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PREGNANCY CULTURE AND POLITICS

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Introduction

The experience of childbirth is a common thread amongst all cultures and societies. Giving birth process is viewed as a universal experience amongst all women. Each woman's experience is unique and different, however, having been determined by the culture in which the woman gives birth. According to Greene (2007), maternal health refers to the health of new mother during childbirth, pregnancy and the post-partum period. On one hand motherhood is seen as a positive event for women while on another ill-health, misery and even death is connected with maternity. The experience of pregnancy and the journey of motherhood is largely influence by the socio-cultural background. Yet, there are many contradicting traditional view of pregnant women that varies from culture to culture. Politics also play a major role in the way woman perceives and prepares for her pregnancy (Greene, 2007).

Cultural Influence: Brief Literature

Each culture is dominated by values, beliefs and attitudes surrounding pregnancy and birth. Culture is defined to be a particular group of people's beliefs, values, norms, lifestyle practices and decision in a patterned manner (Leininger & McFarland, 2005). It plays a vital role in the woman's perception about pregnancy as well as her health. A variety of literature on childbirth journey and culture has been conducted. Ottani (2002) carried a study on cultural norms in United States where large influx of immigrants from other countries have caused a shift in childbirth practices due to difference in Western and traditional Eastern medications. Ottani (2002) claims that women who have strong background of diverse culture, may not have to ability to follow the traditional birth practice because these practices are known to them. A Cambodian women are culturally rich and competent in the areas of diet, weight gain, language and finances.

O'Connor (2002) examined the Arab culture with specific link with childbirth and pregnancy journey. According to O'Connor (2002), many Arab women do not receive adequate paternal health care as it is not considered essential in the Arab culture. In this particular culture, the preventive health care is uncommon. Moreover, Arab men are not really interest in the birthing process or in childbirth education classes. Paternal diet and nutritional practices are also different in different cultures. For instance, in Asian and Hispanic cultures, a hot/cold body balancing system is practiced (O'Connor, 2002). Since pregnancy is considered to be a hot condition so in Hispanic and Asian cultures, hot foods are restricted. In Filipinos culture, it is generally considered that woman must experience birth giving pain and discomfort as part of the childbirth experience (Galanti, 2004). However, Mexican women are known to be loud and expressive during their pregnancy.

Childbirth experience for woman revolves around specific rituals, methods or treatments when in pain. They might choose to view their cultural method of pain management and how they plan on dealing with the pain. The Chinese are taught to self-restraint and might refuse pain medication at their first birth (Galanti, 2004). However, the customs and traditions regarding child birth experience of an Indian woman is discussed below.

Childbirth Experience in Indian Culture:

In Indian culture, pregnancy is mostly viewed as a normal physiologic phenomenon which does not require mother to consult any health care professionals. However, in case of any problem, a pregnant women is allowed to seek medical advice. Indian culture has a fatalistic view about life which extends to pregnancy. Motherhood in Indian culture is perceived to be sign of "proudness" for the women. Many of the Indian women have no or limited control over their pregnancy time period and outcomes. Sons are preferred over the daughters in India due to which women are pushed to terminate the pregnancy in case of conceiving female fetus (Bandyopadhyay, 2003). Herbal medicines are given to pregnant women for development of a male fetus.

Hot and Cold food concepts rule the nutrition related practices where hot foods are deemed as harmful and cold food is expected to be beneficial for pregnant women. However, a pregnant women in Indian culture are advised to eat a balanced cold food and avoid hot food completely for reducing the chances of miscarriage (Choudhry, 1997). In order to facilitate labor, hot foods are deemed to be given to pregnant woman during last days of pregnancy. Some of the pregnant women believe that excessive eating during pregnancy cause troubles in labor. The Indian culture does not believe in restricting physical activity of pregnant women during pregnancies. Women from lower class carry on their tough life routine by doing work and carrying heavy loads. However, upper class women are usually nurtured and pampered by their families (Gatrad, Ray, & Sheikh, 2004).

