Research Journal of Family, Community and Consumer Sciences _____ ISSN 2320 – 902X
Vol. **3(5),** 4-9, July **(2015)** *Res. J. Family, Community and Consumer Sci.*

Perceptions of Community Stakeholders on Safe Motherhood: An Account of Personal Narratives

Batra S and Anand S
Dept of Development Communication and Extension, Lady Irwin College-Delhi University INDIA

Available online at: www.isca.in, www.isca.me
Received 11th June 2015, revised 16th July 2015, accepted 25th July 2015

Abstract

All major decisions pertaining to pregnancy and child-birth that a woman ought to take are strongly influenced by different community stakeholders around her. This situation is especially dominant in the rural set-up of India where a mother-in-law or husband or some influential community leader may have more say in the way an entire pregnancy and child-birth must be handled. Consequently, women in the traditional Indian society lose control over their bodies and any decisions pertaining to it; it is people around her who decide and manipulate the puppet that she becomes. Keeping this in mind a qualitative research was carried out to capture narratives of these influential stakeholders that potentially determine the outcome of a pregnancy to understand their perceptions about safe motherhood. The study was carried out in villages of Haryana, which is patriarchy dominated and has the most skewed sex ratio in the country. Thirty narratives of ten mother-in-laws, 10 husbands and 10 other community stakeholders respectively were taken and analyzed based on guidelines for Narrative Analysis, 2003, by University of Wisconsin. The findings of this research clearly articulate that the state government had come up with unique schemes to promote safe motherhood which were acknowledged by these stakeholders. The findings also stated that the health workers were playing a pivotal role in mobilizing women to access these services. Mother-in-law was found to be the most potent influencer in terms of decision making pertaining to pregnancy and child-birth. On the flipside, the research reiterated the deep-rooted gender bias within the state. Though most community stakeholders were shifting their mindsets in this regard, yet interventions of Behaviour Change Communication are a must. The study found some positively deviant practices, like, government giving a kilo of Desi Ghee as an incentive for early ANC registration, husband/ mother-in-law making alternate arrangement for delivery, going for contraception after birth of two girls and supporting gender equality, not letting the couple get intimate after childbirth or using a Bhajan Samiti as a forum to motivate women to access services from DH, etc, that were making a big difference in the birth outcome for these beneficiaries.

Keywords: Narratives, safe motherhood, community stakeholders, behaviour change communication, gender bias, haryana.

Introduction

Understanding the grave concern that maternal mortality is, given its global importance in the Millennium Development Goals by United Nations; it is imperative that this problem is handled with utmost care and seriousness. Millennium Development Goal 5 stresses on the improvement of Maternal Health[1]. Across the globe, it is the poor and the developing countries that are victimized by this problem the most. Be it the problem of resources, infrastructure or lack of awareness, the third world seems to be still battling hard with maternal mortality. Most maternal, newborn and child deaths can be prevented with available interventions. These interventions can be family planning, antenatal care, preventive treatment of malaria, neonatal tetanus protection, delivery with a skilled birth attendant and postnatal check-ups for new mothers[2].

According to WHO, the major share of maternal deaths is due to direct causes: severe bleeding, infections, unsafe abortions, eclampsia, obstructed labour and other direct causes. As per WHO, indirect causes such as malaria and HIV (Human Immunodeficiency Virus) account for 20% of all maternal deaths globally, but in many priority countries, the high burden of these diseases lead to high maternal mortality[3]. All these causes essentially are driven owing to lack of access to services, lack of awareness, absence of reliable channel of communication in the form of health workers. Studies suggest that limited source of information contribute to poor awareness on reproductive health matters, even among young girls attending higher education[4]. A study done by Kumar and Gupta found a significant difference in the utilization of maternal health care services by caste, women' age at first birth, educational attainment, place of residence, economic status and region[5]. Also it is seen that a young and poor woman reports more complications during pregnancy and lesser use of any health care services[6]. Poor referral mechanism, absence of trained birth attendants and prevalence of home deliveries also majorly contribute to the direct causes of maternal deaths particularly in countries with poor health indicators.

