Chapter 5

Reproductive Health and Fertility
The concept of sexual and reproductive health was first fully articulated at the 1994 International conference on population & development (Abouzhar & Vaughan, 2000). Reproductive health of women is a state of complete physical, mental and social well-being and not merely the absence of disease. Reproductive health is related to the reproductive system and to the functions and processes. It implies that women are able to have a safe and satisfying sex life. It also implies that they have the capability to reproduce and the freedom to decide about it, that is, when and how often to do so. It suggests that to attain reproductive health, a woman requires preventing and solving health related problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations.

The present chapter is an effort to critically examine the reproductive health problems of the Hindu and Muslim women, attitudes related to maternal mortality, abortion, reproductive tract infections, sexually transmitted disease etc. An effort is also made to understand the attitude of women towards their problems and the causes of the problems. This study is based on qualitative investigations of women's perceptions, descriptions of reproductive conditions and dwells upon the societal attitude related to maternity periods, during gestation period and after delivery.

5.1 Reproductive Behaviour and the Role of Women

It is evident that reproductively is affected by a variety of factors including age, family's income and wealth, educational level of the family, caste, class, religious beliefs, culture, residence and occupation etc. The rich get richer and poor get children (Pati, 2003) were the Victorian epigram. It was generally believed that larger families were statistically associated with poverty, unskilled occupation, lack of education. These aspects are related to early
marriage, uncontrolled fertility, excessive child bearing – too early, too late, too many, and at too close intervals. All these dimensions tell something about the reproductive behaviour among different sections of women.

The reproductive role of women all through the processes of gestation, birth, breast-feeding and child bearing places additional demands on her.

In Dibai town, mostly all young woman, are generally married relatively young (analysis done in chapter 3). At a young age, the wife has no idea of limiting the number of children. The notion of not conceiving immediately after marriage is not evident. The reproductive profile of respondents is shown in Table 5.1and Chart 5.1.

Santhya and Jeejobhoy shed light on whether sexual and reproductive health situation and choices differ from those of adult women; and ways in which they differ. Sexual and reproductive health of adolescents in India is conditioned to a large extent by the strong pressures newly married young women face to prove fertility as soon as possible after marriage. Indeed, for many, the only way to secure their positions in the marital home is through fertility and particularly the birth of son. The evidence suggests that pregnancy and childbearing occur before many adolescents are physically fully developed. This may expose them to particularly acute health risks during pregnancy and childbirth. Adolescent fertility rates are high: roughly 107 births take place per 1,000 girls aged 15-19 and the fertility of this age group makes up 19 per cent of nation’s Total Fertility Rate (IIPS and ORS Macro, 2000).
# Table 5.1: Reproductive Profile of Respondents

(N=150)

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<td>Natural</td>
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<td>Induced</td>
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<tr>
<td>Don’t bother about the number of children</td>
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<td>53.33</td>
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<tr>
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<td>100%</td>
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Source: Interviews
Chart 5.1: Reproductive Profile of Respondents

Live Children

- None
- 1
- 2
- 3
- More than 3

Number of live children

Prior Abortion

History of Prior abortion

- History of Prior abortion
- Natural
- Induced
- No history of abortion

History of Prior abortion
Chapter 5

Reproductive Health and Fertility

Contraceptive used

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Intentions

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<td>70</td>
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The case of Neera (upper caste Hindu Woman) substantiates this point. She could not conceive for two years after marriage and was often asked embarrassing questions by relatives and neighbours and she was chided and criticised by mother-in-law and sister-in-law. It is often found that husband’s family, with whom the newly married woman lives as well as her “maayke waale” (maternal family) expect that she would become pregnant as soon as possible and bear a child, preferably a male child. The desire for the first child as son is explicitly as well as implicitly expressed.

Typically a woman knows of no acceptable alternative role for herself other than that of wife and then of mother. The dread possibility of being barren is a nightmarish spectre for a woman who has not yet borne a child and becomes a painful reality for a childless older woman who finally must accept that she will never bear one. For all but relative few, a woman’s destiny lays mainly in her procreation and the mark of her success as a person in her living, thriving children. Her husband’s family arranges matters so that the couple have opportunity for sexual relations, even in families where privacy is otherwise minimized and where elders keep the young wife under strict surveillance. A study conducted by Gould (1969) in Sherupur, a village of Faizabad district, Uttar Pradesh brings the same observation that ‘rather than discourage contact, I have heard mothers-in-law goad in their daughters-in-law in the hope that it will speed the production of an heir.’ The husband’s parents, as was noted above, are eager for a grandchild and give the young couple as much privacy as possible at night, even making a separate room available. The couple has sexual relations frequently, even ignoring periods of ritual taboo. After the birth of first child, the frequency of intercourse is very much reduced, partly from the demand of motherhood and lessened opportunities and partly from the satisfaction of having at least a child. A couple typically observes taboo period during religious occasions, during fasting period, during menstruation period, and during lactation.
Once a woman becomes pregnant she is likely to receive more fond attention than she enjoys at any other time. At her first pregnancy, she is given a kind of respect in the household that she did not get before. During her subsequent pregnancies also, she usually gets favoured treatment, certainly for a young wife, pregnancy is fine, the baby is fun, motherhood is grand and God given. Most of the religious rites in which a woman participates are intended for the welfare of her husband and children. Unless she has living children, her joys and status are the less and so she prays fervently that her children may be many and healthy (Opler, 1964; Jacobson, 1970).

Procreation is considered to be the most important aspect of a married women’s life and efforts are made to rectify the problem if she is unable to do so during first few years of her married life. Shanti (a sweepress) told that her daughter-in-law did not conceive well after more than two years of marriage. She got worried and consulted hakeem (unani / Greek medicine physician) as well as lady doctor practicing in Dibai. Nearly a year passed in the treatment but the problem persisted. She told this problem to her malkin (employer) where she works. That lady advised her to consult a well-known gynaecologist in Aligarh city. Shanti escorted her daughter-in-law to that doctor and after the treatment of a few months (though it was costly from her standard) she could conceive. Now her daughter-in-law has one male child who is two years of age. It is a paradox that during the whole duration of pregnancy they consulted the doctor but childbirth took place at home. Shanti advised her daughter-in-law to have the delivery at the hospital but she said “amma dar lagta hai, voh operation kar dengy” (mother I am frightened, they may operate on me). Thus they called a dai (midwife), who came with her basta (instrument box). Dai gave one pill and injection to induce pain and delivery took place after an hour. Dai asked for one thousand rupees but ultimately agreed for five hundred rupees. Now she wants that her daughter-in-law must bear another child.
5.2 Notion of Safe Motherhood

With every pregnancy there is a risk that something may go wrong. Most of these complications cannot be predicted. The first delivery is a most dangerous for both mother and child. It is important for all families to be able to recognize the warning signs of problems during pregnancy and childbirth and to have plans and resources for getting immediate skilled help if problems arise. In the present section I have tried to present findings related to pre-natal, ante-natal, and post-natal check-ups, the process of delivery, the role of dais and doctors, facilities available to a women during the entire process as well as the taboos which contradict the logic and medical reasoning.

5.2.1 Pre-natal and Ante-natal care

Disparity in pre-natal and ante-natal care, at an alarming rate is evident in different categories during the discussion with respondents. No doubt upper caste Hindu women prefer the services of gynaecologists (MBBS, MD or BUMS, BAMS), who have good and modern facilities related to deliveries and pathological check-ups. These private doctors are capable of performing operations also. In case of upper caste Muslim women majority go for medical check up to the private doctors, hospitals or to paramedics. Though all are not very regular, still they have an attitude to utilise the help of modern facilities if the need is. Lower caste Hindu women also occasionally go to these doctors and hospitals. Many of them go for paramedics also (those who do not have proper medical degree but practice as medical doctors). Therefore, sometimes these paramedics are unable to handle the complicated cases properly and have to be taken to medical hospital (JNMC), at Aligarh, or to hospitals in Bulandshahar, or to some reputed private doctor in these cities. Lady doctors of Dibai refuse to deal in such cases as well. The most pathetic condition is of lower caste Muslim women. For other problems they may go to hospital but during pregnancy they rely only on the advice of some dai or hakeem, and a few on paramedics. Very few of them admitted to have gone to doctors for pre-natal check-ups. Those upper caste Hindu women
who go to doctors mostly follow their advice and are quite regular also. Neetu told that during her first pregnancy; when she missed her menses her mother in law escorted her to the lady doctor. There she was examined and to confirm pregnancy the urine was tested. She told that during first delivery she visited doctor every month very regularly. Now she has four children, the visits to doctor gradually declined with each pregnancy. In the later pregnancies, she dealt with its related problems of her own, on the basis of her past experience.

Another woman, Sunita told that during her first pregnancy she became worried when she did not have menses well after due date. Reluctantly she told about this to her sister-in-law as she was not sure about what to do. Her sister-in-law told about this to her mother-in-law who advised her to go to the doctor’s clinic. After the urine test she got the confirmed news of her pregnancy. Now, when the third time she did not have menses on due date, she tested for pregnancy using a strip at home. After being sure that it is positive she went for check up.

In most of the cases it is found that highest level of care was taken during first pregnancy. Three women echoed the same thing though all were interviewed separately at different places. These serve as representative samples of those who follow the proper procedure. They relied on the pregnancy test to get it confirmed, after that they visited the doctor every month to take advice regarding nutrition and vaccination. During the nine months period they have two doses of tetanus toxin vaccine, took iron folic tablets, and checked haemoglobin, blood pressure, urine test for sugar every month. To solve the nausea problem they were advised a safe tablet which was taken once daily during first three months or as need arises. They were also advised to increase the intake of milk. A pregnant woman needs the best food available to the family; milk, fruits, vegetables, meat and fish (non vegetarian), eggs, grains, peas and beans. Salt used should be iodised. Women who do not have iodine in their diet are more likely to have miscarriage and risk having an infant who is mentally or physically disabled. In the third and eighth month they were
asked for ultrasound test to be done. Before the due date of delivery another ultrasound test was done to know the position of the foetus and capability with anaesthesia was also tested. *Najma’s* foetus had breached position and doctor was well prepared to deal with that. *Asha* told that one additional test was conducted somewhere in third or fourth month (not sure) but was unable to tell, for what it was conducted. They were advised to take salt regularly. The doctor kept a record of the weight gain each month and check up was done to monitor the heartbeat and movement of foetus. Those who do not go to the doctors often rely on homemade medicines, herbal treatment from *hakeem, vaidh* (ayurveda practitioners), and traditional healers. Women who visited paramedics also got tetanus vaccine but use of iron tablets and haemoglobin check up was not done.

Majority of low caste women (Hindu and Muslim) contacted *dai* as well as *hakeem* and *vaidh*. They get herbal medicines for any vaginal infections. Some women told that neem leaves are used for any type of skin infections. One woman told that she was having blisters during pregnancy and *dai* gave her *saffoof* (herb) which cured her problem. One Muslim women also narrated that at the time of pregnancy *dai* did the internal examination and said that *bachhadani* (uterus) is not at proper place and asked to do exercises and gave herbal medicines also. It was cured. But in another similar case, the woman has developed complications and she had to consult doctor. During interviews I came to know about one NGO, which worked in this region for some years and helped women to take control over bodies and health. This NGO trained local women to recognise and treat common gynaecological problems. They also gave information regarding how to identify reproductive tract infection and seek the help of medical practitioner/lady doctor. It is evident in other studies also. NGO’s are working with herbalists or traditional healers, and are documenting their current practices, attempting to evaluate the use, their acceptability among potential users and encouraging these practices when they work. (Shodini, 1997).
Prenatal care is especially important to reduce the risk of HIV transmission (Gabiano, 1992; Boyer, 1994). Although the use of prenatal care by Indian women in general increased from the mid 1980s to the mid 1990s (Mishra et al, 1998), a significant number of Indian women do not receive any pre-natal care (Surbamoorthi et al, 2004).

