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Bed Rest at Childbirth: Exploring Empirical Dimensions of Support and Vulnerability

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Abstract: *The phenomenon of childbirth is a social event, whereby women hailing from both conventional and modern societies bestow substantial credence upon their social counterparts for the provision of emotional and psychological sustenance. The established importance of obtaining social support from one's biological kin has been widely recognised. It is of utmost importance to adopt a discerning perspective when dealing with this reliance and evaluate it from a sociological standpoint, rather than simply acknowledging it as a mundane occurrence. The inquiry into the selection process of women beneficiaries and benefactors in times of vulnerability may shed light on the uncharted rules and norms governing social support. A comprehensive evaluation of the care dependency of expectant mothers mandates a meticulous examination of the sociocultural milieu in which they are positioned. The ongoing inquiry pertains to a specific cohort of women who give birth within a biomedicalized urban setting, wherein modern techniques enable the detection of potential risks with unparalleled efficiency. Expectant mothers are often troubled by the possibility of being classified as high-risk throughout the duration of their gestation period. Pregnancies that present a heightened risk are subject to meticulous oversight, diagnostic evaluations, and targeted pharmacological interventions. Although bed rest is a commonly prescribed intervention for the management of pregnancies with a high risk of complications, its effectiveness cannot always be assured. It is widely acknowledged that a considerable segment of the women lacks the requisite resources and capabilities to comply with the recommended protocols of prolonged antenatal and postnatal bed rest. The present study endeavours to conduct a comprehensive analysis of the organizational culture of Prakash Hospital, with a*

specific emphasis on the impact of unique social and economic determinants on the assimilation of bed rest norms among women. In a general sense, the discussion regarding the notion of bed rest pertains to the capacity of women to alleviate potential risks via reliance on their maternal kinship networks (baper bari).

***Keywords*:** Childbirth, risk negotiation, bed rest, *baper bari* and mother's care, social support.

Introduction

The amalgamation of technology and the process of childbirth resulted in a multitude of conjectures regarding the intricate relationship between the human anatomy and technological progress. In the first half of the 20th century, the traditional practice of childbirth involved the assistance of midwives and birth attendants within the domestic setting. In the latter half of the 20th century, a conspicuous upswing in the bio-medicalization of childbirth was observed on a global scale. This phenomenon can be ascribed to the swift industrial and technological progress that transpired during that epoch (Rattner 2008). As per the research conducted by Johansan et al. in 2002, it can be inferred that the biomedical paradigm postulates the inherent precariousness of the process of childbirth. The emergence of technological advancements has enabled the detection of plausible dangers. According to Johansan's research, a considerable percentage, varying from 20-30 per cent, of pregnancies in India are classified as being of high risk. This particular cohort of gestations is accountable for a remarkable seventy-five percent of adverse health outcomes and fatalities during the perinatal period. According to the research conducted by Johansan et al. (2002), there has been a notable increase in the employment of electronic foetal monitoring on a global scale, encompassing both low and high-risk populations. Although this phenomenon may appear unsettling at first glance, it is worth noting that women do not universally perceive these anxieties in a negative manner, nor do they view them as being especially severe or intrusive. One could argue that these elements are essential to the process of gestation.

The current investigation delves into the utilization of bed rest as a biomedical intervention suggested to assist pregnant women in mitigating potential health risks. The investigation is conducted at the prestigious Prakash Hospital, located in the urban vicinity of Siliguri. The objective is to explicate the rationale underlying the choice of a particular birthing milieu by women of a discrete socioeconomic class, with the intention of experiencing a few

childbirths over the course of their lifetimes. The study aims to emphasize the conventional practice within institutions of recommending bed rest for pregnant women and the resulting consequences for these women. The following document represents a self-reflective investigation into the organizational culture of Prakash Hospital. More specifically, it explores the impact of social and economic factors on women adherence to bed rest protocols. Thus, the paper asserts that a majority of financially stable women who visit Prakash Hospital choose to avail themselves of medical attention and recuperate at their natal domicile during their antenatal period.

