



Where there is no weighing scale: Newborn nourishment and care in Pakistani Punjab



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ARTICLE INFO

Article history:

Received 29 June 2016

Accepted 27 October 2016

Available online 13 November 2016

Keywords:

Pakistan

Newborns

Low birthweight

Breastfeeding

Healing

Community health workers

ABSTRACT

A third of babies in South Asia are born low birthweight, more than in sub-Saharan Africa. This epidemiological enigma has been linked to gender and generational inequalities and to poor health and nutrition over the whole of women's lives. High rates of breastfeeding initiation are accompanied by high rates of colostrum avoidance, the giving of prelacteal feeds and early supplementation with formula or animal milks as well as other substances. Meanwhile, in Pakistan – despite the extensive presence of public community maternal and child health workers – very few babies are weighed at birth. This paper draws on an ethnographic study conducted in 2014–16 in rural and urban Punjab, to shed light on the interpretation, nourishment and care of newborns who are identified to be *kamzoor* (weak), and to comment on the extent to which carers' efforts are influenced by community health workers, who are charged with spreading modern biomedical knowledge and practices. *Kamzoori* is understood to be caused by maternal depletion and is managed at home by augmenting breastfeeding and giving supplementary milks, and by keeping the baby warm and massaged. In cases where weak newborns do not recover weight, spiritual explanations are invoked and treated through a variety of home remedies/methods. There are often similarities between the interpretations of mothers, grandmothers, and health workers. The paper considers health workers to be engaged in complex cultural mediations.

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Introduction

Soraya is in her mid-20s and lives in a village in Punjab. Her first daughter was born at seven months. Soraya believed that the delivery had begun prematurely because she had worked prodigiously hard during the pregnancy. 'All my *jethanian* (husband's brothers' wives) have moved out into their own houses, so I was the only daughter-in-law left to do all the work'. She delivered the baby at a state hospital and she was very *kamzoor* (weak) at birth. Describing her daughter as a newborn, she told us 'she looked like a little mouse', making a cupping gesture with her hands. When we asked about the birthweight, Soraya could not tell us. 'They don't weigh babies at the hospital', she said. The doctor who delivered her instructed Soraya to give her formula milk, as well as breastfeed her, because she was so small that she would need extra nutrition. But the baby preferred to suck from the feeding bottle than from the nipple, and the breastfeeding did not take off. Her daughter is now nearly a year old. Soraya still has a feeling of wonder that this fragile creature managed to survive. 'My mother was thinking, "*yeh nahi bachnewali*, this one isn't going to make it". But she

didn't say that in front of me at the time, in case it broke my heart', she told us with an opaque laugh.

Amongst the women we have interviewed, Soraya's story is unremarkable both in her daughter's low birthweight, in the alacrity with which her breastfeeding was compromised by the encouragement to supplement with other milks, and in the fact that her baby was not weighed at birth. The weighing scale is a quintessential symbol of the normalization of infant nutrition by biomedical science, a tool that allows a newborn's body to be measured and positioned in an international growth curve. It is also a quintessential symbol of state authority. Writing about the Dani people in Irian Jaya in Indonesia, anthropologist Leslie Butt (1998) describes the weighing scale as a potent instrument of the state. Government record cards are ubiquitous reminders about the importance of weighing their infants, intimating to mothers that the health of their baby is a public affair. If the baby lags in the growth charts, spiralling towards the red line demarcating the limits of acceptable growth, they are berated by health workers for their inadequacy as mothers. Butt writes in a vein of scholarship on reproduction that is critical of the intrusiveness of state health policies. But in our study, as Soraya's example suggests, the weighing scale was conspicuous by its absence.

Where there is no weighing scale, how do carers then reckon the health of a newborn? Where growth is not monitored, how do carers

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respond to the vulnerability of a weak baby? And to what extent are they influenced by the health services provided by the state?

Low birthweight, maternal undernutrition and neonatal feeding

Nearly third of babies in South Asia are born at what is classed as low birthweight, a statistic far greater than in sub-Saharan Africa, where – despite making lesser progress than South Asia in many of the wider determinants of infant nutrition – only 13% of babies are born less than 2500 g (UNICEF, 2014). Ramalingaswami, Jonsson, et al. (1996) called this puzzle the ‘Asian enigma’. In their classic enunciation of the problem, they suggested that the enigma revealed the extremity of gender inequalities in South Asia. Low birthweight indicates that the infant was malnourished in the womb and/or that the mother was malnourished during her own infancy, childhood, adolescence and/or pregnancy. The proportion of babies born with low birthweight therefore reflects the health condition of women over the whole of their young lives; ‘the exceptionally high rates of malnutrition in South Asia are rooted deep in the soil of inequality between men and women’ (p.11). Later, their hypothesis was confirmed by the International Food Policy Research Institute, who found that measures of women’s low status make ‘by far the biggest contribution’ to the gap in children’s nutritional status between South Africa and sub-Saharan Africa (Smith, Ramakrishnan, et al., 2003, p.xii).