I explored whether the sonography is being done to opt for the sex of the child or not. Only one upper caste Hindu women (on the assurance that it will not be told to her husband or in-laws), revealed that her first child was a girl. Husband and every member of the family throughout the period of pregnancy reminded her that she has to give birth to a son. At that time they were not aware about the sex detection technique. She often feared what will happen if she could not fulfil their wishes. Her fears came true and after the delivery, proper care was not taken. Family member were very angry with her. After two years, during her second pregnancy her husband brought her to the private hospital and got the ultrasound done. After knowing that it is a girl child he became very upset and told her “yeh bachha nahi ho sakta” (this child should not be born). She resisted but than gave up against the pressure of others and reluctantly agreed. Her mother-in-law arranged for the abortion at a clinic and got it cleaned. Next time it was a male child and finally her woes ended. Now she has one daughter and three sons. This was directly disclosed by a pregnant woman, but also when I interviewed some lady doctors (and only when I gave them full assurance that there identity will not be disclosed), they told that this kind of practice persists here. Not only the women of the town come but women of other villages (near Dibai) also come especially for detection of the sex.

Ironically, the right for safe motherhood and pre-natal care becomes counterproductive in some cases. As narrated by Ramsakhi, the vaccine injected for prevention for tetanus created havoc in their lives. Her daughter in law was pregnant of three months when they consulted a medical - representative (MR) at the local hospital, as doctor was not available there.
Chapter 5  Reproductive Health and Fertility

The MR used the infected syringe and the body part where vaccine was injected started swelling. Within 2-3 days, that part was filled with pus and the whole body was swollen. Complications started internally also and ultimately she had an abortion. Belonging to a poor family, they borrowed for treatment but there was no progress. This incident happened a few years back. The woman has become very weak and could not conceive again. In some other cases also the dubious role of midwives and ill educated medical representative came to surface.

Several studies in India have shown that unqualified or indigenous medicine practitioners practice allopathic system of medicine (Mewmann et al, 1967, Bhatia et al 1975). Patients from rural areas or small towns are not able to make a distinction between qualified and unqualified practitioners (Pachauri, 1999) and this results in the form of reproductive health related problem.

5.2.2 Attitude and behaviour of others towards pregnant women

During my study, I came to know that in majority of Muslim cases the women remained at their in-laws house and do not go to their mother’s house. Jeffery et al (1993) shows that in both the predominantly low and middle caste Hindu women in the rural Uttar Pradesh, which they studied in the early 1980s, woman remained in their in-laws houses throughout their pregnancy and confinement. In these villages there were no rituals to celebrate the pregnancy and pregnancy itself was viewed as a shameful matter. Tulsi Patel’s (1994) study in a rural Rajasthan’s Hindu village provides a different picture. The common practice in this village is for the pregnant woman to return to her parent’s house for her first confinement.

In Dibai, the common practice followed by Muslims is that, the first delivery must take place at sasuraal (husband’s or in-laws house). In Hindus women go to their parents’ house. In many cases women revealed hesitately that the financial burden was generally born by their parent’s side. Otherwise also, there is the custom of sending cloths, foods, jewellery, and other articles,
according to the status, just after the daughter’s delivery. And many times the in-laws also create a lot of fuss regarding these gifts. In a few cases the would be mothers went to their parent’s house (Raathis and Aggarwals), for the simple reason that their parental place had better facilities for the delivery. Questions were asked, regarding the nature of household work in which women have to be involved during the entire period. Barring exceptions where they were advised bed rest for a long period; most of the women admitted to have done work in the kitchen and did household chores. Contrary to this, a few incidents were narrated where in-laws helped a lot throughout the gestation period. *Najma* (sheikh) told that her mother in-law is very kind and considerate. She looked after *Najma* just like a mother. Her unmarried sister-in-law also helped her in all household work.

Another case as told by *Kamlesh*, pinpoints the pathetic condition of women (daughter-in-laws) in some families, where they are treated poorly. *Kamlesh* was only sixteen years old when she got married twenty-three years ago. And eight years after marriage, her husband expired. He was *sarraf* (gold smith) by caste and by profession also. She is a high school pass. *Kamlesh* had a sad story to tell. After marriage she lived in a joint family. Her mother-in-law treated her badly and used unkind and abusive language. When, she was pregnant she was required to do all the household work. At the time of pregnancy she was having a lot of problems. She had three abortions. During pregnancy she had bleeding in the fourth month, and she was under treatment by a lady doctor. But her mother-in-law would not allow her to go to the doctor. Her mother-in-law even did not wanted her to have a child and made her work like a servant. Just three days after delivery, “I had wet cleaned the floors and put threads in the quilts”, she said. She found no support from her husband as well who was a drunkard.

After her husband’s death, she was thrown out of the house and stayed with her parents for two years. Presently she is teaching in a private school and thus supporting herself and her boy. Though her parents are well off, she
does not believe in taking any financial help from them as ‘I have no right over their money now’ she said.

The practice of returning to the natal home for the birth may well play a protective role in the timely health seeking among pregnant adolescents. The attentions she can demand and obtain at the natal home are quite different from the care she can obtain in her husband’s home (Basu 1995). A control study in Maharastra showed for example, that young women who delivered in their parental homes were significantly less likely to die than women who delivered in their husband’s home. The study concludes that young women delivering in their natal home are far better equipped to express the experience of danger signal, and families are far more likely to respond in a timely fashion, than among women delivering in husband’s home. Their families may be more likely to make timely health interventions in their daughters and sisters and to incur expenses to save their lives, than their daughter-in-laws and wives (Ganatra, Coyaji and Rao 1998). In short, because of the value placed on the one hand and the practice of returning home for the first delivery on the other, pregnant adolescent appear to overcome the powerlessness married adolescents face in their husband’s home with regard to fertility related care seeking.

Different accounts reveal that nothing can be said conclusively regarding the attitude of the in-laws towards the pregnant woman. It is the nature of the individual, which determines the attitude and behaviour rather than religion, caste or class.

5.3 Practices and Methods during Childbirth

Safe motherhood demands that women must be aware of the places where safe deliveries take place and the helping hands, which are able to manage the complications, if any, during, or after pregnancy. Hospitals or private nursing homes are safer than home to conduct deliveries. It has become evident during the study that the trend to utilise modern facilities with respect to
childbirth is increasing in Dibai. Still there is gap among different categories regarding the choice of place for childbirth. In Dibai area I found that Hindu women are more progressive to adopt the modern facilities about delivery in comparison to Muslims. But some exceptions are also found there. A sheikh woman told that she is lucky enough to have an educated sasural and everyone has a modern and progressive approach to deal with situations. Though she is married for 10 years only but has heard that her husband’s chachi (aunt-in-law) delivered her first child in the government hospital some 30 years back (at that time there was no private nursing homes and very few deliveries held in the hospital). The general trend was to deliver babies at home. In her case, both her deliveries happened in Aligarh. Her mother in law bore the entire cost associated with (caesarean in this case) deliveries and room was booked in advance in every case.

This case being an exception cannot be generalised. Two other upper caste Muslim women told that their deliveries took place in the doctor’s clinic. In all other cases deliveries conducted at home are the norms. Muslims are very conservative in this matter. Upper caste Muslims call hospital trained midwifes (not local dai) nowadays to perform deliveries but prefer it to be within their home. Lower caste Muslims prefers local dais. All the samples of upper caste Hindu women told that from last twenty years or so, they are preferring hospitals and clinics rather than home.

Discussion on the care and methods used during deliveries.

5.3.1 Practices and methods during deliveries

It is often reported that women in western countries have been struggling for several decades against what is now widely viewed as the unnecessary and excessive medicalisation of child birth. The move to a less interventionist model for childbirth has been a genuine gain for many women in the west (Martin, 1987; Oakley, 1986), though there is a real risk associated with the process of natural childbirth. Within the context of childbirth, there is an
assumption that as births become increasingly biomedicalised, women will put faith exclusively in the powers of medicine to ensure the well-being of mother and child and come to rely less and less on religious faith and ritual (Hollen, 2003).

World Health Organisations (WHO, 1992) policy for some years has emphasised on working through traditional birth attendants (TBAs) as the best path to improve the level of maternal and child mortality and illness in much of the third world. Keeping these developments in mind, I explored the practices associated with delivery, that is, how and where it is conducted and whether the concept of hygiene is important to those who attend the childbirth. In this section I present the pattern related to deliveries which vary according to the religion or caste. I found that the concept of natural childbirth adopted in the western world can not be appreciated here, as many of the births take place naturally but in such an unhygienic condition that it is better to have medical interventions. The information solicited during interviews is given in Table 5.2 and Chart 5.2.

Description of delivery conducted at hospital is narrated by one Hindu woman, which is a good representation of such cases. Archna, upper caste Hindu woman, had four children. She described the development during third pregnancy. “In the last, tenth month of my pregnancy in the morning my water bag burst. I did not have much idea and used cotton to protect my clothes. It had not happened like this for earlier two deliveries. There was a little pain. I felt relieved as my abdomen felt lighter. It happened because the water came out. My mother-in-law was out of town so I did not tell about this to anyone. But after sunset the pain increased. By the time my husband had returned from his shop, I told him about this and he took me to the nursing home immediately. When we reached the hospital it was late night. The doctor said that the baby would be born after three–four hours. The doctor scolded me for being so late. The aayah cleaned me and gave me an enema and sent me to the labour room. During delivery nurse asked me to lie on the
table and tied my ankles with a belt to the side of the table. I gave birth to a male child. After delivery I stayed there for a day”. The position which Archna described is known as lithotomic. The lithotomic position, in which the birthing woman lies flat on her back with her knees bent up and her feet flat on the delivery table, has become routine in most hospitals. This position is preferred by many doctors since it gives them greater ease of access to the baby. However, this position makes labour more difficult for the mother since it weakens and slows contractions and requires the mother to push the baby out without the aid of gravity. It also decreases the supply of oxygen to the foetus (Jordan, 1993).

