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Childbirth Practices among Women in Slum Areas

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Introduction

Childbirth is a normal physiological process, which can become pathological due to the adoption of certain practices and consequently affect the health and survival of the newborn. Good pre and postnatal care and trained assistance at the time of childbirth are thus very important to ensure child survival. In the present study an attempt has been made to examine the pattern and role of practices related to childbirth in some urban ICDS (Integrated Child Development Scheme) areas of Allahabad.

Methodology

The study was undertaken in the Anganwadi centers of the urban ICDS project areas in Allahabad. Thirty-five centers were chosen randomly out of a total of hundred centers. Each center caters to an approximate population of one thousand. All the pregnant women registered at the selected Anganwadi centers during the course of one year formed the study population. In all, there were 661 women.

Each Anganwadi center was visited on a fixed date every month. The mothers registered at the center during each month of the study period were interviewed and the information was recorded on a pre-tested schedule. It included a detailed history of past illness including obstetric problems, a family history of disease, tetanus toxoid immunization during the antenatal period, and childbirth practices including the type of instruments used at the time of delivery.

Results

All the 661 women were permanent residents of the area and had an almost homogenous socio-economic status. They belonged to the lower socio-economic group (by Kuppuswamy's classification), with an average monthly per capita income was Rs. 102.50. As many as 92.4 per cent were Hindu, and the remaining were Muslim. The majority were illiterate (82 percent); a mere 6 per cent were educated above the primary level. Their husbands were better educated 36 per

cent had studied beyond high school and 30 per cent upto junior high school; only 34 per cent were illiterate.

Immunization Status

The two prescribed doses of tetanus toxoid were received by about two-fifths (40.1 per cent) of the women either from an ANM or a doctor. More primiparas (55.3 per cent) as compared to second and third paras (43.3 per cent) and grand multiparas (27.4 per cent) had been immunized; the latter group being least protected against tetanus. Seventy per cent of the women had received at least one dose of the vaccine during pregnancy.

Place of Delivery and Assistance At Birth

Almost two-fifths (59.8 per cent) of the women had delivered at home while the remaining (40.2 per cent) had had their babies delivered at Government or private hospitals (Table 1). The majority of the births (68.8 per cent) were conducted by untrained personnel, with slightly less than a third (31.2 per cent) being attended by ANMs or doctors.

Table 1: Distribution of women by person attending childbirth and parity

Parity	Trained personnel		Untrained persons		Total
	ANM	Doctor	Family member	Dai	
1	19(12.7)	43(28.7)	20(13.3)	68(45.3)	150(100.0)
2 - 3	18(1.8)	24(9.0)	40(14.9)	(186(71.3)	268(100.0)
4 +	59(24.3)	43(17.7)	30(12.3)	111(45.7)	243(100.0)
Total	**96(14.6)**	**110(16.6)**	**90(13.6)**	**365(55.2)**	**661(100.0)**

The percentages have been calculated on row totals and are given in brackets.
$X2 = 66.28$ df = 2 $p < 0.001$

On average, one untrained birth attendant catered to the population of each Anganwadi center that is, to approximately 1000 people, and attended the delivery of over half ((55.2 per cent) of the women (Table 1). While family members provided birth assistance in aver a tenth of cases (13.6 per cent), the ANM or auxiliary midwife and the doctor were almost equally preferred among trained personnel (14.5 and 16.6 per cent respectively).

Parity wise, among those who had utilized the services of trained persons delivery, by and large, the doctor h delivered primiparas (43/62 or 69.3 per cent) while the ANM had been utilized largely by the multiparas (59/102 or 578 per

cent) (Table 1). The services of the untrained dai however, had been most utilized irrespective of parity.

Husband's Literacy Status and Natal Cam

Awareness of immunization of the pregnant woman and the need for trained birth assistance was greater among educated husbands (Table 2). Thus, well over half (56.3 per cent) of the husbands who had high school education and above preferred the services of medical personnel while only 10.2 per cent of those who were fib did so. The latter preferred the services of family members or untrained dais (89.8 per cent). Similarly, almost two-fifths (59.2 per cent) of the women whose husbands had been educated up to or beyond the high school level, had received tetanus tetanus toxoid immunization as compared to those whose husbands were illiterate (19.1 per cent). None of these findings, however, were significant.

Table 2: Distribution of women by person attending childbirth and husband's education

Education of husband	**Person attending childbirth**				**Total**
	ANM	**Doctor**	**Family member**	**Dai**	
Illiterate	15(6.7)	8(3.5)	22(9.8)	180(80.0)	225(100.0)
Primary	18(2.3)	3(3.9)	15(19.5)	41(74.3)	77(100.0)
Junior high school	12(9.9)	16(13.2)	10(8.3)	83(68.6)	121(100.0)
High school & above	51(21.4)	83(34.9)	43(18.1)	61(25.6)	238(100.0)
Total	**96(14.5)**	**110(16.7)**	**90(13.6)**	**365(55.2)**	**661(100.0)**

The percentages have been calculated on row totals and are given in brackets.

Childbirth

Proper aseptic precautions for delivery were taken by all the trained medical personnel. Among the untrained dais, none used a sterilized scissors. The blade was sterilized only in a fifth of the deliveries; in the remaining-over four-fifths (81.9 per cent) of the cases, an unsterilized blade was used. The use of a sterilized blade was more common when the untrained birth attendant was a family member (35.6 per cent). Boiling of the thread used for tying the umbilical cord

was not practiced either by the dais or the family members, whereas all the doctors and majority of the ANMs (95.8 per cent) used sterilized thread.

