ACTIVE PATIENTS: THE INTEGRATION OF MODERN AND TRADITIONAL OBSTETRIC PRACTICES IN NEPAL

NADJA REISSLAND* and RICHARD BURGHART**

*Department of Experimental Psychology, University of Oxford, South Parks Road, Oxford, England and
**Seminar für Ethnologie, Südasiens Institut, Universität Heidelberg, Im Neuenheimer Feld 330, 6900 Heidelberg 1, F.R.G.

Abstract—This paper describes the integration of modern and traditional obstetric practices in a provincial hospital in the Maithili-speaking area of southern Nepal. The doctors and nurses consciously distance themselves from the traditional practices of their obstetrical patients, whom they view as 'ignorant'; but because hospital resources are insufficient to impose the normative form of modern medical organization, patients and their relatives assert a more active role in providing hospital-based care. In consequence, mothers are delivered according to both modern, clinical as well as local cultural practices.

Recent WHO policy has cast modern medicine as the agent in the integration of traditional healing within national health systems. This essay shows that in poor countries the powers of agency may not be exclusively in the hands of the medical profession. Patients, and others in their social networks, have become agents, constraining and negotiating the terms on which modern medicine is to be integrated within their traditional obstetric practices.

Key words—traditional and modern healing in South Asia, child-birth, hospital organization, agency and passivity

INTRODUCTION

In 1978 the World Health Organization called upon member states to integrate traditional healing within their national health systems [1]. Two aspects of this policy are of particular interest. First, the promotion of traditional healers was seen to result from the consciously formulated decision of health planners as agents of modern medicine. Second, the agents of planned change rigidly circumscribed the terms of integration. Certain features of traditional healing, such as the use of native drugs, were thought to be of benefit but only after their efficacy had been proven by the methods of science. The integration of traditional healers and birth attendants into the lower echelons of the state medical system was advocated, but only after the healers had been properly trained in medically approved procedures. In the former case traditional medicine works, but only modern medicine knows why. In the latter case traditional healers are useful as medical auxiliaries, but only after modern medicine has rendered them in key respects scientific and in all other respects harmless. In brief, an ideological boundary, created and defended by modern medicine distinguishes it from traditional healing. Movement across that boundary was to be controlled by the agents of modern medicine.

This paper looks at the ability of the medical profession in South Asia to maintain that ideological boundary in the organization of its clinical practice. Our locus of fieldwork is the provinces: the geographical meeting point of modern and traditional medicine. Looking at the national health system from top down, provincial hospitals appear as regional centres of modern medicine, receiving referrals from village health outposts and implementing community health programmes. Staffed with surgeons, physicians, nurses and pathologists, who have received training in medical schools on the subcontinent or abroad, the provincial hospital is the place where medicine in its modern institutional setting becomes accessible to local people. A rather different picture emerges, however, when one travels to rural districts and observes the organization of clinical practice. Provincial doctors are trained in curative medicine, but recognize that most of the illnesses they treat stem from poverty or 'ignorance'. Their skills are under-utilized; and for job satisfaction, if not professional advancement, they yearn for posting to a hospital in a major urban area. Meanwhile, the resources which come from the centre to finance the hospital and its dispensary are often insufficient. On the one hand, medical staff see themselves as a modern elite, restoring health to people who are 'backward', 'superstitious', 'ignorant' and 'destitute'. On the other hand, they perceive that their hospital, underfunded and understaffed, is constrained by the very same forces which impede the advancement of the people whom they are professionally committed to healing. Local, 'non-scientific' health care practices enter the provincial hospital not as part of a formal government plan to integrate traditional healing within the national health system, but as an admission of the hospital's inability to impose the normative form of their organization which obtains at the national capital. This, at least, is our analysis of the situation which prevails at Janakpur in the eastern Tarai of Nepal. Our research was carried out at the Janakpur Public Hospital, the hospital of referral for the Dhanusa district. The hospital grounds include the hospital with its three wings, a maternity ward, operating theatre and a small conference room and office. The administration is based in a separate building which it shares with the pathology laboratory and the offices.
of a public inoculation programme. Another building contains the out-patient clinic. Other buildings provide accommodation for the director, the doctors and nurses. On the main road, by the hospital entrance, are tea stalls and betel shops, chemists and compounders, X-ray facilities and laboratories for the analysis of blood, stools, and sputum plus several, privately run, clinics. The highpoint of the hospital day is 10 a.m., when hundreds of people mass in front of the out-patient clinic awaiting its opening. Meanwhile the doctors gather for their daily meeting and then, accompanied by nurses, make their round of the wards and open up the out-patient clinic. By noon everything quiets down. The out-patients have returned home; and most of the doctors, unless their name figures on the hospital rota, have gone to their wards and open up the out-patient clinic. By noon everything quiets down. The out-patients have returned home; and most of the doctors, unless their name figures on the hospital rota, have gone to their private, more lucrative clinics elsewhere in town.

