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Healthy mothers and healthy children: Still a long way to go in Mewat (Haryana), India

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ABSTRACT

Healthy population is a pre-requisite for development of a country. The two most vulnerable groups of the society are mothers and children who bear the burden of high morbidity and high mortality due to various socio-economic and cultural reasons complicated by illiteracy, ignorance, and lack of access to health care services. This paper discusses the perspectives of women from villages of Mewat, Haryana on Mother and Child Health concerns to understand their community specific socio-cultural norms and practices related to pregnancy, child birth and child care along with identifying their information needs on the same. The study was carried out in two phases. In phase I, FGDs were conducted with women who were either pregnant or were mothers of at least one child in 0-2 years in four villages of Mewat. In phase II, their information needs were assessed through an interview schedule. The issues addressed were antenatal care, institutional delivery, diet during pregnancy and post-partum, breastfeeding, immunization, family planning, information about provisions under different MCH schemes etc. Majority of women were unaware of the healthy behaviours and desired practices for optimal pregnancy outcomes due to their limited exposure and unavailability of authentic sources of information. They seemed to be unable to follow the right practices because of poor socio-economic status, overwork and pre-conceived socio-cultural norms which impede their health seeking behaviour. Patriarchal structure with resultant gender dynamics and religious norms also seemed to play a major role in ignorance and inadequate health seeking behaviours. They don't seem to exercise any agency over their own body, health and fertility.

Key Words : Mother and child health, Gender, Socio-cultural practices, Mewat, Public health, Family welfare

INTRODUCTION

Health and healthy life is one of such areas in which women encounter more risks than men because of biological, socio-cultural, economic and institutional factors that reflect social inequality and affect women. The Women and Gender Equity Knowledge Network-WHO (2007) stated that gender relations of power constitute the root causes of gender inequality and are among the most influential of the social determinants of health. However, the health and well-being of women of any country impact the development status of that country.

Pregnancy and childbirth are normal events in the life of a woman. Though most pregnancies

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result in normal birth, it is estimated that about 15% may develop complications, which cannot be predicted. Some of these may be life threatening for the mother and/or her child. The Maternal Mortality Ratio (MMR), *i.e.* number of maternal deaths per 100,000 live births in India is very high *i.e.* 167 (SRS 2011-13). Like elsewhere in the world, the five major direct obstetric causes of maternal mortality in India are haemorrhage, puerperal sepsis, hypertensive disorders of pregnancy, obstructed labour and unsafe abortions. Maternal anaemia is a major contributor to the indirect obstetric causes. While most of these causes cannot be reliably predicted, early detection and timely management can save most of these lives. About 830 women die from pregnancy or childbirth related complications around the world every day. Unequal access to information, care and basic health practices further increase the health risks for women (WHO, 2011).

First 1000 days of window of opportunity :

Maternal health and newborn health are closely linked. The 1,000 days from the start of a woman's pregnancy until her child's second birthday offer a unique window of opportunity to shape healthier and more prosperous future. The right nutrition during this 1,000 day window can have an enormous impact on a child's ability to grow, learn, and rise out of poverty. It is critical to break the inter-generational cycle of malnutrition otherwise under nourished girls will become under nourished women who give birth to low birth weight infants.

Global evidence shows that timely nutritional interventions have proven to be effective in improving nutrition outcomes as well as decreasing IMR in children. These are:

– Timely initiation of breastfeeding within one hour of birth.

– Exclusive breastfeeding during the first six months of life. The infant is fed only breast milk and is not given any fluids, milk, or foods, not even water.

– Timely introduction of complementary foods at six months: By the 7th month, breast milk alone cannot meet an infant's energy and nutrient requirements. At this time complementary feeding should begin. Introducing complementary foods before is both unnecessary and dangerous.

– Age-appropriate complementary feeding adequate in terms of quality, quantity and frequency for children of 6-24 months.

– Safe handling of complementary foods and hygienic complementary feeding practices.

– Full immunization and bi-annual vitamin A supplementation with de-worming.

– Frequent, appropriate, and active feeding for children during and after illness, including oral rehydration with zinc supplementation during diarrhea.

– Timely and therapeutic feeding and care for children with severe malnutrition (*First 1,000 days,* n.d.)

This study was planned to understand the prevalent socio-cultural norms and practices related to pregnancy, child birth and child care from the community women along with identifying their information needs on MCH issues and related health programmes. It was also tried to find out the barriers in accessing information and approaching health care services related to mother and child health by the community women.

