

Lund University, Sweden

Lund University Master of International Development and Management

June, 2009

# SAFFRON FOR A FAIR BABY

TRADITIONAL CHILDBEARING BELIEFS AND PRACTICES AMONG WOMEN IN  
TAMIL NADU, INDIA.

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*At this birth...let the woman rightly engender, be relaxed;  
let her joints go apart in order to give birth. Four are the  
directions of sky, four also of the earth; the gods sent  
together the foetus; let them uncloset her in order to give  
birth. Let pusan uncloset her; we make the yoni go apart; do  
the susana loosen...apart the yoni, apart the two groins,  
apart both the mother and the child, apart the boy from the  
afterbirth; let the afterbirth descend. As the wind, as the  
mind, as fly the birds, so do thou O ten month's child, fly  
along with the afterbirth; let the afterbirth descend.*

Atharva Veda, paragraph 01011, verses 1-6<sup>1</sup>.

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<sup>1</sup> Edited and translated by Maurice Bloomfield, Sacred Books of the East, Vol42, Chapter 4.

## **ABSTRACT**

In spite of the modernization of obstetrics in Tamil Nadu, the rural women still adhere to several traditional beliefs and practices, in regard to childbearing and postpartum. The varieties of non-biomedical practices were used in attempt to ensure a risk-free delivery and the birth of a healthy baby, although the collected data shows that some of them are harmful. To understand why the rural women hold on to these traditions, and possible implications, a qualitative grounded theory approach was used; and a constructed grounded theory termed 'Motherhood during a transitional period' was generated. The practical aim was to give health professionals an understanding of the rural women's worldview for creating effective culturally sensitive approaches, such as ethno-nursing methods, so the rural women's cultural needs are taken into consideration and harmful practices are avoided. Thirty-seven individual and four focus group interviews, in six rural villages and two small towns in rural areas of Kancheepuram, Tamil Nadu, Southern India, were carried out. This study showed that rural women are straddling between two systems of divergent meaning in regard to their bodies in general, but also their conceptualizations and experiences of childbearing and birth. Traditions and cultures are inter-linked and therefore it takes time to modernize a society.

### ***Key words;***

Pregnancy, birth, postpartum, culture, beliefs, traditions, Tamil Nadu

## ACKNOWLEDGEMENTS

*I would like to express my gratitude to all those who helped me, supported me and facilitated the field work during my two months in Kancheepuram India. Firstly I would like to thank all the Tamil women and their husbands who took their time and sat down and shared their experiences and knowledge with me, without them this study would not have been possible. Thank you, I will never forget you! I would also like to thank the personnel at Hand in Hand offices in Kancheepuram & Chennai, Tamil Nadu, India, for their warm welcome, and their support during my stay. Thank you team! Peter Gregersen, my supervisor, and the rest of the LUMID management thank you all! SIDA, thank you for your financial support for my study, without this financial support this dissertation would not have been written! Finally my beloved husband Lars, also Emma, Markus and Sara, our beautiful children, without your endless support and acceptance this thesis would never have materialized, thank you.*

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# 1 INTRODUCTION

In most societies childbearing, birth and the immediate postpartum period<sup>2</sup> are seen as a very vulnerable time for both the mother and the child, (Jeffery, 1989; Jordan, 1993). All cultures recognize pregnancy as a special transition period, and many have particular customs and beliefs that dictate activity and behaviour during pregnancy, (Andrews, 2008). Beliefs and customs surrounding the expertise of labour are influenced by the fact that it is a biological event and is basically the same in all cultures, but the birth experience is also socially constructed. *“It takes place within a cultural context and is shaped by the perceptions and practices of that culture”*, (Liamputtong, 2005b, p. 140). Methods of dealing with the pain of labour, recommended position during delivery and the role of the father and the family vary according to the degree of acculturation to western childbirth customs, religious beliefs and individual preference, (Andrews, 2008). The title of the paper was inspired by the Tamil women’s strong wish to give birth to a baby with light skin. ‘*Add a bit of saffron to milk for a fair baby*’ and ‘*Tea and coffee will make your baby dark*’, was the common beliefs, and if the childbearing woman ate saffron during her last months of pregnancy, and avoided black food items the baby should be born with fair skin. A wide variety of non-biomedical practices were used in Kancheepuram to ensure a risk-free delivery and the birth of a healthy baby of a healthy mother. Later on I will come back to this in my chapter on findings and analysis.

The practical aim of this thesis is to form a basis for health professionals providing an understanding of the rural women’s existing traditions and practices as well as their present worldview. In Tamil Nadu, traditional birth systems are undergoing large-scale changes under the influence of Western medicine. It is fundamental for health personnel to understand the traditions and thus design effective culturally sensitive approaches, such as the ethno-nursing methods, so that the Tamil rural women’s cultural needs are taken into consideration and also that dangerous beliefs are avoided.

My interest in this topic can be found in my 20 years experience as a professional midwife in Sweden. I wanted to explore other women’s supposed beliefs and traditional practices regarding childbearing in their culture. This thesis is based upon data collected during eight weeks in autumn 2008, in Kancheepuram Tamil Nadu, Southern India.

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<sup>2</sup> Postpartum period is the period beginning immediately after the birth of a child and extended about six weeks. The woman’s body goes through numerous changes and recover from pregnancy and birth.

## 1.1 AIM OF RESEARCH AND RESEARCH QUESTIONS

This thesis focuses on traditional beliefs and practices regarding pregnancy, birth and postpartum period in Kancheepuram district, Tamil Nadu. First of all, it is important to gain knowledge of various existing traditions and beliefs in regard to childbirth that exist and are being used in the society of the Tamil rural women, and thus finding out which cultural traditions that are harmful and could put the woman and her baby at a risk during pregnancy, birth and postpartum.

In order to effectively being able to change these harmful beliefs it is important to be knowledgeable as to why the rural women maintain these old cultural traditions, this so that awareness could be raised of problems associated with the tradition, and work could begin to eliminate the harmful practices. Thus, this study seeks to investigate and explain why the rural women keep to old cultural traditions in spite of the modernisation of obstetrics. A grounded theory is constructed termed 'Motherhood during a transitional period'.

To fulfil the study's objective, the following research questions are posed;

- What kind of explanations are behind these traditional beliefs and practice regarding childbearing and postpartum period?
- What possible implications will these traditional beliefs and practices have for the rural Tamil women and their babies?

## 1.2 STRUCTURE OF THESIS

The structure of the thesis is as follows; *Chapter 2* provides a background to the thesis research problem and will touch upon the Indian society with focus on family and motherhood. *Chapter 3* starts with presenting the research design and is followed by the methodology used to collect the field data. The sample and the data collection methods are described next, before some thoughts about 'rigour'. How the data was analysed is the next heading, before the chapter ends up with ethical considerations. *Chapter 4* moves on to the empirical findings. The chapter includes the findings of the collected data. It commences with findings during pregnancy, followed by labour practices, and postpartum before ending up with the findings from a gypsy community. In *Chapter 5* the theoretical framework will be outlined. Starting with a presentation of the constructed grounded theory termed 'Motherhood



during a transitional period', followed by an existing theory, of Abrams,(1982), and the chapter closes with a research frontier review. Chapter 6 includes my conclusions and a discussion regarding why change of worldviews takes time. *Finally Chapter 7* finally closes the thesis with a discussion on possible recommendations, such as culture sensitive care.

## 2 BACKGROUND

In this chapter I will present Indian society focusing on family and motherhood. It's important to understand how the Indian society is constructed regarding values and norms to get a complete picture why the rural Tamil women still adhere to their traditional practices and beliefs. The chapter will also include basic facts of India, the state of Tamil Nadu and Kancheepuram district, since I conducted my research there.

### 2.1 INDIAN SOCIETY; FAMILY AND MOTHERHOOD

In India no institution is more important than the family, (Purnell, 2005), and motherhood is very much wanted since it is recognized as a socially powerful role,(Choudhry, 1997). Motherhood may also be due to the fact that being a mother is privileged and valued, often even compulsory in the Indian family context. In addition to this to be a childless woman is to actualize the fear of the loss of heredity (Chawla, 2006). In India becoming a mother of a son is a blessing because the sons carries the family name and takes care of the parents in their old age. Daughters are cause for worries because of the traditions associated with her parents burden of her dowry, and they move away from their parents at marriage, (Van Hollen, 2003). In this study, Bakul, one twin mother of two baby girls told;

*This is enough; we were planning to have an abortion, because we wanted a son also. You see- the daughter's will marry and move away, and nobody will take care of the parents. We would like to have one more child, a son, but we do not want any more children now, this is enough.*

Husband and wife belong to the same class<sup>3</sup> since the husband and wife have been united in the marriage, (Dandekar, 1958). The head of the family is normally a man, based on the principle of the men's superiority over women, (Basham, 1967, pr. 1979; Government of Tamil Nadu, 2003; Purnell, 2005). Pregnancy in India is viewed as a normal physiologic phenomenon, and the childbearing mother is supervised and guided by the older women in the family and/or the community. To visit a doctor required the event of a problem, (Choudhry, 1997). The shift from home births, attended by female relatives and dais<sup>4</sup>, to hospitalized births overseen by biomedical professionals influenced the lives of the people. For many Indian women, childbearing and birth is no longer seen as a natural event, instead it seen as an phenomenon to be managed by using technological interventions and supervised by health personnel. (Liamputtong, 2005a). While medical care is free for all citizens, persons in rural areas often have little access to it. Purity is an important value in the Hindu culture, and is very much concerned with childbearing and the first time after delivery. Many Hindus consider that the most impure substances are the discharges of one's body, and women are seen as impure because of their menstruation,(Coward, 2000). The conception of a child is very impure, since it involves the discharges of body fluids, and makes the mother impure; consequently the baby is also seen impure. I will return to these traditions in my findings chapter further ahead.

## 2.2 INDIA

I have included a section regarding Indian economic status since it is important to understand how poverty and illiteracy affect the rural women's lives, and also maintain cultural traditions and high rates of maternal mortality.

India has one of the ten fastest growing economies in the world (NFHS-3, 2006). While economic policies in the 1990s have been able to remove the constraints on economic growth, the policies regarding social development and health have not been able to remove impediments to allow any significant development (UNICEF, 2008b). The most important challenge for India today is poverty. Although the incidence of poverty has declined by

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<sup>3</sup> Castes in India have to do with class structure; and accordingly to Hindu religious text, the caste system is a group membership that has a specific rank in society.

<sup>4</sup> Traditional birth attendant in India.

almost 50 percent from 1978 to 2000, (WHO, 2007), still 34.7 percent of India's population are living on less than 1 US\$ /day, (WorldBank, 2005).

Education is one of the most powerful instruments for reducing poverty and inequality, (UNICEF, 2008a). Every child in India is entitled to primary school education. School is free and compulsory for children ages six to fourteen. The Indian government has expressed a strong commitment towards education for all; however, India still has one of the lowest female literacy rates in Asia, (WorldBank). This low level of literacy not only has a negative impact on women's lives but also on their families' lives. Numerous studies show that illiterate women have high levels of fertility and mortality, poor nutritional status, low earning potential, and little autonomy within the household, (ibid). Accordingly to UNICEFs, (2008a), maternal mortality is reduced by women's education and they point out that two maternal deaths will be prevented for each additional year of education achieved by 1,000 women. They also highlight that girl's education about health-care practices increased the utilization of health services during pregnancy and birth and by this also reduce the maternal mortality, (ibid).