Our paper concerns one particular aspect of hospital life, the organization of child-birth in the hospital's maternity ward. Our material is based on observations of some 40 births in the ward as well as on discussions with some of the families after their return from hospital. The families were, for the most part, of Maithil background, a people—some 20 million in number—who live in southeastern Nepal and northern Bihar, India. We shall describe the circumstances which lead Maithil women to opt for a hospital delivery, the management of labour in the delivery room, the delivery itself and postnatal care.

Our description culminates with an analysis of the way in which the modern provincial hospital—constrained internally by inadequate resources and externally by the values of Maithil society—becomes the locus of traditional obstetric practices.

ARRIVAL AT HOSPITAL

In rural South Asia nearly all Hindu women expect to give birth at home; and of these women, most do so. In giving birth, the mother wants to be assisted by female relatives who are also mothers—that is mature women of proven fertility and personally experienced in child-birth. Thus she will draw support from her circle of female relatives who are mothers of her natal courtyard to which a young mother may return for the first birth. Excluded from this circle are women who are not relatives (for they may harm the mother and child with ill will), married female relatives who are childless (for their barrenness may have deadly consequences for the neonate) and unmarried female relatives (for they should not see their mother or aunt in pain). The only person, who is ordinarily present at child-birth but who is not a member of the family, is the midwife.

In Hindu society midwifery skills are customarily held by the cobbler's wife. It is the duty of the cobbler to dispose of carcasses, cut skins and prepare hides; as it is that of his wife to cut the umbilical cord and dispose of the afterbirth. A midwife is generally referred to by her caste status as 'cobbler's wife' (Mai. camain), but she may be addressed respectfully and familiarly as grandmother (lit. 'father's mother' or dai). Her customary fee is the coin on which the umbilical cord is cut (in accepting the coin she takes on the responsibility of birth) plus the saree soiled by the mother at the time of birth. The family may also, 'out of happiness', give her a small sum of money or a new yellow saree on the sixth day postpartum when the household is restored to purity. Established, educated families in Janakpur—that is those who have appropriated the forces and symbols of modernity—also prefer home births. But rather than resort to the illiterate cobbler's wife as midwife, they call upon the services of the town's sole medically trained, professional midwife whom they refer to and address by personal name, rather than be caste or kinship title. Her fee, reputedly Rs. 200 (approx. U.S.$12; at 1984 conversion rate), is well beyond the means of most families in town. Despite these different ways in which rich and poor, educated and uneducated, organize child-birth, there is agreement that a closed room within the household is the proper place for delivery to take place.

It follows that the town hospital attracts few mothers who anticipate a normal delivery and who can count on sufficient resources in women or money to help them manage the event. The hospital attracts difficult births: that is births from the hospital's rural catchment area in which problems have developed or appeared after the onset of labour and which the family is unable to manage. Alternatively they attract from the hospital town, pregnant women who live in small or nuclear families, and whose husbands are often in employment, struggling to make ends meet. For them the public hospital offers the prospect of a modern delivery at a relatively modest cost.

These generalizations are born out by our observations at the Janakpur Hospital over an 8-month period. The hospital records from that period suggest two main reasons why women come to hospital. The first reason is that it was the woman's first experience of giving birth. Approximately 50% of all births were primagravidas, 25% second births and 25% third and later births; few mothers came after giving birth a third time. It is likely there was particular anxiety in the family about the first birth, together of course with the fact that the first birth is usually the most prolonged in terms of labour. The second reason for women coming to hospital refers to the emergence of some problem, or perceived problem, in the course of labour. These problem births are indicated in the fact that 12% of all registered births were recorded as still-born (this figure includes both still-born infants as well as live babies who did not survive the trauma of birth). The figure is high, but consistent with other poor countries where traditional midwives refer or abandon difficult cases to the local hospital [2]. The interpretation of these figures must be qualified by the fact that hospital arrivals are unevenly affected by the seasons. In the rainy season month of Bhadra, when the dirt tracks which criss-cross the district are often impassable, only 16 births were registered at the hospital and in Caitra in late spring (during which time there had been unseasonal storms) of births. This contrasts with Kartik, Marg and Pus, the dry cool months of autumn and winter, when cart roads are passable and the main farming season is over. In those months there were 82, 139 and 89 births respectively.

