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Original Research Article

Socio-cultural practices related to mother and child health in Mewat, Haryana, India

Pooja Akshay*, Sarita Anand

Department of Development Communication and Extension, Lady Irwin College, University of Delhi, India

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***Correspondence:**
Pooja Akshay,
E-mail: poojaakshay.phd@gmail.com

ABSTRACT

Background: Mothers and young children bear the burden of high morbidity and high mortality due to various socio-economic and cultural reasons complicated by illiteracy, unawareness, ignorance, and lack of access to health care services. Objective of this study was to discuss the perspectives of women from villages of Mewat, Haryana in India on mother and child health in the context of their socio-cultural norms, practices and assess their information needs related to pregnancy, child birth and child care.
Methods: The study design was qualitative and descriptive in nature. FGDs were conducted in four villages in Mewat district of Haryana with approximately 100 community women who were either pregnant or mothers of at least one child in 0-2 years. Through these FGDs, their responses were documented on prevalent socio-cultural norms and practices about antenatal care, institutional delivery, diet during pregnancy and post-partum, breastfeeding, immunization, family planning etc.
Results: 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, patriarchal structure with resultant gender dynamics and religious norms, overwork and pre-conceived socio-cultural norms which impede their health seeking behaviour.
Conclusions: Knowledge on healthy practices during pregnancy, child birth and child care can promote health seeking behaviour amongst women along with optimal pregnancy outcomes. However, majority of women were unaware about such healthy practices. Hence, it is important to raise awareness amongst women to ensure mother and child health.

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

INTRODUCTION

Pregnancy and childbirth are normal events in the life of a woman. But according to the latest data given by the Registrar General of India, the maternal mortality ratio (MMR), i.e. number of maternal deaths per 100,000 live births in India is still very high i.e. 130 (SRS 2014-16) and it has a long way to go to achieve the sustainable development goal of reduction in MMR to less than 70.[1]

Unequal access to information, care and basic health practices further increases the health risks for women (WHO, 2011).[2]

Maternal health and newborn health are closely linked. In India, 38.4 per cent of children are suffering from stunting (low height for age), 21 per cent from wasting (low weight for height), 35.7 per cent are underweight (low weight for age) and 18.2 per cent had low birth

weight when they were born (NFHS 4, 2015-16).[3] Global Nutrition Report 2018 showed this very evidently by mapping the stunting prevalence in Indian districts through Figure 1.

All of these problems are actually the manifestation of varied immediate and underlying causes. These causes could be poor adolescent and maternal nutrition, inadequate and inefficient infant and young child feeding (IYCF), limited or inappropriate knowledge about mother and child caring practices, limited access to available health services etc.

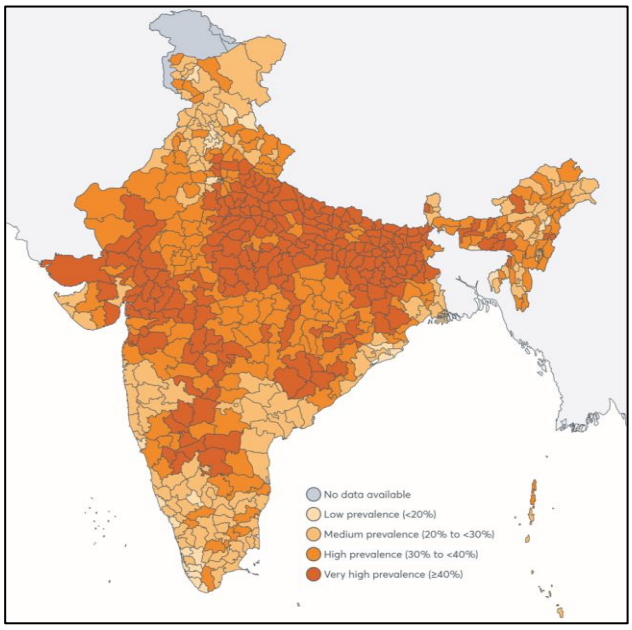

Figure 1: Map of stunting prevalence in Indian districts, 2015-2016.
Source: 2018 Global Nutrition Report.

Poor nutrition starts in-utero and extends throughout the lifecycle, particularly in girls and women. This amplifies the risks to the individual's health but also increases the likelihood of damage to future generations. The girls who survive may grow up to produce low birth weight babies who may have a lower chance of survival than normal-weight babies.

In India, health being a priority goal, there have been and still are a number of government health programmes and schemes targeting different stakeholders. Amongst all, mother and child health has always been one of the main areas for planning and implementing the interventions to generate awareness for health seeking behaviour, various kinds of service deliveries even to the remotest areas, incentivizing the good practices etc. Some of the programmes to name are Pradhan Mantri Surakshit Matritva Abhiyan, Pradhan Mantri Matritva Vandana Yojana, Poshan Abhiyan (National Nutrition Mission), Janani Suraksha Yojana, Janani Shishu Suraksha Karyakram, Mission Indradhanush etc. Though, there has been some progress but overall picture is still far from the ideal.

