Chapter VII

HEALTH, HUMAN REPRODUCTION, PRODUCTION: THE SOCIAL ORGANISATION AND WOMEN'S EXPERIENCE OF CHILD BEARING
Women's workloads and patterns in the domains of social production as well as their caring activities of labour reproduction, in the household domain are intimately intertwined with childbearing. This chapter addresses issues arising in this complex interaction of the productive and reproductive tasks and their implications and consequences for the ill health or health of hill women. Garhwali culture, like patriarchal cultures elsewhere, epitomises child bearing as women's natural function. We begin the chapter with a brief examination of this socio-cultural context and the ways in which control of women's reproductive labour is organised. We then explore village women's experiences through the three broad reproductive stages: antenatal, natal and post-natal and women's perceptions of the child bearing process and the problems and difficulties that they encounter. Through women's own narratives we attempt an understanding of the linkages between women's work, nutrition and reproductive health. We also examine women's access to reproductive health services and how they manage their problems.

Essentially qualitative in nature, the chapter is based on in-depth interviews, group discussions, conversations with key informants and observations and illustrative case studies. As mentioned in the methodology chapter, care was taken to select women from migrant and non-migrant households of all caste-class groups. Both younger and older women were interviewed to capture generational change. The chapter has mainly drawn from the maternity and general health histories of forty-nine women in the field area. Out of this 26 women are from non-migrant households and 23 from migrant households. We try to incorporate a historical perspective in the analysis by comparing older and younger women's experiences to throw light on changing situation. The comparison of migrant and non-migrant household women highlights differences, their causes and directions of change. A special focus on Dom women provides an added dimension of variation.

SOCIO-HISTORIC CONTEXT OF CHILDBEARING

It would be useful to begin with a brief account of traditional socio-cultural beliefs and practices that have governed all institutions and practices that affect the lives of women such as the material context of environment and economy of the people, the value and belief systems regarding birth, death, illness and the existing systems that deal with
illness and disease. As described in Chapter III, these women's perceptions and experiences of child bearing, illness and care have been shaped essentially by this socio-historic context of gender inequality and patriarchal control.

Child bearing was and continues to be a family event that is characterised by patriarchal control exercised by adult members over women in the conjugal family. Control over sexuality was traditionally exercised through early and arranged marriage and the socialisation into a patrilocal family system. The child bride was trained into her multiple roles under strict surveillance usually of mother-in-law and if need be, by violent control exercised by her husband and in-laws. From a far happier childhood in her natal family where the large burden of work is compensated by relatively greater freedom and availability of food and usually a great deal of motherly and familial affection, marriage forced the child bride into a life of striking contrast in the conjugal home.

Married mostly by the age of eleven or twelve in traditional times, there is no concept of *gauna*¹ in Garhwali society. Girls were immediately transported to their marital homes into the custody of in-laws and husband. They could exercise little control over their own sexuality, and the expectation was that they bear children immediately after puberty. Propagation of progeny - especially a new generation of sons - was the most wanted thing, along with work from the new 'buari' (daughter-in-law). If she failed to conceive, or had no living children, she was subject to repudiation. The dominant patriarchal perception has been that the failure to conceive is woman's fault alone. Stigmatised as 'banjh' (barren), life for the infertile woman held the dreaded prospect of her husband marrying again. Thus, even a couple of "barren" years resulted in an anxious and frantic search for a 'cure'. Immediate remedial action took place in the form of a traditional ritual performed at a considerable cost to the women's natal kin.

Immediate continuous pregnancies have been the established order of reproduction. The pattern continues with few changes even to this day. The young women have had little say in the number of children they must bear. Indeed children are regarded as a natural outcome of marital life and women are expected to bear as many as possible. They thus

¹ "Gauna" refers to the ritual which marks the sending of the child bride after puberty to her husband’s home.
routinely undergo several conceptions, often in quick succession, throughout their childbearing years.

Labour and delivery typically thought to be the most 'natural' of women's roles, continue to present a great risk for the woman and her infant. Most deliveries in Bunga and Daurn proceed in a seemingly routine fashion, but hide tremendous risks and morbidities. Women are customarily expected to deliver in their conjugal home. Going to natal village for delivery in Garhwal is not prohibited, but is certainly uncommon. Majority of deliveries take place in the husband's village itself and are attended by sauras kin (conjugal family) of the pregnant women.

Traditionally, birthing in Bunga and Daurn was an occasion of spiritual danger and considered socio-culturally a very polluting occurrence, with heavy emphasis on taboos, confinement and vulnerability to spirits ('bhut'). These beliefs and practices continue to mark the birthing process even to this day. Pregnant and post-partum women are believed to be especially vulnerable. Pregnant women are advised not to go into the forest and deep ravines as they may expose themselves to attack from evil spirits. Confining the mother to the delivery room after birth for a set number of days is also rooted in the same belief. Birth pollution, taboos, confinements and fear of evil spirits are also closely related concepts.

The supernatural world is manifested in dosh (or affliction), and the natural world, in bimari (illness/disease). Dosh is frequently traced to the interference of the supernatural powers like deities, spirits and ghosts. It is believed to be caused due to man's disturbed relations with the supernatural forces, interpersonal jealousies. Women identified three types of afflictions or dosha: chhaya dosha (evil spirit), pitra dosha (ancestral curse) and isht dosha (affliction of the family deity). It is believed that affliction can lead to dangerous consequences for the individual and/or family (dosh lagna). Difficulty of any kind - sterility (especially absence of male progeny), stillbirth, hysteria, disease and illness, death - is attributed ultimately to fate and more immediately to supernatural forces.
Maternity services and clinics came in the post-independence period when PHC services were set up but as we shall see, were very inconvenient to access and inefficient. Both government and private medical facilities are available to the people of Bunga and Daurn at the town centre of Rishikesh or further at Dehradun. None of these are within easy and regular access to the women, as they require a trip by bus or jeep to the towns several kilometers away. Even the government Satellite Allopathic Dispensary (SAD) at Duili entails several hours of walk for women from both villages. Moreover traditional access to midwives ("dai") has been limited in this mountainous region. Since several decades, dais were too far between and too far away for their services to be accessed. It is only as recently as 1980 that a woman from Bunga village accessed a hospital for delivery. The gradual trickle of women into Rishikesh for birthing as well as gynaecological problems seem to have occurred as a result of the availability of a woman doctor in a Charitable Hospital. In general however, the trend of home deliveries continues despite the risks. Cultural beliefs about body fluids and processes, particularly those involved in menstruation and reproduction, affect the way women's problems are managed. Furthermore, spiritual danger and pollution associated with birthing makes it less amenable to change.

WOMEN'S PERCEPTION OF PREGNANCY AND HEALTH

Conceptions And Pregnancies: The Inevitable Burden

In keeping with the culture of total control exercised by the in-laws over the daughter-in-law, interviews with our first generation women (60 – 85 years) bear out adequately the cultural expectation out of the daughter-in-law to bear children immediately on reaching puberty. These women were married at a very young age ranging from 11 to 15 years. The average age at menarche for our interviewees works out to 15 years. They were sent to their marital homes soon upon marriage in the pre-puberty stage itself. Women got their first periods in their conjugal homes. The total lack of control over their own sexuality is reflected in the tremendous family pressure placed on them to bear children immediately upon puberty.
Some of the women had difficulties in conception, which led to ill treatment, verbal abuse and even beating. The immediate remedial reaction came from the natal family. They sought recourse to prevalent cultural remedies, so that their daughters would escape the tyranny of in-laws. ‘Dosh pujas’ like “Rukmani Chaya”, “Chal Chaya Puja”\(^2\) etc. were performed which were believed to be necessary to remove the “dosh” and help them conceive.

Most women however said that they conceived immediately after menarche, around the age of 15 or 16. Being young and immature, many times these women failed to discover they were pregnant till the physical symptoms such as nausea, giddiness etc. were felt. “Absence of menstruation” was often confused with the general condition of “irregular periods” which many women experienced. The conceptions however did not always carry full-term. Women miscarried or had still-births. There were also mothers who lost their first and later children in infancy. Death of an infant child also resulted in considerable ill-treatment of women. Conceptions normally followed in quick succession, and their number ranged from six to sixteen. Many times due to closely repeated pregnancies, they conceived during the period of lactational ammenorrhea.

From the age at marriage reported by our next generation of women (45-60 years), the average was slightly higher at 13.8 to 15.8 years, though there were still few cases of women marrying at 11-14 years of age. The average age at first delivery was 19 years. The data suggest a declining trend, but of course cannot be considered reflective of the actual trends in the region. However this group of women show only a slight fall in total number of conceptions, as compared to the earlier conceptions and they still ranged high from three to thirteen and the average number of children per woman works out to 6.7. The cases of miscarriage, abortions, still births, deaths in infancy per woman, also seem to have somewhat declined - from 1.6 per woman in the older age group to 1.1 in this age group.

There seems to have been little change however in familial pressure to conceive early. Chandramati and Munni, for example, were abused for not conceiving within a year or

\(^2\) Dosh puja refers to several types of religious ceremonies conducted in the girl’s natal home to calm or erase the effect of evil spirits which are the commonly attributed to cause infertility, death of infants etc.
two of marriage. Maheshwari’s husband remarried as she failed to conceive and the children born failed to survive beyond two months. Families continued to seek refuge in the performance of "dosh-pujas" and such other rituals for the favours of children. Even relatively better educated women like Shakuntala (8th class pass) requested her natal family to perform “dosh puja” after six anxious years of inability to conceive. Though her mother-in-law did not physically mistreat her, she had to bear much abuse and taunt.

