present as the first choice provider for delivery.

Apart from the fact that the dai in all likelihood plays a crucial role in decision making it is also hard to infer at what stage of a complication is considered to be serious enough to take the woman to the doctor/hospital. Given the limited knowledge of danger signs and discussions by participants suggest that any decision in this regard is considerably delayed.

3.3.7 Assistance of husbands, family members, health care providers and community in emergency situations

Husband: Several women stated that the husband plays an important role in emergency situations by arranging for money. In addition, most of them said that husbands accompany his wife to the health facility.

Very few participants reported on the role of the husband in arranging for transport in case of obstetric emergency.

The assistance described by husbands and family members had similar pattern to that mentioned by women except that family members emphasized the husband's role in arrangement of transport.

Family Members: Some women mentioned that family members can accompany her to the health facility, take her to the service provider in absence of the husband or arrange money. Few opined that moral support can be provided by the family members in this situation. In rare cases, arrangement of transport and sharing of daily household work was mentioned.

Half of the husbands and relatives were of the same opinion in family members role in arrangement of money and transport. Some mentioned family members accompanying the woman to the service provider in case of an emergency.

Other roles of family members mentioned rarely by husbands and relatives were taking care of household, arrangement of blood, taking care of woman's diet and providing emotional support.

Health Care Providers: Several women, few husbands and most of the family members mentioned provision of better care by health care providers through good medicines and treatment. Rarely, they stated that these providers could assist through charging less money.

Some said that they could give good guidance on the place to seek care from. Rarely, women and husbands expressed that health care providers give no assistance at all. Very few participants mentioned that HCPs can accompany a woman to the referred place.

Community: Many of the women participants stated that members of the community can provide monetary assistance. Some said that they can assist in arranging for transport and accompany the woman to the facility. Participants also rarely mentioned that they can provide moral support. In rare instances women had no idea of any role that community members could play

in case of an obstetric emergency.

Arrangement of money was mentioned by several husbands and half of the family members as the assistance from community people.

Some husbands and half of the family members thought that community can assist in obstetric emergency through arrangement of transport.

Very few husbands and few family members mentioned arrangement of blood in case it is needed. Some family members thought that community people can accompany the woman to the service provider. One of the husbands mentioned that the community people can take care of the household work in case of such an emergency.

Very few of the women and some of husband participants said that no assistance is provided by the community.

On specific questioning, 9 cases of obstetric emergencies were recalled by the participants. In 7 of these, assistance was provided by the community in the form of arrangement of transport or blood and/or money. The details of assistance were not known.

3.3.8 Conclusions

There is distinctly more positive maternal health seeking behavior in rural areas as compared to urban area in DG Khan district, both at home and health services level. The apparent reason is that the participants in urban area were visibly poorer than those in the rural areas.

Overall, there appear to be no clear line of communication or demarcation of roles and responsibilities to tackle an obstetric emergency at the family or community level. For example, arranging for appropriate transport can be a crucial step in preventing delays in case of an obstetric emergency. The women and husband participants interviewed reported that family members can and do arrange for transport in case of emergency. On the other hand the family members who were interviewed placed this responsibility on the husbands. Interventions need to focus on setting up clear lines of responsibility in this regard.

The fact that many of the participants pointed to the role of the community as a whole in arranging for finances bodes well for the establishment of community financial schemes.

The issue of moral support at the family and community level is an important one as it identifies an important albeit intangible role that can be carried out at a level beyond the spousal dyad.

The lack of clear understanding of the overall and comprehensive responsibilities of health care providers bears consideration. Specific interventions are needed to establish their roles and responsibilities and communicate the same to both the providers and the beneficiaries.

The Table 3.8 summarizes the findings reported above.

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Table 3.8: Key Facilitating and Hindering Factors for Seeking Maternal Health Care

Facilitating Factors	Hindering Factors	Recommendations
■ Early recognition of pregnancy ■ Sharing of the news with the husband and family members ■ Effort to improve diet of pregnant women ■ Decreasing workload of pregnant women ■ Desire to seek ANC ■ Faith in LHWs for ANC ■ Effort to seek care from skill provider by some during pregnancy and delivery ■ Availability of all services within few minutes of travel ■ Free services in some facilities outside the community ■ Perceived quality of care ■ Care through religious organizations and individuals such as church, priest, *moulvis* ■ Evidence of community support	■ High unmet need for family planning ■ Lack of knowledge about proper diet ■ Reliance on traditional beliefs about *garam* and *cold foods* ■ Decreased intake of some foodstuffs during pregnancy ■ Low levels of access to TT as well as low perceived importance of TT ■ High reliance on dai for delivery ■ Lack of focus on postpartum care ■ Limited availability of skilled providers within community ■ Non availability of 24-hour skilled care in urban area and some of the rural areas ■ Very limited knowledge about warning signs of obstetric complications ■ Apparent delay in decision making to seek medical care (D1) ■ Inadequate transport arrangements or non availability (D2) ■ Perceived not affordable cost of services (even in public hospitals) ■ Preference for doctors as opposed to institutions ■ No clear lines of communication or designation of responsibility in case of obstetric emergency	■ Link Maternal health with the Family Planning Program ■ MNH program should include a nutrition component based on National Curriculum for Nutrition ■ Focus on TT ■ Maternal health needs to be contextualized in terms of pregnancy, delivery and postpartum care. At this time the postpartum aspect is often neglected ■ Build on the positive associations of seeking skilled care during pregnancy and delivery to extend it for postpartum care ■ Incorporate dais in the Program effectively by defining their responsibilities and educating the community people about their role ■ Improve the knowledge about life threatening obstetric complications ■ Focus on designating roles and responsibilities at family and community level in obstetric emergencies ■ Explore the possibility of harnessing community support for establishing financial schemes ■ Focus of three delays as an organizing schema for interventions ■ Address (mis)perceptions such as high cost of health care

3.4 Current Health Seeking Behavior for Newborns and the Key Factors that Facilitate or Hinder these Health Seeking Practices

3.4.1 Perception of required health services for newborn

Vaccination was the most commonly mentioned required health service for the newborn, and it was mentioned by most mothers and family members and some husbands. They stated that vaccinations help the child to remain healthy. A mother in Jatala Town expressed this in the following words: "Vaccinations should be done, it saves from many illnesses for example polio and measles, the child is protected. After first vaccination three more are given and then one is given" *(hifazati tikay lagwanay chahiyain, bahut si bimarion se hifazat ho jati hay, jaise polio khasra, in se baccha mahfooz ho jata hay. Pehla tika laganay kay baad teen tikay lagatay hain, phir aik tika lagatay hain)*

