Original Article

Newborn care practices: locals' analytical models, and potential medical risks in South-Punjab Pakistan

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Objective: To determine social and cultural construction of newborn care practices in district Rajanpur, Pakistan.

Methodology: Using purposive sampling, this research collected qualitative and ethnographic data from where multiple different themes for analysis and interpretation were obtained.

Results: Ethnomedical, religious, social, and cultural rationales exist among the local community that shape and make their child care practices. The local practices include spiritual etiologies of diseases, sacred-profane constructs, and hot-cold dichotomies which influence cultural practices that sometimes become harmful for the health and nutrition of mothers and newborn babies. Socio-economic factors, cultural capital, and religious beliefs play an important role in determining and shaping different care practices among locals owing to long-term underdevelopment in that area.

Conclusion: Along with structural corrections, increasing the social and cultural capital of illiterate mothers, husbands, grandmothers, and resource-poor communities and localities can improve their knowledge, attitudes, and practices to avoid serious immediate public health concerns. (Rawal Med J 202;46:442-445).

Keywords: Newborn, care practices, analytical models.

INTRODUCTION

Newborn morbidity and mortality remain serious global health challenges in low-and-middle-income countries. Almost 1 million newborns die on the first day of life in these low-resource countries. The large majority of newborn deaths (80 percent) are due to complications related to preterm birth, intrapartum events such as birth asphyxia, or infections such as sepsis or pneumonia.[1] For all newborns, clean delivery and cord care, thermal protection, early and exclusive breastfeeding, and immunization are recommended by the WHO.[2] The newborn death rate in Pakistan is the world's third-highest, especially in rural areas.[3] Better child-care practices help in growth, brain development, and overall health and nutrition.[4]

Although interventions played their role, reduction of neonatal mortality was not well targeted owing to societal norms.[5] Lady Health Worker Program and Behaviour Change Communication (BCC) strategy were the core of such biomedical efforts.[3] Better childcare practices can decrease malnutrition as much as good water, sanitation, and hygienic conditions can minimize infections.[6]

A complex environment composed of social and cultural values of caregivers and family has deep implications on the child's growth, development, and overall wellbeing.[4,7] Females who face lack of opportunities and illiteracy have to suffer in care and feeding practices. In the state of poverty, sub-optimal care and feeding practices might bring more serious implications for the health and wellbeing of infants and young children.[8-10] The aim of this study was to determine social and cultural construction of newborn care practices in district Rajanpur.

METHODOLOGY

The data used in this study was collected during ethnographic research in Rajanpur investigating the sociocultural construction of child and mother malnutrition in Rajanpur.[9] This ethnography is based on 15 months (2016-2018) fieldwork in the communities of Rajanpur district. Sick and malnourished cases visit either at a low-quality public health facility, Nutrition Stabilization Center (SC), or the abode of spiritual healers for health-

seeking. Ethical approval of the study was obtained from the Advanced Study Research Board (ASRB) of Quaid-e-Azam University (QAU) Islamabad.

In this study, qualitative and ethnographic research methods such as Key Informant (n=3), Focus Group Discussions (n=2), and In-depth interviews (n=30) were arranged with the locals of Western areas of district Rajanpur, South-Punjab. Participant-observation was also used for data collection. Thirty households were purposefully sampled for qualitative data acquisition and interpretation.

Statistical Analysis: All data analysis was performed using SPSS Statistics 21.

RESULTS

New-born care practices such as cord-cutting, bathing, prelacteal, circumcision, hair-removing, head-shaping, are always rationalized owing to socio-cultural constructs. It involves multiple medical risks (Table).

Table. Care practices, rationales, and risks.

Newborn Care Practice	Local Term	Benefit or Purpose	Model	Potential Medical Risk
Cutting the newborn's cord/giving a bath	Nara	Dirt is cleaned	Sacred-profane	Tetanus, Skin infection, cold
Gifting on child's first sight	Mun-dikhai	Welcome of child	Social capital and reciprocity	Diarrhea
Giving prelacteal & butter	Ghutti & Junj	newborn body is purified	Sacred-profane & hot-cold	Exclusive breastfeeding is not followed
Performing circumcision	Tahor	Religious obligation	Purity	Hygiene is not followed and skin infection
Removing the child's first hair from the head	Sathee	Newborn hair are impure	Sacred-profane	Use of unsterilized blade Skin infection
Placing the child's head inside an instrument	Munrakha	Skull molding	Beautification	Brain underdevelopment
Wearing anti-evil-eye-necklace	Nazarbatoo	Protection from evil Spirit magic	Spiritual etiology of disease	Protection against spirits

CARE PRACTICES

Cutting newborn's cord (*Nara*) and giving bath: After delivery, the umbilical cord is cut with a sharp blade, and hygiene or cleanliness is less strictly followed during this process. Improper cord cutting makes the navel wrong shaped and ugly due to infection. Therefore, after this, a bath is generally given because the newborn baby is considered profane owing to a long-stay inside the mother's belly. Many times infants became unconscious because they were given a bath in the winter upon the insistence of closed ones. According to a local:

Every birth attendant has its own hand, some have a heavy hand that causes infection, but some have a soft and gentle hand that does not cause inflammation. Mostly turmeric powder and clarified butter are applied on the cord that dries it soon.

