

ORIGINAL ARTICLE

PERSPECTIVES REGARDING ANTENATAL CARE, DELIVERY AND BREAST FEEDING PRACTICES OF WOMEN FROM BALUCHISTAN, PAKISTAN

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Background: Antenatal Care is one of the fundamental rights for women to safeguard their health. Neonatal mortality rates have remained relatively static, compared to the decline in infant and under 5 mortality rates, adverse practices regarding breast feeding and pre-lacteal feeds being the important factors responsible. This study aimed to explore the Antenatal Care, delivery and breastfeeding practices in three districts of Baluchistan. **Methods:** It was a qualitative phenomenological design using Constructivist approach. The study was conducted in three districts of Baluchistan province, Gwadar, Quetta, Qila Saifullah. There were a total of 14 Focus Group Discussions with women regarding Antenatal Care, delivery and Breastfeeding practices, followed by audio taping, transcription as verbatim and analysis through Nvivo version 2. A process was deployed for identification and reporting of the components in order to ensure quality and validity of the qualitative findings. **Results:** Across the sites, women attended ANC at least once. However, their descriptions of ANC often varied. The women preferred *Dais* instead of doctors, due to the affordability, customs and availability. A lack of trained doctors and long distances to get a check-up lead to home deliveries in the study setting. Colostrum was discarded by majority of the mothers, while prelacteal feed was a common practice. **Conclusion:** This paper has explored factors affecting ANC attendance, delivery and breast feeding practices across three settings. Both the demand and supply side factors have an important influence on practices.

Keywords: Antenatal Care; Delivery; Breastfeeding; Baluchistan

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INTRODUCTION

Maternal mortality is a key indicator of international development, its reduction being a challenge in low-income countries.¹ The antenatal period presents opportunities to reach out to pregnant women with recommendations that may be vital to them and their infants. The importance of Antenatal Care (ANC) cannot be questioned with high quality ANC being a fundamental right for women to safeguard their health. ANC offers a set of safe motherhood interventions that may significantly reduce maternal and prenatal morbidity and mortality.² The recommendations advocate at least four ANC assessments by or under supervision of a skilled attendant commencing as early as possible in the first trimester incorporating a range of interventions.³

According to Pakistan Demographic and Health Survey (PDHS1990-91), 70% of pregnant women did not receive ANC, 23% received ANC by a trained doctor, 3% by nurse, lady health visitor or family welfare worker, and 4% by trained or untrained Traditional Birth Attendants (TBAs/Dais).⁴ To add on to this, home deliveries by TBAs/Dais are a cultural norm in Pakistan.⁵ Less than 20% deliveries are conducted by trained health professionals, the number being much lower in rural areas. About 65% of deliveries are conducted at home with TBAs assisting almost 79% of home deliveries.⁵

Infant and under 5 mortality rates in Low Middle Income Countries (LMICs) have declined significantly in the past couple of decades, yet neonatal mortality rates have remained relatively static.⁶ One important determinant of neonatal mortality is the adverse practices regarding breast feeding and pre-lacteal feeds, leaving the child undernourished, influencing the child's overall development. A recent analysis proves that suboptimum breast-feeding in the first 6 months of life, results in 1.4 million deaths annually and 10 % of the disease burden in children under 5 years of age.⁷

Baluchistan is the largest province of Pakistan, with an estimated population of 7,914,000.⁸ Quetta is the largest city and provincial capital of Baluchistan with a population of 759,941 (1998 estimates).⁹ It is relatively urbanized, compared to the other two study areas and has a developed health infrastructure. Gwadar is the district headquarters of Gwadar District with a population of approximately 85,000 according to official figures. Gwadar is one of the few planned cities in Pakistan, but due to lack of trained personnel for ANC in the area, the population has less opportunity to access MCH facilities.

Qila Saifullah is a small town located in Baluchistan with a population of 193,550 (1998 figures).¹⁰ The Maternal mortality rate is 785 per

100,000 live births⁸ with a total of 90 MCH facilities within the entire province.

The experiences of end-users of the services provide a critical means of assessing quality of a system. Poor satisfaction or unpleasant interaction with healthcare providers during pregnancy may compromise women's access to vital services, thus jeopardizing the health of the women and their infants.¹¹ There is dearth of such research in developing countries bearing brunt of maternal and infant mortality.

