



Social Customs and Practices Associated with Pregnancy and Child Bearing in Low Socio-Economic Communities

Sudha Shukla¹ and Bhartendu Shukla^{2*}

Affiliation

¹Employees State Insurance Scheme, Madhya Pradesh, India

²RJN Ophthalmic Institute, Gwalior, India

*Corresponding author: Dr. Bhartendu Shukla, Director of Research, RJN Ophthalmic Institute, Gwalior, India, E-mail:

bhartendushukla@yahoo.com

Citation: Shukla S and Shukla B. Social customs and practices associated with pregnancy and child bearing in low socio-economic communities (2020) Nursing and Health Care 5: 18-24.

Received: Sep 22, 2020

Accepted: Oct 20, 2020

Published: Oct 27, 2020

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Abstract

Child birth is a very significant event in a married woman's life. She is filled with fear and anxiety mixed with a feeling of joy and expectation of the coming child. Apart from physical care psychological care and assurance are equally important. Present study deals with the women of poor workers of the factories who have to undergo deliveries either at home or ill equipped hospitals causing much suffering and even mortality. Detailed history of such 250 women was taken in a questionnaire proforma prepared for the study. A history of age, caste, education, para, occupation, husband's income and knowledge about pre and post-natal care was recorded. Thus 21 tables were made of each case and analyzed in detail. It is a practice to marry girls at an early age as they feel it ensures their safety. Husband's income was quite low and 50% of them were uneducated. 30.8% could only read and only 8.8% were graduate. Illiteracy was a major problem in safe delivery of the child. Old traditional customs were followed some which were not hygienic. Only 19% were employed. Rest were only house wives. Ground delivery was preferred in 74% cases, squatting position in 71.2% and 56% preferred sand in place of mattress. All these are not preferred methods currently. In the second stage of labor birth canal was lubricated in only 8.8% cases. In 76% cases massage of abdomen was done to hasten the delivery. The cord was cut mainly by knife after delivery. Placentas were mainly buried after delivery (74.8%). 56% of women remained lying in for about a week after delivery. 78% mothers took their first bath 3 to 6 days after delivery.

Keywords: Obstetric care, Child bearing, Social customs.

Introduction

In a woman's life after marriage child birth is the most significant event. Particularly the first child birth is associated with lot of anxiety, excitement, fear, happiness and a sense of fulfillment. It is increasingly being recognized that the mind exerts a powerful effect on the body resulting in many psychosomatic disorders like hypertension, diabetes etc. Child birth is intimately connected with the health of the mother and the child. It is rather unfortunate that in many developing countries the conditions of delivery are not very satisfactory particularly in rural areas. Madhya Pradesh, a state in India has a population of about 70 million. Here only 40% women are literate (based on Census of 2011). This leads to lack of awareness of health problems and sticking to the traditional methods of delivery which are usually not very safe. Besides there are many social customs associated with pregnancy, child birth and feeding of the child. They can also affect the health of the mother and the child. All these factors differ from region to region and from community to community. With these facts in mind a study was conducted in Birla Nagar ESIS (Employees State Insurance Scheme) dispensary to analyze these health factors and their probable outcome on health of the mother and child. This locality is mainly inhabited by workers of different factories of Gwalior town who are mainly of low socio-economic status.

Review of Literature

History of obstetric care is as old as history of mankind. It has been changing and improving in efficiency all over the world. In India the development has been rather slow due to long period of slavery and lack of education particularly of women in rural areas. Age old traditions have also retarded the development to a great extent. Government of India appointed a Health Survey Committee in 1943 which observed that about 2 million (20 lacs) women died annually during child birth. The government announced formation of 4,500 maternity and child welfare centers. Maternity and Child Health Services were identified as a priority in National Health Policy (GOI) [1-3].

