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PRACTICES AND METHODS DURING DELIVERIES IN RURAL UP (REPRODUCTIVE BEHAVIOUR AND THE ROLE OF WOMEN)

Ranjana Gupta, Ph. D.

Associate Professor- Home Science, K. R. Girls P.G. College Mathura

Abstract

Earlier there was a ladies hospital in Dibai with the facility to deal with complicated cases. Nurses, midwifes, lady doctor (MBBS, MD) were appointed. They used to stay in the hospital quarters. Due to lack of decent standard of living and social life, MBBS doctors refused to be appointed in such a small town. Therefore the facilities as well as condition of the hospital deteriorated and it ceased functioning. Recently, in late nineties primary health centre has been established in Dibai. It is dedicated to the needs of both males and females. A lady doctor (BUMS) is also appointed who comes on duty daily from Aligarh and leaves in the evening. So the earlier twenty four hours facility for delivery is not available now. Private nursing homes fulfill this need for the locals. 'Ashas' - a heath representative under mother care scheme, also work in this area.

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REVIEW:

It is often reported that women in western countries have been struggling for several decades against what is now widely viewed as the unnecessary and excessive medicalisation of child birth. The move to a less interventionist model for childbirth has been a genuine gain for many women in the west (Martin, 1987:127, Oakley, 1977:127), though there is a real risk associated with the process of natural childbirth. Within the context of childbirth, there is an assumption that as births become increasingly bio medicalised, women will put faith exclusively in the powers of medicine to ensure the well-being of mother and child and come to rely less and less on religious faith and ritual (Hollen, 2003:131).

World Health Organisations (WHO, 1992) policy for some years has emphasised on working through traditional birth attendants (TBAs) as the best path to improve the level of maternal and child mortality and illness in much of the third world. Keeping these developments in mind, I explored the practices associated with delivery, that is, how and where it is conducted and whether the concept of hygiene is important to those who attend the childbirth. In this section I present the pattern related to deliveries which vary according to the religion or caste.

I found that the concept of natural childbirth adopted in the western world can not be appreciated here, as many of the births take place naturally but in such an unhygienic condition that it is better to have medical interventions.

Description of delivery conducted at hospital is narrated by one Hindu woman, which is a good representation of such cases. ***Archna***, upper caste Hindu woman, had four children. She described the development during third pregnancy. "In the last, tenth month of my pregnancy in the morning my water bag burst. I did not have much idea and used cotton to protect my clothes. It had not happened like this for earlier two deliveries. There was a little pain. I felt relieved as my abdomen felt lighter. It happened because the water came out. My mother- in-law was out of town so I did not tell about this to anyone. But after sunset the pain increased. By the time my husband had returned from his shop, I told him about this and he took me to the nursing home immediately. When we reached the hospital it was late night. The doctor said that the baby would be born after three –four hours. The doctor scolded me for being so late.

Methodology, Data Analysis, Results and Discussion:

Process of delivery and childbirth: I explored the questions like when and where the baby was born and who assisted with the delivery, the experiences while having a labour pain and during childbirth, whether pains were normal or induced, body position during childbirth, who cut the umbilical cord, the feeling after delivery etc. To begin with, I present selected cases having special incidents and then a general description is provided. The way in which childbirth is managed in the two religions and in different castes is distinctive, each having special features. Births taking place in hospitals follow common medical practices regarding the process of delivery though Muslims rarely go for this option. Variations are found among those cases where childbirth takes place at homes.

Table 1 : Maternal Health (Maternity Care)

	UCH	UCM	LCH	LCM
Mothers who had approximately 3 ante-natal care	**90%**	**85%**	**65%**	**20%**
Mothers who consumed IFA for 90 days when they were pregnant	**95%**	**70%**	**60%**	**20%**
Births attended by doctors/nurses/ other health workers	**95%**	**5%**	**30%**	**2%**
Mothers who received post-natal care from doctor/ nurses/ other health workers approximately within 20 days of delivery	**95%**	**2-3%**	**20%**	**1%**

