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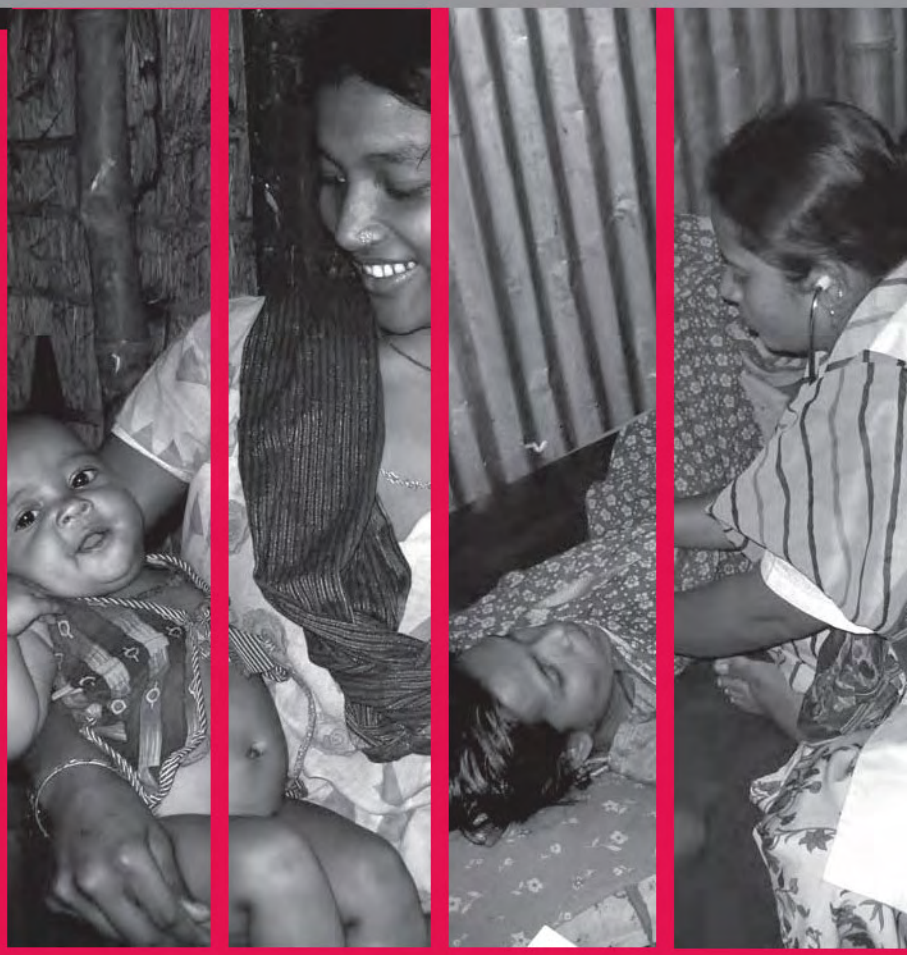
Maternal, Newborn and Child Health Practices

An Exploratory Study of *Korail* Slum in Dhaka



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icddr,b
KNOWLEDGE FOR GLOBAL LIFESAVING SOLUTIONS

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EXECUTIVE SUMMARY

This is a qualitative study of the current state of maternal and neonatal care practices within *Korail* slum of Dhaka city under BRAC's *MANOSHI* programme. This study portrays the practices and behaviours related to the care of the newborn, pregnant and postpartum women, including identifying the underlying reasons behind these practices.

The study population consisted of slum dwellers in *Korail*, where a Maternal Newborn and Child Health (MNCH) programme exists. Sixteen women were interviewed from the entire slum to understand the practices and rituals during pregnancy, delivery, and post birth. Study results revealed that when women suspected pregnancy, all of them sought care from a health facility or providers to confirm pregnancy, to be reassured about the state of their pregnancy and the condition of the foetus. Women employed both folk knowledge and biomedical understandings on protection of their pregnancy. Their past pregnancies without complications contributed to their lack of understanding for the need to access care from a facility. One of the rituals during this time was to follow certain dietary restrictions. They strongly believed the role of the supernatural world and maintained certain restrictions to avoid evil spirits. They generally remained very active throughout their pregnancy.

Women would tend to rely on *dais* and family members during labour pain and delivery, with limited birth preparedness. Initial labour pains were followed, mothers or mothers in law usually observed certain rituals to facilitate quicker delivery of the baby. Most deliveries take place at home. During postpartum care, almost all women reported that they did not find it difficult to follow the dietary restrictions, as they could not afford any extra nutritious food. They did not go for a postpartum check-up because they did not have any major problems.

In terms of neonatal care practices, cutting the umbilical cord of the newborn after the expulsion of placenta was widely practiced. Tying the umbilical cord with thread was common and perceived as a way to prevent bleeding. The main reason for not boiling thread was the lack of awareness of the risks associated with using non-sterile thread. Applying substances on the umbilical stump was an important part of cord care practice for the newborn baby in order to facilitate timely drying up and falling of the stump and the cord. Bathing of the baby was considered one of the immediate priority activities after the birth.

Based on these findings, there is a need to increase knowledge and awareness among women and families regarding the use of health services, birth preparedness, newborn care and exclusive breastfeeding.

INTRODUCTION

The urban population in the country was 31 million and is increasing rapidly (ADB, 2005). As much as 40–70% of urban population growth is attributed to rural–urban migration. UNICEF has forecasted that the urban poor population may rise to 30 million by 2020 (BIP and CUS, 2005). It is estimated that there are 4500 slum settlements in Dhaka city as of 2005 (BIP and CUS, 2005). About 30% of Dhaka's population can be defined as 'hardcore poor' (defined as having per capita monthly income of US $43 or less)[1] and 50% as poor (defined as having per capita monthly income of US $ 65 or less) (GOB, Bangladesh Economic Review, 2004). It is reported that the health indicators are worse for the urban poor than the rural poor (MOHFW, 2001).

Safe delivery services provide protection of life and health of the mother and her child by ensuring safe delivery. Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may cause death or serious illness to the mother, the newborn, or both. The Bangladesh Maternal Health Strategy encourages women to deliver under the care of medically trained birth attendants. Only nine percent of births occur at a health facility, while almost all others are delivered at home (BDHS 2004). Similarly one ethnographic study of three sections of a Dhaka urban slum found that out of 104 adolescent women, 59 (57%) relied on traditional birth attendants and 34 (33%) relied on close female relatives for the delivery of their baby. Only 12 (11%) had their babies delivered in a private clinic or hospital. Poor quality of care in hospitals, costs and shortages of cash result in a reluctance to spend money on something that is perceived to be a natural event and that has essentially been practiced for decades at home with negligible expenses (Rashid, SF, 2005). Nationally, the infant mortality rate is estimated at 71 to 82 per 1000 live births and one in nine children dies before reaching the age of five. In urban poor households, the mortality rate of under five-year-olds is three times higher than of children from well off urban households (HKI, 1997; BBS, 1997).