Our second generation of women were witness to the first signs of medicalisation of reproduction / birth in the region. Munni, a Brahman woman became the first in Bunga to be treated for infertility in the Kotdwara government hospital. She was taken for treatment at the behest of her brother who provided all assistance and also bore the cost. Thus, the shift to modern medicine was underlined by continuity of patriarchal expectations.

The next viz. the third generation group of women were aged between 35-45 years. Their average age at marriage works out to 16 years and ranged from 14 to 16. The age at first conception was 20 years. The number of conceptions averaged 4.6 and ranged from 3 to 7. Only one case each of abortion and stillbirth was reported from this group. Four children also died in infancy. Within this generation, we also note the beginning of family planning operation among women with reproductive age group. Two women underwent tubectomy, but only after the birth of four live children.

The youngest group of women of our sample are those under 35 years. Only two women of this group, both Dom, married at 14 and 15 years respectively. The average age at marriage for this group is 19, indicating a steady overall trend towards later marriages in the villages. The pressure for immediate conception however, as yet persists. Almost all women conceived within two years of marriage, keeping the average age at first conception constant at 20.4 years. The total number of conceptions (average 4.4) also remained the same as that of their immediate seniors. Two women had six conceptions each. Cases of miscarriage, stillbirth and one infant mortality continued to occur. So did the performance of “pujas” and rituals for early conception and survival of the infants.
From this group, a few migrant wives reported condom use by husbands, but no method of family planning was regularly adopted by the women.

Despite the trend towards declining birth rate, there is a continuing occurrence of a large number of conceptions. The large number of conceptions is reflective of the strong desire to have sons. Sons are most valued as providers and as the best prospect of security during old age. Though women assert that they do not discriminate between boys and girls, the desire for male child persists for reasons of social approval and personal satisfaction. Several rituals are performed to assure the birth of sons. The preference for smaller family size did not flow out of women’s decision. Husbands were the main decision makers, at times in consultation with their wives about limiting family size or and spacing children. However, the control of in-laws, especially the mother-in-law seems to have considerably declined, leading to a sharp difference between the situations of the older and younger generation of women. From the perspective of eighty five year old Darshini -

> These days one cannot say much to the ‘buaris’ (daughters-in-law). They do as they think well. They may not want children immediately after marriage. The delay may worry the "sassu" (mother-in-law), but what can she say. They also say that one son is good enough - but is having just one eye sufficient! Sons are like eyes - at least two we must have. (Darshini, 85 yrs, Brahmin, Bunga)

There still prevails a general antipathy to family planning methods. It is believed that these operations will make men or women weak and may weaken men’s capacity to work. Women, it is believed, are already weak and operation will make them weaker.³

The Work Experience During Pregnancy

> I am seven months pregnant. My belly has become so big. But I still have to do everything on my own - housework, animal work and farm work. Our village does not have its own forest nor water source, hence now we have to walk for about five kilometers into the hills to collect fuel wood, fodder and water. The walk itself is tedious and tiring. Then I have to climb trees in this state to lop wood and collect fodder. Carrying water is also strenuous. I find it all very hard. Sometimes my stomach starts paining, my lower back hurts and I feel exhausted. The sun also

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³ Only two cases of vasectomy are reported, that too after birth of 7-8 children. Similarly there are only two cases of tubectomy.
makes me hot and giddy. It is not that anyone tells me to work, but I must do everything. If I won’t work, who else would do the work? Here no one in the village ever gets much respite from work unless she is bedridden. Till you become very sick, no one will or can give you respite as each one is over worked and all must do their own work. (Suman 21 yrs, Gusai-Dom, Goddi)

Suman was one of the three women who were pregnant at the time of data collection. Her case is an apt illustration of the fact that the human reproductive burden has to be borne along with burdens of production and domestic labour. Indeed the expectation is that women combine reproduction and production work even during pregnancy.

The condition of pregnancy is not seen as a time demanding rest and care and has never permitted women to relinquish work. Though there do exist a large number of culturally prescribed work-related precautions, however, they seem motivated not by woman’s well-being, but by the predominant concern to safeguard the foetus / unborn child. Traditional precautions advised women to avoid lifting heavy loads or do bending jobs for long duration. These are believed to cause entanglement of the foetus in navel cord or lead to prolonged labour. Grinding on the grind-stone or the "chakki" (stone flour mill) or bending upon the huge storage baskets ("kothar") to take out unpounded grain are not allowed in the advanced stages of pregnancy because it is believed that the child may die or turn over on the wrong side ("ulta par jatta"). Churning buttermilk ("chas cholna") is taboo, as it would harm the foetus. Equally, ‘too much rest’ is taboo. ‘Too much sleep’, a period of ‘long-rest’, of ‘lying-down unnecessarily’ are believed to cause difficult delivery. Post-delivery confinement lasting for eleven days is also considered as a period of rest.

Whatever may have been the practice of work taboos during older times, when fear and anxiety perhaps dominated worldviews about the reproductive process, they are now a thing of the past. Even the oldest women denied that these norms were ever truly or consistently practised. Indeed women had quite a disdainful tone when asked if their workload was reduced during pregnancy. They insisted that there was absolutely no change in the work quantum or hours. All kinds of work had to be done despite the aches and pains and other discomforting symptoms. Sisters-in-law and mothers-in-law ensured
that the pregnant *buari* did not get an iota of rest. They were quick to abuse and accuse her of laziness if she attempted to snatch some rest.

As the previous chapter showed, in earlier times majority of the peasant households had large plots to cultivate. They remained joint for longer periods of time in order to organise labour for the enormous amount of agricultural work involved. In those days pregnant women had a very hard time. Krapi gives us a vivid account of the typical situation that seemed to have prevailed at that time for the pregnant young daughter-in-law.

*I was the youngest in my in-laws house. I remember my three sisters-in-law were older and physically stronger. They would beat me up. They always objected to all my work. They were never content and in spite of my best efforts, they would be unhappy and beat me. I remember even when I was pregnant I did all the work. I used to get problems while walking uphill and downhill. If I rested for long, my mother in law abused me, and called me lazy. Even at that time she would not give me anything to eat. Once I had gone to my natal home for my sister's wedding. I was three months pregnant then. I remember when I returned from my natal place, I carried back a big bundle of "arasa" and "halwa" (sweetmeats) for my in-laws family. I knew once it reached their hand I would not even get a small piece to eat. Therefore on my way to the homestead I dug a hole in the forest and hid this food. Next day I went to the forest with another village sister. We dug it out and ate it!*

*I remember that in each of my pregnancies I worked the usual hours. I used to get up at 3.00 a.m. and then for one hour grind "atta" and mandua. I used to grind one-one "soupe" (winnowing scoop) of wheat in the "chakki" (stone mill). Then between 4-6 a.m. I would get 3-4 pitchers of water. Thereafter for two hours I would pound rice and jhangora. Then at 10 a.m. I would go to the forest to get grass, fodder and wood. I would not be able to return till 2 p.m. After lunch they would again send me to the forest to get grass. I could return only till 6-7 p.m.*

(Krapi, 69 yrs, Brahmin, Bunga)

Joint family living provided some possibilities of respite only of very heavy work during the last stages of pregnancy.

*In my last month of pregnancy, I was just not able to bend and carry heavy load. One day after I carried a big bundle of harvested wheat to the "khaliyan" (threshing ground), I developed severe pain in my belly. I just could not get up for a whole day. My mother-in-law who otherwise abused me, got worried that my baby may come down. She asked my sister-in-law to take over carrying bundles of wheat and fetching grass and fodder from the forest. Though I still use to go to*
the field to harvest and carry water, and clean the cowshed. Still at least I got some respite after that episode. (Sureka, 76 yrs, Brahmin, Birkatal)

Only in case of serious illness when women were completely bedridden, they did receive help with work:

I was to deliver my second child. I became ill with pneumonia in the seventh month. My stomach swelled up and I could not move around. Soon I could do no work. When I became bedridden, my husband took over the work of carrying water, chopping firewood and grazing the animals. His mother who was staying separately milked the cow, cleaned the cattle and cooked for us. (Chandramati, 56 yrs, Brahmin, Birkatal)

Despite having to carry a lone burden however, women themselves felt that they were better off living separately. As Sunita said:

If a woman is not living in a joint family, she may take time off from work when she pleases and does not have to be forced into work. Though usually she cannot avoid doing work, as there is often no one else in the family to help, especially if she is the mother of a number of small children. (Sunita, 39 yrs, Brahmin, Bunga)

Seasonal variation and household economic position influence the quantum and load of pregnant women's work which have a bearing on mother and child survival. Workload of women from large peasant families was accentuated in peak agricultural seasons. These are busy times and women in an advanced stage of pregnancy are caused great discomfort besides depleting her energies enormously. In the earlier chapter we drew attention to climatic extremes and the situation of working pregnant woman. Her plight in extreme cold or extreme heat and rains can well be imagined. In slack periods, women may not be required to work in the fields. However other activities continue as usual.

Women from less landed households and owning less livestock encounter shorter work hours. However, these families, mostly Doms are often the poorest and assetless. Their women however are compelled to work on others land and put in intense work on their own degraded lands. The less amount of land owned is hardly a panacea for the conditions of acute deprivation in which they live. The two case studies of Jasla and Saraswati given in the following section will show that they work like mules, with no food or care!
Clearly pregnancy brings no special advantage for the village women. Cultural precautions are not followed, as this would mean more work for the mother-in-law. The conditions give the pregnant women few options to control the nature and amount of works they perform. They may at the most adjust their activities, may sit down more where work permits, snatch some rest in between tasks or carry smaller head loads. Though work quantum may remain the same, women adjust the pace, posture or time to make it more bearable.

