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Pregnant women shifting to parental from In-laws home along with other relevant beliefs and practices in Bangladesh: traditional carry out rather barrier for ANC, Delivery and PNC services

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I. INTRODUCTION

This study interest grew through a general observation of pregnant women shifting to their parental from In-laws home among middle-class Bengal families. Questions came to mind, why they shift? And general perception was for better care, comfort, and maybe the attitude of in-laws kin. But when one pregnant woman moves to parental from in-laws home, another pregnant woman shifts to that home, which is her parental home. Now the questions rose significantly, Why? Does this movement obstruct in having ANC and/or delivery and/or PNC health services as these services are a continuum. Keeping those questions in mind, this study was designed to explore reasons, patterns, beliefs, and practices of pregnant women who are shifting to parental from in-laws home during their pregnancy period. What are the effects of these practices were ascertained as well. Before having the above-mentioned primary data, this writing reviewed relevant articles to know significant cultural belief and practices during pregnancy, delivery, and post-delivery and checked the relevancy of this kind of practice among the study area and context.

Over the past two decades, impressive strides have been made in reducing infant, mother, and child mortality and increasing levels of contraceptive use in developing countries. Although exact figures remain elusive, an estimated 525,000 women, almost all from developing countries, continue to die each year from maternal causes (World Health Organization, 2004). The post-2015 maternal health strategy announced by the World Health Organization targeted reducing at least two-thirds of preventable maternal mortality from all countries' 2010 baseline level within 2030. The target of reducing MMR to the average rate is less than 70/100 000 live births worldwide, and the national target for all counties is less than 140/100 000 live births by 2030 (World Health Organization et al., 2015). In Bangladesh, the reduction in maternal mortality levels and improvement of maternal health have been central policy and program goals since the fourth Population and Health Program, which began in 1992. Efforts to address these issues have recently gained considerable momentum with the formulation of the National Strategy for Maternal Health (MOHFW, 2001). This strategy emphasizes the provision of emergency obstetric care and is predicated on the 'three stages' framework of factors that affect safe motherhood service utilization and outcomes: antenatal care, care during delivery, and postnatal care (Thaddeus & Maine, 1994). But in rural areas of Bangladesh, the situation is worse for women when it comes to their health-seeking behaviors and the services they seek during pregnancy and after childbirth (Roy & Shengelia, 2016) compared the BMMS report 2001 and 2010; they stated that although the direct or immediate determinants of maternal mortality have reduced gradually, the indirect or secondary determinants of maternal mortality remain stable. The household survey and other data assessed that about two-thirds of total maternal fatality happened throughout the postpartum stage. Data regarding the indirect or secondary determinants of maternal mortality still unavailable. The process of receiving 'three steps' care during pregnancy and child delivery started from her residence's nearest healthcare. In South Asian societies, traditionally women dwell with their in-law family after marriages; selecting the childbirth place, attendants, and social forms of birthing customs regulate health professionals. Childbirth is usually taken place in an In-law home or the place appointed by the in-law family; under the mother-in-law or traditional birth attendant's supervision. The natal family is a little part of this event (Simkhada et al., 2010; Steinberg, 1996). Pregnant women may shift to parental just immediately before giving birth or after. This is considered a birth custom. Even some Asian women living abroad also maintained childbirth-related customs. In a few cases, the mother comes back to the in-laws' home as she considered this shifting is hampering in having health care services (Gatrad et al., 2004). Rowther and others explained the reasons for shifting parental home during pregnancy to some extent. Though some causes didn't indicate women's firsthand autonomy regarding ANC or PNC. Oppressed by household

duties, attitude and conflicts between in-law family members and negligence of in-law families are responsible for this kind of movement tentatively. The husband's assistance is essentially required to return to a natal home (Rowther et al., 2020).

