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An Inter Regional and Inter Religious Analysis of Prevalent Delivery Practices in Moradabad U.P.

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INTRODUCTION

It has well been accepted that children are the wealth of a Nation. Likewise in India, children are considered as supremely important assets of the nation. Families consider childhood as an important period for imparting lifelong learning. This stage is most crucial and has long lasting impacts on child development. In this regard each stage of child rearing from birth onwards assumes immense significance. Many international organizations including WHO and UNICEF advocate for 'Making Pregnancy Safer' by ensuring medically supported skilled care at child birth.

UNICEF (2015) reports that only 46.9% of women in India access institutional care during child birth. This data suggest that more than half of the women are left to the mercy of traditional birth attendants or sometimes even the elderly women of the house. Similarly, Census 2011 reveals that total rate of institutional deliveries was around 67.0 % which includes both Government as well as private hospitals. The percentage of institutional deliveries in urban areas is 87.9 as against about 60.7 per cent in rural areas.

Despite medical advancements, home based delivery is prevalent and is seen as a comfortable option, especially by rural population. Analyzing the results of a cross sectional survey in urban slums of Delhi, Rahi *et al.* (2006) report that neonatal morbidity and mortality continues to be high in India and newborn care practices are major contributors for such a trend. The major factor comes out to be home deliveries assisted mostly by '*dais'* or family members. Most of the TBAs admitted that they used bare finger to clean the air passage of newborn. More than half of the newborns were not weighed at birth, few received tetanus toxoid injection and cord related malpractices.

On the basis of a survey in Iraq, Siziya *et al.* (2009) describe that about 1 in 5 women are attended by TBAs during the child birth process. Young women within the age bracket of 25 to 34 years are considerably more likely to be attended by TBAs during delivery as compared to elder women. Next, those women who did not receive any formal education were more likely (42.0 %) to utilize the services of TBAs as compared to those women who had attained secondary or higher level of education. Siziya *et al.* (2009) further indicate that women from lower SES were slightly

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ahead in availing the services of TBAs. Also the women who had seven or more children are more likely to go for TBA assisted delivery as compared to those who had one or two children.

Gupta *et al.* (2010) based on their cross sectional study on knowledge and practices related to newborn care in urban slums of Uttar Pradesh, report that "about half of the deliveries took place at home. Majority (77.1%) of the mothers believed that immediately after birth, the baby should be bathed with warm water and dried with clean cloth".

Salam and Siddiqui (2006) maintain that "in recent time, an impression is forming that women coming for delivery by doctors are likely to be advised cesarean delivery. The expenditure of cesarean operation is out of reach of the lower and poor economic status families" (p.127). Hence, affordability of services also remains a strong factor for a person to avail them. A religion wise comparison reveal that Christian and Sikh women utilize the reproductive health services far better than Hindu and Muslim women who are surprisingly alike in not availing delivery care services properly.

Thind *et al.* (2008) conducted a cross sectional study to assess the determinants of home, private and public sector utilization for child birth, in Maharashtra. They reveal that 37.0 per cent of the women delivered at home, while private and public facility deliveries accounting for 32.0 per cent and 31.0 per cent, respectively. They further put forth that women with higher birth order and residence in rural areas had greater chances of delivering at home whereas increased maternal age, complete (three) ante natal visits and greater media impact were positively associated with greater chances of delivery in a public facility. When deciding between a private and a public health facility they show that parental education, scheduled caste/tribe status and exposure to media were found to be statistically significant factors affecting the choice of public versus private facility delivery

Exploring the MCH barriers through a qualitative study, Pandey (2010) found that there are a range of barriers beginning from individual mistrust, cultural norms, family traditions and health provider's behavior to women and children that effect utilization patterns. The findings indicate that financial obstacles, especially in relation to transportation, time constraints, and availability of health care staff and services influence women's utilization of ANC and delivery services. Pandey (2010) also report that women who recognize care during pregnancy and delivery care to be pertinent rise above the logistical barriers with the help of family members, particularly their husbands and mothers-in-law.