At this particular juncture, it is evident that the crucial interplay of social support and the consequential involvement of social supporters are integral components throughout the process of childbirth. According to Oakley's (1984) perspective, the concept of social support extends beyond mere material resources and encompasses a profound sense of interpersonal connection that involves both the provision and receipt of support. According to Oakley's (1984), the conventional professional paradigms surrounding pregnancy, which dichotomize medical and social perspectives, have impeded the acknowledgement of this evidence and its pertinence to policies concerning maternal healthcare. It is becoming increasingly evident that the provision of appropriate social support during the phases of gestation, parturition, and the postnatal period can yield favourable outcomes from a purely biomedical standpoint. For instance, the provision of appropriate emotional support may lead to a decrease in the quantity of interventions necessary during the childbirth procedure.

Oakley (1984) suggested a similar notion that women may manifest decreased dependence on technology and encounter improved neonatal outcomes when provided with sufficient social support. According to the argument posited by midwives, the provision of social support prior to conception, during gestation, and following childbirth presents a feasible alternative to pharmacological measures, aiding women in the management of both physiological discomfort and emotional distress. The phenomenon known as "baby blues," which is marked by feelings of depression and emotional instability, has been expounded upon by Oakley (1984). Contrary to popular belief, this condition is not solely attributable to hormonal changes following childbirth; rather, it is closely associated with the awareness of the attendant responsibilities of motherhood and the dearth of support available to new mothers. Hence, it can be inferred that social support not only serves as a coping mechanism for women in managing physical

discomfort and emotional distress, but also plays a pivotal role in mitigating the risk of postpartum depression.

Methodology

In the present investigation carried out at Aakash Hospital, a cohort of 43 women was selected, consisting of 31 women who had given birth in Prakash Hospital and 12 pregnant women, from whom data was gathered. The demographic feature of this cohort consists of women spanning from the ages of eighteen to forty. Among the cohort of 43 female individuals, a significant proportion of 31 are situated within the age bracket of 21 to 30 years. In the interim, a trifling faction of 3 women either surpass the age of thirty or descend beneath the age of twenty. Among these 31 women, a considerable proportion of 26 individuals underwent a successful cesarean delivery, whereas a comparatively smaller subset of 5 mothers experienced a natural childbirth. In order to provide a comprehensive depiction of the hospital, a total of 8 nurses, 7 Mashi (paid care givers), and 3 physicians were subjected to inquiry. The approach employed for the identification of respondents was a fusion of both random and stratified sampling methodologies. The investigation was limited to female individuals who willingly granted their permission to participate in the interviews. A noteworthy fraction of the female population underwent the surgical procedure of caesarean section, and it was noted that they frequently displayed a state of drowsiness subsequent to the administration of potent analgesic agents. I was afforded the privilege of conducting an interview with them within a scant 48-72 hours following parturition, a period during which their physiological condition had largely mitigated the impact of drugs interventions. All of the interviews were conducted on the premises of the hospital. Subsequent to childbirth, the maternal subjects were subjected to interviews during their recuperation within the confines of the obstetrical wards or cabins. Pregnant women were subjected to interviews within the confines of the hospital's outpatient department (OPD). The individuals in question originate from a socio-economic tier that may be categorized as middle-class, with a monthly household revenue spanning from Rs. 40,000 to 100,000. All the mothers conceived via the conventional biological method, with the exception of the two mothers who underwent in vitro fertilization. The study cohort comprised of women who were both prim parous and multiparous. Despite the institutional focus on Siliguri, the study conducted at Prakash Hospital included mothers from diverse localities who utilized its services.

In the interview held in Siliguri from another hospital, Dr. Jha, 70-year-old obstetrician and gynecologist, explained the ramifications of technological progressions within the realm of obstetrics. As per the analysis of Dr. Jha, the progressions in medical technology have enabled the timely identification of potential hazards, consequently resulting in a surge in the frequency of caesarean deliveries. The facilitation of diagnosis provided by these technologies has been pivotal in this respect. Moreover, Dr. Niranjal Mondal, a renowned obstetrician who practices at a public maternity hospital in Siliguri, contends that there is a dearth of unanimity among medical professionals, patients, and their families with regard to addressing probable hazards linked to childbirth. Consequently, patients and their families tend to exercise caution and rely on the sound guidance of their doctors in selecting the most appropriate delivery method. The esteemed Dr. P. K. Majhi, who serves as both the proprietor and principal obstetrician and gynecologist at Prakash Hospital, has offered a perspective that is appropriately proportionate to the matter at hand. The potential risks of childbirth are not an inevitability. Women who regularly visit Prakash Hospital tend to hold unfavourable views about their physical appearance and experience concerns about the gestational and postpartum stages, perceiving them as an unavoidable challenge. The term "risk" in this context pertains to a pregnancy wherein the woman, her foetus, or both are predisposed to a greater probability of encountering complications during the gestation period or childbirth, as compared to a typical pregnancy.