Very few participants stated a need for check up of a normal newborn by any skilled provider (from LHW to specialist level), and very few categorically referred to **growth monitoring** and stated that weight of the infant should be checked regularly. Only some participants said that a doctor should be consulted if the infant falls sick. A mother-in-law in Jatala Town (urban area) said: " Take (the child) to a doctor if there is any illness, take him to another if there is no relief, life and death is in the hands of Allah, if recovery has to take place it (will) take place at home, if not then it wont happen even if the doctor sit close by and keep checking the pulse" *(takleef ho koi tou kisi doctor kay lejao, us sey aram nahi aata tou kisi aur kay pas le jao, zindigi maot to Allah kay hath mein hay, aram aana ho tou ghar mein aa jata hay, na aana ho tou baishak doctor nabas pakar kar baitha rahe).*

A few of women categorically stated that the child **should not be taken out of the house** in the first 40 days unless there is some extreme illness. Less than half of mother, few family members and some husbands mentioned that the newborn should be **breastfed**. Others probably did not perceive it to be an action for the health of the newborn, hence did not mentioned it. Other services mentioned by some were also home-based actions such as, protection from extremes of weather, cleanliness, improving the diet of mother, giving gripe water, strength giving syrups (vitamins).

In summary, the cultural practices and traditions related to seclusion of the postpartum woman and the neonate as well as the relying on "destiny" as an explanation for adverse conditions are important factors to consider when designing interventions related to health seeking behaviors for newborns.

3.4.2 Availability of services for newborn and their utilization

In all areas, the services of LHWs, vaccinators and male paramedics are available. BHU was present in one area (Chak 136-10/R), which had a male doctor and LHV. Homeopathic doctor is present in another area (Jatala Town). All the four areas have private practitioners in the community but mostly these

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are paramedics, whose services are sought for minor illnesses of newborn. Moulvis for dum, prayers from the Priest and medical store were rarely mentioned. Details are given in Table 3.9.

LHWs appear to be active in these areas as they were reported to be providing vaccinations, weight monitoring, advice for the care of the newborn. A sister-in-law in Shanti Nagar praised the work of LHWs and said: "LHWs come in the area, (she) weighs the child and does vaccinations" *(ilaqay mein health worker bhi aati hay, wazan kar jati hay, aur hifazati teekay lagati hay).*

Participants from all areas mentioned that **services outside their community** are accessible to them. These included THQH Mian Chunnu, THQH Kabirwala, THQH Jahanian and Civil Hospital Khanewal, private doctors and child specialist. Two major reasons were mentioned for seeking care from outside the community: (a) inadequate services in their community and, (b) the good quality of care being provided by facilities outside the community. A currently pregnant woman of Jatala Town expressed: "All the facilities are outside our community, all types of doctors are available, several other facilities for children like medicine stores, government hospital, all are available. If the child has minor illness then we try (treatment) here in the area, but in case of any serious illness we take the infant to the city" *(Sari Sahulatain hamaray ilaqay se bahar hain, har tarah ka doctor maujood hay, bachon kay liyae bahut sari doosri sahulatain jaise dawaiyun ki dokanain, sarkari haspatal sab kuch ha., Halka phulka bimar ho baccha tou yahan hi ilaqay kay undar koshish kartay hain magar agar zara sa zyada bimaar ho tou phir shehar ley jatay hain).*

Another woman, who had given live birth mentioned: "Civil Hospital Khanewal is outside community where medicine is provided for children, they have all machines and do not discharge the infant until the child has recovered" *(Ilaqay se bahar khanewal Civil Hospital hay, wahan bachon kay liyae dawaii deytay hain, sari machinay hain wahan, aur jab tak bacchay ko aram nahi aata tou us waqt tak chotti bhi nahi dayte)*

Very few participants mentioned that seeking healthcare from outside the community is expensive and only those who can afford it avail of these services. A currently pregnant woman from Kita Budhana said: "Few People visit because not every body has money, it is difficult for poor" (log jatay hain likin kam kyunke sab log paise walay nahi hotay, gharib logon kay liyae mushkil ho jati hay).
Discussing personal experiences, several women and husbands reported that they have sought health services for the newborn from a doctor. Almost all of

Table 3.9: Services Available in the Community for Newborn Care

Jatala Town (urban)	Kita Budhana (rural)	Chak 136-10/R (rural)	Shanti Nagar (rural)
■ LHW ■ Vaccinator ■ Private Clinic (male paramedic) ■ Homeopathic doctor	■ LHW ■ Vaccinator ■ Private Clinic (male paramedic) ■ *Moulvi*	■ LHW ■ Vaccinator ■ BHU ■ Private Clinics with male and female doctors and male paramedic ■ Chemists	■ LHW ■ Vaccinator ■ Private Clinic (male paramedic) ■ Visiting doctors ■ *Hakim* ■ Priest of the Church

them visited a doctor for seeking treatment of an illness. The problems for which health care was sought from the doctors for the newborn include fever, abdominal pain, diarrhea, pneumonia, very low birth weight.

The reliance on LHWs for neonatal health care is important to keep in mind. It appears that the LHWs play a vital role during pregnancy and for neonatal health. Their role during delivery and in the postpartum period is limited at best.

3.4.3 Steps to ensure the health of the newborn

Almost all participants mentioned a few specific steps to ensure the **health of the newborn.** Several women and some husbands and family members mentioned breastfeeding, vaccination and keeping warm or cold according to the season. Few participants in all the three groups also mentioned cleanliness, improving the diet of the mother, weighing the infant regularly, check up from doctor, seeking treatment for illness and giving gripe water.

A currently pregnant woman in Chak 136-10/R said: "(We) will protect (the newborn) from severity of weather, it will be good if mothers milk is available (to feed the newborn), (we will) maintain cleanliness, (will give) drops to prevent polio, and will get (him/her) vaccinated" *(Sardi aur zyada garmi se mahfooz rakhein gay, ma ka doodh ho tou hi achi bat ho gi, safai ka khyal karein gay, polio kay qatray aur hifazati teekay lagwain gay)*

A husband in 136-10/R said: "The health of new born is taken care of, the infant is given breast milk, (and) in case of illness the check up is get done by the doctor, and vaccination is also done" *(nai paida huay bachay ki sehat ka khyal rakha jata hay, ma ka doodh pilaya jata hay, bimari ki soorat mein doctor ko check karwaya jata hay, aur hifazati teekay bhi lagwai jatay hain).*

3.4.4 Knowledge About Life Threatening Conditions in Newborn

Almost all (except one) women mentioned 1 to 4 conditions that could threaten the life of a newborn. Details are given in Table 3.10.

A currently pregnant woman in Jatala Town while describing life threatening conditions said: "If (the newborn) gets fever (he/she) cries a lot, gets severe diarrhea, gets effects of *cold" (Agar bokhar ho bahut zyada, baccha rota bhi bahut zyada, pechish lag jatay hain, thand lag jati hay).*

A woman with live birth in Shanti Nagar said: "The newborn's life could be in danger if he is unable to urinate, stops feeding, vomits or gets sardee (effects of cold weather)" *(Agar bachey ka peshab band ho jaye ya dhood na piye or ulteyan karey or agar sardee lag jaye to bachey ki jan ko khatra hota hey)*

Husbands mentioned only two life threatening condition of the newborn. Two mentioned weakness and referred to intake of *garam foods* by mother like honey and egg that could prove harmful to the health of the newborn.

