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Cultural Context of Intra-Partum Care in a Slum of North Karnataka

KEYWORDS: Maternal Health, Health-seeking Behaviour, Ethnographic investigation, urban slum

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ABSTRACT *Fully achieving Millennium Development Goal 5 (MDG 5) target of reducing by three quarters, between 1990 and 2015, the maternal mortality ratio remains a challenging task. Currently the MMR for India stands at 212 per one lakh live births against the target of 109 by 2015. Hence, it is unlikely that India will be attaining MDG 5 goal. This paper attempts to focus on the significance of ethnographic investigation which unveils the role of perceptions and socio-cultural norms during intra-partum period. Findings reflect upon how a woman in an urban slum right is prepared for delivery. It highlights the way people's life is shaped by social institutions and context. These factors influence the behaviour and can result in maternal mortalities and morbidities. Hence, there arises a need for the programmes to consider the cultural context of the people to achieve the desired outcomes*

According to UNICEF, the UN Population Fund and World Health Organisation (WHO), up to 15 per cent of pregnant women in all population groups experience potentially fatal complications during birth. More than 80 per cent of maternal deaths worldwide are due to five direct causes: hemorrhage, sepsis, unsafe abortion, obstructed labour and hypertensive disease of pregnancy. In about 21 per cent of 500,000 maternal deaths occurring each year, women die as a result of severe bleeding. This complication can kill a woman within two hours; control of bleeding, replacement of blood or fast emergency evacuation is needed to save lives (United Nations Factsheet; 2008).

Maternal mortality remains unacceptably high across much of the developing world. Fully achieving Millennium Development Goal 5 (MDG5) target of reducing by three quarters, between 1990 and 2015, the maternal mortality ratio remains a challenging task. However, out of the eight Millennium Development Goals (MDGs) that have made some progress, albeit slow, is MDG5: Improve maternal health. The two targets for assessing MDG5 are reducing maternal mortality ratio (MMR) by three quarters between 1990 and 2015, and achieving universal access to reproductive health by 2015 (WHO, 2012).

In the year 2000, India; a United Nations member state had agreed to MDGs. Since then, it has been working to achieve them. But currently, the MMR for India stands at 212 per one lakh live births against the target of 109 by the year 2015. Hence, it is unlikely that India will be attaining the MDG5 goal (The Hindu July 2, 2012). WHO representative to India; Nata Menabde, opined that India is unlikely to reduce infant and maternal mortality as committed by 2015. A report released by the Ministry of Statistics and Programme Implementation also highlights the same. Recently the WHO India Country Cooperative Strategy (CCS) 2012-17; developed and launched in collaboration with the Ministry of Health and Family Welfare, lays down priorities and focus areas for national health policy in the next five years. Improving the health of mothers and children by raising the scale of reproductive, maternal, newborn, child and adolescent health services is a key focus area under CCS. The Millennium Development Goals-India Country Report 2011 released by the Statistics Ministry forecast that by 2015, maternal mortality at 139 per 100,000 live births will continue to remain higher than MDG target.

Abundant research has been done in order to understand the factors determining maternal morbidities and mortalities. However, this paper mainly focuses on the significance of ethnographic investigation which unveils the role of vital elements viz., perceptions for healthcare-seeking and socio-cultural norms that in turn influence the behaviour and score over other factors responsible for maternal mortalities and morbidities. Findings reflect upon how a woman in an urban slum right from the onset of labour pains is prepared for delivery by bringing in immediate changes with regards to many aspects such as food, physical movements for the benefit of the woman and the newborn. The very fact that these developments are taking place within a city having access to multiple health facilities is not astonishing. But, the reality that though visible these go unrecognized with less emphasis by policy planners and administrators is a pity when there is an adequate scope for anthropological investigations to understand the Indian milieu.

