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ETHNOGRAPHIC RESEARCH

RESEARCH OUTCOMES/INSIGHTS TO INFORM
SOCIAL MARKETING & BEHAVIOR CHANGE
COMMUNICATION CAMPAIGNS
IN PAKISTAN

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ACRONYMS AND ABBREVIATIONS

ANC	ante natal care
BCC	behavior change communication
DVD	digital video disc
FP	family planning
IDI	in-depth interviews
IPC	interspousal communications
LHV	lady health visitor
LHW	lady health worker
LTM	long term methods
MCHP	maternal child health program
MFPM	modern family planning methods
MIL	mother in laws
MNCH	maternal, neonatal and child health
PEER	rapid participatory ethnographic evaluation research
PRA	participatory rural
PSI	population services international
TBA	traditional birth attendants
TV	television
WRA	women of reproductive age



EXECUTIVE SUMMARY

This study was conducted in the Sindh and Punjab provinces of Pakistan to support improved decision making for USAID's Maternal Child Health Program (MCHP). The goal of the study is to generate insights that will inform the development of behavior change communication (BCC) campaigns for promotion of family planning (FP) and healthy maternal, neonatal, and child health (MNCH) behaviors. Key findings and insights are identified in this section and described in detail in the body of the report.

Insight 1

Shift strategic marketing priorities from a focus on WRA from 15-49 as the target group to MIL and older WRA (who have a few children).

1.1. Mother-in-Laws (MIL) are key decision-makers in the arena of MNCH. Husbands play a largely peripheral and passive role in MNCH decision-making. Women of Reproductive Age (WRA) are typically instructed to behave according to the wishes of the MIL. If WRA do not comply with the wishes of MIL, WRA are pressurised and potentially marginalised. WRA either hide Modern family planning methods (MFPM) use from MIL or conspire with husbands to deceive MIL.

1.2. MFPM is associated among a large number of MIL and husbands with being against the will of God and sinful. MIL perceive the ideal family to be necessary to being a good Muslim, maintaining honour and social prestige within the village. A widespread social norm is the preference for male children. The desire for male children is often a barrier to Long-Term Methods particularly among families where the first children are female.

1.3. There are widespread misconceptions about the effect of using MFPM. They include, decreasing long-term fertility and increasing the chance of miscarriage, difficult pregnancies and deliveries, and other illnesses. Many WRA displayed a lack of understanding of how MFPM work and what effect they have on women.

1.4. MILs typically do not have appropriate knowledge of promoted MNCH behaviours. MIL's often encourage (and often instruct) WRA to employ behaviors which are not promoted and which expose WRA to risk. This includes not feeding newborns colostrum, not swaddling newborns, not exclusively feeding newborns with mother's milk.

1.5. Young WRA with no, or few, children have extremely limited decision-making power across all MNCH behaviors. Older WRA with several children (usually with at least one male child) have considerable decision-making power in the domains of newborn and child care. They have greater decision and negotiation power in the arena of FP, ANC and choice of location of delivery than young WRA with few children.

Insight 2

Shift strategic marketing priorities away from a focus on husbands as a barrier to MNCH. Conceptualise males as a primary communication opening that are not presently playing a significant, proactive or productive role in MNCH decision-making but have the potential to play a more positive role.

2.1. The private world of the household and the decisions which are associated with MNCH are underpinned by matriarchal social structures and interpersonal relationships. The MIL makes decisions within the MNCH domain and only consults the husband at specific and limited junctures in the decision-making process.

2.2. Husbands are peripheral decision-makers, consulted only with regard to financial expenditure regarding health decisions. They are consulted only with regard to FP and delivery. They are not engaged by MIL with regard to other MNCH behaviors (newborn care, child care, post-partum care, many elements of ANC).

2.3. Husbands are much more mobile than WRA and MIL. They are the primary communication opening with the external world. Given that husbands do not see it as their role to get involved in many aspects of MNCH decision-making husbands often do not play a positive or proactive role in bringing information or insights from the external world to the household.

Insight 3

Communication between key actors (MIL, husbands, WRA and providers) is usually based on asymmetrical power relations and is typically delivered as instructions without opportunities for dialogue. This communication leads to low self-efficacy and poor knowledge.

3.1. Spousal communication between husbands and WRA is limited and unproductive. Communication between MIL and husbands is embedded in a relationship of power asymmetry. MIL typically tell sons what they would like daughter-in-law to do. When MIL express a desire both son and daughter-in-law typically follow the instruction. If the instructions are not followed this will lead to the scorn and social exclusion of the daughter-in-law.

3.2 Respondents find the world of FP and MNCH opaque, mysterious and unknowable. There is a very low level of self-efficacy across FP, ANC, delivery, post-partum behaviours. Husbands and young WRA with few children experience particularly acute levels of low self-efficacy and self-confidence. The process of conception, pregnancy and delivery are shrouded in mystery and an assortment of misconceptions exists in relation to most MNCH behaviors. This situation is a function of the target population experiencing a lack of confidence to seek information and learn given power asymmetries between themselves and 'experts' or 'providers'.

3.3. There is very limited dialogue between clients/patients and doctors. Doctors issue instructions in a monological fashion. This provides very limited scope for holding doctors to account and provides no space for learning among patients and their family members.

Insight 4

TBAs are the most influential provider for influencing the MIL, and thus influencing the household, and should be included as a target group in MNCH programming. The quality of information and clinical services provided is poor. TBAs do not refer pregnant women in a timely and appropriate fashion to facilities/recommended providers.

4.1. MIL, in particular, have considerable confidence in and esteem for Traditional Birth Attendants (TBAs) rather than bio-medical/recommended health providers (doctors, hospitals, Lady Health Visitors). This makes TBAs the most influential provider guiding and informing MIL in the arena of MNCH decision-making in the household context. Given the importance of the MIL in household decision-making concerning MNCH and the role of the TBA in influencing the MIL the structural relationship between MIL and TBA as a target group is key to social marketing and BCC programming in the MNCH arena.

4.2. The quality of TBAs messaging, health promotion and clinical services is typically poor. TBAs do not usually message to promote recommended behaviors. TBAs often practice in a fashion, which encourages risk to WRA. The knowledge and awareness levels of TBAs with regard to recommended behaviors are low. For instance, TBAs often encourage WRA not to give newborns colostrum. TBAs do not encourage exclusive breastfeeding of mother's milk nor do they provide correct advice about complimentary feeding or swaddling of the newborn.

4.3. TBAs are considered cheaper and more accessible health providers. TBAs refer pregnant WRA to recommended providers or facilities when WRA is experiencing complications or in an emergency. This results in low uptake of promoted behaviors such as the practice of obtaining a recommended number of ANC check-ups and reduced opportunity to receive information for preventative purposes.

4.4. The TBAs refer WRA to providers in an informal capacity. There is no formal mechanism of referral nor an explicit strategy for case management in complicated MNCH situations. Neither are TBAs incentivised

Insight 5

Being perceived to have social prestige and respectability is more highly valued by MIL than having a small family and economic prosperity. Husbands feel internally conflicted. They both want prestige and respectability but they also feel responsible to look after the financial and economic well-being of the household. Birth spacing is more socially acceptable than limiting.

5.1. Husbands tend to be the more routine interface between the secluded household and the external world. Husbands interact with neighbours, acquaintances, members of the professional, medical and religious elite/leadership and sometimes convey knowledge and information from the external world into the household. However, usually the largely separate lives of males and females and gendered distinction of roles/responsibilities and domains of knowledge ensures that households do not leverage the structural position of the husband in a constructive fashion to deal with MNCH issues. The views, opinions and beliefs of religious and community leaders (particularly elders) are very influential in informing norms (including in the arena of MNCH and FP).

5.2. Finance is an important consideration in MIL and husbands making decisions about family sizes but social face, shame, social respect and prestige are more important. MIL and husbands would typically prefer to be respected and considered to be good Muslims than to have a small family and economic prosperity. Birth spacing can be branded as a behavior which reduces long-term health problems of wives which increases the productivity of the wife in the domestic arena and ability to ensure proper wellbeing of children. The wellbeing of boys is particularly important to husbands. Social marketing and BCC activities that focus on husbands with regard to this behavior must be explicit about emphasizing the functional benefits of birth spacing. It is important to emphasize that a large family is not at all incompatible with birth spacing.

5.3. Birth limiting is seen to be against the tenants of Islam and often meets with resistance and opposition by MIL, husbands, TBAs, elders and religious leadership. Birth spacing is less threatening than limiting to these actors and is a practiced behavior among a large minority of respondents. Birth-spacing often becomes less of a controversial idea and more attractive among a segment of husbands once a medium-size family with one or several male children has been reached.

Insight 6

Expensive treatment during emergencies/catastrophes is preferred to prevention.

6.1. TBAs are considered to be a cheaper and more accessible health provider whereas doctors in hospitals are thought to be expensive and associated with a range of barriers to access. The main barriers to accessing recommended providers or facilities include: (i) cost of transportation; (ii) availability of transportation; (iii) shame associated with encountering doctors, providers and members of the general public in the facility setting; (iv) MIL oppose WRA from going to facilities; (v) TBAs encourage MIL and husbands to keep the WRA at home until an emergency situation is at hand; (vi) husbands oppose visits to facilities on the basis that it is not customary, will bring shame to the family and is punitively expensive.

6.2. There is very little motivation or willingness to engage in preventive ANC behaviours (check-ups). Providers and facilities are accessed during the ANC period when there is an emergency or a complication which causes anxiety or poses a risk to the WRA. Many deliveries in hospitals result in Caesarean Section, leading to higher delivery costs. Households typically do not inform themselves of risks, scenarios, processes and procedures prior to events occurring. It would be beneficial to engage MIL and husbands in a discussion about the cost-benefits of no ANC leading to a crisis/emergency requiring an emergency. BCC programs which engage the husbands in a primarily economically informed cost-benefit assessment which focuses on the financial costs and benefits of correct ANC checkups for all women versus crisis-based, emergency, catastrophic expenditure may provide an entry point for attitudinal change among males.

Insight 7

Televised serial dramas attractive to MIL.

7.1. MIL have access to TV and enjoy watching serial dramas. They particularly like realistic, gritty, plot lines with compelling characters experiencing routine challenges. Given the centrality of MIL in household decision-making about MNCH issues and given that MIL and WRA have limited access to information outside the household, serial dramas represent a fertile opportunity for successful social marketing and BCC programming.

Insight 8

Religious leadership and opportunities for MNCH messaging

8.1. Religious leadership play an important role in influencing husbands and may also be key advocates, thought leaders and influencers in the arena of antenatal care, delivery and neonatal care to influence TBAs and MIL. The mosque is a social institution that is respected and relied upon to provide high quality, credible and reliable information to guide ethical and practical decision-making in the concrete world. The rationale for following many non-promoted behaviors is often referred to religious rules and institutions. Many behaviors are predicated on a reading of Islam which is contested, while many strands of Islam and religious leadership would interpret the promoted behaviors as not only healthy but within the parameters of Islamic doctrine and practice. The influence of religious leaders could be sought with regard to behaviors/competing behaviors which are less explicitly influenced by religious practices/beliefs (for instance swaddling of neonates).