Most townswomen whom we met had no personal experience of hospital birth; still they held strong
opinions about its worth, which they uttered with a 'knowing' air. Their overall import was negative: women did not, as a matter of choice, want to go to hospital. Their reasons were diverse. Some said that children died there, and that it was safer to have children delivered at home. Medical data, comparing home and hospital deliveries, was deficient in the economic resources to summon the professional midwife. Alternatively the hospital attracts those who perceive something has gone amiss in labour and the hospital is their sole place of resort. In Dhanusa district, numbering some 183,718 women (1975 mid-term census), only about 850 women give birth every year at hospital.

Although women know roughly when to expect the onset of labour, its timing cannot be predicted and decisions concerning child-birth may be taken precipitously. Any woman, living in Janakpur and planning a hospital delivery, would make arrangements to go to hospital after the first contractions had started. For women who did not plan a hospital delivery, the decision to go to hospital is arrived at in the course of a prolonged labour and is triggered by the fear that the birth passage is too small or the baby too large for an uncomplicated delivery. We did not hear of any explanation with reference to the presentation of the foetus, although thec presentation are remembered. Since a normal course of labour is longer for primagravidas than multigravidas, the first birth occasions particular anxiety in women. The key person here is the cobbler's wife who, upon being called to the household, estimates the time of birth, feels the mother's abdomen to judge the mode of presentation and then may leave until birth is nigh. In their anxiety the family may find this a rather cavalier attitude and pack the mother off to the hospital. Alternatively some midwives preserve their successful reputations by withdrawing from difficult cases. The family is left with no option but to go to hospital.

In only one case did we take part in such deliberations. Labour had set in 24 hours earlier for a primagravida, by which time only the cobbler's wife appeared a picture of calm. After a prolonged attempt to push the baby out some women commented that the mother's birth passage was too small. The midwife proposed lubrication of the birth passage with mustard oil, but one of the women objected, saying that dirt from the midwife's fingernails would make the birth passage septick. The untouchable midwife took this as a slanderous remark; and a row broke out between the two: the midwife said she would not enter the courtyard of such a woman, to which the woman responded she would not allow such a midwife into her courtyard. The midwife left in a huff, and the family had no choice but to bundle the woman into a rickshaw and
escort her over the bumpy, brick roads to the town hospital.

In another case a woman arrived in great distress from a village outside Janakpur in the company of several of her female relatives. It was her first birth and labour pains had apparently begun 4 days earlier in the village. A ‘rustic doctor’ (delhati dakdar), that is a village healer who creatively prescribes modern pharmaceutical items, had been called to look at the mother, and decided to induce labour with an injection of syntocinon. The local perception of such drugs is that they induce birth by creating pain in the mother’s abdomen. For Mutthil women it is not child-birth which creates pain, but pain which leads to child-birth. That is to say, it is not the stretching or tearing of tissue in the birth channel during the expulsion of the foetus which causes the mother’s pain; instead, the infant is thought to constitute one emotional-mental nexus with its mother, such that should the mother come down with a pain the foetus also suffers. When the pain becomes unbearable, the baby is forced to take birth, for that is the only way it can get rid of the pain. The ‘rustic doctor’ injected ‘pain’ into the mother’s body, but on the fourth day the mother, in great agony, had not yet given birth. We presume that the mother had experienced a false labour. As the pain subsided and the baby had not come out of view of the mother, is a small table and an iron cot. Immediately after birth the baby is placed on the cot, not in the cot. A northern light enters the delivery room from a frosted window and projects onto the floor of the bed, where the doctor and nurses work. At night-time the room is illuminated by a bare 60 W bulb that dangles from the ceiling. The air, strong with urine and disinfectant, is circulated by a fan that slowly revolves overhead. Both light bulb and fan are powered by overhead wires, leading from a hole in the wall in which two sparrows had built their nest. Appropriately enough, in the course of our research, the sparrows also gave birth to a brood of young ones whose cheeping could be heard during quiet moments of the day when rest with their babies after giving birth. Alternatively if a bed is vacant and a mother has come early in the first stage of labour, she might lie down for several hours before advancing to the delivery room where she mounts the iron delivery bed in the middle of the room. The bed has an end flap with iron uprights to support the mother’s feet as she bears down in her contractions. The delivery room, is about three times larger than the recovery room. To the right of the delivery bed is a counter where the nurse keeps and sterilizes her equipment: a bin with rubber gloves, a tray containing scissors and scalpels, a glass beaker with pincesets, gentian violet and cotton wool, and string used to tie the cord, an open tray with water for sterilizing syringes and needles and an electric stove with two thin wires, whose exposed ends are inserted directly into the electric source in the wall. At times the voltage is so low that the water fails to reach boiling point. To the left of the delivery bed, along the opposite wall, is a sink and a broken, rusty bed which is recalled to active service when, by chance, two women give birth within an hour of each other. In the corner behind the head of the delivery bed, and out of view of the mother, is a small table and an iron cot.