Hazarika (2011) analysed NFHS-3 data to identify individual level factors that determine the use of skilled birth attendants in India. It is found that "wealth is one of the strongest determinants of skilled birth attendant use, with the poor being at a disadvantage. There are significant differences in the use of skilled delivery care among the urban and rural populations in India. Women in urban areas are more likely to use skilled attendants" (p.1381). A religion wise analysis reveals that Muslim women are less likely to avail skilled delivery services which could be due to certain practices like 'purdah' system and status of women, but it requires further examination. Hazarika (2011) also reports that women with a history of complete antenatal visits are more likely to give birth assisted by skilled attendants whereas women with lower levels of education and rural residence are less likely to avail the services of skilled attendants at birth. He demonstrates that financial, social, regional and cultural factors act as barriers to skilled birth attendant use in India.

Singh *et al.* (2012) using NFHS-3 data have examined the factors associated with maternal health care indicators with reference to adolescent mothers living in rural India. They show unacceptably low utilization of maternity care services among adolescent ever married women in

rural India. Maternal education exerts a significant influence on the utilization of maternal healthcare services by adolescent women but it is not constant across all educational levels. They found that utilization of safe delivery care was found to be significantly lower among Muslim women than among women belonged to other religions.

Putting forth a clear research agenda, Singh *et al.* (2012) indicate that there is an urgent need for future research to recognize the barriers towards healthcare access and utilization by adolescent rural Muslim women. Such an agenda will have larger policy implications and will uncover indigenous factors affecting the phenomena. Taking into account the interface that religion fosters, its insertion in the overall maternal health educational programs can assist the dissemination of the significance of such services.

Mahapatro (2012) reveals that "although women's autonomy in some cases influences the utilization of maternal and child health care, but healthcare seeking behaviors are more strongly affected by socio economic factors" (p. 32). Hence, it can be said that health seeking behavior of women are not only explained by autonomy indices, socio-economic factors play a significant role in utilizing maternal and child health services.

Sanneving *et al.* (2013) reviewed published literature to assess determinants of maternal and reproductive health for achieving MDG no. 5. They show that in India, social structures prevent women from having access to maternal and reproductive health care. These determinants are closely interlinked and difficult to separate from each other. Firstly, In India, one in three women is illiterate and there is a strong association between education and maternal and reproductive especially for family planning. Secondly, economic status is shown to influence access to contraceptives and adequate care during pregnancy and delivery for women belonging to poor households. Thirdly, stratification of caste is one of the strongest social determinants of health in the Indian context, so it is also found to be a determinant of maternal and reproductive health. Similarly, Mukherjee *et al.* (2011) conducted a study in Kerala and concluded that caste-based inequity in household health expenditure reflects unequal access to general health care by different caste groups.

The present research: The primary objective of this paper is to explore factors associated with access to institutional and non-institutional deliveries by women in India. It also aims to assess the effect of region and religion on prevalent delivery practices.

METHODOLOGY

The paper is based upon qualitative data obtained from respondents from Moradabad district of Uttar Pradesh. Eighty young mothers have been interviewed with a semi-structured interview schedule. To compare the effect of region and religion on choices of place of delivery 20 women each (Total =80) have been purposively selected from an urban (*Moradabad Block*) and a rural (*Kunderki block*) region. In all there are 20 Rural Hindu (RH) mothers and 20 Rural Muslim (RM) mothers. In same way 20 Urban Hindu (UH) and 20 Urban Muslim mothers are the respondents for this study. Since Hinduism and Islam are the two major religions in India and in U.P. so a comparison of women belonging to these two religions in their access to institutional services has been done. The findings are discussed in the section below.

FINDINGS

Given several government interventions in terms of financial incentives through NRHM and Janani Suraksha Yojna (JSY) for promoting institutional delivery, the findings of the present study

reveal that only three-fourth of the total respondents (61 out of 80) avail institutional delivery services while rest of the 19 mothers still prefer home delivery. In the rural areas, Hindu respondents (13 out of 20) are found to be more proactive for availing institutional services for child birth compared to Muslim respondents (9 out of 20). Similar are the findings of Fazal (2013) who states that Muslim mothers (33.0 %) are least likely to give birth in a health facility. The perspectives of the respondents with regard to their experiences of child birth at home or in an institutional setting are presented below.

RH 12: At the time of delivery all my in-laws were there and natal family arrived later. It is also believed that the presence of the mother of the delivering woman prolongs labour so mother and other natal family arrived later. My delivery took place at home in a covered area in the backyard because it's a polluted event so generally women doesn't deliver in the living area of the house. It's a norm of the family that the women should deliver at home with the help of a dai only. Sometimes elderly women of the house also assist in delivery. The dai arrived at the last moment of immense pain and asked me to squat and exert pressure for delivery. Though she used clean blade for cutting the umbilical cord, I am doubtful about other hygiene practices. She didn't use gloves and did not wash her hands with soap before the delivery.

