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

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ARTICLE INFO

Article history:
Received 25 October 2012
Received in revised form 13 February 2013
Accepted 3 March 2013

Keywords:
Social support
Qualitative research
Perinatal continuum
Developing countries

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.

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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
at improving the ‘social’ milieu in pregnancy and childbirth have positive practice implications, given that childbirth 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 and in this context 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 the 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,
incorporating both descriptive and interpretive elements (Green and Thorogood, 2009).

Ethics clearance

Ethics clearance was obtained from the Human Research Ethics Committee of the SJMC prior to commencing the fieldwork.

Findings

The results of the analysis and interpretation of the qualitative data are presented as key themes identified with respect to the research question: ‘what is the nature of support—emotional, practical and health related, available to the mother–infant dyad in the perinatal period?’ The following themes emerged:

- Importance of women’s own mothers
- My place (ooru)
- Female support network
- Role of husband
- The ambivalent role of the family

‘I would tell my Amma about everything’: importance of women’s own mothers

If there was one universal theme that emerged out of all the interviews, it was the reliance that women placed on their own mothers (Amma). Women relied on their mothers for support, advice, for their presence, their help. Being supported by the mother and being with the mother through some or even a major part of the pregnancy was strongly endorsed by participants. As one young woman said ‘During pregnancy I worried a lot about the delivery, especially the pain. I felt I couldn’t get through that on my own without support from (my) Amma.’ The mother was seen as a constant, someone women relied on for everyday succour or advice throughout the perinatal period, but also someone who was the essential support through the whole delivery process. Apart from women who were geographically too distant from their mother, did not have a mother or were estranged from them; all women interviewed had their own mothers present at the time of the delivery.

There are enough people around me to talk to and support, (but) mainly I would tell my mother about everything. She has been very supportive throughout. (29 years, educated)

Women who had good access to their mothers felt they were particularly lucky. This reliance on the mother and the natal home was sometimes used as a buffer to protect women who did not have such an easy time in their husband’s or in-law’s home setting.

My in-laws came here at seventh month to take me back, but my parents didn’t send because child may get ‘cold’ there. I had abortion [miscarriage] one time at second month, after that one year I didn’t get [another] child, so my parents thought if I will be there [in-law’s house]. …I have to work so I won’t be able to take rest also, that is why they [my parents] brought me here. (25 year old participant, Christian)

When the mother was not available, either due to distance, lack of mother (death), or due to socio-cultural factors (‘love marriage’), this was remarked upon with sadness. The issue of having a love marriage or an own-choice marriage (discussed later), was particularly poignant if the marriage choice was not supported by the family.

I missed my mother a lot (during pregnancy). I feel that we miss support from both sides of the family, we often feel bad about that. (20 year old, love marriage, poor family)

No (about lack of access to mother). It is very far….so I was calling my mother daily and asking her for everything. (23 year old, comes from a north eastern State in India)

The postnatal period in particular, was a time when women relied on their own mother for prolonged support. If women were unable to go to their mother’s house, their mothers visited them and stayed on for as long as was feasible.

The mother was also a major source of advice throughout the perinatal period. Mothers could be relied upon to empathise with their daughter’s situation. Mothers were acknowledged to be wise and experienced in pregnancy, childbirth and childrearing.

And I call my mother that time, sometimes she suggests me to go to St Johns,…sometimes she says this is normal in pregnancy,…then I feel relaxed. (28 years, educated participant)

My mother gave me good advice. She told me to keep mind always fresh, to read books and to listen good music. So I was reading bible and listening to devotional songs and I was not getting anger. (25 year old, Christian)

My mother had 11 children, out of which seven surviving… therefore she gave all advice (during pregnancy). And I followed her advice. (32 years, working woman)

‘Namma ooru’: My/our place

The strong natal links with own mother also flowed on to a sense of connection to the natal home or ‘ooru’. The emotional connection with their natal home (ooru…native place, usually a village) was reinforced by the expectation and the reality of spending some time being nurtured in one’s own home. The culturally sanctioned period of time that women were allowed to spend at their own mother’s (or natal) home seemed to be flexibly determined depending on the family context. Some women spent a major part of their pregnancy and the postnatal period in their mother’s home. One participant had spent much of the pregnancy on and off at her parents’ house, post-delivery she had stayed on for 11 months in her natal home.