METHODOLOGY

The study was carried out in five villages of Mewat, Haryana in two phases. In Phase I, FGDs were conducted with community women in four villages (Papra, Guhana, Jahtana and Khedikala) to understand the prevalent socio-cultural norms and practices related to pregnancy,

child birth and child care. In Phase II, a knowledge test using a structured interview schedule was orally administered on the community women to test their knowledge on MCH issues, related health programmes and also to find out the barriers in accessing information and approaching health care services.

For FGDs, four villages in Mewat district of Haryana were visited, two of these, were Muslim majority and two were Hindu majority villages. It helped to gain insights into the religious perspectives held by the women regarding child birth and care practices. Information needs of the women of five villages (Papra, Guhana, Dungeja, Khedikala and Uleta) were assessed using interview technique. Purposive sampling along with snow ball technique was used to approach the women respondent in community. The criteria for selecting the respondents was that the woman should be married and belonging to the age group of 18-40 years and should be either pregnant or mother of a child in 0-2 years or both.

The probes for FGDs and knowledge test were broadly from the following topics:

- Socio-cultural norms and practices followed during pregnancy and on child birth
- Importance of Antenatal Care, Intra natal care, Post-natal care
- Registration of pregnancy and Antenatal care
- Nutrition and Diet during pregnancy and post-partum
- Importance of Institutional delivery
- Breastfeeding (early initiation and exclusive breastfeeding)
- Family planning
- Immunization
- Provisions and benefits under different Mother and Child health related schemes

RESULTS AND DISCUSSION

Early age marriages and education :

The legal age for marriage is 18 years for women and 21 years for men. But as per Census 2011 data an alarming 30.2% of all married women, or 10.3 crore girls, were married before they had turned 18. Similar trends were recorded from the women respondents in all four villages under study. Girls were found to be married off in the age group of 13-15 years and some of them even become mother of 2-3 children by the time they are 18 years of age. Though they were aware that the legal age of marriage for girls is 18 but said that due to poverty, they are married off early. If there are more girls in a family, then to save the expenses of marriage, two daughters are married off together irrespective of their ages with adverse consequences on their health.

Most of the girls and women in these villages were illiterate and if educated, maximum qualification was primary, only a few were high school pass. They don't value girl's education and hence don't send them to schools. They said that ultimately they have to do household chores and take care of the family, so there is no point getting them educated. Another reason was of their safety because of which they are not allowed to go to schools if the school is far away from their homes or community. Observance of veil was also seen in front of male members and elders that somehow limits their exposure and interaction with their surroundings to know and learn new things too. Rahman and Rao (2004) found in their study that restrictive cultural practices such as strictly enforced rules of seclusion or *purdah* (veil) for women are significantly associated with worse gender equity.

Dowry- a reason for child marriage and son's preference :

Dowry was reported a common practice in these communities and was also found to be a reason for early age marriages and son's preference. A study in rural Tamil Nadu by Smith *et al.* (2008) supports this finding and reported that financial cost associated with girls in the form of dowry was the main reason for daughters' aversion and preference of son.

It was also reported that despite having low economic standards, people take loans for their daughters' marriages to fulfill dowry demand that increases with increasing age of girl, educational level of boy and financial status of his family. The dowry could be in the form of cash, gold, vehicle or any other items as gifts but they said that giving vehicle to the groom is compulsory, it can be a bicycle, mostly a bike or a car if the boy is high school pass and belongs to a financially sound family.

Son's preference :

Shields and Aly (1991) stated that parents in many parts of the world prefer sons to daughters based on the available demographic and economic literature on sex preferences. Indian society is no different. Son's preference has always been there in India just as patriarchy and the onus of producing one is on women and if they don't, are blamed, taunted and tortured for the same. Due to unawareness of the fact that biologically, it's the father who is responsible for the sex of the child, women face all kinds of pressures and humiliation for not giving birth to a male child. Many a times it is seen that in case of not being able to produce a male heir for the family, they are either abandoned or are forced to live a gloomy life of neglected first wife after husband's remarriage. Bagchi (2017) stated very rightly that a woman's most obvious power to reproduce and nurture the species is then made into the most effective engine of her enslavement.

According to them the ideal family in terms of number of children, should have two boys and one girl or two boys and two girls but the real life situations were very different. Most of the families had 8-15 children irrespective of their religion that seemed to be result of their wish to have son or desired number of sons. This is supported by Shelly Clark (2000) in her study while examining the effects of differential stooping behaviour (DSB) at the family level rather than at the national level, in which she mentioned that girls belong to larger families because families with girls tend to become large in an effort to have boys. Also, the larger families with many girls are often the families that did not want many girls.