8.2. Whilst families are often a barrier to WRA, newborns and children from accessing quality MNCH services there are a sub-set of families that are motivated to facilitate access for WRA. These families act as a mechanism to overcome constraints related to mobility and costs related to hospital-based care.

8.3. There is very little knowledge about the importance of WRA having time to recover and heal in the post-partum phase particularly among women that had emergency Caesarean Sections. Social Marketing and BCC programs should encourage women in a community to help out other women in the community at times of need as an informal means of supporting women at this exhausting and vulnerable phase in their reproductive life.

8.4. Attractive promoted behaviors practiced by the target population, such as vaccinations for children, can be leveraged to include messaging around MNCH and FP health. Messages that leverage off vaccination campaigns may be trusted and resonate with the target audience.

8.5. There is an embryonic social shift occurring in Punjab as the social structure of families is transforming slowly. In Punjab, which has a higher level of wealth than Sindh, families are moving from extended family structures to nuclear families. In such nuclear families MIL have much a much less significant level of influence over MNCH behaviors and husbands and WRA have increased room for dialogue and joint decision-making.

8.6. Husbands socialise in the public arena and routinely garner the ideas, suggestions, and advice of key influencers in the community. IPC and BCC needs to leverage these public arenas and key influencers (i.e. religious leadership) to engage husbands.

1. INTRODUCTION

This document presents the research outcomes and insights related to an ‘Ethnographic research to inform social marketing and behavior change communication campaigns in Pakistan’.

2. PROGRAM OBJECTIVES

This report aims in Pakistan which has the goal of improving MNCH outcomes in Sindh and Punjab provinces.

The Health Communications and BCC component of the program will promote and increase healthier family planning and maternal, neonatal, and child health services among underserved Pakistani women through coordinated BCC activities across multiple implementing partners. It is intended that by using mass media, mid-media, mobile messaging and IPC, both demand and supply side barriers will be reduced.

3. RESEARCH OBJECTIVES

The goal of the study is to generate insights that will inform the development of BCC campaigns, both long and short format, through various channels. These campaigns will share the common objective of promoting family planning and healthy maternal, neonatal, and child health behaviors.

The key question that this study will answer is: what solutions to the challenges to contraception use and MNCH behaviors faced by rural Pakistani women can be offered through social marketing and BCC?

The specific objectives of the consultancy include conducting fieldwork and analysis that will achieve the following:

1. Generate a detailed understanding of the social, cultural, religious and environmental barriers to the use of family planning products and to MNCH behaviors.
2. Generate insights into effective strategies for promoting family planning products and MNCH behaviors to underserved families in Pakistan.
3. Understand family planning and MNCH decision-making of married women of reproductive age ¹.
4. Gain insights into how social marketing and BCC programs can influence family members to support women in making decisions that will improve her health and the health of her children.



4. STUDY APPROACH

Section 4 ‘Study Approach’ presents a summary of the study design, methods used, locations in which data was captured and sampling strategy employed. Readers are referred to a study design document which underpins the ethnographic research approach and which provides a much more detailed and comprehensive account of the study approach than this summarised presentation.

The study employs an ethnographic research approach. The study employs a diverse assortment of qualitative, participatory, projective, observational and ethnographic approaches to generate data and insights. Ethnographic techniques

¹ This ethnographic study finds PSI’s focus on the centrality of decision-making of WRA as problematic. WRA typically have considerably less power than MIL and husbands. WRA only start to have genuine decision-making power when they have obtained a large number of children, which contain at least one male child and have developed considerable level of experience in the FP and MNCH arenas. The report provides a lengthy exploration of this issue. However, at this point in the report is important to emphasize that this report looks at household decision-making and not WRA decision-making.

provide rich insights into the social, political, economic, structural and ideological barriers that operate in the domain of Family Planning and MNCH behaviors.

Whilst WRA are a key population investigated through ethnographic techniques and processes, the focus of this study is the household and how decisions and barriers operate at the family/household-level. WRA are therefore interviewed as well as other key actors including husbands and mother-in-laws (MILs) of WRA.

The program extends over both Sindh and Punjab provinces. At the micro-level ethnographic research has taken place in 4 villages in Sindh and Punjab provinces. Two villages in each province will be selected. One village had better access (i.e. road networks) and services than the other.

Given that the study intends not only to investigate family-level decision-making and dynamics but also how social, economic, religious and structural process and institutions influence MNCH behaviors and decision-making a broad ethnographic approach has been adopted. Key informants and institutions at the village level (religious leaders “mullahs”, elders, Lady Health Visitors, professionals, influential local actors (educated acquaintances and friends) have been approached as respondents within the study.

4.1 Methodology

This section describes the methodologies and research approaches employed in the ethnography.

4.1.1. Rapid Participatory Ethnographic Evaluation and Research (PEER)²

PEER is an innovative participatory approach to qualitative research. Ordinary community members (members of the study target group) conduct detailed discussions with trusted others in their social network. The strength of this method is that rich, detailed, honest and open narratives are provided about intimate aspects of their lives to trusted others.

4.1.2. In-depth Interviews (conducted by Community Researchers)

A series of structured in-depth interviews were conducted by Community Researchers. Community Researchers are educated individuals who come from the area in which the study was implemented. They have been trained by professional researchers in key research methods.

4.1.3. Participatory Rural Appraisal (PRA)

The ethnographic research includes a series of participatory methods, tools and processes (which are referred to as Participatory Rural Appraisal (PRA)). Participatory tools are an effective means of understanding the social, economic, livelihoods and environmental dynamics, which impact a household.

4.1.4. Key informant interviews

Key Informant interviews were employed to gather insights from frontline workers such as doctors. Other Key Informants included mullahs, village elders, peers of both husbands and wives (who are all identified as important influencing actors in decisions).

4.1.5. Direct observation

Direct observation has been employed to support in the development of an understanding of context (daily routines, social practices, social relationships, media habits etc). Direct observation is an ethnographic technique that can help generate rich insights into the social practices of the target population as well as their behaviors in relation to particular health areas.

4.1.6. Presentation and use of data by method

Supporting data for key study insights is presented in the form of quotations for PEER, IDI and Key Informant IDIs.

Insights emerging from the PRA data are presented in the report as narrative interpretations. Insights emerging about the gendered dimensions of mobility result from an analysis of participatory mobility maps drawn by

²<http://www.options.co.uk/peer>



“Doctors suggested us to feed him [the baby], to keep him in neat and clean warm clothes and suggested us not to bathe him, etc. Also, they asked us to avoid passing the child to too many hands.”

(SEIM2. Mother-in-Law, Target audience IDI, Sindh data)

respondents and are presented in narrative statements in the report. The livelihood activities and household/domestic responsibilities which are presented as narrative interpretations in this report are based on participatory exercises with respondents in which simple compelling and participatory activities lead to the generation of a very crude responsibility/activity 'matrix'.

Direct observation data was primarily insightful with regard to data generated about media habits and use of mobile phones. In particular, the finding that women rarely own mobile phones and tend to use phones when in the presence of male relatives and for short periods of time was an insight generated through direct observation.

4.2 Sampling

68 respondents were interviewed/engaged in dialogues in PEER and target audience IDIs. 12 Key Informants were interviewed. A more detailed description of the sampling approach is presented in the study design. .

Supporting data for key study insights is presented in the form of quotations for PEER, IDI and Key Informant IDIs.

5. RESEARCH OUTCOMES AND INSIGHTS: SOCIAL, RELIGIOUS AND ENVIRONMENTAL BARRIERS TO THE USE OF FP PRODUCTS AND TO MNCH BEHAVIORS

Section 5 presents research outcomes and insights that to barriers to the use of FP products and MNCH behaviors.

5.1. Social Relations and Interpersonal Dynamics within the Community

5.1.1. Elders

There is a profound and extensive respect for the status and decision-making role of elders within the community. Age is the key factor that informs this power and the status of elders.

"Our member [of local council] is the most respected person in our community. After him his elder son is respected the most. Our mullah is also respected as he teaches us the Holy Quran..." (CPEIH1. Husband, Target audience IDI, Punjab data)

"Here is Azeem Shah who is my uncle and cousin of my father. He is senior person of the village in all political and social activities. People of the village obey him and they trust him as well."(CPHIH-1,Target audience IDI, Punjab data)

"I ask my parents or any elder person in family for advice. My parent's advice is important for me as they are elder and senior." (CPEIH1, Target audience IDI, Punjab data)

Traditional beliefs influence the practices promoted by elders for FP and MNCH. The elders' influence and role as community educators is a barrier to the use of FP and MNCH behaviors because the traditional practices that they aim to reproduce are often unhealthy behaviors (which are not promoted behaviors), and have the potential to compromise the health of WRA and baby. Examples of the practice and position of elders that compromise the health of WRA and baby/child include: promoting large families when WRA have had problematic and complicated births; promoting large families when a household does not have the financial means to look after existing children nor do they have the time to ensure the wellbeing of all children; washing of neonate for religious reasons; lack of promotion of ANC checkups. The following quote illustrates this point.

"I have no brothers and we were a short family consisting of two sisters and a brother. My parents wished me to have more children. That's why I couldn't have a gap". (CPHIH-1,Target audience IDI, Punjab data)

5.1.2. Religious Authorities

There is great respect for the role and status of religious authorities' within the community, giving them heightened power within the community. Similar to elders, religious authorities are traditional and conservative in their beliefs of proper conduct, including use of FP, and MNCH behaviors.

Religious authorities influence various aspects of FP and MNCH, which often serve as barriers to proper use of FP and healthy MNCH behaviors. Religious authorities typically believe in and reproduce norms that causality and events within the FP and MNCH arena are primarily the domain of Allah and therefore the use of MFPM is often considered at odds with the religious teachings and rules of Islam. In some cases, religious authorities emphasise that small families or families with no (or few) boys, in which MFPM has been used to birth space/limit, are unnatural and 'sinful'.

"Children are gifts from God and we will take as many as God will give us." **(SEPEM2. Mother-in-Law, PEER, Sindh data)**

"He [husband] considers FP a sin. He says that children are a blessings from Allah, they are born as a result of his will." **(PEIM2. Mother-in-Law, Target audience IDI, Punjab data).**

Religious authorities perform and often promote rituals that mark the introduction of a newborn baby into the Islamic community. These rituals are not recommended or promoted neonatal behaviors (as articulated by PSI/Pakistan) and have the potential to compromise newborn health.

"In our village there is a tradition to give a baby a little dose of saliva from a respected elderly religious person. My two sons got the same. It makes a child religious, pious and obedient." **(PHPEH2. Husband, Hard to reach, Punjab data)**

"They [the parents] cleaned the baby as soon as they came home so they can name the baby and perform the rituals (giving Azan in ear of the baby to make him Muslim)." **(SEPEW4. WRA, PEER Easy to reach, Sindh data)**

A key insight emerging from the data is that religious authorities consider the increase of availability of contraceptives through provision through the private sector to be contrary to the tenants of Islam.