Considering the paucity of research and absence of comparative studies, drawing on the results from a subsample of a larger study, this paper aims to explore the cultural practices of ANC, delivery and breastfeeding practices in three districts of Baluchistan (Gwadar, Qila Saifullah and Quetta districts). Data from the three research sites are presented providing an opportunity to investigate the factors responsible for various practices at each study site and to propose areas for potential policy interventions.

MATERIAL AND METHODS

The study was approved by Ethics Review Committee of Aga Khan University, Karachi. Informed consent was obtained from all participants before enrolment in the study and confidentiality of data was strictly maintained. As the data was collected through focus group discussions oral informed consent was obtained and with the agreement of participants, verbal consent was voice recorded prior to each interview or focus group discussion.

This qualitative study is a part of a large quasi experimental design conducted under the Early Childhood Development Baluchistan Project (ECD-BP). Data was collected in three districts of Baluchistan namely Gwadar, Qila Saifullah and Quetta using Purposive Sampling Technique.

Study respondents were women aged 15–49 years, resident of the research sites. They were identified with the assistance of community workers. A point of saturation approach was also applied to the total sample of women.

Constructivist approach of qualitative phenomenological design was used for the research. A total of 14 Focus Group Discussions (FGDs) were conducted by trained persons with women, for understanding ANC, delivery and breastfeeding practices of infants. Semi-structured guidelines were developed based on the themes of ANC, delivery and breastfeeding. Probing questions were asked where required to explore details. Sessions were conducted in Urdu, the national language of Pakistan. Considering the availability of the participants the FGDs were conducted mostly during daytime in a community centre. The FGDs were conducted over a period of two to three months. Each was of 60–120 minutes duration having a

minimum 5 and maximum 13 participants. Notes were taken by a note-taker and a moderator and sessions were audio taped. Photographs or video coverage of sessions was not allowed by participants. A translator was present during sessions as participants switched to the regional language, Balochi, during discussion. This translator later helped in transcription of data.

The data was transcribed as verbatim and analysed through Nvivo version 2 for all the themes. There was a process for identification and reporting of the components in order to ensure quality and validity of the qualitative findings. Data collection and analysis were carried out in parallel, whereby emerging themes could be identified and incorporated into revised interview guides to provide a comprehensive insight into the relevant topics.

RESULTS

Thematic analysis identified six prevalent themes of practices, as shown in table-1. The mothers from the study sites were asked about how they get to know about their pregnancy. Majority of women quoted that they recognize their pregnancy due to presentation of symptoms such as: they do not feel good, miss their monthly cycles, and have symptoms of nausea, vomiting, dizziness, somnolence and heartburn.

According to mothers from Gwadar:

"When I feel pain in my feet and when I start vomiting, then I go to see the doctor".

"We go to the doctor only if the child is unwell or if the mother has excessive bleeding".

A grandmother from Quetta had the following statement regarding care during pregnancy:

"We worked for whole 9 months. We used to get pain at night and in the morning the baby was delivered. That is how people used to know of our pregnancy".

A Mother from Qila Saifullah stated the following regarding care during pregnancy:

"The one who takes care of us is Allah, we do all (house work) by ourselves. I work all the time. I want to work, the position of my child remains proper".

Respondents were not very clear regarding the number and timings of recommended ANC visits with varying responses from, as less as one, to even up to 9 visits. Visiting the doctor largely depended on availability of a lady doctor in their area. There was no striking difference between the three study areas. Around 96% of the women both from Quetta and Gwadar stated seeking medical help for confirmation of pregnancy, once they have the symptoms mentioned earlier. Grandmothers however, did not seek medical confirmation for any of their child, stating their experience to be sufficient to confirm the conception. In Qila Saifullah however, women were referred to a doctor only in case of serious complications or if the child was unwell.

According to mothers from Gwadar:

"When I am pregnant, I don't see a doctor as she doesn't know anything. Nowadays Dai gives us injections so that the child is normal... Dais are much better than doctors".

"Antenatal Care should start from the beginning; mothers should get their check up from doctors. Here (in Gwadar) the women go towards the end (last trimester) and doctors are available in Karachi."

A Mother from Quetta had the following statement:

"We get an injection, get a check up, they (doctor) check the level of blood. Doctor says to get a TV X-ray (Ultrasound) in 7 months."

Five barriers to care were significantly reported during all the interviews; these included financial problems, transport problems, time conflicts, unawareness of the importance of ANC, and a lack of knowledge regarding ANC.

Mothers from Qila Saifullah had the following statements:

"I become very weak when I am pregnant. The doctors working in government setup don't check us. I don't have money and have to go twice in a month for the check-up."