Socio-cultural norms and practices :

India offers a rich variety of socio-cultural diversity in almost every aspect of life. This diversity in terms of various norms and practices is passed on from generation to generation within the families. The birth of a child is one of such occasions which is celebrated in different ways from culture to culture and region to region. But, one commonality amongst all is that the celebration for a boy is much more elaborate than that of a girl. Similar things were reported in Mewat too.

There is no celebration during pregnancy, but after the child's birth sweets are shared with loved ones and neighbours. It was reported that though people celebrate as per their economic capacity but in case of girl, mostly there is no celebration. It is tried that neighbours should not know about it and birth of a girl child actually turns into a mourning event for the family.

In Hindu families, the birth of a boy is celebrated by sharing sweets, beating plates *(thali bajana)* and singing songs *(jachcha gaana)*. The two specific events- *"chhati poojan*" that is celebrated on the sixth day of child birth and "*kuan poojan"* that is worshipping a pond after

around one and a half month are performed only for a boy. In Muslim families, arrival of a boy is celebrated by sharing sweets and organising a family gathering called '*Hakiko*' after 40 days of child's birth. Mother's natal family members bring gifts for the new born and other family members on this occasion. It was also reported that relatives and midwifes are given money or expensive gifts *(neg)* like gold or silver ornaments only on the birth of boy. One of the women shared very sadly that when a girl is born, mothers do not get nutritious diet and proper rest and are also asked to get back to the normal routine from 4th day onwards which is around 10-15 days after a boy's birth. All these differences in rituals, traditions and behaviour of the family members on the birth of a boy and girl also reinforce the preference of a male child even by mothers. Women find themselves in a better bargaining position if they give birth to a male child.

Dietary pattern during pregnancy :

Ransom and Elder (2013) stated that adequate nutrition, a fundamental cornerstone of any individual's health, is especially critical for women because inadequate nutrition wreaks havoc not only on women's own health but also on the health of their children.

All the women respondents said that their diet during pregnancy depends on the financial conditions of the family at that time. If they can afford nutritious diet including fruits, milk and milk products etc. then they get to eat them otherwise not. This is supported by Moni Nag (1994) in her study where she quoted based on a number of diet surveys among women in Indian communities and hospitals that there is almost universally no increase of intake among low income group women during pregnancy. It was also reported by community women that their diet during pregnancy is generally not a matter of concern in their houses and they are asked to eat whatever is available at home. Moni Nag (1994) also reported the same in her study that in household food distribution, pregnant women hardly get any special consideration. Many a times these women have to go to forest for fodder or to fetch water in full time pregnancy and sometimes delivery happens in farms in very complicated and unhygienic conditions putting mother's and child's life on risk.

Registration of pregnancy and antenatal care :

Antenatal care is the systemic supervision of women during pregnancy to monitor the progress of foetal growth and to ascertain well-being of the mother and the foetus. Baqui *et al.* (2008) demonstrated a 34% reduction in neonatal mortality in the Sylhet district of Bangladesh, associated with pregnancy surveillance and registration that allowed antenatal and day 1, 3 and 7 neonatal home visits by trained community health workers.

As per latest data of NFHS-4 (2015-16), Mewat is recorded to have 37.7% institutional births whereas India and Haryana state has 78.9% and 80.5% institutional births respectively. Similar pattern is observed for women who had full antenatal care with 19.5% in Haryana and only 2.3% in Mewat This shows a very sad reality of mother and child health in Mewat region.

Home deliveries are one of the major reasons for high maternal mortality. It was reported from the villages under study that most of the deliveries (approximately 90%) take place at home with the help of traditional birth attendant *(dai)* or other experienced and aged women of the family or community. The reasons documented for not going to the hospital for delivery were unavailability of proper facilities in their nearby hospital, rude and insensitive behaviour of hospital staff members, convenience of delivering at home, preference of family members (mainly husband and mother-in-law) to deliver at home etc. So, until there is some complication which a midwife can't handle, they don't prefer to go to hospital. One of the old women who had delivered all her children at home and

as a mother-in-law decided the same for her daughter-in-laws said that this generation of pregnant women can't tolerate pain and have to go to hospital unlike the earlier times when women used to bear pain but deliver at home only. It is supported by a study conducted in Mali to look at the influence of intra-familial power on maternal health care. It was found that mothers-in-law who adhere to and believe in the efficacy of traditional practices of child birth and post-natal care may see institutional care as unnecessary or even detrimental, such that they discourage their daughters-in-law from seeking care from trained providers (White *et al.*, 2013).