Park et al, conducted a study in Dabra in Gwalior and found 21.5% low birth rate in 1051 cases of delivery. Park et al, conducted a similar study in Gwalior on 2927 deliveries and found low birth rate in 18.6% cases. It was 16.6% in males and 20.7% in females. Balfour found 2899 grams average birth weight in Indian infants. Risk of death associated with complications of pregnancy are measured in terms of maternal deaths per 100 thousand live births per year and is known maternity mortality ratio. Ranjan reported 474 maternal deaths per 100 thousand live births in a year. Maternal mortality ratio is 3 times higher in rural population than in urban areas though it differs in different provinces in the country. Central eight states of the country had much higher mortality rate (Govt of India, 2001). WHO started a strategy Heath for all [4-11].



It was based on the concept that the vulnerability of illness results from number of interacting biological factors such as genetics, environment, psychosocial status etc that can be measured as expression of probability of future need for care. The Risk Approach uses these estimates to know a woman's need for help and guidance. However it is a fact that maternal deaths are not avoidable by traditional preventable health care. In order to save maternal deaths good quality of obstetric services must be available particularly in emergencies. Majority of deliveries in Central India, particularly in rural areas continue to take place at home under traditional settings which are not very hygienic. In such a situation first referral unit can offer little and facility should be available to reach proper care center at reasonable time. About 75% maternal deaths occur in the last trimester and the first week following the end of pregnancy [12-14].

There are various population based approaches for estimating the obstetric risk such as

i-Vital Registration: It is widely available source of information on maternal death. In many developing countries the coverage of registration is poor and the cause of the maternal death is not mentioned. Even from some developed countries like UK, USA and Latin America maternal deaths are not properly recorded [15-24].

ii-Vital Registration with interview: This approach is particularly suitable where the registration is fairly complete but scientific information on cause of death is not available. This approach has been tried with some success in USA, Bangladesh, Egypt, MOH and UK. However, in developing countries this method was not found very useful [25-29].

iii-Sisterhood Approach: This is an indirect approach to circumvent the problem of large sample size needed to collect the data [30].

iv-Networking Approach: In this the respondents are asked to identify ant maternal death of which they are aware [31].

Then there are model based approaches of estimating obstetric risk. It was first used by WHO in 85 countries [32]. Drvraj et al, [33] Ranjan [34] and Borema [35] also developed modes. Blum and Fargues [36] used existing life tables to estimate maternal mortality. Ranganathan and Rode [37] Fathalla [38] and Thaddeus and Maine have also described different methods [39,40]. Madhya Pradesh is a part of central India where obstetric care is quite poor. A survey was carried out in Madhya Pradesh in 2003 which covered 25% of rural population. It was found that 763 deaths occurred in 2003 for every 100,000 live births (Govt of Madhya Pradesh). It was much higher than the incidence in urban areas [41].

Rao et al, conducted a survey on protein malnutrition in poorer sections of the society [42]. They found that 92% infants were breast fed for 6 months after which supplementary food was added. Onset of pregnancy was the main cause of weaning. Belavady et al, studied breast feeding in tribal areas of South India and found that breast feeding was up to about 12 months probably as they did not have any supplementary food to add [43]. Gopalan found that they used garlic, tamarind and cotton seed as they believe them to be lactogogues [44]. Mahadevan in a similarly found that longer the breast feed longer would be life [45,46]. Pasricha in a diet survey of 70 lactating women found an average intake of 1860 calories with a mean intake of 40gm protein, 300mg calcium and 25mg iron. Karmarkar et al, in a similar found intake of 1400 calories, 40gm protein and 30gm fat, Calcium was 300 mg and iron was 30 mg [47,48].

Wicks and Davidson found that the incidence of breast feeding was falling in higher societies [49,50]. Newton NR and Newton M observed that in breast feeding mother's attitude was important. Mathews and Platt also found prolonged breast feeding in low socio-economic groups. Ahluwalia observed that in some communities delivery was conducted in squatting position of the mother. He also found that in some cases some type of shock was given to the mothers if the delivery was getting prolonged. In postnatal period visitors were restricted up to 40 days [51-55].