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

5.3.2 Process of delivery and childbirth

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

### Table 5.2: Maternal Health (Maternity Care)

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</tr>
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<tbody>
<tr>
<td>Mothers who had approximately 3 antenatal care</td>
<td>90%</td>
<td>85%</td>
<td>65%</td>
<td>20%</td>
</tr>
<tr>
<td>Mothers who consumed IFA for 90 days when they were pregnant</td>
<td>95%</td>
<td>70%</td>
<td>60%</td>
<td>20%</td>
</tr>
<tr>
<td>Births attended by doctors/nurses/other health workers</td>
<td>95%</td>
<td>5%</td>
<td>30%</td>
<td>2%</td>
</tr>
<tr>
<td>Mothers who received post-natal care from doctors/ nurses/other health workers approximately within 20 days of delivery</td>
<td>95%</td>
<td>2-3%</td>
<td>20%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Interviews

<table>
<thead>
<tr>
<th><strong>UCH</strong></th>
<th>Upper Caste Hindus</th>
</tr>
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<tbody>
<tr>
<td><strong>UCM</strong></td>
<td>Upper Caste Muslims</td>
</tr>
<tr>
<td><strong>LCH</strong></td>
<td>Lower Caste Hindus</td>
</tr>
<tr>
<td><strong>LCM</strong></td>
<td>Lower Caste Muslims</td>
</tr>
</tbody>
</table>

### Chart 5.2: Maternal Health (Maternity Care)
The experiences recounted by Khadeeja, a teli Muslim woman can be a representative case of some lower caste Muslims such as teli, dhobi, bhatiyara, quraishi or kasai. She told that she started feeling very uncomfortable as the eight month approached (though earlier also she was not very comfortable) and it became very prominent. She lives in a big joint family (which is a general pattern in most of the cases) with father and mother-in-law and five brothers and one sister-in-law. Her husband is at number seven out of eight brothers and one sister. Two brothers live in separate houses in another mohalla (locality) and others with their families in their ancestral house which is not big enough. One of her jeth (elder brother-in-law) has five daughters and four sons (eldest daughter is married off). Two young brothers-in-law are unmarried. She used to do all the household work with her sisters-in-law and covered a big dupatta (scarf/veil) to hide her. Most of the time during her pregnancy she remained in her sasural, because her mother-in-law warned her not to travel as it may terminate the pregnancy, “safar mein dhakkey lagtey hai” (in travelling there is lots of pushing and shoving). She recounted the experiences of her first pregnancy that for three to four months she had nausea feeling and vomiting. Then three months were somewhat better and again after seventh month it became very difficult to move. She gained 15 kg weight and her legs were swollen. In this difficult condition mother-in-law (who was considerate enough) advised her to do “garm pani aur sendha namak ki sikai” (message of hot water with salt). After completing household work at night, she used to fill the tub and put some salt in it and would put both her legs in it for some time. She felt better after the massage. She further told that a dai used to visit every month or whenever she had any problem. After nine months of her pregnancy the dai told that, ‘you have to wait for another ten-twelve days’. Her in-laws or husband did not take her to the doctor as it was not the trend in this family. A few days after the ninth month she felt pain in her stomach. After bearing it
for some time she told about this it her mother-in-law. She being an experienced lady asked her to rest in a room which is in one corner of the house. All the previous deliveries had taken place in that particular room only. She laid down there on the bed and then her sister-in-law also came to talk to her and started offering prayer. Her mother-in-law sent for the **dai** who lived near by. The **dai** came immediately and examined **Khadeeja**. **Dai** asked her to walk in the room. She gave a tablet to eat with lukewarm water. On the basis of the position of the child, the dai told to wait for some time. She left and asked her mother-in-law to call when the pains become severe. In this state **Khadeeja** remained in for eleven hours. The pains started at around nine at night and she remained in this state for the whole night, crying with pain. Her mother-in-law and sister-in-law consoled her throughout night. In the morning at seven they sent for the **dai** again, this time she came with some instruments. She again gave her a tablet. By now the pains had become unbearable and she started shouting and crying. **Dai** asked her to stand up and walk. But it was very difficult. At this point I asked **Khadeeja**, whether the tablet, were given to increase pains? **Khadeeja** replied that at that time she had no idea but now after three deliveries she is sure that tablet helped in inducing pain. (She told that in her last (fifth) delivery, she was attended by a nurse, she would give her some medicines which relaxes, and dilates inner walls of vagina and increase contractions. With this the passage becomes clear for the baby to come out and the baby pushes downward).

The **dai** told her with conviction that, “a baby is born when the pains are strong and without pain how will you deliver the baby? Women are constructed as having inner strength due to their ability to withstand the pain of childbirth.” Muslims believe that after the delivery the woman becomes as pious as new born baby and all her **gunaah** (sins) are washed away and it is a gift from ‘**Allah**’ to the mother.

After some time **dai** started massaging the stomach and pushing the baby down and asked her to put in efforts. After an hour or so baby came out with a
thud and she felt as a great burden has been removed and felt relaxed. It seems that for a few seconds she became unconscious but again gained consciousnesses. After delivering the child dai started pulling ‘naal’ (umbilical cord) and when it came out she cut it with a razor and tied the baby’s cord with thread. Dai gave a bath to the child (a baby girl) and handed over the child to her mother-in-law. (Khadeeja narrated one instance of her third delivery. During her third delivery every thing happened so fast that they could not arrange for razor and nothing was there to cut the cord. Then the dai broke a glass cup and with that cut the cord. She said that women delivering at home should refrain from shouting out loudly because men in nearby houses might hear the screams and moans and that would be embarrassing or unseemly.

I asked whether she was afraid that something may go wrong (like breach child, cord around child’s neck, no heart beat, no movement etc.) and that she or the baby may die. Khadeeja said at that particular time she was not thinking about all this but she is aware of few cases where the same dai could not deliver the baby due to complications and mother or child or both died. But nothing can be done to avoid such mishappening as her family is orthodox and conservative.

They even can not think about hospitals for delivery. Khadeeja’s case is a good example of the dai’s helplessness in difficult situations. Though, through experience they gain enough knowledge to deal with simple delivery cases, they are uncomfortable with complicated deliveries. In such a situation they have to wait. At the last moment if everything is not well or dai finds it difficult to deliver she asks the woman to be take to the hospital or call a doctor. She does this (i) because she feels unable to tackle the situation; or perhaps more importantly (ii) because she does not want to be responsible for any mishap or to ruin her reputation by being involved in a problem delivery which may lead to the death of the birthing mother and/or the baby.
The umbilical cord is also known as the ‘road’ between mother and child. The road indicates more than a path for physical transportation, however, it is also the metaphor for relatedness (Merrett, 1992). Vital substance flows from the mother to the unborn child along this path and the cord is the source of life for an infant. The importance of this is recognized by elderly women by conveying that the cord should never be cut before it stops pulsating or while it has life. The substance which flows from mother to child comprises the food a woman eats, but it also conveys aspects of identity to the unborn (Lipuma, 1988; Meigs, 1988; Strathern, 1972; Weiner, 1982). An infant relies totally on his or her mother for life and, until the cord is cut and tied, remains physically attached to his or her mother. This connection binds the child with mother. After delivery, the form of this link remains through direct consumption of mother’s substance or breast milk (Merrett, 1992).

I found that the pattern followed in a childbirth in most of the cases, is far from satisfactory. In the descriptions given by different women some common features emerged; like lack of hygiene, lack of proper knowledge about complicated deliveries, lack of use of medical services, use of taaviz (amulet) etc. More or less the same process is followed in the Muslim community with respect to deliveries. Irrespective of the caste or class and education, Muslim families prefer to deliver birth at home. Only variations lie with the availability and use of the attendants, whether it is a dai, midwife or a trained nurse. Earlier only dai used to help in the process but nowadays midwife or nurse may also be called according to the status of the family. Very poor families still rely on a dai (local midwife) or they manage it themselves also. In very poor families dai or mehtrani (sweepress) is called for cutting the cord only, as it is considered such a mean thing that the family members can not perform themselves. It is a paradox that Muslims in Dibai do not want pregnancy to take place in the clinic or hospital though in critical situations they go to nearby cities. Another important feature is that the daughters or daughter-in-law of the same families, who live outside Dibai
(some other town or city) choose hospitals for deliveries. Thus it can be argued that Muslims in Dibai have developed a culture where to conduct deliveries in the hospital is considered inappropriate.

Kalpana Ram’s (1998) research on childbirth in the southern regions of Tamil Nadu suggests that women here were critical of biomedicalized birth. Ram argues that most women preferred to give birth at home with a midwife, partly because they wanted to avoid the condescending attitudes of the hospital staff.

In other interviews with Muslim women more or less the same description was given. Slight variations were also found. In one case, woman told that when she was having pain and the child was not moving down, the dai put her hand in the coconut oil and tried to widen the opening of vagina. She was not given any tablet but some safoof (herbal medicine) instead. She placed another hand on the stomach and put pressure downward so that child gets the right position and comes out easily. It seemed that the child’s head was stuck and dai was facing problem in delivering the baby.

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

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

Starting at the beginning of the last month of pregnancy, some women I met, took a mild diluted homemade herbal powder every night just before going to sleep. Most people made this herbal powder by boiling ground dried ginger and jiggery in water and drinking the mixture while it was warm. Others made
it by mixing various ingredients - dried ginger, juggery, cumin, anise, black coriander seeds- and eat this powder every night. These mild herbal powder were said to enable the pregnant women to pass urine easily and to help bring on labour pains gradually. Many people also give barley water to facilitate urination during pregnancy. This is viewed as an antidote to edema. Most commonly, this powder is taken once the women had the first inkling that the real pains had begun. Although the ingredients were same, these were far less diluted and were expected to have immediate, dramatic results. Dried ginger is the most important ingredient, and at times it is made into paste and consumed plain for extra potency. In addition to the ingredients already mentioned, some people include pepper, drumstick leaves, and coconut. This powder helps in determining whether or not the pains which the woman is experiencing are genuine labour pains. If the pains increase in intensity and frequency after the woman consumed this herbal powder, it means that they are real labour pains, and credited with speeding up the contractions. If, however, the pains subsided, after the woman took the herbal powder, then the pains are said to have been caused by indigestion and gas, as ginger is effective in indigestion. Arandi ka tel (castor oil), tea mixed with ginger and cloves, and hot water is also consumed to increase labour pain.

A lower caste Muslim woman, who had eleven live births during last seventeen years told me that “I can’t work during pregnancy. I get swelling. I also have nausea for five to six months and cannot eat a thing. I do not go to hospital for births, all my deliveries occurred at home. I know some good tricks. As I feel that delivery time is approaching, I drink some coconut oil and lie down. This grease makes the delivery easy and the child comes out easily”. I enquired that from did she got this idea, and she said that someone told this to her. She further added that, “though earlier some helping hands like my mother-in-law or dai used to be with me and helped in cutting the cord. But in last two deliveries I was alone. I asked my eldest daughter which is twelve years of age (presently) to bring some boiled water
in a tub, a knife put in it, soap and some lukewarm water to be kept on a stool in the room. Clothes and cotton I arranged beforehand. In last two deliveries I lied down and put efforts so that the child would came out easily, in each case. I cut the umbilical cord with knife and tied it with thread after doing all the cleaning myself and after giving bath to baby, I called my daughter to take the child away. After taking rest for an hour or so I breastfeed the child.” Amazed after hearing all this I wondered how possibly could she have managed all this. Childbirth is the most painful and difficult form of labour. While some women locate the pain of birth deep inside the pelvic region, others do not give a specific location, indicating instead the diffusion throughout the body. Women say the pain of birth is so intense they lose all thought or awareness of who or where they are (Merrett, 1992).

Only in one case among Muslim women, Najma (a sheikh woman) had her deliveries in a private hospital at Aligarh. She had caesarean deliveries. In the first case she did not have labour pains till the due date. She consulted the doctor at Dibai but the doctor asked her to wait for a few more days and even conducted ultrasound. But the doctor did not do anything. Around ten-eleven days after the due date she felt uneasiness and consulted the lady doctor again in Dibai. She started having bleeding and the doctor could not do much and advised her to be take to Aligarh. As they already had a room booked in the hospital, immediately they rushed to Aligarh. Doctor there asked to arrange for the blood and after watching her condition for sometimes, decided to operate. She remained in the hospital for six days and had proper medication. In the second time, delivery she fainted suddenly for three to four minutes and as soon as she got consciousness her sister-in-law took her to the hospital. Gynaecologist admitted her, undertook the necessary checkups and after observing for some time, performed the operation.