All of the family members mentioned either 1 or 2 life threatening signs which include jaundice, pneumonia, diarrhea, excessive crying, getting hot or cold or if the newborn does not get timely treatment in case of illness.

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Table 3.10: Knowledge of Life Threatening Conditions In Newborn Among Different Groups of Participants				
Conditions	**Woman (24)**	**Husbands (8)**	**Family Members (8)**	**Total Participants (40)**
Fever	11	0	4	15
Pneumonia	5	0	4	9
Abnormal breathing	6	0	0	6
Diarrhea	3	0	3	6
Excessive crying				
Thand	5	0	1	6
Weakness	2	2	0	4
Does not cry	3	0	0	3
Does not take feed	3	0	0	3
Constipation	2	0	0	2
Jaundice	0	0	2	2
Intake of *garam foods* by mother	0	2	0	2
Whooping cough	1	0	0	1
Flu	0	0	1	1
Measles	1	0	0	1
Extreme lethargy	1	0	0	1
Vomiting	1	0	0	1
Abdominal pain	1	0	0	1
TB	0	0	1	1
Typhoid	1	0	0	1
Underweight	1	0	0	1
Deficiency of blood	1	0	0	1
Severely malnourished	0	0	1	1

It could be concluded that the knowledge of life threatening conditions is good among women as they were able to mention the two major killer diseases among the life threatening conditions i.e. diarrhea and pneumonia. But, apparently this knowledge is very inadequate among husbands. The fact that husbands refer to maternal diet as being harmful for infants bears attention for two reasons. One, this could serve as a means to promote improved dietary intake for lactating mothers on the other hand this belief might result in blaming the postpartum woman of negligence for any illness that the newborn contracts. Furthermore, reference to "effects of cold" are an interesting cultural phenomenon and have some relation to pneumonia.

3.4.5 Actions taken for threat to life of Newborn

As compared to mothers, newborns appear to be receiving more medical care in case of an emergency. All women mentioned that they prefer to take the newborn to a doctor or hospital in life threatening situation, with very few mentioning hospital as the first choice. Rarely *desi ilaj*[24] was mentioned as an initial effort to treat the illness at home but if the condition aggravates then the medical care is sought.

[24] Desi ilaj: home remedies

A woman with live birth from Shanti Nagar said: "(we) immediately call the vehicle and take (the newborn) to hospital because children are dear to everyone and every mother takes care of them" *(Foran sawaree kara key haspatal ley jatey hen kion ke bacha to bohat pyara hota hey sab ko, har ma khiyal rakhtee hey)*

A currently pregnant women from Chak 136-10/R said: "we take the newborn to the doctor under all circumstances" *(Hum to har surat mein doctor ke pass jatey hen agar koi bhee masla ho to)*

Among husbands, many mentioned that in such a situation the newborn is taken to a doctor or hospital, while one mentioned consulting dai. Most of the family members also stated that the newborn is taken to a doctor or hospital in case of such an emergency, except one mentioning home based treatment as the first choice.

Only two cases of emergency of newborn were recalled by the participants and participants recalled that assistance was provided by the community in one of the cases.. This assistance took the form of monetary help, accompanying to the hospital and providing moral support.

3.4.6 Conclusion

The perception of most of the participants about required health services for a normal newborn is home care and many advocated breastfeeding. However, most participants believed that vaccinations were necessary to prevent the newborn from several diseases. Besides these two measures they also emphasized the need to protect the newborn from the extremes of weather, especially cold weather. But the knowledge about life threatening conditions is very limited, especially among husbands.

Table 3.11: Key Facilitating and Hindering Factors in Health Seeking for Newborn

Facilitating Factors	Hindering Factors	Recommendations
■ Positive attitudes for seeking vaccinations ■ Early seeking of treatment on appearance of symptoms ■ Desire to seek treatment from skilled providers ■ Accessible services outside community ■ Knowledge among women of diarrhea and pneumonia as life threatening conditions for newborn ■ Reliance on formal health care system in the form of the LHWs	■ Belief that child should not be taken out of home for first 40 days ■ Lack of knowledge for check up from skilled provider immediately after birth ■ low knowledge about life threatening conditions of newborn in husbands ■ Limited availability of skilled providers in rural areas ■ Perceived unaffordable cost of services ■ Lack of skilled providers within the community ■ Non availability of 24-hour skilled care in urban area and some of the rural areas	■ Provide basic information on care necessary for a neonate immediately after birth and also in the first 40 days ■ Provide information about warning signs in newborn ■ Advocate improvement of services in rural and urban slums

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3.5 Current Birth Preparedness and Complications Readiness Behaviors and the Key Facilitating or Hindering Factors

3.5.1 Preparations made for birth by woman, husband and family members

Spousal Communication: A very clear trend is seen about spousal communication and discussions with other family members regarding birth preparedness. Several women and husbands mentioned that they discussed issues related to delivery with their spouse. In order of frequency of responses, these include amount of money required, place where delivery should take place, where to go in case of complications, who will accompany the woman, transportation arrangements and who will give blood

A woman with live birth in Shanti Nagar said: "We, husband and wife had already decided that in case of any complication, we will go to Civil Hospital Khanewal, and my sister in law would accompany me and we had also arranged for Rs. 2000" *(hum mian biwi ne pehlay hi say socha tha kay hum Civil haspatal khanewal jain gay agar koi bhi mushkil waqt aae ga, aur meray sath meri jethani hi jai gi, aur hum ne paison ka intizam do hazaar kya hua tha)*

A currently pregnant woman from Chak 136-10/R said: "the family members and we, husband and wife, have made our mind that whenever labor pains start, we will call the vehicle and reach the doctor, my mother in law would certainly accompany me and husband will also join, we have decided to consult the same provider from whom we seek antenatal care" *(ghar walaon ka aur hum mian biwi ka zahan bana hua hay kay junhi taklif shoru ho gi tou gari mangwa kar doctor kay phonchain gay, meray sath tou meri sas lazmi jain gi, khawand jai ga, irada tou yahi hay kay jidhar check up karwatay hain wahin pahonch jain).*

As evident from the above sentences of the participants, some preparations for birth and complication readiness are taking place in this district.

Most of the women, husbands and family members mentioned **money arrangements** as the primary preparation, The amount mentioned ranged from Rs. 400 to Rs. 20,000, with most mentioning from Rs. 2000 to Rs. 10,000. This indicates that the amount being collected is enough to meet the expenses of delivery by a skilled provider or take care of complications. Some participants mentioned that higher amounts are arranged if it is known earlier that the delivery will have to be conducted in a hospital.