"Antenatal Care is important, but there are no hospitals here, so where can we have the check up? I get an injection from Kardaana (an area at some distance), then go to Gwadar for delivery."

Traditional practices of delivery involving Skilled Birth Attendants (SBAs) were widely prevalent in all three districts. Some system-related barriers were also reported in all the three sites; inadequate or lack of maternity care providers, complex and time-consuming process of registration, inconvenient clinic hours especially for rural women working as farmers in fields, long waiting hours, language and cultural disparity between the women and the providers of ANC, negative attributes of the clinics including hostile behaviour of the staff, uncomfortable surroundings and expensive procedures. Moreover inadequate social support system also leads to hampering women accessing antenatal care services.

Home deliveries were found to be a common practice in all three districts, with 67% of women stating of taking services from the *Dai*. People trusted these *Dais* more than doctors, who had been serving them for many years during deliveries. One woman from Gwadar mentioned that she does not go to the doctor for an ANC check-up as the doctor asks her to remove her clothes, which is a challenge for her.

Giving prelacteal feed to the new-born was a common practice in the study settings with almost 97% of the women giving their child prelacteal feed. The composition of prelacteal feed varied across the three areas, however there were some similarities witnessed as well. Honey was given to almost every child at birth.

In case of unavailability, water mixed with sugar was given. The reason stated behind this practice was the cleansing of the child's stomach. A common practice was the use of butter and some natural herbs on the first day of birth. Some mothers also stated giving the child green tea to clear the stomach. In Quetta the practice was of giving butter (*Desi ghee*) to the child, while in Qila Saifullah along with butter they also gave the child herbs mixed in water. In Gwadar they had the practice of giving the child dates and cereal. It was also noted that for mothers giving the child prelacteal feed was part of custom and tradition that had been in place for generations.

Mothers from Quetta stated the following:

"We give our child desi ghee (butter) and natural herbs to clear the impurities in his stomach."

"Giving the child prelacteal feed and honey is a custom here."

According to mothers from Qila Saifullah:

"We give the child sugar water; we give this when the child's stomach is bad."

"First we give the child natural herbs and green tea. This is good for his health. His stomach is cleaned through this."

Wasting of Colostrum was mentioned by around 24% of the women, with a diversity of reasons behind the practices. On exploring the reasons, it was evident that it is the result of perceptions such as contamination, traditional practices as well as adverse experiences, such as stomach upset. However, mothers from Gwadar and Qila Saifullah were of the opinion that colostrum had beneficial effects on the urinary system, the stomach and also stated that the child grows faster when he/she is given the first milk. Mothers from Gwadar stated the following:

"I discard the milk that comes after child birth. I did that after every child birth."

"When a child takes first milk, the impurities within the stomach are removed."

"When I used to breastfeed my child, evil spirits used to come."

Mothers from Quetta had the following views:

"The child's stomach gets upset; therefore the first milk is discarded."

"The elders say that the first milk is to be discarded... I don't know why..."

A majority of mothers were aware of the importance of Exclusive Breast Feeding (EBF) and also practiced it. Breast milk, however, was not fed at all by 21% of the mothers in three of the districts, owing mainly due to their adverse health conditions such as weakness, feeling of dizziness, sinking of heart, and depletion of body fluid, which left the mother with no choice but to start her child on bottle feed. Some mothers also mentioned the myths attached to the practice, including advice by the Muslim clergy suggesting evil spirits

attached to the practice, due to which they had stopped breastfeeding their child.

Mothers from Quetta stated that:

“Mother’s milk is very good for health, compared to formula milk.”

Practices of child care were interlinked with customs and traditions which included forming the facial and body parts like limbs by tying a tight cloth. Myths regarding evil eye commonly prevailed among the community, which according to the mothers, mostly lead to the ill health of the child, the child used to cry constantly, and there was also sign of shedding of the child’s eyelashes. To counter such incidents, the mothers went to religious leaders who gave them a *taaweez* (written Holy verses to counter the effect of evil eye) to be tied around the child. The children were then kept away from others when born. Pregnant women, those who were menstruating and those wearing holy verses were not allowed to enter the child’s room. This practice was found throughout the three districts. For some women, child demise was also linked to the evil spirits.

According to mothers from Gwadar:

“We don’t bring the child in front of those who have an evil eye. The child cries when brought in front of such people.”