### 2.3 THE STATE OF TAMIL NADU

Since the state of Tamil Nadu differs from many other states in India in regard to the wealth and literacy of the population, and also in regard to obstetric care, I have included a section regarding Tamil Nadu. I wanted to give some context in regard to my field research, and therefore I have included a short section about the district of Kancheepuram in the end of this section.

Tamil Nadu is located in the South of India, (see figure 1) and the state's population was approximately 62 million as per census 2001, (Government of Tamil Nadu, 2003). The main city is Chennai and is a historic centre of the traditional Tamil medical system known as Shidda<sup>5</sup>, and has remained a setting with multiple forms of medical systems, (Van Sickle, 2008).( I will expand the concept of Shidda in chapter four). Tamil Nadu is a state characterized by heavy industrialization and it's a leading commercial and manufacturing

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<sup>5</sup> A traditional form of medicine indigenous for Tamil Nadu, equivalent with Ayurveda in Northern India.

centre. The population is much more literate and wealthy than the country as a whole, (ibid), and this state is often considered one of India's model states with respect to the provision and use of allopathic<sup>6</sup> maternal-child health (MCH) care. According to the latest national health survey, Tamil Nadu showed that 90 % of all reported deliveries in the state were institutionalized<sup>7</sup>. This indicates that the rate of institutionalized deliveries in Tamil Nadu is significantly greater than those for India as a whole, (41%).

Figure 1 Kancheepuram district in Tamil Nadu, India.



Source: Wikipedia

## 2.4 KANCHEEPURAM DISTRICT

Kancheepuram district is an area in the northeast part of Tamil Nadu. At the time of the study Kancheepuram district had a population of approximate three million persons, and the main town is Kancheepuram. Agriculture is the main occupation of the people with 47% of the population engaged in this sector. The main religion in the district follow the rest of the India; Hinduism, (88%), followed by Christians and Muslims, (Registrar General & Census Commissioner, 2007). Kancheepuram town is one of the seven most sacred pilgrim centres for the Hindus (NIC, 2008).

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<sup>6</sup> Allopathic medicine refers to the broad category of medical practice that is sometimes called Western medicine, biomedicine, scientific medicine, or modern medicine.

<sup>7</sup> 99.4 % of in urban areas and 86.7% in rural areas

## **Summary**

While economic policies in India have been able to remove the constraints on economic growth, the policies regarding social development and health have not shown the same result. One of the most important challenges for India today is poverty. However the diversity both within India and between different social classes is large. The state of Tamil Nadu is well off with a healthier and more educated population than the country as a whole. The state has made an effort into expanding maternal care, and the state is often considered one of India's model states with respect to the provision and use of antenatal care and births in institutions. In spite of this, in many rural areas in Tamil Nadu, women still adhere to traditional practices that sometimes are harmful. Becoming a mother is very desirable, and the childbearing mother is supervised and guided by the older women in the family and/or the community. The shift from home births attended by female relatives and dais, to hospitalized births overseen by biomedical professionals was influenced the lives of the people. These two discrepancies, introduction of maternal care and adherence to traditional practices, is why the Tamil women are in a transition period at the moment, and have one foot in each camp. This discrepancy formed the basis of my thesis. I will return to this issue and discuss this more specifically later on in the findings and theory chapter.

## **3 METHODOLOGY**

In this section, the study's methodological approach is presented; the methodologies used to collect the field data are accounted, the sample is described and the problems that occurred in the field data collection are reviewed.

### **3.1 RESEARCH DESIGN**

This thesis is based upon primary material collected during field work that was carried out during eight weeks in August and September 2008. In this thesis I have used the grounded theory as an overall approach, and I emphasize with Charmaz,(2006), constructivist grounded theory approach, since she advocates that grounded theory must move on from its positivist origins. A constructivist grounded theory approach emphasizes the studied phenomenon of study, and sees both data and analysis as created from shared experiences and relationships with participants and other sources of data. Her approach differs from the classic grounded

theory, in the sense of how the theory will be discovered. Glaser and Strauss, (1967) have a discussion about discovering theory as emerging from data separate from the scientific observer. Unlike their position Charmaz, (2006) argues that neither data nor theories are discovered, she claims that researchers can't claim scientific neutrality, since qualitative research of all sort relies on those who conduct it "*We are not passive receptacles into which data is poured*" (p. 15).

She advocates that we construct our grounded theories; nevertheless researchers are required to be reflexive about what they see, and how they see it. Finally the Charmaz approach offers an interpretive portrayal of the world studied and not an exact picture of it. This is a statement that is in line with my own belief of research.

Grounded theory researchers can use either quantitative or qualitative data, but it is almost exclusively adopted in qualitative research, (Schreiber, 2001). I found that a qualitative methodology suited my interest very well, since my research seeks answers to questions that stress how social experience is created and gives meaning, (Denzin, 2008). By using qualitative methods, I hoped to be able to go beneath the surface and analyse the women's subjective experience of childbearing, and obtain a deeper understanding of the existing beliefs and practices regarding pregnancy and childbirth in Kancheepuram district, Tamil Nadu, India. I also wanted to explore, what kind of possible implications these traditional beliefs and practice had for the rural Tamil women.

In grounded theory, data collection and analysis, and eventual theory stand in close relationship to one another, (Strauss, 1998). Glaser and Strauss, (1967) call attention to the significance that the researcher starts the study with as few preconceived ideas as possible, and that the research question/s should be broad and flexible enough to search into a phenomenon in depth. Also Charmaz (2006, p. 17), points out; "*we need to remain as open as possible to whatever we see and sense in the early stages of the research*". This approach suited me well and with that knowledge I entered the field.

### 3.2 ENTERING AND GAINING ACCESS TO THE FIELD

During internship<sup>8</sup> at my organisation<sup>9</sup> I had the opportunity to follow a medical team around in the different parts of Kancheepuram district. My intention during these visits was just to introduce myself, become familiar with the people and the villages and come back later on for my interviews. When it was time to start collecting the data I got help from the organisation where I did my internship. A member of the staff who was willing to serve as a gatekeeper<sup>10</sup> and he also helped me initially to select the first villages. To gain access to the hospital and to patients, a medical officer helped me with necessary approvals.

### 3.3 THE SAMPLE

The study was conducted in rural areas of Kancheepuram District, Tamil Nadu, South India, and the majority of the participants were located in outlying rural agricultural areas of Kancheepuram district, which included six villages and two small towns. A small number of participants were located in Chennai, the capital of the state of Tamil Nadu, and were interviewed at the postnatal care unit at Meenaski Medical Hospital in Kancheepuram, (see appendix 9.5 for information regarding the different villages). Most of the interviews took place, in the respondents' home; but for the convenience of the participants sometimes the interviews were carried out in a room provided by a school or other organization. Five interviews were carried out at Meenaski Medical Hospital in Kancheepuram.

The participants represented in the beginning of this study were found by chance after I together with the interpreter had walked around in the villages and asked for volunteers. Later on when I had gained more insight and realized that I needed to fill in gaps in my data, I selected my research sites and informants bearing this in mind. Criteria such as the different castes were then taken into consideration. Since I wanted to explore traditional beliefs and

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<sup>8</sup> Lund University Master of International Development and Management, (LUMID), is a two-year programme with one semester based in the field. The students are attached to an organisation and it's is required that the students carry out their field work and data collection during this time, as the foundation for the final master thesis. The organisation in this case was *Hand in Hand India*, a local NGO with head office in Kancheepuram.

<sup>9</sup> Hand in Hand, Kancheepuram.

<sup>10</sup> Someone who can provide access to the field and participants or whoever else is needed for a study

practices regarding childbearing and birth, then it was mostly Tamil women who were interviewed and I used the selection criteria below to find my respondents;

- Women
- Aged 15-49 year
- Women who had given birth in the past 5 years
- Had given birth to at least one child
- Residing in the study area

Despite my selection criteria I have five interviews with women who were pregnant for the first time, since sometimes during field research you have to go off the cuff. My interpreter helped me to find my respondents, since I did not speak Tamil, and in these cases he forgot the selection criteria. I decided however to conclude the interviews.

To gain a deeper understanding of the topic, I also included men, in focus group interviews. Also three field nurses and one traditional birth attendant, dai, were interviewed.

A total of thirty-seven (37) individual interviews, and four focus group interviews were carried out. This gave a total of fifty-six (56) respondents, since the group interviews had totally nineteen (19) respondents. (See appendix 9.3 for details). In this study, the sample was restricted to forty-one (41) interviews, since saturation was reached at the 41<sup>st</sup> interview. How I determined saturation will be discussed further in this chapter, (see section 3.6 Data Analysis).

### 3.4 DATA COLLECTION METHODS

According to Charmaz (2006, p. 15), "*methods are merely tools*", but some are more useful than others. And they have consequences for your research. My research problem shaped the method I used therefore four data collection methods were combined namely;

- Semi-structured individual interviews
- Focus groups interviews
- Informal and unstructured interviews
- Literature review



The primary source for collection of data in this study was interviews. According to Charmaz, (2006), interviewing is a useful data-gathering method using various types of qualitative research. She states that it is a functional method for the interpretive inquiry, since interviewing permits an in-depth exploration of a particular topic or practice, (ibid).

I recorded almost all the interviews<sup>11</sup>, for the purpose of documentation, detailed transcription and analysis. The tape-recorder was never used without a participant's explicit permission. Probing was done according to each respondent's answer, which is why the interviews did not follow an exact route of questioning. Each interview lasted between 20-50 minutes, entirely dependent on the participants' children's willingness to participate. Since it sometimes was a very noisy environment, such as babies crying or needed to be breast fed, I sometimes forgot to ask the participants my socioeconomic questions such as age or education. This explains why I do not have full background facts of all my respondents, or why the interviews sometimes were short in time. Another issue was the Indian caste system<sup>12</sup>. For the rural people this was a very sensitive matter, and I was advised from my organisation not to ask directly regarding their caste. Instead I should ask where they resided, since the most forward caste resides closest to the temple and the schedule caste and tribes live more remotely. It ended up with a drawing where the respondents showed where they lived, see appendix 9.3 for further details. I also got help from a staff member to find out where the respondents lived and their caste, in spite of this, I ended up with ten unknown.

The transcriptions of the audio taped interviews were carried out by me. Complementary to this, handwritten notes were taken during the interview, and after each session I also wrote down the main aspects of the interview, such as observations of behaviour etc. Because language is a principal instrument in research, (Hahn, 2008), the ideal would be that I could have spoken and used the local language Tamil, in my research. Since that was not the case, an interpreter was used for the interviews. I had the privilege to employ the same interpreter for almost all interviews, apart from the two first. The interpreter was familiar with the local context and also trusted by the communities. However, in the end the translator made his own

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<sup>11</sup> Sometimes the situation did not make it possible to use the voice-recorder, such as noisy environment.

<sup>12</sup> Castes have to do with class structure and castes divide the Indian society of those in the lowest and outside positions, calling the untouchables/polluted, to the superior and most 'pure' part of Indian people, forward castes.

judgements about how and what he translated, and sometimes I got a feeling that he perhaps found difficult to betray his own 'people' in the presence of a foreigner.

#### 3.4.1 SEMI-STRUCTURED INTERVIEWS

According to Hahn, (2008), structured interviews are particularly useful for determining patterns of knowledge and belief, because the same questions are asked of multiple participants.