However, for receiving parental care, and other health services during pregnancy, women's place of residence is a strong determinant (Chaudhuri & Mandal, 2020). Where pregnant women in Bangladesh prefer to live during their pregnancy and post-delivery period and why? Keeping these questions in mind this study was designed. Focusing on this issue of movement from in-law's to parental homes, this study aimed to explore pregnant women's shifting time, patterns and reasons behind, and other related and relevant traditional believe and reasons behind other related and relevant traditional beliefs practices. Resultant of this reallocation during pregnancy and after delivery in having ANC, Delivery, and PNC services were also investigated to generate relevant personnel's opinion on this concern. Based on reviewing relevant articles and grey literature and adopting qualitative tools of primary data collection (In-depth interview), this writing explored traditional believe and practice concerning pregnancy, delivery, and post-delivery period of care and concern. The study revealed some cultural barriers to receiving proper care during and after pregnancy, which is rooted in family relations and behavioral believe and taboos. Finding demonstrated how traditional belief and practices influence these behaviors, acts, and relations. Women's movements from in-laws to parental home during or post-delivery hamper the ANC, delivery, and PNC services which was clearly indicated by the related health service providers

Maternal Health Care situation in Bangladesh

The report "Trends in maternal mortality: 1990 to 2015" assessed by WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division declared that the MMR declined almost 44% in the last 25 years worldwide, and approximated 216 maternal deaths per 100 000 live births occurred in 2015. Among developing neighborhoods, the MMR rate declined to 66% from 1990 to 2015 in Southeastern Asia; compared to the developed regions, the rate was 48% (World Health Organization et al., 2015). Measuring the community-level data regarding the MMR is essential as more than 40% of childbirth happen in the absence of experienced health professionals in the WHO South-East Asia countries (WHO & World Bank, 2015). At the same time, a notable portion of maternal mortality occurs beyond health-care facilities (World Health Organization et al., 2015).

Millions of women in developing countries experience life-threatening and other serious health problems related to pregnancy or childbirth. Complications of pregnancy and childbirth cause more deaths and disability than any other reproductive health problems (UNFPA, 2012). The situation is worse in developing countries like Bangladesh due to inadequate access to modern health services and poor utilization. One of the public health challenges in developing countries such as Bangladesh is, therefore, to identify vulnerable groups and to provide them with needed preventive and curative health services. Bangladesh was on the right trail and placed 9th position among 75 Program countries in achieving the primary target of MDG 5 by 2015. For Bangladesh, to fulfill the Ending Preventable Maternal Mortality (EPMM) target (59 maternal deaths per 100,000 live births by 2030), a more 64% of the MMR needed to be reduced. In 1998–2001, the MMR was 322 deaths per 100,000 live births (95% CI: 253–391); the country decreased that ratio from 322 to 194 deaths per 100,000 live births (95% CI: 149–238) within five years (2007–2010) (Ahsan et al., 2020). The MMR per 100000 live births was estimated at 143 for Bangladesh in 2015, but the achieved ratio was 176 in that year (World Health Organization et al., 2015). On average, countries from South-East Asia and Sub-Sahara Africa suffered the highest child mortality. Following the SDG, Bangladesh remarkably declined the neonatal fatality rate from 1990 to 2015. The rate was from 63.4 to 23.3 deaths per 1,000 live births; that was gradually achieved by the development of leading primary health-care (Rajia et al., 2019). The remarkable progress of Bangladesh in maternal and child health was noticed but still, it's a problem. The most important issue is to maintain this positive change forward.

II. MATERIALS AND METHODS

This study is based on a literature review and semi-structured in-depth interviews with pregnant women and newborn mothers, their husbands, mothers-in-law, and community health workers. Educational and financial diversities were considered in selecting women, mother, and their respective in-laws kin. Thematic analysis was adopted for data analysis and interpreting findings. Both the review and primary data were presented under various themes identified from examining the literature and compiling selective codes of transcribed data. Under each theme, reviewed findings and respective primary findings were piled up respectively.

Literature was searched in 'Google Scholar', 'PubMed' and 'Science Direct' online database with keywords; "dietary believe and practice", “food taboos”, "mobility restrictions", "traditional treatment practices" and "shifting home" AND/OR "pregnant women" and "Newborn mother" Few grey Literature regarding

maternal mortality and health status were collected available in online. Scientific articles were selected going through the title and reading abstract and findings, directly and indirectly, connected with traditional beliefs and practices and their impact on pregnant women and newborn mothers' health care. Primary data were collected from the village name, *Salmanpur*, ward no 24 in *Comilla* City Corporation, Bangladesh. Total 19 In-depth Interviews were conducted with 4 pregnant women, 4 mothers of the newborn, 2 husbands of pregnant women, 2 husbands of newborn mothers, 4 mothers-in-law and 3 community health workers (FWA, HA, and FWV). Audio recorded interviews were transcribed verbatim and