Material and Methods

The ESIS dispensary is situated in Birla Nagar area of Gwalior town in India. There are three big factories nearby including JC Mills, CIMMCO and Steel Foundry. All workers in these factories go to the above dispensary for all types of treatment. The serious or complicated cases are referred to specialty departments of the local medical college hospital. All family members of the workers are also treated here. The study was conducted mainly on a detailed history taken according to a questionnaire proforma prepared for the study. Although a large number of women and their relatives were interviewed but because of poor level of literacy and knowledge complete answers could be taken from only 250 cases after repeated interviews. In many cases the answers too many queries had to be obtained from the mother-in-laws of the women or from their other relatives. Many women were found to be very reluctant in disclosing their personal matters and had to be persuaded with great difficulty. Data thus obtained was recorded in 21 tables and was analyzed in this study.

Discussion

As regards the age of the mothers 50% mothers were in the age group of 21-30 years. There was no difference between the age groups of 21-25 and 26-30 years (**Table 1**). Park et al, also found maximum incidence in 21-30 yrs [4]. Age group (56.6%) In his subsequent study at Gwalior he found the incidence a little higher (61.6%). In his both studies women below the age of 20 years were 21% whereas in our study it was only 12.8% [5]. In low socio-economic families it is a general trend to marry girls at a fairly early age. A married girl is considered much safer than an unmarried young girl. However with growing education in women this trend is gradually declining. Earlier the society was strictly divided into four casts viz. Brahmin (learned class), Kshatri (warrior class), Vaishya (trader class) and Shudra (labour class). Marriages were done mainly within one's own caste. However from last about 70 years there has been a considerable case of inter caste marriages. Hence from **Table 2** showing the caste no definite indication could be made out. It may be said that the upper (Brahmins and Kshatriyas) and lower classes (Vaishyas and Shudras) are nearly equal. In **Table 3** the husband's income is certainly very low affecting the welfare of pregnant women and the new born child. As shown in **Table 4a** 50% of women were totally illiterate and another 30.8% could only read local language.

S.no	Age (Years)	Total Numbers of Mothers	Percentage
1	Upto-20	32	12.80%
2	21-25	61	24.40%
3	26-30	61	24.40%
4	31-35	38	15.20%
5	36-40	21	8.40%
6	41-45	12	4.80%
7	46-50	15	6.00%
8	Above 50	10	4.00%

Table 1: Distribution of mothers by age.

Only 8.8% women were graduate. Misra [56] in her extensive study on education of women in India observed that in 1965-1966 in primary education (class 1-5) there were there were 30.12 million boys and the number of girls was only 19.52 million. If the figures for low socio-economic group are considered the difference would be still more [57]. Due to lack of education there was very little health awareness including maternity problems and the women were mainly guided by age old traditions which were not very hygienic. All these factors led to high maternal morbidity and high maternal mortality rate. Park in his study at Dabra found 21.5% and at Gwalior 18.6%. **Table 4b** shows the literacy level caste wise [4,5]. The maternal mortality is much higher than in Western countries [15-17,20,35].

Table 5 shows the mother's age at the time of marriage. It is alarming that 31 mothers (12.4%) got married below the age of ten years.



Sno	Caste	Total Numbers of Mothers	Percentage
1	Brahmin	41	16.40%
2	Kori and koli	50	20.00%
3	Kayasth	17	6.80%
4	Thakur	55	22.00%
5	Vaishya	23	9.00%
6	Jat	5	2.00%
7	Punjabi	22	8.80%
8	Punjabi sikh	3	1.20%
9	Maharashtrain	7	2.80%
10	Marathi	5	2.00%
11	Tailor	1	0.40%
12	khatri	1	0.40%
13	Marwari	1	0.40%
14	yadav	1	0.40%
15	kumhar	2	0.80%
16	kewat	1	0.40%
17	Gujrati	1	0.40%
18	Bihari	1	0.40%
19	Madrasi	1	0.40%
20	Pahadi	2	0.80%
21	Sindhi	1	0.40%
22	Kashmiri	1	0.40%
23	Weaver	2	0.80%
24	Barber	1	0.40%
25	Muslim	2	0.80%
26	Christian	2	0.80%

Table 2: Distribution of mothers by caste.