A currently pregnant woman in Chal 136-10/R quoted: " If we know the date and that the delivery is not to be conducted at home and the woman is to be taken somewhere then we keep all this in mind. Money is to be arranged, transport is to be called in (and) all this is to be thought earlier because everything could not be decided at the last moment" *(Agar pata hay kay falan tarikh hay aur ghar mein case nahi karma, kahin lay kar jana hay tou*

in sab baton ko zahin mein rakha hota hay, paison ka intizam hota hay, gari ka hota hay, yeh sab tou socha hota hay, waqti tour par tou saray program nahi bantay).

But distinctly, the money arrangements made by urban participants were far less than that reported by participants from rural areas, which usually ranged from Rs. 400 to Rs. 500. These are only enough to pay the fees of dai. These findings in large part have to do with the fact that the urban participants came from areas with greater poverty.

As part of preparation, monetary arrangements are arranged mainly through savings. However, if additional is required in emergency situations, it is collected through contributions from close relatives, selling of livestock and loans.

Several women stated that the decision for the **place of delivery** is done in advance. For some the choice is home for the expected normal delivery and dai is informed some days in advance. Very few women also reported that items required for delivery such as blade and thread are also arranged. A father-in-law in Chak 136-10/R said "We decide that the delivery will take place at home and talk to dai (about it) in advance *(dai se pehlay hi baat kar leytay hain aur is baat ka faisla bhi karlayte hain kay baccah ghar mein hi paida hoga)*.

While others mentioned that they decide about using an LHV, nurse, doctor or hospital even for expected normal delivery, and the decision is influenced by the amount of money available.

In case of anticipated complications, the provider is discussed in advance. The available options included dai, nurse, doctor and hospital. Husbands and family members also expressed similar opinions as part of preparation for birth.

A currently pregnant woman in Jatala Town (urban area) mentioned: " We have decided that delivery will take place at home (and) we will call the dai. In case there is any emergency, we will go the dai who works at Tej" *(hum ne soocha hua hay kay paidaish ghar pe hi ho gi, dai ko bolain gay, agar koi emergency hogai to tej mein jo dai hay us kay pas chalay jain gay).* The reason for moving from one dai to the other dai (perceived to be more skilful) was pointed out to be the non-affordability of other providers.

Half of women, several husbands and very few family members mentioned that **arrangements for transport** are made in advance. These arrangements include: availing and keeping the phone number of the transporter, identifying car rental service, discussing credit options with the transporter. The transport arranged varies and includes tonga, rickshaw, car, wagon. A woman with live birth in 136-10/R describing this arrangement said: " We had taken the number of the transporter and had informed him that we may need his services" *(socha hua tha kay agar emergency hogi tou ham ne gari walay ka phone number liya hua tha aur us ko bataya tha kay hamain us ki zaroorat parh sakti hay)*

One area did not have availability of any proper vehicles, hence alternate arrangements were planned. A husband in Kita Budhana said: "for delivery, I had arranged horse cart because I had one, in our area there is no vehicle or

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rickshaw to go to the city" *(delivery kay liyae tangay ka bundobast kya hua tha kyunke mein khud tanga chalata hun, hamaray ilaqay se koi gari rickshaw shehar nahi jata.*

However, some arrangements were not satisfactory as one husband in Jatala Town motioned: "in case of emergency it is decided where to take the woman, since we have motorcycle, there is no problem of vehicle" *(emergency ki surat-e hal mein kisi aur jagah le janay kay baray mein hum ne pehlay se socha hota hay, hamaray pas ghar mein motor cycle hay, is liyae sawari ka masla nahi banta).*

Very few women, husbands and family members mentioned about **antenatal care** as a preparation for birth. Interestingly, except one, all were rural participants.

Very few women and family members and some husbands mentioned prior discussions about **arrangement of blood**. These arrangements included identification of donors such as close relatives, husbands and friends; and also place for purchasing blood and who will buy blood if needed in an emergency. A woman with live birth in Jatala Town said : "A close relative was told that he will be giving blood if required" *(Hamaray khandan mein aik banda nazdeek hi tha jis ko bola hua tha kay khoon ki zaroorat pari tou aap dein gay)*

A husband in Shanti Nagar said: "Regarding donating blood she forbids me as she thinks that I will become weak. She says her either her brother will donate or we will purchase" (Khoon denay kay liyae wo kehti hay kay aap na dein aap kamzoor ho jain gay, mera bhai de day ga ya bazaar se kharid lein gay).

Very few participants mentioned that they **seek assistance of relatives**. Specific individuals (sister, sister-in-law, mother-in-law) are informed in advance that they will have to accompany the woman in case of emergency or to come and live with her during the postpartum period.

Many women, few husbands and half of family members reported that necessary **clothes and bedding** are prepared for the infant and few also mentioned these for the mother.

Acquisition of desi ghee for feeding the mother and the baby after delivery was mentioned by some women and family members.

Measures taken for improving the **diet** and changes in the **daily routine** are implemented so that the woman remains healthy during pregnancy and in the postpartum period as part of birth preparedness practices. Details regarding diet and changes in daily routine have been discussed earlier.

Only two woman mentioned **abstinence from sexual intercourse** as a measure to stay healthy in the later months of pregnancy.

Half of women mentioned that service providers helped them in preparation for birth or complication readiness by providing good care and advice during pregnancy. The advice provided by them included guidance for diet and rest; supplements like iron, vitamins and calcium; TT vaccination, prior information for operation. Most of these providers were skilled providers, either doctor or LHV. Few mentioned that LHWs had visited them at home and provided guid-

ance. Very few women expressed the opinion that service providers do not provide any help whatsoever.

Several husbands and family members stated that the advice is given by doctor, nurse, LHV, LHW and dai, while the remaining expressed that the providers have given no support in BPCR.

It can be concluded that discussions about BPCR between wife and husband and with other family members is fairly good. The five key activities taking place are collection of money, preparation of clothes for the infant, arrangement of transport, selection of place of delivery, and some improvements in diet. The extent to which such discussions can occur in a systematic and coordinated manner the more successful the BPCR practices among families would be.

The money being collected is mostly enough to meet the expenses of delivery by a skilled provider or meet expenditures for complications. Some of this might have to do with the fact that the rural participants in this specific sample appear to be relatively well off. Usually urban residence is associated with greater access to and hence utilization of skilled services but in this particular sample that is not the case. It is evident that the crucial factor for seeking appropriate skilled care for maternal health needs is not associated with residence (urban vs rural) but instead a function of socio-economic status.

The help from service providers is mostly limited to antenatal care. Some participants expressed negative opinions about the help that providers supply for BPCR. Hence provider related roles and responsibilities can be clarified and strengthened.