"The biggest result is that Ulmah's discussing contraceptives in their Friday Prayer briefing and the female turnout at family Planning Clinics, I will show you that stock of Condoms which were provided to us by USAID which we distribute through our clinics as they cannot go to the store to buy them due to the culture of this place." **(CPEKI-2, social leader-Key informant, Punjab)**

Furthermore, LHVs and vaccinators tend to visit hard-to-reach areas much less than easy to reach areas partly because religious authorities emphasise that Family Planning and western medicine are unislamic. In these areas this social norm is associated with a generalised sense of insecurity whereby LHVs and vaccinators feel unsafe travelling in hard to reach areas and interacting with local communities.

In some cases religious authorities promote key elements of the behavior and principles of MNCH as articulated by PSI/Pakistan. Key Informants that were religious authorities indicated that a smaller, more manageable family, provides the mother with the time and means to provide children with the attention that is required to ensure their physical health and the cultivation of a 'good' Muslim with a well elaborated sense of morals and ethics (within an Islamic framework).

"A female is not a child birth machine. When a child comes into this world the main role of the mother is training him about how he should lead his life and giving him a knowledge of Islam. The first institution of learning for the baby is the mother's lap." **(SHKI-4. Key Informant Interview. Sindh).**

5.1.3. Health Actors

In general, the word of both Traditional Birth Attendants (TBAs) and hospital doctors is respected, and in most cases, abided to. Whilst this level of confidence in health providers has distinct advantages there are risks associated with this dynamic. This constitutes a barrier to the use of FP and MNCH because decision-makers have such high levels of trust in health providers that they do not ask any more questions or learn more about the issue(s) being treated, products being used, or procedures being conducted. Moreover, the lack of dialogue between client and provider does not provide an entry point for discussion of preventive MNCH behaviors in the future. WRA, husbands and MIL lack sufficient FP or MNCH-related knowledge and this is especially problematic when complications or adverse health outcomes arise due to products, practices or procedures recommended by health care providers/professionals.

For the most part, if a biomedical health professional such as a doctor is involved throughout a pregnancy and delivery period, correct information is typically provided to the WRA, MIL and husband regarding FP and MNCH.

When asked, “In your opinion when should one start giving other things to the baby [to eat]?” the WRA responded, “As per doctors, it should be after six months.” **(SEIW1. WRA, Target audience IDI, Sindh data)**

“Doctors suggested us to feed him [the baby], to keep him in neat and clean warm clothes and suggested us not to bathe him, etc. Also, they asked us to avoid passing the child to too many hands.” **(SEIM2. Mother-in-Law, Target audience IDI, Sindh data)**

In general, the services and clinical care provided by doctors and clinics is considered to be safer and more reliable than TBAs however in practice the majority of respondents described preferring to see a TBA first. The main reasons provided for this relate to proximity, convenience, familiarity and cost.

On the other hand, there is a large segment of the population who do not trust biomedical providers and rely exclusively on TBAs for support in the MNCH arena.

Some respondents described particular doctors as being venal and interested only in the material benefits of extracting significant amounts of money from patients at a time of vulnerability.

“Yes she is MBBS doctor. She is just pulling the money from public. She admits the patient saying that baby will be delivered normally after that she conducts surgery by trapping them in issues like risk of death of mother or baby.” **(CPEIH-2, Target audience IDI, Punjab)**

Trust in TBAs is often based on beliefs and norms which are transferred through informal discussion and are transferred between generations. TBAs promote a traditional understanding of FP and MNCH based on causality and beliefs that are embedded in indigenous systems of medicine and metaphysics as well as a locally interpreted form of Islam. They are not based on science or bio-medical factors as promoted by PSI/doctors.

“It is our tradition that the TBA gives the baby a bath because until the baby is cleaned the family cannot give Azan in the ear of the baby (to tell the baby that she/he is born in a Muslim family and which is a religious practice common in Muslims all over the world). After the bath and Azan a name is given to the baby and then mother gives the baby her milk.” **(SEPEM2. Mother-in-Law. PEER, Sindh data)**

In addition, TBAs employ medicinal practices which are embedded in local indigenous and traditional understandings of the body and metaphysics.

“The Daai checked my daughter-in-law [WRA] and told us that the baby is about to arrive, then the Daai asked us to make a hot milk sweet dish siwaiyaan for her [WRA] and the TBA also spread fresh original ghee on her [WRAs] vagina.” **(PEPEM3. Mother-in-Law, Easy to reach, Punjab data)**

“From centuries our forefathers are living in same area, here is a family of native midwives. From generation to generation we rely on them. Daai care my daughters-in-law during their pregnancies.” **(PHPEM1. Mother-in-Law, Hard to reach, Punjab data)**

“They [mother-in-law] are not concerned with the health of the daughter-in-law at all because she has taken medicine from the trusted TBA who has delivered her 10 children.” **(SEPEM3. Mother-in-Law, PEER, Sindh data)**

“the Dai put Desi Ghee with cotton on the vagina of the woman to make the delivery easy but the side effect was that the women experienced infections.” **(CPEKI-1, LHW-Key Informant IDI-Punjab)**



Narratives of respondents who described the practices of TBAs and health-seeking/treatment episodes in the MNCH arena that involved interaction with TBAs indicate that TBAs often do not have knowledge or ability to support the practice of promoted behaviors among MNCH clients. TBAs often promote unhealthy or incorrect behaviors (i.e. not giving newborn colostrum; not promoting swaddling the new-born, not encouraging the new-born to drink breast milk after one hour of delivery etc).

Lady Health Visitor Key Informants interviews emphasise that LHV are not in favor of counselling newlyweds and young couples to use contraception. Indeed LHV emphasized that the use of contraception should be promoted only when a number of children have been born.

5.1.4 Integrated Health Actors

Although not formally integrated, TBAs (Dais) and doctors in hospitals are highly interconnected in a strong informal referral system. TBAs are often preferred when the course of antenatal, delivery and neo-natal phase is considered to be proceeding in a normal or at least non-life-threatening fashion. However, when a case becomes too complex/complicated, TBAs refer their patients to biomedical health providers (doctors, nurses and hospitals), as they are typically preferred in emergency contexts. They are also more frequently preferred if complications occur during pregnancy.

“First the baby was born at home. When it came to the delivery time for the second baby I called a midwife. She checked and said its complicated case because of the baby’s position, so I should take my wife to hospital. Then we went to Dera Gazi Khan City government hospital.” **(PEPEH2. Husband, Easy to reach, Punjab data)**

“...two times I took my wife to hospital because the Daai told my mother that there is a thread like thing inside the mothers abdomen which was wrapping around baby. So the Daai advise her to go for an operation in a hospital. But doctors managed the situation later on, and it was a normal delivery.” **(PHPEH1. Husband, Hard to reach, Punjab data)**

“We rely on a traditional Daai. We really wanted that the Daai would handle the case [delivery]. The Daai also cared for her during her pain and took care of any complications during pregnancy, but when the Daai came to our house she said the time is getting late and late and baby not coming out with traditional interventions so I must take her to hospital otherwise the baby and mother both will be in danger. At that time my mother-in-law and sister-in-law and my sister were present there, and they decide to take her to hospital.” **(PHPEH2. Husband, Hard to reach, Punjab data)**

Decision-makers trust this referral system so much that they do not typically seek out biomedical health care without the referral from their TBA. This serves as a barrier to accessing FP and other MNCH-related products or services that are beyond the scope of the TBAs capabilities and knowledge. This barrier can obstruct the adoption of healthy FP use and MNCH behaviors.

“We have a Masi (aunty). We always go to her for advice first. If she can handle the delivery we do not go to doctor. If she cannot handle the deliver then we go to the doctor. This time she said she can handle it and the baby delivered at home. The baby was normal, my wife was healthy and she handled the situation well.” **(SHPEH1. Husband, PEER, Sindh data)**

5.2. Social Relations and Interpersonal Dynamics within the Household

5.2.1 Status of Mother-in-law (MIL)

Whilst rural Pakistan is often characterized as a patriarchal society, this characterization does not capture the structure and dynamics of decision-making and practices in the arena of MNCH, which can be described as matriarchal with the MIL positioned structurally as the power-holder.

“The mother of the house is the key decision maker, whereas the other women are much suppressed.” **(PEK11. Key informant IDI, Punjab data)**

Age is a key factor in informing the status of MIL, who are thought to have more knowledge with regard to MNCH issues because of more life experience.

“I know how to care for a mother and a child, as I am the mother of 9 children.” **(PHPEM1. Mother-in-Law, hard to reach, Punjab data).**

“My own mother gave birth to 11 kids so she guides my wife all the time. Old ladies know everything. They are experienced.” **(PHPEH1. Husband, Hard to reach, Punjab data).** This trust was echoed in the testimonies of women.

“Me, my mother and wife sat together to consult with the TBA. My mother is old and she knows everything.” **(SEPEM2. Mother-in-Law, PEER, Sindh data)**



MIL typically hold traditional beliefs which inform the practices employed with regard to FP and MNCH.

“The delivery should be performed within the home. We believe that when a woman delivers in the hospital she is handicapped by the doctor. If the doctor says stay in the hospital for five days she has to stay there, if the doctor says stay for eight days she should be there. However, when a delivery is in the home the woman is fine.” **(SEIM2. Mother-in-Law, Target audience IDI, Sindh data)**

Traditional practices are a barrier to the use of FP products and healthy MNCH behaviors because they are not promoted behaviors and have the potential to compromise the health of the WRA and newborn. When asked, whether a woman should take a gap between children or not, keeping in mind the MILs daughter-in-laws had experienced severe difficulties during their pregnancies, the MIL responded, “I am aware of my daughter-in-laws difficulties, but abortion is a sin. It is God’s will to bless children so one should not go for gap or family planning even if there are problems.” **(PEIM2. Mother-in-Law, Target audience IDI, Punjab data)**

There is an embryonic social shift occurring in Punjab. The social structure of families is transforming slowly in Punjab. In Punjab, which has a higher level of wealth than Sindh, families are moving from extended family structures to nuclear families. In such nuclear families MIL have much a much less significant level of influence over MNCH behaviors and husbands and wives have great room for dialogue and joint decision-making.

5.2.2. Status of Husband

In the MNCH arena, husbands are typically subordinate to the hierarchical position and decision-making power of the MIL. Husbands lack knowledge and do not engage in WRA reproductive health matters or MNCH in general. There are a small minority of husbands who are engaged in MNCH decision-making who are an exception to this statement. However, husbands typically do not engage and do not experience normative pressure to be engaged in MNCH decision-making. Husbands trust MIL as educators and decision-makers. MIL often promote and practice incorrect and unhealthy FP and MNCH behaviors.



“When I need advice first of all from my mother-in-law. I take advice from her. After that I take advice from my husband.” **(WRA, Target audience IDI, Sindh data)**

“My mother-in-law calls the midwife (Daai) during the pregnancy because the husband does not talk about it and is not responsible for it.” **(SEPEM1. Mother-in-Law, PEER, Sindh data)**

“I take advice from mother-in-law because she is the elder woman of the home and she is kind to me. My husband does not listen to me.” **(WRA, Target audience IDI, Sindh data)**

In Punjab, where there is a more predominant nuclear family structure than Sindh an embryonic pattern of dialogue and decision-making is occurring between husbands and WRA. Husbands are playing a more significant role in MNCH decision-making in Punjab (though this role is still embryonic and largely focused on Family Planning rather than other MNCH behavioral areas).