Another dimension of causes associated with maternal mortality is social in nature; wherein social norms, often inhibit woman to

access health care services. Women's autonomy and its association with her reproductive behaviour is indeed a concern, as potential power in the hands of the woman can reduce maternal mortality and improve child health[7]. It is also to be realized that decision making of women is a tool of converting the economic empowerment into social and political empowerment[8]. As per the report by BBC Media Action, 2014, unsupportive attitudes and norms are prevalent in many communities, especially among key decision-makers, men and older women[9]. These inhibit women to access health services that she must at the time of pregnancy and childbirth. This situation is more visible especially in the rural set-up of India where a mother-in-law or husband or some influential community leader may have more say in the way an entire pregnancy and child-birth must be handled. The long hailed patriarchy and the grounded gender divide in our country can be easily blamed. Consequently, women in the traditional Indian society lose control over their bodies and any decisions pertaining to it; it is people around her who decide and manipulate the puppet that she becomes.

As observant in most countries of South Asia, mother-in-laws play a crucial role in the decisions revolving around accessing health care facilities and providers[10]. A study done in Bangladesh by Chowdhury, Mahbub and Chowdhury, 2003, found that older women, especially mothers-in-law did not consider ANC essential during pregnancy and often discouraged their daughters-in-law from attending these[11]. Another study found that family planning use was lower when the mother-in-law lives with the couple as compared to when the couple lives separately from the mother-in-law[12]. Speizer et al, reiterate that given the important role of the sister-in-law and mother-in-law and that women living in poorer settings are less likely to use modern Family Planning, outreach programs to slum/poor areas may be crucial for improving the social context for Family Planning[13]. Social equity with respect to the distribution of facilities has been found as the utmost important prerequisite in accessing Ante-Natal Services in the Empowered Action Group states [14].

Also, influence of the husband in decision making cannot be ignored, especially in a patriarchy dominated country like India. Evidence demonstrates that women were more likely to follow the appropriate practices when their husbands supported them[15]. Agreement of partners regarding perceptions about the healthcare system appeared to be an important driver of decisions about delivery-location[16]. The study done by Upadhyay, et al, confirmed that both the woman and her male counterpart influenced the decision to utilize maternal health care services. According to Upadhyay et al, it is evident that non-indigenous women are vulnerable groups and have a limited decision-making capacity on their utilization of maternal health services. The study recommended that interventions for improving utilization of ANC and delivery care should be hence emphasized on the couple[17.]

The involvement of husbands and mothers-in-law is indeed important in decision-making, indicating the need to consider the influence of household gender and power dynamics[18]. Based on this premise, that mother-in-laws, husbands and other community stakeholders are the potential influencers in decision making pertaining to pregnancy and childbirth, a qualitative research was carried out to understand their perceptions about safe motherhood.

Methodology

The study aimed at understanding perceptions of potential influencers in decision making for women pertaining to pregnancy and child-birth and hence identified three set of influencers, based on literature review and pilot findings. Hence, mother-in-laws, husbands and other community stakeholders were the sample for this qualitative study.

Since Haryana is a patriarchy dominated state which stands strong on social grounds and has the most skewed sex ratio, the state was purposively selected as the locale for the study. The state also runs a free of cost, incentive driven scheme for promoting institutional delivery, known as the "Delivery Hut Scheme" which also set the background for valid probing on autonomy related to pregnancy and childbirth when free services existed within the state. Within the state, a low performing, poor sex ratio and low Human Development Index district, Jhajjar was selected as the locus of the study. Within Jhajjar, Delivery Huts at villages of Kiloi, Dujana and Bir Chuchakwas were approached to identify relevant sample. To elicit candid data from the respondents on their perceptions related to safe motherhood, the method of "Narratives in personal story form" deemed appropriate. Narratives from ten respondents from each category, making it to a total of 30 narratives were documented for this research.

Use of narratives for qualitative analysis is a recent technique; hence, certain guidelines were followed on initiating dialogue through the use of relevant probes in a personal interview manner. The probes used to elicit relevant information from the respondents were: i. Tell us something about yourself, your family, ii. Ease of expression within the family, iii. Trust on Health Workers, iv. Institutional Delivery, v. Pressure exerted by the family to have a male child, vi. Family Planning, vii. Other.

The above probes were relevantly modified for different categories of stakeholders: mother-in-laws, husbands and community stakeholders respectively.