The proprietor and obstetrician, Dr. P. K. Majhi, has provided his verbal agreement for the utilization of the premises by the researcher. In order to gain further insight into the biomedical methodologies employed by Dr. P. K. Majhi at his esteemed maternity hospital, I arranged for an additional consultation with the distinguished obstetricians and gynecologists. In accordance with its institutional ethos, every establishment customizes and accommodates the encounter of women visitors. The model of organizational culture has been employed to gain a comprehensive understanding of the institution in its entirety and its impact on the nature and placement of convalescence beyond the hospital setting. It is conceivable to observe the disclosure of risks and the advocacy of bed rest throughout the diverse stages of women's reproductive journey. By elucidating the preferred site for bed rest, we shall proceed to explicate the manner in which institutional culture impacts birthing practices beyond its confines.

Bed Rest and Risk: A Sociological enquiry

Bed rest is a common treatment for women with high-risk diseases such as multiple pregnancies, premature labour, hypertension, antepartum haemorrhage, and foetal development retardation, despite contradictory evidence regarding its efficacy (Crowther 1995). The study conducted by Maloni et al. in 1993 revealed that the process of bed rest resulted in a deceleration of postpartum recovery due to the deconditioning of the muscles and cardiovascular system. The spectrum of bed rest recommendations spans from a modest few hours of reclining at home to a more rigorous regimen of spending the entirety of one's day in a hospital bed. In the study conducted by Josten et al. (1995), it was observed that a significant proportion of high-risk expectant women were subjected to varying degrees of bed rest. Specifically, 20 percent of the participants were prescribed total bed rest, while 38 percent were advised to engage in partial bed rest, which entailed reclining on their side with their feet elevated during the day and limiting their bathroom privileges. As a result of their childcare duties, sound health, household commitments, lack of assistance from their significant others or kin, unease, and occupational obligations, over 33 percent of these women failed to comply with the directive to remain in bed throughout the day. Hence, we can establish a correlation between the significance of adequate rest and the provision of social reinforcement.

When examining the consequences of bed rest, one may also consider the research conducted by Maloni et al. (1993), which revealed that women subjected to complete bed rest exhibited heightened dysphoria, weight loss, and gastrocnemius muscle dysfunction in comparison to those who were subjected to partial or no restraint. As per the findings of Josten et al. (1995), there existed no discernible variance in the pregnancy outcomes of expectant women at high risk who complied with prescribed bed rest guidelines vis-à-vis those who did not. Furthermore, it has been observed that the consequences of pregnancy, such as gestational age, birth weight, and perinatal mortality, were found to have no correlation with customary hospital bed rest during twin pregnancy, as reported by Hartikainen Sorri and Jouppila (1984). The present investigation delves into the female perspective regarding the practice of bed rest, without engaging in any debate regarding the effectiveness of the medical practitioner who recommended it. The focal point lies in the socioeconomic status of women belonging to the middle-class stratum, who possess the financial means to avail themselves of the privilege of bed rest.

Bed rest and Place of bed rest

Women are aware that pregnancy and childbirth may entail a certain degree of risk; thus, they utilise psychological and societal adaptive strategies or coping mechanisms to mitigate their apprehensions. For a woman to fully appreciate the advantages of bedrest, it is imperative that she possesses significant social reinforcement, whether it be derived from her natal family or in-laws' sources.

The term "bedrest" connotes a state of complete physical repose within the confines of one's home, characterised by an absence of physical exertion or labour, and a preponderance of time devoted to reclining, dozing, or sitting upon a bed. The concept of bed rest stands in stark contrast to that of physical exertion and activity. Dr. P. K. Majhi advocates for the implementation of bed rest at home as a precautionary measure to mitigate the likelihood of potential complications during pregnancy for his antenatal patients. He recommended that women at different stages of pregnancy adopt bedrest as a measure to mitigate potential risks. A significant proportion of the female population experienced the ramifications of heightened blood pressure and anaemic conditions. Additional complications during pregnancy encompassed indications such as heightened sugar levels, thyroidal anomalies, insufficient amniotic fluid, and discomfort in the abdominal or limb regions. The medical recommendation of bed rest was also extended to women who have previously experienced miscarriage or neonatal mortality, yet exhibiting no accompanying complications. Throughout the gestational period, the physiological augmentation of thyroid activity, blood pressure, and blood glucose levels, in conjunction with the concomitant reduction in haemoglobin concentration, are deemed usual biological occurrences. Whilst these commonly observed physiological alterations are often perceived as troublesome and potentially implicated in the emergence of risk factors, they constitute the fundamental basis for the prescription of bed rest. Consequently, we can ascertain the manner in which the incidents situate all females within the risk classification and how the prescription of bed rest ensues.