BRAC's community based intervention called *MANOSHI* is a five-year project. It will be implemented in urban slums of six city corporations, namely,

[1] US $ 1 (one dollar) = Taka 70 (seventy) BDT (July 2006).

Chittagong, Sylhet, Rajshahi, Barisal, Khulna, and 15 statistical metropolitan areas of Dhaka, to provide services to 8 million populations throughout the project period. It will adapt the Essential Care Programme model that has been successful in rural Bangladesh to the urban setting. The components of the project include: capacity development of the community health workers and birth attendants; health service provisions for pregnant and lactating women, neonates and under-five children; timely referral to quality health facilities; community empowerment through development of women's groups; and linkage with government (national and local), community people, and NGOs. The community health workers and Urban Birth Attendants will be trained to offer antenatal, safe delivery and postnatal care, neonatal care and child health care.

The uniqueness of the programme will be to identify all pregnancies and follow them up no matter where women seek care. Pregnant women will be encouraged to give birth at birthing huts for maintaining privacy and hygienic delivery. In case of complications, women will be ensured comprehensive emergency obstetric care in preselected referral facilities, preferably Urban Primary Health Care Project (UPHCP) run health facilities operated by the Ministry of Local Government, Rural Development and Co-operatives (MoLGRDC).

OBJECTIVES

The objective of this study is to see the current state of maternal and neonatal care practices within *Korail* slum.

Specific objective:

- Understand the practices and behaviours related to the care of the newborn and pregnant and postpartum women.
- Further understand the reasons behind these practices

METHODOLOGY

Study Site

The study was carried out among slum dwellers in *Korail* slum of Dhaka city where an MNCH program exists. *Korail* slum has been selected as one of the pilot areas for all MNCH formative research.

Study Population

To know the practices and ritual during pregnancy, delivery, and after birth, respondents were selected from lactating mothers of babies within one year and those pregnant women who have already delivered at least once. Sixteen women were selected as respondents for interview from the whole slum (eight lactating mothers and eight pregnant women) were selected.

Study Design

It was a qualitative study. In-depth interviews were used to address the research questions.

Sampling

Eight pregnant women were randomly selected from the pregnant mother's list. Since there is no existing list for the recently delivered women, eight lactating mothers were selected purposively from *Korail* slum.

Data collection occurred from March to April 2007.

RESULTS

A number of themes emerged from the interviews with mothers in *Korail* slum on pregnancy and newborn care. This report is divided into 3 main sections, the first part outlines the background of the respondents, the second section discusses in detail practices and experiences surrounding pregnancy, delivery and postpartum care, and the final section outlines new born care practices.

Respondents' Profile

Below is a brief description of the respondents of *Korail* slum area. Like many slums, it remains marginal and has not especially benefited from any of the large development projects in the surrounding locality. The respondents are residing in this slum for quite some time, ranging from 8 to 25 years, and only one respondent was a recent resident, having moved only one year ago. The mean age of respondent is 24 years. Most of them did not receive any formal education. 10 out of 16 respondents were involved in income-earning activities, mostly in garment factories, but due to pregnancy, they had left their jobs. Their home districts varied and included Comilla, Sherpur, Mymensingh, Patuakhali, Feni, Barishal, Bhola and Sylhet. Most of the respondents' husbands were rickshaw pullers; some were working in small businesses, as tea shop assistants, or guards in government departments. The urban poor are constrained by their complete lack of qualifications and the only work available tends to be labour intensive, stressful, low paid and at times dangerous in a highly competitive sector.

Out of 16 respondents, eight of them were currently pregnant with having one or more child, and eight others were postpartum mothers, having borne a child less than one year ago.

Pregnancy, Delivery and Postpartum Care

For most of the women, pregnancy, delivery, and post partum care was seen as a normal event, which did not require any particular medical intervention, unless significant complications arose during this period, a finding reported elsewhere (Blanchet, 1994; Afsana and Rashid, 2000; Afsana, 2005; Goodburn et al.). The role of family members during these periods was important and they played an important role in influencing behaviour. While health care providers are

important and a key link to accessing antenatal care and can serve as a bridge for referrals and shaping decisions, most of the women continue to place great importance on existing social, cultural practices and norms which dictated behaviour, diet, and mobility as well as delivery care rituals.

The First Signs

All of the women said they became aware that they were pregnant when they experienced amenorrhoea, nausea and vomiting, and loss of appetite. All of the women went to check their suspicions by doing a urine test or physical examination in a nearby health facility. In a number of cases, health providers working for BRAC conducted the examination and urine test in the women's homes. The costs of physical examinations and urine tests at the health facility or home visits ranged from Tk. 15-60 only.

As one woman respondent, aged 22 said (ID# KR 10),

> *"First indicator of pregnancy is stopping of regular menstruation, and then to confirm this pregnancy we consult with a doctor"*

Women believed that the urine test was the final indicator of pregnancy, and did not know that urine tests can also give a negative result even if the woman is pregnant. In one case, a respondent (aged 25, parity 3) stated that when she missed her first menstruation she conducted a urine test, which gave a negative result, so she was sure she was not pregnant despite having symptoms of pregnancy. She had spent Tk 20 on the test and was convinced she was not pregnant. After a period of four months, the woman became suspicious as her abdomen had distended and she felt foetal movement. She said,

> *"After four months of pregnancy, the baby started moving, moreover I felt a lump and then I understood that I am pregnant"* (ID # KR 11)

She did not seek out a health provider after she discovered she was pregnant because of lack of money. Almost all of the women discussed their pregnancies first with their husbands. Only two women also informed their mothers-in-law and sisters-in-law immediately. One of the women said,

> *"My husband said we are blessed by Allah, now it is your (indicating his wife) responsibility to take care of this, so you should take care of it by being careful and following appropriate norms and behaviour"*

Antenatal Care

Role of Providers

According to the National Mother Health Care Guidelines, a pregnant woman should attend ANC from trained service providers at least three times during her pregnancy. In *Korail*, BRAC staff were offering a package to cover the costs of antenatal care for Taka 300 during the period of fieldwork This package is meant to include home visits to ensure ANC takes place and to provide suggestions for TT and referrals for complications. Of the 8 respondents, those who are currently pregnant, only one respondent availed the BRAC package.[2] Women also sought suggestions from other groups of providers including Club Ghor (private), some clinics such as Marie Stopes (NGO operated) and Nabisco Clinic (privately operated), and also a *kabiraj* from nearby, which provided services for pregnant women and children.

Women said they themselves did not usually seek out ongoing antenatal care facilities on a regular basis from nearby health facilities, as they did not see an urgent need for it, except to reconfirm pregnancy. However, they said that they were open to providers conducting home visits, namely those conducted by BRAC staff.