S.no	Income	Total Number of Mothers	Percentage
1	Rs. 50-100	55	22.0%
2	Rs. 101-200	131	52.4%
3	Rs. 201-300	31	12.4%
4	Rs. 301-500	11	4.4%
5	Rs. 501-1000	16	6.4%
6	Rs. Above 1000	6	2.4%

Table 3: Husband's income.

S.no	Education	Total Number of Mothers	Percentage
1	Illiterate	125	50.0%
2	Can read	77	30.8%
3	Can read and write	10	4.0%
4	Up to Middle	7	2.8%
5	Up to Matric	9	3.6%
6	Graduate	22	8.8%

Table 4a: Education of Mother.

Another 140 (56.0%) got married between 11 and 15 years whereas the law of that land states that marriage below 18 years is illegal. It also reflects the callousness of local authorities to take proper action. This is an alarming situation. In poorer people it is the belief that the girls are safer after marriage and hence marry them at the earliest. The state authorities have also been not very strict unfortunately. However the trend is changing with education and awareness.

Table 6 shows the distribution of mothers by occupation. With very low level of literacy and early marriages 81% of women were simply house wives without doing any other kind of work to supplement income of the family. Only 2% were employed as teachers and the rest were either laborers or doing odd domestic jobs. Park in his two studies found only 16% primipara [4,5]. Thus with more number of children it becomes difficult for a mother to do even a part time job. Only 54.4% mothers had some awareness about antenatal care. The rest had no knowledge about it **Table 7**.

In **Table 8** practices regarding the first stage of labor are shown. Shaving of the skin and enema was not given in 78% cases. Ground delivery was much preferred (74%) than cot delivery (26%). Sand was

S.no	Caste	Total Number of Mothers	No. of literate	Percentage
1.	Brahmin	41	35	85.30%
2.	Kori and koli	50	5	10.00%
3.	Thakur	17	15	88.20%
4.	Vaishya	23	10	43.40%
5.	Punjabi	22	20	90.90%
6.	Punjabi Sikh	3	1	33.40%
7.	Maharashtrain	7	4	57.00%
8.	Marathi	5	3	60.00%
9.	Guajarati	1	1	100.00%
10.	Madrasi	1	1	100.00%
11.	Pahari	2	-	-
12.	Sindhi	1	-	-
13.	Tailor	1	-	-
14.	Marwari	1	-	-
15.	yadav	1	-	-
16.	Kewat	1	-	-
17.	Kumhar	2	-	-
18.	Kashmiri	1	-	-
19.	Jat	1	-	-
20.	Weaver	2	-	-
21.	Barber	1	-	-
22.	Muslim	2	-	-
23.	Christian	2	2	100.00%
24.	Bihari	1	-	-
25.	khatri	1	1	100.00%

Table 4b: Literacy Status by Caste.

S.no	AGE (Years)	No. of mothers	Percentage
1	Below 10	31	12.4%
2	15-Nov	140	56.0%
3	16-20	70	28.0%
4	21-25	6	2.4%
5	26-30	3	1.2%

Table 5: Age of Mother at Marriage.

S.no	Occupation	Mothers	Percentage
1	House wife	203	81.20%
2	Teacher	5	2.00%
3	Labour	20	8.00%
4	Others	22	8.80%

Table 6: Distribution of mothers by occupation.