Women who have grown up daughters are generally relieved of heavy work such as carrying head loads of fodder, firewood or water. In certain difficult situations a sister-in-law or mother-in-law may also share the work, but these expectations depends greatly on the kind of relationships that exist.

Women who are wives of better-off migrants have good relations with their mothers-in-law have a relatively easier time. For instance Sudeshi who is married to a school teacher and has three children:

*I did not have any problem. I used to go for my check-ups to the ANM at Binak. If she was not available, I used to go to G.T. Government Hospital in Rishikesh. I got all my injections and took iron tablets. My mother-in-law also was supportive. I did not have to work like other women. We have a gas stove so I did not need to collect firewood. We have many fields, but the wage labourers only plough them. I normally do the weeding and other tasks. But in my pregnancy period, I did not pay much attention to the fields. We don’t want our fields to become barren. But it’s okay if the produce is not too much. I ate well too. I used to get vegetables and fruits from the lala’s shop in Binak. When I went to Rishikesh, I used to buy Horlicks. Whenever my cow was not giving milk, I would buy 250 ml of milk everyday to drink. Pregnancies were not a problem for me.* (Sudeshi, 30 yrs, Rajput, Birkatal)

Women's work continues till the onset of labour. Women narrated several instances of the advent of labour while working in the fields or in the forest. Maheshwari started labour pain in the fields. She came home to deliver, but before lying-in she cooked *khitchri* (dal and rice cooked together) and made tea for her mother-in-law. She even collected the haystack for her bedding and sharpened the *dharati* (sickle) to cut the cord. Many others had similar experiences.
The whole day I was winnowing the grains. In the evening, I had pain in my stomach. One woman in the neighborhood told me “don’t you know you should have not done this work”. After sometime my son was born. (Golli, 62 yrs, Brahmin, Bunga)

The day my youngest daughter was born, that whole day I was in pain. I did all the work. In the evening, I told my mother in law “I am having pain so please call the ‘byah’” (dai). Then I went and kept away all the things for delivery in the room. In the night I had my daughter. (Susheela, 52 yrs, Brahmin, Bunga)

I made food during my labour. I did so myself, though I is trembling all the while. I also finished the rest of the household chores. (Jasla, 75 yrs, Auji-Dom, Bunga)

It is also not unusual for births to take place in the field. Onset of labour pain hardly deters women from continuing their work. They have a lot to finish always and they carry on till they can. Some are not even permitted to stop work by their mothers-in-law.

Suman named her daughter Banmati as she was born in the forest (“Van”) when she had gone to cut grass. After the child was delivered, she cut the umbilical cord with the “dharati” (sickle), wrapped the infant in her shawl, and walked back to the village, a distance of more than three kilometers. (Suman, 37 yrs, Jagari-Dom, Birkatal)

Under such conditions, miscarriages and abortions regularly occur.

Kavlo, reported a five month miscarriage “perhaps on account of too much work or perhaps because I had to lift too much weight.” (Kavla, 40 yrs, Auji-Dom, Bunga)

Sundari, said that “I lost my five month foetus because I had climbed the tree to lop wood and fodder.” (Sundari, 70 yrs, Rajput, Daurn)

Jasla felt that she lost her three-month foetus because she had eaten goat’s liver and thereafter carried a huge bundle of firewood. (Jasla, 75 yrs, Auji-Dom, Bunga)

Reproductive data on miscarriages/ abortions of all ever-married women in the age group of under 35 years of the village are alarming. Out of the total of 49 women twelve have had miscarriages and nine have had stillbirths.

However today in a few better-off migrant households, pregnant women do not have the same quantum of workload as their mothers-in-law had when they were young. Talking of her 24-year-old daughter-in-law who was five months pregnant, Kamla Devi said:
Where our daughters-in-law work the way we were made to work! My son sends them money regularly. She does not even have to collect firewood because he has bought her a gas stove. She has a cow and a small field, she barely works hard. She even buys rice and wheat from the "dukaan" (shop). She is not even willing to pound rice. Pounding grains (kutna) is "good" in advance stage of pregnancy, as the downward action of paddy pounding enables the foetus to descend to the lower part. Too much rest is not good anyway for the pregnant women. She will have a difficult delivery. But where she will listen to me. (Kamla, 64 yrs, Rajput, Daurn)

However as shown in the earlier chapter, decline in agricultural cultivation and the trend towards family division have escalated demands and pressures of work. Setting up an independent hearth and home places an added load on women in nuclear households. When pregnant, women have to shoulder all female responsibilities alone right till they give birth. In nuclear settings, they are accorded greater flexibility, which acts as the only source of relief. But the magnitude of work can scarcely permit rest or relaxation.

Food, Nutrition Work And Pregnant Women's Health Link: Women’s Perceptions Of Links

Pregnancy and heavy workload demand higher food and nutritional requirements. However, the widely prevalent reality in a hostile family environment for pregnant young buaris (daughters-in-law) is that of being underfed, undernourished and/or malnourished. Diet regulations operate only in the form of restrictions and taboos and not the providing of special nutrient-rich food. The women themselves are acutely aware of their nutritional deprivation. They also see the link between their general poor health and poor food consumption. Conceptions of women’s bodies as tough, hardy and having incessant capacities for toil are not matched by cultural ideas that they require an adequate quantity of food to replenish their bodies and build energy levels. On the contrary, a gender discourse of diet operates, which neglects women’s nutrition and prescribes less food requirements for women. Women’s low cultural value has a bearing on even a basic necessity such as food. Their value does not change in the crucial years of pregnancy, childbirth and lactation. Nutritional deficiencies are thus a direct result of women’s subordinate location in unequal gender relations. Social practices of food taboo curtail intake of adequate food and nutrient-rich food. There is an overtly sympathetic complex
of ideas concerning taboos, pollution and confinement relevant to various stages of the birthing process. However in actuality, malnutrition is inbuilt in women’s lives. It is particularly harmful during the varied stages of childbirth when the hill peasant women’s famed multiple role performance is at its most complex and difficult!

Economic constraints is exacerbated by unequal distribution of food in the family. Even households, which were capable of providing adequate amounts of food to women, did not necessarily do so. There was gross deprivation in the olden times despite the surplus produce. All women stayed with in-laws. As soon as her pregnancy was noticed, the woman was placed under the surveillance of the mother-in-law who had the sole authority over family diet. She decided which and what quantities of food were to be cooked, who ate how much or what. She alone distributed the food. Thus many of our older women including those from relatively prosperous backgrounds have memories of food deprivation.

Ours was a rich peasant household. Our home was so big that it was known as “bungalow” in this region. We had plenty of fields and herds of cows and buffaloes. Despite that I spent my years in hunger. My mother-in-law did not even give me food to eat properly. Those days the mean mothers-in-law used to just give “paleau” (jhangora in buttermilk) to their daughters-in-law to eat. They seldom gave wheat flour roti or “daal”. It was only possible to eat wheat flour roti or rice at a marriage in the village. Many a times if there were no buttermilk, she did not even give me “paleau” to eat. Then she would simply give me mandua in water to drink. It is difficult to remain hungry - so I used to fill my stomach with that also. The situation during pregnancy was no different. Even in those periods I was never given sufficient food to eat by my mother-in-law. She did not care. She used to abuse me and said that I ate like an elephant when what she gave me was not even sufficient for an ant! Many women in our villages will tell you similar stories (Krapi, 69 yrs, Brahmin, Bunga).

A few who were not under the watchful eye or iron hand of the mother-in-law recollect being well-fed on home grown grain and dairy produce.

Every time I was pregnant I had enough to eat. We had enough grain from our fields. And there were always a few cows that were giving milk. Ghee was in the house as usual. Other special things I did not have. Maybe fruit and vegetables would have been good. But where can we get those things here. At least not in our times. If you had enough from your fields to fill your stomach, you were lucky. Then I did not have a mother-in-law to ration out food to me. I ate what I wanted
and however much I wanted. Of course I avoided prohibited food – it would harm my baby. (Darshini, 85yrs, Brahmin, Bunga)

On the whole, women from better off households, largely Brahmin and Rajput, were likely to get better intake of staple diet. If they had enough cattle, they drank milk when they could, but nothing else was available. Seasonal variation in food availability also influences diet.

Low caste women however generally did not get enough food to fill the stomach in their poverty-stricken households. As a rule they got nothing better than “mandua roti” to eat.

There was nothing to eat. Even during my pregnancy, I just ate whatever I got – mostly mandua ki roti. Often I felt hungry and thought it would be good if there were some celebration in the village. I may get some “dal-roti” to eat or even some mutton. But for me it was mostly jhangora, mandua, paleau and “lal chai” (tea without milk). My mother-in-law saved up pulses, wheat and rice for the visitors and as bride price for marrying my sisters-in-law. (Jasla, 75 yrs, Auji-Dom, Bunga)

During pregnancy and childbirth I did all the work like getting grass, wood and grazing animal in the forest. But despite all this labour, I was given very little to eat. Really speaking I don’t remember getting a stomach full of food. The least desirable and left over food was given to me. My in-laws did not give me anything special to eat during pregnancy either. I was not given milk, ghee or any such healthy things to eat at all. Truly speaking I was always hungry. My mother-in-law also never explained me as to what I should do or what I should eat and what I should not eat. Whatever I was given to eat or whatever work I was asked to do – orders had to be followed. No one cared about what you wanted or needed. Under these conditions I gave birth to so many children. Because of this I am weak. (Saraswati, 55 yrs, Lohar-Dom, Birkatal)

Food restrictions during pregnancy further aggravated the undernourishment. The foetus is considered to be ‘garam’ (hot) and hence pregnant women are not allowed to eat ‘hot’ things, which may accentuate heat and trigger off an abortion or harm the foetus. Foods like jaggery, green leafy vegetables, pumpkins, gourd, brinjal, urad dal, meat, eggs, fish are forbidden during pregnancy. Despite experiencing weakness and being aware of receiving less food, women themselves strongly subscribe to the prescribed diet restriction for fear of harming their unborn child. The beliefs continue to influence their actions even to this day. Food avoidance practices are even today voluntarily followed, even though earlier the mother-in-law enforced them.
Some women did not consider it important to change the type or quantity of food during pregnancy. They found difficulty in digesting much food under normal circumstances as well. Physical exhaustion seemed to cause a reduced appetite. Thus work burdens have another negative effect compounding the situation of inadequate dietary intake in pregnancy.