ANTHROPOLOGY OF MATERNAL HEALTH

Most of the social science evaluations often fail to penetrate the traditional worlds of clinical medicine and public health (Horton, 2010). The studies and findings often privilege clinical over socio-cultural factors. Sometimes interviewing skills remain a weak spot and influence the quality of verbal autopsies and analysis, investigations rarely attend to gender, family, & power dynamics or the conflicting interpretations of 'cause'. It is here that anthropological investigations prove superior to give exact contextual reflections. Community-based and health system–based ethnographies of healthcare and health services are powerful antidotes to common assumptions about healthcare (Berwick, 2008). Ethnographic investigations are helpful in examining indigenous beliefs, attitudes and knowledge that influence behaviors, choices and decisions about healthcare. They establish trust to elicit patient narratives, local knowledge and conflicting interpretations of cause. Such focus can promote and integrate evidence-based practices and local knowledge for provider and patients. Thus, we must retrain our lenses to see health as embedded in, and deeply influenced by, social, economic, cultural, and political conditions that affect everyday life at all levels of the society.

The sociological and public-health literature; offer some theoretical guidance about human behaviors within social and economic contexts. Giddens's (1984) structuration theory highlights that human behaviors must be studied by examining the point-of-view of the individual actor and his/her social, cultural, political and physical environment. Stokols' (1992) socio-ecological model explains that an individual's individual socio-physical environment, biological and psycho-

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logical factors in conjunction with environmental, geographical, technological and socio-cultural factors influence health and health behaviors (Mistry et al, 2009). Health-seeking behaviour is conceptualised as a 'sequence of remedial actions' taken to rectify 'perceived ill-health'. It clearly varies for the same individuals or communities when faced with different illnesses, cultural and ethnic background. Health-seeking behaviour arises with the perception of "illness". It includes "all meanings and activities a person and his/her networks engage in response to symptoms". It "includes symptom recognition, self-care, symptom communication and lay referral, traditional and biomedical care, and treatment adherence/ compliance".

Research Context and Methodology

Ethnographic investigation was used to understand and analyse how women are prepared for delivery in Jannath Nagar, an urban slum that has grown rapidly in terms of population and houses; located in the midst of Dharwad city of Karnataka state. Geographical locale of the slum connects it to various resources (healthcare centres, pharmacies, markets, transport etc) in the city for healthcare but; not in practical reality for many reasons. Majority of the slum-dwellers live in joint families in rented, improperly ventilated semi-pucca houses with an average of two rooms per house. The slum-dwellers lack access to clean water, hygienic public and private toilets, appropriate drainage systems, and stable employment leading to poor economic standards to access - transport, nutritious food, cooking fuel, healthcare services; though available within the city. The reason being, that the slum is situated at the lowest point in the centre of the city and Dharwad being a semi-malnad region; worsens the state of affairs of the slum by flooding it during monsoons. Muslims form the dominant community of the slum-dwellers and next to them are Hindus. Christians and people of other religions form the minority. Jannath Nagar thus forms a resource-poor setting with a blend of diverse socio-cultural milieu which in fact is homogenous in nature when it comes to seeking healthcare services.

Preparing the woman for delivery:

Intra partum period begins when the woman starts developing the signs of delivering the baby. These signs are increasing pain in the lower abdomen and lower back, *paseena* (sweating), *shir ghoomna* (giddiness), and radiating pain in the thighs. People opine that these signs are of important and the significance attached to them is directly proportional to the increase in status of these signs; for example increasing pain, sweating and radiating pain is considered to facilitate smooth, safe and early delivery. People attending the delivering woman look for these signs and see that there is development in these signs.