In Pakistan, epidemiological surveys leave little doubt that this ‘ignominy of low birthweight’ (Bhutta, 2012) is driven by poor maternal health. National estimates of low birthweight are approximate, of course: in the latest Demographic and Health Survey, from 2012 to 13, only 12% of infants had been weighed at birth (Measure DHS, 2013, p.148). Nevertheless, according to UNICEF, (2014), in 2009, some 32% of infants born in Pakistan were below 2500 g. In relation to maternal health, the 2011 National Nutrition Survey showed that 18% of women of reproductive age were underweight and half the pregnant women were anaemic (Government of Pakistan, 2011, p.28 and p.30). This bleak picture regarding the proximate influences on newborn and maternal health is matched by the wider picture of poverty, inequalities between urban and rural areas, provinces, religious communities, sects and castes, and gender and generational inequalities in virilocal family structures (Oppenheim-Mason, 1997; Winkvist & Akhtar, 2000; Towghi, 2007; Varley, 2008; Bhatti & Jeffery, 2012; Mumtaz, Salway, et al., 2014). Women’s health-seeking depends typically on the cooperation of their affinal kin, embedding their recourse to healthcare within these gender and generational inequalities too (Mumtaz & Salway, 2006). As Mumtaz and Salway (2009) have also shown, the power dynamics of women’s marital homes may be softened by the textures of their domestic relationships. It is not necessarily the case that the most ‘autonomous’ women are the ones most able to seek healthcare. It may rather be those who are the most ‘central’ – who work to make themselves indispensable to their in-laws – who are best supported to do so.

Surveys in Pakistan have found that breastfeeding initiation rates are high, especially in the least wealthy families. However, rates of colostrum avoidance are also high, as is the giving of prelacteal feeds during the first three days after birth and early supplementation with animal milks, formula milks and other substances (see inter alia Khan, 1991; Morisky, Kar, et al., 2002; Ali, Ali, et al., 2011; Hanif, 2011; Premani, Kurji, et al., 2011; Ahmed, Chaudhry, et al., 2014; Chaudhry, Ahmed, et al., 2014). Ninety two percent of children born in the two years previous to the Demographic and Health Survey had been breastfed at some stage, but only 18% were breastfed in the first hour after birth and only 58% were breastfed in the first day after birth. Meanwhile, 75% of babies were given something other than breastmilk to drink during the first three days of life (Measure DHS, 2013, p.169). The estimates from the 2011 National Nutrition Survey are somewhat higher, indicating that 40% initiated breastfeeding within an hour of birth (Government of Pakistan, 2011, p.46). Both these national surveys

confirm that early breastfeeding is least common in Punjab, the province where we worked.

There are relatively few sociological-anthropological studies to shed light on these infant feeding practices, although Dorothy Mull’s (1991, 1992) detailed work on Karachi slums is an important exception. Her studies indicate pervasive mistrust of the nutritional quality of mother’s milk and fears about spiritual malevolence in the form of jealous *nazar* (evil eye) or a *saya* (shadow/spirit) cast by a ritually unclean woman. Anxieties about the susceptibility of breastmilk to the spoiling effects of a mother’s exposure to excessive cold or heat, her dietary indiscretions, or a new pregnancy are further influencing factors. Mothers readily reported a spoiling or drying up of breastmilk. Mull also describes mothers seeking breastmilk testing from folk healers alongside what she calls ‘pseudoscientific’ testing, namely ‘medically needless’ assessments sought from private pathology labs (1992, p.1288). Meanwhile, another study of Karachi slums, by Fikree, Tazeen, et al. (2005), explains the giving of *ghutti* (prelacteal feeds) in terms of mothers’ preoccupation with cleaning out the newborn’s abdomen or with encouraging newborns to urinate frequently and thereby dissipate the heat that is understood to be brought into them by childbirth. Similarly, they find that mothers avoid colostrum because they believe it is foul milk that has been stagnant in the breasts for nine months.

This paper builds on these studies by exploring popular etiologies of neonatal nourishment and practices of care. Secondly, we explore the extent to which these are being scrutinized by health workers, who have been charged by the state with trying to shift these views.

Maternal and child health workers

Pakistan has an extensive cadre of primary healthcare practitioners who have been given training by the government specifically to spread modern biomedical knowledge and practices in relation to maternal and child health. The largest of these cadres of state health workers, the Lady Health Workers programme (LHWs), has been in operation since 1994, when it was established with the assistance of the World Health Organization in the policy ambience following the Alma Ata conference (Hafeez, Mohamud, et al., 2011). LHWs are women members of the community who are supposed to have at least eight years of formal education. They undergo 18 months of government training to provide a door-step service of more than twenty family planning, antenatal and child health services. Our examination of LHW training materials confirms our observations and conversations with LHWs, in that this training seems designed to raise their awareness of biomedical science in order to enable them to filter out the ‘good’ aspects of traditional practices from the ‘superstitious’ and harmful, such as the taboo on colostrum and the giving of prelacteal feeds (see e.g. UNICEF/Mehekma-e-Sehat, 2010, p.10, p.17 and p.28 for examples). There is a remarkable fit between the health promotion messages that the LHWs are charged with disseminating and the colonial discourse that Saha, in this issue, illuminates from turn-of-the-century India decrying how ‘the unfortunate baby is given honey, sherbert, a concoction of ghur and spices, bazar milk, in fact anything but its mother’s milk’, p.TBC).

In theory, a LHW serves a population of 1000 people and extends these services through monthly home visits. In addition, her own residence is designated as a Health House where people can come as a first port of call for guidance or treatment. Each LHW is supposed to be supplied with basic items for her Health House and essential drugs to treat minor ailments, in addition to contraceptives, to be provided free to the population in her catchment area. The programme now operates in 60–70% of rural and urban slum populations, and there are more than 100,000 LHWs across Pakistan. Evaluations of the programme show that health indicators are significantly better than the national average, in the areas served by the LHWs. However, evaluators identify serious weaknesses, most notably the irregular provision of drug supplies, delayed disbursement of remuneration and poor district health system referral support (see

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