3.5.2 Hindrances in BPCR

Almost all women, family members and husbands pointed out hindrances in BPCR, both for mother and newborn. Almost all women and family members and several husbands mentioned **money** as the major hindering factor in undertaking any BPCR practices. However, only some gave examples of desired actions in case they did have the money. These actions included: arrangement of transport, delivery by doctor or in a hospital, and treatment from appropriate place in case of obstetric emergency and new born complications.

A woman with live birth in Chak 136-10/R said: "Money is the most important thing that becomes a hindrance in preparation (for birth) or arranging anything" *(Kisi bhi cheez ka agar intizam ya tayari karni ho tou sab se aham aur zaroori cheez jo rukawat banti hay wo hay paisa)*

Another woman, currently pregnant in Jatala Town said: "Everybody thinks about it but without money how can one do it"*(Soch tou har aik ki hoti hay, paisa hi nahi hota tou kaise karein tayari)*

A husband in Chak 136-10/R said: "If there is any hindrance in preparing for birth, it is money"*(paidaish ki tayari kay liyae bhi agar rukawat hay tou sirf paise ki)*

Only some women and half husbands and very few relatives mentioned the

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non-availability of **transport** in their area, as a major hurdle at the time of delivery and dealing with the maternal or newborn emergency. These were mentioned both by urban and rural women. A woman with live birth in Chak 136-10/R said:" The biggest hurdle in preparation is the arrangement for transport. There are not many vehicles in this area and we have to call them from outside the community. It is difficult to find a vehicle during an emergency *(Sab se zyada jo cheez in kamon ki tayari mein rukawat banti hay wo hay gari ka intizam karma, ilaqty mein itni garian nahi hain, bahar se mangwani parti hay, agar emergency ho jai tou gari ka milna mushkil hota hay)*

Few women participants (5 out of 24) mentioned **non availability of the service provider** at the facilities as a significant hindrance. A woman with live birth in Kita Budhana, describing this problem said: "It is very troublesome if one does not find a dai or a doctor while preparing for the delivery" *(zichgi ki tayari mein agar dai na milay, doctor na milay tou bahut mushkil hoti hay)*.

A husband in Chak 136-10/R said: "The non availability of doctor after 1 to 2 pm is a problem and hurdle if there is an emergency with a newborn" *(Doctor ka dupahar aik do bajay kay baad na hona emergency ki surat mein aur nai paida huay bacchay ki sehat kay liyae rukawat hay aur masla hay)*

Very few women, all from rural areas, expressed that **living in a nuclear family** becomes a hurdle in making appropriate preparations. According to them, it is difficult to manage in the postpartum period without the support of other family members.

Very few women and husbands mentioned that **distance from the closest health facility** as a hindering factor.

Only one woman referred to **non cooperative attitude of husbands and family members** as a hurdle in preparations.

One currently pregnant woman pointed **dai as a hindrance** in birth preparedness and said: "Women believe in dai and ask her for everything and if she says that you (the woman) should go for check up or ultrasound, she will obey her" *(aurtain daiyon par hi yaqeen rakhti hain, usey se poochti hain sab kuch, agar dai aurton ko kahey kay tum apna check up karao ya ultra sound karwalo tou wo us ki baat maan lein gi)*.

Rarely, participants indicated lack of knowledge about what to prepare as a limitation in preparation.

3.5.3 Conclusions for BPCR

The key facilitating and hindering factors for BPCR and the recommendations are summarized in Table 3.12

Table 3.12: Key Facilitating and Hindering Factors for BPCR

Facilitating Factors	Hindering Factors	Recommendations
■ Discussions among husband and wife and family members about birth preparation. ■ Collection of money for delivery and complications ■ Decision making for place of delivery and attending provider ■ Efforts to make arrangement for transport ■ Support from family members ■ Good care in pregnancy by service providers	■ Not enough money ■ Lack of perception that ANC is part of birth preparation ■ Very limited skilled female staff in rural areas ■ Prior decision about the appropriate provider or facility to be taken to in emergency by a few only ■ Non availability of transport or inappropriate transport ■ Services by skilled providers not affordable by all ■ Prior arrangements for blood by few ■ Living in nuclear family ■ Non cooperative attitude of husband	■ Introduction at home level of specific topics that merit discussion at the spousal level ■ Introduce innovative messages and materials that address the real and perceived issues related to the lack of money as a hindrance to BPCR ■ Consider schemes related to making transport available at community level Advocacy at the policy level regarding provider staffing at the local level ■ Need to have roles and responsibilities of actions to take in an emergency clearly laid out ■ Clarify roles and responsibilities of HCPs and communicate the same to both the providers and beneficiaries ■ Shared (Male and family) responsibility for positive maternal and neonatal health outcomes can be a key message

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3.6 Religious and Cultural Practices Surrounding Maternal and Neonatal Health

3.6.1 Religious/cultural ceremonies

Religious/cultural ceremonies and taboos during pregnancy: Almost all the women participants mentioned that no cultural ceremonies are performed during pregnancy. Only one stated the ceremony of *goud bharai*[25] in pregnancy. Several women said that various *Surah*[26] of the Holy Quran are recited during the period of pregnancy. These included *Surah Yasin, Surah Marium, Surah Yousuf, Surah Rahman, Surah Hujrat, Surah Fateha, Surah Qaf, Panj Surta*[27]*, Darood Sharif*[28] *and Tasbeeh*[29]. Some participants (2 out of 6) in Shanti Nagar mentioned reading of Bible during this period. *Surah Maruim, Durood Sharif, Tasbeeh and Panj Surta* are recited for facilitation in delivery, Surah Yousuf to have a beautiful infant and Surah Yasin for safe delivery and blessings of the Almighty.

A currently pregnant woman from Chak 136-10/R said: "*Surah* Yousuf is recited to have a beautiful infant and Surah Marium is recited for facilitation in delivery" *(Surah Yousuf is liye parhtey hen ke bacha khubsurat hota hey or Surah Marium is liye parhee jatee hey ke asaani sey pedaish ho jaye)*

Very few women mentioned that they get *tawiz*[30] to avoid fits during pregnancy, place matchbox and money inside the holy Quran, distribute alms among needy on every Thursday for easy delivery and to ensure that God blesses the mother and child.

Almost all of the husbands and family members stated that no cultural or religious ceremonies are performed during pregnancy though half of them pointed out that Surah (verses) from the Holy Quran are recited. These included *Surah Marium, Surah Yasin, Surah Muzammil, Surah Rahman, Surah Ikhlas, Darood Sharif* and Qul Sharif. Few of the husbands in Shanti Nagar mentioned reading of Bible during pregnancy. Few relatives mentioned distribution of alms among poor and needy during pregnancy.