The use of gentian violet and Neosporin powder on the cord was followed by medical personnel. The untrained dais usually used mustard oil (59.7 per cent) or hot ash (30.9 Per cent) on the cord. Among the deliveries conducted by family members, 80 per cent applied mustard oil on the cord; cow dung was also used to a greater extent by family members.

Complications

Two hundred and six (31.2 per cent) of the deliveries were conducted by trained personnel, among which 13 perinatal deaths occurred. Thus, the perinatal mortality rate worked out to 67.4 per 1000 live births. On the other hand, the untrained persons (dais and family members) conducted 455 deliveries (68.8 per cent) and 61 perinatal deaths occurred giving a perinatal mortality rate of 154.8 per 1000 live births.

Twenty five still births occurred among the deliveries conducted by untrained persons and birth asphyxia was the main cause of death (accounting for 52 per cent). In sharp contrast, only eight still births occurred among the deliveries conducted by trained personnel. Here too, birth asphyxia was the leading cause of mortality, but occurred to a much lesser extent (37.5 per cent), while hand prolapse (5 cases) and rupture of the uterus (2 cases) were responsible in the other cases. In 10 cases the exact cause of death could not be ascertained.

In all, 36 neonatal deaths occurred among the deliveries conducted by untrained personnel, against five in those conducted by trained personnel. The causes of neonatal death were low birth weight (14 cases), tetanus neonatorum (6 cases), septicaemia (3 cases), neonatal jaundice (4 cases), congenital anomalies (3 cases) and uncertain causes (11 cases). It is notable that deaths due to tetanus neonatorum occurred only among deliveries conducted by untrained personnel.

Discussion

Delivery is a normal and natural phenomenon for a woman but one which cannot be left unattended by health personnel. However, this does happen in urban slums where no organized MCH services exist. The services available elsewhere are not utilized either because they are not affordable or because they are considered unnecessary especially by the illiterate. As a result, more than 50 per cent of the deliveries are conducted by untrained persons thereby posing a potential hazard to the health of the mother and the child.

According to UNICEF A., only 33 per cent of all births in India are attended by trained birth attendants or medical personnel. The results of this study confirm this statement-only 31 per cent of the deliveries had been assisted by an ANM or a doctor and, that these services had been utilized largely by primiparas or multiparas (4+). Women undergoing their second or third delivery utilized their services the least. Similar observations have been reported by Joshi et al B. and Agarwal et al C. The association between parity and type of personnel was found to be statistically significant (Table 1).

These observations may be explained by the fact that complications occur more frequently in primiparas and multiparas (4+). As a result, a larger proportion of such women avail of the services of the ANM or doctor in anticipation of possible complications or are forced to seek help from trained medical personnel for complications arising during delivery.

The majority of the slum dwellers had no faith in hospitals. They preferred and trusted the untrained dai who belonged the same socio-cultural milieu. They also utilized her services in order to conform to tradition and custom. And this, despite the fact that the untrained birth attendants did not observe aseptic precautions for delivery or cord cutting. The application of mustard oil on the cord stump often led to infection and was responsible for the ill health of the newborn, while tetanus neonatorum could be directly attributed to the practice of applying cow dung on the cord stump. These practices are entirely due to ignorance, illiteracy and lack of education of the dais as well as family members.

The complications occurring during delivery dearly show the unhygienic practices and the inability to identify 'high risk' mothers by the untrained personnel resulting in perinatal deaths which could have been avoided by adequate training.

The results indicate that untrained dais have an extremely important role to play in the provision of natal care in urban slums. To make natal care services both acceptable and safe for mothers living in slums and for their newborn, it is essential to train the dais to use hygienic childbirth practices, to promote tetanus immunization, and to recognize 'high risk' mothers and other preventable causes of death like prolonged labor. This can be done through orientation programs and practical demonstrations. It is worthwhile pointing out here that it is these untrained birth attendants, rather than the ANMs, who require regular orientation and training, as it h they who are sought and trusted by the women (and their husbands who live in slums and who are most in need of MCH services.

Summary

Six hundred sixty one women were interviewed from 35 randomly chosen Anganwadis in the urban ICDS project at Allahabad, about various natal practices. The women belonged to a similar low socio-economic status and were mostly illiterate. They preferred the services of the local untrained dai for delivery inspite of the fact that most of the dais did not follow aseptic precautions for delivery and cord cutting. It is suggested that to improve the natal care services within the framework of acceptability, local dais should be trained in hygienic childbirth practices and identification of 'high risk' mothers so that preventable neonatal deaths do not occur.

References

A. Grant, J.P.: The state of the world's children, Table 7 pg. 76, UNICEF, USA, 1988.

B. Joshi, P.L., Bhattacharya, M., Dwivedi, S. and Raj, B.: "Current trends in natal care in a rural community," The Journal Family Welfare, XXXIII(3):40)46 (1987). Graph

C. Agarwal, D.K., Kaur, P., Katiyar, G.P. and Agarwal, K.K.: "Pattern of care during pregnancy and lactation in Sunderpur," Ind Journal Public Health, XXIV(2):82)91 (1980).