S.no	Awareness	No. of Mothers	Percentage
1	Yes	136	54.40%
2	No	114	45.60%

Table 7: Awareness of Antenatal Care of Mother.

more preferred than mattress as it would absorb blood, maternal discharge etc. Squatting position was preferred (71.2%) than lithotomy position (28.8%) as it might help delivery by gravity. Vaginal examination was usually not done. In diet, milk, ghee liquefied butter, date palm and jaggery was preferred. In the second stage of labour (**Table 9**) lubrication of birth canal was done. Cotton sarees were mainly used. For hastening the delivery massage of abdomen was done in about three fourth cases (76%). No drug or food was usually given in second stage. In the third Stage **Table 10** knife was usually used for cutting the cord (59.2%). Blade or scissors were also used in some cases. Cord dressing was done mainly by hot oil (54%) or turmeric with hot oil (20%). Placenta was usually buried (74.8%) but in some cases it was thrown away. **Table 11** shows the duration of lying period in the initial post-natal period Majority of mothers kept lying from 4 to 6 days (56.0%). 30.0% were lying for 2-3 days. 4% took bed rest. Some patients however took rest from (7-15 days).

Usually after first delivery mothers take lesser time in subsequent deliveries. However, this was not found in the present study. **Table 12** shows the post-natal bath habits. 78% took first bath between 3rd and 6th days (78%) and 22% between 7th and 10th day. The second bath was mainly taken between 7th and 10th day. The time for 3rd bath was variable. Timing of bath also depends on season.



S.no	First Stage of Labour		No. of mothers	Percentage
1	Shaving of Skin	Done	55	22.0%
		Not done	195	78.0%
2	Enema	Given	56	22.4%
		Not given	194	77.6%
3	Site of delivery	Cot	65	26.0%
		Ground	185	74.0%
		Sand	140	56.0%
		Mattress	110	44.0%
4	Position	Lithotomy	72	28.8%
		Squatting	178	71.2%
5	Vaginal exam	Done	70	28.0%
		Not done	180	72.0%
6	Special diet	Milk and ghee	149	59.8%
		Only milk	83	33.2%
		Jaiphal and milk	7	2.8%
		Milk+ date palm	2	0.8%
		Milk+ajwain	2	0.8%
		arhar	1	0.4%
		jaggery	6	2.4%

Table 8: First Stage of Labour.

S.no	Stage of Labour		No. of mothers	Percentage
1	Lubrication of birth canal	Done	22	8.80%
		Not done	228	91.20%
2	Type of lines used	Cotton sarees or cotton	221	88.40%
		Other pads	29	11.60%
3	Method of hastening delivery	Massage of abdomen	190	76.00%
		Not above	60	24.00%
4	Use of drugs	Jaiphal sonth and milk	15	6.00%
		Not given	230	92.00%
		Castroil	5	2.00%

Table 9: Second Stage of Labour.

S.no	Stage of Labour		No. of mothers	Percent age
1	Method of cutting of cord	knife	148	59.2%
		Sikee or blade	46	18.4%
		Scissors	56	22.4%
2	Before or after the delivery of placenta	Before	76	30.4%
		After	174	69.6%
3	Cord dressing	Oil (hot)	135	54.0%
		Turmeric and oil	50	20.0%
		Mc paint and spirit	56	22.4%
		Ashi	9	3.6%
4	Disposal of placenta	Buried	187	74.8%
		Thrown away	63	25.2%
		Burnt	63	25.2%

Table 10: Third Stage of Labour.

S.no	No. of Days	No. of mothers	Percentage
1	3-Jan	75	30.00%
2	6-Apr	140	56.00%
3	15-Jul	35	14.00%

Table 11: Post-natal Period-I Lying Period.

Table 13 shows the practice of perineal toilet. Neem or Ajwain in warm water was the commonest method (28.0%). Warm water with dettol was also common (22.0%). Neem is a well-known antiseptic and was also used with warm water. Table 14 shows the time after delivery

when visitors are allowed. It is necessary to avoid infection to the mother and the new born. In majority of cases visitors were allowed between 4-6 days (52%).