List of IDI participants

Method	Respondent	Number			
In-depth Interview (IDI)	Pregnant Women	Educated	Uneducated	Poor	Rich
		1	**1**	**1**	**1**
	Mother of Newborn	Educated	Uneducated	Poor	Rich
		1	**1**	**1**	**1**
	Husband of Pregnant Women	**2**			
	Husband of the Mother of Newborn	**2**			
	Mother-in-law of Pregnant Women	**2**			
	Mother-in-law of a mother of Newborn	**2**			
	Health Service Providers	**3**			
Total		**19**			

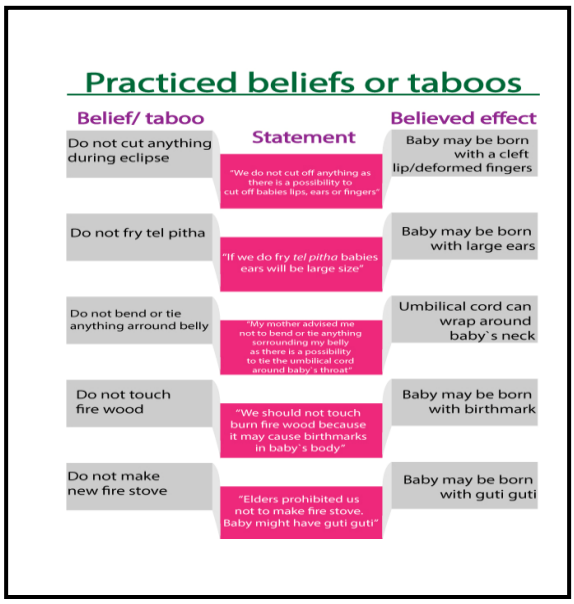
followed by open codes, axial codes, and finalized with selective codes. Themes were confirmed through appraising primary findings and codes along with cross-checking the review literature. After selecting the themes, both the reviewed findings and the respective primary findings were assembled under the same themes.

III. FINDINGS

This study reviewed some literature on traditional health care practices and believe during pregnancy and post-pregnancy as well. Dietary believes and practices, food taboos, women's movement and other restrictions, and attitude of the in-law's family members regarding ANC and PNC cares are significant factors in receiving three stages of care. Pertinent practices were identified by examining existing literature and cross-checking through primary findings evolved from this study context.

Traditional believe, conventional attitude, and behavioral restrictions towards pregnant women

Primary findings indicated that common explanations for illness included an attack by evil spirits or as a result of food eaten, in addition to physical causes. As a result, it was found that many mothers during their pregnancy took precautionary measures against evil spirits. Younger mothers seemed less likely to believe these explanations, at times ignoring their elder's advice about correct behavior, which could lead to restrictions placed on women's movements by relatives. The study found several activities that women in Bangladesh are supposed to avoid during pregnancy, including going outside at night or in the afternoon, going out with one's hair down, or allowing the end of one's sari to trail on the ground. Food taboos were also common during pregnancy and the puerperium in Bangladesh. For example, pineapples were said to cause abortion, coconuts were believed to make a baby blind (a condition described as a white eye), and duck

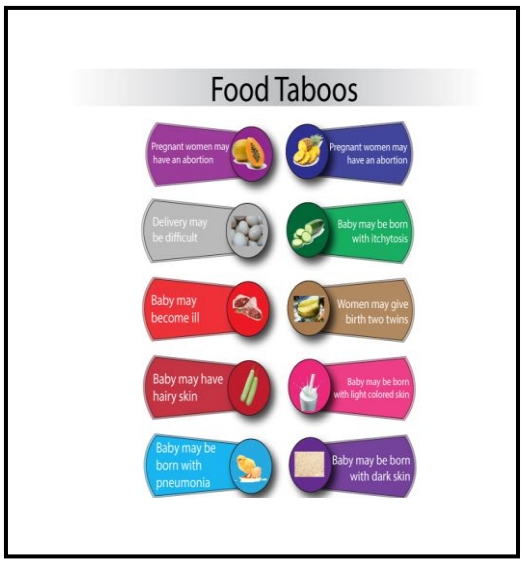


eggs were thought to cause asthma in the baby. Although there is some variation, one belief is common: certain 'hot' foods should be avoided during pregnancy and encouraged in the early postpartum period.