Regardless of whether it is a planned hospital delivery or an emergency, a day’s journey or a mere hurried flight, a married woman’s trip to the hospital is supervised in such a way that her personal virtue is protected and the reputation of her husband’s family is preserved. The expectant mother usually arrives at hospital, together with several married women of her own generation and those of her superior generation, comprising either her affines if she comes from her natal household or her female kin and male kin’s spouses if she comes from her husband’s household. Additionally she is accompanied by a male guardian, who may be her husband but more often than not is the husband’s younger brother. Her husband’s elder brother, father and father’s brothers are inappropriate guardians, for in front of them a Hindu woman veils her face and restrains her speech. At hospital the male guardian remains a peripheral figure. By contrast, the expectant mother and her female relatives from her natal household, often outnumbering hospital staff, where they quickly establish their authority in the management of labour.

THE MANAGEMENT OF LABOUR

The maternity ward of the Janakpur Hospital comprises two adjoining rooms in the woman’s wing. From the main corridor one enters the recovery room, about 9 feet square, in which stand two iron cots separated by a small night table. Here mothers rest with their babies after giving birth. Alternatively if a bed is vacant and a mother has come early in the first stage of labour, she might lie down for several
corridor outside the delivery room and, judging from
the cries inside, infers the time of birth for the family
astrologer.

Despite the clinical setting, hospital discipline is
very much constrained by the values of rural Maithil
society. Throughout labour, birth and postpartum
the nurses and female relatives, to a varying extent,
establish their own rules in the organization of birth.
Many women refuse to be examined by a male doctor
or have a male doctor present at delivery. They say
that if a man were present, they would lose their
reputation. Nor did male doctors generally enter the
maternity ward without being invited; if they did so,
they ran the risk of being roundly abused by relatives
of the parturient mother. Occasionally a male doctor
would be summoned by relatives who had become
anxious about the mother's distress, but he would
venture his opinion after looking at the patient, or
possibly after feeling her abdomen, and then leave.
Male doctors took no role in the delivery of children.
Some women found the prospect of a medical exam-
ination so highly embarrassing that they even refused
examination by the hospital's female doctor. Hence
most vaginal examinations were carried out by those
women with the lowest status in the hospital—the
nurses and peons. The female doctor attended as a
matter of course only when the health of the mother
or child seemed gravely at risk; and only she could
perform a forceps delivery. But, even here some
women did not countenance the penetration of
the forceps, which they took could be an assault on their
reputation. In one tragic case a woman arrived at
hospital with a malpresentation. She refused both
vaginal examination as well as forceps delivery.
Labour dragged on for more than 24 hours by which
time the patient was consumed to the trauma. In the end
the mother still had to submit to a forceps delivery to
remove the dead child from her womb.

Once in the delivery room the expectant mother
mounts the bed, and the nurse comes round to take
her blood pressure, listen for the heart beat of the
foetus, feel its position and estimate from the cervical
dilatation. In order to accelerate labour, the mother's
relatives sometimes resort to their own procedures to which
the hospital staff, for the most part, turn a blind eye.
Procedures include loosening the mother's saree and
undoing her hair so as to deconstrict the body and
remove impediments from the baby's path, thereby
quietening the mother by telling her that if she does not
close her mouth, the baby will 'come out the top'.
Unlike home births, where the mother may walk
around the birth room and adopt various positions
which bring temporary relief, in hospital births the
mother is expected to remain in a dorsal position with
her feet pressed against the iron supports. Hospital
discipline, in keeping the mother in a dorsal position,
was enforced as much by the mother's relatives as by
the peon.

In order to accelerate labour, the mother's relatives
often resort to their own procedures to which
the hospital staff, for the most part, turn a blind eye.
Procedures include loosening the mother's saree and
undoing her hair so as to deconstrict the body and
remove impediments from the baby's path, thereby
quietening the mother by telling her that if she does not
close her mouth, the baby will 'come out the top'.
Unlike home births, where the mother may walk
around the birth room and adopt various positions
which bring temporary relief, in hospital births the
mother is expected to remain in a dorsal position with
her feet pressed against the iron supports. Hospital
discipline, in keeping the mother in a dorsal position,
was enforced as much by the mother's relatives as by
the peon.

In order to accelerate labour, the mother's relatives
sometimes resort to their own procedures to which
the hospital staff, for the most part, turn a blind eye.
Procedures include loosening the mother's saree and
undoing her hair so as to deconstrict the body and
remove impediments from the baby's path, thereby
quietening the mother by telling her that if she does not
close her mouth, the baby will 'come out the top'.
Unlike home births, where the mother may walk
around the birth room and adopt various positions
which bring temporary relief, in hospital births the
mother is expected to remain in a dorsal position with
her feet pressed against the iron supports. Hospital
discipline, in keeping the mother in a dorsal position,
was enforced as much by the mother's relatives as by
the peon.