In 28.4% they were allowed between 7 to 15 days. It is not only the time but the type of visitors and precautions taken by them. They are supposed to put off their shoes and the child is not allowed to be touched without washing hands. With the advent of potent antibiotics people have become slightly slack in observing these precautions Table 15 deals with breast care and methods by which secretion of mother's milk can be increased. In this about 90% of mothers knew much about breast care. Jaggery, pulse, meat soup and green vegetables were given. Pasricha and Karmarkar in similar study observed that Indian women in spite of inadequate diet were able to produce a fair quantity of milk for a long time. Wicks, Davidson and Newton had similar findings. Jaffe, Mthews and Platt found that prolonged feeding was because they did not have any supplementary diet to offer [47-54].

Table 16 shows resumption of work during post-natal period. 67.6% women returned to partial work after a week. 20.4 mothers returned to work after 2-3 weeks almost three fourth returned to full work after a month's time. However, there are other factors also which can influence this period such as age, health of mother etc. Hence there is no rule of thumb.

S.no		No. of Days	No. of mothers	Percentage
1	1 st	6-Mar	195	78.00%
2	Bath	10-Jul	55	22.00%
3	2 nd	10-Jun	183	73.00%
4		15-Nov	67	27.00%
5	3 rd	15-Nov	155	64.00%
6		16-20	42	14.80%
7		21-30	30	12.00%
8		30-40	12	4.80%
9	4 th	No. 3 rd Bath	11	4.40%
10		15-20	35	14.00%
11		21-20	120	48.00%
12		31-40	30	12.00%
13	5 th	No 4 th Bath	65	26.00%
14		30-40	127	50.80%
		No 5 th Bath	123	49.20%

Table 12: Post-natal Period-II.

S.no	Toilet	No. of mothers	Percentage
1	Thymol, Neem and Warm Water	70	28.0%
2	Warm water and Dettol	55	22.0%
3	Turmeric, Oil	31	12.4%
4	Oil	38	15.2%
5	Country Wine	40	16.0%
6	Jaggery and Oil Mixture	10	4.0%
7	Cow's Urine	6	2.4%

Table 13: Post-natal Period-III Perineal Toilet.

S.no	No. of Days	No. of mothers	Percentage
1	1-3	26	10.4%
2	4-6	130	52.0%
3	7-15	17	28.4%
4	16-30	9	3.6%
5	31-40	14	5.6%
	Total	250	

Table 14: Post-natal Period-IV Visitors.

S.no	Breast care	No. of mothers	Percentage
1	care taken	225	90.0%
2	not taken	25	10.0%

Table 15: Post-natal Period-V Breast Care and Lactogogues.



S.no		No. of mothers	Percentage
1	Peeper	20	8.0%
2	Mash and Pulse	25	10.0%
3	Jaggery	42	16.8%
4	Mash and Milk	94	37.6%
5	Milk	59	23.6%
6	Meat Soup	2	0.8%
7	Soft Coconut and Green Vegetable	8	3.2%

Table 15a: Lactogogues.

S.no	No. of Days		No. of mothers	Percentage
1	5-Jan	partial activity	20	8.00%
		full activity	-	-
2	10-Jun	partial activity	169	67.60%
		full activity	-	-
3	20-Nov	partial activity	51	20.40%
		full activity	25	10.00%
4	21-30	partial activity	3	1.20%
		full activity	26	10.40%
5	31-40	partial activity	7	2.80%
		full activity	192	76.80%
6	2 Months	full activity	3	1.20%
7	3 Months	full activity	2	0.80%
8	6 Months	full activity	3	1.20%

Table 16: Post-natal Period-VI Visitors.

S.no	Care		No. of mothers	Percentage
1	Eyes	Yes	217	86.80%
		No	33	13.20%
2	Sleeping with Mother	Yes	197	78.80%
		No	53	21.20%

Table 17: Care of New Born.