While male migration and nuclearisation increased women’s workload, the changing situation has been a mixed one with negative as well as positive aspects. One the whole however, the food scarcity did have a direct negative impact on women’s consumption.

Though agricultural decline resulted in declining food resources, the new familial condition accorded greater control to women of available food. Just as they were able to control and manipulate work, when women became de-facto heads of households, they had greater access to the grain store. The pregnant woman in such a household acquired the freedom to eat, as she desired, albeit in accordance with the household’s economic condition.

I set up a separate hearth when I was twenty-six years old. I was pregnant for the fourth time. I found that now I was in complete control of the food grain. I could eat dal and rice, something, which my mother-in-law never gave me to eat everyday. I could even drink milk as I had a cow which was giving milk. I had saved some ghee as well. On the whole it was much more peaceful. (Susheela, 52 yrs, Brahmin, Bunga)

However such positive aspects of nuclear households for women must not be overdrawn. Food security of women was deeply affected by the worsening situation. Fields did not produce enough to meet family requirements. The numbers of cows and buffaloes per households decreased, reducing the availability of milk for home consumption beyond what was required for tea. In households where extra quantities were available, women themselves felt that children or men must be given priority of access. Most women had several children and thus barely got enough food or milk whether pregnant or not!

My in-laws were dead by the time I was pregnant for the third time. So we were living alone. Farming was average and I had many mouths to feed. Whatever food I had I shared it with my children. If there was some milk they would ask for it. How could I drink it then? I gave away even the small amount of milk or ghee in the household to the children. (Ghunti, 56 yrs, Rajput, Daurn)
Control over food did not necessarily ease an unfavourable labour condition marked by lack of help. For instance take the case of Rakhi from Daurn, whose husband worked in an Ambala hotel. At the time of fieldwork she was six months pregnant and lived with her two daughters aged four and three:

*How can I get complete rest? My children and animals will die of hunger. There is no one to take over from me. I had separated from my mother-in-law in my last pregnancy. Of course it meant that I had to do everything on my own now. But separating from her certainly gave me control over the granary. I can eat what I want and when I want. I also do work according to my will. I do not regret my move. If there is someone to do pregnant woman’s heavy work – any woman will stop. But that is never possible in the village.* (Rakhi 39 yrs, Rajput, Daurn)

In today’s times social vulnerability rooted in unequal gender relations combines with economic vulnerability to determine what a pregnant woman gets to eat. Our field observations reinforced the fact that on the whole few pregnant women ate any differently from what they ate when not pregnant. The general pattern of women’s food consumption revealed that most women generally had three meals a day. In the morning they usually had a cup of tea with left over chappatis. Lunch consisted of dal and rice, and dinner of mandua or wheat rotis with dal or some homegrown vegetable, if any available. Women usually ate last after their husbands, children and parents-in-law had been fed. They were often seen sitting alone eating directly from the cooking vessel itself. Poor women often ate a little rice with green chillies and a very watery dal. Some even ate rice only with green chillies and salt. One old woman Kamla, (pointing out to her food), chuckled:

*Eating even this much my stomach swells up – it is more than enough for me – where is the question of becoming weak then. And if there is sufficient dal for the men and children that itself is enough.* (Kamla, 68 yrs, Rajput, Daurn)

Kamala’s sunken eyes, with her stomach sticking to her back and her bony hands with visible veins, told the story of her health.

In general, the huge imbalance between work and food is apparent for most women irrespective of caste and class. However most Doms as described in previous chapters continue to live in conditions of acute deprivation and poverty. Only some Brahmin, Rajput and few Dom households with better-off migrants may be in a position to provide
adequate food to women and a better overall quality of life. Apart from provisions and other things brought by migrants, these families are able to avail additional supplies from markets at Binak and Duili.

**Perceived Health Problems During Pregnancy And Access to Antenatal Care**

Over and above the work that they do, pregnant women experience a wide variety of unpleasant symptoms and health problems that aggravate physical discomfort. Symptoms of *garmi* (heat) including nausea and vomiting, repulsion to odours/itching in the genitals, burning while urinating, burning chest are all common complaints. Women also experience loss of appetite, lack of blood in the body (*khoon ki kami*), intermittent bleeding, and white discharge through most of the pregnancy period. Few also stated fainting and experiencing blackouts. Swollen legs and ankles, back pain, pain in the stomach, general weakness are other reported problems. Additionally many pregnant women suffer from *rathundo*, a form of night blindness and *chhaya*, a facial skin allergy. General illnesses like fever, pneumonia and dysentery also afflict them.

Nausea, vomiting, and repulsion to odours usually disappear after three months of pregnancy. Other conditions persist throughout. Explanations are sought in belief systems and local ideas about evil spirits and food and work taboos. Women believe for instance that *rathundo* or night blindness is an outcome of diet restrictions, which forbid them to eat the "desired" foods. When the prohibitions are removed after the delivery, the problem gets slowly corrected on its own.

When I was pregnant with my son, my eyesight became poor. I used to get giddiness and I became weak and used to feel very cold. After he was born, my eyesight became all right and eyes also stopped paining (Shanti, 40 yrs, Gusai-Dom, Goddi).

Limping / “legs giving way” in pregnancy (*pav lachkana*) is a state attributed to the “wrong movement of the foetus” caused due to lifting very heavy loads. Symptoms are accentuated while doing agricultural work or collecting fuel and fodder. As Munni explained:
“Pav lachakna” happens more to women who have to carry heavy loads. If heavy load is lifted off the ground without help, there are more chances of affliction with pain, because the stomach gets compressed due to bending and the foetus gets affected (Munni, 59 yrs, Brahmin, Bunga).

Similarly chhaya which takes the form of black marks on the face is believed to be a condition brought upon pregnant women by “chaya dosh”. Only appeasement of this evil spirit with a specific ritual can cure it!

Yet significantly, women felt that many pregnancy related problems were rooted in their general poor health, weakness (kamzoori) and/or anaemia (khoon ki kami). Weakness is experienced as constant state throughout pregnancy and readily attributed to many conceptions, over work and poor diet. As the case of Guddi aptly illustrates:

Guddi is a frail, anemic looking 32-year-old Dom woman. Theirs is one of the poorest families in Bunga. Rais, her husband owns just one nalli of land. He works as a wage labourer doing any kind of work, which will fetch some money. During ploughing season, he ploughs other fields. Guddi got married at the age of 19, and subsequently for five years, each year she delivered a child. Guddi has no major health problem but she is very weak and suffers from severe pain in her back and joints. She is aware that her poor health is a result of five conceptions in quick succession, poor food to eat and life full of drudgery. “My life is full of drudgery – even after working hard there is always too little. Each childbirth was followed with pneumonia and weakness began to creep in my body. Ours is a very poor household. We did not even have money to buy a cow. If we had a cow, I could drink milk and regain some strength. Now my body is so weak.” Guddi feels that the excessive workload and poor diet that she had to live with thorough her pregnancies caused her poor health. “Now my body is perhaps worn out. As a result of life of hardships I am weak and sick all the time– as if I have no strength. I am now not able to even do household work properly.” (Guddi, 32 yrs, Auji-Dom, Bunga)

Pregnant women regard most health problems pregnancy as “little” problems (thori-thori pareshani). Being perceived as “small”, by family members and the woman herself, the symptoms are unlikely to entitle her to either rest or medical care. Many of the problems are attempted to be countered by the observance of dietary restrictions and other taboos. A balance between “hot-cold” foods is maintained to prevent adversity. Rituals prevent attacks by evil spirits. Moreover many of the problems are believed to be self-limiting and usually self-correcting after women have given birth. They thus must simply be endured. Medical treatment in pregnancy is generally considered unnecessary.
Pregnant women rarely consult the PHC (Primary Health Centre), dispensary, hospital or private clinic. Visit to vaids or dais for consultations are seldom made. In any case such decisions do not rest with the woman herself. Financial constraints inhibit the seeking of medical care. Most cannot afford to go to doctor, or need to borrow money. Medical check-ups or follow-ups by an ANM (Auxiliary nurse midwife) are almost absent as health practices. Manori is eight months pregnant. She says:

"ANM never visits us in the village. She has not done any check-up nor has she explained me anything. Even to get the children immunised we have to go to them. I myself visited her a couple of times. But on most occasions she was not at the centre. But I persisted and hence took two injections and she gave me some medicine for 3 months. But she has not done any examination. What examination? They don’t even touch us. How will they examine us?" Manori hopes she will not have any problem in her delivery. “If there is any big problem, then hopefully my family will take me to Rishikesh. Here there are no arrangements. Otherwise I will just die”. (Manori, 21 yrs, Guri-Dom, Goddi)

For cases of feotal distress ("bachcha khisakna") and abdominal pain women may seek advice of the dai in Mohanchatty. Dais of this region never conduct any internal examination. They claim to be adept at identifying foetal parts through physical touch. They also claim to have the skills of manipulating the position of the foetus by massaging. This is stated to relieve the pain and distress of the pregnant woman. If such indigenous methods fail to relieve the woman’s suffering, family members may avail of the allopathic medical services. In such cases, a doctor, vaid, RMP (Rural medical practitioner) or chemist dispenses the medicines.