Personal interaction with the community stakeholders led to individual field notes and video recordings that transcended into thirty 700 word narrative which was more of "Limited Portrait" as Riesmann, 1993 (University of Pretoria, 2006) calls it. The process began with rapport formation, followed by debriefing about the purpose of the research, seeking consent from the

participants and then probing. Some cases grew on personal losses, grief and other plethora of emotions. It was a moving experience for the researcher too, to empathize with what these subjects have gone through and how most of them had emerged with time.

Primarily guidelines by University of Wisconsin, 2003, for Narrative Analysis were followed. Hence open coding was resorted to. Codes/metaphors were made and then texts from narratives were assigned to these codes and summaries were made.

Operational definitions of codes that were used is given in the table 1 below:

Table-1
Description of Codes/Themes for Narrative Analysis

S.No	Code (Theme)	Description of Code
1.	Context	This shall include all basic background of the respondent, his/her relationship with the others involved in the plot and the basic context of the story.
2.	Institutional Delivery/DH	This shall include the text within the narrative that describes about institutional delivery, anything pertaining to why, who, when, what and how of institutional delivery, previous incidences of home delivery and in particular the institute that has been deemed appropriate by the respondents for institutional delivery. This shall also include perceptions about ANC and PNC
3.	Gender Bias	This shall in particular highlight any verbatim or text where a gender bias has been indicated for the child to be born and what are the views of the respondents about it.
4.	Role of Health Workers	This shall include what the respondents feel about the role of health workers; as in any way in which health worker has been able to bring about a behaviour change or been able to guide the respondent to access health services through inter-personal communication.
5.	Contraception/ Family Planning	This shall in particular include respondent's views on contraception, their use, ways and practice of family planning and contraception and why is it considered important.

Results and Discussion

The findings and discussions are reported stakeholder-wise under the following heads (pre-defined codes):

Perception of Mother-in-laws: Context: Most of these mother-in-laws took good care of their daughter-in-laws at the time of their pregnancy and awaited the birth of their grandchildren. On one hand some of the mother-in-laws were educated and well to do. While on the other hand some of them faced financial constraints too. Their previous experiences influenced their perception about institutional deliveries and care of their daughter-in-laws.

Institutional Delivery: A shift was observed from their preference for home deliveries to their preference for institutional deliveries. Majority of them succumbed to loss from home deliveries previously in their families and hence well understood the importance of an institutional delivery and now did not want to take any risk. Free of cost deliveries at Delivery Huts along with financial incentives were a boon for families from the below poverty line or with lesser resources. Early confirmation of pregnancy led to early interventions related to ANC and the pregnancy test kit was a welcomed technology by most mother-in-laws in this regard. The Delivery Hut other than providing basic services like ANC/PNC, institutional delivery, immunization and family planning also provided the free ambulance service that strengthened the referral system.

Most mother-in-laws were apprised about the latest updates on health norms and schemes from the health workers and adhered to practices to be undertaken at the time of ANC and PNC to ensure a safe motherhood to their daughter-in-laws. Haryana government's scheme of Surakshit Maa Award that provided a kilogram of desi (pure) ghee to the pregnant woman for early ANC registration was taken in a positive stride by most mother-in-laws as they affirmed with the traditional and nutritional values of feeding Desi Ghee to a pregnant woman. Private hospitals or Government hospitals were being resorted to for deliveries only in cases of complication or where a need for C-section was felt. Most well to do mother-in-laws intended to seek ANC services from the nearby Delivery Hut but wished to get the delivery of their daughter-in-laws at the government or private hospital, just to play safe and avoid complications. ANC component at the DH included providing Iron and Folic Acid supplements, blood tests, weight and blood pressure monitoring and immunization. Some mother-in-laws were immensely supported by the health workers throughout the pregnancy of their daughter-in-laws. While some mother-in-laws resorted to alternate arrangement of delivery, others relocated or temporarily shifted to an acquaintance's residence that was near to the place of delivery at the time of due date. Most mother-in-laws understood the importance of small family size and tried to convince their daughter in laws to go for some mode of contraception to rear the new born child already born better. Infact, some went to the extent of sleeping with their daughter-

in-laws for three months after delivery to ensure avoidance of intimacy between the couple.

Gender Bias: Most mother-in-laws preferred that their daughter-in-laws gave birth to atleast one son which testifies the deep rooted patriarchy and skewed sex ratio in the state.