Immediately after the woman reports pain in the lower abdomen; she is given *garam kaali chaa* (hot black tea). *Jeera seeds are boiled and the decoction is given to the woman to drink* it hot. People opine that hot black tea and boiled jeera seeds decoction induces increasing heat in the body which results in *paseena* (sweating) and increases labor pains to further facilitate early delivery. *Shevya*; a sweet prepared and given to woman for consumption is prepared by boiling dried and very thin long strands of wheat dough in milk, water, sugar or jaggery. This sweet is believed to be the best diet for the woman in labor as wheat is considered to be a hot food to induce heat and also an energy food that makes the woman bear strong pains. Sugar or jaggery balances the draining energy and is also considered to induce body heat. Hot water is poured on *peet ke upa*r (legs) to increase body temperature. Feet are selected for hot water to be poured with the belief that it increases body temperature resulting in labor pains and sweating. The woman is made to lie in a semi-sleeping position with her back against and supported by wall. Timing of delivery is approximately estimated by pouring oil on the *bombi* (umbilicus). If the oil flows in *ada* teda (not in a straight line) direction then the delivery is going to be late. If the oil flows in a *shida* (straight line) direction; then it indicates that the delivery may take place anytime. *Pucca* (real) signs for delivery are noticed. *Pucca* (real) signs are *shir garam* hota (head becomes hot), *paseena hota* (sweating profusely). *Shir garam hota* is judged as the best indicators for delivery. Some people who believe that colour of vaginal discharge indicate sex of the newborn; wait and watch to attribute the sex to the baby to be born. These few people opine that red coloured discharge indicates a female and white discharge indicates a male. Prayers are also offered to God for *sab acchha hona* (everything to go well) and a safe delivery.

People believe that body is conceived as *ghatt* (tight). Hence, it has to be loosened for delivery to take place. Consequently, the woman is made to walk around to loosen the muscles and help the baby come out easily. They say it can help in avoiding *operation* (c-section deliveries). Further hot water is also poured on the lower back of the woman for the same reason and also to give a soothing effect from pain.

The woman is then taken to the hospital decided for the delivery. In case, the woman or any family member is reluctant in getting the delivery done at the hospital, then it is a home-delivery. Factors that influence this decision are lack of capital, rude behaviour and quality care of the hospital staff. Some elderly women highlight that it has become a fancy matter for the women of younger generation to go in for caesarean sections after they reach hospitals to avoid tras (pain). A woman says "*hotti koyyudrinda kya milta ma, sharer haal agtaiti*" (what will you get if you get your stomach cut; body gets spoilt). They also say that of late hospitals are interested in *hotti koyyudu* (c-section deliveries) to earn money. Sometimes if the situation does not favour hospital delivery, then it is a home-delivery. Factors responsible for these decisions are time-factor and capital.

Nevertheless people conceive the body as an entity that is influenced by movements, food and prayers for easy and safe delivery and hence, prepare the woman for delivery.

DISCUSSION

The data highlights the way a woman is subjected to various aspects of care when labor pains set in. Indigenous perceptions and concepts play a vital role in practicing the do's and don'ts by the woman and the people attending the woman. They view body as an entity whose physiological changes can be brought in when subjected to hot-cold food and water especially to facilitate smooth and safe delivery.

Nevertheless, the implications of these practices and concepts related to delivery process can prove fatal when viewed from biomedical perspective. For example; people are unaware about placental rupture and thus conceive red vaginal discharge (blood) as an indication for male baby. Severe increasing pain and profuse sweating can also indicate fluctuating blood pressure, haemorrhage and convulsions. This is risky for both mother and child resulting in mortalities and morbidities. The programmes thus; have to address the notions, indigenous ideas, beliefs and cultural context of the people. Awareness strategies must be planned to bring about appropriate changes in the people's perceptions.

CONCLUSION

People's life especially in slums and rural places is shaped by their indigenous beliefs, social institutions, cultural contexts and it becomes the core of their healthcare practices. Unless the programmes directed towards down-trodden people do not consider the cultural context, the programmes will not achieve desired outcomes. Perceptions regarding signs, indications, hot and cold dichotomy can prove fatal when there is a delay in accessing healthcare services. Hence, one needs to understand the context through ethonographic investigations and ground-level realities which in turn can result in lesser mortalities, morbidities and culturally congruent policies.

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