In this study a semi-structured interview guide was used, containing a list of questions I wanted to be addressed. Kvale,(2008), points out that no standard procedures or rules exist for conducting a research interview, but he recommended planning and thematizing the interview study, in order to attain a better quality of collected data. According to this advice I developed an interview guide, which contained different themes regarding my subject, (see appendix 9.5). The interview schedule contained open-ended questions. According to Kvale, (2008) and Charmaz, (2006), the use of this kind of open-ended, non-judgemental questions encourages spontaneous statements and stories to emerge. Since I was undertaking sensitive research, I began each interview with "small talk" on matters that were not necessarily relevant for the interview i.e. icebreakers to make the respondents more relaxed, since according to Kvale, (2008), the first minutes of an interview are crucial to gain their confidence, so they can talk about their experience and feelings unreservedly. I also reflected upon how many respondents I would need for my research, since I did not have unlimited time and resources. But since I had decided to have a grounded theory approach I had to accept that this matter should solve itself by saturation<sup>13</sup>, and I had to "go with the flow".

#### 3.4.2 FOCUS GROUP INTERVIEWS

Focus group interviews are ideal for exploring people's opinion, and experiences related to a topic, and for generating discussion about issues of important concern to the community, (Hahn, 2008). In this study four focus group interviews were carried out. Two groups consisted of only men, one group consisted of three elderly women, and one individual

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<sup>13</sup> Saturation occurs in qualitative research when an researcher believes that s/he cannot longer learn new things by studying additional instances of a particular empirical category (Ragin, 1994)

interview ended up into a group interview in a gypsy community, even though the whole village attended the interview there were four active respondents. Later on I will come back to the gypsy community in the finding and analysing chapter. The number of participants in the groups' differed. In question of the ideal number of focus groups participants, some argue that it is between 8 and 12, but researchers who perform sociological studies usually prefer to work with smaller groups of five to six, or even as few as three participants, (Pettersson Odberg, 2004).

I regarded focus groups as an appropriate method to explore men's views on traditional practices and beliefs regarding childbearing. The topic dealt with women's reproductive bodies, and in the case of sensitive taboo topics, focus group interviews may open a perception that is usually not accessible (Kvale, 2008). The men were chosen by visiting the villages early in the mornings before the males went to work. In this manner the group members were men who happened to be around at the time of the interview. It was a mere chance that there were different ages, occupations and marital status in the group members.

I also realized that I wanted to gain knowledge from the elderly generation of Tamil women; therefore I also selected one group with elderly women, since this was a rapid way to deepen my knowledge about the topic.

In the gypsy community, the group interview came up spontaneously. My intention was to carry out an individual interview, but the interview ended up as a group interview, consisting of four active respondents, (one woman, and three men). Almost all of the members of the village were around us at the time of the interview. This involvement of the extended family, friends, and even neighbours is described by Choudhry (1997) and Coward (2000), as a part of the Indian social order, since this provides emotional and social support.

### 3.4.3 INFORMAL AND UNSTRUCTURED INTERVIEWS

According to Hahn, (2008), informal interviews are hardly interviews at all, since the researcher participates in a normal conversation and records comments of interest on the research topic. My first informal interview started spontaneously during a conversation early in my study. The second one occurred further on, and as a part of my theoretical sampling. According to Corbin (2008, p. 143) theoretical sampling is;

*A method of data collection based on concepts/themes derived from data.  
The purpose of theoretical sampling is to collect data from places, people,  
and events that will maximize opportunities to develop concepts in terms  
of their properties and dimensions, uncover variations, and identify  
relationships between concepts.*

In the informal interviews I did not use any interview guide; handwritten notes were taken during the conversation, since both occasions came up spontaneously. I did not have my voice-recorder nor my interview guide around, but I could not let this restrain this opportunity to gain data.

#### 3.4.4 LITERATURE REVIEWS

Accordingly to Charmaz,(2006), the reading of related literature should be postponed until a later stage of research. The purpose of delaying the literature review is to avoid preconceived ideas that could possibly influence the work, i.e. create an independent analysis, (ibid). I was aware of these instructions regarding the literature review in grounded theory. However since this thesis is a student research project, the teachers required that I should submit both a literature review and a theoretical framework and this lead me to the library months before I conducted my study. I solved this by gaining a very brief overview of the subject in an attempt to identify gaps in my knowledge. During the research when I entered new areas of knowledge I did the same kind of search to fill in gaps by theoretical sampling as I mentioned earlier. I constructed an independent theory named, ‘Motherhood during a transitional period’, and then I searched for existing theories for a comparison. This is in according to grounded theory. I have also made a literature review for comparison with my findings from the field.

#### 3.5 REACHING FOR QUALITY

In most qualitative research the researcher herself is the main tool for data collection, and Bryman (2004), states that in qualitative research the researcher herself is the key instrument for data gathering. What is observed and heard and also what the researcher decides to concentrate upon is very much a product of her predilections, (ibid). Also Charmaz, (2006), supports this opinion, as I earlier discussed in the methodology chapter. I am aware of this

matter, also that my profession and work experience will affect my research and my interpretation of my data. Qualitative researchers have to be aware that research is ideologically driven; there is no value-free or bias-free design, (ibid). However I have to strive for quality and that analysis of my data is of a high quality and trustworthy. I am more interested in authenticity than a single version of truth. With authenticity I mean to get the women's sincere perception of their worldview. Liamputtong, (2005c), uses the term 'rigour' when she refers to the issues that are raised by the terms validity and reliability, since she thinks these terms, (validity and reliability), derive from quantitative research methodologies, and are used to assess statistical and experimental studies, and are hard to apply to qualitative research. However qualitative researcher cannot abandon this issue, but they need to be conceptualised differently such as rigorously. To ensure rigour in my research I have striven to use an appropriate method to my research problem, and tried my best to clearly document my methodological and analytic decisions. Ethical aspects are also taken into consideration as reflexivity. Reflexive research acknowledges according to Liamputtong,(2005c, p. 43), *“/.../ that the researcher is part and parcel of the setting, context, and culture they are trying to understand and analyse”* that is to say, the researcher is the instrument of the research, and by this I am back where I started this discussion.

### 3.6 DATA ANALYSIS

The classic grounded theory texts of Glaser and Strauss (1967) and Glaser (1978) provide an explicit method for analyzing processes. The main steps in classical grounded theory consist of open, axial, selective coding and to finding a core category. The approach is iterative, meaning that data collection and analysis proceed parallel, repeatedly referring back to each other i.e. constant comparison. Charmaz, (2006), does not use exactly the same steps as Glaser and Strauss, instead she carries out her coding in three phases initial, focused and theoretical coding.

This study is a snapshot of the current situation in Kancheepuram during eight weeks in August and September 2008, and will only reflect the current situation in the selected villages and towns, and will not generate any general knowledge about the topic.

### 3.6.1 INITIAL CODING

In this study I went through the collected data at the end of each interview day, and compared my data with data, and a short summary with methodological notes. I started with no concepts, and initial coding is the first step of theoretical analysis that pertains to the early finding of categories and their properties. Initial coding can be compared to brainstorming for opening up the data to all potentials and possibilities within them. I stopped and asked analytical questions regarding the data I have gathered, and by this I tried to see actions in the segments of data. For example the questions were such; “what is the data about?”, and “what can I see in the data?” I went through it fast, since speed and spontaneity is required during initial coding, and created codes that best fit the data. This is an advantage with grounded theory since initial coding is provisional and you can always come back and change if necessary. All my codes arise out of the collected data.

I began to study the data word for word and line-by-line<sup>14</sup>, since the data consisted of very detailed information and this gave me a close look at what the participants said, and struggled with. In the beginning the codes were very short such as; normal delivery, blessing, food, mother’s house, breast milk, donkey milk etc. For example when I asked a woman if the pregnancy had changed her daily routines somehow she answered; “*My parents told me not to sleep the whole time, do not eat papaya, and do not lift heavy weights*”. From this answer my original codes were tiredness, food restriction and miscarriage. I then coded with gerunds<sup>15</sup> since Glaser (1978) advocates coding with gerunds. Gerunds help the researcher to detect processes and gain a strong sense of action, (Charmaz, 2006). By using *in vivo codes* I tried to check up if I had grasped the importance of the data, if my interpretation and the participant’s meanings and actions have been preserved, since, in-vivo codes is concepts that use the actual words of research participants rather than being named by myself. For example; ‘red flower’, ‘mother’s house’, and ‘sweet words’, were commonly used by the respondents in my data. I then moved on and tried to find as many codes as possible; and to compare the codes with new ones. These initial codes helped me to separate data into categories and to see processes according to Charmaz, (ibid). I asked myself questions about the data continuously. Such questions included; ‘what processes are at issue here?’ and ‘how can I define it?’ or ‘what are

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<sup>14</sup> Line-by-line coding means naming each line of your written data, (B. G. Glaser, 1978).

<sup>15</sup> The nouns turn the actions into topics, by using gerunds. With gerunds you gain a strong sense of action and sequence in your coding.

the consequences of the process?’ From the beginning of the coding of data, I wrote memos<sup>16</sup>. This memo-writing continued throughout the whole coding and helped me to clarify and identify which codes to treat as analytical categories early in the research process.

### 3.6.2 FOCUSED AND THEORETICAL CODING

Focused coding means “*using the most significant and/or frequent earlier codes to sift through large amounts of data*” (Charmaz, 2006, p. 57), and requires decisions about which initial codes make the most analytical sense to categorize your data. Focused coding helps the researcher to check the preconceptions about the topic, (ibid). After this I continued to select and create larger segments of data. The most significant and/or frequent earlier codes such as hot and cold beliefs, wish for a light skinned baby, social cultural traditions, safe delivery, evil spirits, mother in law were put into broader categories. For example the codes food restrictions and food taboos, were now lifted higher levels such as woman’s diet. By this time I had a large amount of categories that needed to be compared for discovering possible relationships and patterns between them. My memos helped me during my “zigzag” route through the data. If I realized that some category was weak or incomplete i.e. I had some gap, I sought more data by theoretical sampling, since the main purpose of theoretical sampling is to direct you where to go, and seek events or cases that clarify your categories, (ibid). Through the use of theoretical sampling I moved forward. When new data did not give me more insights, nor gave me more categories, I decided that I had reached saturation. Then I continued to study my categories and memos and I asked myself questions such as; “are the definitions of major categories complete?”, and “have I established strong theoretical links between categories and their properties in addition to the data?” I started to see which ones to treat as the major concept and in the end identified and selected the core category. This means that the categories were organized around a central explanatory concept that explained what my research was about; *safeguard the life and well-being of the baby during pregnancy, birth and postpartum*, since this concept could be related to all the other categories in the analysis.

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<sup>16</sup> Preliminary analytic notes about the codes comparisons and other ideas about the data that occur to the researcher.

### 3.7 ETHICAL CONSIDERATIONS

Ethical questions require special attention in the study of a culture in which the researcher is an outsider (Sobo, 2009). During the data collection I had permission from the administrations of Meenaski Medical Hospital, and also approvals from the Panchayat<sup>17</sup>, and village leaders.