In the initial stage when women suspected pregnancy, all of them said that they either sought care from a health facility or from providers who conducted home visits for the purposes of confirming pregnancy through urine test, to be reassured about the state of their pregnancy, and the condition of the foetus. In some cases, it was reported that mothers-in-law and husbands encouraged their wives or even accompanied their wives to attend ANC, particularly when the woman first suspected she was pregnant. Women employed both folk knowledge, and biomedical understandings on protection of pregnancy. For example, in the

[2] It must be noted that for past pregnancies, BRAC was not working in *Korail* slum. BRAC started the MNCH program in slums in Dhaka in late 2006. Some of the past pregnancies took place earlier.

case, a woman (aged 25, parity 4, ID # KR-13) after abortion of her last pregnancy, her mother-in-law gave her an amulet (*tabeej*)[3] from a *Kabiraj* to avoid more mishaps and she also sought initial care from a health provider. This was not unusual as many women sought multiple forms of services and advise to ensure safe pregnancy.

During this interaction health providers were message bearers on pregnancy care, focusing their information on the need for iron supplementation, and for eating extra food and continuation of regular check-ups. Although, home visits were conducted, and women received iron tablets, they did not appear to take them regularly. This finding emerged from discussions with almost all respondents with many stating,

> *"I got many Iron tablets but I did not take them, because it would make my child big in size, moreover it dries the flow of breast milk"*
>
> *"The tablet smells and makes me more nauseous"*
>
> "*The tablets will make my baby big; I will have a difficult delivery"*
>
> *"My stool colour has changed and it makes me feel worried…"*

Another barrier to ANC was the lack of importance given to it by the women. Many claimed that they had pregnancies in the past without complications and did not understand the need to access care from a facility during a period which was seen as normal and natural part of life.

Table 1: Pregnancy and ANC Care of Mothers (multiple responses)

Tests or services done during ANC visit (home and facility both)	Respondent (n)
-Urine test	13
-Iron supplementation	10
-Blood pressure	9
-Fundal height	8

[3] *Kabirajis* (traditional healers) provide amulets with prayers for protection of women during pregnancy. This is an extremely common practice to ward off evil spirits and any negative energy which may harm the baby (see Blanchet, 1994; Afsana and Rashid 2000).

-Body weight	7
-TT injection	5
-Vitamin supplementation	5

Advised on the followings during pregnancy	Source of information (n)	
	Relatives/ neighbour/elderly people	Service providers
-Iron or vitamin supplementation	-	13
-Take one more handful food	4	10
-To do checkup	7	9
-TT immunization	-	9
-Taking rest or refrain from heavy work	2	8
-Food and nutrition	4	8
-Advice to do urine test	5	8
-Instruct to keep clean	2	4
-Not to stay with husband	11	3
-Not to drink cold water or any cold thing	3	3
-Ultra sonogram	-	1
-Not to take any medicine without prescription	-	1
-Restriction while eclipses	12	-

Role of Family, Relatives and Neighbours

Family members and relatives (both kin and non-kin) also played a very significant role in advising women on how to behave appropriately during the pregnancy period to ensure an easy and safe delivery. While health providers emphasize iron supplementation, regular checkup, and ANC care, contrarily, family members highlight the importance of dietary restrictions (although, from women's reports, this was more significant during postpartum period), restricted mobility to avoid supernatural elements, as well as, avoiding sexual intercourse with husbands.

The Mothers' Food and Mobility Restrictions

Women reported a number of rituals surrounding pregnancy care. Proper food intake during pregnancy was reported to be very important. Many women said they were able to follow certain restrictions on their diet – mainly avoidance of

certain fish fairly easily, because they had loss of appetite and nausea during the first trimester of the pregnancy. A common remark was,

> *"I couldn't eat anything, what could I do? I was always getting bad smell in food"*

In one case, the woman (age 35, parity 3, ID# KR-12) only lived on rice and jiggery (sugar cane) for the first three months. Fish such as *Mrigael, Pangaash, Baieng, Hilsha, and Taki* were commonly mentioned as those to be avoided. A few of the respondents also mentioned avoiding mutton and duck meat. Women reported that it was commonly believed that taking fish with big mouths could make the child's mouth big as well. These women reported that since their mothers, mothers-in-law and other elderly people had been following such restrictions for a long time they also tried to comply with similar ways.

However, in one case, a young woman said she did not believe in any food restrictions. She did not follow a special diet during pregnancy. She said that a mother should eat well to be healthy and strong. It is unclear why she held such different views from the rest.

Influence of Supernatural Forces

Most of the women mentioned that eating restricted fish can attract evil spirits and should be avoided. The role of the supernatural world is extremely pervasive and critically informs understandings of pregnancy mishaps, miscarriages etc. Women said that usually during pregnancy, females should avoid certain spaces/locations at particular times of the day – during the call of prayer (dawn, noon and evening). In interviews, women said that abortions and stillbirth happened due to the result of *bhoot* action and for violating mobility or other restrictions.

> *"I never hold Hilsha fish while coming back from haat (bazaar) ……because bhoot/jeen (evil spirits) likes this fish a lot."*

During initial exploratory visits to *Korail*, it was not uncommon to hear older women frown and remark on the way younger women carried themselves.

> *"Today women walk with their bellies sticking out and won't they lose the baby then. Of course the women will have more complications…they have no shame so of course they will have problematic pregnancies. In our time, only when the baby cried (after delivery) did people in the community realize we are pregnant"*

The women claimed that they maintained the mobility restrictions but whether in actual practice they followed it is difficult to assess and beyond the scope of this exploratory research. However, in all of the interviews women did mention the power of *bhoots* and it was generally reported that evil spirits were more active in the evening, at noon and at night, so pregnant women avoid leaving the house at those times. Some of them did state that if they needed to go out they took other precautionary measures, such as tying their hair and/or covering their hair.

> *"Evil spirits can cause miscarriage of the foetus; that is why I did not go outside in the evening, noon and midnight"*

> *"A Pregnant lady must not travel unnecessarily for it entails risk"*

A few women reported that protection could be brought by ensuring a piece of iron or matches, and even dry bones of a cow were effective in keeping away the evil gaze of the spirits. In one case, a woman reported that her mother-in-law brought a bone from a cow from her own village and gave it to her for her safety. In this case, the researcher observed the woman walking around with the bone in her hand when being interviewed. She said,

> *"I usually take the bone with me whenever I go to the toilet as the evil spirits lurk there the most!"*

Most of the respondents mentioned that pregnant women could be affected by lunar and solar eclipses. Twelve out of the sixteen women reported staying inside the household, sitting or walking near the home or inside the home, but they never lay down on the bed during eclipses. A common statement was, *"no one should lie down during an eclipse"*. They also reported certain restrictions during this period, they did not eat or cook, cut, twist anything, as they perceived that the child would be born with a cleft palate or with deformed features. Many of the women reported that family members, landlady, and spouses were the main informants as to when there was a lunar or solar eclipse.

The understanding of pregnancy rituals places the onus on the woman to be responsible and maintain a safe pregnancy as she is usually blamed for any pregnancy failure (Blanchet 1994; Rashid, 2005). An urban slum study found that older women increasingly blamed young women for their mal-pregnancies and miscarriages, stating that they did not want to follow expected norms of behaviours. They complained that women were far too eager to leave the house and not practice *purdah* anymore, leading to more incidences of infertility and miscarriages (Rashid, 2005).