For illness not directly connected with pregnancy, such as fever and cough, local healers are sometimes consulted or women are treated with medication from doctor, chemists, RMP or self-declared doctors. Treatment is often abandoned if the woman does not recover fast.

Kavlo developed high fever in her sixth month of pregnancy. It became so bad that it led to pneumonia. Soon she became bed-ridden. Her husband, an auji-drummer-tailor in the village first went to the "bakki" (local healer) in Ghaikhal who told him to sacrifice a cock. That would calm her "grahas" (stars) and she would become all right. But nothing of this sort happened. So Amir Chand went to the RMP in Dulli and bought some medicine. But Kavlo's condition only worsened. Another RMP and vaid from Mohanchatty was consulted. But
medicines were not helping. What else could they do? Kavlo delivered prematurely a month earlier. The child died in 3-4 days. Kavlo remained in bed for another 2-3 months while she took all kinds of treatment. Somehow she got on her feet. (Kavlo, 40 yrs, Auji-Dom, Bunga)

As stated earlier the public health services are located at considerable distance from the two villages. The sub-centre at Binak is the closest for the two village women, but it is seldom opened. The ANM stays at village Umra that is 13 kilometers away from Binak. The SAD (State Allopathic Dispensary) at Duili is located about 12 kilometers from two villages. It can take upto four hours to reach Duili. The PHC at the Block head quarter Yamkeshwar is much further (28 kilometers) and more poorly connected. Direct bus services to Yamkeshwar are unavailable. A four-hour bus drive has to be first taken upto Amola village after which a private jeep has to be hired to carry the patients to Yamkeshwar. The long travel may turn fruitless if the PHC medical officer is not available or neglects to conduct a proper examination of the patient. The PHC in any case has no gynaecologist or obstetrician. There are never sufficient drugs and / or facilities for pathological tests etc. Hence patients usually have to access these services at Kotdwara or Rishikesh. The gravity of the situation can be judged by the fact that in our study villages, not a single person had ever availed PHC services at Yamkeshwar. With such a poor outreach, people are almost denied modern health care. Only as recently as 2001, a private medical college (viz. Himalayan Institute Hospital Trust, Jolly Grant, Dehradun) has started providing services through bi-monthly heath team visits to a few Health Centres opened in the Block. One such Health Centre was recently opened at Magatha village as well. However, these are basically in the nature of family planning services, and the primary responsibility lay exclusively with the outreach staff.

Women on their part also have very little awareness about the ANM and her responsibilities. They have little understanding of dangers in childbearing being often caused by the negligence and the need to take tetanus toxoid vaccinations. Even in recent years only three women in the age group of upto 25 years reported visiting the SAD in Duili for antenatal check-up during their pregnancy period. Mamta, 31 years old, is Class 10 pass and is married to a schoolteacher. She has had 3 deliveries upto now.
Throughout my pregnancies I used to go for all the checkups and also took the injections. If ANM in Binak was not present, I went to the Dispensary in Diuli. I know that ANM does not come for house visits, but these check-ups are important, so I went there on my own. (Mamta, 31 yrs, Rajput, Birkatal)

Very few women went for prenatal check-ups too. Those who have taken the injections have visited the SAD at Diuli or the sub-centre at Binak to get them; though relatively more women report getting their children immunised. This owes partly to the view that pregnancy and childbirth are “god-made” natural phenomena, which does not require any outside intervention. However non-utilisation of prevalent services is also a question of the quality of service in rural Garhwal. In general, the services are unsatisfactory. Since the sub-centre at Binak is mostly shut and the ANM is rarely present, there is no possibility of antenatal or high-risk mothers check-up and least of all attended deliveries. Women are generally sceptical about the benefits of government services. If the situation demands, they prefer to consult private practitioners in Rishikesh. But visits to Rishikesh depend on money, time and willingness of women’s family members to organise them. Multiple social and structural constraints foreclose the possibilities of health care of pregnant women.

WOMEN IN LABOUR: DANGERS AND DISTRESS

Beliefs of spiritual danger, pollution and vulnerability to spirits continue to determine practices around the birthing process even today. Since birthing is considered a “common” knowledge, it is felt that everybody is able to manage a delivery. Women may resort to services of public and private health personnel for various ailments, but in matters of childbirth they at most consult kinswomen and other knowledgeable senior women in the village who are experienced in delivering children. Even if a few women attend “check-up” during pregnancy, very few will be present for birth itself in institutionalised set-up.

Pregnant women usually inform mothers-in-law or other kinswomen of the onset of labour. Thereafter they enter the delivery room and they prepare for the delivery. Older women of the family or neighbourhood are traditionally charged with the management of labour and delivery. At times it is carried out by the labouring woman herself.
Knowledge about the labour process is passed on from one generation of women to the next and women learn through self-experience. No outside help is generally asked for and the attending kinswomen usually provide emotional and physical support to the woman in labour. The inexperienced are usually assisted in the descent and delivery of the babies, especially for initial deliveries.

In the olden days, women gave birth in the cattle shed on the mud floor. This practice is now nearly extinct. They may have relinquished the cowshed, but labouring women are still allotted the worst room in terms of hygiene and ventilation. It is separated from the main residential area since birthing is a polluted process. To ward off evil spirits, an old knife or sickle is placed under the pillow of the woman. Darshini, now 85, throws light on a typical birthing scenario:

*Our deliveries take place in our homes. In my time we delivered in the cattle shed away from the house. Today things are better. Usually the room on the ground floor behind the kitchen where we store firewood and have bath is used for deliveries. A bed of dry straw is provided for the woman to lie on, as the ground is damp. It is an uncomfortable place as the room is damp, dark and often filled with smoke from the kitchen. But the labouring daughter-in-law (suili) cannot deliver elsewhere as she is very polluting.*

*Older women of the village perform the delivery, especially if it's the first time. We rarely call a dai — for many kilometers you will not find a single dai. We make the woman in labour sit and apply force by pressing both hands on the ground that is laid with "paraal" (haystack). As a result of the pressure, the child comes out on the floor. The delivering woman cuts the umbilical cord with "dharati" (sickle) herself. After that a warm water bath is given to the newborn and the mother. (Darshini, 85 yrs, Brahmin, Bunga)*

Virtually all women experience such a delivery even to this day. There is no momentousness of the occasion unless it is the daughter-in-law’s first delivery. Village women and neighbours take turns to look in upon the labouring woman and lend psychological support and encouragement. Help is necessary to heat water and milk, make tea and massage the woman when she is in pain. The numbers of non-family women present at birth is usually a function of the number of children the woman has delivered. The more births a woman has had, fewer members are present.
By the time a women reaches her fourth or fifth delivery she is experienced enough to conduct it herself. If she anticipates any difficulty, she may call upon a kinswoman for assistance.

I returned home after harvesting jhangora. The pain had started. I went and gave my cows their feed. Then I heated some water, pulled out an old saree, I sharpened the sickle and prepared a bed for myself in the delivery room. I lay in pain for five hours. By that time my labour pain became intense. It was so much that my clothes became completely wet. I had begun cooking food for my children, but I just couldn’t continue. I went into the delivery room and lay on the floor. Soon I was wild with discomfort. I was very much uncomfortable. I had never experienced so much discomfort and pain in my earlier deliveries. So I called out to my elder daughter and I sent her off to my aunt who lived 6 – 7 houses away. My aunt came with two more women. She gave me some warm tea to have and massaged my stomach gently with some oil. Then they helped me to squat on two bricks and encouraged me to push. With their assistance I finally delivered my baby in the wee hours of the morning. (Munni, 59 yrs, Brahmin, Bunga)

After the baby is delivered, the birthing woman herself cuts the umbilical cord, as it is perceived to be a polluting thing. In fact the body of the birthing woman, the baby, the placenta and umbilicus are all regarded as defiled and defiling. Disposal of the placenta, washing of soiled clothes and re-plastering of the mud floor are the work of the delivering woman. It leads to immense weakness and vulnerability to fever. Munni described the physical stress or discomfort of the lone new mother:

After I gained some consciousness, my aunt gave me some warm water for my bath. I bathed the baby and myself. It was the month of January – it was very, very cold. I had to re-plaster the room with cow-dung and had to wash my clothes. I was feeling very weak and tired. Doing all this I shivered, but I had to do it. Next day I was down with pneumonia. The fever was very high. I was shivering and sweating at the same time. I became very sick. After three weeks when I became worse, my mother-in-law thought I would die. Then she sent my husband to Musrali to call a vaid. After taking treatment for almost one month, I was able to recover. (Munni, 59 yrs, Brahmin, Bunga)

Only when some complication arises extra attention is paid. Complicated cases of prolonged or obstructed labour warrant the summoning of the dai. Older women like Shakuntala Devi remember two dais in the vicinity:

Dais were called “byah” in our villages. Until four decades back a dai lived in Nail village which is 5 kms from Bunga. She served the villagers until she died.
There was another Dom Dai in the scheduled caste village Ghiyalgoan located 3 kilometre from Bunga. This woman did not like being called a dai, but attended a few births and would agree to deliver under duress if the dai from Nail could not be found. The dai helped the labouring woman to deliver and cut the umbilical cord. She bathed the mother and child and washed the soiled clothes. For this she was paid a sum of Rs.40 and presented with a saree. (Shakuntala, 66 yrs, Brahmin, Bunga)

Ever since the death of these two dais, Bunga and Daurn have not had any. At present the nearest available dai for residents is a Dom woman living near Mohanchatty, a village at a distance of 10-12 kms making it very inconvenient. She is called for emergencies, especially in cases of extended labour.