Pollution and fear of bhoot (ghost /evil spirits) are closely related concepts. The use of pora pani (sanctified water), as in the two examples given, earlier, serves to protect mother and child against bhoot, as does the taaviz tied
around the baby’s neck immediately after birth, as in the case of Zori’s baby. Belief in evil spirits (also referred to as bhoot-pret or jin) is widespread and certain illness are consistently explained by referring to evil spirits (bad air) in Bangladesh (Aziz and Maloney 1985; Blanchet 1984; M. Islam 1981, 1989; Mahtab 1989; Maloney et al. 1981; Rozario 1992). Women are more vulnerable to evil spirits than men. In particular, unmarried women, new brides, pregnant and postnatal women are said to be very vulnerable to the attack of bhoot. Hence they must try to avoid the nazar (evil or greedy eye) of the bhoot at all times. The times when the malevolent spirits are most active are high noon, sunset and midnight. Thus post-natal women, who are most vulnerable, must refrain from going out of the delivery room or hut at those times. In fact they must remain confined in their delivery room except for coming out to relieve themselves or perhaps to have a bath. This confinement lasts for a set number of days, which varies according to religion, class and lineage as well as the structure of the family, that is, whether it is nuclear, joint or extended.

Hindus are said to be strictest in this regard; post-natal Hindu women are supposed to be confined for thirty days, although in practice poor Hindu women in nuclear families may find it difficult to follow and leave their delivery hut much earlier, sometimes after eight days, sometimes after fifteen days. It is not uncommon for Hindu husbands to cook the meals during this time in the absence of other female members in the family.

On average, Muslims are said to be confined in the delivery room for five days in the case of a female child and six to eight days in the case of male child. In addition to other purification rituals their confinements come to an end with the shaving of the infant’s hair. Christian women’s post-natal confinement generally comes to an end with the baptism of the baby, which usually takes place after about fifteen days. Apparently, baptism used to take place between three to six days after the birth in the recent past. Muslim and Christians do not build separate huts for
delivery, but they should ideally give birth in a separate room. However, this is not possible in most cases; so they use the kitchen for this purpose, while others use one side of the main room by partitioning it with a wooden bed if available.

In addition to their confinement for a certain period of time, women have to follow certain food restrictions during pregnancy and the post-natal period. It is believed that the *nari* (umbilical cord) of the baby remains *kacha* (raw) for some months and therefore the breastfeeding mother should be careful about what she eats. North Indian women are also reported to follow food restrictions during this time (Jeffery et al. 1989). A typical diet for post-natal women during the five to seven days after birth is *path* or *achwani* - made of grinded dry fruits, *gond* (gum), *khash-khash* (poppy seeds) and *desi ghee* (clarified butter) and milk. After a week or so they can start eating some curries without spices. However, for up to three months or till they breast feed they should avoid very spicy foods, curd, and rice. Most of these women have had very little protein in their food intake during pregnancy, so that post-natal food taboos aggravate at an already existing food deficiency.

The elaborate precautions taken in relation to pollution and *bhoot*, contrast with the lack of precautions to avoid infection and the frequent unwillingness to seek biomedical aid. It is not that Bangaladeshi villagers are unconcerned about the risk to the mother or her child. My interviews confirmed that the family’s fear that they may lose the mother and/or the baby is very real. However, the dangers to the woman’s life and the newborn’s baby’s life are seen to derive from pollution and the potential attack of *bhoot*. Thus miscarriages, menstrual complications, extended labour pain, stillbirth, haemorrhage, post-natal diarrhoea, infant’s diarrhoea and tetanus are explained by evil spirits. The *bhoot* is the symbolic representation of all the danger of births.

Precautions against the evil spirits are therefore seen as a central to protecting the mother and newly born child from illness. Confining the mother to the
delivery room after birth, and ensuring that she observes the food taboos strictly, are therefore important first line of defence. It appears women are becoming increasing aware that it is important to have nutritious food during the post-natal period (though sometime they can not afford it). In any case it is clear that these young women are not yet convinced that eating prohibited food is not going to be harmful for themselves or their babies.

Other minor precautions may be taken to protect the birthing mother and the baby from jinn/ bhoot. Women place a piece of iron (scissor or knife) under the pillow of the new baby to ward-off the evil spirits. The village women place an old knife, old shoe or a broomstick under the mat of the birthing women (Bhatia et.al.1980).

Hindu women in addition to calling on the services of the ojha (evil spirit dispeller), sadhu (Hindu holy man) or peer (Muslim saint), also offer puja (worship) to a Hindu deity, such as kali for protection against attack from the evil spirits. Alternatively, they will often make a mannat (vow) that if everything goes well, a big puja, accompanied by a feast will be held in honour of the deity.

5.3.3 Concept of induced pain

Among Muslims, there is a notion that only fortunate women go through the pain and hardships of pregnancy and delivery and it washes away all their sins. One respondent told vehemently “baanjh aurton ka aisa naseeb kahan, yeh takleef to qismat walo ko milti hai” (where does a barren women, have such luck as to experience such pain). Another concept of “gunah se paak hona” (cleaned of all sins) is associated with delivery. The same women argued that “bacche ki paidaish ka dauran Allah aurat ke saare gunah maaf kar deta hai”(she becomes pious again as a new born baby as she goes through a process of life and death). Another woman told that giving birth to a child is equivalent to performing Haj (pilgrimage to Mecca), and even those
women who attend to a delivering woman also get this sawab (blessings of Allah).

Jeffery et al. reported that over one-third of women delivering in the North-Indian village of Dharmnagri in 1982-1983 received such injections from private male nurses. Jordan’s Yucatan study also showed that Mayan midwives were using B12 injections to induce labour at home.

This case provides a clear example of how people in Dibai employ multiple techniques to attempt to speed up labour. It is particularly interesting to find (as discussed earlier) the tensions which sometimes arise between allopathic and non allopathic approaches to managing birth. There are serious risks with using allopathic drugs to induce labour without immediate access to emergency care. The risk includes uterine rupture and decreased oxygen supply to the baby (Davis-Floyd, 1992). Kitzinger (1991) explains that extremely powerful contractions such as those induced by oxytocin drugs, “are likely to interfere with the blood flow through the uterus and so cause foetal distress”. If the cervix is not “ripe” and ready for labour and oxytocin is administered, the uterus may not respond to the hormones and it may then be necessary to proceed with a caesarean. Furthermore, Kitzinger writes that if labour is induced, it is critical to monitor contractions using an electro-foetal monitor. Such technology cannot be used in home deliveries in Dibai. Davis-Floyd also points out that these drugs are strong antidiuretics and when given with IV fluids to fasting women, they ‘can result in water intoxication, which itself heightens the woman’s risk of pulmonary edema in those rare cases of gastric aspiration.

5.4 Attitude related to Breast Feeding

Facts for life, (a publication of UNICEF & WHO, 2002), brings out the importance of breast feeding and its positive impact on the child’s health. Babies who are breastfed are better nourished than those who are fed other drinks and foods. As a matter of fact if all the babies were fed only breast
milk for the first six months of life, the lives of an estimated 1.5 million infants would be saved every year and the health and development of millions of others would be greatly improved.

This information regarding the importance of breastfeeding led the researcher to enquire about the attitude, pattern, scheduling etc towards breastfeeding the child. In all the case studies collected I tried to explore various dimensions related to it. It has been found that whether to breastfeed or not is not an issue among the Muslim as well as Hindu women of Dibai town. All agreed that they breastfed their child and there is no hesitation regarding this. They even were amused to know that it is a great issue and many women in modern cities do not follow this practice due to one or other reasons. They raised and mocked the idea that breast feeding affects the figure of the women.

A well educated sheikh woman Najma said that “breast milk is the only food and drink an infant needs for first six months. No other food or drink, not even water, is usually needed during this period”. She said that as she had caesareans deliveries she was not clear about breastfeeding in such cases but her doctor emphasized the need of breast milk. She said that newborn babies should be kept close to their mothers and should begin breastfeeding within one hour of birth. As after the delivery she was under the impact of anesthesia, her doctors fed the baby with bottle. She has got stitches and was unable to move or sit for two days, she didn’t breastfed her child. But after that she relied on this and continued the practice till her son became two years old. Najma further informed that in Islam it is prohibited to breastfed the child after two years of age, therefore, she reduced the frequency after 1 ½ years by that time the child was well on the solid diet. Though she continued to breastfed the child for two years but simultaneously gave the formula feed also. She was sometimes not producing enough milk so she started giving formula feed and cow’s milk after nearly three months. Thus we find a contradiction between her attitude towards breastfeeding and the behaviour she has shown. She understands the importance of this but due to certain
constraints she relied on additional liquid diet also. At the time of the birth of her girl (second child) she was teaching in a college and used to cover around 25km daily. In that case she gave bottle to her child. She emphasized that she took care of the cleanliness up to the highest level. She used to keep 5 or 6 bottles and after every feed the bottle was boiled and sterilized properly. She took care that formula milk is not kept for more than 30 minutes. Fresh milk was prepared as and when the child required the feed.

For women working in the organised sector, the government of India has a highly progressive Maternity Benefit Act of 1961, that established legal paid maternity leave for women who had been working for a particular employer for at least 160 days prior to delivery. This act provides women with up to three months paid leave following delivery if they work for the government or for a company which is large enough to have a worker’s insurance scheme. The act also stipulates that employers must allow women “nursing breaks” at least two times daily. Young babies, of course, needs to be nursed more frequently than that. A more significant problem, however, is the fact that many women working in the organized sector work far away from home that such “nursing breaks” are not feasible. In 1995 some companies were beginning to establish day care on their grounds to deal with this problem.

**Shabana**, a lower caste woman (*gaddi*), has 5 children and never gave them bottle. Somewhere after nine or ten months (it varied in each case) she started giving additional food with milk, *khichdi* (a preparation of rice with pulse boiled together), *kheer* (sweet dish of milk and rice), *daal* (pulses), and sometime even *roti* (Indian bread) was given. She never had any problem of lack of milk. According to her “*khoob doodh hota hai to kyon upar ka doodh bacchha ko pilayen*” (when I have plenty full of milk in me, why should I give some other milk). She further explained that it helped her in keeping a good space between two children. Her mother-in-law as well as her own mother told her that “*doodh pilaney se dosra bachha dair se hota hai*” (breastfeeding delays the second child). She kept this advice to her best and
followed it religiously. As cited in the facts of life (2002) breast feeding can give women more than 98% protection against pregnancy for six months after giving birth but only if her menstrual period not resumed, if her baby breast feeds frequently day and night, and if the baby is not given any other food or drinks.

A young Hindu woman named Meena told hat she has three children. The younger one is seven months old. She breast fed all her children. She explained that “maa ka doodh bacha ke liye sabse achha hai. Yeh jaldi pach bhi jata hai aur garmiyon mein bhi bachhe ko pani ki kami nahi honey deta” (mother’s milk is most nutritious for the child. It easily gets digested and in summers it covers up the deficiency of water.) She further told that her sister-in-law who lives in Aligarh gives bottle to her child and he often gets diarrhoea and other illness. She added that “meri babhi dibbe ke doodh par bohat paisa kharcha karti hai, phir bhi bachha theek nahi rehta, doctor ke chhakkar alag se laganey padta hai.”(my sister-in-law spends a great amount of money on tinned milk powder, but still the child does not keep well and she often has to take the baby to the doctor.)