During the birth giving process, laboring women are isolated due to pollution and bad omen beliefs. Women usually is expected to scream and cry in pain as the birth approaches. Profuse bleeding is deemed as a positive sign as it is linked to the purification of the uterus (Mientka, 2013). Mother and child are separated from each other immediately after delivery so that any impurity and pollution can be abstained. The confinement period of postpartum for pregnant women can exceed 40 days. A confinement period is referred as the period after pregnancy during which the women and child are considered to be in vulnerable state and can catch diseases after giving birth (Queensland Government, 2014).

In Indian culture puffed rice, tea and hot water diet is preferred for the women after giving birth. Milk, butter, ghee, meat and fish are encouraged after pregnancy for increasing the quantity of breast milk and

quality of milk by mother. However, spices, yoghurt, green vegetables, fiber, papaya, eggs, limes, oranges, spicy food, cold food, oily food, melons, pumpkins and bell peppers are restricted for women during confinement period (Gatrad, Ray, & Sheikh, 2004). All pregnant women are required to consume less water during and after pregnancy in India. The placenta is disposed or buried under the floor where the birth was given in order to avoid an enemy or evil spirit from seizing it and affect the long life of child. A health professional is required to offer the placenta to the mother after birth. Cold bath and showers are restricted after giving birth whereas a warm bath is accepted. Rural women are allowed to take only head bath on the 11^{th} day of delivery, till then only sponge bath is allowed for women. Solar and lunar eclipse fear is settled in the minds of rural as well as educated families where it is believed that during eclipse a pregnant woman should stay in bed. (Gatrad, Ray, & Sheikh, 2004)

Newborns are believed to be susceptible to evil eye and any admiration of new born is usually discouraged. Any physical examination of the newborn is restricted due to which Indian families feel reluctant in weighing their new born babies. Black spots are marked on new born babies to prevent the consequences of evil eye (Galanti, 2004). During 40 days, mother and child remain close to each other whereas infants are massaged on daily basis.

In Indian culture, western medicine is usually promoted due to its popularity amongst the wealthy and educated. They believe much in Ayurvedic medication for pregnant women. According to Ayurvedic theory, three humors are required to balance the health i.e. fire, water and wind. The new mother is also given Ayurvedic tonics to help in the contraction of pelvic area and uterus (Choudhry, 1997). It is believed that nay disturbance in this balance can cause illness. In Indian culture, premature birth in the eighth month is considered to be highly a bad omen and occurs as a result of cat having entered mother's room in a former confinement period. It is highly believed that a child born in eighth month would die on eighth day, eighth month, eighth year or eighteenth year of age and hence consider number 8 as "unlucky" (Gatrad, Ray, & Sheikh, 2004).

Political Influence: Brief Literature

Politics play a major critical role in health affairs. Significant number of achievement are acquired in global health industry over the past decade but reducing maternal mortality is the low and middle countries is still posing a serious threat. The Millennium Development Goal (MDG) also includes the target of reducing the maternal mortality ratio. The average annual decline in the global maternal mortality ratio has been 2.3% against the target of reducing the maternal mortality ratio by 5.5% (Jat, Deo, Goicolea, Hurtig, & Sebastian, 2013).

\In this world of global health, some of the issues gain high levels of political attention due to its complexity. It is widely known that the political framework plays a vital role in success and failure of the intervention. Any issue becomes the political priority as a result of the complex processes (Goli, Moradhvaj, & Rammohn, 2016). Many different health issues and initiatives are subject to vary in the way in which these are prioritized by the political leaders and the policy makers.

Political priority has been defined as the degree to which the political leaders pay attention to an issue. The political programs are designed for eliminating or solving the issues by support of financial, technical and human resources.