Several taboos were mentioned by the participants during the discussions, which included persons, places and occasions which pregnant women should strictly avoid. Most women mentioned different **persons** that should be avoided. These included other pregnant women, postpartum women, women who have had a miscarriage, women who have had stillbirths, infertile woman, woman who get fits, woman wearing amulets. Several women mentioned

[25] Goud bharai: A cultural ceremony performed in the first pregnancy in the last trimester in which the women is dressed like a bride and the relatives place fruits, dry fruits, money, flowers and she leaves for her mothers home on completion of the ceremony for delivery.
[26] Surah of Quran: chapters of Quran
[27] Panj Surta: Five holy verses
[28] Durood: recitation of specific holy verses
[29] Tasbeeh: a string of 100 beads for keeping counts of holy recitations
[30] Tawiz: amulet

occasions that a pregnant woman should not attend, and these were funerals and weddings. Some women pointed out various **places** that should not be visited during pregnancy, which included graveyard, shrine, and haunted places. The reason for applying all these inhibitions is that they have bad effect on fetus and could lead to its death.

A woman in Shanti Nagar said: "A pregnant woman is forbidden to attend the funeral of a woman who died during postpartum because her (the dead woman's) spirit starts teasing the pregnant woman" *(Jo aurat chillay mein mar jai to us ki mayat mein janay se mana kartay hain, is liyae kay us aurat ki ruh is hamla ko tang kanma shoru kar deti hay)*

Several husbands also mentioned persons who should be avoided, which included infertile women and, women who suffer from convulsions. Half of the husbands pointed out places that should be avoided such as deserted places and shrines. It is believed that in deserted places she could be influenced by evil spirits and jinnee. The occasions were similar to those mentioned by women i.e. weddings and funerals.

Many family members also mentioned the need to avoid the persons listed above, most also mentioned the two occasions and few gave similar responses about the places to be avoided.

A mother-in-law from Kita Budhana describing restrictions on attending some specific occasions mentioned: " Several women follow this so rigidly that if they are pregnant or in postpartum period, they do not attend the funeral even if it is of their real brother or sister, as something (bad) may not happen to their expected infant" *(kai aurtain to is baat mein itni pakki hoti hain kay agar hamal ya chillay mein hon aur saga bahen bhai bhi foat ho jai tou us ka munh dekhnay nahi jati, kay aanay walay bachay ko kuch ho na jai)*

Three out of 40 participants also mentioned that a pregnant woman should not even touch the water that has been touched by a woman wearing an amulet or infertile woman or a sick woman. It is believed that this would lead to miscarriage. Two participants even emphasized that a pregnant woman should avoid crossing or walking over the water discarded on streets from the homes of these women.

Only two participants, one woman and one husband from two different areas did not harbor any of these beliefs.

Around the time of delivery: Very few (4) women participants mentioned cultural or religious practices around the time of delivery. A woman with live birth reported that the dai brings an amulet that is tied around the right leg or she brings gur with dum to eat. Both these measures are believed to facilitate the delivery and make it less painful. Another explained the use of *marium ki buti*[31] (a closed flower obtained from Saudi Arabia), which is kept in water when the labor pains start. It is believed that the duration of labor depends on the blossoming time of the flower. The water from the pot containing the flower is also fed to the woman. This practice has a direct implication on the perception of prolonged labor. If the blossoming is delayed even for two days,

[31] Marium ki buti (a flower bud obtained from Saudi Arabia) is kept in water when the labor pains start. It is believed that the duration of labor depends on the length of time it takes the bud to blossom.

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the labor is considered to be normal. Two men stated that they give *sadqa*[32].

In postpartum: Few women, some husbands and most family members also identified places, occasions and persons that should be avoided by a woman during the postpartum period. These were similar to those mentioned for pregnancy and almost indicated having bad effects on the newborn.

A husband in Shanti Nagar stated: " (We) do not allow (woman in postpartum) to attend a wedding, because infertile women cut some of their hair so that they may also bear children, but the child of those women whose hair is cut dies" *(Shadi kay moqay par nahi janay daite kyunke jin kai yahan bacchay nahi hotay wo chillay wali aurat kay thoray se bal kat leiti hain, take unke yahan bhi bachay paida hon, aur jis ke baal kate jate hain is kay bachay foat ho jatay hain)*

In addition, prohibition for walking under trees was mentioned by one woman who believed that the *jinn*[33] will overpower the woman and pass through her into the newborn during breastfeeding and kill him/her.

Only one woman and 2 family members mentioned about calling *Azan*[34] in the ears of the newborn immediately after birth. This activity is religiously followed for every infant by all Muslim families, but was not mentioned by most participants as it is considered a religious duty rather than a ceremony. Some women and husbands specifically mentioned that they celebrate *Aqiqa*[35] (christening ceremony). On this day relatives are invited, head of the newborn is shaven, newborn is given a ring, and sweets are distributed. Half of the women, several husbands and some family members mentioned that they distribute sweets such as *laddo*[36], sweet rice, cooked vermicelli, *suji ka halwa*[37] etc. on the birth of the infant within the first fortnight. A few of family members mentioned additional activities such as beating *dhol* (drum) and women cited inviting relatives for food. Several participants mentioned that celebrations are more common if the newborn is a male.

A currently pregnant women in Shanti Nagar (rural area) said: "A boy is given more importance as upon growing up he will be an earning member and lend a hand to his father, while a girl is not given much value, because she belongs to someone else (goes to someone else's house after marriage)" *(Larkay ko zyada ahmiyat daitay hain, ye bara ho kar baap ka sahara banay ga, jab kay larki ki koi qadar nahi hoti, kyunke ye parai hoti hay)*
A husband in Kita Budhana said: "Feel happy on (the birth of a) son and distribute sweets, while cry on (the birth of a) daughter, as she is yet another person who does nothing but take away rather than give in return". *(Baitay kay liyae khush hotay hain, laddo taqseem kartay hain, baiti par ronay lag jatay hain, kay ab ye bhi lenay wali aagai)*

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[32] Sadqa: a religious act in which cash or slaughtered animal is distributed among needy to protect from or ward off the bad effects
[33] Jinn: a spirit able to appear in human and animal forms and to posses' humans. Belief in bad effects of Jinn is part of religious faith. Holy Quran confirms their existence and informs the believer that they can give harm to them, which could include ill health
[34] Azan: call for prayers made five times in a day from the mosque
[35] Aqiqa: Christening ceremony
[36] Laddo: rounded sweetmeat
[37] Suji ka halwa: A sweat dish made from semolina, butter and dry fruits

In summary, while there are few reported cultural and religious practices - the recitation of specific verses from Holy Quran that correspond to specific times during the pregnancy and delivery appear to be universal.

Women are also inhibited to meet certain people, visit places and avoid occasions, some of which has important program connotations. For example the fact that women are requested to avoid - other pregnant women and postpartum women is relevant as they might make the establishment of any peer support and networking interventions to be particularly challenging. This underscores the need for using mass media where available and/or relying on individual interpersonal communication.