However, data cannot generally be collected from or about human beings without their consent, (ibid). When finding the participants, I kept in mind that the villagers had the right to decide whether they wanted to participate and share their personal privacy for research purpose. Since it was not practical or feasible to use a written agreement, the researcher used a verbal personal approval of all the respondents in the study, and of all research participants taking part on a voluntary basis. The interview was introduced by a briefing, in which I briefly told the respondents the purpose and goals of my research, further information or questions waited until the interview was over. I was very careful not to create any false expectations that I was not able to fulfil in the future, but perhaps I did not pay enough attention to discussing the returns of attending the research. Sometimes I felt that I was left in the dark in regard to what was actually presented to the respondents, if they understood the purpose of the research, since I did not speak Tamil. I have earlier mentioned this matter concerning interpretation, when I discussed data collecting methods (section 3.4). The respondents were also informed that they had the right to withdraw at any stage of the interview without any consequences. In this study, where the respondent's statements from a private interview situation may appear in a public report, safety measures such as coding of the respondent's name and place were needed to be taken to protect the participants' privacy. All respondents will remain anonymous; since the participants chose that their identities not would be revealed. Therefore in all quotations I have used pseudonyms.

## 4 FINDINGS AND ANALYSIS

In this chapter I will present and discuss the findings of the empirical data collected during my field research. This will be presented in four main sections: pregnancy, delivery, postpartum practices, and finally the findings from a gypsy community.

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<sup>17</sup> A Panchayat is a cluster of 2-3 villages.



Traditions can be both beneficial and harmful or neutral. Harmful traditions must be those that affect the mother and or child negatively and beneficial affect them positively. I will carry this concept forward when I present and discuss my findings in this chapter. The category ‘traditions’ emerged from the data, and was one of the categories linked to the core category. (See chapter 3, methodology for further details, and appendix 9.2 Table 2 for an overview).

WHO, (2001, p. 11), define Tradition;

*Traditions are the customs, beliefs and values of a community which govern and influence people's behaviour. Traditions constitute learned habits which are passed on from generation to generation. Traditions are often guided by taboos and they are not easy to change. People adhere to these patterns of behaviour, believing that they are the right things to do*

## 4.1 PREGNANCY

In Tamil Nadu, antenatal care<sup>18</sup> has been an essential part in the extension of primary health care. In this study 100% of the women, who have been pregnant in the last five years, stated that they had monthly received some basic antenatal care. This is consistent with India's latest National Family Health Survey, (NFHS-3, 2006), which shows that 99% of the women who gave birth in the last three years received antenatal care. However the knowledge regarding why they attended antenatal care was often vague. Very few women mentioned the relation between antenatal care and to ensure a safe delivery. Most answers related to the growth of the baby i.e. they did not see the benefits for themselves.

### 4.1.1 BEHAVIOURAL PRECAUTIONS

During the whole childbearing period the elderly woman in the family such as mother-in-law, or other elderly woman in the community provided guidance and assistance to the expectant mothers, since childbearing was seen as a very vulnerable condition. The pregnant women's activities were restricted in many ways. The pregnant woman is considered responsible for

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<sup>18</sup> The aim of antenatal care is to monitor the progress of pregnancy in order to support maternal health and normal development of the unborn child. Antenatal care in Kancheepuram is primarily provided through village health nurse, or by a multipurpose health worker.

her baby's protection, i.e. her behaviour influences her pregnancy, and thereby the outcome of the birth. To avoid miscarriage or stillbirth<sup>19</sup>, childbearing women are warned to avoid rigorous activities such as hard work, and also avoid lifting heavy weights such as rice bags, and water buckets. Most women were aware of this and tried to adjust their work, but for some poor women this was impossible advice to follow. Aishani a rural poor woman told; *"I have heard the advice, 'do not do the hard work', but I have to go out and work, because of the money, I have to do it..."*. Otherwise normal household work and walking were encouraged activities since it was believed to prepare for an easy delivery. A couple of women mentioned that they shared the hard household work with the mother in law during pregnancy to protect the baby.

Travelling by bus during childbearing was another restricted activity. Many pregnant women state that they avoid travel by bus up to the fifth month of pregnancy<sup>20</sup>, and some pregnant women also mentioned that they avoided busses during the whole pregnancy. The reason behind this was 'jam-packed' buses and they feared that this could harm the baby, and even cause miscarriage. Sleeping on the left side was not recommended either to pregnant women since the common belief was that this would harm the child. Some women also asserted that this would lead to the baby getting in to the wrong position, (breech presentation), and cause a difficult delivery and even caesarean.

Water in different ways was avoided by pregnant women. They feared coldness and to bring sickness not only to themselves but also to their unborn babies. Washing clothes and other household work connected with water were therefore avoided. One nurse explained for me; *"/...and I do not want to wash any clothes, no need for washing... / Not at any times I will put my hands in the water, I will get sick"*

The reason behind this was the hot and cold theory<sup>21</sup>, and I will come back and describe this theory, in more detail in the section regarding 'dietary precautions' in this chapter. One

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<sup>19</sup> Stillbirth; a child which has issued forth from its mother after twenty-fourth week of pregnancy, and which did not at any time after being completely expelled breathe or show any other signs of life.

<sup>20</sup> Tamil women are often said to be pregnant for ten months, in Europe and western countries, women are said to be pregnant for ninth calendar month. This distinction is due to different solar calendar. In Tamil Nadu some still use the ancient Tamil calendar based on lunar cycles, and some rural women have only knowledge of this calendar(Van Hollen, 2003).

<sup>21</sup> In India the theory of "hot and cold" play a central role, it's a construction of the body as fluctuating between states of "hot and cold" and health as a balance between these two states.

woman also feared miscarriage and mentioned that she couldn't visit her mother since she needed to cross a waterway and there was no bridge.

Another strong cultural conviction was that expectant mothers should not get together; especially during the last months of pregnancy<sup>22</sup>. It was associated with extreme bad luck, sickness and even the death of both babies. For same reason expectant mothers were particularly advised not to meet women with previous miscarriages, nor the husband's sister. The avoidance to the husband's sister was complicated and was somehow linked to the family relations. The problem arose when they lived in different villages, if they lived together in a joint family there were no problems. Deepa, from a rural village tried to explain for me; *"Both sides do not want to see each other; the relationship will be there, so they don't want to meet each other"*. Several women also mentioned that a childbearing woman should avoid newborn babies since it was believed to cause excessive crying of the newborn.

The rural women also told me that they were recommended to stay calm and avoid strong emotions such as anger and fear during pregnancy. Indignation was believed to result in sickness or death for the unborn baby, and also for the mother. For the same reason some pregnant women have been recommended not to attend any funerals nor be around any sort of death since sighting a dead body and smoke of a funeral pyre, could cause breathing problems for the child. As Vahini a rural women to me; *"If some people have died, I do not want to go to the house, it's not good for the baby, because they get a shock, not good for them, they will be sick"*

As a midwife who has her whole working experience from Swedish obstetrics, I was surprised that several of the respondents had experienced the death of one or more children. The women often mentioned it through an oversight, and it seemed to be something that they thought to be natural and they accepted it. To deal with this reality the Tamil people have created different kinds of beliefs and practices, and this study shows that in most cases with premature dead babies, the participants blamed evil for having attacked and killed their unborn babies.

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<sup>22</sup> Some women mention that it was dependent upon the sex of the unborn babies. Same sex was harmless, but if the babies have different sex it would bring sickness and death. And because they did not know the sex, they avoid each other.

#### 4.1.2 EVIL SPIRITS

In India a pregnant woman is attractive to evil spirits, (Jeffery, 1989), since pregnant women are believed to send out a special smell which attracts evil spirits. This study established that evil spirits are seen as particularly obstinate and lethal. Almost all respondents told me about the strong belief in evil spirits and the evil eye. Very few women stated that they did believe in the evil spirits, but during my probing questions most of them acknowledged that they took measures for protection against evil spirits, and only a few maintained that they did not believe in evil spirits at all. Especially dangerous periods of time for pregnant women were dusk and dawn, because of the amount of evil spirits, who could occupy them and cause harm. Also going outside after darkness, was thought to be very dangerous and not recommended. If it was unavoidable to leave the house, the women expressed great fear, and protection against evil spirits was important. Most common was to put herbal leaves in their hands, wear leather shoes, and more rarely they had also brought a stick. Kalavati, who was a 24 year old rural woman, and had the experience that her first child died intra-uterine when she was seven months pregnant, told me;

*./.../ after six o'clock I will not leave the house or the village. It's so dark, and so many evil spirits are out there, ..different kinds of evil in the village, it's true actually,..I know. The evil is staying outside, and if I go out alone at this moment, they will come and attack and crack the baby. My first child was like that, it only happened, the evil only attack- that is that.*

During twilight hour the women also avoid any kind of household work. Cutting vegetables, was believed to harm the child, resulting in a handicapped child, and thereby caused a difficult delivery. The same caution was also valid during midday, at 12.30. Almost all interviewed women stated that they stayed inside their houses during this time, since the evil was around, and the women preferred to take a rest after lunch. Not even relaxing activities such as stitching clothes, or binding flowers were recommended. The poorest rural women said that they were forced to continue their work burden even during midday, and they expressed great fear and worry for that reason.

Some rural women who have had a previous premature dead baby also said that they did not take any unnecessary risk in the next pregnancy. They preferred to stay inside their houses

during almost the whole pregnancy, so they avoided attacks from evil. The only exceptions to this were if they needed to go to the hospital for antenatal check-ups, or for a quick bath.

#### 4.1.3 DIETARY PRECAUTIONS; TRADITIONAL MEDICINE AND HOT AND COLD THEORY

Medical beliefs in India are a blend of modern and traditional theories and practices, and include multiple forms of biomedicine, traditional systems of medicine, homeopathy, and a wide variety of medical knowledge tied to religious practices and astrology, (Van Hollen, 2003). The traditional systems of medicine in India are based on the Tridosha theory<sup>23</sup>, and Indian healers, use Ayurvedic<sup>24</sup>, Siddha, and Unani medical systems. In Southern India and in Tamil Nadu most local health traditions spring from Siddha, which is an indigenous system of medicine, and is largely based on an understanding of food as medicine. (Purnell, 2005; Van Hollen, 2003). The theory of “hot and cold” play a central role and it’s a construction of the body as fluctuating between states of “hot and cold”, and health as a balance between these two states. For example too much heat in the body is believed to cause hot diseases<sup>25</sup>. Generally women are considered to be hotter than men, and pregnancy is considered to be a very hot state, since, during pregnancy the woman’s heat in her body will increase substantially.

This study points out that the hot and cold theory is still very important in Kancheepuram. Avoidance of hot food was particularly important for Tamil women in early pregnancy, since heat was believed to stimulate uterine contractions and result in a miscarriage. Papaya<sup>26</sup> was one of the most widespread and feared food items during childbearing, and was considered taboo. In chapter five under research frontier, I will go into more details regarding papaya and present what Adebisi, (2002), and Ferro-Luzzi, (1980), have found regarding this.

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<sup>23</sup> The body is made up of modifications of the five elements; air, space, fire, water and earth. These modifications are formed from food and must be maintained within proper proportions for health.

<sup>24</sup> Ayurveda; traditional, Hindu system of medical diagnosis and practice, based on ancient Hindu texts.

<sup>25</sup> The symptoms are external visible and include redness of the skin, rashes, boils, swelling and other skin maladies. Also liquid flowing out of the body such as vomiting, diarrhoea, bleeding and abortion are seen as hot diseases, (Pool, 1987).

<sup>26</sup> Papaya is supposed to cause diarrhoea with pain in lower abdomen, and hence cause abortion of the foetus.

Mango, pineapple pumpkin, sesame, black seed, curry, and spices in general, were other items to be avoided for the same reason. Many women also restricted non-vegetarian food such as pork; mutton and chicken since these foods were also seen as very hot. Banhi, a young rural women told me; *“During childbearing I do not eat papaya and pineapple during the whole pregnancy papaya, since they are restricted. Black grapes are also restricted”*.