In order to accelerate labour, the mother's relatives
sometimes resort to their own procedures to which
the hospital staff, for the most part, turn a blind eye.
Procedures include loosening the mother's saree and
undoing her hair so as to deconstrict the body and
remove impediments from the baby's path, thereby
quietening the mother by telling her that if she does not
close her mouth, the baby will 'come out the top'.
Unlike home births, where the mother may walk
around the birth room and adopt various positions
which bring temporary relief, in hospital births the
mother is expected to remain in a dorsal position with
her feet pressed against the iron supports. Hospital
discipline, in keeping the mother in a dorsal position,
was enforced as much by the mother's relatives as by
the peon.

In order to accelerate labour, the mother's relatives
sometimes resort to their own procedures to which
the hospital staff, for the most part, turn a blind eye.
Procedures include loosening the mother's saree and
undoing her hair so as to deconstrict the body and
remove impediments from the baby's path, thereby
quietening the mother by telling her that if she does not
close her mouth, the baby will 'come out the top'.
Unlike home births, where the mother may walk
around the birth room and adopt various positions
which bring temporary relief, in hospital births the
mother is expected to remain in a dorsal position with
her feet pressed against the iron supports. Hospital
discipline, in keeping the mother in a dorsal position,
was enforced as much by the mother's relatives as by
the peon.

In order to accelerate labour, the mother's relatives
sometimes resort to their own procedures to which
the hospital staff, for the most part, turn a blind eye.
Procedures include loosening the mother's saree and
undoing her hair so as to deconstrict the body and
remove impediments from the baby's path, thereby
quietening the mother by telling her that if she does not
close her mouth, the baby will 'come out the top'.
Unlike home births, where the mother may walk
around the birth room and adopt various positions
which bring temporary relief, in hospital births the
mother is expected to remain in a dorsal position with
her feet pressed against the iron supports. Hospital
discipline, in keeping the mother in a dorsal position,
was enforced as much by the mother's relatives as by
the peon.

In order to accelerate labour, the mother's relatives
sometimes resort to their own procedures to which
the hospital staff, for the most part, turn a blind eye.
Procedures include loosening the mother's saree and
undoing her hair so as to deconstrict the body and
remove impediments from the baby's path, thereby
quietening the mother by telling her that if she does not
close her mouth, the baby will 'come out the top'.
Unlike home births, where the mother may walk
around the birth room and adopt various positions
which bring temporary relief, in hospital births the
mother is expected to remain in a dorsal position with
her feet pressed against the iron supports. Hospital
discipline, in keeping the mother in a dorsal position,
was enforced as much by the mother's relatives as by
the peon.
seems at an ebb, an intravenous injection of water serves as a restorative.

Occasionally nurses did induce labour by adding syntocinon to the saline solution, but women also resorted to their own methods. Their procedures were family recipes, passed down from mother to daughter or mother-in-law to daughter-in-law. Rather than divulge the technique to outsiders, a woman prefers to come to the aid of her neighbours and thereby guard the secret for herself. One old woman in the delivery room brought forth from her bag a handful of sacred ashes, a pinch of which was given to the mother to swallow. Then, with the remainder, the old woman traced a line down the mother's body, from throat to abdomen upon which she smeared some ashes and then continued in a line down to the pubis. Then she encircled the abdomen with a white sweet-smelling flower, called sughanda raja, and tied it in the saree on the mother's right side. Next she tied a small twig of wood in red thread and fastened this to the sash on the mother's left side. A mantra was recited. We were unable to obtain details of the mantra and the species of wood. The white flower, however, is used in worship by Saivites; the colour red by devotees of Siva's consort. The right and left position also indicate the presence of male and female deities respectively. We assume that the old women seated Siva and Sakti on the right and left side of the mother's abdomen, after having Used the sacred ashes to create a path for the descent of the baby.

Other recipes are thought to work naturally. One woman bound a twig of wood with string and tied it around the mother's abdomen. She kept secret the name of the wood, for she said it was highly dangerous. If administered improperly, it would not only bring out the baby and afterbirth but also the mother's stomach. The women effectively guarded their knowledge from us; the only recipes we acquired to induce labour, and to expel the foetus and afterbirth came from a local ayurvedic healer. The fact that he freely gave the recipes to us led us to conclude that he, as a man, had not had much occasion to use them.

When birth appears imminent, women may turn off the ceiling fan above the delivery bed, for it is important that the 'wind does not blow' at this critical moment. Similar procedures are observed in home births at which time the door is closed and all windows shuttered so that wind-born malevolent or capricious spirits do not enter the room and cause harm to mother or child during her period of extreme vulnerability.