Another upper caste Hindu woman Neetu, told that she delivered the baby in a doctor’s nursing home. Though she was feeling very weak but her doctor insisted for breastfeeding. Nurse helped her to feed the child by putting the baby in the right position and squeezed the breast. Her mother-in-law asked the doctor to clean the khees – the thick yellowish milk (colostrums) which mother produces in first few days after birth and is the perfect food for newborn babies. It is very nutritious and helps protect the baby against infections. Doctor asked her mother-in-law that not feeding colostrums to the child is incorrect. On being asked about the frequency of feeding, Neetu told that usually this gap was of two to three hours. If baby slept more than three hours after breastfeeding, the baby was gently awakened and offered the breast milk. Neetu recounted what her doctor told her. She said that breast milk is the baby’s first immunisation. It helps to protect against diarrhoea, ear
and chest infections and other health problems. The protection is greatest when breast milk alone is given for the first six months. No other food or drink can provide this protection. Breastfed children get more attention and stimulation than those are left to feed themselves with bottles. Attention helps infants grow and develop and helps them feel more secure. It also creates a special bond between mother and child.

In another case, when I was interviewing a *lodha* (lower caste Hindu) woman, what I observed was clearly in contrast to whatever the doctors advice. I found that about six or seven months old baby boy was lying on a cot. He had a milk bottle attached to his mouth. Flies were flying everywhere and the entire place was very dirty. The bottle fell down on the floor and the child started crying. The mother picked up the bottle and again gave it to him. I told her that unclean bottles and tarts can cause illness such as diarrhoea and ear infections. Diarrhoea can be deadly for babies. Illness is less likely if the bottles and tarts are sterilised in boiling water before each feed. I asked her whether she breast feed her child or not. She replied to me that this is the eight child and she does not produce much milk. Though she breastfeed also but giving bottle is very convenient. She gives buffalo’s milk to her child. This trend of giving feeders to the children is observed in many other lower caste Hindu and Muslim families. I feel that they have a perception that giving feeder to the child raises their status in the eyes of others and therefore the use of feeder has become prevalent in these sections of society. K Ram (1998) propound that maternal milk is seen as an emanation, suffusing the mother’s body at the very sound of her child’s cry, endowing the child with far more than biological nourishment.

5.5 Family Planning and Need for Contraceptives

Rapid population growth, at times, is blamed for all social ills facing the human race. It has its impacts on economic development, widespread hunger and poverty, environmental degradation. Due to low economic development major section of the society does not get basic services. Reduced population.
growth through reduced fertility rate has far reaching implications on the various dimensions of society and government. The availability of allocated government resources for health, education and welfare activities would improve. Thus fertility decline is a major concern and it is directly related to the reproductive health of the womenfolk. The transition in fertility is observed throughout India across wide sections of society. NFHS data has also revealed that the TFR has declined from 5.7 births per women in 1970-72 to 4.5 in 1980-82 and to 3.7 in 1990-92. The TFR estimated by NFHS for the 1990-92 periods, however, was 3.4 births per woman. Notwithstanding the differences in the TFR estimates of SRS and NFHS, it is certain that fertility in India has declined during the last 20 years by at least two births per woman.

Thus it was an area of concern in the present study also and therefore I have made efforts to know the perception of the women in Dibai regarding the methods used for family planning. In the present section the analysis based on the interview is presented which covers the knowledge and use of various methods of contraception and their impact on health.

5.5.1 Knowledge of family planning methods

During the survey, I asked women, ‘Have you heard of ways and methods that women and men can use to avoid pregnancy?’ Nearly all the women responded positively. They reported that they are aware of presence of different ways to terminate pregnancies. When asked to name such methods mostly all, excluding the newly married women (of lower castes and uneducated) and few others, were able to mention at least one method of family planning. Many of them were aware of more than one method. It was further probed whether they are able to differentiate between traditional and modern methods or not. More than half of the respondents could name at least one modern method of contraception spontaneously – that is without prompting. After giving each respondent an opportunity to name family planning methods spontaneously, I probed by reading the name and a brief
description of some methods, both traditional and modern, that the women did not mention spontaneously. After that I asked if she has heard about these methods. Only a few were aware of most of the methods but nearly all, barring a few, acknowledged that they have heard about one or more methods. As I asked only if the respondent has ‘heard of’ each method, however, a positive response indicates awareness of the method but not necessarily an understanding of how to use it correctly. Positive responses also do not indicate whether respondents are aware of benefits and drawbacks of using these methods.

Recognition of contraceptive methods varies according to women’s education and other socio-economic characteristic, but it does not vary as much. Nearly all women with more than a primary education know of at least one family planning method. Also, high class women in both the religions are more aware of the methods and aware of more methods in comparison to lower caste women.

5.5.2 Trends in the use of family planning

The interviews have revealed that contraceptive use is common in upper caste Hindu women. The use of modern methods namely, voluntary sterilisation, oral contraceptives, intrauterine devices, condoms is more, in comparison to the use of traditional methods. In fact, in this category the use of traditional method has declined. But in lower caste Hindu women the use of traditional methods is also prevalent and only few modern methods are used. Among Muslim women the use of family planning methods is least. Both upper and lower caste Muslim women are apprehensive in using modern methods.

Oral contraceptives are the leading modern method among the Hindu. The family planning policy has a special bearing on the lives of women. But it cannot be treated as a problem of women in isolation from their men and in the wider social context. In order to understand the use of family planning methods and their acceptance among different categories of responses, we
need to understand the mindset of women, their men and significant others of
different categories. The prevalence of family planning is common in Hindu
women in comparison to Muslim women and I think the cause lies in the
theological traditions of Islam.

The unwillingness to exercise family planning among majority of Muslim
women in Dibai area is in the line of belief prevailing in Muslim population
across different countries. It is often cited that Islam prohibits the control of
fertility; therefore, in many Islamic states sterilisation and abortion are
considered illegal. I found during interviews that many Muslim women
echoed the same sentiments. They believe that it is un Islamic to control the
birth of child by any artificial means. But if you have control on your nafiss
(will power) then it is permitted. Which means abstinence and coitus
interruptus can be followed as a family planning method. There is a debate
among the scholars over the issue of contraception in Islam; Maududi (1980)
argued that family planning is condemned in Islam. Khalid (1980) pointed
that only abstinence is mentioned in Hadith (prophet’s teaching) since no
other methods of contraception were available at that time. Chatto (2000)
cited that coitus interruptus is the only method of contraception allowed in the
Islamic Texts.

Even though the Medical Termination of Pregnancy Act, 1971 has been
defined as ‘un-Islamic’ and against Islam by many Muslim scholars in India,
there does not seem to be any legal support for considering a termination up
to the 12th week as being ‘un-Islamic’. The second provision of the MTP Act
exceeds this limit by three weeks. Further, both medical and Islamic laws
allow termination of pregnancy under conditions of severe threat to the life of
the mother or the child. Neither of the two laws considers it to be the method
of the first choice. The limit of the seventeenth week was fixed by the Hana’fi
(a Muslim sect) jurists, though it is not mentioned in the Quran or the hadith
(Chattoo, 2000).
Though believing that terminating the pregnancy is un-Islamic, the Muslim women in this area are exposed to the family planning programmes through health centre and the NGO which is working in Dibai. They are also exposed to the concept through mass media specially by radio and television. At the same time it seems that they appreciate the benefits of family planning and try to use those methods which are not very prominent and can be used in the privacy.

5.5.3 Characteristic of contraceptive users

**Education:** In most cases the better educated women is, she is more likely to use family planning. Women with primary education use contraceptives than women with no education but not as likely as women with the secondary education or more education. I found that upper caste women in both Hindus and Muslims are better educated than low caste women.

Urbanization and industrialization might cause a decline in fertility but a more relevant factor associated with health improvement is education because by and large education changes attitudes and outlook whereas urbanization and industrialization might improve the economic status of women (Desai and Krishnraj, 1987).

**Woman’s Age:** The use of contraceptives for family planning is lowest among young women, reaches a peak among women in thirties, and decline among older women. This pattern reflects the desire for child bearing among young women, then growing interest at first spacing and later ending with child birth. Once the desired size and sex composition of the family is achieved, and as the couple grow older, the women can exercise their will more freely in such matters. Some of the young women narrated that they wanted to adopt family planning due to ill health but it was opposed by their husband and mother in-law (the role of other male family members is restricted on these matters and is still considered taboo in Dibai area). The cases where the women due to ill health wanted to take precautionary
measures after marriage were coerced by husband and others to bear at least one child within the first year of marriage, as it is of umpteen importance. Das (1988) also discussed that elderly women share patriarchal authority with men and, in fact can be seen to be acting as patriarchs. Though in the survey it has also been found that a few women started using these methods just after marriage and have updated information regarding the availability, benefits and drawbacks of using any of the method. Quite strangely, contradictory to the prevalent belief among Muslims, a newly married Muslim young woman Zeba of 25 years of age (post graduate) told that presently she is using oral pills with the consent of her husband but without the knowledge of in-laws. She said that I want to enjoy life and after the child it will put restrictions on my free movement in social circle. She also wants to pursue her studies further. She goes for check up routinely to the gynaecologist and takes advice regarding the continuation of pills. Zeba's case shows that in upper caste educated Muslim women the perception regarding family planning is changing and they also welcome the modern methods to make their life happy. At the same time it shows that the new generation goes against the prevalent customary norms. Though the educated husbands are understanding and encourage using family planning methods but in-laws do not favour it especially during early period of family life. Zeba fears that her mother-in-law should not know about this as she asks very frequently, but indirectly that 'der kyon ho rahi hai' (why is it getting late?) and she also took her for check up.

Number of Children: Estimates of potential demand for family planning are based on the responses to questions about women's reproductive intentions vis-à-vis number of children. I asked women 'whether they prefer to have or not any more children'. If they do not want to have more children then whether they follow any birth control measure or not. I found that the use of contraception increases with the number of children a woman has up to the third to fourth child. Many women who have reached their desired family size
seek to stop having more children. In lower caste Hindu and Muslim women category, majority of the women with many children do not use contraception because they want to have large families also, many women with more children are older and may not be using contraception for reasons associated with their age.

During interviews Munni mehatrani (sweepress) told that she has four daughters and two sons. She narrated that she had consecutive births of 4 daughters in the hope of son. After deliveries she started having problems, ‘khoon ki kami ho gayi’ (got anaemic), ‘kamar mein dard aur chakkar aane lage’ (backache and giddiness problem started). She was not cared adequately by her mother-in-law and was not given proper and enough food to eat as she was bearing girls only. Her husband cared for her and occasionally would brings delicacies to eat but her mother-in-law resented it and always created fuss. She treated her like banduwa mazdoor (bonded labour) and created problem for her. The mother-in-law used to say that she is as good as banjh (barren woman), ‘ek diya nahi jala saki’ (cannot light a lamp i.e. give birth to a boy). During the course of giving birth to girls, Munni pleaded to get operated. But at that period one of his neighbours suggested her local medicine for delivering the male child. She was saying that ‘meri padosan ne mujko sah palat ki dawa di jiske bad mujhko ladka hua’ (my neighbour gave me a local medicine for gender turn around, after taking which I gave birth to a boy). After that she delivered two male children consecutively. Again she wanted to get operated but their father-in-law insisted that, ‘ek ladka aur hona chahiye’ (there should be one more boy). Munni and her husband tried again, she conceived again but after some time miscarriage occurred. At present she is having reproductive health related problem but nothing much can be done.

Thus the entire discussion reflects the knowledge and demand for family planning method but always these are not used. Estimates of potential demand for family planning are based on the responses to questions about women’s reproductive intentions vis-à-vis number of children.
Caste Differences: I also found that the caste plays an important role in using or not using any contraceptive. The discussion revealed that upper caste women are more likely to use contraception specially the modern methods than lower caste women. This applies to Hindu as well as Muslim women though the use of contraception is relatively low among overall Muslim women. There are several reasons that upper caste couples are more likely than low caste couples to use contraception. They are educated and have ‘modern attitudes’ that includes wanting smaller families; it is more expensive to raise children at a desired status; and also have less need for children’s labour.