Gift giving on childbirth (*Mun-dikhai*): After delivery, relatives and neighbors congratulate and give used currency notes into the infant's hands. As these currency papers are old, dirty, and circulate from people to people, there are higher chances of pathogens' transfer and infections.

Giving prelacteal (*Ghutti*), and butter (*Junj*): Prelacteal of various types (charcoal, castor bean, cow milk, honey, brown condensed sugar, rose nectar, etc.) are introduced to the newborn babies soon after birth. It is believed this practice is necessary to clean dirt and pollution of the child because of nine months stay inside mother's profane belly. The child is also given sweet, soft, and fresh butter, which is locally known as *junj* before the age

of six months because it is perceived that this butter makes infants healthy, beautiful, and fat.

Performing circumcision (*Tahor*): When a baby girl is delivered, her ears are pierced at three places, and when a boy is born, he is circumcised soon after birth. A few days after birth, a *nai* (barber) is invited to perform circumcision, known as *Tahor* in their native language. A sharp blade is used by the *nai* to perform circumcision. Usually, it is performed immediately because it is considered awkward at a young age when a child has grown up.

Removing child's first hair from head (*Sathee*): On the seventh day of birth, the *nai* shaves the child's first hair. These hairs are religiously considered profane (*haram).* Silver equivalent to the weight of this hair or sometimes money is also distributed among the poor as a kind of *sadka* (voluntary charity) because it protects a child from evil spirits.

Placing child's head inside an instrument (*Munrakha*): *Munrakha* is a mud-brick in which two tiny wooden columns are so fixed that it does not only help to cover the sleeping infant with a shawl but also used to shape the top and back of the soft head skull of a newborn. Some people use a metal plate for this purpose.

Wearing newborn an anti-evil-eye necklace (*Nazarbatoo*): *Nazarbatoo* is tied around the neck of an infant; it is used for the protection of newborn babies from the evil or bad-eye (*nazar*). According to a local, "*when jealous and envious people deeply ogle at the child, it ensures safety from the bad and harmful intentions of the beholders."*

Grandmothers recommend this as an antidote and opposite to repel the black magic and evil spirit away from the newborns' innocent and fragile body.

DISCUSSION

The way a child's body is conceptualized and symbolized has repercussions on the child and mother as cultural activities are performed. Locals tie a pacifier around the neck of the baby, which is put into the baby's mouth off and on who sucks it more often, especially when weeping begins.[11] Majority of neonatal deaths in developing countries occur in the first week of life that impact newborn's nutrition.[12,13]

In rural Pakistan, accessibility, affordability, and quality of healthcare services are low. The rural poor prefer home deliveries by less trained traditional-birth-attendants or mothers in-laws.[14] Cords-cutting is performed with unhygienic blades or knives, and for healing purposes, the dung of a cow or ash is applied.[3,4] This practice might lead to tetanus. In Northern Pakistan, a child's head is tightly tied with a piece of cloth to mold the newborn's head in a round shape, and this cultural practice sometimes might be dangerous for the newborns.[4,15]

In Pakistan, traditional birth attendants handle most of the pregnant females, and antenatal care is rare.[16] Midwives in India, Bangladesh and Pakistan are low castes, inferior, old age, and illiterate woman, often working on a small remuneration and visit during labor only and rarely provide prenatal or postpartum care.[17-19] In Pakistan and the South-Asian context, socio-cultural ideals strongly influenced child-caring practices.[20] Models of binary opposites, contradictory, dichotomous, lingual construction are basic, simple, but very real for the majority of the local population.[9] In Pakistan, 50% of the population from the poorest, rural, and remote areas are without LHWs cover owing to structural failures and administrative incompetence.[21]

Sub-optimal newborn care practice among pregnant and lactating mothers in the poorest districts of South-Punjab might be associated with low household income, maternal illiteracy, high fertility, low birth interval, and lack of access to antenatal care opportunities.[22] Rajanpur as the most underdeveloped district in the South-Punjab indicates a high poverty level where 60% of the total population has been identified as poor and food insecure.[23] The total population of the district comprised 85 percent rural and 14 percent urban population. Forty percent houses have electricity. There are 33 Basic Health Units, 6 Rural Health Centers and only one hospital with 40 beds. The literacy rate is significantly low with 29 percent male and only 11 percent female literacy rate.[24]

CONCLUSION

Increasing social and cultural capital is imperative for rural areas of South-Punjab of Pakistan. Thus, it necessitates a complex matrix of social and structural determinants of health along with

biomedical interventions and behavior change communication strategies for full discernment of the culture-development paradox.

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