“If a woman has periods (menstruating), she shouldn’t come to the room where the child is. That way the child becomes ill.”

“The molvi gave us a taaweez. The child had stopped breathing. Therefore when the child was 8 days old, he passed away. The doctor said that he had fever since morning. I went to the molvi, he said the child had been possessed by evil spirits.”

Mothers from Qila Saifullah stated the following:

“We shape the child’s head by tying up a cloth on the child’s head. We swaddle the child with a cloth.”

Table: Major themes of focus group discussions

Theme 1: Confirmation and care during pregnancy
Theme 2: Antenatal Care practices and preferences
Theme 3: Barriers in access to Antenatal Care and resource availability
Theme 4: Local practices of prelacteal feeds
Theme 5: Perceptions and practices regarding breastfeeding practices
Theme 6: Traditional practices after child birth

DISCUSSION

Traditional practices regarding pregnancy and ANC have shown to cause everlasting harm to the woman and the child.¹² Utilization of ANC services provides opportunities for a complete range of health promoting services and chances of counselling women about possible serious complications to pregnancy and delivery and to promote institutional delivery.¹³

According to the Pakistan’s World Health Organization (WHO 2010) health profile, only 28% of

Pakistani women have used ANC services (4 plus visits), whilst 39% of reported births in Pakistan had used skilled birth attendant services, whereas 59% fell within the WHO’s regional average.¹⁴ In our study site, women preferred TBAs over trained doctors and mentioned all reasons from doctors being unavailable or expensive to deal with, to the discomfort in exposing themselves during the check-up. Supporting this data, evidence suggests that low income is one of the most important predictors of insufficient antenatal care. Families with incomes below the poverty level consistently reported higher rates of late or no ANC and lower rates of early care.¹⁴ A study from the *katchi abadi* population of Karachi suggested similar pattern of ANC, with 41% of the women not receiving ANC because of lack of financial support, 33% stating lack of family support in the decision to get ANC and 13% said transportation was an issue.¹⁴ The poor performance of healthcare providers of Baluchistan is attributable to their suboptimal working conditions, poor infrastructure and lack of basic functional equipment needed for ANC and assessment.^{8,15,16}

Colostrum is a vital element of breast milk and is responsible for providing the new born with immunomodulatory components, thus ensuring protection and development of the immune system. However, use of colostrum for the child varies across different communities. Delayed breastfeeding initiation, colostrum deprivation, supplementary feeding of breast milk substitutes, early introduction of complementary feeding, and incorrect weaning from breast milk are commonly found practices in communities around the world.¹⁷ According to figures from The UN Children's Fund (UNICEF) there is limited practice of Exclusive Breastfeeding practice in Pakistan(16%).¹⁸ Evidence suggests use of colostrum being influenced by factors such as lack of knowledge, ignorance, undesirable socio-cultural beliefs, and misconceptions prevailing in the community are reported to influence breastfeeding practices of mothers.¹⁹ Similar influences have been highlighted in the study participants, with the practice of discarding the first milk on account of it being harmful for the child’s health. However, religious leaders being involved in the advice against breastfeeding of the child was a striking finding in our study.

The use of qualitative methods enabled analysis of how a range of factors influences ANC attendance. Moreover, the analysis of data from several sites – with a combination of varied social and cultural contexts, and varied and similar ANC delivery and attendance profiles – meant that the interaction of factors associated with the delivery of, and the demand for, ANC could be explored. Hence the social and cultural contexts of ANC delivery and uptake were explored together and compared and contrasted across the sites.

A review of the health records of the ANC facilities could have provided evidence regarding frequency of utilization and attendance of the facilities. This could further lead to triangulation of data that would have added to the strengths of the study. Nonetheless, in spite of this, sufficient data on ANC were collected to enable a thorough comparative analysis of the factors influencing attendance.

CONCLUSION

This paper has explored factors affecting ANC attendance, delivery and breast feeding practices across three settings. Both the demand and supply side factors have an important influence on practices. *Dais* remains the preferred choice for ANC and delivery, along with prelacteal feeds being prevalent across the sites. Efforts concentrated to increase positive perceptions of pregnant women may influence their health as a result of utilization of available resources and ultimately improve the state of Maternal and Child Health in Pakistan.

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AUTHOR'S CONTRIBUTION

The project was funded by AKFP, GR was the Principal Investigator. The study and tools were designed mutually by GR, AZK and SAS. Data was collected on the FGDs by AK. Analysis and write-up was done by AK and SAS.

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