5.5.4 Trends in use of contraceptives

Sterilisation is the method about which the women of even lower castes are aware, but not about other modern methods of contraception. Sometimes they are not aware and sometimes they do not have access to them due to restricted socio-economic conditions. The following narrated episode reflects the positive attitudes towards family planning, whether it is arising out of need or out of choice.

Santosh, a lower caste woman has five children, two daughters and three sons. After facing a lot of problems during deliveries she decided to adopt any suitable family planning method. Doctor advised her for operation, and without informing anybody in the house she adopted the method of sterilisation. But at present she is facing a lot of problems. She is having urinary tract infection, and thus is not happy after adopting this method.

On the other hand, another women named Jameela (upper caste Muslim) woman having three daughters and three sons), showed entire different attitude regarding family planning. She did not face any problem during first delivery but the second was not so easy. During second delivery she often visited ‘midwife’ but never took proper medicines and nutrition. When she became pregnant the third time, keeping in mind the problems faced in
previous delivery, she consulted the lady doctor. The third child was born in the hospital as it was a breach pregnancy (at the last moment family members took her to Aligarh). She said “bachha ulta tha” (child was in wrong position). Next time Jameela faced a lot of reproductive health problems. Then she gave birth to twins and her health has deteriorated further but her spirits are high. According to her “bacche Allah ki dein hain” (child is a gift of Allah). The theory of conception does not recognise the female contribution in conception (Yusuf, 1938). She is not in favour of operation for controlling birth. According to her it is against Islam, “kya jahannum mein jana hai” (do I have to go to hell). She has a rigid attitude regarding sterilisation but is willing to take pills if these do not make her banjh (barren). Thus the notion of family planning and use of contraception methods is quite contradictory to each other. Any methods which control birth permanently is considered a sin and must be opposed, while those methods which control birth temporarily are accepted. The religions and ethical dimensions dominate the mindset but economic and health conditions propel to think in a different line also. These sentiments are discussed by Chatto (2004) also in her work conducted in Kashmir. She concluded that abortion and sterilization were perceived to be gunnah (sins) in that these acts implied an attempt to interfere in Allah’s will and his am’l (act of creation); since conception is believed to be the result of Allah’s will rather than merely the physiological result of the sexual act. What is important is that the more appropriate term in this context, is shirk (an act equivalent to polytheism in Islam), and was never used in speech by the women under the study. This may be explained by the fact that shirk has a quality of finality, which puts the subject immediately outside the community of Islam (Izutsu, 1995). Women often defined abortion as qat’l (homicide or infanticide), while some perceived sterilization as potential infanticide of all those babies who might have been sent by Allah. Those who had formal Islamic training were more specific by saying that each potential human being is after all the property of Allah. Contrary to this Freed and
Freed (1985) observed that majority of the couples who opted for sterilisation said that large families were unmanageable, since it was very expensive to educate and raise children. Misri and Tripathi (1971) observed that many husbands disapprove any method of contraception.

Thus, in other studies also, conducted in different parts of the country, the attitude regarding permanent method of contraception is always not positive. Mostly, due to economic hardships rather than willingness, in lower caste these methods are adopted. During my interviews I came across many women, mostly in the lower class Hindus and Muslims, having a curiosity regarding the oral pills. They wanted to know the name of any such pill which is economical and free from side effects. This throws light on the attitude regarding the acceptance of any safe and temporary method for family planning. Table 5.3 and Chart 5.3 show the problems faced by contraceptive users.

5.6 Practice of Family Planning and use of Contraceptives

5.6.1 Traditional methods of limiting fertility

The issue I wanted to probe was how women of Dibai manage to limit the number of children? Women are quite vocal regarding this and provide detailed description of the methods which they follow. During the course of discussion it evolved that the methods which are generally followed include a good deal of abstinence, practice of coitus interrupts and induced abortions.

**Abstinence:** Many lower caste Hindu women were of the opinion that it is necessary to control sexual desire as it sucks energy. Their men work hard in the fields or as labourer, therefore, energy must be saved. Some sexual abstinence for a man is considered to be good for him. As Moni Nag has put it, ‘there is a widespread belief among Hindus that semen is a great source of strength for men and so men are very much concerned about loss of their strength through coitus (1972)’. Semen is considered to be life maintaining as
Table 5.3: Problems Faced by Contraceptive Users  
(N=80)

<table>
<thead>
<tr>
<th>Nature of Problems (multiple responses)</th>
<th>Number</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Excessive Bleeding</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Scanty Bleeding</td>
<td>10</td>
<td>12.5</td>
</tr>
<tr>
<td>Irregular Bleeding/Spotting</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Amenorrhea</td>
<td>5</td>
<td>6.25</td>
</tr>
<tr>
<td>Pain</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Others</td>
<td>5</td>
<td>6.25</td>
</tr>
<tr>
<td>TOTAL</td>
<td>80</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Interviews

Chart 5.3: Problems Faced by Contraceptive Users
well as life generating and in the popular belief that a man has only a limited store of it, each drop formed at the cost of forty (or in some versions, hundred) drops of his blood. So the loss of semen is believed to dilute a man’s energies, thickens his wits, and if drained in ‘excessive’, may take away his life. (Gould, 1969; Wayon and Gordon, 1971; Poffenberger and Poffenberger, 1973). Tuberculosis, the principal cause of death among young adults, is often ascribed to sexual over-indulgence. And mothers of infants should have as few sexual acts as possible; in popular belief, a nursing infant may be imperilled, if the mother has intercourse because her breast milk may thereby become spoiled. (Pathare, 1969; and Poffenberger, 1973). A good many Indian Muslims also are concerned about excessive loss of semen (Carstairs, 1957; Nag 1972). On the contrary a few women were of the opinion that to fulfil the sexual desire does not have any impact on energy and it is the men’s prerogative to fulfil it.

During the discussion curtailment of frequency has been reported by women in their thirties. Among lower class / caste families, the houses are very small having only one or two rooms. Most of the members sleep in the open, outside the house or in the aagan (courtyard), specially during the summers. Among those families, a man enters a woman’s room only for a specific purpose and for a limited stay. Usually men visit their wives late at night and soon return to join other family members, unseen and undetected.

Women also told that in this region the frequency of intercourse varies with the seasons. Couples sleep together more often in the winters for warmth (Wyon and Gordon, 1971). Several studies of the monthly rate of conception in various parts of India conclude that the rate of conception is much higher in the colder months than in the hot months (Planalp 1971, Stoeckel and Choudhary, 1971).

It is found that to control birth; one of the critical factors is whether a woman has sexual relations during the fertile 72 hours or less of her menstrual cycle. For this reason Pool (1972) questions the importance of the frequency factor,
at least on the societal level. Women narrated that to postpone or to avoid another pregnancy and for spacing they rely more often on periods of abstinence. It is followed per week or month, and the frequency is reduced.

There is one kind of abstinence, however, that paradoxically may result in higher than lower fertility. It is popularly believed that a women’s most fertile comes in the days immediately following the cessation of menstruation and that the rest of menstrual cycle is ‘safer’. Sexual relations are forbidden during menstruation and almost all couples rigorously observe this taboo. But in a number of groups a postmenstrual taboo is also favoured. In a sample of women in Mysore village, 66% abstinence for at least 8 days after onset, as did 40% of the women in a sample from a middle class of Delhi. As Chandrasekaran points out, with such abstinence periods ‘the timing of coitus appears to coincide with the days of the women’s ovulation’ (1952). This misapprehension apart, observance of the biologically signalled periods of abstinence has helped reduced fertility rates.

Abstinence is followed in Muslim women also but not continuously. Whenever the couple becomes casual, pregnancy occurs. A common problem was narrated by Zareena, (lower caste) Muslim woman. She told that most of the women in that mohallah (locality) are like her whose husbands remain out of town for 3 – 4 months to sell durries (cotton mats). Whenever they would come back for whatever little time, they were not able to pay any attention to any taboo and were not able to control their desires. At that time it becomes very difficult for women to follow abstinence as it is an effort made from both sides. The same sentiments were disclosed by lower caste Hindu women also whose husbands are truck drivers and are out of the town for many days.

The Withdrawal Technique: A method that has been very effectively used in some societies is coitus interrupts, involving the men’s withdrawal during coitus before ejaculation. It remains one of the major contraceptive techniques other than modern methods (Bendict, 1970). In my study I found that it is also
a technique used occasionally among educated and wealthier than among the poorer and uneducated people. In Dibai region most surveyed women are aware of this technique but all of them do not use it or ever used it. This technique is used when women are not using any other method of contraception and husband desires to have sex. The onus of using this technique goes to male partner and not to women. Only a small percentage of men and women know of it at all (Mysore 1961), but the most likely circumstances is that reported from a village of Meerut district (incidentally Dibai also falls in this geographical belt which is very fertile). Withdrawal is nearly universally known there as a way of preventing conception, but, as with complete abstinence it is considered appropriate only for older couples who have married children (Marshall, 1972).

It was also revealed that couples used this technique as an individual basis. Many women told that sometime they follow this or followed once but complete satisfaction is not derived due to this; that is why it is not followed regularly. Shyly a woman told that, she feels guilty as husband is unable to get satisfaction. One woman told that sometimes it is used but she thought that it is the indigenous method experimented by her only. She was surprised to know that it is a well known practice for family planning and used wide spread. She, though an educated woman, had limited knowledge about the contraceptives and was not much clear that what to follow regularly.

Some Muslim women reported slight variations of this technique. Some women reported to take a bath and wash the vagina after coitus. One woman said that she put a piece of cloth soaked in mustard oil into the vagina just after coitus. It is found that the use of this technique is not regular and lapses are there. Some women use other methods also like the use of jarhi booti (herbs) along with this method. But those can not be considered foolproof method to limit pregnancy. For some these methods work and for others these may fail. It is noteworthy that among Muslim women those who were trying
to limit their fertility, many were using the traditional methods of coitus interrupts abstinence, and safe period.