5.2.3 Status of WRA

The WRA is almost entirely powerless in the domain of MNCH except with regard to FP where the WRA may conceal FP behaviors (from the MIL) either individually or with the collusion of the husband. However, this is rare. Typically the WRA is encouraged by the MIL to practice FP or MNCH behaviors that are not promoted behaviors.

A WRA is typically treated as a subordinate passive actor without decision-making power when she is younger. This perspective was narrated by MIL, WRA, husbands and Key Informants. The following extract from a Key Informant interview with a religious authority illustrates this point: ‘it is the Mother-in-Law who resolves all the Daughter-in-Law’s health related issues such as her diet plan, taking care of children including hygiene and cleanliness’ (SHKI-4. Key Informant Interview, Sindh). The WRA is viewed as a resource, and as an instrument, to facilitate the physical reproduction of the family and look after the newborn and child. However, once WRA has several mature children and becomes a MIL she adopts, and is treated as the preeminent decision-maker within the

household regarding MNCH. This transformation is partly engineered by the MIL who employs effective strategies to control WRA and sons. However, the MIL is only provided the opportunity to control WRA due to cultural norms that assert the dominant role of older social actors and the subordinate role of younger social actors. In most cases, MIL perpetuate incorrect FP and MNCH information and behaviors to the next generation [WRA], which is then passed on to subsequent generations when the WRA becomes a MIL.

5.2.4 Role of Other Family Members

Sisters-in-law sometimes provide practical support to WRA when the WRA has a newborn in the form of doing domestic chores on behalf of the WRA. Sisters-in-law also play a role in supporting and guiding the WRA during the antenatal, delivery, neo-natal and child care phases. Sisters-in-law will often accompany WRA during delivery (either in the house or if delivery occurs in the hospital). Sisters-in-law typically have limited, if any, decision-making power.

“my brother’s wife guided her [WRA] during her pregnancy, as my mother is not alive.” **(PHPEH2. Husband, Hard to reach, Punjab data)**

“In dire need I use to call my own daughters to come and manage the home and be a companion to their sister-in-law during labour, etc.” **(PEPEM2. Mother-in-Law, Easy to reach, Punjab data)**

“...my sister-in-law wife of brother (bhabhi) helped me during all cases [of pregnancy]. Sister-in-law took care of my first kid during my second case.” **(PEPEW1. WRA, Easy to reach, Punjab data)**

Without the help of other family members, many WRA are expected to reengage in challenging domestic tasks early after the post-partum phase. Similarly, WRA are often pressured by MIL and husbands to work through the period of pregnancy which may be a risk factor for pregnant women causing complicated deliveries and negative health outcomes for mother and child. This serves as a barrier to healthy maternal health as it often puts WRA under intense physical stress and appears to have negative health outcomes. In some cases when emergency Caesarean Section have occurred there appears to be an expectation that WRA resume work immediately without sufficient time for recovery. For instance, a MIL explained, “My son likes the meal cooked by me or his wife, so she [WRA] started making meals 4-5 days after the delivery. He doesn’t like to eat meal cooked by anyone else.” **(PEIM2. Mother-in-Law, Target audience IDI, Punjab data)**

5.3. Gendered Norms and Segregation

5.3.1 Mobility

Ethnographic insights emerging about gendered dimensions of mobility emerge primarily from PRA research exercises. Respondents were asked to draw a map of their movements over the last month. This data was then tabulated. Data associated with mobility was not generated through IDIs or PEER dialogues in a focused or systematic fashion. Gender norms regulate mobility of social actors. Men are encouraged and permitted to move extensively from location to location. Men reported a wide diversity of locations to which they had travelled for work, recreational, social and family reasons. Women are encouraged to remain within the domestic arena. Depending on the characteristics of the household, WRA have variable opportunities to move through social spaces external to the household. Typically movement is limited to neighbor’s houses, to accompany or be accompanied to seek health services/treatment, visits to family members (either in the village or outside), trips to larger towns bazaars or shopping trips (accompanied by husband, male relative or sister), trips to funerals and weddings in the village or outside. Movement outside the village requires that a relative accompany the women. There are however exceptions to this. For instance, a respondent who is a Lady Health Worker reported that she is mobile and travels independently. Some WRA reported work as day laborers in fields proximal to their village, and were able to travel from the home to fields without a male chaperon. MIL mobility is similar in diversity to WRA.

One testimony demonstrates clearly how gendered norms regulate mobility within the Sindhis group in a community in Punjab area, “Sindhi women do not go out of her home. Her husband arranges everything himself. Whenever I go home women become silent if they are quarrelling... I have ordered my family’s women to wear the

big white Hijab instead of black and cover their faces. Normally the black Hijab doesn't cover the face completely. But one cannot continuously watch your women, they may open their veil in your absence in bazaar but we should do whatever we can. No strangers are allowed to go inside our home. Only women are allowed. We respect everyone." **(PHK11. Key informant IDI, Punjab data)**

The restricted mobility of WRA is a barrier to accessing FP and adopting MNCH healthy behaviors because there is limited (if any) privacy or opportunities for the WRA to seek out FP or MNCH information or products independently. The lack of mobility of women also constrains their ability to access MNCH information and messaging in the public arena. The interaction between patients and doctors in hospitals typically occurs during a moment of crisis/emergency. This crisis situation is not conducive to a dialogue that provides opportunities for learning about the MNCH arena which would be applicable in the future. Moreover, the doctor/patient relationship is based in a monological approach to communication in which the doctor instructs the patient and does not provide rationales for interventions nor provide a space for dialogue and learning for the WRA patient and MIL who typically accompanies the WRA to the hospital.

"She [the doctor] doesn't ask anything. The doctor of the village never asks anything about this they just give pills." **(SHIW-2. Key Informant Interview. Hard to Reach, Sindh)**

"...doctors aren't interested in the person they are only interested in charging their fees." **(SHIW-01. Key Informant Interview. Hard to reach, Sindh data)**

5.3.2 Roles and Responsibilities

Lives of people in Pakistan are structured by powerful and extensive gendered norms. The relationship between MIL, husband and WRA is largely informed by socially constructed rules about appropriate behavior and roles. Gender norms regulate livelihood and domestic roles and responsibilities. Men's primary responsibility is generating income outside the house. Men are also responsible for some household maintenance and tasks such as, wheat husking, collecting drinking water from the water pump, taking children to school and to some extent supervising children. WRA are typically responsible for attending to domestic chores, looking after children, cooking, cleaning, feeding/tending livestock, embroidery and handicrafts (ie. weaving carpets). When women are experiencing health issues or problems that relate to pregnancy, delivery, or the post-partum phase, etc., their husbands and MIL are sometimes reticent to accept a shift in roles/responsibilities. This constitutes barrier to proper MNCH. This is firstly because it often puts considerable physical and health pressures on WRA which may lead to negative health outcomes for the WRA. In addition to this, the domestic pressures placed on WRA during episodes of exhaustion and physical pain mean that WRA have less time to care for new born babies and younger children which may have negative health implications.

"I alone am responsible for maintaining the home, and taking care of kids. When I became pregnant this becomes a big problem for me, as I am left alone in my home to take care of the whole household." **(PHPEW2. WRA, hard to reach, Punjab data)**

"...at the time of my daughter's birth I was alone. I worked whilst experiencing pain. I had the responsibility of having 3 kids, two were small and one baby was inside my body. Although my husband is very caring, he is very strict regarding having his food on time, having his clothes cleaned on time." **(PHPEW1. WRA, Hard to reach, Punjab data)**

Occasionally WRA practice MFPM to birth-limit to avoid the problems associated with having too many children in addition to significant domestic duties.

"I practice FP to give proper time to children, to my husband and home, that's why. If I don't have pills I shall have another child which will cause problems for allocating time to other children, time for my father and mother-in-laws and time for home." **(SEIW1. WRA, Target audience IDI, Sindh data)**

5.4. Economic and environmental context

5.4.1 Poverty

There is a pervasive experience of poverty that is a barrier to the use of FP and to MNCH behaviors. Households do not have sufficient income to cover expenses that relate to MNCH, such as the cost of care during a pregnancy and delivery, transportation, hospitalization if needed, proper nutrition of WRA and child, etc. Husbands, broadly speaking, engage in daily labor work. Household budgets do not provide sufficient scope to pay for expensive hospital based health care unless there is a significant willingness to pay and motivation to prioritize the health of pregnant WRA. This typically requires entering into punitive debt.

“We went to the doctor and she advised her [daughter-in-law] to use juice, milk, lassi, etc. [during pregnancy]. She also advised her not to lift items that are heavy and take rest. We are farmers, we can give her the milk, but we don’t have juice and fruit. Doctor advised to follow the precautions strictly with medicines but we don’t have money to purchase fruits and medicines together. We are poor and our men who do labour work for Rs.100-150 a day. We have to manage all our domestic expenses with this small amount of money. How can we purchase medicines and fruits for her out of this money?” **(CPEIM1. Mother-in-Law, Target audience IDI, Punjab data)**

When speaking of her daughter-in-laws’ multiple miscarriages and current pregnancy, the MIL stated,

“Now we are using medicines for her for safe delivery. I am spending everything on her. Yesterday the doctor charged us Rs.400 for a test. I said that I am poor, please take Rs.200. She refused and said that her fee is Rs.400.” **(CPEIM1. Mother-in-Law, Target audience IDI, Punjab data)**

“Most men prefer the old fashion way which is the home [delivery] through Daai because it is the least expensive way since in this locality we are not that well off.” **(PEK11. Key informant IDI, Punjab data)**

“One time I was out of city so I advised my brother on phone not to take [my] wife to hospital because I was away and if any emergency happens they do not have money to manage the hospital expenses, nor anyone else bare the expenses except the father of child.” **(PHPEH1. Husband, Hard to reach, Punjab data)**

5.4.2 Environment

There are a host of local risks and barriers preventing pregnant WRA from accessing biomedical health facilities and services, including hazardous outdoor conditions that represent risks to the WRA, including inclement weather which makes transportation difficult, lack of access to public and private transport to travel to hospitals.

“I remember at midnight we were taken her to hospital, I called my brother-in-law for his Suzuki carry van to take her to hospital as there was no public transport available in the day time and it is even worse at midnight.” **(PHPEH2. Husband, Hard to reach, Punjab data)**

“One night it was raining heavily in our village. At midnight my wife slipped and experienced great pain. There was no car or public transport available at that time. I called a midwife and she massaged her with oil and recommended me to take her to hospital. When morning came I took my wife to hospital, and doctors operated on her and told us that the baby is dead because she is not breathing enough.” **(PEPEH1. Husband, Easy to reach, Punjab data)**

“...two times I took my wife to hospital because the Daai told my mother that there is a thread like thing inside the mothers abdomen which was wrapping around baby. So the Daai advise her to go for an operation in a hospital. But doctors managed the situation later on, and it was a normal delivery.”

(PHPEH1. Husband, Hard to reach, Punjab data)



6. RESEARCH OUTCOMES AND INSIGHTS: FP AND MNCH DECISION-MAKING WITHIN THE HOUSEHOLD

6.1 FP and MNCH Decision-making

6.1.1 MIL and FP and MNCH decision-making

MIL play a central and dominant role in all areas of FP and MNCH decisions. In many cases, the MIL is viewed as the expert regarding FP and MNCH, therefore, the WRA accepts the preferences and decisions of MIL in a passive fashion. The MIL typically instructs the WRA what is the best course of action or decision. Husbands described liking to be consulted in decision-making in these areas but do not expect to play an active or influential role in that decision-making process. Typically husbands comply with the decisions and preferences of MIL in a passive fashion.