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 mother and child health (MCH) issues. The study also attempted to identify the barriers in accessing information and approaching health care services related to mother and child health by the community women.

METHODS

It was a qualitative descriptive study. Locale for the study was Mewat which is a district of Haryana state in India. Mewat is predominantly inhabited by Meo Muslims. The data was collected from the period of November, 2017 to March, 2018 using focus group discussions with community women in four villages- Papra, Guhana, Jahtana and Khedikala of Mewat district, Haryana.

Table 1: Details of FGDs conducted in eight villages of Mewat, Haryana.

FGD	Village	Block	Approx. number of community women in FGD	Average age of women participants
FGD 1	Papra	Punhana	8	13-45 years
FGD 2	Papra		13	
FGD 3	Guhana	Nuh	11	
FGD 4	Guhana		14	
FGD 5	Jahtana	Punhana	12	
FGD 6	Jahtana		12	
FGD 7	Khedikala	Firozpur Jhirka	15	
FGD 8	Khedikala		15	

Eight FGDs were conducted with approximately 8-15 women in one FGD and around 100 community women in total. The criteria for selecting the respondents for FGDs was that the woman should be married and should be either pregnant or mother of a child in 0-2 years or both.

After completing all the FGDs, some emerging themes were identified from the documented responses and further all the data was categorized under these themes.

All the themes were separately taken, analyzed and discussed in detail.

The respondents were explained the purpose of the study. Their written consent was obtained for participating in the study after reading out the ethical considerations. Ethical clearance was obtained from the Institutional Ethics Committee of Lady Irwin College, University of Delhi which was held on October 13, 2017.

RESULTS

Emerging trends were observed and noted from documented responses just to understand the socio-cultural norms and practices related to pregnancy, child birth and child care in Mewat and not to arrive at any generalization.

Table 2: Emerging themes from FGDs based on documented responses.

Emerging themes from FGDs	Noted responses (≥67%-majority, 50%-half, 33%-one third).
Early age marriage	Majority of girls were found to be married during the age of 13-15 years.
Education of girls and women	Majority was illiterate, maximum qualification was primary.
Dowry	Majority said that dowry is a common practice and a reason for child marriage and son preference.
Son preference	Most of the families had 8-15 children irrespective of their religion to have son or desired number of sons.
Socio-cultural norms and practices	Majority said that though people celebrate child birth as per their economic capacity but in case of girl, mostly there is no celebration.
Dietary pattern during pregnancy	Majority said 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.
Registration of pregnancy and antenatal care (ANC)	Majority was unaware of registration of pregnancy and nearly half of them preferred home delivery over institutional delivery.
Breastfeeding (early initiation and exclusive breastfeeding)	Majority said that giving pre-lacteal food (*ghutti*) to the child immediately after birth is a common practice in Mewat. Women were completely ignorant about exclusive breastfeeding and its benefits.
Immunization and health check-ups of the child (0-2 years)	Majority of them had not got their children completely immunized on the pretext of pain due to injection and post-immunization fever.

Early age marriages and education

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 years 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 age with adverse consequences on their health.

Most of the girls and women in these villages were illiterate and if educated, maximum qualification was primary. They said that ultimately girls 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.

Dowry- a reason for child marriage and son preference

Dowry was reported a common practice in these communities and a reason for early age marriages and son 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.[4]

It was also reported that despite having low economic standard, 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 form of cash and/or kind including gold, vehicle or any other items as gifts.

Son preference

According to community women the ideal family in terms of number of children should have two boys and one girl or two boys and two girls. But, 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 Clark in her study while examining the effects of differential stopping behaviour (DSB) at the family 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, larger families with many girls are often the families that did not want many girls.[5] This proved to be true when a traditional birth attendant (*dai*) shared that her daughter-in-law wanted to get operated after six daughters but she didn't allow her for the sake of continuing family's name. One of the ASHA workers in a

village had 12 children. An ASHA worker who is expected to encourage people for adopting family planning methods would just not be an ideal person to talk about family planning if she herself would have 12 children.

Socio-cultural norms and practices

It was reported that though people celebrate as per their economic capacity but in case of girl, mostly there is no celebration. 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 organizing a family gathering called '*Hakiko*' after 40 days of child's birth. One of the women shared very sadly that when a girl is born, mothers do not get nutritious diet and proper rest. They are 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 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

It was reported that women's diet during pregnancy depends on financial conditions of the family at that time. If they can afford nutritious diet including fruits, milk and milk products etc., they get to eat them otherwise not. This is supported by Nag 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.[6] It was also reported 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. Nag also reported the same in her study that in household food distribution, pregnant women hardly get any special consideration.

Registration of pregnancy and antenatal care

Antenatal care (ANC) 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. Every pregnant woman should ideally make at least four visits for ANC, including the first visit/registration. But sadly, Mewat has only 2.3 per cent women who had full antenatal care with only 37.7 per cent institutional births (NFHS-4, 2015-16).

