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'My Mother…My Sisters… and My Friends': Sources of maternal support in the perinatal period in urban India

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ABSTRACT

Objective: to explore the wide-ranging sources of support that the maternal–infant dyad need or expect throughout the perinatal period in urban India.
Design: qualitative interviews and ethnographic approach.
Setting: homes and community settings in greater metropolitan Bangalore, South India.
Participants: using in-depth interviews of 36 mothers from different socio-cultural and socio-economic backgrounds who had given birth within the past two years in a tertiary hospital, we explored the nature of support, advice and emotional sustenance through pregnancy, childbirth and the early child rearing period available to these women.
Findings: the overwhelming importance of women's own mothers in practical and emotional terms, the connectedness to 'native' place or '*ooru*', the role of the diverse, extensive female network and the more contingent role of the husband emerged as major themes. The family was a major source of support as well as distress. While the support from their own mother was a constant, women used various forms of support throughout the perinatal continuum.
Conclusions and implications for practice: we call for a more nuanced understanding of what women in urban India expect and need in terms of support throughout the perinatal period. Clinicians and policy makers need to understand the various players, their different roles at critical times through the perinatal continuum and be able to identify those who are vulnerable and in need of enhanced support. Although the health sector is not a strong player in the socio-cultural milieu in the perinatal period, their role as facilitators of this support is crucial.

Introduction

The perinatal period is the largest contributor to disease burden in low and middle-income countries (Lopez et al., 2006). India contributes to the greatest number of child deaths and malnourished children in the world, with infant mortality rates still at 57 per 1000 live births and almost half the child population being underweight (DHS, 2007). India is *not* on track to achieve the 2015 health-related Millennium Development Goals (MDGs) and more focused attention on the perinatal continuum is warranted (Bhutta et al., 2010). The challenge of delivering appropriate maternal and child health care in urban India is now a major issue for the government (Bhaumik, 2012; UNICEF, 2012). While social determinants such as poverty, illiteracy, poor status of women, as well as dysfunctional health systems are critical underlying factors that adversely affect maternal and child health in India, these factors are relatively difficult to change in the short term (Bhutta et al., 2005).

A critical gap in our knowledge on how to improve perinatal outcomes, is how family and community practices influence maternal and child health and support seeking behaviours (Bhutta et al., 2005). There is considerable evidence mainly from western countries to suggest that intervention programmes aimed

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at improving the 'social' milieu in pregnancy and childbirth have positive practice implications, given that childbearing so strongly bridges the biological and the social (Oakley, 1985; Oakley et al., 1990). Research has demonstrated the positive association between social support and maternal mental health and breast feeding (Bhopal, 1998; Balaji et al., 2007; Barona-Vilar et al., 2009). While the importance of social support in the perinatal period in developing countries is acknowledged (Maimbolwa et al., 2003), much of the research literature about this period, focuses on antenatal and delivery practices (Goodburn et al., 1995), with an emphasis on care-seeking of maternal and infant 'illness' (Mesko et al., 2003; Ronsmans et al., 2010), or specifically around maternal depression (Rahman et al., 2003; Andajani-Suthahjo et al., 2007), and intimate partner violence (Daruwalla et al., 2009).

An emerging literature from Africa and South Asia is documenting the importance of social support for mothers in the postpartum period (Mbekenga et al., 2011a, 2011c) as well as documenting particular concerns of fathers (Mbekenga et al., 2011b; Sapkota et al., 2012) and specific roles for midwives (Lugina et al., 2001). There have been some excellent anthropological explorations of pregnancy and childbirth in South Asia, particularly focusing on the rural setting (Gideon, 1962; Blanchet, 1984; Ram, 1994; Rozario, 1998; ; Pinto, 2008); however, there is a paucity of research exploring the perinatal psychosocial milieu in urban settings, with particular reference to sources of support throughout the perinatal continuum.