The Mothers' Workloads

Women said that they generally remained very active throughout their pregnancy. Observations during fieldwork found that women were busy cooking, cleaning, washing clothes and keeping the household clean. According to the women, till their first labour pain began, they did all of their household work, carried water jugs, and continuing their arduous work as usual. In *Korail* slum, often, women had to walk 8 to 10 minutes to the periphery of the slum to access water, in the heat of the day. Water access was also intermittent so when water came, usually there was a rush to get their job done within the time limit and then keep water in a water drum. Women said that it was difficult to access water in the summer months as there was serious water shortage and many were forced to walk outside the slum for water access to the neighbouring locality.[4] Pregnant women would have to sit and cook in congested spaces, inhaling cooking fumes as they cooked for the family. One extensive study on slums reported that most slums are high density, very congested, with the average size of rooms being between 76 and 100 sq ft (BIP and CUS, 2005).

> *"In the morning after getting up from bed I clean my house, clean the utensils, bring water, wash clothes, and all types of household work"*

> *"What I did before…I am still doing ….I did not change my lifestyle. I have to do all the work in the household. Everyday, I have to bring 8-10 Kaloshi (pots) of water from the TNT colony area. I have no ability to afford a worker or servant"*

[4] During our interviews in the summer months, there were serious water shortages in the slum. Women were frantic about accessing water and we found that it was sometime difficult to interview the women and also have them talk about their pregnancy experiences during this difficult time, but we managed.

> *"Three months after conceiving, I left my job. I felt weak, couldn't tolerate the hot weather at the garment factory and I couldn't work ...sitting for hours on the machine and I couldn't take any type of food"*

While there appears to be a general understanding among the women that it is better not to be engaged in hard physical work during pregnancy, it was difficult for many to rest. We found only one case where the respondent took rest on a regular basis during her pregnancy period. Usually women try and take help from their relatives especially sisters-in-law, mothers-in-law, sisters or mothers. In a few cases we found that the husband helped in household activities. Paying for someone to assist them is out of the question for almost all women as they are poor. In only one case, we found the husband could afford it and the woman appointed a maidservant to help her.

Of the eight women currently pregnant, one was planning to move to her own parent's house for delivery so she could receive help and support from her mother and sisters.

> *"As there are no helping hands for me in the household, and moreover, I do not have capacity to keep one maid, so I'll move to my own mother's house for delivery"*

> *"In my father-in-law's house none can help me in household activities, and all the heavy work makes me weak, that is why I had to leave my job"*

One woman claimed that it is the custom to give birth to the first child in her father's compound so she went to her father's house. This practice of giving birth to the first child in one's own natal home has been found in other studies as well (Blanchet, 1984; Afsana and Rashid, 2000; Chowdhury et al, year).

Delivery

The study also revealed trends and practices of delivery preparedness, labour pain and any interventions made for expulsion of placenta, and attendance at the time of deliveries. Women's behaviours are shaped by social and cultural practices and norms. Women tend to rely on *dais* and family members during

labour pain and delivery. Birth preparedness as normally defined is almost non-existent.

Birthing Preparedness

Delivery preparedness is defined as selecting a skilled birth attendant, arranging articles needed for safe birth, identifying where to go in case of emergency and arranging money and transport for this purpose. There was almost no concept of birth preparedness under the definition outlined above.

> *"I did not have any plan; I knew that in the event of the delivery pain, I would be able to call any of the neighbours who will bring a dai for delivery"*

A majority of the women said that they did not arrange money to meet emergency expenses, citing that if necessary they would take a loan or get the money from their landlady. Observations reveal that many of the women are quite reliant on their landladies for credit/loans as well for advice and suggestions during the pregnancy period. Many were fatalistic in attitude and placed their trust in Allah, in the event of an emergency.

> *"We are poor people, Allah will help us; He will never give us any burden which goes beyond our capacity"*

Some women said they had only collected some old clothes, which they kept separately, but they had not stitched any new dress or *Katha* (local quilt covering) for the arrival of the baby. Women believe that it is bad to buy new clothes or plan too much for the new arrival as it can bring bad luck. This is a superstition not only confined to the poorer classes, but also followed by the wealthy and middle classes.[5]

Labour Pains and Interventions to Expedite Birth

Whenever labour starts, women said that they tried to remain silent, sharing the beginnings of the labour pain only with close female family members and

[5] Often women have a celebratory function during the 7th month of the woman's pregnancy – friends and relatives usually do not buy any presents for the arriving baby to as to avoid bad luck and instead focus on buying gifts for the mother.

sometimes with their husbands. Women reported that usually mothers or mothers-in-law discouraged sharing this news with others. There is a widespread understanding that the more people hear the news about an impending delivery pain, there is greater delay in delivery, resulting in prolonged labour for the mother (Afsana and Rashid 2000; Afsana 2005). After the initial labour pains, mothers or mothers-in-law usually take various steps and observe certain rituals to facilitate quicker delivery of the baby. Women reported that sometimes mothers or mothers-in-law feed them *pora pani* (sacred water that has been blown on by *Kabiraj* or *Huzur* after reciting a prayer) to give the woman mental strength. The *pora pani* is usually brought by the mother or husband from the *Kabiraj*. A few women said that they took warm milk or *liquor chaa* (black tea) to get strength, and one woman said she drank water with *Mariam Phool*, a flower brought from Mecca[6] by a dai.

For strengthening and energizing the delivering mother as well as for intensifying labour pain, two mothers said they had taken saline and injection from a neighbouring pharmacist. In these two cases, the role of the *dai* was important in referring a pharmacist.

It was reported that a very common practice for *dais* is to massage oil (mustard or coconut oil) on the lower abdomen of the woman to expedite delivery. As one woman explained,

> *"In case the foetus was in the wrong position, massage helped to bring it to the right position; moreover, it could give little comfort to my pain and made me feel better"*

The Birthing Environment

Almost all the respondents, except for two, reported that their previous deliveries were conducted at home. One woman delivered in a hospital and another woman on her way to the hospital ended up delivering in a vehicle. Most of the deliveries took place at the woman's/husband's house. The choice of giving birth in one's own house was explained as following family customs and also ensured that women would receive more care and comfort. Whether the delivery is in one's

[6] Mecca is a holy city for Muslims– and it is mandatory for all Muslims who are able to and can afford to, to make a pilgrimage to Mecca and perform Hajj.

own home or at husband's home, the delivery generally takes place in the one room with male family members and younger relatives leaving the space to give women privacy. It was also reported that it was difficult to confine and separate the woman and her baby from the rest of the family soon after the delivery. As most of the urban poor tend to live in one small room, and it is impractical for them to heed the customs of pollution, still adhered to in the rural areas.
Almost all deliveries took place on the floor; some took place on the bare floor, but most often on cloth or jute sack. According to the women, the few materials placed on the floor made cleaning easier and could easily be disposed off after the delivery.