MIL do not have accurate knowledge concerning the health benefits of birth spacing and the use of MFPM. This leads to MIL pressuring WRA daughters-in-law and sons to not use MFPM.

When asked, “should a woman have a gap between deliveries or not? Tell me about this keeping in mind your daughter-in-laws difficulties during pregnancy” the MIL responded, “It is God’s will to bless children. One should not go for a gap or family planning.” **(PEIM2. Mother-in-Law, Target audience IDI, Punjab data)**

“Mother-in-law will never allow her [WRA] to have a gap. They want more children.” **(SEPEM1. Mother-in-Law, PEER, Sindh data)**

MIL typically do not want the WRA and husband to use MFPM. MIL often maintain this position even if the WRA has experienced difficult deliveries in the past. The prevailing social norm among MIL is a preference for a family with a large number of children (particularly male children). A large family size with many boys is believed to be a part of the natural order of things and to be the will of God. A large number of children and particularly male children are associated with blessings, good luck and fecundity. A minority of households believe that smaller family sizes reduce expenditure and provide opportunities for better child care (including health care and education).

“I suggest to her that she have an operation to cease giving birth to more children. But now she has agreed to go for such operation. I didn’t force her but she happily agreed to this. She says mother what you are saying is OK and I am ready. But this all is happening according to her own will.” **(SEIM2. Mother-in-Law, Target audience IDI, Sindh data)**

“Since her young baby has a blood disease and her blood is not being produced so doctors are suggesting that if she has more children all will have the same problem. This means that if this baby boy is not having any issue so the next baby surely will have this issue that’s why I thought the baby girl is having medical issues so I suggested her not to give birth to more children.” **(SEIM2. Mother-in-Law Target audience IDI, Sindh data)**

In some instances, MIL exercise their decision-making power by encouraging vaccinations and intravenous drips during the pregnancy, delivery and postpartum periods. This decision is taken because MIL are aware of the threat of disease and illness that could result from not taking vaccinations.

“Doctor said use ice to cool down the baby. We did the same after that his fever was reduced and his pain was also reduced and then the child was healthy. This is good because if you have it [vaccine] you don’t get Polio and other diseases.” **(SHIM2. Mother-in-Law Target audience IDI, Sindh data)**

“She [WRA] went for ultra sounds during pregnancy and also got vaccinations.” **(SEPEW4. WRA, PEER Easy to reach, Sindh data)**

“My daughter-in-law was injected during pregnancy and her baby is also being injected now.” **(PEIM2. Mother-in-Law, Target audience IDI, Punjab data)**

“When Daai came she did the check up and felt that it is not normal so Daai advised them to take her [WRA] to hospital where the doctor gave her drip and delivered a normal child. They took this decision among the family and only consulted with the Daai first and mother-in-law, elder daughter-in-law and sister-in-law took the decision.” **(SEPEM1. Mother-in-Law, PEER, Sindh data)**

6.1.2 Husbands and FP and MNCH Decision-making

Husbands typically do not see FP and MNCH as a domain in which they should be required to have knowledge, nor do they have a well-articulated position on MNCH issues. Husbands do like to be consulted by MIL and WRA about FP and MNCH-related decisions. However, husbands typically evaluate decisions through the prism of health outcomes, expenditure, access and effect of expenditure on household economics.

“The elder most daughter had a bad experience of Daai in our area. Her second baby died because of Daai negligence. The dirty abdominal fluid went inside the baby’s mouth but Daai didn’t handle the situation properly. So after that my sons never allowed me to call Daai to deal with labour.” **(PHPEM2. Mother-in-Law, Hard to reach, Punjab data)**

Husbands play a very limited role in decision-making regarding FP. Typically males are not supportive of the use of FP. In the event they are supportive of FP they are rarely willing to accept responsibility for the acquisition or mechanics of the use of MFPM.

“My husband is very careless in this regard [family planning]. He leaves this matter to me. He never cares about it. Nor he is interested to have any more kids.” **(PHPEW2. WRA, Hard to reach, Punjab area)**



“Often my husband brings condoms, but he dislike it. So now he decided that I would have injection for this purpose [family planning/gap in pregnancy].” **(PHPEW1. WRA, Hard to reach, Punjab data)**

“Her [WRA] husband is cooperative and agrees to do FP but he will not use any method his wife has to do FP. He was clear in the beginning when they started using FP that he will not use condom or anything else.” **(SEPEW2. WRA, PEAR, Sindh data)**

There are also several misconceptions about FP which inform husbands’ decision of whether to seek out or utilize MFPM.

“I do not allow my wife to take any tablets. It may harm her.” **(PHPEH2. Husband, Hard to reach, Punjab data).**

“I asked my husband to use condoms but he said condom will harm his manhood. My husband is not against family planning but he is not satisfied with condoms.” **(PEPEW1. WRA, Easy to reach, Punjab data)**

This section presents husbands as largely peripheral to or oppositional to FP behaviors promoted by PSI/P. However, there are notable exceptions in the data-set. A segment of husbands understand the value of FP in promoting a healthier family which is more economically prosperous. The extract below illustrates this point.

“Because they tell us that this is good for both mother and baby’s health, and if mother is young age or weak, in that way she will be weak and unhealthy. If we use family planning methods then both will safe and healthy.” **(SKHKI-05. Key Informant, male respondent (member of the community), Hard to reach, Sindh data).**

Furthermore, a small (but not insignificant) segment of males within the community are actively advising other males to use FP to achieve healthier families and a more financially secure livelihood.

“Yes my friend tells me that if you have large family that you can’t live happily. You will face health problems and challenges in generating income for the household.” **(SKHKI-05. Key Informant, male respondent (member of the community), Hard to reach, Sindh data).**

6.1.3 WRA and FP and MNCH Decision-making

WRA play a limited role in FP and MNCH decision-making. Sometimes the WRA does not want more children or has faced difficulties in previous pregnancies so they resist their husband and MIL through the strategy of using FP without their knowledge.

A WRA stated that she is fearful of the pain associated with childbirth and therefore this is the rationale in her decision to practice FP [without the knowledge of her husband] to prevent pregnancy.

“She fears that she has given birth to a child with high levels with high pain, that’s why she takes FP to increase the birth interval.” **(SHIM2. Mother-in-Law, Target audience IDI, Sindh data)**

In other cases couples jointly decide to resist the will of the MIL with regard to FP and MNCH. When this occurs the MIL will not be explicitly opposed but a strategy of resistance will be employed involving deception or the management of privacy with regard to FP or MNCH decisions. Sometimes husband and wife do not want more children and are faced by a MIL who explicitly promotes this. If husband and wife face pressure to have more children (and not birth space) couples may occasionally resist the MIL through the strategy of using FP without the knowledge of the MIL.



“... mother-in-law and sister-in-law oppose [family planning]...but her [WRA] husband used condoms for some time.” **(SEPEW4. WRA, PEER Easy to reach, Sindh data)**

“FP is important. It was the decision of me and my wife. My family is against FP. My parents are not allowing us to do this. They are saying FP is not good or correct. Now we [wife and husband] will have a gap of four years and then we will think about having other kids.” **(SEPEH1. Husband, PEER, Sindh data)**

If the decision of the WRA, or WRA and husband, is at odds with the MIL’s position (i.e. refusing to have more children, or insist on using MFPM against the will of the MIL), the MIL will punish and scold the WRA for lengthy

periods of time. In some cases, the MIL resents the WRA for extended periods of time for her act of disobedience. The husband typically does not face repercussions from his mother [the MIL].

“When she was facing difficulties in getting pregnant her MIL and husband abused her and scolded her about why she has used FP. She has few kids so she is not required to use any kind of FP. She was using injections at that time. Until she got pregnant again has been treated very badly. She offered special prayers to get rid of the curse of the sin she has committed. She took the treatment for 10 months and when she got pregnant her family was afraid of miscarriage because she has used the FP previously. She will never use FP again because she has learned her lesson and because she only has two children she does not need to use FP.” **(SEPEM2. Mother-in-Law, PEER, Sindh data)**

6.1.4 The Family as a source of Social Capital and MNCH Decision-making

There were a number of examples of family members acting as a source of support for WRA in accessing clinical care and attention.

“In village areas a woman’s parents, in laws or relatives help her. Moreover it is also a husband’s duty to help her as she is his partner” **(CPHIH-2, husband IDI, Punjab)**

Whilst the family is often a barrier to WRA, newborns and children accessing high quality MNCH among families where there is an intention and motivation to access MNCH services the family is a powerful social mechanism to facilitate this access.

6.2 Delayed Health/Treatment-Seeking Decisions

Health and treatment-seeking decisions in the antenatal, delivery and post-partum period are reactive rather than proactive, which is not promoting or fostering healthy MNCH. Households take decisions when complications arise and a situation becomes an emergency. Households typically do not inform themselves of risks, scenarios, processes and procedures prior to events occurring. This approach to decision-making is partly influenced by the mode of communication between client and provider which is based on the provider giving instructions and guidance without the client entering into a dialogue with the provider (or using the interaction as an opportunity to learn).

6.2.1 Family Planning

There is a generalized sense of mistrust, lack of confidence and pervasive misconceptions about MFPMs and FP. This promotes a widespread sense of anxiety and is an influence behind many WRA, husband and MIL decisions of whether to use MFPM. In particular MIL believe that the use of MFPM can cause miscarriage, difficult pregnancies and deliveries, and other illnesses. Many WRA displayed a lack of understanding of how MFPM work and what effect they have on women.

“My wife asked me about using injection but I fear that something bad will happen with her health from injection, so I don’t want my wife to be in trouble. I like to use condoms instead.” **(PEPEH2. Husband, PEER, Easy to reach, Punjab data)**

“FP can cause cancer so we don’t want to do FP.” **(SEPEM2. Mother-in-law, PEER, Easy to reach, Sindh data)**

“She was healthy in previous pregnancies but now she has become weak because she had used FP. Now she always feels dizzy, having fever and other problems from FP.” **(SHPEW1. WRA, PEER, hard to reach, Sindh data)**

“Doctors inject women but it’s not good. These vaccines cause lots of issues in ladies health.” **(SEIM2. Mother-in-Law, Target audience IDI, Easy to reach, Sindh data)**

6.2.2 ANC

There is a lack of knowledge of appropriate ANC and pregnancy-related care, including risks and warning symptoms and signs for unhealthy pregnancy, and when to access medical attention. This often results in delayed health/treatment-related decisions, which has the potential to seriously harm the WRA and baby.