Role of Health Workers: ANMs and ASHAs often became the first contact point between the mother-in-laws and the services being provided at the Delivery Hut. Most of them kept the mother-in-laws apprised of the latest norms and schemes pertaining to safe motherhood. According to most mother-in-laws, the health workers performed duties of immunization, institutional delivery, referral arrangements and family planning. Some of the mother-in-laws established friendly relation with the health workers owing to their extra ordinary support at the time of their daughter-in-law's pregnancy and delivery. Most mother-in-laws believed the word of the health workers and hence adhered to their advice on practices related to safe motherhood. Since befriending with health workers did not come tough for most mother-in-laws they often took their daughter-in-laws for an interaction with them.

Contraception/Family Planning: Some of the mother-in-laws empathized with their daughter-in-laws and did not stress on having a child soon after delivery or still birth. Mother in laws belonging to families with limited resources understood that a small family size was ideal and often convinced their daughter-in-laws to adopt sensible methods of contraception like copper-t or permanent sterilization. Some mother in laws even resorted to sleeping with the daughter in laws for three months after delivery to ensure a good PNC for her and not giving an opportunity to the couple to get intimate thereby aiding in forced celibacy for the couple. This gave the new mother's body enough time to make up for the losses in pregnancy and childbirth.

Perception of Husbands: Context: Most husbands of women had just become fathers or were soon to become fathers. Most of these husbands stayed in joint families, while some were migrants. A large number of husbands were self sufficient to afford child birth of their wives at a better paid facility; while some had financial constraints or were jobless. A few others lived in below poverty line families. Previous incidences of home delivery that resulted in loss in their families were strong influential factors in motivating the husbands to provide for institutional delivery to their wives.

Institutional Delivery: Majority of the husbands were satisfied with the services they availed from the nearest Delivery Hut. Free of cost treatment along with incentives were attractive enough for most husbands that resulted in influencing their decision for institutional child birth. Husbands seemed to welcome the shift from home deliveries to institutional deliveries that ensured a safe motherhood for their wives and a secure birth outcome, that too without any expenditure. Most husbands ensured that they accompany their wives for the ANC to the nearest DH. The services under ANC included vaccination, counseling, weight and blood pressure monitoring. Most husbands empathized with their wives and especially if their wives had gone through a c-section. They understood that their wives needed rest and time to make up for the losses during pregnancy and childbirth. Husbands certainly preferred the nearest accessible DH as the place of delivery, yet had made alternate arrangements for delivery at other government and private hospitals to avert any risk in case of a complication. Husbands did not mind taking time out to care for their wives are it by accompanying them for their ANC sittings, being concerned about their diet and weight gain, planning to take a week long leave at the time of child birth. Though very few, but some used technology "Google" to find simple remedies for pregnancy related problems of their wives. Some husbands also laid stress on the importance of post natal care and ensured that their wives were taken to the doctor for PNC appointments despite the most inhibiting circumstances. Some of them even requested their mothers to sleep with their wives to ensure avoidance of intimacy between the couple. Some husbands were proactive and took note of not so normal symptoms and immediately took action. For example, a husband proactively got an ambulance arranged for referral to DH when his newborn child was unable to suck the breast milk after delivery.

Gender Bias: Some husbands did wish that they have a son so that their families could be complete. On the other hand, some husbands supported their wives on the birth of a daughter, when their own mothers exerted pressure to have a grandson. Mother-in-laws were the most potent force on daughter-in-laws to bear a male child and they used traditional symptoms to identify what was the sex of the fetus in women's womb. Some even requested their sons to go to the city and get a prenatal sex determination done. Most of the husbands did not discriminate between a girl and a boy child and were happy with birth of either of them.

Role of Health Workers: Majority of the husbands trusted the health workers and was satisfied with the work they did. The health workers proactively managed cases of complications and were there to answer any calls from the clients. Field visits were being taken by the health workers for identifying pregnant cases in vulnerable communities. A male staff nurse at one of the PHCs was a sign of comfort for most husbands visiting there as they could easily share their wives' concerns with him. A care provider simply by being who he/she was able to attract beneficiaries for seeking care. Beneficiaries' trust on their good will could be the major factor for this.

Contraception and Family Planning: Most couples were satisfied with two children and agreed that in such inflating times two children were more than sufficient, even if both were girls. They wanted a reliable contraception thereafter either in the form of copper-t or sterilization. Husbands whose

wives had a c-section empathized with them and did not want their bodies to take additional stress; hence they themselves opted for sterilization or prevented sleeping with their wives to avoid physical intimacy.