Mohanchatty is far. If we have to call her we have to rely on the men to go and fetch her. Moreover we must be ready to pay Rs.300-400. It is easier to put the pregnant women on a “charpoi”(string cot) and carry her to Rishikesh (Shakuntala, 66 yrs, Brahmin, Bunga)

Alternatively an effort to call an ANM is made. However as one woman grumbled:

ANMs are also seldom present, since they are located far away and when you need them most they cannot be contacted. Even if you are able to contact them, you have to plead them, beg them to come, besides pay them for their services. (Guddi, 39 yrs, Auji-Dom, Bunga)

As mentioned earlier the ANM for these villages stays in a far way village Umra (13 kilometers away). Women don’t usually bother to call her since she is known to charge a hefty fee of a few thousand rupees. The only reported consultation was at the time of Mamta’s second delivery.

The labour had extended for more than 18 hours and my husband sent for the ANM. Though she took four hours to come, she assisted me in a difficult delivery and saved the child and my life. For her services she charged Rs. 3000/-. My husband could afford her fees because he is a schoolteacher in Pokharkhal. (Mamta, 31 yrs, Rajput, Birkatal)

Village women are not perturbed by the absence of dais. As the following case studies reveal their expertise seems seriously deficient. Usually they were called for cases of prolonged labour which made families anxious. Prolonged labour is a commonly stated obstetrical problem, especially in the older days when the birthing woman was very young. Women recalled that in most case labour extended from to 8-10 hours to 16-17
hours. Most commonly labour is stated to be at least for four hours. Women in labour would generally just lie-in, getting up occasionally to squat and push. Sometimes they drink the prescribed hot food to advance labour spasms and aid delivery. Seldom was any outside help sought.

Radha a migrant's wife had extended labour for more than 12 hours. The dai from Mohanchatty was called. She came and massaged her stomach. The pain continued for another day but she did not deliver. The dai just packed up and went away. Radha panicked but the elder women comforted her. Next day she delivered with their help. (Radha, 36 yrs, Rajput, Daurn)

Several young women had similar story to tell:

Pinky, a 23-year-old Rajput woman was married to Gabbar Singh who worked in a factory in Shahadra, Delhi. He left his pregnant wife with his parents for the birthing of their first child. In the 7th month of pregnancy she had a severe pain in her stomach. She went to the dai in Mohanchatty who examined her. The dai explained that the foetus had moved and hence the cause of her pain. So at the time of her delivery, the same dai was called. For two days the dai was confident of being able to deliver the baby, but when it was the third day, the labour pain increased and the baby did not come out. Then the dai left, leaving the labouring woman in a state of fright. However her mother in law and other women calmed her down. With their help she delivered the next day. Pinky feels that if her husband had taken her to Delhi, she would not have suffered so much. She would have delivered with ease in the hospital. (Pinky, 23 yrs, Rajput, Birkatal)

Rekha a Rajput women from Birkatal had her first conception at the age of 19. In the 9th month she began severe labour pains, which went on for four days. On the fifth day, the dai from Mohanchatty was called. She vigorously massaged her stomach. Rekha delivered a dead girl, after that she fell very ill. Her left leg became numb and she could neither walk properly nor put any weight on this leg. At that time Rekha's husband was posted in Assam. She went away with him and got herself treated in the Military Hospital. (Rekha, 38 yrs, Rajput, Birkatal)

In Rakhi's case, too the labour lasted long and the same dai was called who repeated the vigorous stomach massage. Nothing happened but Rakhi continued to be in immense pain. The family then decided to put her on a "charpoi" (string cot) and carry her to Rishikesh. She later delivered in the hospital, but the baby died. (Rakhi, 35 yrs, Brahmin, Bunga)

All four cases are examples of the dai's helplessness and ineffectivity in difficult labour and lack of support from the PHC. When faced with potentially high-risk circumstances,
it is clear that labouring women do not receive proper care. Apart from the physical pain and danger, they are under great mental and emotional distress about their infant’s death.

As we have mentioned, modern health care services are not locally available. Thus the critical decision in an emergency is whether or not to call a dai/ ANM or carry the woman to a hospital in Rishikesh. Economic factors are crucial to this decision making. Costs have to be counted in terms of money and time and weighed in terms of perceived benefit to the “buari” and baby. The decision is generally not the prerogative of the woman concerned. The sole authority in these matters lies with the mother-in-law or senior most in-law or the woman’s husband, if he is a non-migrant or is present at that time. The mother-in-law decides hospital treatment is necessary or whether the case can be handled at home without much expense and trouble through known indigenous methods. Besides the costs involved and distance, the need for an escort to take the woman to the hospital can serve as a deterrent factor. Equally importantly, someone is needed back home to take care of the woman’s other smaller children as well as her work responsibilities. Not surprisingly therefore, women are taken to hospital only when the case is perceived by attending relatives as life threatening. Most women undergo home deliveries even when their actual condition is serious and may result in maternal or infant death. Health care seems thus also a matter of family dynamics.

In the course of our conversations with women, recurrent references were made to four cases of maternal mortality and infant mortality that seems to exist in women’s collective memory and affected them greatly at the subconscious level.

Kamla: her entire body had become swollen. She was taken to the doctor at Mohanchatty who administered some injection to induce pain. But after three hours, when nothing happened, he asked them to go ahead to a “bigger hospital” in Rishikesh. Kamla died on the way.

Sunanda: her baby died in the womb when she was full-term. Later Sunanda also died. It was during monsoons. Landslides had blocked the road to Rishikesh and hence she could not be taken.

Lata: She lost three babies. Towards her fourth pregnancy, she again had convulsions. The doctor in the hospital administered her some injections. She gave birth the next day, but this baby too died a few hours later.
Rukamani: She had a difficult delivery. There was excessive bleeding. She died a day later.

Maternal death is much rarer as compared to infant death. There were few reported deaths of women during pregnancy and/or shortly after delivery. Though for majority of the women most deliveries were without complications, we found on probing that women had experienced problems, which could have become serious. In labour as well as delivery, women had felt breathless or as if something was constricting their breathing. Few found difficulty in squatting as their legs and feet had greatly swollen.

Eight month pregnant Manori (aged 21 years) exhibits the general health seeking behaviour of pregnant women in the village:

I had nausea for four to five months and could not eat anything. I got swelling and found it hard to work. Therefore I went to Binak to the ANM. Only on my third trip there I found her. I took red tablets and some tonics from her. She did not do any check-ups, but just gave these medicines. I will not go to the hospital for birth. I will deliver at home. If there is some complication, I hope my relatives will take me to Rishikesh. Else I may just die. It's all in God's hand (Manori, 21 yrs, Gusai- Dom, Goddi).

Relatively speaking, the younger generation of women attempt to visit the sub-centres or clinics to avail themselves of packets of pills or bottles of tonics; they sometimes visit private or government practitioners for medicines, injections and for ailments that disrupt their daily work. But the same cannot be said about birth. Even today, the majority still have births at home attended by senior women. Hospitalisation is therefore almost always an emergency resort.

POST PARTUM PERIOD: CONTINUING DEPRIVATION AND ILL-HEALTH

In the post-partum period the miseries of birthing women continue unabated. Having overcome the risks of child-births, they now encounter the dangers of post-partum illnesses. Health problems emerge soon after delivery causing a lot of physical pain and distress. More tragically, they can also cause death. Given the conditions during pregnancy and childbirth, almost all kinds of reproductive health problems manifest themselves. Uterine, pelvic and stomach pains occur, which sometimes last upto a month.
after delivery. Women neither seek nor get any treatment for this. The standard remedy is to eat “soft food” such as “khichdi”.

Most women fall ill with high fever, dizziness, shivering, and “pneumonia” (the word was used by women themselves) immediately after the delivery. Fever is often accompanied with diarrhoea making the condition worse. Given the unclean birthing environment and methods, infections are bound to occur. Older women however attribute these illnesses to attack of evil spirits:

_I had the delivery without any trouble, but the next day I developed fever. I was shivering with fever and also got severe diarrhoea. This continued for three days. My “mausi” (aunt) in the village told me that this was due to cold, which had got lodged in my tubes. When this happens evil spirits attacks the body and cause high fever of this kind. (Golli, 62 yrs, Brahmin, Bunga)_

_Sutkia rog_ is another kind of fever that afflicts parturient women and is regarded as fatal. The woman’s body swells up and she gets very high fever. Women identified _thand_ (cold) as the main cause of this ailment since most women who deliver in the cold season contract it. Kavita who suffered with _sutkia rog_ feels it was only by a stroke of luck that she survived!

_When I was delivering my fifth child I became very sick. I had labour pains for 3 days and my mother-in-law delivered the child with great difficulty. After a few hours my stomach swelled up and I got high fever. When I became unconscious, I was carried to Rishikesh and admitted in G. T. Hospital. When I reached the hospital the attending doctors told my husband that I was as good as dead. Any case they started my treatment. I remained bedridden for 3 months. (Kavita, 38 yrs. Rajput, Birkatal)_

_Ginthia_ is another condition that afflicts women in the postnatal period. _Ginthia_ causes severe pain in the legs accompanied by a painful pulling sensation in the calf. Women attribute this pain to “shrinking of veins” due to weakness, excessive cold condition and the occurrence of several poorly spaced pregnancies. Massaging the leg with cow’s “ghee” is supposed to ease the pain.