RM 5: The delivery happened at home. The dai came and helped in it. First she tried to make me deliver by making me sit on bricks. When nothing happened and I began to faint, my husband shouted that give her two hard slaps, she is shouting so much. The dai then gave me an injection and the delivery happened in a minute. The child was taken to the bed and handed over to me after bathing. The dai did not put on gloves nor paid any attention to any other hygiene practice. Only new blade was used to cut the umbilical cord. Then the umbilical cord was buried into the earth. The child was made to lick honey and then given colostrum. My mother in law had insisted that the delivery will happen at home. Even though my health deteriorated she did not allow my going to the hospital or to a doctor. The dai had said that if the delivery did not take place in 10 minutes, I would be required to move to the hospital. But still I was kept at home. It was Allah's wish that my life was saved, otherwise there was little chance.

RM 19: I delivered at a private hospital in Moradabad through operation. My in-laws and natal family were there to support me. My family, as well as I, believes in hospital delivery because of which everybody helped me in reaching the hospital. I delivered by operation because of some complications. Hospital was generally clean. The child was cleaned after birth and given to me wrapped in clothes provided by my family.

Most of the mothers who have had institutional deliveries believe that it is more scientific, modern and appropriate method of child birth. Some of the RH respondents report the unavailability of a female member at home and location of a PHC close by as the two prime motivating factors for institutional delivery. Similarly, few rural Muslims have also opined that they adopted institutional delivery because of lack of money for the payment of traditional birth attendants, commonly called as *dai*. In absolute numbers, 7 and 11 mothers out of 20 each in RH and RM categories, respectively opted for a home delivery as a method of child birth. A majority of these women have reported doing so because of the pressure of their in-laws. A few supported it and interestingly they accused others of being greedy for the stipend which they would receive in the hospital. Two RM respondents also opined that they have undergone home delivery to avoid unnecessary exposure to male staff of the hospital.

It is evident that decisions of where to go for delivery of a child are not very much those of the couple; it is sometimes the in-laws and at other times other factors that come into play. Likewise,

Kesterton *et al.* (2010) reveal that seeking institutional care for child birth is primarily influenced by a variety of factors. These include community access, economic status, education, region and birth order, importance of the community context and cultural circumstances. Social interactions with family and community may effect, influencing people's attitudes and opinions regarding care seeking. Next the belief that child birth is a natural process and does not require medical attention, is also a barrier in seeking health services for child birth.

The views of a few urban mothers regarding place of child birth are presented below:

UH 2: I have full faith in government hospitals and I had a normal delivery. My mother encouraged me to deliver in a government hospital because the doctors there do not rush for an operation and wait for a normal delivery. The doctors cleaned the baby and gave it to me for immediate breastfeeding.

UH 4: I delivered my baby at a private clinic. The delivery was normal. The hospital was generally clean and the doctors were supportive. Immediately after birth the child was cleaned and wrapped in old clothes and given to me.

UM 9: I delivered my baby at a private hospital and was accompanied by both natal family and in-laws. The hospital was clean and hygienic. The doctors behaved nicely and politely explained my condition. The child was delivered through normal delivery and was given to me after bathing.

UM 17: My delivery took place at the District Women Hospital. As my husband knew the doctor personally so we were given special treatment. People think that we went to government hospital to save money but I stayed in a private room, which was quite clean. My husband gave money to a sweeper separately, so they maintained cleanliness. Despite all this attention I delivered through major operation. The child was given to me after cleaning. It was a good experience in the hospital.

In the urban areas, it is encouraging to note that institutional deliveries are almost universal in both the religious groups (37 out of 40). Salam and Sheikh (2006) who conducted a cross sectional study of NFHS-III data reveal that Christian and Sikh mothers were more frequent to deliver their babies with the help of professionals when compared to Hindu and Muslim mothers who are showing almost similar performance in seeking professional help at the time of delivery.