Birth Attendance

According to a joint WHO/International Federation of Midwives/ International Federation of Gynaecology and Obstetrics definition, *"A skilled attendant is a qualified health professional- such as a mid wife, doctor or nurse-who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, child birth and the immediate postpartum period, and in the infection, management and referral of complications in women and newborns"*. In *Korail* slum, of the 16 women interviewed, 15 were not attended by a skilled attendant with only one delivering in a hospital. Most were assisted during the delivery by *'dai'* who were either relatives or neighbours.

> *"I went to my own mother's house because my chachi (parental aunt) is a dai there; I could get her help"*

Many women also use *dais* because of their perceived skills and for reasons of cost.

> *"Dai is less expensive, since we can only afford one soap, but she never demands more."*

In one case we found a delivering mother provided a saree to her dai after completion of delivery related work. Usually for poor women living in slums, the widespread cultural acceptability and practice of utilizing dais along with their low costs discourage women from accessing any other kinds of facilities or providers outside the home, unless there is a perceived complication. It is

reported that more than 90% of births take place at home in Bangladesh usually with the assistance of a *dai* or female relative.

Position for Giving Birth and Expulsion of Placenta

Seven out of the 16 women reported that their preferred position was squatting when giving birth. This may, and often does, change as labour progresses. A number of these women, who squatted, also ended up changing positions and delivered, lying supine. For some of the women, the squatting position was seen as more painful than lying. Usually the position taken was often decided in discussion with the *dai* and other female relatives.

> *"Delivery in the squatting position helps us to give pressure effectively and facilitates quick delivery"*

> *"Delivery in the lying position is less painful compared to squatting position"*

The third stage of labour is the period from the delivery of the baby to the delivery of the placenta. Many of the women reported that *dais* and family members adopted various measures to speed its delivery. The most commonly adopted measures to expedite delivery of the placenta was 'giving the women hair to eat,' and some *dais* insert their fingers into the women's mouths to induce vomiting, which is believed to help expel the placenta through abdominal contractions. As in labour, *dais* often massage the lower abdomen with mustard oil or coconut oil. Women reported that *dais* did not cut the placenta immediately and they usually held it up for some time, so that blood could enter the body of the newborn through its naval.

Postpartum Care of Mother

In this study, almost all women mentioned they stayed on the floor till *dais* cut the cord. Then she is washed especially the lower part of the body by the dai or close relatives like mother or sister-in-law, immediately. Family members tend to advocate for traditional practices around food restrictions and limited social mobility.

Nutrition

During pregnancy women report restrictions, but observe few of them. However, after birth their diet is rigidly controlled, and the choice of food curtailed. In this period, especially the first 7 days, women mentioned that various dietary restrictions are imposed on them. For two of the 16 women, no food was allowed at all for the first 3 days after delivery, other than rice or *chira*. In general for most mothers, except for rice and *chira*, no other food was given at all during the first day after delivery to allow for healing of the birth passage. Usually, the mother is advised to eat dry food and rice with smashed potato or *kalijira* (black cumin seed). These are believed to keep the stomach of a woman cool and initiate production of breast milk (see Table 2). All the women mentioned that after giving birth, the flesh inside becomes flaccid and soft and therefore, the mother must avoid "hard" foods. Almost all women reported that they did not find it difficult to follow the dietary restrictions, as they were very poor and could not afford any extra nutritious food – chicken, eggs, and beef - which are not restricted but unaffordable for the women.

Table 2: Food restricted and or especially taken/or consumed during the postpartum period as reported by the respondents

Food restricted	**Time period**	**To prevent**
-any type of fish	40 days	Measles, and diarrhoea
-brinjal	40 days	Itching of baby
-any hot spicy	21 days	Heart burning of mother, diarrhoea, and naval pain of child
-onion	21 days	Foul smell in child's mouth
-any sour food	21 days	Delay in healing of umbilicus
-leafy vegetable	7 days	Child's diarrhoea and oedema of mother
Food especially consumed	Time period	To support
-Sabu and milk	1st day	Production of breast milk and strength
-raw tea	3 days	Reduction of body pain, and healing birth canal
-chapatti/poratha	3 days	Recovering from oedema
-only on puffed rice, chira, biscuit	3-4 days	Healing the mouth of the canal, to remove the excessive water from the body
-Kalijira bhorta	7 days	Production of breast milk
-potato smashed	7 days	The reduction of body weight
-Bitter-gourd fry	7 days	Recovering from oedema and severe body ache

-Hot rice with chillies	7 days	Healing the birth canal
-Shing fish	After 3 days	Increase energy and blood volume

Checkups

The postpartum period is vital; it is when most maternal deaths and infant deaths occur. A prompt postpartum check up can help identify problems such as puerperal sepsis, breastfeeding difficulties, retained products of conception and neonatal illness, as well as providing support and advice to the mother and on her and baby's health, nutrition and vitamin A supplementation. Fifteen out of 16 women received no postpartum check-up. These mothers reasoned that they did not go for a check-up because they did not have any major problems. Moreover, none of any health providers came to do any postpartum check-up at home after delivery.

> *"After delivery no health provider has come yet, I do not know where to go, what to do"*

Life after Delivery

All mothers reported that they were aware that up to after 40 days of delivery, women should not do any heavy work. But in reality this varies a lot depending on support from the household and where they delivered. Many of the women said that they began their normal activity within 10 to 12 days after delivery. For women who give birth in their natal homes, the scenario is slightly different. For example, one respondent who delivered in her mother's place received all the support from her mother and sister up to three months. She did not do any household activities for the entire period.

Women said that sexual intercourse was restricted for up to 40 days. They said this was important and was written in the Hadith and prohibited. However, whether in reality women had the power to stop husbands from having sex with them is debatable. A study found that women were often forced to have sex with their husbands before the 40 days. This depends on whether the women are in their natal homes, or whether they give birth in their husband's home, and also on

the support from other family members (mothers-in-law, sisters-in-law, and mothers) towards this practice.

Neonatal Care Practices

This section describes the existing care practices and perceptions related to care of newborn babies and the role of the different persons in performing those practices in *Korail* slum. The mothers of the babies reported these practices and roles during the unstructured in-depth interviews.

Cord care

Cutting the umbilical cord of the newborn babies after the expulsion of placenta is widely practiced. Twelve out of 16 mothers confirmed cutting the cord after the expulsion of their placentas during their immediate past delivery. In most of these cases, the newborn babies were kept on a thin bed on the floor during the intermediate period between the delivery and cutting the cord. The waiting time ranges from 2 to 20 minutes.

The actual care of the newborn baby starts only after the cutting of the cord. The families are concerned about the time spent between the delivery and expulsion of placenta. They are aware of cutting the cord as soon as possible and starting of care for the newborn baby. As an attempt to foster the process of the delivery of placenta and reduce the time gap, some indigenous efforts are employed. One woman mentioned that the *dai* puts hair (of the birthing woman) inside her mouth to make her vomit. She vomited and with the increased pressure inside the abdomen during vomiting, the respondent perceived, her placenta came out.