S.no	Clothing	Total No. of mothers	Percentage
1	Naked	78	31.20%
2	Old clothes	142	56.80%
3	New clothes	30	12.00%

Table 18: Care of new born-III Clothing.

Table 17 shows some aspects of the care of the new born. 80% of mother slept with their child to take care during the night time. Many of them were of the eye complications also and consulted accordingly. In the day time relatives were available to take care. Table 18-20 shows about the bath and of clothing of the new born and the mother. 56.8% used old clothes of the relatives as they considered softer than the new ones. Nearly one third children remained naked. Mostly warm water and soap was used for bathing. 54.8% mothers took daily bath in summers but only 6.8% in winters. In winters most mothers took bath twice a week. Table 21 shows about the feeding pattern. Breast feeding was started from the first day by only 12 mothers (12.2%). 36 mothers (14.4%) started from the second day while 169 (67.6%) from the third day. In most cases it was supplemented by cow's or goat's milk. 18 mothers (7.2%) resorted to the help of other lactating mothers. Rarely glucose was given.

Conclusions

A study was undertaken to know about various social customs and practices associated with pregnancy, child bearing and child rearing in 250 women in the industrial area of Gwalior city of India. They were mainly from three factories via JC Mills, Gwalior Rayon and

S.no	Mode of Bathing	Total No. of mothers	Percentage
1	Warm Water + Earth	30	12.00%
2	Warm Water and Soap	110	44.00%
3	Warm water + Ground gram	105	42.00%
4	Warm Water, Myrtle gram	3	1.20%
5	Cold Water in Case of Female	2	0.80%

Table 19: Care of new born-IV Bathing.

S.no	Seasons and Time		No. of mothers	Percentage
1	Summer	Daily	137	54.80%
		Alternate day	113	45.20%
2	Winter	Daily	17	6.80%
		Alternate day	83	33.20%
		Biweekly	150	60.00%

Table 20: Care of new born-IV Bathing B.

S.no	Feeding	No. of mothers	Percentage
	ARTIFICIAL		
1	Honey	55	22.00%
2	Ghutti (Jaggery + Thymol)	51	20.40%
3	Milk, Cow's and goats	88	35.20%
4	Lactating Mother	18	7.20%
5	Top Feeding	35	14.00%
6	Glucose	3	1.20%
	NATURAL		
	1 st Day	32	12.20%
	2 nd Day	36	14.40%
	3 rd Day	169	67.60%
	6 th Day	13	5.20%

Table 21: Care of new born-V Feeding.

CIMMCO factory. All of them are situated in the Birla Nagar locality of Gwalior city. All workers in these factories came to ESIS (Employees State Insurance Scheme) hospital for their treatment as well as treatment of their family members. Study was conducted on the women of the employees and various details about the social customs in vogue during pregnancy, child birth and after care of these child and the mother. In these matters many family traditions are usually followed and many of them are not very hygienic and are due lack of education and awareness.

Hence health education is very important in these cases which was also done along with the study. Ahluwalia [55] has rightly observed that that women in low socio-economic strata are very reluctant to give the traditional methods of conducting delivery and refrain from unhygienic practices. Misra in her extensive study on women education in India and MP State (Gwalior is in MP State) has mentioned that lack of education is the main cause of many health problems in women including child birth. Traditions die hard. Hence many women and their relatives often resist many hygienic practices which are advised. It is therefore better to win their confidence first that we are their sincere well wishers before trying to exert our authority on them. With growing education and awareness the situation is improving in India even in the villages [56,57].

Acknowledgements

We wish to express our deep gratitude to Prof. AK Govila, MD, FAMS, former Dean and Professor of Social and Preventive Medicine for guiding us in many ways. We are also thankful to Mr. A Chaurasia for providing many references for this study. Dr. Lakshmi Misra, MA



Ph.D, former Professor of Education has been very kindly provided two important references and has given constant encouragement. Our thanks are also due to Mr. Vijay Birwal in preparation of this article

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