The practice of bed rest can be categorized into three distinct classifications. Given our current understanding that bed rest is a recommended course of action for women, it is imperative to oversee adherence to this prescribed regimen. Henceforth, the state of bedrest is bifurcated into three distinct classifications, necessitating women to elect a singular option:

(i) Total Bed Rest (TBR)- when women spend the majority of their time resting in bed,

(ii) Moderate Bed Rest (ModBR) - when a patient complies with the recommendation for bed rest but also engages in other physical activity,

(iii) Minimal Bed Rest (MinBR) - when women do not take daytime bed rest.

The analysis of the data reveals that out of 43 women, 22 (51.16 percent) followed TBR in good faith. Such a figure is reflective of women and their conception of childbirth, which is entangled with bio medicalised childbirth. There were 17 women out of 43, or 39.53 percent, who were able to combine moderate bed rest (ModBR) with other physical activity. These women chose ModBR or were constrained by factors other than their own will. Minimum bed rest (MinBR) mothers comprised 14 of 43 mothers, or 32.55 percent. This number is the bare minimum, though it is not a far departure from ModBR. MinBR reappears under two conditions: first, by choice, and second, by necessity.

There are three categories of place of bed rest:

1. Natal family (*Baper bari*),
2. In-laws' residence, (*Sasur bari*) and
3. With spouse

Quantitative analysis is important to evaluate sociological events and their correlations in greater depth. Following that we find 51.16 percent of women stayed with their natal families, 37.20 percent with their in-laws, and only 11.60 percent with their spouses. As the paper contends the effective correlation between TBR and place of bed rest, the results indicate that 72.72 percent of women took their TBR at their natal family, 22.72 percent at their in-laws' home, and 4.54 percent with their spouse. The above quantitative analysis suggests that the majority of mothers take bed rest in their natal family, where they can adhere to total bed rest (TBR).

Ethnographic Narrations

In the following section we would discuss by employing the ethnographic narrations the relationship between bed rest and place of bed rest. The case of concerning TBR in natal family is only referred to considering the limited scope of a paper.

Let us begin with the case of Nabanita Bhattacharya. At the age of 29, she has already taken on the role of a mother. Subsequent to her marriage in 2017, she has been living with her spouse, as well as her paternal and maternal in-laws. She planned to commence the process of procreation and bear offspring for the first time in the year 2022. Nabanita pursued her academic endeavours until the tenth grade, a level of education that falls beneath the normative standard of the female demographic that visits Prakash Hospital. She currently occupies herself with the duties of a homemaker. Her spouse is gainfully employed within the governmental sector of the Siliguri Municipal Corporation, and is situated within the middle echelons of the socio-economic stratum. Upon receiving Dr. P. K. Majhi's recommendation for complete bed rest, she went to her natal home to bed rest and receive attentive care. The individual in question presented with high levels of both blood pressure and blood sugar. She exhibited a significant weight and experienced symptoms of nausea and morning sickness. During her pregnancy, she expressed a consistent sense of exhaustion. The various physiological alterations that occurred during her pregnancy phase rendered her eligible for prescribed bed rest. She gave an evident expression and answered when enquired about the sharing of household chores during pregnancy:

> No, because I was there in my mother's place, I was not required to labour. In my third month, I went to my mother's house. Then, two months later, I returned to my in-laws' home to celebrate the ritual of Punchamittra, which can only be observed there. I returned to my mother's home after the celebration because I needed bed rest. In your mother's place, you do not need to labour, and as I am also to avoid strenuous labour. If you remain at your mother's house, you receive the care and affection you desire. She cooked all of my favourite meals. Although you cannot continue to relax at your in-laws' home, you must complete some household chores.

Her mother was sitting close during the interaction and interested to give her opinion. She stated her version in this way:

> After realising that she is pregnant, she came to me because she, too, required rest. A pregnant daughter feels comfortable staying with her mother. Regardless of what others may think, there is distinction between *Baper bari* and *Sasur bari* (natal and in-law's family).