Throughout the first stage of labour one had at times the impression of being in a hospital; at other times in the birth room of a house. Delivery procedures switched back and forth from the clinical to the domestic. For the most part, the nurses, peons and the women of the courtyard let each other get on with the ways they knew best. Neither side—hospital staff or female relatives—got its way all the time. When they came to an impasse, neither could force the issue on the other. All they could do is put emotional or moral pressure on the other by staging a walk-out in the delivery room. The doctors and nurses occasionally found themselves confronted by 'ignorant' women unable to see that compliance with clinical procedures lay in their self-interest. Unable to persuade the mother of the necessity of an examination or a forceps delivery, the female doctor or nurse would storm out of the room, leaving the mother to her fate. Meanwhile, the women of the courtyard were occasionally confronted by the 'immorality' of the hospital staff. In the second stage of a very prolonged labour a panic-stricken mother endangered the foetus by rolling back and forth on the delivery bed. The peon and nurse, in their struggle to immobilize the mother on her back with her knees flexed and thighs abducted, slapped the mother's thighs. The mother's relatives left the delivery room in a rage. They were annoyed by their relative's lack of self-control, but were shocked by the hospital staff, saying that they would not remain in a room in which a woman is beaten. Ultimately the mother quietened down when told that her own life was in danger. The female doctor was called and made a forceps delivery to get the whole thing over with. The departure of the upset relatives implied, however, that they treated the hospital ward rather like the courtyard of a neighbour whom they hope to persuade by demonstrating the strength of their own righteous convictions.

**CHILD-BIRTH**

Clinical procedure did, however, take over in the middle of the second stage of labour upon the nurse's return to the delivery room. Donning a plastic apron and rubber gloves, the nurse evicts from the room all but one or two relatives who remain behind to assist in the delivery. The mother is urged to push in time with the contractions. One relative, often an elder sister or sister-in-law from the natal or affinal home, lies across the mother, pressing down her shoulders or clasping her hand over her mouth, stifling her cries. The peon presses on the abdomen in time with the contractions, helping the mother push. Sometimes she even mounts the bed and straddles the mother in order to gain better purchase. Meanwhile the nurse lubricates the perineum with sterile gel or, if none is available from the hospital dispensary, with mustard oil, and awaits the appearance of the baby's head in the interutis. At this stage primagravidas are, almost as a matter of hospital routine, given episiotomies. These are carried out by the nurse, using scissors from the sterile tray on the counter beside the delivery bed.

Once the baby's head emerges, the nurse turns the baby round easing it out of the birth passage, and quickly passes it to the peon who holds it aloft by the ankles. The nurse then clamps the cord in two places and cuts it with the same pair of scissors with which she did the episiotomy. Next the peon bundles the baby in an old saree and deposits it on the small table behind the mother, out of her view. If the baby is not crying, the peon attempts to initiate breathing by slapping the soles of its feet or, more strongly, by spanking the baby's bottom. She may also take the end of an old saree and clear the neonate's mouth of mucus, if she perceives some difficulty in breathing. If that does not work, the peon shocks the baby by splashing cool water on its warm body. If the baby cannot be startled into life, the nurse comes to...
The integration of modern and traditional obstetric practices in Nepal

massage its heart. As a final resort the peon, nurse or doctor will try mouth-to-mouth resuscitation.

Meanwhile, the mother is not informed immediately of the baby's sex, for it is said that if she were to learn that she has given birth to a son, she would be so overjoyed that the afterbirth would not come out. It is for this reason, it is said, the baby is not given immediately to its mother, but instead is placed out of her view. In point of fact, though, the mother learns soon enough, for the sex of her child is the key question on everyone's mind. The corridor, to where most of the women have been temporarily banished, buzzes at first with comment and then with curiosity. It is only a matter of moments before the women flock back into the delivery room to observe the baby and comment approvingly (if it's a boy) or disapprovingly (a girl) on its sex.

Otherwise the nurse remains with the mother, awaiting the afterbirth which she hastens by gently pulling on the loose end of the umbilical cord. There is no attempt to examine the polluting afterbirth to determine whether any portion of the placenta has been retained. When the placenta emerges, the nurse leaps back to let it slide into the bucket at the base of the bed, containing the other effluvia. She then begins to sew the episiotomy. The suture without anaesthetic is painful. Having more or less controlled their pain throughout labour, this was clearly the part of the delivery from which women greatly suffered. Their screams could hardly be stifled by their relatives. The nurse then takes one cotton menstrual pad and pushes it into the vagina in order to staunch the flow of blood; and then ties another pad around it with string. Assuming no further complications, the nurse removes her apron and gloves and returns to her duties elsewhere in the hospital. The mother remains on the bed.