A rural (22 out of 40) urban (37 out of 40) comparison reveals that urban mothers are appreciably ahead of their rural counterparts in accessing hospitals for child birth. It is consistent with the findings of Salam and Siddiqui (2006) who report that the place of residence of mothers makes a difference in availing existing health care services. Similarly, women residing in rural areas are less likely as compared to those in urban areas to have received complete antenatal checkups, have delivered at hospital and have assistance by medical/health care professional. Interestingly, all the mothers of both of the religions universally are aware and accept the advantages of institutional delivery. However, those women who underwent home delivery confessed that they did so under the influence of mothers-in-law and to follow family traditions. As incidence of home delivery is high in the rural areas so it can be inferred that it is difficult for rural women to go against family traditions hence for many of them home delivery becomes a forced choice.

Cleanliness during delivery :

Observing unclean practices during delivery is a major factor responsible for local infection and sepsis to mother and newborn. Hence, it is imperative to maintain cleanliness during child birth to ensure safe survival of both mother and baby. Although in the present study nearly three fourth (55 out of 80) of the total respondents (N=80) confirm about maintaining cleanliness during delivery

but there is a sharp difference in rural v/s urban respondents. The rural respondents, both Hindus and Muslims (N=40) report similar experiences of unclean practices during delivery.

The rural mothers' views regarding mode of delivery is described below:

RM 2: I delivered at home. The Dai used ash to clean her hands and also applied it on umbilical cord before cutting it with a blade. Cleanliness was as usual and no special attention was paid. The Dai did not put on gloves.

RM 9: I delivered at home with the help of 'dai'. No attention was paid to clean practices by her and the home also was not especially prepared for delivery. The umbilical cord of the child became infected.

It is surprising to note that half of mothers of both religions in the rural areas (9 in each category) have admitted a sheer lack of cleanliness during delivery while the other half reported usual cleanliness practices. Unclean practices have been reported by those respondents who had either undergone home deliveries or the one who delivered at PHC or government hospitals. The rest of the mothers (in both religious categories), who delivered at private hospitals, report to observing usual cleanliness during delivery process.

In the urban areas, Hindu respondents (17 out of 20) are slightly ahead of Muslims (15 out of 20) in reporting about cleanliness during delivery. The urban mothers have frequently reported of clean delivery practices as compared to rural mothers because of the higher rates of institutional deliveries in the urban areas. However, a Hindu and Muslim differential is observed and this is due to the fact that Hindus, being better in SES than Muslims, are frequently using private hospitals for child birth which are quite cleaner than government health facility.

Discussion and Conclusion:

Institutional delivery proves to be an issue of grave importance and the study reveals that majority of the mothers' report of availing institutional delivery services whereas a quarter of the respondents avail home delivery assisted largely by TBAs. The RM respondents are more often to go for home delivery as compared to RH respondents whereas no such religious difference is found in urban areas. Such a trend can be attributed to their lower educational achievement and low SES in the entire sample. The present study establishes that family traditions, pressure of mothers-in-law, difficulties faced in hospitals, unnecessary exposure to male staff (RM) are the important factors promoting home deliveries. Additionally, since rural Muslim mothers are most often living in a joint family as compared to the rest of the sample so the authority of a mother-in-law is strongly exercised leading to greater incidence of home deliveries.

Mothers who underwent home delivery have confessed a sheer lack of cleanliness during child birth. Regarding bathing of the newborn, as many as a half of the mothers admit that they practiced immediate bathing of the newborn. It is important to note here that immediate bathing of the newborn is a negative practice as per WHO norms and can cause hypothermia among them. This practice is more prevalent in urban areas and more common in respondents who either delivered at home or private hospitals. On the other hand, the mothers who delivered at government hospitals have reported that the child was wiped and cleaned instead of bathing by the hospital staff. This suggests that government health facilities are adhering to WHO norms more than the private hospitals. Therefore, it can be inferred that choices of healthcare facilities for child birth are actually made based on the reliance on the traditional practices, affordability of the respondents, cost benefit analysis of the services provided and trust over the system and not by religion as a determining factor.

The present study acknowledges the role of the mothers-in-law in care practices. However,

at the same time, some practices like adherence to home delivery and aversion to institutional delivery in the name of traditions and religion are not in line with current health norms. The study recommends including grandmothers along with the mothers in interventions to raise awareness on the benefits of institutional delivery. Wherever women conglomerate in the community (sitting on *charapoys, kirtan mandlis*, sewing class groups, etc.), that place itself should become the place for raising awareness. Appropriate IEC material such as posters and flip charts would certainly have a much desired impact in promoting desirable practices of child care.

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