_My first-born was a son who died within few hours of birth. The next was still-born. When my third son died during birth, my mother in law got so angry with me that she said, “Let her die too”. She did not even heat some water for my bath. It was the month of January and it was freezing. I had to bathe and wash_
in cold water. I was attacked by “ginthia rog”. I just could not straighten my left leg. There was shooting pain and I got fever. A woman in the village saw my condition and felt sorry. She quietly gave me some cow’s ghee which I use to hide and massage my leg. It took very long to get cured. Even today my left leg pains more than the right though both are now affected by “bai” (local term for arthritic type joint pain). I have never gone to a hospital for treatment. Medicines can’t cure ginthia (Kraji, 69 yrs, Brahmin, Bunga)

Excessive bleeding and foul smelling discharges are other common experiences. Bleeding for two or three days is considered “normal”. It is positively viewed as “cleansing of the womb”, and “discharge of unwanted, dirty, accumulated blood”. Most women however experience severe bleeding for ten days or more, but nothing is thought of it.

Women also seem to suffer from a host of uterine infections that result in long-term bleeding or white discharge. The symptoms are described as safed or laal paani parna (red or white discharge) or khoon parna (bleeding). Women believe that this is a result of weakness caused by numerous pregnancies - their bones melt and get discharged. They also believe that if they eat hot food the condition worsens. Discharge increases and results in extreme weakness.

After my son’s birth I felt shortage of blood in my body (khaun ki bahooth kami). There was excessive white discharge. My bones were melting away and coming out of the body. Losing blood made me very weak. I became vulnerable to fever and body ache. (Shanti, 40 yrs, Gusai-dam, Goddi)

During the lactation period, septic boil on the breast accompanied by fever is another painful ailment that women commonly suffer. Most women treat it themselves by making an incision with a blade and extracting the pus from the boil. Religious healing is also commonly sought for this particular ailment. Seeking treatment from a doctor is not even a remote thought.

When my eldest son was born I had a boil on my breast. This infection was there because our god Nagraj got angry. On advice of the “bakki” I offered prayers to him. The boil got all right without any medicines. I didn’t think it was necessary to go doctor. (Kamla 48 yrs, Brahmin, Bunga)

Shakuntala’s right breast got infected with a big boil. She first did some devta poojan but the boil did not heal. Soon it became septic and started to throb. She
then asked the “village doctor” to attend to it. He gave it an incision, removed the pus and put some local medicine - saatti (paddy) was burnt and applied on the boil. With three weeks of bandaging, it slowly healed. (Shakuntala, 50 yrs, Brahmin, Bunga)

Besides these problems, women in Bunga and Daurn suffer from several gynaecological problems/conditions which are all probably indicative of a combination of other unknown obstetric problems caused by the generally unhygienic living conditions and infections. Women suffer from multiple gynaecological problems that cause a great amount of weakness and discomfort. Vaginal discharge, chronic pelvic pain, long, painful or irregular menstruation and excessive menstrual bleeding are some of the more severe problems. Some women associate the general feverishness, fatigue, weakness and backache constantly felt by them to gynaecological symptoms.

Women suffer from white or yellow vaginal discharge (dhat chinh), reddish discharge (pairwa), burning and itching while urinating and itching in vagina (sujak) as the most commonly suffered problems. Viscid, white vaginal discharge (leucorrhoea) is described by women as a profuse, painful and chronic discharge that has plagued them for years.

Since last six-seven years I have been suffering from excessive white discharge and excessive blood flow in each menstrual cycle. When the discharge is particularly profuse, I get severe pain in my abdomen and my back. White discharge started after my fifth daughter was born. After her birth for a long period I did not have menstruation. Instead I had white discharge. When I went to my native place I told my mother about it. She bought me medicines. It stopped for a few months. But it started again. I have also undertaken treatment at Duili. But it only gave my temporary relief. (Kavlo, 39 yrs, Auji- dom, Bunga)

Majority of the middle aged and older women have experienced these problems at some stage. Most reported that the problems ceased on their own as they grew older. Women both young and old had tried seeking some treatment for white discharge. Most consider this as not being a serious illness, but rather a choti bimari (small ailment). Despite the discomfort that white discharge caused, women however, felt more troubled by other health problems.
I have white discharge for last 4-5 years. But more than this I am troubled by my general poor condition of health which makes it difficult for me to fulfill my work and other responsibilities. (Savitri, 40 yrs, Gusai-Dom, Goddi)

They are almost regarded as common experience. Women believe that through these conditions related to childbirth "weakness creeps into the body" and it remains in their body forever (kamzoori baith jati hai jeevan bhar ke liye).

Uterine prolapse (bacchedani bahar anan) was a problem suffered by a few older women, though it has afflicted few relatively not so old women also. Heavy workloads along with several poorly spaced and uncared for pregnancies and lack of postnatal health care seem to have cumulatively contributed to the occurrence of this problem. It causes the greatest of discomfort and affects work and normal functioning.

I did not get a healthy diet during pregnancy. Nor did I get anything especial to eat. Just after the delivery I had high fever for a week. My eyes were burning. I could feel that my whole stomach and pelvic region had become swollen and soft. It started to hurt in the pelvic region and the red discharge also became excessive. I felt very tired and drained out. But I did not call a doctor because I thought this is normal after delivery. It will cease after a few days. Yes I have a prolapsed uterus. If one has 7-8 children it will happen. Most of the older women have it. No we don't go to a doctor for it. When its not too bad, we just push it with our hand. When it comes out, it affects our movements. It's very uncomfortable in the beginning, but then one gets used to it. I feel pus has formed there. There is itching and burning and I feel it's wet all the time. But where can I go. (Kamla, 48 yrs, Gusai-Dom, Goddi)

Moreover lack of hygiene is evident in the way the women deal with their menstrual cycle. Water for washing themselves and the cloth menstrual pads that are used, is generally in short supply. After washing the pads are normally hung to dry in the cowshed, where they often collect flies. In some hamlets where forests have greatly depleted, it has become increasingly difficult for women to find private spaces for urinating. Women are thus compelled to exercise control for long stretches of time. This not only causes them extreme discomfort, but may also lead to urinary tract problems. These seem plausible from women's descriptions of some highly prevalent urinary symptoms such as pain during urination, burning etc.
As in pregnancy, there is a culturally prescribed period of rest and confinement. However even the eleven day period of postnatal pollution confinement is impossible to follow for the women. Although they strongly express the yearning for rest, they are compelled to step out of the delivery room for work. In situations where religious norms are widely broken, post partum work taboos are not practised at all. Where women could have traded off some rest in exchange for the ignoble polluted status that is cast upon them, they are expected instead to take charge of their onerous duties almost immediately upon delivery. At most, the fortunate few could snatch two-three days of rest.

However in the older days, women's confinement was relatively strictly observed. They came out only to relieve themselves. As Darshini recounted:

*The postnatal pollution period lasts for eleven days. The mother and child are considered polluting and to avoid pollution ("chhot") they are not allowed contact with other family members or outsiders. The "suili's" (parturient mother) "grahas" (stars) are weak and therefore there is a fear of "chhaul-chhraeta" i.e. attack from evil spirits. So she must confine herself in the delivery room for eleven days. She is forbidden to even step out of the room except to relieve herself. However three days after the delivery she can come out and bathe at the "gaddera" (spring). This is when the woman must wash her defiled clothes etc. as doing these jobs at home causes water pollution ("paani ki chhoot"). The child is brought out in the sun for the first time only on the fifth day. Ideally even the food has to be cooked and served to the suili by someone else. She is not allowed to cook for the family for eleven days though she may cook for herself after 3-4 days, if she is able to, or if there is no one to help her. On the eleventh day again the priest sprinkles "gaunth" (cows urine) and performs a purificatory ritual. By now she is half pure. The final purification ceremony called "paani pe lagna" is performed only after a period of forty days. After this ceremony she is regarded as completely recovered and is allowed free movement and normal living.*

(Darshini, 85 yrs, Brahmin, Bunga)

Such strict confinement is practically unfeasible today. Washing at the gaddera (the local stream) and cooking starts barely three days after delivery. Fuel and fodder gathering and light agricultural tasks are resumed within five or six days. A week at the most is all the parturient mother gets before her daily grind resembles exactly that of the 'normal' women. This is considered sufficient time for her to recover and her body to be fit

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* The parturient woman is expected to wash her own soiled clothes at gaddera as no other woman of her husbands family will do it for her as the job is considered dirty and defiling.
enough for work. A little help from family and neighbours is usually forthcoming but only for the initial few days.

In some households it is not uncommon for husbands and in-laws to cook the meal (often only for themselves) during the pollution/prohibition period especially in the absence of other female members in the family. The postnatal woman fends for herself and of course is loaded by the rest of the household work.