3.6.2 Preferred and forbidden food items for breastfeeding mothers

Milk was the predominant preferred food for mothers among all groups of participants and was mentioned by many participants. The stated reason was that it increases the milk production of the lactating mother. Fruit was mentioned by some women, few husbands and several family members. Few mentioned *desi ghee*, meat and egg, while very few mentioned vegetables and *yakhni*[38]. Rarely mentioned preferred food items were *yakhni*, chicken, pulses, dry fruit, *panjiri, and halwa*[39]. Details are given in Table 3.13.

Table 3.13: Preferred Foods for Lactating Mothers

Foods	Number of Participants Who Specified Different Preferred Foods																										
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
Milk	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Fruit	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■												
Desi ghee	■	■	■	■	■	■	■	■	■	■																	
Egg	■	■	■	■	■	■	■	■																			
Meat	■	■	■	■	■	■	■	■																			
Vegetable	■	■	■	■	■	■																					
Yakhni	■	■	■	■	■	■																					
Pulses	■	■																									
Halwa	■	■																									
Panjiri	■																										
Chicken	■																										
Dry fruit	■																										

Several **forbidden foods** were identified by the participants. These included food items that are perceived to be *difficult to digest, badi*[40]*, garam foods, cold foods*[41]*.* List of forbidden foods is given in Table 3.14.

Examples of difficult to digest food were items like pulses, guava, half cooked meat and vegetables (cauliflower, turnip, carrots, radish, spinach). *Daal*[42] is con-

[38] Yakhni: watery soup of chicken or meat
[39] Halwa: a sweet dish made of semolina, clarified butter and nuts
[40] Badi: produce gas in the body
[41] Cold foods: foods that are believed to have cold effects inside the body
[42] Daal: Pulses

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sidered to give abdominal pain to the newborn who is being breastfed. Cold foods included chilled water, orange, juice as these can cause cold and flu in the newborn. A few also mentioned other items like fruits, spicy items, rice and sour foods, etc. Almost in all cases the foods were forbidden as they were considered to have bad effects on the newborn except one participant who stated that such things could cause a decrease in mother's milk for newborn.

3.6.3 Precautions taken during postpartum to ensure safety of mother and newborn

Several precautions were mentioned by the participants. The leading ones stated by women, husbands and other family members are:

- Half of the women and family members stated that the mother and the newborn should not go outside of the house during postpartum period to avoid evil eye and *saya*[43]
- Some women, few husbands and family members mentioned that mother and newborn should be protected from severity of weather

Table 3.14: Forbidden Foods for Lactating Mothers

Foods	Number of Participants Who Specified Different Preferred Foods													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Pulses	■	■	■	■	■	■	■	■	■	■	■			
Orange	■	■	■	■	■	■	■	■	■	■				
Carrot	■	■	■	■	■	■								
Radish	■	■	■	■	■									
Guava	■	■	■	■	■									
Cold foods	■	■	■	■	■									
Garam foods	■	■	■											
Sour foods	■	■	■											
Chilies	■	■	■											
Spinach	■	■	■											
Rice	■	■												
Turnip	■	■												
Potato	■	■												
Cauliflower	■	■												
Banana	■	■												
Juice	■	■												
Roti	■	■												
Fish	■													
Egg	■													
Lassi	■													
Lemon	■													
Sugarcane	■													
Mango	■													
Tamarind	■													
Chilled water	■													
Half cooked food	■													
Badi foods	■													

[43] Saya: effect of evil spirits

- Some of the women and half of the family members said that mother and newborn should never be left alone during postpartum period, as both could be overpowered by evil spirits
- Few women and some husbands were of the opinion that mother should not undertake heavy household work like washing clothes, lifting weight etc because this could cause bleeding and getting effects of *thand*
- Some women and family members said that mother should place an iron instrument like a knife, amulet or a match box beside her and a lock should be hanging with her bed to keep the evil spirits away, and also to ensure that she and the newborn do not get scared
- Two out of six Christian women participants said that Bible should be placed under the pillow of the mother and newborn to keep the evil spirits away
- Half of the husbands and very few family members stated that mother should be given a good diet during the postpartum period
- Some husbands mentioned that the newborn should be taken to a doctor or LHW for check up and only one stated for vaccination
- Rarely mentioned precautions by participants included breast feeding and ensuring happiness of the mother

A woman with live birth in Jatala Town said: "(the woman) can not go out of the house neither could carry weight, the newborn is not left alone because he could get scared and if a newborn is left alone, a knife or something else is placed near him" *(Ghar sey bahar naheen ja saktey, waznee cheez naheen utha saktey, bachey ko akela naheen chortey who dar sakta hey agar akela chorna par jaye to churi wagera sath rakhtey henn)*

A woman with live birth from Kita Budhana stated: "If no body can sit with the mother and the newborn then their cot is locked to protect them from getting scared" *(Agar ma or bachey ke pas koi naheen beth sakta to charpoy ko tala laga detey hen takey who darey na)*

3.6.4 Feeding of newborn

Most of the participants mentioned *Ghutti*[44] as the first item of the intake while very few suggested breast milk.

Ghutti is given for two major reasons. It is believed by certain people that the person, who gives the *ghutti*, transfers his/her personality traits to the newborn. Hence it is given by any elderly member of the family or a pious person. The second major perceived reason is that it cleans the stomach (only rose water or honey are also given for this reason).

The composition of ghutti is variable and its main content could be honey, goat milk or rose water, and the additions are sugar, *gur, desi ghee*. Rarely, it is also purchased from the market.

A woman with live birth in Shanti Nagar (rural area) said: "First of all the newborn is given a little bit of sugar dissolved in rose water. It is said that it cleans the stomach of the newborn and it is to be given by a pious person only, as the infant develops the character traits of the person who gives the *ghutti." (Bacchay ko sab se pehlay cheene thori se arq-e gulab mein mila kar deitay*

[44] Ghutti: mixture given as a ritual first food to newborn and later to soothe the infants

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hain, is se kehtay hain ke bacchay ka pait saaf ho jata hay aur ye kay koi naik banda hi day, kyunke jo ghutti daita hay baccha ussey par jata hay)
A husband in Jatala Town (urban area) said: "First of all, the newborn is given ghutti, as it passes out any filth from inside the body)" *(Nai paida honay walay bacchay ko sab se pehlay ghutti di jati hay, bacchay kay undar koi bhi gand waghera ho you wo nikal jata hay)*

Discussing the **first feed of mother's milk**, some women (10 out of 24), husbands (3 out of 8) and family members (3 out of 8) mentioned that it should be given within the first hour of birth. Very few women and a few husbands mentioned timings that fell within 1-6 hours. Some women and half of family members stated that the first feed of mother milk should be given on the second or third day. The main reason given for delayed initiation of breastfeeding is that milk flows from the breast after 2-3 days.