Till 11 months (after the baby was born) I was in my mother’s place. I feel happy here. (25 year old, high school educated, not working)

Being cared for in their own home was a culturally legitimate place for them to be in the perinatal period. It was common for husbands to visit on and off while women stayed in their natal home. Other aspects of the natal home that were supportive included the fact that for many women, childhood friends and extended family still lived in the ooru. Some women felt that the entitlements that were owed to them in the perinatal period while in their ooru were not available to them when they moved to the city. As one grandmother put it, ‘in our native ooru my daughter-in-law got special food, child care kit, money, everything. In city only, they are not giving anything.’ When women were unable to go back to their native place either due to work or family circumstances, they longed for their ooru to come to them or looked for ways to connect back to their native place.

I have a friend here from my native place; with her only I am sharing my feelings. (26 year old, high school educated)

The desire to go back to the natal home was often shared by the husband, especially if he was also from the same village.
Again pregnancy and childbirth appeared to be triggers for reconnecting with one's real ‘home’; a shared longing that was culturally sanctioned. As one husband wistfully put it, ‘for next pregnancy we want to go back to our native ooru. If we go there we won't have any problem.’

For the women who were geographically and culturally distant from their native place, it was particularly difficult to negotiate the perinatal period. This was more so for poor women, who had little possibility of being able to travel to their native place. One Muslim participant with minimal education from Bengal was instructive in this regard. While she was part of an extended family network that had migrated from Bengal in search of work, she never quite made a ‘home’ for herself in Bangalore. She had no local language skills, did not use any of the local health or support facilities and was in no position financially to make the trip home to her native place or even to have her mother come and visit her. This family had many other risk factors including poverty, lack of support, being culturally dislocated, but from the woman’s point of view the lack of access to her own mother, and being unable to be looked after in her native place in Bengal was a source of ongoing distress.

‘You must be lucky also to find a good friend’: female support network or women-to-women bonds

Another great source of support and friendship that participants mentioned was female support. This could be provided by female relatives (particularly sisters, cousins or sister-in-law), female friends or older female friends who were usually referred to by a relationship name (commonly ‘auntie’). Some women had numerous sources of support, their own mothers, female relatives and friends. Many participants described their pregnancy and childbirth period, virtually enveloped by positive female presence. In the context of sexual segregation, particularly strong in some Muslim families, women-to-women bonds are easy to access without arousing suspicion. Women are also a prime source of reproductive health knowledge. Female friendships were particularly important in those who lived in nuclear households or those who were far away from their own families.

When I was vomiting for the first few months, three different friends used to cook different dishes for me every day; they looked after me so well. (27 year old, nuclear family)

My neighbour ‘aunties’ are there for any help or support. Everything…they help me with. (25 year old, from a different state)

As with the lack of own mother, those who did not have strong female networks or friendships missed them.

Here my mother, sisters and friends are there in Bangalore to support me, but I am alone in there (in Muscat). I feel very lonely. (22 years, Muslim)

Some women had language or cultural constraints in being able to form friendships; this was more pronounced in those with limited education. Others spoke about the special friends and supports they had in their ooru (native place), which they were not able to replace in the big city. Some women were too busy with work and family to afford friendships, but nevertheless missed them.

I have no special friends here. You must be lucky also to find a good friend, no? (32 year old, full time worker)

Sometimes the advice from family and female supports had nothing much to do with health or nutrition, but was supportive and therefore acted upon. As one young Muslim woman laughingly said ‘everyone told me to eat 2 apples daily, some badam (almonds) and half litre of milk; I did that daily. That's why I have such a beautiful, fair baby daughter.’

‘As good as a mother, I must say’: role of the Husband and other male relatives

All participants interviewed were married and had husbands, although the role of the husband was far less predictable than the expectations women had of their own (natal) families. Women generally mentioned their husbands as sources of support well after they mentioned their own mother and other female supports. Women who relied strongly on their husbands for support were invariably in nuclear households. As one educated 31 year old woman with a very supportive husband reflected, ‘I have a soft, good husband.’ Those who relied almost exclusively on their husbands either had ‘love’ marriages or had significant trouble with in-laws and had sympathetic husbands.