Perception of Community Influencers: Context: Most community stakeholders were aged and influential men and women and included people from diverse groups and castes. Most community stakeholders seemed to have contributed to the health system or health of the community by spreading awareness, influencing others, using unique ways to communicate or have either contributed by providing a platform for the health system to function properly, e.g. lending a personal property on rent for a Delivery Hut to function, or using a self help group as an interface for group members and ASHAs to network. Most community stakeholders were triggered by their personal and past experiences that made them sensitive to the health needs of the community. Some of the community stakeholders felt distressed with the prevalent situations and that actually made them feel the need to get involved and become change agents.

Institutional Delivery: A generational shift was evident from the narratives of the community stakeholders where in most case their own children were delivered at home and their grandchildren were being delivered at the Delivery Hut of their respective villages. Most community stakeholders asserted that home deliveries and lack of ANC caused miscarriages, still births and abortions. Most community stakeholders appreciated the functioning of the Delivery Huts that provided 24X7 free of cost services ranging from ANC and PNC, institutional delivery and family planning. At most villages DH worked 24X7 and conducted deliveries day and night. Free of cost services and cash incentives were a strong motivating factor for most of the community stakeholders that they felt could motivate clients to seek services from DH. At some places it was the popularity of the name of the doctor or the health worker that was attractive enough to invite high numbers for institutional delivery. One of the best part of the DH scheme as cited by most community stakeholders was the ambulance service which aimed at increasing the efficacy of the referral system.

Gender Bias: Most community stakeholders found Mother-in-laws as the most influential in insisting upon their daughter-in-laws to have repetitive pregnancies in order to have at least one son so that continuity of the family's name could be ensured. Most community leaders agreed that times had changed and one should not discriminate between a girl and a boy and sensibly plan a family.

Role of Health Workers: Interpersonal, friendly and caring communication from a caregiver was able to attract clients to the Delivery Huts. Most community stakeholders found that community was able to establish a rapport and a relationship with the health workers which lent them relational addresses such as "Chachi Ji" and"Bua Ji" (Relationships of patriarchal families for universal acceptance in the patriarchal family set up). Health workers performed duties such as giving ANC, immunization, institutional delivery, counseling and family planning services. Appreciation for ASHA workers extensive mobilization came from most community stakeholders who also asserted that ASHAs kept track of the woman since she got pregnant till the time she delivered.

Contraception and Family Planning: Elderly community stakeholders did not shy away from talking about contraception and creating awareness about it. Often suggestive measures of contraception that came in from them included avoidance of intimacy between the couple, copper-T and permanent sterilization once the family was complete. Most community stakeholders also realized the makeshift in time and were convinced that a small family size is ideal and contraception must be used for spacing. A health worker's influence was found pertinent in motivating adoption of contraception among couples.

Conclusion

The findings of this research clearly articulate that the state government had come up with unique schemes to promote safe motherhood which were acknowledged by these stakeholders. The findings also stated that the health workers were playing a pivotal role in mobilizing women to access these services. Mother-in-law was found to be the most potent influencer in terms of decision making pertaining to pregnancy and child-birth. On the flipside, the research reiterated the deep-rooted gender bias within the state. Though most community stakeholders were shifting their mindsets in this regard, yet interventions of Behaviour Change Communication are a must and should strategically target these change agents. The study also found some positively deviant practices, like, government giving a kilo of Desi Ghee as an incentive for early ANC registration, husband/ mother-in-law making alternate arrangement for delivery, going for contraception after birth of two girls and supporting gender equality, not letting the couple get intimate after childbirth or using a Bhajan Samiti as a forum to motivate women to access services from DH, etc, that were making a big difference in the birth outcome for these beneficiaries. Thus, positively deviant practices pertaining to safe motherhood not just needs to be encouraged but also advocated to men, women and other potential influencers around, as it costs nothing but a slight shift in the behaviour, leading to a positive upshot.

Acknowledgement

The research was carried out as a part of Ph D work from Delhi University. The primary author has received scholarship under UGC JRF and SRF to carry this research. No other institutional funding has been provided for the same.