“At the time of her second baby she [WRA] bled for three months so then her husband took her to the doctor and she went through treatment for one month.” **(SEPEW4. WRA, PEER, easy to reach, Sindh data)**

“In her [WRA] first pregnancy she went for check up but not after her first baby because she did not have any pain.” **(SHIM1. Mother-in-Law, Target audience IDI, Hard to reach, Sindh data)**



When asked whether her daughter-in-law went for medical checkups during pregnancy, the MIL responded,

“The first time she went for medical check up but not after her first baby.” When asked why she did not have a check up in the other pregnancies, MIL responded, “Because after that she [WRA] did not have any pain.” **(SHIM2. Mother-in-law, Target audience IDI, Hard to reach, Sindh data)**

In many cases the reason for making delayed health/treatment-seeking decisions is a result of the WRA typically not admitting to anxieties and experiences of pain during pregnancy until symptoms become unbearable. MIL discourage WRA from divulging too much information about difficulties associated with pregnancy or delivery. This leads to the tendency of households delaying health/treatment-seeking later than is recommended. Furthermore, WRA emphasized that husbands do not understand the dangerous nature of complicated delivery and health expenditure/resources required during this period is therefore insufficiently prioritized.

“Now I remembered my seizure, when the doctor suddenly said that I am going to have a seizure during delivery. My husband said this cannot be the case because previously the doctor said it’s a normal delivery case. But at suddenly the doctor said it’s not normal case. Then my husband was concerned and talked to his parents and they told him that the doctor knows better and we had better follow the doctor’s decision”. **(SEIW-2. Target Audience Interview, Easy to reach, Sindh Data)**

In some instances, delayed health/treatment-seeking result in death and failure to access recommended health providers at an appropriate time, “...a few days back a woman died while on the way to the hospital. Due to severe labour pains her baby was delivered at home and after delivery she started bleeding excessively. Then after many difficulties the family members arranged for her to be transported to the hospital and when they reached the hospital the doctor declared the woman had died 10-15 minutes before reaching the hospital. In another incident, a couple while on the way to the hospital the woman started to have severe pains and had to take cover in a shop which was on the way. She had no one to care for the woman. So some women were gathered from nearby who then arranged for a Dai for cord cutting, cleaning etc. and the child was born in the shop and the couple returned home from there... The women in our village said that they did not know that it was time to take her to the hospital.” **(PEKI1. Key informant IDI, Punjab data)**

Despite the often incorrect and potentially harmful health effects that could arise from traditional ANC practices, MIL and TBA often administer herbal supplements for WRA during pregnancy, which also have the potential to harm the WRA and baby.

“Traditionally we make some food supplements for women during her hard time, it includes natural herbs and some dry fruits, I made a sweet dish for such purpose, and we wrap black thread around pregnant ladies’ neck or wrists so that they are saved from evil souls. **(PHPEM1. Mother-in-Law, Hard to reach, Punjab data)**

“My MIL made powder of some natural herbs called joush. I had to take that powder for a long time, she said that powder strengthen the skin wall that covers baby’s body inside the mother abdomen.” **(PEPEW4. WRA, Easy to reach, Punjab data)**

Respondents who described going to clinics or hospitals for ANC tended to prefer privately run facilities to public facilities. Public facilities were neither trusted nor valued by respondents. Given that private clinics are considered to be expensive Willingness to Pay is a prominent barrier to accessing ANC in rural Punjab and Sindh.

6.2.3 Delivery

There is a lack of knowledge among the target group and TBAs about appropriate maternal care during the delivery phase, therefore preventing WRA, husbands and MIL from making informed decisions and from seeking appropriate health/treatment behaviors. Caesarean Section appear to be a common practice during hospital based delivery, and widely accepted within households; however the decision to deliver via caesarean section is often delayed and made well into the third trimester of a pregnancy.

“On the eleventh hour doctor recommend me for operation. Then I had an operation.” **(PEPEW1. WRA, Easy to reach, Punjab data)**

“In my 8 to 9 months check up doctor said I have germs of black jaundice and I must have an operation for my second kid. Then my husband took me to a government hospital in DG Khan city, but there was no such facility to deal with the case. Then my husband took me to a private hospital and I had a second operation for my second baby... The second operation cost around 40,000 Rs. I sold my gold jewellery to find this money.” **(PEPEM2. Mother-in-Law, Easy to reach, Punjab data)**

Respondents described a strong sense of discomfort with regard to delivery at a public hospital. Whilst hospital might be considered to be safer than delivery at home the culturally informed sense of shame associated with delivery in a hospital with an unknown doctor tended to override the preference for safety.

6.2.4 Post-partum care of mother

There is a lack of knowledge among the target group about appropriate maternal care in the post-partum phase. There is a lack of knowledge about when and how to seek help for post-partum problems (ie. pain and infection in abdominal stitches from Caesarean Section), which delay the decision to seek health care /treatment. Husbands and MIL often pressurize WRA to continue domestic chores even if there has been a complicated or problematic delivery. In the opinion of respondents this often leads to women have lifelong health complications.

“When my boy became 9 months old I got pregnant again, my boy was so young and small that it was hard for me to manage first baby and home. The first few months passed but later when it cross 5 months I had pain in my abdominal stitches... and heavy vaginal liquid... Actually, my abdominal stitches were not recovered properly and stitches were like fresh and wounds were not dry at that time. I haven’t had any bed rest and started work, and got pregnant again that’s why I faced trouble.” **(PEPEW1. WRA, Easy to reach, Punjab data)**

In some rare instances and despite having limited knowledge, some WRA are active in seeking postpartum care. When asked whether she had sought anyone’s help when she went for check up after delivery or if she had asked someone if it was okay to get medical check up after delivering her baby, WRA replied, “Yes, I asked my family and they said that it is better to get checked medically to avoid any issues. The doctor checked for blood shortage or

any internal issue.” (SEIW1. WRA, Target audience IDI, Sindh data)

There is a lack of knowledge within the household about what constitutes a good diet for WRA in the post-partum period. MIL expressed, “After delivery they gave pure (Banaspati Ghee) to mother with sugar for 21 days. After 6 days a bit of milk, mung beans and meat. Our main diet is Ghee with sugar.” (SHPPEM4. Mother-in-Law, PEER, Sindh data)

6.2.5 Neonatal

The target group lack knowledge in the areas of proper neonatal health, which often inhibits them from making healthy decisions about such things as breastfeeding, swaddling and bathing of a newborn baby.

There is a widespread lack of knowledge and misconceptions about colostrum which deter WRA from breastfeeding her newborn baby within an hour after birth. The majority of WRAs do not give colostrum to newborns because MIL emphasize the misinformed/false negative health outcomes linked to ingestion of colostrum.

“Colostrum is useless and dirty milk. We waste it and then start breast feeding the baby. After birth on the second day we place a spoon of honey on tongue of baby, and then give the baby its first bath.” (PEPEM2. Mother-in-Law, Easy to reach, Punjab data)

“I never heard about colostrum. The first milk is wasted as old ladies says it’s bad for the new born.” (PEPEW4. WRA, Easy to reach, Punjab data).



“In our village there is a story of a LHW. She lives as our neighbor. When she breast-fed colostrum to her baby, promptly her baby started to vomit and defecating later on. Within a week her baby died. So it’s famous among us that first breast milk is dangerous for babies. I wouldn’t like to take risk also.” (PEPEW3. WRA, Easy to reach, Punjab data)

In many instances, study respondents [WRA] reported that they were not able to make the decision to feed their newborns breast milk after delivery, as they were unconscious due to the anesthetic administered during Caesarean Section. “I was not conscious enough to take care of new born. My baby went in my sister’s arms, and my sister does not know about colostrum.” (PEPEW3. WRA, Easy to reach, Punjab data). Another WRA reported a similar situation, “I was not conscious of giving milk or colostrum to my baby [because of the operation]. My sister-in-law gave packed milk to both my babies as a first meal after birth”. (PEPEM2. Mother-in-Law, Easy to reach, Punjab data)

The decision to feed newborn babies milk substitutes such as ‘ghutti’ and milk from animals (goat, donkey or cow) tends to be favored and practiced. Ghutti is a mix of herbs in a beverage formula that is traditionally believed to help stimulate and improve a newborns digestive system. Some families also believe that goats milk and honey can supplement breast milk or stimulate hunger in a baby, as noted by a WRA, “Until I got milk they fed goat milk to the baby. It is normal that those mothers who do not have milk gave goat milk to babies.” (SEPEW4. WRA, PEER easy to reach, Sindh data)

When asked, “Did you give him [newborn] Ghutti?”, MIL responded, “Yes, we gave him Jaggery as first diet... It is our practice for long times.” “If a girl is born, a woman gives her ‘ghutti’, and if a boy is born, a man gives him ‘jaggery³’.” When asked what is the reason for that and what is its benefit, MIL responded “There is not benefit, it is just a custom.” (PEIM2. Mother-in-Law, Target audience IDI, Punjab data)

³Sugar made from sugar cane, date palms or coconut

"Mother gives the first milk after half an hour of birth to child and they also give Ghutti to child to clean the stomach." **(SEPEM1. Mother-in-Law, PEER, Sindh data)**

"Breast-feeding until 3 days and then we gave him hot cow milk. My mother [mother of mother-in-law] gave me this advice and then I told this to my daughter-in-law." **(SHIM2. Mother-in-Law, Target audience IDI, Sindh data).**

"Ladies used to give the baby the milk of donkeys, they say it is very useful for the human baby when it get sick." **(PHPEH1. Husband, Hard to reach, Punjab data)**

A lack of knowledge of the importance of not bathing the baby immediately after birth, and swaddling are barriers to proper neonatal care and newborn health. Newborns are typically not swaddled after birth or kept close to the mother for skin-on-skin contact. Baths are often given shortly after birth so that traditional rituals can be performed on the newborn to mark the babies' religion.

"They give bath to the child after 10 minutes of the birth, and wrap the baby in a towel." **(SEPEM3. Mother-in-Law, PEER, Sindh data).**

It is very rare that MIL or WRA give proper care in swaddling, "We kept him [baby] in blanket, kept the room warm and while giving him food clean the hands and kept his clothes clean." **(SEIW1. WRA, Target audience IDI, Sindh data).**

6.2.6 Child Health

MIL, WRA and husband do not have adequate knowledge of child development and health, especially nutrition, in order to make informed evaluations and decisions regarding their child's health.

"Right now I have 2 grand children; both kids are in good health. I told my daughter-in-law to feed them her own breast milk and cow milk is also very good. Also I chew almond and give the crushed almond to the baby boy." **(PEPEM1. Mother-in-Law, Easy to reach, Punjab data)**

There is a high degree of acceptance across most respondents of the importance of vaccinations for children. Almost all respondents described children being vaccinated and articulated forcefully the benefits of vaccination. Very few respondents could recall the specific vaccinations administered and the disease area in which the vaccination would benefit the child. Almost all respondents described the benefits of vaccinations as self-evident.

There was a sub-set of respondents who described prevailing norms of distrust concerning vaccinations. Typically, this sub-set of respondents felt that vaccinations were part of a conspiracy to achieve state goals concerning population control.

"People say that this will make our babies impotent when they will grow up. Injections are to make our children impotent". **(CPEIH-2, Target audience IDI, Punjab)**

7. GENERATE INSIGHTS INTO EFFECTIVE STRATEGIES FOR PROMOTING FAMILY PLANNING PRODUCTS AND MNCH BEHAVIORS TO UNDERSERVED FAMILIES IN PAKISTAN

This section does not formulate detailed strategies that can be implemented off-the-shelf by BCC and social marketing programs in Punjab and Sindh. This section presents key insights and broad suggestions for possible strategic directions that could be taken by BCC and social marketing organisations based on a structured process of marketing planning and collaborative dialogue with programmers and marketers.