With the nurse gone, the peon turns to look after the baby. Using mustard oil and an old saree as a rag, she rubs the blood, meconium and vernix from the neonate's body. This follows Matthil practice in that the baby should not be washed with water, except in a life-threatening situation when cool water is used to shock the infant into taking the first breath of air. Then the cord is cut. It must be born in mind that the nurse has already cut the baby from the placenta; still about a foot-long length of cord remains, clamped at the end. The peon ties the cord in two places close to the umbilicus and then makes the cut, using the scissors that the nurse had left behind. The remaining bit of cord is thrown out the window.

The peon, however, does not cut the cord without being paid a fee by the mother's relatives. At the very least this fee is Rs. 5 for a girl and Rs. 10 for a boy. But its amount is subject to some negotiation and the starting price can be as high as Rs. 25 if the peon thinks she can get away with it. Often the relatives protest, saying that patients should not have to pay such a fee at a public hospital. Or they try to avoid payment by claiming that their male guardian has paid their money. But few get by without paying; and in the several cases of women who gave birth out of wedlock, the nurses got together and offered from their meagre salary some token payment on the patient's behalf. If anyone tried to avoid payment, the peon would announce that it was, anyways, time to go 'off duty'. Before she could leave the delivery room, the other women would have their purses room open.

The peon's fee is claimed at the same time as that of the cobbler's wife in home births, but it would seem that the two fees are not entirely equivalent. The cutting of the cord is one of the most important aspects of child-birth at home, but for in doing so the cobbler's wife takes on the pollution of birth. Her agreement to take on the pollution is sealed by the fact that she accepts the coin on which the cord is cut. Six days later, on the morning of the ceremony called chatiyar (meaning the 'ceremony of the sixth'), the cobbler's wife may also receive a payment from the family, who are pleased with the birth of their child. Since the family will be greatly pleased to have a son, the cobbler's wife in such cases expects a gift of greater value. The hospital peon, however, collects her gift on the spot, otherwise she would never receive it.

Of course, not every child-birth ends successfully. Some babies are stillborn or die in the trauma of birth. They lay on the small table, where they were placed at the time of birth. No one wants to touch them. The family does not want to claim it. The nurse has disappeared; and the female peon will have nothing to do with it. In some case the family is obliged to take care of the dead baby. If there should be another family in or around the delivery room awaiting to give birth, they will insist that their baby not be put on the same table from which the dead baby had been removed. Monstrous births, however, are dumped in the basin by the delivery bed. These births greatly aroused the curiosity of women in the ward who came to gaze and comment upon the distorted foetus. Later they were disposed of in the hospital incinerator, together with the afterbirth.

Although it was during the second and third stages of labour that the hospital was able to assert its authority in managing the birth, it should not be taken as a measure of its force, for in a home delivery it is during this very period that the family lets the cobbler's wife take control of the labour. The delivery of the child, expulsion of the afterbirth, cutting of the cord and cleansing of the baby are actions which pollute both mother and midwife. The mother's relatives do not generally touch the baby until these actions are complete. Their contact with the mother at this time is limited to restraining her mouth and the upper part of her torso. There were clear points of difference between clinical and domestic procedures in the second and third stages of labour (i.e. the episiotomy and the cutting of the cord prior to the expulsion of the placenta), but no clash of wills between nurses and relatives over the place of the baby in the delivery bed. To reiterate, the reason for this did not entirely lie with the hospital's ability to exercise clinical authority at the critical moment of birth; it also lay with this being the period when the family customarily withdrew from the management of labour. Traditionally they resume control only after the baby has been cleaned by the midwife.
POSTNATAL CARE

For around half an hour after the expulsion of the afterbirth the mother remains on the bed in the delivery room. The peon wraps the baby in swaddling clothes, usually a strip of cloth from an old sari, and a member of the family will take it in her arms. At this time, in the case of a home birth, a fire is lit in the room, offerings of grain are made to the fire and the senior woman of the household blesses the mother by applying a tika to her forehead. The entire ritual is not performed at hospital, but the woman who is chief worshipper at the family shrine blesses the mother on the delivery bed with a tika. The form of the tika varies according to caste and family traditions, but it is usually red in colour and sex-specific. Variant forms include: for mothers of boys a vertical line from the crest of the forehead to the tip of the nose and of girls a dot in the centre of the forehead atop a semi-circle; or of boys a vertical line from the crown of the head along the hair parting, intersected by two horizontal lines across top and down across the forehead to the tip of the nose, whereas for a girl just the vertical line. Some mothers received only the normal dot of a tika, regardless of whether they had given birth to a boy or a girl.