**Induced abortion:** The significance of abortion as a method of birth control in India has been estimated by an official body (Mandelbaum, 1974). Abortion was denied as any pregnancy ending before 28 weeks of gestation, and still birth as that of a child born dead after more than 28 weeks (potter et al.1965). Natural abortion and still birth do not fall under the category of induced abortion. I found no upper caste Muslim woman who would admit to having had an induced abortion. One lower caste Muslim woman, named *Dilshad* narrated her need to go for induced abortion. She already has three daughters and two sons and got pregnant. Her husband was not keeping well. Initially she was taking Maala-D (oral pills) but this method failed. Due to her family problem she could not pay attention earlier. She decided to abort her child at the clinic. After persuading one doctor (only registered not MBBS) she aborted her sixth child in the fourth month of pregnancy. Later on she came to know that it was a male child and then she regretted a lot. After abortion she did not take any rest and went to work directly (he was a housemaid). She was a housemaid. After that *Dilshad* did not need to use any contraceptive as her husband died after few months due to tuberculosis. Thus we see that in those cases where oral pills become ineffective then much choice is not left with the women. A number of women had more than one induced abortion, suggesting that ‘the woman who has a successful experience of the first induced abortion is more likely to go in for further induced abortions, than the woman venturing first time’ (Gandhigram, 1963). Quoted in population report (2000), poor women and young women often suffer the most mortality and morbidity from unsafe abortions. Where abortion is restricted, they rarely have access to safe services, and they also are more likely to have unintended pregnancies because they lack access to family planning.
I interviewed women regarding the methods for abortion. *Vakeela,* a ‘dai’ told that earlier she used to introduce a stick with an irritant into the cervix but now a days she uses a *batti* (medicinal cotton thread) purchased from market. One woman also confirmed the use of *batti* which she got for Rs. 30 from the market but *dai* sells it for Rs. 100. *Batti* has to be inserted in vagina for 24hrs and after that menses starts. Some women use self administered oral medicines like *gajar ka beej* (carrot seeds), *saunth* (dried ginger), *haldi* (turmeric), radish seeds, and *bhilai* (herb) flowers. Pregnancy up to ten weeks can also be terminated by eating regularly these things. *Kele ki jarh* (banana tree root) is eaten earlier for stopping conception. Women who do not want pregnancy start eating *tibarsa gurh* (a type of juggery) as soon as menses starts. Potions are available with midwives, *dais* and *hakeems.* Medicaments taken orally to act as abortifacients are usually available to women, though their effectiveness may be dubious. Gandhigram (1963) in his study found that the most common method, used in 21 of 32 instances, was ‘by directly introducing a stick with an irritant into the cervix, carried out by a barber midwife.’ Three abortions were said to have been accomplished by taking medicines obtained from ‘homeopathic and native doctor’s; eight abortions were attributed to ‘self-administered oral medicines like papaya, juggery, etc.’ The use of thin stick by a midwife has also been noted from villagers near Baroda and the west Bengal (Poffenberger 1969; Nag 1962).

Ayurvedic system of medicine has such medicines in their repertoire. A brief account of contraceptive prescriptions in the ayurvedic literature also contains valuable prescriptions for abortion which are simple, non-toxic, and do not have harmful after affects (Prakash 1967). Others who may provide potions for the purpose are local *hakeems* and *vaidhs,* midwives, and even an occasional priest.

It is a cause of concern that many indigenous methods are not worthy of use and may lead to problems like infertility, or sometimes may lead to death also. Deaths related to unsafe abortion in developing regions are estimated as
high as, 400 deaths per 100,000 abortions in Asia. WHO estimates that 10% to 50% of undergoing unsafe abortions in developing countries needs subsequent medical care. Four factors, along with the overall health of the woman undergoing an abortion will experience medical complications or die from the procedure - 1- the abortion method, 2- the provider’s skill, 3- the length of gestation and 4- the accessibility and quality of medical facilities to treat complications if they occur.

In Sherupur village, U.P, Gould observed, women who had already given birth six or more times make their own decision to try to have an abortion if they became pregnant again. They can make a unilateral decision because ‘the folk methods leading to abortion are entirely a woman’s world (1969). But every time these methods are not safe for the health or even life of women. Rashida, a sheikh woman narrated her feelings of fear regarding the use of potions. She and her elder sister were married in the same house to two brothers. Her sister had seven children. She conceived next time but could not come to know about it as she was breast feeding her child and gap was not maintained. Somewhere after third month she realised that there was some development due to the nausea feeling and other symptoms. She visited a midwife and insisted for helping her to get aborted. After consulting the dai she took some herbal medicines. But her health deteriorated and dai could not manage the case. Rashida’s sister died and this instilled a feeling of fear for life. Rashida also has five children but she can not think about the use of any such thing.

Despite a great condemnation of induced abortion by families, it appears that mostly women with more children obtained abortions, by crude means. This is probably so among poorer low caste women. Thus, to lower fertility the traditional methods of withdrawal and periods of abstinence can be encouraged.
5.6.2 Modern methods of limiting fertility

The traditional cultures have always resorted to self regulatory procedures to increase or reduce fertility, as a strategy to balance family size with resources. Historical evidence also suggest that pre-modern norms and social regulations were designed to intervene in reproduction (Roussel, 1980).

Therefore, today’s modern methods of family planning are not novelty. What is novel in modern era is the scope of the interventions that have expanded enormously (Correa, 1994).

But the use of new methods of contraception is not welcomed in every family, particularly in Dibai area. As everywhere, in this town also, the marriage is interpreted as granting men the right to unconditional sexual access to their wives and the power to enforce this access through force if necessary. Women who lack sexual autonomy often are powerless to refuse unwanted sex or to use contraception and thus are at risk of unwanted pregnancies. During interview a mother of six children, low caste Hindu said, “what can I do to protect from these unwanted pregnancies unless he agrees to do something? Once when I gathered the courage and told him that I do not want to have sex, he asked what else has he married her for? He beats me and have sex whenever he wants.”

These kinds of sentiments were expressed explicitly or implicitly by majority of women. Mostly all the women think that it is their duty to sexually please their husband. Not surprisingly, many women have sex out of fear. For refusal to their husband’s sexual advances, might make their husband angry and they might beat them. Upper caste women also voiced that they do not refuse to have sex (though at times not having any desire) because it hurts their husbands mentally and tension prevails between them for many days. Therefore, the recourse which is left with is to use any of the method to restrain fertility.
Though most of the upper caste women are aware of the modern methods of contraceptive but it has to be seen that how many of them really practice these methods.

**Condoms:** Condom is a simple but effective method of contraception if used correctly and consistently. It holds a special place among the contraceptives due to the dual protection it provides both from unwanted pregnancy as well as sexually transmitted infections. It is one of the methods of contraception which ensures male involvement in preventing unwanted birth. Among all the four categories, upper caste Hindu women and some upper caste Muslim women tend to prefer this method over others for spacing. Most of the Hindu upper caste women said that they use condoms regularly. When asked whether they are aware of female condoms and used it or not, most of them were surprised to know that such a thing exists. Only a few have heard or read it as a passing reference. *Neelam,* mother of one daughter said that, her husband started using condom after their first child. The reason cited for its common use are; prevents STIs (sexually transmitted infections) and pregnancies, safe - as no hormonal side effects, can be stopped any time, easy to keep in hand, in case sex occurs unexpectedly, can be used without seeing a healthcare provider first, usually easy to obtain and sold at many places.

The use of condoms by other groups is occasional. Some upper caste Muslim couples also use it. Some lower caste Hindu women were very critical and vocal regarding the use of contraceptives. They asked: why are we always in the receiving end of contraception? The majority of methods known to them are targeted towards women like Tubectomy, Copper-T, Mala-D (the pill), Diaphragm, and Abortion.

**Intra Uterine Devices:** The IUDs offer almost complete protection from pregnancy. The newer IUDs have a longer life–span and are more effective. In my study I came across women, mostly upper caste Hindu women and only one from upper caste Muslims, none from lower caste Muslims and a few lower caste Hindu women, who used IUDs. It is called Copper-T and at the
time of interviews some were using IUD which last for three years only. These women have varying number of children and use it as a spacing technique and not as a semi permanent method (no one used IUDs which last for 5 to 10 years). Kavita told that it is very convenient in use and she even does not remember that she is using it. It does not have any hormonal side effects and there is no interference with sex also. The only problem which she faced was longer and heavy menstrual periods initially. Contradictory to this, another respondent narrated a different experience altogether of her and her sister-in-law. She said that the doctor whom she consulted for IUD did not tell about the side-effects. Earlier she had no idea that such side effects or more serious complications might result from IUD insertion. When she came to know about these complications and started having problems, she consulted another doctor.

Many negative side effects are associated with the use of IUDs. Among the most serious complications is the possibility of developing pelvic inflammatory disease (PID), which can lead to infertility. PID can occur with an IUD when a pre-existing lower tract infection is not treated; the process of IUD insertion carries the infection into upper tract. PID can also occur if the IUD or the IUD inserter is not sterile. Less serious but most common side-effect of IUD use is an increase in menstrual bleeding, painful cramps, and backaches.

5.7 Violence Leads to High Risk Pregnancies

In India it is very common practice that women have been abused physically or sexually by their husbands. Violence during and after pregnancy is having serious consequences for women; in Dibai area also I found that this problem exists. Farzana a lower caste Muslim woman narrated her story in these words; “in the early days of my marriage, my mother -in- law would suppress me a lot. My husband was also with her and supported her behaviour towards me. And when I was pregnant, one day in anger, he hit me with a stick on my
head. I got 18 stitches on my head and due to which I started having permanent head-ache, later on I developed liver problem and high B.P.”.

According to the population report (2000), pregnant women who have experienced violence are more likely to delay seeking pre-natal care and to gain insufficient weight. They are also more likely to have a history of STIs, unwanted and mistimed pregnancies, vaginal and cervical infections, kidney infections, and bleeding during pregnancy.

Adverse pregnancy outcome: Violence has been linked with increased risk of miscarriages and abortions, pre-mature labour, and foetal distress. Several studies also have focused on the relationship between violence in pregnancy and low birth weight, a leading contributor to infants’ death.

**Violence and Maternal deaths:** Maternal deaths are also found in Dibai area though I could not found any written records from the private hospitals, or from community health centre, and during survey no respondent freely told about maternal death. But I observed that in illiterate lower class families, there is no care of pregnant women. All the time they work and if they do any mistake they are beaten and abused by their in-laws and husband. When I was in Lohchab Hospital in Aligarh, a case of pregnancy had come from Dibai. The case was serious and referred from one of Dibai’s nursing home. The condition of the woman was critical. The husband and sister-in-law were with her. When the doctor advised them that an immediate operation is required, both of them got angry. But after lots of convincing by the doctor, they agreed to it. The pregnant woman was operated upon immediately, but the baby was not alive and the condition of the mother was also not good. On knowing that baby was a boy, both the husband and his sister got very furious, and took the woman with them even without the doctor’s permission and the discharge slip. The woman was in real danger and the doctor kept saying, “agar woh isko le jayenge to woh mar jayegi” (if they take her in this condition, she would die).
Such type of negligence and wife beating are quite common among low caste Hindu and Muslim families, but these are not made public. Women also hesitated in bringing out these points to me. Though some of them admitted that under the influence of alcohol (mostly Hindus), wife beating occurs but did not relate it to reproductive health problems (exceptions were also there). In Muslims, wife beatings were mainly due to economic hardships, causing frustration and an built-in social habit (boys grow up watching their fathers abusing and beating their mothers and they think that it is an acceptable and normal behaviour).

In population report on the Indian subcontinent, violence may be responsible for a sizeable but under recognized proportion of pregnancy-related deaths. In India verbal autopsies from a recent surveillance study of all maternal deaths in over 400 villages and seven hospitals in three district of Maharashtra revealed that 16% of all deaths during pregnancy were due to domestic violence (1964).

Health Maintenance Organisation (HMO) studies suggest three main conclusions about the health consequences of physical and sexual abuse of woman:

- The influence of abuse can persist long after the abused has stopped.
- The more severe the abuse, the more severe its impact on woman’s physical and mental health.
- The impact of different types of abuse and multiple episodes over time appears to be cumulative (population report 2000).

5.7 A Dai and her role

Vakeela, a local dai, aged 47 years claims to have attended to about thousand delivery cases, where she had performed the functions of a doctor and midwife, as done in a hospitals. Out of these in about two hundred cases she was unsuccessful and the child had died either immediately after delivery or at the time of delivery. Vakeela got married at the age of twelve. Thirty five
Chapter 5

Reproductive Health and Fertility

year into her marriage, she is a mother of eight, with three boys and five girls. One daughter had died immediately after birth. Vakeela does not discriminate between sons and daughters. Delivering babies is one of the ways in which she tries to supplement her family’s income.