The key actor to mobilise and engage in BCC and social marketing programs is the MIL. Social Marketing and BCC programs must resist the temptation to conceptualize the WRA as the decision-making actor with agency and power. MNCH and FP social marketing and BCC strategies can only be successful with the blessing of MIL and if they appeal and have meaning to this primary target audience. This is at odds with the standard PSI behavioral framework which posits the centrality of the individual actor being at the heart of the behavior change. In the target population the unit of behavior change is not the individual WRA it is the household and more specifically the MIL.

Televised serial dramas are very popular among MIL and WRA, especially among MIL. Although serial dramas are enjoyed because they provide entertainment and opportunities for escapism most MIL emphasized that they prefer gritty narrative plot lines with realistic and believable characters. Husbands did not refer to being viewers of serial dramas. Dramas that promote MNCH behaviors are a promising proposition because the format



would be able to embed messaging in storylines which provide entry points for tackling the structural social relationships which underpin MNCH behaviors. Serial dramas provide an arena within which the power relationships between household members and the external world can be explored in a realistic, entertaining and compelling fashion.

The principle decision-making actor in the FP and MNCH arena are MIL. MIL rely on, have trust and confide in TBAs as long as the health issue faced by the WRA, neonate or child is not an emergency. TBAs therefore have a huge influence in the process of maintaining and reproducing norms through their relationship with MIL that are unhealthy and risky for WRA, neonate and child. The strategy most likely to shift norms, behavior and practices of the target population is to reform the way in which TBAs do business. This process of strategic reform would require the following activities: (i) increase the skills, knowledge, beliefs and practices of TBAs; (ii) enroll TBAs in a formalized professional network; (iii) improve the quality of TBA practice through training, monitoring, quality assurance and on the job supervision; (iv) incorporation of TBAs into a network with standards; (v) establish a higher degree of formalization and formal integration between TBAs and the bio-medical health systems; (vi) messaging to TBA to encourage health behaviors that PSI is promoting.

Whilst TBAs may in a PSI framework be considered to typically be promoting competing MNCH behaviors (ones which often promote risk and are probably unhealthy for mother and her newborn and children) TBAs are the key health provider to which the target population go for routine health issues and advice in the MNCH arena. A Social Marketing and BCC program must engage with this category of actor to achieve impact.

TBAs do informally refer clients to hospitals and clinics during the prenatal and delivery processes if the health issue is outside of the arena of expertise of the TBA and the TBA fears for the well-being/life of the WRA. There

marketing and BCC programs aim to promote earlier referral of pregnant women when signs and symptoms suggest that this is required through a more formalized relationship between TBA and hospital/clinic.

Husbands respect the opinions of community leaders, particularly religious leaders/clerics ('mullahs'). Religious leadership may not be supportive of birth limiting but will often be supportive of birth-spacing within the parameters of a large family. Religious leaders should be engaged and enrolled into Social Marketing and BCC programs to promote birth-spacing within the context of larger families.

Religious leadership may also be key advocates, thought leaders and influencers in the arena of antenatal care, delivery and neonatal care. Religious leaders are able to influence TBAs and MIL. Their influence could be sought with regard to behaviors/competing behaviors which are less explicitly influenced by religious practices/beliefs (for instance swaddling of neonates).

There is a deeply embedded norm within the target population that colostrum is 'haram' and dirty. The categorization of colostrum as haram among a large segment of the rural population of Sindh and Punjab does not echo the views of many Muslim scholars and public health experts. Religious clerics at a senior level should be engaged to issue a decree that colostrum is beneficial for the health of newborns and is halal.



Husbands obtain access to issues, trends, opinions and experiences of other actors through routine social interaction with other men in the public arena. Men frequently mingle with other men at hotels, tea shops and tea stalls. Whilst a key focus of this social interaction revolves around entertainment, watching sport and relaxing chatter, this social arena provides an opportunity for content/issue based discussion, information exchange and exposure to BCC and IPC activities. Creative IPC in such public arena where men socialize could provide an entry point for eliciting conversation, learning and the promotion of responsibility among men to take a decision-making role in key FP and MNCH behavioral domains. Many of the locations where men

mingle show sport and other satellite/DVD-based entertainment. It might be possible to engage males in public spaces with mid-media (i.e. a DVD spot) followed by a short group conversation.

Men often own or have access to mobile phones. Women tend not to own mobiles and only use phones when a male family member allows her to and is often physically present during the call. mHealth programs could leverage mobile phone channel as a means to communicate with and inform husbands.

mHealth could additionally be a point of contact for MIL and husbands who are worried about WRA during pregnancy and delivery. MIL and husband might be able to access information, advice and guidance at particular points in decision-making. This would provide social marketing entities and BCC programs with an entry point to influence decision-making to promote earlier health-seeking behaviors in the antenatal and delivery phases.

Key informants indicate that FP messaging within an Islamic/religious framework is much more successful than messaging which is detached from a religious, ideological and moral structure. BCC and Social Media organisations will benefit from engaging in open, reflective and non-prescriptive dialogues with senior clerics and local religious leadership to establish means of embedding FP acceptably within a religious framework.

BCC and Social Marketing programs that attempt to engage WRA and MIL outside the domestic arena must explicitly target based on patterns of movement/mobility of WRA and MIL. Women are not very mobile and the space

for encounters is limited but valuable. Women spend time in bazaars, shops and in health facilities when they leave the home. Bazaars and shops may not provide a comfortable environment for engaging WRA and MIL in meaningful dialogue or exposing these actors to relevant messaging. Health facilities are perhaps the most effective location to message WRA and MIL. The treatment encounter between hospital/clinic health provider and WRA/MIL is a vital opportunity for ensuring that key behaviors are being messaged about. This is often difficult when the episode is situated within an emergency or crisis scenario. Often however the clinician will have opportunities to engage in dialogue with MIL who may internalize key messages given that medical professionals are trusted especially during emergency/crisis situations.

Across all behaviors there is a very low level of knowledge and a plethora of misconceptions, beliefs and attitudes that are not supportive of promoted behaviors. There is significant scope and room for messaging and knowledge improvement. Given that these insights apply to all promoted behaviors Social Marketing and BCC programs need to strategically prioritize which behaviors to promote.

Of all the promoted behaviors, vaccinations for children appear to be the behavior which is most attractive and practiced by the target population. Messaging around MNCH and FP health that leverages off vaccination campaigns may be trusted and resonate with the target audience.



There is an excessive degree of trust and confidence among the target population in doctors and hospital/clinic service. There is additionally a high degree of confidence for TBAs among many respondents. This level of trust does not promote a dialogue between provider and client and does not facilitate learning which can be a foundation for effective preventative behaviors. Social marketing and BCC programs will need to promote a more active dialogue between these actors. If this does not happen doctors and bio-medical health providers will continue to be accessed only during emergencies or to deal with crises. Furthermore, this will encourage what appears to be a tendency among doctors to overly emphasize emergency Caesarian Sections as a strategy for dealing with complicated delivery and promotes a tendency among TBAs to behave in an unaccountable fashion practicing clinically without regard to global best practice in the MNCH arena

Husbands prioritize family expenditure on children rather than WRA. Social marketing and BCC programs that engage husbands on ANC and delivery may have more success promoting the behavior if ANC behaviors are marketed as a means of ensuring the wellbeing of children.

Many respondents described WRA having emergency Caesarian Sections. The cost associated with emergency Caesarian Sections is high. It would be beneficial to engage key household actors in a discussion about the cost-benefits of no ANC leading to a crisis/emergency requiring an emergency Caesarian Section in contrast to a correct number of ANC checkups which might provide information which allows households to deal with complications together with the health provider as they emerge. When this conversation takes place it is important to prompt respondents to acknowledge the significant costs of having a WRA in the household who has health problems and is less productive after having a C-section.

There is very little knowledge about the importance of WRA having time to recover and heal in the post-partum phase particularly among women that had emergency Caesarian Sections. Social Marketing and BCC programs should encourage women in a community to help out other women in the community at times of need as an informal means of supporting women at this exhausting and vulnerable phase in their reproductive life.

Social marketing and BCC programs need to formulate solutions to promoting greater dialogue and questioning by WRA and MIL in the patient/doctor encounter. These encounters are not presently used for learning.

“Because they tell us that this is good for both mother and baby’s health, and if mother is young age or weak, in that way she will be weak and unhealthy. If we use family planning methods then both will safe and healthy.”

[SKHKI-05. Key Informant, male respondent (member of the community), Hard to reach, Sindh data].



Women spend a great deal of time at home engaged in domestic chores. However, television was mentioned more frequently as being compelling among WRA and MIL. This may be a function of radio content being less well tailored to MIL and WRA than TV serial dramas. Given that most households have a radio and given that the radio can be listened to when chores are happening there are entry-points for serial dramas within the radio format.

It is the view of Key Informants that FP programming should be embedded within a broader framework of MNCH. Messaging about FP tends to provoke opposition and resistance from the target population. The focus of programming and messaging should be MNCH with FP conceptualized as a sub-component of MNCH promotion.

8. GAIN INSIGHTS INTO HOW SOCIAL MARKETING AND BCC PROGRAMS CAN INFLUENCE HOUSEHOLD DECISION-MAKING THAT WILL IMPROVE THE HEALTH OF WRA AND HER CHILDREN

It is vital to recognize that WRA have limited decision-making power during the phases of pregnancy, delivery and period of neonatal care. The MIL is the key decision-maker during these phases. Behaviors related to prenatal care, delivery, antenatal care are the domain of the MIL. Social marketing and BCC programs must be targeted at MIL as the primary target audience in these phases.

Husbands are consulted during the phases of pregnancy and delivery by the MIL. Typically the husband exerts some influence over decision-making employing the prism of cost of practicing behaviors during the prenatal and delivery phases. Social marketing and BCC programs should be designed to target husbands as the secondary target audience during these phases.

WRA (particularly younger WRA with fewer children) are instruments of the MIL during the phases of pregnancy, delivery and neonatal care. Social marketing and BCC programs that focus on younger WRA with fewer children will most likely not be cost-effective.

WRA (particularly younger WRA with fewer children) have a very limited role in influencing decisions over family size and FP. Social marketing and BCC programs that focus on younger WRA with fewer children may not be cost-effective in the short and medium-term but prepare the WRA to play a more active role in negotiating with MIL and particularly husbands when they are older, more experienced and have more children.

Younger WRA with fewer children and no male children have almost no role in influencing decisions over family size and FP. Social marketing and BCC programs that focus on this segment will most likely not be successful in shifting behaviors in the short and medium time-frame (which is the focus of this program). Programs of this nature would contribute to long-term generational transformation however.

WRA with a few children (or many children) particularly those with at least one male child experience increasing space, agency and decision-making power in all areas of MNCH. In particular, this segment have greater power to make decisions about FP and care of children. Furthermore, this segment of WRA are closer to becoming MIL than their younger counterparts. This segment represents a more fertile group for targeted programming in the arena of FP and care of children.