Restrictions on water intake were also mentioned by some rural women, leading back to the fear of the growth of the baby into a large baby, and thereby cause a difficult delivery. Water intake was also believed to lead to swollen legs, as explained by nurse Kamalkali; *“ /...this is a problem. The village people believe that they do not need to drink more water during pregnancy, they believe if they drink water, the leg will be swollen...so they avoid water”*

Restrictions regarding coffee and tea were mentioned by a few women. The reasons behind this differed. Fear for a hairless child, miscarriage and *dark skin of the baby* were the most frequent. Makshi a rural woman explained;

*/.../ the fruit and all this will be restricted...I avoid this...I eat only apple, all other fruit I will avoid. Papaya, pumpkin, black grape's, and black seed. All black fruits and black items I will avoid” Why? Because of the baby, the skin will be black. We eat the red flower so the skin will be red*

As Makshi mentioned, the women in this study had a strong desire that the baby will be born light skinned<sup>27</sup>. That's how I chose my title for this thesis as I mentioned earlier in my introduction chapter. Most of the rural childbearing women ate saffron<sup>28</sup> and avoided all sorts of black food items, such as black grapes, seeds, fruits, dates, in their anxiety not to pass on the blackness to the baby. Even oral iron supplementation<sup>29</sup> was avoided. The intake of saffron started from the sixth month of pregnancy and onwards until delivery. Salvi one of the pregnant rural women mentioned that she had tried saffron but was advised to end it by her doctor;

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<sup>27</sup> According to Das Gupta, (2007), the ideology of “fairer is better” was promoted by colonialism, but it goes back even further to the caste system, which existed 2000 years before India was colonized. The system equates light skin with a more revered caste. Members of the highest caste are supposed to be lighter than the poorer labourers, they are comparatively darker.

<sup>28</sup> Commonly mentioned as the ‘red’ flower’.

<sup>29</sup> Iron tablets are *black* coloured, and iron tablets causes *black* stool of mother.

*Black grapes I don't eat, not either black fruit, the baby will get black. I have heard and believe about the red flower, because the elderly people say so, and they have right sometimes. I believe this, and once I ate the red flower so the baby will come out shining-but you know what?-the doctor's advice was to not to eat the red flower,-and I accepted the doctors advise.*

Traditional herbal medicine was very common during late pregnancy. The elderly women in the household such as the mother in law usually prepared it for the mother to be. *Kashayam*<sup>30</sup> mixed together with coffee was believed to cause and strengthen labour pains. Strong labour pains, were desirable for a quick and easy (normal) delivery. Other traditional home remedies mentioned as *mellgu*, *cira*, *rassam* were also used for the same reason. A few women also believed that garlic and bananas would give an easy birth.

#### 4.1.4 'SEEMANTHAM' AND LEAVING HUSBAND'S HOUSE

In Tamil Nadu the people celebrated a traditional pregnancy ritual called '*Seemantham*'. It was a ritual for honouring and celebrating a woman's first pregnancy, since in Tamil Nadu; the sanctity of motherhood is a concept. Every woman in Kancheepuram, irrespective of caste or religion, celebrated '*Seemantham*'<sup>31</sup>, and the ceremony was held in the ninth month of pregnancy. Sometimes it was a whole series of ceremonies if the women's family was very caring about her<sup>32</sup>. The reason given to celebrate was to satisfy the pregnant woman's desire, '*akai*', and bless her so that she would feel happy mentally, since this would take away unnecessary fears about the pains of delivery and make the women relaxed, and by this; ensure a normal delivery and thereby a healthy child.

The day after the woman has celebrated '*Seemantham*', the woman leaves her husband's house in order to stay at her parent's<sup>33</sup> house, often in another village. The women generally stayed at their parent's house between one to two months prior to delivery, and most commonly three to six months afterwards. It was said to be an old socio cultural tradition, and

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<sup>30</sup> Kashayam is a herbal decoction usually of cumin.

<sup>31</sup> With the exception of the couple that have "marriage by love", e.g. not arranged marriage.

<sup>32</sup> Seemantham were then celebrated in the 5<sup>th</sup>, 7<sup>th</sup>, and 9<sup>th</sup> month of pregnancy. Different relatives then share and arrange it for the pregnant mother.

<sup>33</sup> Named 'mother's house' by the participants

the official function behind was that the pregnant woman could relax and rest from household work, and as well be nourished by the parents<sup>34</sup> i.e. prepare for the birth of a healthy baby. The male respondent also pointed out that it became less tense between the couple, and all men interviewed in this study were said to be pleased how it was organized, and they visited their wives regularly. In my theory chapter I will develop and discuss the different functions more detailed.

### **Summary**

Pregnancy is a critical period with increased vulnerability for women, but it's also a process of maturity and increased possibilities for women. The elderly women in her family and society guide her about what kind of demands the new role will put on her, and what kind of danger there are during this period of time, and how to protect against these threats. The stated purposes behind the advice were to avoid abortion, stillbirth and a difficult delivery. The pregnant woman's state of mind made her also very subjected to supernatural forces. Today almost all rural Tamil women also attend antenatal check-ups monthly at the village health nurse or by hospital, in spite of this; the pregnant women are restricted in their activities and diet by the traditional practices and beliefs.

Beneficial traditions, for both the pregnant mother and her child, were founded such as shared or avoided hard household work, take a rest during midday, wearing leather shoes during evening time and '*Seemantham*'. Traditions such as dietary precautions and restrictions of the pregnant woman's intake of water, and meat and fruit, are most likely harmful, since they can result in dehydration and iron and vitamin insufficiency, especially if the woman is malnourished before the occurrence of her pregnancy. Avoidances of 'jam-packed' buses, as the consumption of saffron for a light skin, and the different precautions regarding the evil spirits are more complicated to be clear about. If the women are dependent on travelling by bus to i.e. the hospital for some reason, then this practice could be seen as harmful, otherwise it's neutral. Saffron itself is not harmful for the woman nor for the baby, but if it preserves biases about peoples' values then it can be understand as a harmful tradition. The fear of evil spirits restricted the woman physically, and sometimes the data showed that it caused feelings of guilt, if she has earlier experienced a miscarriage or stillbirth. It could also restrict the women to their homes, and preserve power relations within the family and the society. This

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<sup>34</sup> If the pregnant women's parents are dead, she stays in her husband's house until delivery time.



could also be valid to the practices that the pregnant women moved back to her parent's house during the last month of pregnancy. At a first glance this is beneficial for the pregnant women and her child, on the other hand it perhaps maintains the power over the young woman.

## 4.2 DELIVERY

Institutional births under supervision by skilled health personnel are today the prevalent norm in the state of Tamil Nadu. The majority, (90.4%), of children in rural Tamil Nadu are today born in a hospital or clinic<sup>35</sup>, (NFHS-3, 2006). In the past the Tamil children were born at home, often under the supervision of a dai, (Mulder, 1995; Van Hollen, 2003). This study indicates that the few deliveries that still occur at home in Kancheepuram are really due to early and unexpected delivery, or non availability of timely transport to the institution. As Chardrika, 28 years old rural women explained;

*The first child, the boy, I delivered on the way to the hospital. The second child was a home delivery because of the fast course of events and it was an easy birth. The third child was delivered at the hospital*

Only one woman answered that she has planned to give birth at home in her mother's house, assisted by her sister who is a nurse, because she did not want to deliver at the hospital. One woman mentioned that she delivered her first child at home assisted by a dai, the rest of the respondents stated that they had delivered at a hospital or Public Health Care centre, (PHC). The exception was the gypsy community, all of whom had delivered at home assisted by the village dai, and I will come back later on to these findings in section, 4:4, regarding the gypsy community. Men were usually not present during the birth. Instead the female relatives supported the pregnant women at the hospital or PHC. The study did not find any taboo against the father being in the delivery room, but by cultural traditions, the men waited outside the delivery room, if he did not stay at home.

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<sup>35</sup> Based on the last 2 births in the 3 years before the survey, (NFHS-3, 2006).

### 4.3 POSTPARTUM PRACTICES

There were many traditions directly after delivery, some harmful and some beneficial. One harmful tradition, that was however diminishing, was the practice of three days of initial fast. A small number of women in this study mentioned the practice to avoiding foods or drinks during the first three days after delivery. The given reason behind this initial food taboo was to keep the female body dry<sup>36</sup>, and by this healing internal wounds, as Daya a rural women told; *“After birth, I did not eat up to three days, I only ate some bread, so I did not breast feed my baby during these days”*. This must be seen as harmful since women in generally are in need of both food and beverage after a delivery. One woman had had a drip at the hospital during the initial first three days of fast, since this was a recommendation by the doctor.

#### 4.3.1 VULNERABILITY

After delivery the woman and her newborn are seen as particularly weak and vulnerable<sup>37</sup>. They have to be protected against diseases and evil spirits. Before entering the parent’s house the first time after delivery, ceremonies against evil spirits was performed. The first eleven days, the new mother and her baby were recommended to stay indoors, and the majority of the women stated that they stayed inside the house with the baby for at least three months. Exceptions were only made for the baby’s bathing, and to catch some sunshine since sunshine was believed for good growth of the baby’s hair. Staying inside at the parent’s house provides rest for the new mother, and also a release from household responsibilities. It can also be seen as an important time for bonding with her baby, as well as protection from transmissible diseases. By viewing it in this way it must seen as beneficiary for the new mother and her baby. But if the practice isolated them and possibly delayed health care for mother and child, it can be harmful.

Protection against evil spirits were very important, since they were seen as even more dangerous than during the pregnancy. Iron items in combination with coral and herbal leaves

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<sup>36</sup>Postpartum women are believed to be cold and wet, since the babies bring the heat from the womb, when leaving the woman. This is referred to the hot and cold theory again.

<sup>37</sup> The woman has lost blood (which is seen as warm), and the baby is vulnerable after have left the warmth in the mother’s womb.

were the most commonly used<sup>38</sup>. The baby was believed to be in danger for the evil eye, 'Nazar'. The evil eye was thought to enter the house through jealousy among celebrating visitors, and rituals were performed to prevent the evil eye to enter the house. In spite of all these security measures, the babies got sick from time to time. The evil eye was blamed for causing sickness especially high fever in the baby. But other illnesses such as excessive crying, digestive problems were believed to be caused by the evil eye. General protection consisted of blessings, twisted black and red strings placed around the baby's ankle and wrist, and also black dots, (done by a kohl pencil), in the baby's forehead and under the baby's foot. Green herbal leaves, 'Veppali', and white flowers were placed in the baby's hands<sup>39</sup>. To cure sick newborn, homemade remedies and temple blessing, were the initial cures provided by the elderly women. As Oma a rural women told me;

*I know about it. What kind of diagnosis of the children. If the baby is crying I know. Sometimes it is cold, and sometimes is fever. If the baby is crying and has fever, we go to the hospital, 'if it not is the cold items fever', then we go to a temple for blessing.*

Excessive crying was traditionally treated by a procedure called 'uram' relief using the technique of rolling the baby in a long cloth, and turned the baby upside down, and finally shaking it. Most Tamil women were familiar with this practice, but few used it. Aanu a rural woman explained the custom with unskilled practice; "...sometimes they did not know how to do. That's why they do this..." If the baby continued to be sick in spite of this treatment, the women state that they seek care at a hospital or PHC. However some mothers said that they seek healthcare providers' advice in case of any problem with the baby.