Vakeela’s mother-in-law was also a dai, a midwife in the municipal corporation hospital. And she taught her professional art to her daughter-in-law and trained her well. Vakeela was also a good learner and learnt the art well. I asked her what problems does the young mothers, married at a very early age face during pregnancy and at the time of delivery. She said, that it is a wrong notion that there are complications and risk to the very young pregnant girls; nor are the new born very weak. She says that the death rate at the time of delivery, among the not so mature girls is also very low.

On being asked about the problems faced by ladies, who got pregnant without any gaps and gave birth in quick successions. To this she said that the problems are mostly faced by women in the lower income group, where due to financial restrains, proper diet is not provided to the would be mothers and also even after the deliveries. Lack of basic nutrition diet is the main reason that creates problems both to the mother and child, who is naturally born weak. Malnourished mothers then develop various diseases such as tuberculosis, anaemic, abdomen and back pain, etc and at times their uterus gets ruptured on successive delivery.

Vakeela has tackled many difficult deliveries also. In some cases where child’s position is breached, complications arise. If the mother has courage I can deliver but in most of the complicated cases there is a risk on child’s life. In a few cases it was found that child was already dead in the abdomen and it is very dangerous to mother’s life. In such situations she advises family members to contact a doctor. She disclosed that she had also done several abortions as well, many among them illegal. To perform these abortions, she uses a tube which is freely available in market and a string method trick. She also explained the demerits of intercourse during pregnancy which leads to
abnormality; in one such case, the head of a baby was not in the proper shape and there was a wound on that.

Apart from these functions, a dai's most important job is that of cleaning up of the filth. In the north Indian context, Jeffery et al. (1989) argue that the dai's function is concerned with the removal of pollution: It is inappropriate to regard the dai as an expert midwife in the contemporary western sense. Even in the absence of medically trained personnel, the dai does not have entire control on the management of deliveries. Nor is she a sisterly and supportive equal. Rather she is a low status menial necessary for removing defilement. They also note that the childbirth pollution is the most severe pollution of all, far greater than menstruation, sexual intercourse, defecations or death. Touching the amniotic sac, placenta and umbilical cord and delivering the baby, cutting the cord and cleaning up the blood are the most disgusting of tasks.

I wanted to know as to how far are these notions relating to filth present in Dibai. So I asked Vakeela about a dai's role in the cleaning up or removing of the pollution at the time of delivery. Vakeela confirmed that the removal of gandagi (pollution) is one of the major functions of a dai. She also emphasised that women needed dai not because of her expertise only, but because they are not willing to deal with the pollution involved in delivering the baby. Contact with the birthing substances and especially the cutting of the umbilical cord are perceived to be so polluting that these task are reserved for a dai. If the dai cannot be obtained, the birthing woman may be made to cut the cord herself (Rozario, 1995). And for this reason Vakeela refuses to pass on her professional experiences and expertise to her daughters or daughter-in-law. After all her experiences she has come to the conclusion, that, this is not a clean profession after all.
5.8 Doctor’s Role

Dibai and its surroundings are basically a very conservative society, and hence the role of male obstetrics and gynaecologist can not be appreciated by the local population. Private nursing homes and the government hospitals cater to the needs of women with their reproductive health problems. To these clinics do the women go for deliveries. The information provided by one of the doctor of community health centre is shown in Table 5.4. During my research I conducted interviews with the lady doctors, and one such doctor Shweta Bansal runs the biggest nursing home in Dibai. She told that majority of the patients are Hindu (approximately 80 per cent) and a few Muslim women also come for consultations. She has been practicing in Dibai for last thirteen years and have attended thousands of delivery cases and she recalls only a few cases where patients were Muslim women. Though Muslim women do come for pre-natal check-ups but very few of them go for hospitalised delivery (this substantiates the point which emerged during discussion with Muslim women). She thinks that Muslim culture and traditions prevent women from leaving their home for delivery. She also knows that if situation deteriorates, and if need arises, then these Muslim women prefer to go to near by cities such as Aligarh or Bulandshahr. And after their deliveries when these women visit her again for consultation, they tell about the happenings and their experiences.

Average age of mother at the time of first birth is 20-21 years. The cases of normal deliveries are up to 70% and in remaining 30% cases operations are conducted. She advises the women that when any of the symptoms of childbirth appear, they must immediately contact her. These symptoms include starting of labour pain at the lower abdomen, discharge of water and severe occurrence of bleeding. In some case women do not show any symptoms till many days after due date. In that situation she tries to induce labour and if still childbirth does not take place she chooses to operate, to deliver the baby. During normal deliveries sometimes the outer passage is
small, therefore, she cuts the mouth of vagina, and so that baby comes out easily. Later on stitches are made on the cut (episiotomy). In some cases the use of forceps is also done to bring the baby out. Now days, women prefer to have painless deliveries with the help of local anaesthesia. In some instances, if the medical staff were unable to sufficiently calm down a woman

Table 5.4: Demographic Analysis of Family Planning Programme (2002-2003) Community Health Centre-Dibai

<table>
<thead>
<tr>
<th>Area</th>
<th>Tubectomy</th>
<th>Copper-T</th>
<th>Distribution of Nirodh</th>
<th>Distribution of Oral Pills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>228</td>
<td>143</td>
<td>10340</td>
<td>619</td>
</tr>
<tr>
<td>Rural</td>
<td>35</td>
<td>348</td>
<td>22660</td>
<td>1481</td>
</tr>
<tr>
<td>Total</td>
<td>263</td>
<td>491</td>
<td>33000</td>
<td>2100</td>
</tr>
</tbody>
</table>
### 2-Religion wise distribution

<table>
<thead>
<tr>
<th>Contraceptive</th>
<th>Hindu</th>
<th>Muslim</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vasectomy</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Tubectomy</td>
<td>258</td>
<td>5</td>
<td>263</td>
</tr>
<tr>
<td>Copper T.</td>
<td>397</td>
<td>94</td>
<td>491</td>
</tr>
</tbody>
</table>

#### Religion wise distribution

![Bar chart showing the distribution of contraceptive methods by religion](image)
### 3-Caste wise distribution

<table>
<thead>
<tr>
<th>Contraceptive</th>
<th>Backward caste</th>
<th>Scheduled caste</th>
<th>Other Caste</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vasectomy</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Tubectomy</td>
<td>43</td>
<td>155</td>
<td>65</td>
<td>263</td>
</tr>
<tr>
<td>Copper T.</td>
<td>42</td>
<td>226</td>
<td>223</td>
<td>491</td>
</tr>
</tbody>
</table>

**Caste wise distribution**

- **Vasectomy**
- **Tubectomy**
- **Copper T.**

![Caste wise distribution chart](chart.png)
### 4- Distribution on the basis of children

<table>
<thead>
<tr>
<th>No. Of children</th>
<th>Contraceptive</th>
<th>Vasectomy</th>
<th>Tubectomy</th>
<th>Copper T.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-</td>
<td>-</td>
<td>102</td>
<td>102</td>
</tr>
<tr>
<td>2</td>
<td>-</td>
<td>-</td>
<td>128</td>
<td>128</td>
</tr>
<tr>
<td>3</td>
<td>-</td>
<td>20</td>
<td>75</td>
<td>95</td>
</tr>
<tr>
<td>4</td>
<td>-</td>
<td>-</td>
<td>76</td>
<td>95</td>
</tr>
<tr>
<td>5 or more</td>
<td>-</td>
<td>-</td>
<td>92</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td>263</td>
<td>263</td>
<td>491</td>
<td>491</td>
</tr>
</tbody>
</table>

**Distribution on the basis of children**

- **Vasectomy**
- **Tubectomy**
- **Copper T.**
### 5- Distribution according to the age of wife

<table>
<thead>
<tr>
<th>Age (yrs.)</th>
<th>Tubectomy</th>
<th>Copper T.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 15</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>15-19</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20-24</td>
<td>4</td>
<td>148</td>
</tr>
<tr>
<td>24-29</td>
<td>124</td>
<td>184</td>
</tr>
<tr>
<td>30-34</td>
<td>113</td>
<td>110</td>
</tr>
<tr>
<td>35-39</td>
<td>20</td>
<td>34</td>
</tr>
<tr>
<td>40-45</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>More than 45</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>263</td>
<td>488</td>
</tr>
</tbody>
</table>

DISTRIBUTION ACCORDING TO THE AGE OF WIFE

![Graph showing distribution according to age](image-url)
### 6- Distribution according to the education of husband and wife

<table>
<thead>
<tr>
<th>Education Standard</th>
<th>Tubectomy</th>
<th>Copper T.</th>
<th>Tubectomy</th>
<th>Copper T.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate</td>
<td>90</td>
<td>90</td>
<td>204</td>
<td>275</td>
</tr>
<tr>
<td>Primary</td>
<td>42</td>
<td>37</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>Middle School</td>
<td>46</td>
<td>56</td>
<td>24</td>
<td>51</td>
</tr>
<tr>
<td>High school/Intermediate</td>
<td>75</td>
<td>238</td>
<td>16</td>
<td>108</td>
</tr>
<tr>
<td>Graduation/P.G.</td>
<td>10</td>
<td>70</td>
<td>1</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>263</td>
<td>91</td>
<td>263</td>
<td>491</td>
</tr>
</tbody>
</table>

Source: Community Health Centre, Dibai

![Graph showing distribution according to education level](image-url)
who was anxious due to the pain she was experiencing, then they gave her valium (diazepam, generally referred to as ‘calm pose’). This tranquilliser is given to induce sleep and to relax the woman in labour. This can however slow down contractions, so doctors are often reluctant to administer it unless it is very necessary. The goal in administering valium is to calm down an unruly woman, contrary to the practice of alleviating the pain for her own sake. Doctors working in maternity wards/homes are generally not trained to administer analgesics other than local anaesthesia used for such things as episiotomies.

Maternal mortality rate is about 0.7% - 10%. Very critical cases are referred to hospitals at Aligarh or Bulandshahr. Mostly all of the women are anaemic due to the initial period. In 40% of cases it is mild and in 10% cases it is severe. Anaemia is severe if haemoglobin is less than 7 up to 10 and normal if Hg is more than 10 (which is the case in 40% cases) if iron folie tablets are taken regularly. 95% of the women get tetanus vaccine. In 75% - 80% cases ultrasound is also done.

Average weight of babies is between 2.7kg-3kg. Many of them are low birth weight babies. High-risk newborns are referred for medical examination. In 50% of the first pregnancies, miscarriage occurs and, therefore, DNC has to be conducted. DNC is conducted with the help of local anaesthesia. These miscarriages result due to the lack of proper understanding and safety measures during pregnancy. When asked about the induced abortion she told that now a days rural woman go for abortion after 4 live births and local Dibai women prefer to go for abortion after 3 live birth. If the first child is a girl and if they come to know that second is also a girl, abortion is preferred. First child abortion also takes place, only if pregnancy is too early after marriage (within a month of marriage). In case of foetal death, neglected cases are becoming less. Three years back it was 10% of the deliveries but now it has been reduced to 3-5%. Attitudinal change with respect to health and hygiene of the child and general literacy are the causes of low foetal death. Three
percent of the women have –VE RG factor. In such cases an injection is injected within 24 hrs. of delivery to safeguard mother for further delivery, 40%-60% are high risk pregnancies. To manage gynaecological problems interpersonal communication and counselling are carried out at the time of pregnancy. Women are told about the family planning methods. Mostly followed methods are tubectomy, oral pills, IUDs (Intra Uterine Device), and condoms. In a few cases vasectomy also conducted. Approximately 70% of the women rely on oral pills, 25% women have gone for Multi load-Copper T for or 3 years.

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