Dietary believes and practices

Studies assessed traditional beliefs and practices regarding food consumption during the pregnancy, later in the pregnancy, during the early postpartum period, and in the postpartum period. In the study, Grewal and others showed that family members stimulated women to consume foods that can help to urge labor pains. They believed some food have hot effects for assisting body balance; serving cold food during the postpartum period may generate an inconsistency as a woman's body became frail after giving birth (Grewal et al., 2008). For increasing breast milk and cooling the stomach; rice and *varta* (mashed potatoes with cumin seeds), including all kinds of dried food, were prescribed to new mothers in Bangladeshi food cultures. Green herbs, pumpkins, and apples may induce diarrhea in 2-3 months old baby if mothers do not restrain consuming those items. Sometimes, views concerning the outcomes of diets on the baby's growth determine meal suggestions and constraints (Withers et al., 2018). Cultural and religious practices regarding dietary behaviors are indicated as the presumable reason for the lower average birth weight of babies among Hindu communities in the South-Asia region. Many Hindu women are vegetarians, ; they aren't allowed to consume any kinds of animal proteins even in pregnancy; moreover, environmental determinants and hereditary may also be a part of this circumstance (Gatrad et al., 2004).

It was revealed from primary data that local believe surrounding dietary practices in pregnancy were widely held among the study population. Many women initially were reluctant to discuss these beliefs, particularly in the presence of other family members. These beliefs are deeply rooted in the community's generally profoundly rooted in the community's culture, and mothers-in-law and elders often reinforce their importance. We found that when belief ran counter to nutritional information disseminated at the health centers, women often would rather adhere to these beliefs. Sometimes those beliefs turn to food taboos as shown in the box. Eating more will enlarge the babby's size which will be a problem while delivery is a common understading.



Movement and mobility-related believe and practices

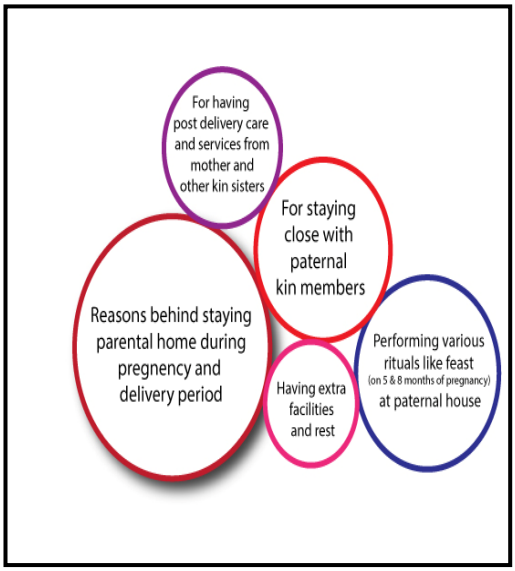
According to literature, religious aspects and some cultural practices defined the mobility of pregnant women, influenced the decision -making about preferring a delivery place, and may create barriers to use advanced medication and guidance. For instance, a study addressed that 13% of Muslim women aren't willing to go for hospital delivery, as showing private parts of the body and revealing individual life to others is prohibited in Islam (Chaudhuri & Mandal, 2020). In rural Bangladesh, mothers, and newborns infrequently received PNC within 42 days of delivery due to weak health care services and cultural restraints (Shahjahan et al., 2017). In a systematic review study; Withers and others demonstrated the notion of purity and pollution regarding one month postpartum among the communities in Nepal, India, Bangladesh, and Papua New Guinea. Postpartum considered as pollution; women were beings separated, to prevent other family members from the polluted situation; they are not allowed to assist food preparation, cropping, or collecting water (Withers et al., 2018). Movement outside the home or solo outside traveling during pregnancy is customary restrains for women. Studies reported that in most instances elders or male family members are the decision-makers; women's autonomy to mobility depends on their engagement and consent (Rowther et al., 2020). Banu stated that husband or other in-law family members' views, practices, and involvement in regulating women's movement during pregnancy. In many Asian societies, women living in in-law homes are assigned to complete household chores in time; going for ANC check-ups or other health care services is obstinate in this situation (Banu, 2016).. Pregnant women met severe constraints when they move outside the home searching for reproductive health services even with accompanying in a country like Pakistan (Mumtaz & Salway, 2005).