WRA of all ages are responsible actors albeit frequently passive ones in the care of neonates and children. Social Marketing and BCC programs that focus on WRA during the neonatal care and child care phases will provide WRA with a platform to increase the likelihood of practicing promoted behaviors (notwithstanding the constraints of the pressures exerted by the MIL).



WRA and husbands experience difficulties in cooperating to negotiate effectively with MIL. A small minority of WRA have husbands who are supportive of WRA's choices in the arena of FP. If this contradicts the preferences of MIL the WRA and husband may deceive the MIL and pretend that no MFPM is being employed. In some cases the husband advocates for the preferences of the couple with regard to the MIL. Typically, this is only possible if the couple has at least a couple of children and at least one child is male. Social Marketing and BCC programs that focus on couples in this category to cooperate more effectively and negotiate more successfully with MIL will provide an impetus for FP decisions which are healthier and will promote household wellbeing.

WRA are the MIL of the next generation. Social Marketing and BCC programs that are inclusive of WRA provide a platform for contemporary WRA to engage with future daughters-in-law in a fashion which will promote improved MNCH behaviors over a long-term framework.

Husbands do not perceive themselves to be responsible for the MNCH domain. MNCH is typically seen as the domain of women (particularly MIL). The exception to this is the arena of

FP and family-size decisions which are a concern among husbands. However, husbands frame their understanding discussions about FP primarily through the prism of expense. Husbands are powerfully influenced by norms focused on preferences for large families and male children. There are entry-points for engaging husbands in decision-making related to FP.

Husbands described rich and frequent interactions with male peers in the public domain. Social marketing and BCC strategies must be designed to engage husbands in public domains in the context of male social gatherings.

Husbands are influenced by key male actors outside the household domain. Typically these male actors are perceived to be educated community leaders (i.e. clerics) or professional (i.e. doctors) who are considered to have expertise in the FP arena and are considered to be moral authorities and thought leaders. Social marketing and BCC strategies should focus on key community level thought leaders to influence husbands who are influenced by such actors.

Family planning and MNCH behaviors are intimately linked among husbands with their sense of social status, social respectability and community perceptions of the male and his family from a moral perspective. Much of how a man derives his sense of social status and value is through the size of his family and the number of boys in his family. This is as important to him as being seen to be a good Muslim and having moral integrity. Having a large, or medium-sized, family is a key means of assuring that the husband is perceived as a man and a respected member of the community. His pride and social standing are among many husbands seen as more important than ensuring the economic wellbeing of the household. Social marketing and BCC strategies must be designed to support husbands to advocate for birth spacing and possibly limit within the parameters of these key male requirements. Marketing the benefits of the medium-sized family that employs both birth spacing may be a means of communicating the benefits of both birth spacing and birth limiting in a delicate fashion which will not catalyze resistance and opposition.

Strategies and practices of marriage were observed to be diverse in Sindh and Punjab. In Sindh, exchange marriage is more prevalent. In Punjab marriage within the extended family or community is more prevalent. This study did not study differing marriage practices and family structures in detail. However, it is assumed that inter-personal dynamics and power relationships will differ in families of different structures based on differing

marriage practices. We do not make conclusive recommendations in this regard. It is suggested that FP and MNCH programming be mindful of the marriage practices and family structures at a local level.

Religious leaders (mullahs) play a particularly important role in influencing attitudes and norms about FP and family size/structure. Social marketing and BCC strategies that focus on religious leaders provide an entry-point for shifting social norms that are a barrier to promoted family behaviors.

There is a sub-group of men who are engaged (but do not see it as their responsibility) to take ownership of FP and MNCH decision-making. This sub-group presents an opportunity for MNCH and social marketing programming. Husbands in this group should be engaged with messages that focus on the role FP and MNCH can play in improving the wellbeing of children (particularly male children).

MIL are the key actor in MNCH decision-making in the family. The key external allies of the MIL are TBA/Dais. Social Marketing and BCC programs that wish to influence MIL must engage TBAs/Dais as a primary target audience in shifting norms, attitudes, beliefs and practices related to MNCH (particularly behaviors that relate to pregnancy, delivery and neonatal care).

The behavior of TBAs (as described by respondents) reflects a striking lack of correspondence with promoted behaviors or clinical quality within the biomedical framework of PSI. The practice of TBAs is informed by knowledge which may be crudely described as traditional or indigenous. This traditional indigenous knowledge is influenced partly by local understandings of biological processes and treatment and socially constructed understandings of religious rituals that are embedded in neonatal care practices. Displacing unhealthy care and treatment practices that are deeply embedded in the life-experience and normative framework of TBAs will probably be challenging. Comprehensive efforts to reform the clinical practice and quality of TBAs will most likely be perceived to be an assault on the normative values of TBAs (which have flown from generation to generation). Focusing on shifting beliefs and knowledge around particular behaviors which are least challenging to the normative framework, identity and status of TBAs is likely to be the most effective approach to behavior change among TBAs.

Most husbands firmly believe that families with large numbers of children constituted by at least one, and preferably several boys, are the idea. The notion of birth limiting is therefore a proposition that typically creates resistance and opposition. However, a segment of males do value the health and wellbeing of children and wives. Among such husbands there is considerable potential to message and program with the goal of achieving birth-spacing.



Birth spacing can be branded as a behavior which reduces long-term health problems of wives. This increases the productivity of the wife in the domestic arena (which is a priority for husbands). Similarly, a healthy wife is seen as an important actor in child care which

ensures the wellbeing of children. The wellbeing of boys is particularly important to husbands. Social marketing and BCC activities that focus on husbands with regard to this behavior must be explicit about emphasizing the functional benefits of birth spacing. It is important to emphasize that a large family is not at all incompatible with birth spacing.

MIL and husbands prefer to seek the attention of health providers/treatment when during pregnancy, or delivery, the WRA is experiencing either acute pain or is in a crisis/emergency situation. This places the WRA at considerable risk. Very few respondents reported WRA having a recommended number of antenatal checkups nor the rationale for such checkups. This often leads to seeking healthcare/treatment that is costly and frequently catastrophic from the perspective of household livelihoods. Barriers to undertaking antenatal checkups include resistance by MIL, lack of engagement or encouragement by husband and tendency of TBAs to provide an unsatisfactory surrogate for high quality antenatal care (which is attractive to all members of the household because it is significantly less expensive than antenatal checkups through doctors/clinics and Lady health Visitors). BCC programs which engage the husbands in a primarily economically informed cost-benefit assessment which focuses on the financial costs and benefits of correct ANC checkups for all women versus crisis-based, emergency, catastrophic expenditure may provide an entry point for attitudinal change among males.

Lady Health Visitors were remarked upon as providing high quality services and care. LHVs are attractive to the target population because they are mobile and come to the household. This is attractive because it reduces the cost of transportation to a health provider and the stress involved in women circumnavigating the world external to the domestic arena (which is not considered an appropriate place for women to be according to the views of respondents).



ANNEX A: COMMUNICATIONS STRATEGY

Target Audience	Channels	Rationale for Channel	Messages
Mothers in Law	<p>TV Serial Drama</p> <p>Listening groups</p>	<p>- MIL enjoy gritty, realistic, TV serial dramas. Provides an opportunity to discuss and transform views about age-based power asymmetries between MIL and daughter-in-law and to message around MNCH behaviors.</p> <p>- Gathering MIL and TBAs in one room to discuss content, characters, issues, messages in TV serial drama provides an opportunity for changes in social norms.</p>	<p>- Increasing the time between deliveries improves the chances of your child living and being healthy.</p> <p>- Increasing the time between deliveries improves the chances of the mother living and being healthy.</p> <p>- A medium sized family tends to be more prosperous and have a better of quality of life whilst still being respected and valued in the community.</p> <p>- Promoted MNCH behaviors improve the chance of your child living and being healthy.</p> <p>- Detailed description and guidance on promoted MNCH behaviors.</p>
TBA	<p>Listening groups.</p> <p>Franchise or accredited network</p> <p>Output-based financing</p>	<p>- Gathering MIL and TBAs in one room to discuss content, characters, issues, messages in TV serial drama provides an opportunity for changes in social norms.</p> <p>- Enrol TBAs into a franchise or accredited network in which they will receive training, capacity building, protocols, standards across the diversity and range of MNCH behaviors.</p> <p>- Reward TBAs for referring patients early to facilities.</p>	<p>As TBAs you should be promoting the following:</p> <ul style="list-style-type: none"> - Regular ANC visits. - Early referral if home based births become complicated to a facility. - Giving newborn colostrum. - Etc...

Target Audience	Channels	Rationale for Channel	Messages
<p>Older WRA</p>	<p>Women self-help group.</p> <p>- TV serial drama.</p> <p>- Small group IPC with same sex/same age-category WRA.</p>	<p>Women are often vulnerable and exhausted after a complicated pregnancy/delivery or C-Section. Women can collectively help each out (at times of need) to do domestic chores/child-care.</p> <p>- To provide messages around promoted MNCH behaviors.</p>	<p>- Support neighbours and acquaintances who are women who have experienced a complicated birth or pregnancy and need your help to deal with their domestic chores. Other women will help you if/when you are in the same situation.</p> <p>- Increasing the time between deliveries improves the chances of your child living and being healthy.</p> <p>- Increasing the time between deliveries improves the chances of the mother living and being healthy.</p> <p>- A medium sized family tends to be more prosperous and have a better of quality of life whilst still being respected and valued in the community.</p> <p>- Promoted MNCH behaviors improve the chance of your child living and being healthy.</p> <p>- Detailed description and guidance on promoted MNCH behaviors.</p>
<p>Mothers in Law</p>	<p>- Age based negotiation skills through interactions with Male Motivators.</p>	<p>- Provides an avenue for improving negotiation skills with MIL.</p>	<p>- Increasing the time between deliveries improves the chances of your child living and being healthy.</p>

Target Audience	Channels	Rationale for Channel	Messages
	<ul style="list-style-type: none"> - Group IPC. - Individualised IPC. - Mid-media 	<ul style="list-style-type: none"> - Provides an opportunity for knowledge and self-efficacy to increase. - Provides opportunities to discuss cost-benefit analysis of ANC visits, emergency medical care and facility based/home-based deliveries. - Leverages the structural relationship of the man as the primary communication opening to the external world. 	<ul style="list-style-type: none"> - Increasing the time between deliveries improves the chances of the mother living and being health. - A medium sized family tends to be more prosperous and have a better of quality of life whilst still being respected and valued in the community. - Engage in a rationale calculation of how much it costs your household to have emergency ANC/delivery if your wife does not go for regular/recommended ANC visits versus going for regular/ANC visits. Consider the risks and benefits of both scenarios from a health and financial perspective.
Religious leadership	- Peer-based dialogues.	- Provides an opportunity for religious leaders to discuss and dialogue about key issues of importance in a safe and private setting around sometimes sensitive issues.	<ul style="list-style-type: none"> - Can you consider issuing a fatwa promoting feeding of colostrum to newborns? - Can you consider promoting medium-sized families as a responsible approach to achieving economic prosperity and having social status for a good muslim family?
Young WRA	- Same sex IPC.	- Provides an opportunity for knowledge and self-efficacy to increase.	- Detailed description and guidance on promoted MNCH behaviors.



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