> *"She (the TBA) put my hair inside my mouth and then I vomited and after that phul (placenta) came out"*

The in-depth interviews revealed that there was a widespread awareness of using sterile instruments for cutting the cord among the families and birth attendants. Except three, all respondents reported that the cutting instrument was either boiled or burnt (one case) before it was used to cut the cord. Among them, one mentioned using scissors, while the rest used a blade. Among the three exceptions, one mentioned that the blade was not boiled and the remaining two

mentioned about the use of blades, but did not specify sterilization. Most of the mothers who used boiled blades for cord cutting used a brand new blade.

It was revealed from the in-depth interviews that birth attendants and the families generally knew about the dangers of using a non-sterile blade. One respondent, who once worked as a *Shasthya Shebika* (community health worker), instructed the TBA about sterilization of blade.

> *"In the water to boil the blade and thread I told the TBA to put some rice. When the rice is cooked then you can understand that the blade and thread is ready to use"*

Tying the umbilical cord with thread was found to be practiced widely. All respondents reported tying the cord twice with a gap between the abdomen and the first tie and between ties. The reason for tying the cord properly as perceived by the mothers was to prevent bleeding.

> *"The first tie was made after four finger-widths (from the abdomen). Again there was two finger-width of space before the second tie. The cord was cut in between the two ties"*

> *"Tie two places of the cord with thread. The tie must be tight so that there will be no bleeding from the umbilicus stump. If there is bleeding then it would create problems. So the tie must be tight and then cut the cord after the expulsion of placenta"*

However, there was some indication of not keeping enough gap between the ties or between the abdomen and the first tie.

> *"The first tie was close to the umbilical stump and then there was space of about four fingers' width. The TBA cut the cord in between these two ties."*

The concern about boiling the thread was not very strong as opposed to the concern about boiling the blade. The main reason for not boiling thread was the lack of awareness of the risk associated with non-sterile thread. Thus, some mothers did not report boiling the thread before using it to tie the umbilical cord. However, the families that knew about the danger posed by a non-sterile thread used boiled threads.

> *"The thread was boiled with water and then used to tie the cord. Dai kept two finger widths from the abdomen and the second tie was given keeping two finger widths again (after the first tie)"*

Some of the mothers, who reported boiling the blade or thread, mentioned that the birth attendants wiped the blade or thread with a cloth. This practice poses a potential threat of contamination even after boiling the instruments. Four mothers reported a similar practice.

After cord cutting, the important components of cord care practices are: applying substances to the umbilical stump, cleaning the stump and its surrounding area, and applying heat massage on and around the stump. These practices are performed as routine newborn care practices with the ultimate goal of facilitating drying up and timely falling off of the umbilical stump.

Applying substances on the umbilical stump is an important part of cord care practice for the newborn baby at home as found in the in-depth interviews. The mothers mentioned a range of substances they applied on the umbilical stump which includes a single as well as combination of materials. They are: mustard oil, mustard with chopped smashed garlic, coconut oil, boric powder, talcum powder, savlon (an antiseptic liquid) and *chular mati* (earth from a clay oven). The main objective of applying substances on the umbilical stump is to facilitate timely drying up and falling off, of the stump and the cord. Thus this practice usually continues until the umbilical stump dries up.

Table 3: Substances used on/around umbilical stump of the newborn babies in *Korail* slum

Substance(s) used	Reasons of use
Mustard oil with garlic on the stump	To dry up the umbilical stump and prevent from it the infection
Warm mastered oil on the stump	To dry up the stump
Talcom powder on stump	To dry up the stump
Boric powder on the stump	To dry up the stump and prevent infection
Savlon on the stump	To prevent infection
Coconut oil on the stump	To dry up the stump
Chular mati (earth from the clay woven) around the stump	To dry up the umbilical stump quickly. To prevent discharge from the stump.

Usually the caregivers apply the substances on the umbilical stump with their fingers or with a piece of cloth soaked with the substance if it is any liquid. In case of mustard or coconut oil they slightly heat the oil, cool and test with their own skin to measure the temperature and finally apply the oil on the stump when they are sure that the temperature of the oil is tolerable for the baby.

Applying heat massage (*shek dewa*) to the umbilical stump and surrounding area is an integral part of the routine newborn care at the home which was found to be almost universally practiced among the families in this study. There are two prominent ways of applying heat massage. First, holding a ball of soft cloth close to the fire and placing it on the umbilical stump until it loses its heat. In between the caregiver checks it to make sure the temperature is bearable for the baby. The second common method includes putting one's thumb on or close to the chimney of a kerosene lantern and then placing the hot thumb on the newborn's umbilical stump.

The process is repeatedly applied for 10 to15 minutes. Heat massage is applied 1 to 3 times a day and continued even after the cord falls off – the practice is continued for up to 3 to 40 days of the baby's life. The reasons mentioned by the study respondents are as follows,

- To dry up the umbilical cord and stump
- To reduce pain in the umbilical stump
- To dry up the stump quickly
- To prevent discharge from the stump
- Suck up the fluid around the umbilical stump
- Prevent infection around umbilical stump
- To give the stump a proper shape

The mothers also mentioned cleaning the umbilical stump. Mothers and caretakers (role of specific caretakers will be described in a later section of this chapter) usually cleaned the stump with a piece of wet cloth and soap or antiseptic liquid such a dettol. Dettol soap – an antiseptic soap, widely available in the market – was mentioned as well, as a cleaning agent.

> *"Before bath I massage mustard oil all over the baby's body. Then I apply some mustard oil around the umbilical stump. During bath, with a wet cloth socked with soap, I clean the umbilical stump. At*

night I apply shek (heat massage) on the umbilical stump with a heated folded cloth. Sometimes I wipe off the umbilical stump with Dettol-mixed water"

Bathing and Cleaning the Baby

Mothers commonly reported bathing the baby just after cutting the cord. Bathing of the baby was considered one of the immediate priority activities after the birth of the baby. Only exception in the perception level was a mother who once worked as a *Shasthya Shebika* of BRAC. However, despite her awareness of the danger of bathing immediately after birth and her request for not bathing the baby, she could not stop it.

"After delivery I felt so sick that I couldn't sit and notice what was happening around the bathing of the baby. Despite my request to the TBA not to bathe (the baby), but to wipe, the baby was still bathed. As a Shasthya Shebika I know that the baby shouldn't be bathed for seven days after birth, otherwise it may catch a cold"

Most of the mothers assumed bathing the baby as soon as possible after birth as a normal practice. There were no strong contradictory opinions and the babies were widely bathed just after the cutting of the cord.

"After delivery and cutting the cord the baby was wiped off with a piece of cloth and kept on the bed. Then water was poured on a bowl and the baby was bathed with soap. The baby was placed on the bowl and slowly water was poured on its body"

The strong cultural notion of purity and pollution (*pak-napak*) guided the families to have their newborn babies bathed immediately after birth, particularly after the expulsion of placenta. Delivery fluid and blood are regarded as polluted and hence the baby is not purified until it is bathed to remove all bloody fluids that came with it from the womb.