#### 4.3.2 IMPURITY AND CLEANSING

As I mentioned in the background chapter, childbirth is linked with pollution, as the women are seen as be in a state of impurity during the postpartum period,(Lauderdale, 2008).There are therefore several concerns and strict rules regarding this unclean period, (Jeffery, 1989).

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<sup>38</sup> The belief in iron and steel was earlier also common in the Nordic countries hundred years ago,(Höjeberg, 2000). For example in Sweden they put a knife of steel in the newborn babies cradle, and also nails of steel were fastened in the threshold, so no troll could lay hands on the baby.

<sup>39</sup> They use these protective items until the child is around one year's old.

Bathing of mother and baby is a general practice, since it helped them to shift into cleanliness. The bathing of the child can also be seen as an indicator of its separation as a part of the mother. The bathing for the new mother can be harmful if it leads to lower abdomen infections by unclean water; on the other hand cleanness keeps diseases away if the water is clean. The same must be valid for bathing the newborn, unless it will not lead to cooling and hypothermia<sup>40</sup> as an effect, then it is harmful.

The baby was not considered as an individual and not a member of society, until a certain ceremony, '*tiddukkarittal*' was carried out. Prior to this day, the baby remains unnamed and was dressed in second-hand clothes. Eleven days after delivery, the baby was given a purifying bath, new clothes, and was given its name, and then the baby became a member of society with its own identity.

#### 4.3.3 MOTHER'S AND BABY'S DIET

In Tamil Nadu it's believed that a great deal of the woman's body heat is thought to be lost during the birth, and therefore women have to avoid all kinds of coldness, (Lauderdale, 2008; Van Hollen, 2003). The avoidance of cold foods was widespread and mentioned by all those interviewed in the study. The new mother's diet and behaviour was also believed to influence the quality of her milk, and for this reason, when breast-fed babies suffered from respiratory infections the mother's milk was often blamed for being "too cold". All household work that included water was also avoided for this reason. Equally if the babies got red rashes on the skin, it was believed that the breast feeding woman had eaten hot food items.

Due to traditional practices breastfeeding had not started until the fourth day following delivery. Colostrums feeding<sup>41</sup> had been withheld, since the first milk have been associated with impurity, and believed to cause sickness to the baby, (Van Hollen, 2003). This harmful tradition is something that has been given high priority in different health programs in Kancheepuram. Almost all interviewed mothers stated that they had started to breast feed within three hours after delivery, that is to say; they colostrum feed their babies. However

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<sup>40</sup> A condition in which body temperature drops below that required for normal and body functions.

<sup>41</sup> The mother's first milk, raw milk, contains a lot of antibodies and vitamins from the mother; it's produced during pregnancy and comes before the established milk production.

sometimes I got a feeling that the respondents gave me a ‘correct answer’ on this matter and I often reflected on the degree of truthfulness, in regard to this question.

Prelacteal<sup>42</sup> feeding to newborn with honey and donkey milk was commonly used by the grandmother’s whom have seen generations of people who have undergone these procedures and they stated that they were all fine. Donkey milk was given to prevent sickness such as throat problems and ‘chevappu’<sup>43</sup>. All men in the focus groups interviews stated that they had had donkey milk as a child, and since they were healthy, they repeated it with their own newborns. “*We give some donkey milk to the baby for protection against sickness. Everybody here has had donkey milk when they were babies, so the baby will be healthy and act in response*”.(Vardhaman). Honey was given to infants for cleansing purposes<sup>44</sup>, and contributed to some kind of circulation in the mouth, resulting in freely speaking, “*sweet words*”. These practices can be harmful, since newborns need the mother’s breast milk, and to give anything else then breast milk or baby formula disrupt further breast feeding.

## Summary

In Kancheepuram the woman and her newborn are seen as particularly weak and vulnerable<sup>45</sup>, after delivery. They have to be protected against diseases and evil spirits. Explanations of causes of illness and death demonstrated the worldview of the Tamils, .i.e. holistic and magico-religious, as earlier mentioned in the theory chapter. The newly delivered woman was also seen as polluted after delivery, and during the postpartum period traditional practices and rituals such as purification rituals incorporating the woman, into another phase of her life, motherhood. The baby was not considering as an individual and not a member of the society, until eleven days then the baby became a member of the society with its own identity. Since the women breast feed their children, food taboos strengthening its position during this time period. Prelacteal<sup>46</sup> feeding to newborn with honey and donkey milk was commonly used.

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<sup>42</sup> To give newborn babies feeds like honey, water, glucose water or cow/buffalo milk, before the mother's milk comes in.

<sup>43</sup> Skin problems, red colour in baby’s skin

<sup>44</sup> To get rid of meconium, that is the earliest stools of an infant.

<sup>45</sup> The woman has lost blood (which is seen as warm), and the baby is vulnerable after have left the warmth in the mother’s womb.

<sup>46</sup> Traditionally a new born is given prelactal feeds like honey, water, glucose water or top milk, before the mother's milk comes in.

This section showed that some traditions were harmful for both the mother and her child. It also showed that if information and education is given to the mother's, such as the given information regarding colostrums feeding could diminish harmful traditions, since almost all interviewed women state that they had colostrums fed their babies.

#### 4.4 GYPSY COMMUNITY

A section of India's population is classified as "tribal", and these are groups which traditionally have not been integrated into the caste hierarchy, and have much the same status as 'untouchables'. Tribal people are seen by others Indians as simple forest dwellers who are the descendants of the original population of India, (Shurmer-Smith, 2000). There are different clans of gypsies in India, such as Sapera, (snake charmers)-live mainly in Rajasthan- and the Narikravar in the South,(Kenrick, 2004). During my stay in Kancheepuram I occasionally ran into these gypsy communities. Some groups are still nomads or have been so until the relatively recent past. I choose to present my findings from this gypsy village since they have been set aside in the modernisation of obstetrics in Kancheepuram district. They represent an exception from the rest of my respondents, and I wanted to show that even Tamil Nadu as a whole can show very good statistics, there are large disparities in the society, as I mentioned earlier in the background chapter.

The gypsy community which I visit and where I carried out my interviews consisted of 40 households, and their main occupation was pearl work alongside catching birds. They have slowly started to adapt to being settled. Their children attended school, and their pregnant women received antenatal care provided by a nearby village health nurse. Because of their earlier lifestyle of travelling the women haven't attended any antenatal check-ups during their pregnancies. Guiding during pregnancy was still predominantly provided by the elderly women in the village. Home deliveries were still the common procedure in the village, assisted by the dai. The village leader also claimed that he had assisted ten births, but I am doubtful about the degree of truth in that statement.

The dai in the gypsy community has inherited the occupation from her mother who has performed the same task, and she had obtained her traditional knowledge by practical

experience<sup>47</sup>. As Komela the dai told; *“I have learned it by practical life problems...one by one...one by one.....step by step...I have learned, I have learned from all experience”* It was very uncommon that the people in the village went to hospital for any minor illnesses, for that reason; it was claimed a life threatening situation.

To solve obstetric problems during labour, traditional practices were first tried. To correct mal presentations<sup>48</sup>, the dai used her hands to get the baby in to the right position. If this did not succeed, she told me, that she recommended hospitalisation. On the question if she had delivered any breech and/or footling presentations, she told me that living babies always come in head presentation, footling presentation represented dead babies. Komala the dai explained; *“/...if they die in the stomach, they always come out with the feet first, otherwise they come with the head first”*. This part was very touching for me, since these presentations are trickier to deliver than head presentations, but in Sweden all babies in this position are supposed to survive.

After delivery the gypsy women also stayed inside their homes. Two-three days was most commonly, and after that time period, they could leave the house. Also in this gypsy village there was a strong belief in evil spirits, and measures were also taken for protection. The gypsies tackle the problem as the rest of the interviewed respondents<sup>49</sup> in my study.

## 5 THEORETICAL FRAMEWORK

In the previous chapter my findings and analysis were presented and discussed. In this chapter I will start with a presentation of my constructed ‘Motherhood during a transitional period’ theory, and continue with a presentation of Abrams, (1982) Historical Sociology Theory to which my constructed theory is compared to. Since this thesis has a grounded theory

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<sup>47</sup> Being a dai was and still are a part of a family tradition in India. Young women were introduced into the lore by their elders, however many of them have gain experience by watching deliveries, and have no educational training, (Mulder, 1995). Most dais are from poor backgrounds and from a low caste, (Jeffery, 1989).

<sup>48</sup> The head is the most common and preferred presentation of the baby during delivery.. Mal position and mal presentations of the foetus are complications during delivery and present the midwife with a challenge during labour. Recognition and diagnosis should be detected before delivery by antenatal check-ups since some of them demand caesareans.

<sup>49</sup> Hindu blessings and choral dots in the forehead, and black and rep twisted ropes around waist, wrists and ankles.

approach, and the theory is grounded from data, the theoretical framework is presented after the chapter regarding findings and analysis.

## 5.1 MOTHERHOOD DURING A TRANSITIONAL PERIOD

The title of the theory was inspired by the Tamil women's span between two worldviews, i.e. shift in systems of knowledge about the body in general and women's conceptualizations and experiences of childbearing and giving birth. As I presented in the previous chapter concerning findings and analyses, several traditional beliefs and practices still exist in Kancheepuram, and many of the rural Tamil women still adhere to them and take several of them seriously. These practices and beliefs run in parallel with the modernisation and transformation of obstetrics. The theory of 'Motherhood during a transitional period' will explain why the rural women keep to their old emotional cultural beliefs and practices in spite of the modernisation of obstetrics, that are rational with a target focus, they today are a part of. Although several of the traditions are harmful, I have found, two different explanations to this phenomenon and will discuss and develop these ideas;

- The Tamil women are in a transition phase between two worldviews.
- Modernization of a society and its inhabitants take time and at varying speed.

Below I will elaborate on my two propositions.

**Proposition:** The Tamil women are in a transition phase between two worldviews.

From the collected data it emerged that all those interviewed have found it necessary to explain the phenomena of nature and to offer solutions to life's mysteries .i.e. they have their own old worldview of childbearing and giving birth. The women, their families and society have their own historical experiences, and these historical experiences are crucial to have, so they can use them and compare with the new 'modern' obstetrics they are offered. If they do not have this historical experience what then to compare with? The women cannot change their worldviews if they are not convinced/assured that the new worldview is superior and can offer something better than their old worldview. They need to experience that the stillbirth and/or infant's mortality will decline, or that they feel healthier, as a result of modern obstetrics care. This will only happen when the explanatory power has been exhausted from the old beliefs. Once this has happen they will accept and change their worldview, Abrams,



(1982) theory 'Historical Sociology' supports this. The women are so to say in a transition period between two paradigms.

**Proposition:** Modernization of a society and its inhabitants take time and at varying speed.

But these paradigms are slow to change, since old existing traditions are deeply rooted in the culture. On many occasions old traditions prevent new experiences from being made, for instance, if the head of the household decides that it is not necessary to visit hospital then the benefits of modern obstetrics will not be discovered.

Traditions could moreover have more than one function. For example the widespread practice that the pregnant woman leaves her husband's house and return to her parent's house. The manifest function is to provide the pregnant woman with rest and to be nourished. But there can also be a latent function behind this tradition, such as preserve power for the elderly rural women, and fit the pregnant women into a system of values and norms. And this latent function slows down the speed of the transformations.