The case of Litika Dutta Talukdar can also be taken up to understand the link between TBR and place of bed rest. She is a *secondi gravidae* (mother

who is giving birth for the second time) at the age of 31. She was married in the 2016 and became a mother to a boy in 2018, and in 2022 she again gave birth to a baby boy. She has a degree of graduation and is a home-maker. Her husband is a bank employ and earns around 50,000 per month. Her natal family as well as her in-laws' family is in Siliguri.

Having known that she is pregnant in July 2021, she went to the doctor who suggested her to take all possible care since she had an abortion on her previous conception.

She narrated her experience:

> I was advised by my doctor, P. K. Majhi, to take complete bed rest because I was extremely feeble. He prohibited me from performing any type of physical labour and instructed me to eat well from the beginning of my pregnancy. I have completed all the testing he suggested, including those for haemoglobin, sugar, HIV, and thyroid. All the results were negative, only I had a problem with high blood pressure. The ultrasound was performed in the 2nd, 5th, and 7th months, as well as the 9th month. I performed an ultrasound at the 7th month because I became ill and was haemorrhaging due to a low-lying placenta (placenta pervia). I spent two days in the hospital after being admitted. I was given saline and administered medication. Then I travelled to my mother's residence.

She stayed at her in-laws' place till 7th month during her period of gestation, but when asked for a total bedrest after hospitalisation, she shifted to her mother's residence. She informed:

> I stayed with my in-laws throughout my entire pregnancy, but I returned home when I began to fall sick in the seventh month. At my maternal residence, I have my mother and brother. My sibling has never been wed. At my mother's home, the toilet facility is good. It is inside the home, whereas at my in-laws' it is outside, so it is more comfortable at my mother's house. In addition, at my mother's house we have a commode and at my in-laws' house there is an Indian toilet. As the doctor also advised that I not apply the pressure below, I decided to stay with my mother. Although foremost, the care aspect is more significant. When I shifted to my mother's home, I also limited to perform domestic duties. If my mother-in-law is working at my in-laws' home, I am unable to just sit and take rest, and I must labour alongside her. In my *baper bari*, my mother takes care of everything, allowing me to take rest

> entirely in bed. I will return to my mother's home and stay there for two to three months and only return after I have totally recovered.

The third case study is Montai Mahato Sharma who was also a secondi gravida at the age of 34. She was married in the year 2015 and had her first girl in 2016 and had her second child (boy) in 2022 (April). She is a graduate and a home-maker. Her husband has a business in transport and earns around 50,000 a month. Her natal family is from Siliguri, however, her in-laws place is in Dalkhola which is 131km to Siliguri. Even with a history of normal delivery Montai was also suggested the same. She narrated:

> From the start, he told me I should take bed rest all day. This is because I had problems, such as chest pain and high blood pressure. Although, my other tests were fine. I had a normal birth in my first pregnancy, and the pressure wasn't that high. When I was in my fourth month, there wasn't enough fluid in my womb, so I went to the hospital. Even my haemoglobin is low. Both sugar and the thyroid are fine. My blood pressure was high, but the doctor didn't give me medicine to lower it. Instead, he told me to observe salt intake. He told me to take calcium and a few other medicines that I can't remember right now. I stayed with my in-laws until the first trimester (the third month), and the only time I went to Siliguri was to see the doctor. Later, when the doctor told me to take bed rest, I came back to Siliguri with my mother around the third month. In the meantime, I would go to Dalkhola every 15 days or in a month. My last visit was during Diwali in November, and I didn't go to my *sasur bari* after that. I did not do any kind of heavy chores or physical activity because I had to take complete bed rest. When I was pregnant with my first child, I was in my *sasural* for seven months. After that, I went to my mother's house and had the baby in Ramkrishna Seva Sadan, (another hospital). Because I had a C-section this time, I have to stay at my mother's place for a longer time, until I am fully cured and can work on my own.