Source**:** Interviews

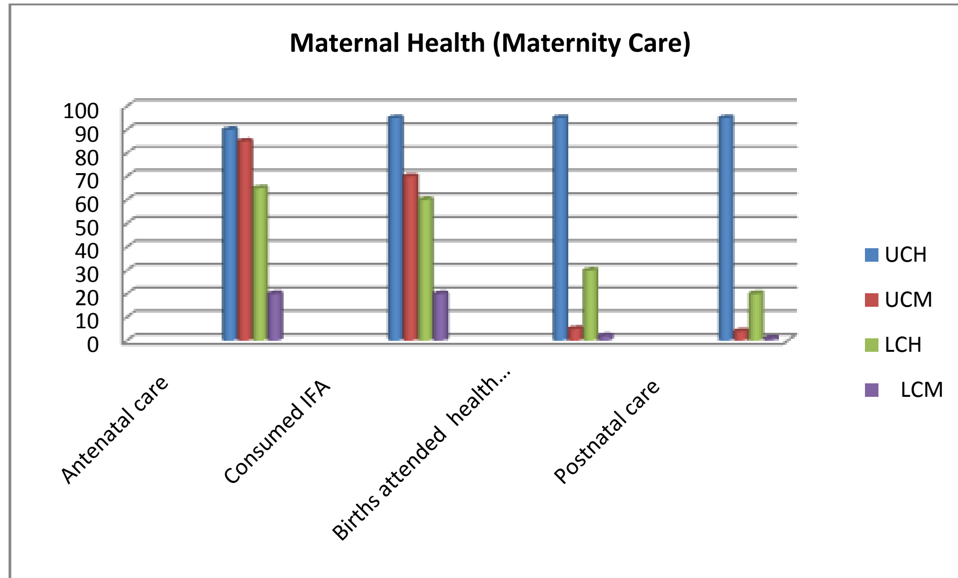
UCH Upper Caste Hindus

UCM Upper Caste Muslims

LCH Lower Caste Hindus

LCM Lower Caste Muslims

Chart 1: Maternal Health (Maternity Care)



Another woman told that due to severe and long labour pains, her breathing slowed down and she started having hiccups. All the family members became extremely concerned and worried. Her sister-in-law started crying and praying to *Allah* for safe delivery.

One woman told that she has a great faith in one *maulana* (Muslim priest). He gave her *taaviz* and asked to tie it on her thigh after the labour pain starts so that the 'normal' delivery takes place. She followed the advice and she did not have much problem during childbirth. Some women told that their female relatives brought *aab-e-zam zam* (holy water of Mecca) during pains and asked them to drink.

Pollution and fear of *bhoot* (ghost /evil spirits) are closely related concepts. The use of *pora pani* (sanctified water), as in the two examples given, earlier, serves to protect mother and child against *bhoot*, as does the *taaviz* tied around the baby's neck immediately after birth, as in the case of Zori's baby. Belief in evil spirits (also referred to as *bhoot-pret* or *jin*) is widespread and certain illness are consistently explained by referring to evil spirits (bad air) in Bangladesh (Aziz and Maloney, 1985:14-15, Blanchet, 1984:146-47, M. Islam, 1980:51-52, Mahtab, 1989:209-10; Maloney, et al. 1981:144, Rozario 1992:15). Women are more vulnerable to evil spirits than men. In particular, unmarried women, new brides, pregnant and postnatal women are said to be very vulnerable to the attack of *bhoot*. Hence they must try to avoid the *nazar* (evil or greedy eye) of the *bhoot* at all times. The times when the malevolent

spirits are most active are high noon, sunset and midnight. Thus post-natal women, who are most vulnerable, must refrain from going out of the delivery room or hut at those times. In fact they must remain confined in their delivery room except for coming out to relieve themselves or perhaps to have a bath. This confinement lasts for a set number of days, which varies according to religion, class and lineage as well as the structure of the family, that is, whether it is nuclear, joint or extended.