Then the mother, supported by her relatives, makes her way to the bed in the recovery room. During the first few hours postpartum the female relatives take the infant in their charge. They comment approvingly or disapprovingly on its sex (better to be a boy), its skin colour (not too pink), its facial appearance (a high forehead and straight nose are signs of beauty), its babbling (it must be having a word with god), and so on. If the head has become elongated in squeezing through the birth passage or if the nose appears flat, so on. If the head has become elongated in squeezing through the birth passage or if the nose appears flat, some women press the cranium or pinch the bridge of the nose to correct the fault. The women also offer the first food to the baby by twisting a piece of cotton wool, drenching it in sweetened water, or goat's or cow's milk by means of a twist of cotton wool. Alternatively the baby may be wet-nursed by a relative or a neighbour who is treated as a 'sister'.

Meanwhile the baby is not put to its mother's breast, but must await the second or third day postpartum by which time the mother's colostrum (the 'stale' milk) has cleared and her 'real' milk has come. The disgust, which colostrum evokes in mothers, is widely felt; and no amount of persuasion by hospital staff could induce mothers to change their mind. Until the third day postpartum the baby is fed sweetened water, or goat's or cow's milk by means of a twist of cotton wool. Alternatively the baby may be wet-nursed by a relative or a neighbour who is treated as a 'sister'.

The hospital staff do not approve of all the postnatal practices of Maithil women [3,4], but they make no attempt to enforce 'enlightened' ideas on their patients, respecting instead the traditional procedures and advice of the mother's support group. In this way the mother is looked after for about 2 days whereupon, if there is no sign of haemorrhage or of infection from the episiotomy, she is discharged.

CONCLUSION: TRADITIONAL OBSTETRIC PRACTICES

Certainly clinical practice at the Janakpur Hospital is seriously constrained by the values of Maithil society and the domestic organization of child-birth. In some respect these constraints pervade the entire hospital system. All but one of the doctors were men and most were Maithil in origin, but no man ordinarily entered the delivery room. By contrast, no Maithil women were nurses. This was beneath the dignity of high caste women and beyond the reach of poor, uneducated women who could only qualify as peons. The nurses, perforce, were Nepali speakers from the hills, and they took pride in their work. At times they resented the provincial virtues of Maithil women who found hospital work necessary, but would never degrade themselves to take on such employment. The same provincial values which barred male doctors from the maternity ward also barred local women from becoming nurses and ensured that the peons would be local women of low caste.
Because the nurses, peons and relatives of the mother had their own ideas of obstetric practice, the implication of the hospital staffing arrangements was that obstetric services were a succession of modern, medical and local, Maithil procedures. The hospital lacked the resources to maintain an adequate nursing or midwifery presence, and so was forced to rely on the local practices of the peon. Thus hospital procedures were intermittently observed in the first stages of labour, but came into force only at the time of delivery. In the nurse's absence the women of the courtyard assumed authority. Traditional procedures of controlling the mother, accelerating labour and of postnatal care prevailed. Moreover, given the fact that the nurses were able to assert control only at the time of maximum pollution—the delivery—when the courtyard normally relinquished control, it could be argued that the nurses as 'modern healers' were integrated into the traditional system, not vice versa. Occasionally domestic birth practices took place in the presence of the nurses, but these were often tolerated if they were medically harmless and formed part of the family's care of the mother and neonate.

Similarly the peon's practices were tolerated if they were harmless and moral (there was some unease among nurses about the peon claiming a fee in a public hospital). As for the hospital practices which were ambiguous in their interpretation (e.g. offering warm tea to the mother in labour which the nurses said induced urination and the patients said warmed, and thereby loosened, the lower abdomen), the nurses knew which interpretation was 'right'; and they were familiar enough with the local interpretation to consciously manipulate in order to reassure the mother and to secure her compliance (e.g. encouraging mothers to drink tea by saying that the warm liquid loosens the abdomen). But not all hospital practices (e.g. the nurses predisposition to episiotomies) seemed to be based on the awareness of their cultural character. Ideologically speaking, the nurses shared in the local view that the main problem was the presence of a culturally specific theme in obstetric practices suggests that modern medicine—far from being universal in form—may allow cultural styles in its practices and preoccupations. Such practices run counter to medical ideology in that the medical staff claim to require cultural knowledge to understand their Maithil patients but not to understand themselves. That is to say, the nurses had cultural knowledge of their patients which they self-consciously manipulated in order to reassure the mother and to secure her compliance (e.g. encouraging mothers to drink tea by saying that the warm liquid loosens the abdomen). But not all hospital practices (e.g. the nurses predisposition to episiotomies) seemed to be based on the awareness of their cultural character.
Majesty's Government for permission to carry out research on the socio-cultural parameters of public health in Nepal. A preliminary version of this paper was read by Jan Savage to whom we are indebted for her detailed comments.

REFERENCES