"Everybody can't take the baby on the lap because the baby is smeared with blood all over. If one touches the baby, one will get suit laga (becomes unpolluted). Seniors can't take the baby on their lap because they can't pray (in an unpolluted state). So the baby is bathed just after birth"

> *"In Hadith, (it is instructed that) the baby should be bathed just after birth. Otherwise, no one can touch it and take it on the lap because the baby then remains napak"*

Frequency of baths during the first week ranges from two to seven for a normal baby. If the baby is sick, the frequency of baths is less. The first bath was always reported to be used with slightly warm water. Many of the mothers reported mixing dettol with water and using soap when giving babies their first bath. Evidence of putting other materials such as raw turmeric and grass with a ritualistic purpose in the water was also found. One mother also mentioned dipping a piece of silver and gold (an ornament) into the water used for bathing the baby. Putting or dipping these materials was perceived to purify the water.

To prepare the water to bathe the newborn baby, mothers mentioned mixing hot water with a bowl or tub of cold water collected from the tap. The families tried to collect clean water to use for the bathing of their newborns babies. Though the primary purpose of the first bath was mentioned to be the ritual purification of the baby and make it ready to receive all other routine care, including from putting it on one's lap to breastfeeding, from the family and society, the description of first bath revealed that some regular cleaning activities also took place during the first bathing. Normal toilet soap was commonly reported to be used during the first bath of the newborn baby. Mothers reported the use of Dettol soap, an antiseptic soap available in local market, for the bathing of their babies in the days following. Mothers perceived dettol soap as having more antiseptic 'power' than normal bath soaps.

Some mothers maintained a regular timing of bathing their newborn babies. The risk of getting a cold was the main concern in determining the time of the bath.

> *"I usually bathe my baby within 11 AM or noon so that the time is not too early or late. The baby could catch a cold either way. So I bathe the baby between 11 AM to 12 noon"*

> *"I bathe the baby daily. There is a variation between people in terms of the practice of bathing the baby. There are some women who get the baby cold during bathing (because of their improper practice). They don't understand how to bath (a newborn baby) properly. I bathe my baby in a way so that it does not get cold. The water is warm and I add savlon or mustard oil in the water." (KR11)*

Mothers mentioned some measures to prevent their newborn babies from cold just before and after bath including massaging with mustard oil (before and after bath) and wrapping the body afterwards.

There was strong evidence of rigorous efforts to remove the vernix during the first bath and afterwards. Vernix was generally perceived as a filthy thing which the baby got from its mother's womb. Mothers also said that baby looks ugly with the vernix on its skin. Except two, all mothers reported the efforts to remove vernix from the newborn babies' skin. Mothers reported adapting culturally prescribed preventive measures to avoid vernix as well as preparation of getting rid of it as soon as possible after the birth of the newborn baby.

> *"Those (vernix) are the filthy things the baby gets from the mother's womb. It looks ugly if that (vernix) is not removed. The skin looks dry"*

> *"I rubbed off those (vernix) after birth. I rubbed properly with a piece of cloth. It was winter so I did not bathe my baby. I was afraid the baby would get cold so I only wiped the body. After three days I bathed the baby"*

> *"I never ate chal bhaji (parched rice) when I was pregnant. Usually I eat rice but also sometimes parched rice. But people said that if I ate chal (uncooked rice grain) during pregnancy, my baby would have khataish (whitish filthy things, vernix) on its skin. By the grace of Allah my baby did not have those khataish. He had a little bit but it was rubbed off by a piece of cloth and soap during bathing"*

> *"I have cooked mustard oil and garlic very well and kept it in a bottle. Afterwards (after the birth of my baby), I shall apply that mixture on the baby's skin as long as it removes the whitish dirty thing (vernix) from the skin. If I apply that mixture on the skin of the baby frequently that thing (vernix) will remove itself slowly and there will be no need for rubbing"*

Sometimes the pressure from the family and the provider (TBA) to remove the vernix is strong enough to neglect the mothers' advice about doing otherwise.

> *"I told the TBA not to remove the vernix, but she did not listen to me. She just rubbed the vernix off"*

Cutting the Baby's Hair

Cutting the birth hair of the newborn babies is important to the family and there is a trend of choosing an odd number of day (i.e. 3rd, 5th, 7th etc.) after birth to cut the hair. However, choosing of an odd numbered day is not very strictly followed. Mothers reported having their babies hair cut on an even day as well.

The primary reason for the families' eagerness not to delay in cutting the hair of the newborn baby is the perception that the baby remains in an unclean state as long as it has its birth hair.

> *"It is not necessary to cut off the hair within seven days after birth. You can keep it till 40 days after birth but it is said that if you don't cut off the hair then the baby remains napak"*

> *"Until you cut off the hair of your baby you can't go outside the house. You can't do any household chores. Suit lage (things become polluted). Grandmother or the elders who pray can't take the baby on their laps because the baby remains napak until the birth hair is removed. The baby also can't go outside the house until the hair is cut"*

Rituals during Newborn Period

Overall, we did not find strong ritual practices during the newborn period in the in-depth interviews in *Korail* slum. However, we found two ceremonies to be observed mentioned by three mothers: hair cutting ceremony and naming ceremony. Sometimes these two are inseparable and are celebrated together. Both ceremonies involve a gathering of a number of close relatives, the birth attendant and a few very close neighbours in a feast. The family of the baby invites them and they come to join the feast and pray for the baby. The family arranges the ceremony according to financial ability.

> *"On the sixth day I clean the clothes and mop the floor (ghor lepchhi). These are the rules according to the seniors. There was a feast that day. We cooked good food like chicken; I ate those. Those who were in the choti ghor (birthing room) were invited. They came, ate and took the baby on their lap (showed their affection to the baby)"*

> *"We fed the young children with shinni (a sweet food cooked with rice and gur), invited the dai and fed her good food, gave her a new saree as a present, named the baby and offered sweets to everybody"*

> *"Three days after birth, the hair of the baby was cut. Then we applied raw turmeric paste all over the body and then the baby was bathed. There was a feast among the relatives after this"*

Another ceremony was mentioned to be observed on the 9th day of life of the baby, though reported by a mother from a relatively wealthier family.

> *"There was a feast. Beef, chicken, polao (fried rice) were cooked and guests were invited. We invited relatives and people from our own village, who live in this slum. The expenditure for this feast was about 4000 Taka. The guests brought money and presents for the baby. We are poor so we could not arrange a big feast. Among the rich the feast is huge and they get valuable gifts"*

Exclusive Breastfeeding

The evidence of exclusive breastfeeding is extremely low. Only two of sixteen women reported giving only breast milk to her baby up to six months of age while one mother mentioned the same practice, continuing till four months. However, one mother mentioned that she would continue exclusively breastfeeding her baby until the baby 'can sit on its own'. To know whether the mother was able to fulfil her desire is beyond the scope of this study. There are two dominant reasons (one perception and one practical) behind not maintaining exclusive breastfeeding. First, there is a strong perception of giving water or sweet food to the baby as the first food. Secondly, the mothers experienced a need of an average of three days after childbirth to have milk in their breast. The practice and perceptions related to food for the newborn babies will be discussed in the next section.