Change also depends on factors involved such as; peoples understanding of health, diseases or illness, i.e. people's health belief systems. In Kancheepuram the causes of illness were categorized as natural illnesses, or illnesses sent by supernatural forces, such as evil spirits. Natural illness reflects the symbiosis and balance between the human being and her physical environment. (Andrews, 2008). Tamil people's explanations of the causes of illness demonstrated the prevailing holistic worldview<sup>50</sup>. When all elements are in balance and in harmony; then the system is healthy, but if one element is unbalanced, all other parts are affected. This implies that many parts must be reappraised before the transition of a new society has taken place. Since all parts are interlinked you cannot just change one part of the paradigm, in this case the modernisation of the obstetrics. In general, to change only one part of a society without putting that change in a wider cultural context will make the change of that society's worldview slow. To put this into the Tamil context, to change the obstetric care without considering that society needs to absorb the change in the society's culture will make the transition period significantly longer.

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<sup>50</sup> In the holistic paradigm the forces of nature itself must be kept in natural balance or harmony. Human life is only one aspect of the nature and a part of the general order of cosmos, and everything in the universe has a place and a role and together they make the universe complete. (Andrews, 2008)

## 5.2 ABRAMS HISTORICAL SOCIOLOGY THEORY

I will continue my theoretical discussion and also bring forward Abrams Historical Sociology Theory with the intention to find support for my ‘Motherhood during a transitional period’ theory. Abrams (1982, p. 3), Historical Sociology Theory, was developed to understand how societies, sociologically, are formed as a process historically by individuals that in turn are formed historically by society.

*We can construct new worlds but on the basis and within the framework of what our predecessors have constructed for us. On that basis and within that framework the content of our activity may re-make or un-make the institutions that surround us.*

Abrams theory explains why societies still hold on to their old traditions and beliefs although they are in transition. Abrams theory compares a society’s development with a child’s development to an adult. He is pointing out the necessity of an individual’s adolescence; that is to say the transitional phase. The period during the adolescence gives the individual time for reflection and comparison of its history as a child, also what lays ahead, i.e. the life as an adult, since the adolescence is a time of searching. “*Creativity feeds on experience not will*” (Abrams, 1982, p. 255).

His theory also discusses why of necessity it takes generations to adopt and incorporate new concepts into a society’s worldview. Abrams differs between biological and sociological generations, with this he means familial and cultural generations. A familial generation is based on age. A sociological cultural generation is the time between significant changes in worldviews. Abrams claims that the driving force behind the development of a society is connected to the aging of the individual. The worldview that parents pass on to their children is the worldview they received from their parents, together with the changes in values and norms that life experience has provided. This supports my own theory above when I claim that change takes time.

Adams leading idea is that society goes through constant alteration and this is the same as the individuals searching for their own identity. The process towards finding his or her identity is the same as the change in society. This idea also stipulates that the changes of the individuals affect society. The changes in society then in turn affect the individuals. This interaction is a

process that takes time. Individuals need to experience changes before they can reshape their values and norms. Cultural change to society relies in turn on new values and norms.

Abrams theory,(1982), explains why harmful traditions and beliefs can emerge. He claims that individuals form their worldview from personal experiences gained through life. However Abrams Theory does not give any suggestion how to avoid these harmful traditions emerging. This could be seen as a shortcoming of his theory. If gained experiences are misinterpreted, and traditions or behaviours are formed from such misunderstandings, this may lead to harmful traditions and beliefs. One example could be the withholding of colostrums for newborn babies since the women feared that colostrums caused diarrhoea and nausea for the baby. This belief could, for instance, have its origin from breast feeding a newborn, in combination with sickness, and then been misinterpreted as colostrums causing the problem.

### 5.3 RESEARCH FRONTIER REVIEW

Now when the theory has been presented the literature review follows. Since this study is inductive, and has a grounded theory approach, the literary review is presented in the chapter following findings, analysis, and theory, this in understanding of the nature of the grounded theory.

Indian women`s particular beliefs, traditions, and taboos during pregnancy and postpartum are well documented, (Choudhry, 1997; Jeffery, 1989; Matthews, 2005; Nielsen Bruun, 1998a; Van Hollen, 2003). Especially the research about food habits in relationship to childbearing and postpartum period in India are well documented, as well as the concept of 'hot and cold', (Ferro-Luzzi, 1980; Pool, 1987; Zeitlyn, 1997). These beliefs have also been widely reported from other parts of Southeast Asian countries (Wilson, 1980), Latin America (Messer, 1987) and Iran, (Ahlqvist, 2000).

Among the food avoidances of pregnant women in India and Tamil Nadu, papaya is the most feared food item, (Choudhry, 1997; Ferro-Luzzi, 1980). Ferro-Luzzi, found in his study, of 1200 women from all districts in Tamil Nadu, that 82% of the women excluded papaya during childbearing, since papaya is "accused of" causing abortion, as it's classified as very 'hot'. He also found that even men declared that they felt hot after eating papaya. Adebisi, (2002),

tested rats to ascertain if papaya consumption was unsafe in pregnancy, since his theory was that papaya could provoke uterine stimulation, and miscarriage. The findings showed that consumption of ripe papaya during pregnancy may not be dangerous; however unripe or semi-ripe papaya produced uterine contractions, and should therefore be avoided in pregnancy (ibid). Theilgaard-Andersen, (2003), on the other hand found that very few women excluded papaya during pregnancy due to its 'heating' effect on the mother and her unborn baby, the reason behind excluding papaya was vomiting and 'gas producing'.

Due to rapid social and economic transformations in many parts of the world, and the 'export of Western obstetrics', the focus has changed more into the topic of the shift from home births and traditional birth attendants versus the modernization of obstetrics, (Liamputtong, 2005b; Nielsen Bruun, 1998a; Ram, 1994; Van Hollen, 2003).

Van Hollen, (2003) ,discusses how this shift from one institutional site (i.e. the family and the midwife), to another institutional site (i.e. the public hospitals as site of both the state and biomedicine<sup>51</sup>) affect the poor women's lives. The central theme for her discussions is how poor women in Tamil Nadu made decisions about what kind of care to seek during childbirth, and the issue of what kind of 'choice' they have. She also highlights the shift in systems of knowledge about the body in general, and also how new concepts of maternity emerged in the context of the modernisation of childbirth in a community in transition. Her observations are in accordance with my own observations during my research period in Kancheepuram. The influence of western medicine was very perceptible when I talked with the rural Tamil women, and traditional medicine was often portrayed as 'backwards, old-fashioned, unhealthy and uncivilized'. Several rural women were uncomfortable about the question regarding the elderly women's advice to them during childbearing and postpartum period, and laughed embarrassedly when they admitted that they in reality followed their guidance. I interpreted that traditional medicine was something that the rural women adhere to but were ashamed of. These rural women live in a passage/threshold between old cultural traditions and new western medicine, and the woman may be torn between traditional ways and the western medicine.

Also Ram, (1994) discusses the women's responses to modern medical 'management' of pregnancy and birth in Tamil Nadu. He argues that women's decisions, whether or not to seek

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<sup>51</sup> Bio-medicine; medical system of Western civilization /medicine, "modern medicine".

medical care during pregnancy and where to give birth, are based in their earlier experiences of how they had been treated by higher class and caste power. Ram,(1994) ,also pointed out the enormous tensions that are created for the women since they are required to mediate between world views. Poor and low caste women are targets for new medical reforms because they are 'traditional' in their modes of childbirth, childcare and hygiene, and they still derive their basic ideas of femininity and maternity from archaic religious and cultural currents. Older forms of hierarchy are mapped into new versions, with high caste intolerance of impurity, pollution and medical science.

The beliefs and practices of Tamil pregnant women have also been documented, (Nielsen Bruun, 1998a). She studied different aspects of antenatal care in rural Tamil Nadu, with regard to background and risk factors for maternal and perinatal morbidity and mortality<sup>52</sup>. Her findings were similar to mine, i.e. that the women were very much concerned about their pregnancies, and have many strategies to ensure a safe delivery and a healthy child. Bruun-Nielsen,(ibid), found nevertheless that some of those strategies were conflicting, and the Tamil women had to choose to prioritize between a safe delivery or a healthy child. Many women then gave priority to their own health, since they believed that they could always improve the health of the child after birth. My analysis did not indicate this conflict.

## 6 CONCLUSION

Despite rapid health transition and the extension of obstetric care in Tamil Nadu, the rural women still adhere to several traditional beliefs and practices in regard to childbearing and the first period after delivery. In order to understand the underlying causes behind these traditions and beliefs, the study therefore began with an investigation of rural women in Kancheepuram. The second stage analysed what possible implications the adherence to these traditions could have for the rural Tamil women and their children.

First of all the analysis showed that the old traditions claimed to safeguard the life and well-being of the baby. Although the data collected showed that some of the beliefs and practices them were harmful others were harmless or beneficial for the women and their babies.

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<sup>52</sup> Maternal mortality; the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of the death

To answer the second research question why the rural women in Tamil Nadu hold on to these sometimes harmful traditions in spite of the modernisation of obstetrics, a grounded theory termed, 'Motherhood during a transitional period' was constructed. The theory explains that the Tamil women are in a transition period between two worldviews, and also that modernization of a society and its inhabitants takes time and is at a varying speed.

The Tamil woman, their families and their society have their own old view of childbearing and giving birth. At the same time these women are under pressure to be 'modern', and are told to attend maternal care and come to the hospital and deliver, to attend the 'new' worldview. This is equivalent with Abrams Historical Sociology theory that compares a society's development with a child's development to an adult. He points out the necessity of an individual's adolescence; that is to say the transitional phase, a time to reflect and compare. This is the same for the Tamil women, therefore they need varying time to compare the old and new, and experience the new maternal care they are offered.

The presence of the deeply rooted traditions in combination with the modern 'top-down' maternity care put the women in a very difficult position; therefore these women are torn between traditional ways and the western medicine. By providing cultural sensitive care, we can respond to the Tamil women's cultural needs, and also enhancing quality humanistic and holistic care to the Tamil people in their own culture. You may consider that this is something that the leaders of the society may have overlooked, in their ambition to show the world declining numbers of maternal and infant mortality. You may argue that, the leaders have not been capable of integrating the culture into the modernisation of obstetrics, and therefore not been able to effectively change these harmful traditions and beliefs. Culture has always been central to development and must be integrated into development policy and programs since culture is of such a fundamental part of people's lives. At a national level, the Indian government need to raise the status of women and girls and work against women's low status in the society. The government also need to offer education for women and girls, since an educated mother is less likely to die during childbirth. And with education perhaps we also will see a change in the deep-rooted cultural belief that "Saffron will give a fair baby"!

## 7 RECOMMENDATIONS

The Tamil rural women of today live their lives in a passage/threshold between old traditions and Western obstetrics. They also live between an old and new worldview regarding their

bodies, childbearing and giving birth. I therefore suggest one way of how to provide cultural sensitive health care to the rural Tamil women by an ethno nursing method, derived from Leininger's Culture Care Theory, (Leininger, 2006). It was developed in the mid-1950s and early 1960s to find ways to give care to people who have different values and life styles. Among several nursing theories and methods I choose Leininger since this is one of few that include cultural competence<sup>53</sup>, that is to say, explore the relationship of culture and care, and the focus also includes care for families, groups, communities, culture and institutions. Cultural Care is defined as;

*Subjectively and objectively learned and transmitted values, beliefs, and patterned life ways that assist, support, facilitate, or enable another individual or group to maintain health and well-being, to improve their human condition and life ways, or to deal with illnesses, handicaps, or death” (Leininger, 2006, p. 13)*

The Tamil women have a holistic worldview, as I earlier described in the theoretical chapter, and this fits well with Leningers' theory, (2006), therefore she points out that *care always occurs in a cultural context*, and information on culture is essential for holistic assessment of an individual, family, or community. The method will provide culturally congruent care, therefore many more ethical and moral issues will be identified related to culture, and that will lead to a request and need for dramatic new policies and ways to serve culture.