No one was there to provide support after delivery at home, apart from husband. Husband took some leave and looked after me and the children. (20 year old, love marriage, poorly educated)

Mother or mother-in-law did not give us any support. (My) husband says: we had no family support at all. I got all support from my husband only. (28 year old, Muslim, major family feuds)

The roles played by husbands and expectations women had of their husbands varied widely. Working women, especially those in nuclear families spoke proudly of their husbands’ ability to help them with household work and with childcare responsibility. As one educated working woman said ‘actually he (husband) is very, very helpful…as good as a mother I must say.’ Others could not conceive of their husbands helping out at home as it was their domain.

Oh, he leaves at 9 am, returns at 8 pm. (He) does not help with household duties at all….why, it is my job…no? (giggle)! But he loves to help with the baby, she is his pet. (25 year old, Muslim)

Some women did not mention their husbands at all unless questioned specifically about them. These women were more likely to be surrounded by female supports and networks, and exist in a gender-segregated milieu. There were certain roles that were more likely to be expected of the husbands. These included taking the woman to hospital for delivery or emergencies and providing the financial resources for health care. When presented with a hypothetical scenario portraying a medical emergency, most women chose to tell their husbands first and expected their husbands to take them to the hospital. Participants who had not mentioned their husbands even once through the interview revealed that their husbands would have to respond to their needs and take them to hospital in case of a medical emergency. Other family men, commonly the husband’s older brothers (if husbands were not available) or fathers in law were also mentioned as potential supports when needing to seek urgent medical care. As one woman put it, her greatest sources of support for health matters were ‘my husband and my husband’s uncle’s son; I can’t forget their help in my life.’

Another role for husbands and fathers-in-law was one that was perhaps thrust on them. Women who did not have access to their own mothers due to geographical distance or family factors, even in a gender segregated social group such as traditional Muslim families, relied on husbands or fathers-in-law for practical and emotional support in the perinatal period. As one Muslim participant (29 years old, educated), who lived in an extended family said ‘my father-in-law is very sensitive about how I am feeling,'
he would suggest I lie down if I looked unwell.' Another Muslim participant also relied on the father-in-law for practical help such as hospital antenatal visits, as the husband worked very long hours and her natal family lived in Bengal.

'More tension when the in-laws are here': family support and family tension, the ambivalent role of the family

Although families were the single biggest sources of support for women and their babies, a major source of stress for women in the perinatal period was family tension, usually though not exclusively emanating from the extended family or in-laws. Very often this tension was just referred to as 'in-law tension', the words used in English. Most marriage partnerships were arranged marriages, and it was common for the participants to count themselves lucky if they had 'good' or even non-interfering in-laws. Family tensions occurred across the three groups, they were compounded if the woman felt unsupported by the husband.

More tension when my mother-in-law was here, there were lots of fights at home… and she doesn’t like people visiting me. Also my husband supports his mother ‘a bit.’ (30 years old, educated)

My in-laws didn’t want my parents to come here (to support me). They were scolding always… if anyone from my family comes. (20 year old, high school educated)

In-law tensions could be soothed as well as inflamed by support from one’s natal family. As one mother disclosed in an emotional outburst about how her daughter was being treated by her in-laws: ‘We didn’t get any help from their side. They have so much money, but they didn’t help. They just ignored it (her pregnancy related ill health). Once she came to my place (natal home), they thought it was the end of their responsibilities. They are only responsible for her ill health. In this pregnancy, she has had bleeding since 1½ months. There… (husband’s house) she doesn’t have any rest at all. Her mother-in-law… she is a step mother (aside), asks her to do more work, asks her to repeat something if she is not satisfied. Due to these tensions, she is not very happy.’

The converse of this situation occurs when the mother and baby dyad are supported by both sides of the family. Some marriages particularly for women from rural backgrounds, were within extended family or clan networks, so there was a greater degree of comfort and familiarity with the ‘in-laws’. One woman whose own mother was dead, relied very strongly on in-law support; and the in-laws stepped in to provide the extended nurturing and care during the perinatal period that is usually provided by the own mother.

Other sources of advice and support through the perinatal period

Looking at the perinatal period chronologically, from conception through to the early childhood period, women used and needed different types of support (see Fig. 1). While the need for own mother support was a constant throughout the perinatal period; the need for the mother’s physical presence was most strongly articulated around childbirth and the postnatal period. Female to female networks, within and extra-familial, seemed to be relied upon in the first and second trimester of pregnancy and then again in early infancy. Women who had one or two other young children, often relied on their female networks, to help out with childcare or to provide advice about infant feeding. For acute health events, involving the mother or the infant, husbands and male relatives were important. Health-care professionals were never mentioned routinely as sources of support, but occasionally women mentioned their obstetrician as someone they could call for advice in an emergency relating to pregnancy, a paediatrician or private doctor if there was an acute health problem for the infant.