It is generally believed among the study people that evil spirits are more active in the evening, at noon, and at night, so pregnant women should avoided leaving their homes during those times. Walking through graveyards was also thought to be harmful to pregnant women. If they did so, they tied up their hair and covered their heads with veils.

"Evil spirits could cause miscarriage of the fetus that is why I did not go out in prayer time"

-IDI, A lactating mother

A few women reported their belief about carrying a piece of iron which would ensure protection. Matches were also reported to be effective in keeping away the evil gaze of the spirits. People believed that solar and lunar eclipses result in harmful effects on their lives. Many people believed that pregnant women should stay indoors during the solar eclipse to prevent the baby from developing congenital disabilities. From the study, it was known that all respondents took special measures during the solar and lunar eclipse.



Treatment-related Traditional believes and practices

Many studies revealed that cultural beliefs and practices often lead to self-care, home remedies, and consultation with traditional healers in rural communities (Nyamongo, 2002). As clinics and hospitals treat patients and diseases, the concept of utilizing maternal healthcare from health clinics and hospitals is stigmatized. Some rural community people grasped that only sick and complicated pregnancies can be treated there. In Bangladesh, giving birth to a child in a hospital or clinic considered as being "sick"; women with a defective body require hospital care (Afsana & Rashid, 2001). In rural areas, 80% of childbirth conducted at home. The concepts of child care and maternal issues are entirely natural to the community people. Studies revealed the relation of socio-economic determinants of this aspect; most families are unable to bear healthcare facilities for women and children, thus hiding their economic constraints with that belief and practice (Shahjahan et al., 2017). Applicable raw findings denoted that supernatural phenomena may often be viewed as causing complications or difficulties during pregnancy. They further described diverse social norms and expectations that may affect delivery behavior, explaining how rural women may be ostracized.

Shifting to parental from in-law's home

Gatrad and others stated, for a pregnant woman, taking rest after the immediate postpartum period is required and shifting to the parental home as a part of the birth custom. After the delivery, pregnant women go to their parental home for 40 days at least. Even some Asian women living abroad also maintained childbirth-related customs mentioned in the same study. Authors of the study attested that taking rest for 13-40 days after immediate birth-giving is culturally practiced. Female members of marital and parental homes were involved in taking care of household chores and childcare in the rest period. If women live the whole trimester in a matrimonial home, they usually move to their parental home when they are seventh to the eighth month pregnant, facilitating the arrangement of the expected childbirth and the rest period in advance (Gatrad et al., 2004). The in-law family members, especially the mothers-in-law, controlled the resources and managed childbirth, healthcare decision-making, and accessing parental care (Edmonds et al., 2012; Rowther et al., 2020). Other senior attendants or traditional birth attendants (TBA) assist the situation when the labor period entrenched. As the mother-in-law plays the role of controlling circumstances, sometimes, the TBA recommendation is even skipped by senior family members (Steinberg, 1996).

Most of the married women asserted that it is like a tradition for them to give birth to their child in their parental home as their elders also followed this in their pregnancy. As a reason for this practice, respondents reported that they thought they could be able toey could stay more comfortable and rest in their parental home than their in-laws. They also told that when the delivery comes closer, they go to their parental home to get extra care from their mother and sisters. They believed that this would help them to have safe motherhood and safe delivery. They also mentioned that during pregnancy in eight-ten months pregnant women feel more unrest and ill than earlier. At that time they feel to have extra care and rest and for this, they prefer to stay in their parental home than in-laws. In some cases, women also asserted that after delivery as they could not work anything due to sickness then, women also asserted that after delivery as they could not work anything due to sickness, they needed a close person to take care of her newly born baby. And for this, they feel relieved to stay with their mother and parental close kin members in that period for having cared services. Though their mother-in-law can take care of them and their baby, but staying in parental home help though their mother-in-law can take care of them and their baby, staying in parental home helps them stay more comfortable and healthy during their delivery period. Moreover, after delivery in the Bangladeshi cultural context, women are considered to be impure during this time. They are not allowed to touch any food to prepare meals for other family members. It was reported that parental relatives, especially mothers of newly delivered women, cook food for new mothers.

The mothers of newly delivered women and the elders played a dominant role in deciding what foodstuffs the new mother can eat.