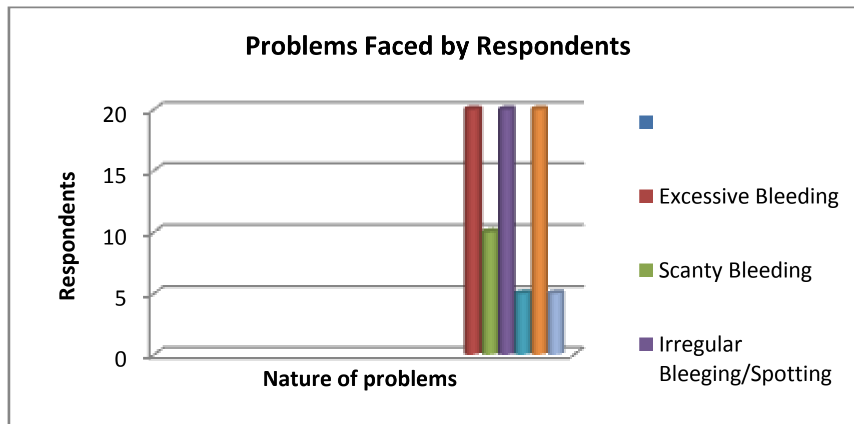
TABLE 2: Problems Faced by Contraceptive Users

(N=80)

Nature of Problems(multiple responses)	Number	Percentage
Excessive Bleeding	20	25
Scanty Bleeding	10	12.5
Irregular Bleeding/Spotting	20	25
Amenorrhea	5	6.25
Pain	20	25
Others	5	6.25
TOTAL	**80**	**100**

Source: Interviews

Chart 2: Problems Faced by Contraceptive Users



Violence and Maternal deaths: Maternal deaths are also found in RURAL area though I could not found any written records from the private hospitals, or from community health centre, and during survey no respondent freely told about maternal death. But I observed that in illiterate lower class families, there is no care of pregnant women. All the time they work and if they do any mistake they are beaten and abused by their in-laws and husband.

Apart from these functions, a *dai's* most important job is that of cleaning up of the filth. In the north Indian context, (Jeffery et al., 1989:39-40) argue that the *dai's* function is concerned with the removal of pollution: It is inappropriate to regard the *dai* as an expert midwife in the contemporary western sense. Even in the absence of medically trained personnel, the *dai* does not have entire control on the management of deliveries. Nor is she a

sisterly and supportive equal. Rather she is a low status menial necessary for removing defilement. They also note that the childbirth pollution is the most severe pollution of all, far greater than menstruation, sexual intercourse, defecations or death. Touching the amniotic sac, placenta and umbilical cord and delivering the baby, cutting the cord and cleaning up the blood are the most disgusting of tasks.

A closer examination of the variables used in the analysis suggests that some of them may play substantial role in the reproductive health and fertility variations. It may be that some of these factors are at the same time a cause as well as a consequence of health related problems. Women using health services during the ante and post-natal period are precisely the women who have reduced their fertility. This suggests that the supply of health services has impact on reproductive behaviour. Birth control is becoming common and a small family is good for the mother and the family.

References:

Barna, Alka. 2000. Reproductive Health Needs of Married Adolescent Girls in Rural Maharashtra. Paper presented at National Workshop on Reproductive Health Research, Tata Management Training Centre, Pune, Maharashtra.

Gupta, J. A. 1993. People Like You Never Agree to It: An Indian Family Planning ~ Reproductive Health Matters. Vol. 1: 39-43.

Gupta, S.D. 2003. Adolescent and Youth Reproductive Health in India. Status, Issues, Policies and Programmes. Policy Project. Indian Institute of Health Management Research, Jaipur.

Rani, Manju and Sekhar Bonu. 2003. Rural Indian Women's Care Seeking Behaviour and Choice of Provider for Gynaecological Symptoms. Studies in Family Planning. Vol. 34 (3); 173- 185.

Visaria, L. and P. Visaria. 1998. Reproductive Health m Policy and Practice, India. Washington, D.C.: Population Reference Bureau.

Visaria, P., L. Visaria and A. Jain. 1995. Contraceptive Use and Fertility in India: A Case Study of Gujarat. Sage Publications, New Delhi.