One mother mentioned putting mustard oil in the mouth of her baby to clean *bizla bizla* (mucus) before feeding honey. Although mustard oil was not used as food item in this case, this practice might have health implications.

Other Diets of the Newborn Baby

> *"After birth the baby was fed sugar water and honey then the baby was given breast milk after 5 to 6 hours"*

> *"Honey is needed when a baby is born. They looked for it but did not find it. Then I told them to collect talmisri instead of honey"*

> *"For the first three days after birth there was no milk in my breasts. The baby sucked a lot but got no milk. The baby cried in hunger. Then I gave the baby talmisri water and then sucked my breasts. After three days there was sufficient breast milk and I did not feed it anything except breast milk"*

As indicated earlier, the first food of the newborn baby is mostly sweet food – sugar water or honey. Giving sugar water or honey in the mouth of a newborn baby has a ritualistic purpose. In general, the sugar water and water, both of which are sweet in taste, are meaningful on this occasion for their sweet taste only. The perception promoting this behaviour is that sweetness as the first taste of life will influence the baby to have a pleasant personality when it will grow up.

> *"If the baby is given honey as a first food the baby will talk sweet" (Two respondents)*

> *"When someone comes to this world he/she should be welcomed with sweets"*

> *"I learnt this from seniors that the mouth of the baby remains dry after birth. If you give honey it works like a moisturizer. The baby can gulp easily. … If you feed the baby something sweet first then the baby will speak sweetly"*

One mother, however, mentioned a health utility of honey as an initial food item for the newborn baby. She said that she gives honey to her newborn baby from the beginning because it protects *gha* (infection) inside the mouth.

Mothers widely knew about colostrum and its benefits for the newborn babies. However, the practice of feeding colostrum was less prevalent as opposed to having knowledge of it. One mother went further to explicitly to mention that she

threw colostrums first and then gave breast milk to her baby after one and a half day of birth.

It is evident from the in-depth interviews that the biggest barrier of breast-feeding in general and exclusive breastfeeding in particular is the perceived and/or experienced insufficient breast milk in mothers. This perception/experience led most of the families to give additional food to their newborn babies from the day of birth. They divide the trend of giving additional food according to the age of the baby: wait until the third or fourth day, and from then onwards. Mothers reported giving mostly liquid foods such as sugar water, cow's milk, *Milk Vita* (brand name of a packet liquid cow's milk available in the market), *Lectogen* (a tined baby food, imported) during the first few (3-4) days when mothers experienced having no or very little breast milk. (This excludes the customary practice of putting sweet items in the mouth of the baby immediately after birth).

After the initial few days, mothers reported having increased amount of breast milk but most of them did not have a sufficient amount to fully rely on that. Therefore, they provided additional food as well. The nature of food changes, as the baby grows. They are started with 'lighter' foods and proceed on to 'stronger' ones. In the earlier stage of life, the babies continued to be given additional liquid foods such as sugar water and cow's milk. After two to three months, when the family perceived that the baby increased its digestive capacity, additional food was given such as cow's milk, cooked rice flour, *jao* (rice porridge) and smashed rice. Mothers used feeder bottles to feed their babies liquid food. The primary reason of giving these additional foods to babies younger than six months of age again is the insufficient breast milk in the mothers.

Mothers, who had sufficient milk to feed their babies adequately, at least for six months, did not feed any food except breast milk. Only two such mothers were found.

> *"Just after birth I fed my baby breast milk. There was no need for tola khabar (additional food). The baby received sufficient breast milk and there was no need for other food. I started (to feed the baby) khichuri, vegetables, fish etc. when the baby became ten months old. Simultaneously, I fed breast milk till three years at a stretch"*

Role of Providers, Household Members and Others

The general trend in newborn care is that the role of the mother increases as the baby grows. Mother has very little influence at the time of delivery including delivering the placenta, cutting the cord and bathing the newborn baby. This situation turns almost to the opposite in a few weeks time when the mother becomes almost solely responsible to provide routine care of the newborn babies.

Most of the mothers reported the TBA as the person to cut and tie the umbilical cord of the newborn baby. Other persons present inside the 'delivery room' were mainly elderly female family members and occasionally neighbours – who assisted the TBA in preparing equipment for the birth. They helped the TBA in boiling the blade and the thread, in cases where the thread was boiled. An exception of cutting the cord by the mothers herself was mentioned by two mothers. She might have inherited this practice from the particular region of Bangladesh she migrated from.

> *"We are from Mymenshing district. In our village, the mother has to cut the cord after delivery. If the dai or someone else cuts the cord, she would not able to pray for the next 41 days. Therefore, I had to cut the cord"*

The TBA was responsible for attending to the baby after it was delivered. She held the baby, and in most cases, wiped and bathed the baby. Mother and mother-in-law of the woman, if present in the delivery room, played an important role in attending to the woman and the newborn baby. They held the baby after it was wiped and bathed.

Involvement of the TBA in routine newborn care is basically over after the first day of birth, more specifically after the bathing of the baby. The mother and the family members are increasingly involved in newborn care since then. Families in the slum do not include many family members. They also do not have many relatives living nearby. Thus, involvement of the mother in newborn care is tremendous. Activities such as taking care of the umbilical cord by applying heat massage (shek dewa), putting on substances and cleaning the stump were mostly done by the mother herself. Three mothers reported receiving support from their mothers, mothers-in-law, or neighbours during these activities. It seems that the grandmother liked cutting the hair of their newborn grandchildren. An increased

involvement of the grandmother of the child was reported by some mothers, although the mothers were strong enough by the time the baby needed to have a haircut.

The in-depth interviews revealed that preparing food for the baby and feeding them were almost entirely the responsibilities of the mothers. In a few cases, maternal grandmother and paternal aunt of the baby were mentioned to assist the mothers.

MANOSHI RECOMMENDATIONS

Based on the findings, the following is recommended for the *MANOSHI* programme.

There is a need to increase knowledge and awareness among women and families including following key messages:

- pregnancy is a normal event but can sometimes be dangerous for the woman and the baby—danger signs during delivery and for newborn
- importance of using health services – ANC, delivery care, PNC – to detect problems
- birth preparedness to plan for clean and safe delivery
- immediate newborn care, especially clean delivery and delayed bathing
- importance of exclusive breastfeeding and appropriate supplemental feeding

Interventions around these messages need to be focused at multiple levels – community, family, and individual. Community level interventions could include mass media campaigns (through radio, TV, and/or drama), promotion of role models from the community and formation of community groups. Family and individual level interventions could include group discussions and personal counselling.

These messages should be reinforced during home based ANC and PNC visits, especially with influential family members. In addition, the messages should be reinforced in women's groups, husband's groups, and other community groups with community leaders. The programme could also use ritual events for increasing interaction with the community and ensuring context specific appropriate messages.

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