Women got advice about pregnancy, childbirth and childrearing from a range of sources; there was no clear hierarchy of authoritative sources for health advice. As one woman with high school education said, ‘I was given lots of advice from everyone… many friends, my mother and mother-in-law. Eat vegetables, ‘soppu’ (spinach), fish, non-veg, don’t eat ‘jolla’ and papaya. I followed everyone’s advice.’ Women often found it difficult to differentiate between different sources of advice, and indeed different personnel among health workers. As one young woman with poor education said, ‘Doctor told me… eat whatever you want, but avoid heathy food.’ When asked specifically about advice given in pregnancy, some women did mention the hospital as a source of advice about nutrition in pregnancy. Most often this ‘nutrition advice’ from the hospital was actually provided by the research team involved in the cohort study.

Ethnographic observation added some weight to the source of confusion for women about sources of health advice. Women enrolled in the cohort study spent half an hour to an hour with the research team each visit, answering a range of questions relating to perinatal health and nutrition, sometimes having investigations performed. They referred to the research team as ‘Nutrition people’ and most women interviewed had developed a rapport and connection to one member of the team, even mentioning them by name. Some women would come back to show their infants and spend time chatting to the team, even after they had graduated out of the study. By contrast antenatal and postnatal hospital visits last less than five minutes each, there is little time to ask for or receive health related advice, let alone garner support.

Discussion

This paper highlights the range of sources of support, psychological, socio-cultural and practical, that women and their infants need through the perinatal period in urban India. The realm of the ‘social’ in the perinatal period has been explored in the last two decades as an avenue for positive intervention in the west, particularly in the form of home visiting and structured social support (Oakley, 1985; Oakley et al., 1990). Social support as conceptualised or provided in developing countries, is often narrowly defined; such as social support during labour and delivery,(Campero et al., 1998; Maimbolwa et al., 2003; Khresheh and Barclay, 2010), or postpartum support (Lugina et al., 2001; Mbekenga et al., 2011a). Our research suggests that women in urban India are supported predominantly informally throughout the perinatal period, this support is largely provided by the own mother and an extensive, diverse female network.

Research that has emerged recently has focused on the early postpartum period. Mbekenga et al.’s studies on postpartum experiences and needs of mothers in urban Tanzania, have documented the informal supports available in the form of family, partner and neighbours (Mbekenga et al., 2011a, 2011c). The overwhelming reliance on own mother for support, has not been documented and is likely to be a common socio-cultural behaviour across South Asia. Kakar in his psychoanalytic study of Indian society, describes the special relationship that mothers and daughters have, a mother’s ‘unconscious identification with her daughter that is normally stronger than with her son’(Kakar, 1981). This connection is strongly played out as our research suggests in the perinatal period, where biological and social needs coalesce. The connection to the own mother, extends to the emotional bond with the natal home and the native village. Gideon’s ethnographic account of pregnancy and childbirth in rural Punjab describes this
relationship with the native village beautifully. ‘...the atmosphere was free and easy. She (expectant mother) could go and visit her neighbours as and when she wished, and there was no need to cover her face’ (Gideon, 1962).

In the urban setting, we found that women-to-women bonds existed, were strengthened through the perinatal period and when they didn’t exist were created in various ways. Women drew on females members of their natal or extended families, adopted new ‘aunties’ or surrogate mothers, relied on old or new friendships, even making strong connections with the researchers for support. Mumtaz and Salway discuss how crucial women’s social relationships with other women are, in the realm of reproductive health, particularly in their rural setting in Pakistan where low education and female segregation was the norm. They describe strong (majboot) women as those who had female-to-female relationships and were able to negotiate care during pregnancy when not forthcoming (Mumtaz and Salway, 2009). Women in our study negotiated practical and emotional support from their networks, as and when they needed them.