A currently pregnant woman in Jatala Town (urban area) said: "Breast feeding is started after discarding the milk first on third day and goat milk is given (to the infant) during this period" *(Ma ka doodh doosray, teesray din utarta hay, us waqt dho kar doodh daite hain, is doran bakri ka doodh daite hain)*

Different items were mentioned as alternative for mother's milk, which are given in the first 2-3 days. These include goat milk, cow milk, *ghee*.

Once initiated, the feeding of breast milk has been mentioned frequently by most of the participants. One-third of the women stated that the newborn should be fed on demand, while half mentioned that feeding should be done frequently, ranging from half-hour to 3-hour intervals. The remaining did not give any response. Among husbands, three-fourth mentioned every 2-3 hours, while the remaining said 6-8 hourly. Family members' stated higher frequency, as several mentioned "on crying", while the remaining gave duration from every 1-4 hours. No difference was seen among urban and rural participants.

The misconceptions pertaining to initiation of breastfeeding and feeding of colostrums are important intervention areas.

3.6.5 Bathing patterns

Almost all women and family members and several husbands were in favor of giving a bath to the newborn immediately within the first hour after birth. The remaining felt that this should be done between 2 to 24 hours after delivery.

In the following days, the frequency of bathing for newborn was mostly stated to be daily by the three groups, especially in summer where few felt that it should be done twice a day.

Most women and several husbands and family members were of the opinion that the mother should take her first bath between third to fifth day, to become *pak*[45]. Only two women and 1 family member mentioned that it should be taken on the second day. While the remaining participants mentioned different timings for the first bath that ranged from 8th day to 40th day.

The frequency of bathing of women in postpartum was mentioned by most of the women was every 7th to 10th day. Among husbands and family members,

[45] Pak: clean in religious terms

several said that it should be done daily or when desired, while few mentioned gaps of 3-15 days.
There seem to be no clear cut patterns associated with bathing of the mother. The neonate is often bathed fairly quickly post delivery. Given the worries associated with "cold" things it is possible that appropriate precautions are taken to ensure that an optimal body temperature for the neonate is maintained during the bath. However, what precautions are taken is not clear and merit further review.

3.6.6 Presence and effects of Nazar (evil-eye)

Except one woman, all the participants from the three groups, both from urban and rural areas, believed that *nazar* exist. Interestingly, very few expressed that it does not affect the pregnant or postpartum women, but only the newborn.

Pregnant women: All of the husbands expressed that *nazar* has bad effects and half of them thought that it could cause miscarriage, while the remaining expressed that it can lead to illness of woman or abnormality in fetus. One even believed that a male fetus could become a female with the effect of *nazar*. In contrast, three-quarter of women mentioned that pregnant women can get *nazar*.

The affect mentioned by all was some kind of illness, except one who mentioned death of the fetus in the womb. Variable symptoms were reported that includes lethargy, headache, fever, burning and watering from eyes, abdominal pain, body aches, irritability, pain in the bladder. Among family members, all except one believed in the bad effects of nazar on a pregnant woman. Many of them mentioned that she could fall sick, while one mentioned miscarriage.

Women in postpartum: Almost all husbands stated that women could get illnesses such as fever, fits or that their breast milk does not flow. All family members believed that it results in some problems like mothers' milk drying up, mother and infant falling sick and burning eyes. Many women believed in the effect of nazar during postpartum. They mentioned different symptoms, which includes, headache, fever, weakness, pain in the lower abdomen, burning and watering from eyes and body aches

Newborn: All, except two participants believed that the newborn could be affected by the evil eye. The women mentioned that the newborn falls sick. Almost all mentioned that newborn cries a lot, stops drinking milk, becomes irritable, rubs their eyes, develops fever, gets watery eyes and becomes pale. Husbands and family members mentioned that the child could fall sick or become irritable under the influence of *nazar*.

Measures to protect mother and newborn from *Nazar*: The measures mentioned to protect mother and newborn from *nazar* are:

- Putting *nazar* kanta in neck
- Putting *til* (black mark), mostly behind the ears or neck
- Placing a black thread around the wrist
- By not exposing the newborn to outsiders
- Mother should act lethargic in front of outsiders

[46] Harmal: turmeric

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- Mother should not eat in front of non-family members
- Keep a knife or scissor under or lock on the side of the bed
- Avoid dressing the infant in good clothes while going out of the house
- Keeping a name that would protect the newborn from *nazar*

Measures to overcome *Nazar* in mothers and newborn: Some specific measures to overcome the effects of *nazar* were mentioned by all groups of participants:

- *Dum from Moulvi*
- *Tawiz*
- Collect soil from the path traversed by the person who inflicted nazar and burn it in fire
- Treat the affected with smoke of red chilies, sugar, or of alum
- Rotate lemon, salt, alum, chilies, match stick, *harmal*[46] and soil over the head of the affected and burn in fire
- Seek prayers of priest (Christian participants in Shanti Nagar)

3.6.7 Conclusion

Some cultural beliefs and practices have positive effects on health, others have negative effects, while some have neither. The Table 3.15 gives a summary.

Table 3.15: Summary of Positive and Negative Cultural Practices

Positive Practices	Negative Practices	Recommendations
Surah of the Holy Quran is recited during pregnancy and delivery for gaining Allah's blessings. Hence give psychological comfort and strength	Delay in blossoming of "marium ki buti" could lead to acceptance of prolonged labor as normal	Focus on nutrition as an intervention Early initiation of breastfeeding
Milk is given to breastfeeding mothers and effort is made to give good diet mother during pregnancy and postpartum	Not feeding colostrums considering it to be bad for the baby and giving replacement feeds like goat milk, cow milk, ghee, etc.	The importance of giving newborn colostrums should be stressed
Breastfeeding the infant, early initiation and frequent feeding	Preferential treatment for male child	Optimal and appropriate bathing and feeding patterns need to be promoted and established
Protecting mother and newborn from the severity of weather	Forbidding mothers from healthy foods during pregnancy and postpartum	Might consider addressing preference for male children as an overarching social norm
Restricting mother from undertaking heavy work	Restricting the mother and newborn from going outside of the house during postpartum	Work on highlighting that measures to overcome nazar should simultaneously be carried out with medical interventions
Efforts to keep mother happy	Mother should take her first bath after between third to fifth day	

Regular bathing of the newborn	Bathing by mother in postpartum on every 7th to 10th day	
	Symptoms in mother like lethargy, headache, fever, burning and watering of eyes, abdominal pain, body ache, irritability, pain in bladder, etc are related to Nazar. This could lead to delayed medical intervention.	
	Symptoms in newborn like excessive crying; irritability, becoming pale, watery eyes, stopping feeding, and fever are related to Nazar. This could lead to delayed medical intervention.	

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