References

1. Desai T., Improvement in Maternal Health -Have We Done Enough. *Res. J. Family, Community and Consumer Sci.*, **2(8),** 8-10 **(2014)**

2. www.un.org/millenniumgoals/childhealth.shtml **(2015)**

3. WHO, UNICEF, UNFPA and The World Bank. *Trends in Maternal Mortality: 1990-2013.* Geneva: WHO. **(2014)** Retrieved from http://apps.who.int/iris/bitstream/10665/112682/2/9789241507226_eng.pdf?ua=1

4. Rajpoot S.S., Gupta K and Srivastava M., Study about Reproductive Health awareness among Rural College going Girls in Varanasi district, Uttar Pradesh, India. *Res. J. Family, Community and Consumer Sci.*, **3(2),** 5-10 **(2015)**

5. Kumar P. and Gupta A., Determinants of Inter and Intra caste Differences in Utilization of Maternal Health Care Services in India: Evidence from DLHS-3 Survey, *Int. Res. J. Social Sci.*, **4(1),** 27-36 **(2015)**

6. Mousumi, G. Association of Maternal Age and Low Socio-Economic Status of Women on Birth Outcome, *Int. Res. J. Social Sci.*, **3(10),** 21-27 **(2014)**

7. Mahapatro, S.R. Utilization of maternal and child health care services India: Does women's autonomy matter? *The Journal of Family Welfare*, **58(1), (2012)** Retrieved from http://medind.nic.in/jah/t12/i1/jaht12i1p22.pdf

8. Reena Kaur R. and Nikita, Impact of SHGs on the level of Participation of the Women in Decision-Making Process: A Comparative Analysis, *Int. Res. J. Social Sci.*, **3(5),** 29-31 **(2014)**

9. BBC Media Action, What influences maternal health practices in four countries? *Research Briefing Issue 04 March 2014 Health.* London: **(2014)** Retrieved ,from http://downloads.bbc.co.uk/mediaaction/pdf/research/what_influences_maternal_health_in_four_countries_research_briefing.pdf

10. Simkhada B, Porter MA, and Teijlingen ER**.** The role of mothers-in-law in antenatal care decision-making in Nepal: a qualitative study**.** *BMC Pregnancy Childbirth.* **10,** 34 **(2010)**. doi:10.1186/1471-2393-10-34

11. Chowdhury AMR, Mahbub A and Chowdhury AS, Skilled attendance at delivery in Bangladesh: an ethnographic study, *Research Monograph Series,* Research and Evaluation Division, BRAC Dhaka, Bangladesh, 22 **(2003)**

12. Kadir MM, Fikree FF, Khan A and Sajan F., Do mothers-in-law matter? Family dynamics and fertility decision-making in urban squatter settlements of Karachi, Pakistan, *J Biosoc Sci*., **35,** 545-58 **(2003)** doi:10.1017/S0021932003005984

13. Speizer I.S., Lance P., Verma R. and Benson A., Descriptive study of the role of household type and household composition on women's reproductive health outcomes in urban Uttar Pradesh, India, *Reproductive Health* **12,** 4 **(2015)**

14. Singh R.K. and Patra S., Differentials in the Utilization of Antenatal Care Services in EAG states of India. *Int. Res. J. Social Sci.,* **2(11),** 28-32 **(2013)**

15. BBC Media Action, What influences maternal health practices in four countries? *Research Briefing Issue 04 March 2014 Health.* London: **(2014)** Retrieved ,from http://downloads.bbc.co.uk/mediaaction/pdf/research/what_influences_maternal_health_in_four_countries_research_briefing.pdf

16. Danforth E.J., Kruk M.E., Rockers P.C., Mbaruku G. and Galea S., Household Decision-making about Delivery in Health Facilities: Evidence from Tanzania, *Journal of Health, Population, and Nutrition*, **27(5),** 696–703 **(2009)**

17. Upadhyay P., Liabsuetrakul T., Shrestha A. and Pradhan N., Influence of family members on utilization of maternal health care services among teen and adult pregnant women in Kathmandu, Nepal: a cross sectional study, *Reproductive Health*, **11,** 92 **(2014),** doi:10.1186/1742-4755-11-92

18. Blanchard et al. An Exploration of Decision-Making Processes on Infant Delivery Site from the Perspective of Pregnant Women, New Mothers, and Their Families in Northern Karnataka, India, *Maternal Child Health Journal*, **(2015)**