It was reported that women were not aware of registration of pregnancy, when should it be done, importance of four ANCs and what benefits and services they can get by registration of pregnancy. Though ASHAs of these villages said that they go to their houses in the third month of pregnancy for registration but women do not show much interest and do not come for ANCs even after repeated reminders.

It was also reported that most of the women did not have much say in any decision related to health care they receive. But, a few of them shared that having cordial relationship with their husband and in-laws could help them to evince their wish to deliver at a health facility rather than at home.

Breastfeeding (early initiation and exclusive breastfeeding)

It was reported that instead of breastmilk, giving honey *ghutti* to the child immediately after birth is a common practice in Mewat. In case honey is not available, either sugar syrup or a few drops of tea is given as *ghutti* even in hospital without consulting any nurse or doctor believing that *ghutti* clears the food pipe of the child.

Majority of women 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.

According to WHO, "exclusive breastfeeding" is defined as no other food or drink, not even water, except breast milk for 6 months of life, but allows the infant to receive ORS, drops and syrups (vitamins, minerals and medicines).[7] It was found from the villages under study that except a few, women didn't know about exclusive breastfeeding for first six months. Though, they breastfeed their children up-till the age of two or three years. They give water to their children if weather is hot and also some handy food items like biscuits or chapatti 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)

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 per cent (NFHS-4, 2015-16). For Haryana state, it is 62.2 per cent but for district Mewat, it is quiet worse i.e., 13.1 percent in total that further goes down to only 11 per cent for rural population.[8,9]

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. 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 hence 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.

DISCUSSION

Result from this study shows high number of underage marriages. But, Census 2011 still gives some hope for betterment of this situation by finding an interesting relationship between educational level and underage marriages. It is statistically reported that share of underage marriages gets smaller with higher level of education which was 38.1 per cent for illiterate, 30.9 per cent for primary, 15.3 percent for secondary and 5.2 percent for graduate or above. This clearly shows that education can actually change this gloomy picture of early age marriages and save girls and women from related burdens.

With only 2.3 per cent full antenatal care and only 37.7 percent institutional deliveries, Mewat needs more concerted efforts to influence and persuade families to change for better health outcomes of mother and children. The communication efforts have to work to overcome the age old conservative approach to child birth and mother and young child nutrition. Also, importance of regular monitoring of pregnancy has to be reinforced.

It was found out from women that having cordial relationship with their husband and in-laws could help them to evince their wish to deliver at a health facility rather than at home. Hence, the interventions for mother and child health should also focus on husband and other family members who could then be more aware and prepared for ensuring good health to the mother and child. Allendorf (2010) also found in his study that married women who have good relationships with their husband and in-laws are more likely to obtain better maternal health care than those with poorer relationship.[10]

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 substances present in colostrum which facilitate development of the child's immune response system.[11] Hence, it is very important that the mothers should know about colostrum and its importance for her child ensuring that they feed colostrum to the child.

It was found in the study that women do not get their children properly immunized saying that it hurts their children and causes other kinds of side-effects. They were also of the view that their children are doing well without immunization, hence there is no need to give them pain. Kumar et al, documented the similar reasons for partial or non-immunization in their study too. The three most common demographical factors affecting the immunization status found in their study were maternal education, religion and place of delivery.[12] Hence, all mothers should be made aware of the importance of immunization, misconceptions associated with it along with consequences their children might have to face without proper immunization.

From the findings it can be seen that how early marriage as a norm in the communities can result in early age pregnancies making young mothers and their children vulnerable. Also, prevalent socio-cultural practices during pregnancy and child care and patriarchal structure deprive women from accessing health services during the time when they need them the most. Their busy routine even during pregnancy leave them overworked with no concern for taking nutritious diet or proper rest making them feel child birth just as any other task. It not only results in poor maternal nutrition but also put the life of the child on stake leaving the child with poor health forever. Further, norm of home delivery, no birth spacing, son preference and delay in starting breastfeeding and incomplete immunization of the children further aggravates poor mother and child health conditions.

CONCLUSION

Based on the results, this study draws attention to two points. First and the most important one is lack of awareness amongst women about mother and child health (MCH) and even if they have, they do not get enough support from family members to adopt health seeking behaviour. Thus it is very important that MCH related key messages and provisions and benefits of government health schemes should be repeatedly shared and discussed not only with women but also with their family members especially husband and mother-in-law. It was also observed that these communities do not have much media penetration through which awareness on various issues could have reached them easily. Hence local media of communication like drama, folk songs, community radio etc., should be used for awareness generation. Second, women who were mostly illiterate did not seem to have any role in decision making, be it related to their own health or any household decision. In such a patriarchal environment, girls' education can play a very proactive role in developing positive self-esteem and build their confidence to be able to raise their voice what they feel is right and to express their choice what they need and want. Hence there should be consistent efforts for girls' education which can really work as a catalyst for a healthy and prosperous society.

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