The role of husbands and male relatives in supporting women through the perinatal period was more nuanced and contingent upon the kind of family structure and type of marriage. Husband support was also moderated by social class in that more women who were educated seemed to be able to rely strongly on their husbands and male relatives. Men and the socio-cultural construction of masculinities are now recognised as having important implications for women’s reproductive health outcomes, and there has been a concerted effort at involving husbands in antenatal care and in delivery particularly in Nepal (Mullany et al., 2007; Sapkota et al., 2012). Our research may have been strengthened if we had canvassed the views of husbands and fathers separately. Taken together recent studies from developing countries, suggest that ‘male involvement’ is not a singular behaviour; understanding this complexity needs to take into account the socio-cultural mix, the role of women’s agency (Carter, 2002; Mullany et al., 2005, 2007; Mumtaz and Salway, 2007) and husbands’ ability to provide practical support and health oriented advice (Carter, 2002). Low involvement from husbands in childcare and the perinatal period has been shown to be a risk factor in maternal depression in India (Rodrigues et al., 2003). There is strong support now for greater male involvement in reproductive health in South Asia (Mullany, 2006).

The role of the family as the major source of practical and emotional support as well as the source of significant stress and tension in the perinatal period needs to be acknowledged. Perinatal stress due to abuse from in-laws is not uncommon among women in India and may adversely affect maternal and child health; among poor women in Mumbai indirect abuse included domestic labour, food denial and preventing medical care (Raj et al., 2011). In our study, ‘in-law tension’ (this often included sisters-in-law) was the single biggest source of stress for women. Other studies have found that in-laws may be a greater source of abuse in the perinatal period than husbands, and that women suffering from intimate partner violence (IPV) are more likely to report in-law abuse (Raj et al., 2006; Khosla et al., 2005). Simkhada et al.’s study of the role of the mother-in-law in antenatal care (ANC) utilisation in Nepal also documented the dual role played: a positive influence when encouraging women to seek ANC, but more often a negative role in discouraging women from accessing ANC (Simkhada et al., 2010). Bhopal’s study of perinatal social support patterns used by South Asian women living in London suggest that the role of the paternal grandmother and other female paternal kin was significant particularly in providing child-care support (Bhopal, 1998). Clark et al.’s exploration of the role of family in IPV in Jordan also found a more complex relationship between the natal family and the in-laws, in mediating risk and resilience to IPV (Clark et al., 2010). As with men’s role in the perinatal period, the role of the natal and extended family needs to understood in a more nuanced manner.

Social class and education did seem to play some role in women’s ability to garner support in our study, but it was mediated by other factors such as living in nuclear versus an extended family. More of the educated women had the ability to go to their mother’s home or have their mothers or female relatives stay with them for extended periods of time. More of the educated women also seemed to be able to rely on their husbands for practical as well as emotional support. The maternal and infant dyads most at risk were those who were poor and socially isolated, physically distant from their mothers and natal homes, those with major family/in-law tensions, those who were

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**Fig. 1.** Sources of support in the perinatal period for women and their infants in urban India.
culturally dislocated or those who were unable to recruit the support that they needed.

Conclusions and policy implications

The urban milieu is soon going to be the major challenge for health services delivery; by 2050 it is estimated that 70% of all people will live in urban areas with major implications for women and children who are the most vulnerable (Trudy, 2009; UNICEF, 2012). Apart from dealing with the obvious challenges of burgeoning populations, increasing inequity and poor access to basic services, for many urban dwellers particularly in South Asia their social and cultural reference points are back in their native ‘oora’ and many do not exist within formally organised social structures. While this study suggests that women in urban South India access and demand varied sources of support throughout the perinatal period, there are clearly women and infant dyads who are vulnerable due to poor or no support. For the health sector, which is largely absent from the ‘social’ realm of the perinatal period in urban India, we would advocate a greater understanding of women and children’s needs throughout the perinatal continuum. Clinicians and health policy makers need to facilitate women’s access to social and support networks where they are weak or don’t exist, bolster existing support services with access to appropriate health information and advice and acknowledge the rapidly evolving role of husbands and male partners. This may be as critical to achieving MDGs 4 and 5 in urban South Asia, as the package of essential interventions in maternal, newborn and child health (WHO, 2011).

Conflicts of Interest

We declare there is no conflict of interest of any members of this research group to this piece of research.

Acknowledgements

We gratefully acknowledge the invaluable support and help provided by Dr. Sumithra Mutthayya and members of the Nutrition Research team from St John’s Research Institute, St John’s Medical College, Bangalore. The first author is particularly grateful to all the women and families who so freely gave their time to this research.

References