In 2003 a prospective birth cohort study was commenced at St. John's Medical College (SJMC) Hospital, Bangalore, India, to explore the association of maternal health and nutrition with pregnancy and child health outcomes. Several salient reports and results have already emerged out of this cohort study (Muthayya et al., 2006); the single most important factor in determining birth weight and hence child outcomes in this cohort was maternal education level. We situated our research study within this cohort to elicit psychosocial and cultural factors that influence perinatal outcomes, for mother and infant dyads in urban India. In particular we wanted to determine where and how women got their support, advice and emotional sustenance through pregnancy, childbirth and early child rearing, broadly conceptualised as the perinatal period.

Methods

We used an ethnographic approach with in-depth qualitative interviews as we were looking to generate new theories and hypotheses (Fitzgerald, 1997), as well as achieve a deep understanding of the socio-cultural context of the perinatal period in urban India.

Selection methods and study site

This was a nested sample within the existing birth cohort in SJMC Hospital, a faith-based health-care service in Bangalore. This 1200-bed tertiary teaching hospital draws patients of diverse socio-economic status, from urban slums to high-income residential areas. Description of the cohort has been published in other studies (Dwarkanath et al., 2009); pregnant women aged 17–40 years attending SJMC for delivery and willing to participate, were recruited during their first trimester. For our qualitative study, we identified women who had been through pregnancy and childbirth within the last two years. We used semi-purposive sampling to ensure a mix of social and cultural groups (i.e. language and religion) from within three education levels from the cohort. These included women with low education levels (primary school—Group 1), women with medium education levels (completed high school—Group 2) and women with high education levels (tertiary education—Group 3).

Setting

Interviews and ethnographic fieldwork were conducted in greater metropolitan Bangalore. This is a contemporary urban landscape in India and includes large areas that were until recently considered villages (rural), but have become incorporated into the city (Greater Metropolitan Bangalore). Participants came from a wide geographical spread with some residential locations up to 40 kms away from the hospital. Participants were interviewed in the location of their choice; most often it was their home, sometimes it was their mother's house, or their in-laws' house, occasionally it was their workplace.

Ethnographic observations were carried out during fieldwork for the larger study on socio-cultural factors and health-care utilisation patterns (the first author spent six months between August 2008 to January 2009 and a month in December 2010 in Bangalore). This consisted of visiting homes or workplaces where interviews were agreed upon; spending time observing and interacting with the extended family and friendship network of the participants and doing non-participant observation of maternal and child antenatal and postnatal health-care visits. Key findings from ethnographic research are reported in subsequent publications pertaining to health-care utilisation.

Data collection

In-depth semi-structured interviews were carried out with 13 participants in group one (low education), 11 in group two (medium education) and 12 in group 3 (high education). While the interview subjects were women who had been through pregnancy in the last two years, due to the ethnographic approach taken and the reality of conducting qualitative research in India, often the extended family or even friendship network participated. Interviews were conducted by the first author (SR) and a research assistant (RA) who is a native Kannada speaker, fluent in other local languages. Interviews were conducted in five different languages including Kannada, Hindi, Tamil, Telugu and English; the language of interview being chosen by the participants, the language they were most comfortable in. Prior to commencing the interviews, we formulated an interview guide based on a literature review. Topics broadly explored aspects of the home environment, sources of support, pregnancy and childbirth expectations, practices and experiences, access to health and support services, access to basic needs and infrastructure. A hypothetical scenario involving the mother falling acutely unwell in pregnancy was included to elicit responses about who would provide emergency help and support. Interviews were modified after each of the first few interviews, based on reflection and ongoing enquiry. Interviews were continued until saturation of themes was reached. Each interview lasted from 1.5 to three hours.

Analysis

Audio taped interviews were transcribed (from the language of interview to English) as soon as possible following the interview either by the first author (SR) or the RA. Transcriptions were crosschecked with the recordings by first author and the RA. Transcriptions recorded were as close as possible to the vernacular or in Indian English to preserve the 'voice' of the participant. Thematic analysis of transcribed interviews and ethnographic field notes was carried out (Braun and Clarke, 2006). Overall analysis was iterative, being guided by the principles of phenomenology,