Political Prioritization of Safe Motherhood: India

There have been many efforts lately to assess the political prioritization of safe motherhood at the national level in many countries. In India, a study by Shiffman (2007) revealed that maternal health has been one of the main components in the national program in India since independence. It was also reported that the maternal health had emerged as the political priority in India in 2005 as a result of the events concerning the problem definition and generation of policy alternatives. Health is a state subject in India and falls under the sub-national level. As a result of the emergence of maternal health as a political priority at national level, several state governments also followed by making maternal health a priority. Before this, maternal mortality reduction had received policy attention since it was included in the population policy made during 2000s. However, without the help of political resources and support, it became difficult to institutionalized maternal health as a priority (Shiffman J. , 2006).

In 2005, the policy alternatives like emergency obstetric care and skilled attendance at birth worked and reduced the maternal mortality sharply in many states of India. The state government adopted the new policy solutions in 2005 for improving the maternal health that included the policies for improving the antenatal care and increased the institutional deliveries (Greene, 2007). The referral transport system also strengthened and improved the quality as well as availability of the emergency obstetric care services.

In 2005, four key strategies were adopted by the state government in order to improve the maternal health. First strategy involved improvement in the quality and coverage of ante-natal care services that was sought through the mobilization of the accredited social health activists. The second strategy involved avoiding the three delays through continuity of education for pregnant women and the fellow family members in order to strengthen the referral transportation with service delivery. The third strategy involved the steps taken to increase the institutional deliveries through capacity building of the health care providers for skilled birth attendance. Fourth strategy involved strengthening of EmOC services by upgrading the health institutions (Shiffman J. , 2006).

Increased number of debates and discussions on the maternal health also helped India in sensitizing the politicians on the issues that were related to maternal health. The issue of poor status of the maternal health services and high levels of maternal mortality started being discussed and debated in the political and social forums during 2005 (Gatrad, Ray, & Sheikh, 2004). The supportive policy environment and the launch of NRHM along with effective policy solutions, marked a major success by increasing contribution in maternal health on priority policy agenda. With the launch at national level in 2005, the government of India contributed significantly in reducing the maternal mortality rate and improving the maternal health. Number of schemes like Mother Protection Scheme has contributed to the phenomenal success in increasing the number of institutional deliveries. However, with rise in the institutional deliveries, the demand for more synchronized efforts for ensuring the availability of the human resources has risen (Galanti, 2004).

High out of pocket expenses during maternity are pushing the households below the poverty line. However, recently the researchers have also started to explore the question i.e. could maternal healthcare related costs become catastrophic for the households particularly in India. Researchers in India have found evidences of high cost of ANCs and delivery care in low-income settings in India. For reducing the out of pocket expenses on the maternal healthcare services system, the Government of India and many of the state level governments have implemented the financing schemes like Janani Suraksha Yojana, Agra Voucher Scheme and MAMATA scheme. The Janani Suraksha Yojana is the world's largest Conditional Cash Transfer scheme that is aimed at reducing the financial barriers in the maternal health care services (Greene, 2007).

Conclusion

In the modern Western Culture, the women might rely on doctors of medicine in order to oversee the logistics of their pregnancies, however in developing nations like India, cultural norms and aesthetics have much more to do during pregnancies. The discussion above has recognized few of the cultural norms prevailing in Indian society that rules the pregnancies of women and their health care system. Many of the norms are influenced by the myths that are often fragmented and are the contradictory bits of knowledge that is passed along the successive generations of men and women.

Politically, maternal health has gained priority in recent years as well as a result of a convergence in the development that is taking place in the politics stream at international, national and state levels. The factors that are associated with the emergence of maternal health as a political priority are emerging as the evidence of high magnitude of maternal mortality and human rights violation. Due to high media coverage and supportive policy environment, Indian political system has launched the NRHM policy for improving maternal health and reducing maternal mortality rate at state levels (Shiffman J. , 2007). The influence of political events and cultural factors from international and national levels have significantly contributed

into the development of maternal health as a priority in India. The efforts have remained successful to some extent in order to improve the maternal health conditions at the state level, but still several implementation challenges are still required for special attention.

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