*My mother-in-law was living separately. And my husband was not here. In the morning after the delivery my neighbours gave me some water. I had small children in the house. So I cooked food for myself and also for them. The next day onwards I started doing every work. I even went and brought two pots of water. How could anyone help me everyday? I used to go to the stream and wait there with my “bantha” (pot) for someone to pour the water in it so that I could wash the clothes, take home drinking water for my children and cook for them. I did all the housework like bringing water, washing utensils and sweeping. I went to collect grass for the cows. I milked them. The next day I was in the fields weeding. After all I had to take care of my family. After 15-20 days I had started doing all other work as usual. (Gunti, 56 yrs, Rajput, Daurn)*

*I did not have a mother-in-law. But my father-in-law used to stay with me. After the delivery, a kinswoman gave me some rice and water to cook my food. I made wet rice and had it. The next day I got up and went to the water to wash and carry water for the cattle. I did all the housework like cleaning utensils etc. Only I did not cook for my father in law. For five days he cooked his own food. After four days I went to do “mandai” (threshing) in the fields and beating and husking grain. After fifth day I started doing all routine housework like bringing water, cooking etc. for my father-in-law as well. (Golli, 62 yrs, Brahmin, Bunga)*

*In the hills after delivery, we start work in two or three days. I cooked immediately after the delivery and I started doing routine work within 5-6 days after delivery. I did entire household, fieldwork and animal work. Mothers-in-law are there, but who receives any help from them! I did not get any rest at all. (Saraswati, 55 yrs, Lohar-dom, Birkatal)*

*My husband cooked his own food for eleven days. But I had to cook for my daughters and myself. My mother in law was not alive and there was no one else who could do my work. My husband said that he could not cook for the whole family (Kamla, 64 yrs, Brahmin, Birkatal)*

In addition to this confinement for a certain period of time, women have to follow certain food restrictions during delivery and postnatal periods. “Cold foods” are taboo and “hot food” are thought to provide the mother strength and combat the exhaustion. A “no-salt”
diet is recommended for forty days. Darshini provided the detailed diet chart before and after childbirth:

_A thick “khitchri” of urad dal, is fed to the woman during labour, so that the child may become slippery and may come out early and easily. Some give a glass of tea or hot milk with spoonful of pure ghee, or warm “dalia” (porridge) for a quick easy delivery. After the bath “suili” is given her first meal that is basically light and easily digestible. People give “khitchri” made of pulses and rice cooked together, or “halwa” made out of wheat flour and sugar or jaggery with lots of ghee or simply wet rice with sugar or jaggery. If a woman is unable to eat immediately, she is given a glass of hot milk or tea, with some ghee mixed in it to drink. Only hot water to drink is given. Cold water is strictly avoided till child is forty days old. But drinking too much water is not recommended as it causes “thand” (cold) in the “nas” (veins) and the infant will get loose motion. Food like cold rice and green vegetable are never given after a delivery. In fact she must eat preferably “halwa” for a few days after delivery. But usually the economically better off families alone can afford to give this rich food. Others can afford it at the most for one day and mostly follow it up with khitchri or wet rice later._ (Darshini, 85 yrs, Brahmin, Bunga)

Even now social taboos continue to prevent a woman from eating certain “cold” food like green vegetable, cold rice, salt and cold water. However the inclusion of recommended special foods like ghee, milk, _khitcheri_, _halwa_ in the lactating women’s diet is minimal. Hardly anyone could get a good diet _khorak_. As a matter of fact most women are unable to afford even a minimally good diet for more than two to three days:

_There was nothing to eat. At the time of delivery I was given wet rice mixed with sugar. I did not even have any special diet at that time. I would just eat whatever I got - mostly wet rice. Only the economically better off families alone can afford to give halwa and ghee. If there was half a kilo of ghee, the children would ask me to put it on their rotis and I would give it to the children (Jasla, 75 yrs, Auji-dom, Bunga)_

Today after delivery, women consume a few cups of sweetened tea and wet rice with some sugar mixed in it. After a week or so of eating semi-solid food, viz. usually _kitchri_, wet sweetened rice and rarely _halwa_, women returned to regular diet, viz. _rotis_ with _dal_ and a small portion of seasonal vegetable. The right quantities of nutritious health-giving food is a dream! Rather the oft-repeated statement “_taqat ka khana kahaan mila_” (“where did we get nutritious food”) reflects the reality of food deprivation.
Following the pattern during pregnancy, factors like joint or nuclear family residence, patterns of co-operative labour within the conjugal family, availability of support from migrant husband, all determine women’s postnatal experiences. Those belonging to nuclear and poorly off families' find it impossible to follow any confinement rule whatsoever. Especially if the fields are many and cattle herds are big and there is no money to hire labour, the parturient women have to take on the burden. In extended families, mothers-in-law refuse to be burdened by buari’s work. The woman is subject to her mother-in-law’s authority.

As during pregnancy, for a few women things have changed for the better during the postnatal stage. The cases of Sunita and Sudeshi (aged 23 and 30, Brahmin and Rajput respectively) for instance, illustrate the difference.

*Sunita and Sudeshi said that their mothers-in-law are/were extremely co-operative and kind. They did not allow them to do any work for eleven days. They were even provided hot water in the house itself for bath and washing their clothes. Hence they did not even have to walk to the “gaddera” and bathe in cold water. Slowly after three weeks they started doing “light” jobs like cooking and household chores. They got all the rest and care that any town woman would aspire for.*

Sudeshi (30 years) was one of the few who delivered in institutional set-up and was able to partake a nutritious diet after the delivery.

*During pregnancy I got all the necessary check-ups, injections etc. For my first delivery when pain just started my husband took me to G. T. Hospital, Rishikesh (Government Hospital). But since there were no good facilities in G.THospital, my husband took me to a private hospital called Nirmal in Rishikesh. There I delivered through a small nick. All my other 2 deliveries were also performed in the hospital. I did not follow any diet restrictions -my mother-in-law did not ask me to follow any taboos - neither during pregnancy nor at and after childbirth. I used to regularly get whatever vegetables and fruits the lala’s shop was selling. There was plenty of milk and ghee. For several days I had only eaten “halwa” cooked in ghee. I also had asked my husband to buy Horlicks for me from Rishikesh. Earlier villagers did not allow a newborn child to see the sun. But I took the child out in the sun as the doctor said that it helps the child to grow faster. I feel pregnancy and delivery can also be medical conditions, especially when some complications arise - and hence must be also shown to the doctor. I took full care of my baby and myself in postnatal period. The immunisation for the...*
children was complete. I also took tonic, vitamin pills and Horlicks prescribed by a private doctor in Rishikesh”. (Sudeshi 30 yrs, Rajput, Birkatal)

Today, younger women claim that they are more aware about the need for postnatal care and have started giving it more attention. However the statement is not fully substantiated by in-depth interviews done with women and by our observations. In these relatively remote villages where health care services are so inaccessible, the age old cultural practices are slow to go. Following two case studies powerfully depict this cumulative compounding situation for majority of the women even today. The first case is of a Dom woman and the second of a Brahmin woman.

Savili, aged 35 years, belongs to a very poor household in Goddi. Her husband and elder son usually work as wage labourers – whenever work is available. They have only one nalli of land, which hardly suffices their family. Savili says that hardly any agricultural wage work is available, and most of the days they earn nothing. They go to the roadside teashop and ask for work. If work is available in nearby villages they go there too. “I got married at a very young age of 13. I gave birth to six children, but now only two are alive. I don’t know what problems I have. That only the doctor can tell. But my children died in infancy. I was weak and there was never much to eat. What could my husband do. Poor man had little land, no money. Work was not easy to get. He tried to go to Rishikesh several times. But there too he hardly earned anything. Most of the time he was unemployed. So he use to return. I have lived my life in poverty with never enough to eat. Besides this, I have conceived so many times. There was no food and there was so much work to be done. Many children were born but many died. Birth and death left a scar on my mind and body. Naturally I became very weak. When we had hardly any money to buy food, where can we think of going to a doctor or taking any treatment? Now I am weak and frail. You said you are my age – who will believe that!” (Savili, 35 yrs, Gusai-Dom, Goddi)

Vimla 37 years old, Brahmin from Bunga got married into a rich farming household at the age of at 20. “I had no problems in the beginning. Some dowry in form of earrings, nose-ring, bed, bedding and “bantha parat” (utensils) was given and my parents had borne all the marriage expense”. For 2-3 years Vimla could not conceive. She was sent home and there her natal family performed some “dosh puja”, but to no avail. Two years later she had her first child who was born with many big boils on his head. He died in 3-4 days. The next child was a stillbirth. Vimla’s in laws got very angry. “The behaviour of my conjugal family was not good any more. My in-laws started to fight with me. The work burden in my in-laws house was much more than my parent’s house, but I used to do uncomplainingly. Earlier my in-laws family were happy with my work since I used to do all the work. Now occasionally my mother-in-law started to scold me even for my work. Conflicts between us due to my childbearing problems came to the
forefront. Now my natal family got very worried. They again did the “chal puja” as suggested by a reputed “bakki”. They also performed “jhar phunk”. They believed that because of some “dosh”, both the children died and this was essential”. On behest of her brother who was living in Rishikesh, Vimla was also taken there for treatment. One and a half year later, she delivered a healthy girl. Thereafter Vimla gave birth to two more sons. Vimla is bitter about her life. She worked hard in her in-laws house. But she was always treated as an outsider because she had difficulty with having children. She feels “neither my in-laws, nor my husband even paid attention to my health. They had no sympathy with my grief. After my deliveries they would expect me to return to my work as if nothing had happened”. Vimla feels that “in any case women are weaker and men stronger because women give birth to children which weakens them. Moreover young children demands more attention, and we do all the work related to their upbringing. Hence we become weak. My health which was worsening because of heavy workload, got further ruined because of being pregnant so many times and the constant anxiety and tension with which I have spent my life.” (Vimla, 37 yrs, Brahmin, Bunga)

Hence we can conclude that though the diffusion of new ideas has begun, but it has been a very slow process. Rest and good quality diet are still very elusive entities for pregnant and parturient women even if they are aware of it. Most importantly, the desirability of whatever rest and food is made available to women revolves around fear of threats to foetal well being during pregnancy and safe delivery of the infant. Protecting the infant from physical illness and shielding “others” from birth pollution are the other dominant concerns behind certain taboos that bind women. The birthing woman seems to be of little consequence and therefore taking a pregnant, labouring or sick woman to a hospital becomes the last resort to be deferred or preferably avoided. Thus even today her status within the family and the underlying economic and social conditions mean that most women experience the most dangerous risks of pregnancy, delivery and post-partum period and often succumb to them.