In the next case study, we will discuss about Pushpa Prasad. She was married in 2017 and in 2023, at the age of 26, she became a *primi garavidae* (a mother who gives birth for the first time). She has lived in Delhi with her spouse and is a graduate. She took medicine for her infertility issues. She relocated to her natal family in Siliguri after two years under continual medication and after successful conception. In her second month, she visited

a female doctor, but in her fourth month, she switched to Dr. P. K. Majhi for better care. She narrated:

> My cousin suggested I switch to Dr. P. K. Majhi because I had problems conceiving and could get better care and therapy there. Although my in-laws' home is in Bihar, I decided to travel to my mother's house for care and rest. I did not stay back with my husband as there were no one to take care of me. My doctor advised me to rest and eat well every three hours. Even though my mother and in-laws advised me to work a little, I preferred to rest the majority of the time, as the doctor had advised the same.

Her natal family bore the cost for her pregnancy. The interview was being conducted while her spouse was still in Delhi. She added the following:

> Since I had stayed with my natal family from the start of my pregnancy, they were the only ones who had to pay for everything. My spouse is currently in Delhi and it would take him some time to come to Siliguri, thus the expense of hospitalisation and delivery will also be covered by my natal family. The admission was based on an emergency, therefore he wasn't informed about it until the day before yesterday, just before admission.

The case study also illustrates the financial cost bearing along with care bearing. In her research of pregnant women in Tamil Nadu, Hollen (2003) used a similar narrative and referred to the child bearing women as an "auspicious burden". According to the customs, in her study, the natal family will be responsible for paying all their daughter's pregnancies and deliveries, as well as any antenatal rituals and ceremonies costs.

At the age of 34, Moumita Saha Das is a mother of two. Both the residence of her in-laws and her birthplace are in Siliguri. Due to a family ritual that bans her from visiting her natal family before the designated period, she only came to stay in the natal family after seven months of gestation. I have had significant hypertension since the beginning of my pregnancy, the narrator said. She narrated:

> I had to take 4-5 medications to control my high blood pressure because of the extreme hypertension. Before seven months, I wanted to go see my birth family, but I stayed because of the ritual. Although the ritual can be modified when women are in critical condition. I must observe the customs of my in-laws' family even though there are no such practices in my natal family. After I came to my natal family in the seventh month I did not return. I

have come to the hospital from my natal place and go back again. Only after a couple of months I will return to my in-laws' family.

Conclusion

The present investigation conceptualizes bed rest through the lens of a patriarchal paradigm. The familial bonds that exist within society provide the fundamental structure for the conceptualization and implementation of bed rest practice. The woman is perceived by her in-laws as an industrious worker, yet her gravid state renders her incapable of fulfilling domestic functions. Women cohabiting with their affinal kin perceive themselves as indispensable caretakers, and accounts of ethnographic nature evince their disinclination towards availing care from their affinal relatives. In an effort to circumvent the patriarchal expectations imposed by the family of their spouse, women may opt to pay a visit to their natal kin during this juncture. The societal conventions have normalized the practice of women delivering offspring at their natal family. Certain customary traditions forbid the visitation of women to their consanguineous kin until the completion of the certain gestational period. As a result of this entrenched custom, a considerable number of expectant mothers who had planned to visit their natal family during the initial phases of their gestation were precluded from doing so. The ritual can also be interpreted as a poignant reminder of the woman's ongoing obligation to render her services at her husband's family residence during this period. Subsequently, she may opt to transfer to her biological kin for further bed rest and care. This predicament may also be perceived through the lens of circumventing the phenomenon of role reversal. The practice of bed rest presents a unique opportunity for a paradigm shift in familial dynamics, wherein a daughter-in-law may assume the position of a beneficiary and in-laws may adopt the role of a benefactor. However, such a deviation from the established patriarchal norms and gender-based expectations may prove to be disruptive to the customary cycle of familial roles. The concept of gender is a dynamic and fluid construct that is in a constant state of flux and subject to transformation. The concept of gender is not a static construct, but rather a dynamic and iterative process that is continually revisited and redefined. Judith Butler endeavours to unveil the ostensibly inherent assertions of gender, and explicating it through the lens of socio-cultural context facilitates her pursuit. As posited in Butler's seminal treatise, Gender Trouble (1999), the act of contravening and dismantling gender norms represents a subversive means of exposing the inherently constructed nature of gender and debunking its purported naturalness.

Women perceive the act of bed rest as a means to mitigate the probability of risk associated with pregnancy and childbirth. The medical community commonly prescribes bed rest as a medical act, yet women interpret and navigate this recommendation through sociocultural norms. Given that their societal position is deeply entrenched within broader patriarchal familial structures, the act of being confined to bed poses a plethora of supplementary normative predicaments.

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