Breastfeeding (early initiation and exclusive breastfeeding) :

According to a WHO guideline document 'Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services' (2017), improving breastfeeding rates globally can prevent over 800,000 deaths in children under 5 years of age and 20,000 deaths from breast cancer annually.

It was reported that instead of breastmilk, giving honey *ghutti* to the child immediately after birth is a common practice in Mewat. If honey is not available then either sugar syrup or a few drops of tea is given as *ghutti* even in hospital without consulting any nurse or doctor. According to them *ghutti* clears the food pipe of the child. Children are regularly given *Mughli ghutti* till the age of 5 years.

Women from the villages under study were not aware about colostrum or its benefit except a few who said that it is good for their child's health. It was reported that in their previous home deliveries, they were asked to squeeze out the initial yellow milk and throw it on ashes *(raakh)* on the pretext of ensuring continuous flow of milk. Colostrum, the yellowish, thick breast secretion during the first two to three days postpartum, is important for infant survival (Jatrana, 2003). But, they were not allowed to breastfeed their children until they take bath after three days of child birth, traditionally called *nahan.* Santosh Jatrana (2005) also found in his study while examining the determinants of infant mortality in the Mewat region of Haryana that the practice of squeezing out milk from the breast deprives the child of both nourishment and the vital substance present in the colostrum which facilitate the development of the child's immune response system.

But with some increase in institutional delivery, this practice is changing. Women shared that in hospital, nurses ask mothers to breastfeed the child immediately. Majority of them said that now children who are born at home also are breastfed immediately after birth but they were of the view that breastmilk is not secreted until mother takes bath on 3rd day which is nothing but a misconception. The age long practices of not breastfeeding the child immediately after birth, discarding it for three days and giving pre-lacteal feeds like honey or tea can weaken the sucking and rooting reflexes of the newborn and may not result in a successful start for breastfeeding. Even now, many of them don't feed their child before third day's bath.

Butz *et al.* (1982) found in their study that infants who survived the first 6 months had lower mortality subsequently if they were fully breastfed in the first 6 months. But, it was found from the villages under study that except a few, women didn't know about exclusive breastfeeding for first six months. Because of their unawareness on importance of exclusive breastfeeding, they give water to their children in this period if weather is hot and also some handy food items like biscuits or chapati roll when they are of 3-4 months. This kind of unawareness on such important issues is alarming and contributing to high infant morbidity and mortality.

Immunization and health check-ups of the child (0-2 years) :

Immunization has been one of the most significant and cost-effective public-health interventions to decrease childhood morbidity and mortality. Despite the Universal Immunization Programme of Government of India that provides vaccination to prevent seven vaccine preventable diseases (*i.e.* Diphtheria, Pertusis, Tetanus, Polio, Measles, severe form of Childhood Tuberculosis and Hepatitis B), the coverage for fully immunized children in India is only 62% (NFHS-4). For Haryana state, it is 62.2% but for district Mewat, it is quiet worse *i.e.* 13.1% in total that further goes down to only 11% for rural population.

Awareness about the benefits of immunization was negligible in the community women. There were very few of them who had got their children fully immunized. They only take their children to hospital when they are not well. In Papra village, women said that health check-up of the children is done at aanganwadi but limited to taking height and weight only. It was also reported that ANM comes to their community for children's immunization and mothers are informed by ASHA to bring their children and immunization card to aanganwadi centre. But, it was found from ASHA workers that even after repeated reminders, women do not bring their children for immunization. Majority of them were of the view that their children are doing well even without immunization, and so there is no need for it. Also, they don't want their children to get hurt, bear pain of injection or get fever as side effect of any vaccine.

Conclusion :

The paper suggests that for positive behaviour change and to encourage health seeking behaviour amongst women, awareness about MCH issues is very important. The key messages and provisions of govt. health schemes should be repeatedly shared and discussed through local media of communication (drama, folk songs, community radio etc.) not only with women but also with their family members like husbands and mother-in-laws. Men should be encouraged to participate and extend their support in ensuring a healthy life and positive environment to women so that motherhood can become a happy and blissful experience for them and a reason for a healthy and prosperous society.

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