> "*Since the child's delivery, my mother and sister prepare the food as the newly delivered women (Poaati ma) are not supposed to cook till 40 days after the delivery because their body is considered to be impure. People wouldn't like it if I cook and it's not good for me even. My mother brings me food in my room so that I don't fall ill."*
>
> -IDI, a one-month newborn baby's mother

The outcome of the shifting concerning health care

Advice from older women in the household is instrumental in healthcare-seeking behavior (Delgado et. al, 1994). These factors are common amongst women, resulting in a delay for seeking treatment for themselves and resulting in a delay for seeking treatment for themselves and their children's illnesses. In the rural Bangladesh context, a notable proportion of mothers-in-law discouraged ANC's necessity due to their past happenings. Women are expected to do all household chores even in pregnancy. The level of perceptions of the benefits of ANC is also not engaging because most mothers-in-law considered that ANC matters only in complexities (Simkhada et al., 2010). Sometimes, newly mothers, newly mothers, newly mothers who shifted to parental; get back to In-law's home after 40 days due to continuing their antenatal and postnatal appointments in the health clinics near their marital home. Sometimes they come back as health access for antenatal and postnatal appointments is not convenient in their parental home. Thus, the study hypothetically stated that attending antenatal and postnatal appointments and accessing clinical services may hinder shifting to the parental home (Gatrad et al., 2004).

This study showed that though married women usually live with their in-law families, often at great distances from their parental family members but for ANC, delivery, and PNC services during their pregnancy and after delivery, women relied heavily on their parental kin for support. They shift from in-law family to maternal family because of in-law family members' attitude prevailed a gap in receiving ANC and PNC. As most of the female respondents asserted that they shifted to their parental home for having extra care than in-law so they cannot be able to maintain a schedule of receiving ANC from health service providers. It was also seemed to happen again during PNC when they shift from their parental home to in-law family after child delivery. As such, the service provider reported that due to this shift of placement, pregnant women and newborn children and mothers cannot receive proper ANC and PNC care as along with their shifting, schedule and pattern of health service care also change varying locality and placement of care. On the whole, only a few women who delivered at home sought postnatal care from medically trained personnel, despite the postnatal period being one of the riskiest periods for life-threatening complications. Data was not found indicating the use of postnatal care by place of delivery. It indicates that women seek medical care in the postnatal period from a wide range of sources, ranging from traditional/religious healers to consultant obstetricians and gynecologists. The proportion of women seeking postnatal care from a 'medically competent person' was found very low.

IV. DISCUSSION

This study finding demonstrates food taboos and dietary restrictions, mobility restrictions, and movement belief, treatment-related traditional attitudes, and many more issues connected with pregnant and newborn mother's behaviors and care. These are often obstructing in ensuring proper care and health services of pregnant women and newborn mothers and are considered significant bottlenecks in controlling maternal and child mortality. In-law's family members' attitudes and pregnant women shift to parental from in-law home adding new dimension and significance to this issue. Only a few studies (Chaudhuri & Mandal, 2020; Gatrad et al., 2004; Rowther et al., 2020) focused on the importance of the place of residence of women for receiving Postnatal Care (PNC), and socio-cultural aspects of shifting women to maternal home; nonetheless, no study assessed shifting maternal home as a direct barrier of Anti-natal Care (ANC). These health services are a continuous process, this shift may create inconsistency and hamper health care services. As stated in a study, Sometimes pregnant women or newborn mothers get back to the marital home, who shifted earlier to parental, due to continuing their antenatal and postnatal appointments in the health center near their marital home. Sometimes they come back as health access for antenatal and postnatal appointments is not convenient in their parental home. Shifting to the new environment of parental home is not an isolated event; rather, it is an integral part of a woman's status in her family and attitude of in-law family members which may hinder the process of receiving 'three steps' care during pregnancy and child delivery.

V. CONCLUSION

Pregnant women and newborn mothers shifting to parental from In-laws home is not an isolated part and as usual practice of the society, instead, it is an integral part of diverse traditional beliefs, attitudes and practices concerning mother health care, health status and maternal and child mortality and morbidity. This shift

and other mentioned conventional beliefs and practices are considered barriers as these are significant bottlenecks in ensuring better health care and services of pregnant and mothers of newborns and children. Further studies regarding the effects and impacts of this shift and the detailed process exploration and explanation will lend hands to the decision-makers and policy planners engaged in mother and child health issues.

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