Leningers' theory, (ibid), demands the health practioners to individualize their care practices and standards, to be able to work against harmful traditions such as food taboos for pregnant and postpartum women. Practical examples at grass-rote level could be: education of health care workers to provide knowledge and understanding of the traditions, awareness-raising in societies of problems associated with harmful tradition, and mobilization of people to work against these harmful practices and beliefs. The national leaders must start to draw attention to gender inequality and power relations that are widespread and deep-rooted in many cultures. Gender equality is a human right, and women's empowerment is critical for promoting human development. The leaders in the global association must also keep in mind not to overlook the

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<sup>53</sup> Cultural competence is a set of behaviours that transcend mere good intentions such as accepting that cultural differences exist, and willingness to explore the client's own strengths and adaptive capabilities (De Chesnay, 2008)

culture, since people and culture are interlinked and a part of each other and you may argue that it is complex to 'import' western health care as a blue print to developing countries.



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## 9 APPENDIX

This appendix includes tables with socio-demographic facts, classification of traditions and hot and cold food items. Also included is a figure with residential area and caste. Included are information regarding the held interviews and the interview guide. Finally the appendix ends with a short novel of a fictive rural Hindu woman.

### 9.1 THE INTERVIEWED WOMEN'S SOCIO-DEMOGRAPHIC CHARACTERISTICS

Characteristics of the thirty seven (37) individual interviews.

Table 1 The interviewed women's socio-demographic characteristics.

<b>Sample characteristics</b>	<b>Number of Women</b>	
<b>Parity</b> <sup>54</sup>	Nullpara (Not given birth, but was pregnant)	5
	Primipara (Given birth one time.)	16
	Multipara (Given birth two times or more)	16
<b>Number of pregnancies</b>	Unknown	2
	1 pregnancy	12
	2 pregnancies	17
	3 pregnancies	3
	4 pregnancies	1
	> 4 pregnancies	2

<sup>54</sup> Parity refers to the number of times the woman has given birth to a child, live or stillborn.

<b>Sample characteristics</b>		<b>Number of Women</b>
<b>Number of living children</b>	0 children	7
	1-2 children	28
	3-4 children	1
	> 4 children	1
<b>Level of education</b>	No education	5
	1-8 years education	12
	9-10 years education	12
	11-12 years education	6
	Unknown	2
<b>Family type</b>	Nuclear	14
	Joint/Extended	20
	Unknown	3

<b>Sample characteristics</b>		<b>Number of Women</b>
<b>Woman's age</b>	< = 18	0
	19-24 years old	18
	25-29 years old	13
	30-34 years old	3
	> =35	3
<b>Woman's age at marriage</b>	< = 18	7
	19-24 years old	20
	25-29 years old	2
	30-34 years old	0
	> =35	0
	Unknown	8
<b>Years of marriage</b>	Married 0-1 year	5
	Married 2-3 years	11
	Married 4-5 years	8
	Married 6-10 years	4
	Married > 10 years	2
	Unknown	7

<b>Sample characteristics</b>		<b>Number of Women</b>
<b>Caste</b>	Forward cast	0
	Backward cast	6
	Most backward cast	14
	Schedule cast	5
	Schedule tribes	2
	Unknown	10
<b>Religion</b>	Hindu	27
	Christian	6
	Muslim	0
	Unknown	4
<b>Occupation</b>	Housewife	27
	Weaving	1
	Stone factory	2
	Field work/farming	2
	Computer worker	1
	Health personal	3
	Unknown	1

Source: Own data



## 9.2 CLASSIFICATION OF BENEFICIAL, NEUTRAL AND HARMFUL TRADITIONS

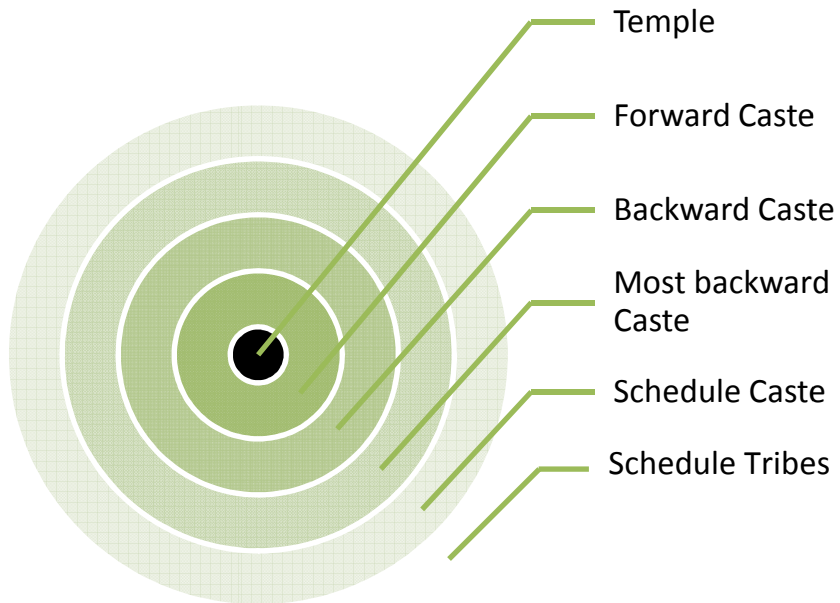
Table 2 Beneficial, Neutral and Harmful Traditions

Beneficial	Neutral	Harmful
<ul style="list-style-type: none"> <li>• Institutional Deliveries</li> <li>• Antenatal care</li> <li>• Breast feeding</li> <li>• Shared or avoided hard households work</li> <li>• Women relieved of work after delivery at parent's house</li> <li>• Wearing leather shoes during pregnancy</li> <li>• Take a rest during midday 12.30, during pregnancy</li> <li>• Stay at the parent's house before delivery for rest and nutrition</li> <li>• 'Seemantham'</li> </ul>	<ul style="list-style-type: none"> <li>• Wearing amulets black kohl dots in baby forehead, and twisted strings around baby's neck, wrists-keep evil away</li> <li>• Stay at the parent's house before and after delivery</li> <li>• Avoid travelling at jam-packed busses</li> <li>• Consumption of Saffron and avoidance of black items</li> <li>• Fear of evils</li> <li>• Consumption of homemade remedies such as 'Kashayam' during pregnancy</li> <li>• Wearing iron items, herbal leaves, and kohl during and after pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>• Changed dietary habits and food taboos for pregnant and postpartum women</li> <li>• Eating less to avoid large babies</li> <li>• Restrictions of water intake during pregnancy and initial postpartum</li> <li>• Son's preference</li> <li>• Prolactal feeding to newborn baby such as honey and donkey milk</li> <li>• Treat neonatal illness with homemade remedies, delay treatment by health personnel</li> <li>• Initial fast of three days after delivery of new mother</li> <li>• Withholding colostrums feeding for the newborn</li> <li>• Isolated and restricted to stay inside the house the first 11 days after delivery, if delaying health care</li> <li>• Traditional initial first bathing a newborn if hypothermia</li> <li>• Home deliveries</li> </ul>

Source: Own data

### 9.3 MAP OF RESIDENTIAL AREA

Figure 2 Residential area and caste



Source: Own data

#### 9.4 CLASSIFICATION OF HOT AND COLD FOODS

Table 3 Hot and Cold classification in Kancheepuram District.

##### Hot Items

Alcohol  
Black grapes  
Chicken (very hot)  
Chilli  
Coconut  
Coffee and tea  
Dates  
Dried fish  
  
Egg  
Garlic  
Guava  
Jackfruit  
Jiggery  
Mango  
Mutton  
Non-vegetarian food, meat  
Oily items  
Onion  
Papaya  
Peanuts  
Pineapple  
Pork (extremely hot)  
Pumpkin  
Sesame grains  
Spices in general, Curry, (masalas)  
Wheat flour

##### Cold Items

All leftovers  
Apple  
Banana (green banana; ok)  
Chutney  
Coconut  
Milk, Yoghurt  
Most fruits  
Most vegetables especially green leafy  
vegetables  
Orange  
Refrigerated cold items  
Rice, tomato rice, curd rice  
Sugar  
Butter milk  
Isel (small insect)

Source: Own data

## 9.5 NUMBER OF INTERVIEWS AND RESPONDENTS

The summary below shows the interviews were held and it also shows how many respondents in each place.

The table also shows that forty-one, (41), interviews were carried out, with a total of fifty-six, (56), respondents. Of these were four group interviews, (3,4,5,7=19 persons) and thirty seven, (37), individual interviews.

### Chennai City

080808, 1 individual interview with woman

### Nattapattai Village

080828, 2 individual interviews with women

081001, 1 group interview with 5 men

### Meensaki Medical Hospital

080915, 5 individual interviews with women

### Kilar Village

080916, 4 individual interviews with women

080930, 1 group interview with 7 men

### Marutham Colony

080916, 2 individual interviews with women

### Avalur Village

080917, 5 individual interviews with women

### Uttiramerur Town

080918, 4 individual interviews with women

080918, 1 group interview with 3 elderly women.

### Walajabad Town

080919, 4 individual interviews with women

### Arpakkam Village

080919, 7 individual interviews with women

## Vagariyar Nagar

080924, 1 individual interview with 1 dai

080924, 1 group interview with 4 respondents (1 woman and 3 men)

## Han in Hand office Kancheepuram

080929, 1 individual interview with female nurse

080930, 1 interview with 2 female nurses

## 9.6 ADDITIONAL INFORMATION VILLAGES

Table 4 Demographic information

<b>Village</b>	Number of Households	Number of inhabitants	Main occupation of inhabitants	Distance to nearest health care	Distance to Kancheepuram City
Arpakkam Village	815	2734	Stone Factory	20 km Kancheepuram	20 km
Avalur Village	486	1194	Farming	0 km PHC* in Village	23 km
Kilar Village	353	1500	Farming	8km PHC*	20 km
Murugan Colony	570	2189	Silk Weaving/ farming	7 km Kancheepuram	7 km
Nattapattai Village	286	1259	Silk weaving	6 km Kancheepuram	6 km
Uttiamerur Town	6136	23656	Not applicable	0 km PHC * in Town	25 km
Walajabad Town	8626	43380	Not applicable	0 km Own hospital in town	21 km

Source: Own data

\*PHC, Public Health Centre

## 9.7 INTERVIEW GUIDE

### **Informed consent**

- Thank you for taking part in this interview.
- Give a short background to the interview. (I inform very short about the purpose).
- I will use a voice-recorder during the interview. Does the person have any questions regarding this?

Note place, date and time, and number for interview!

### **“Softening” socio-economic questions:**

- Age
- Marital status
- Length of marriage
- Educational level
- Occupation
- How many family members in the household
- Number of children/ age of the children
- Religion
- Resident area

### **Theme: Pregnancy, Delivery, and postnatal care.**

Can you tell me / Do you remember / What happened in that episode you recently mentioned?

- Behavioural precautions/ practice
- Food/nutritional taboos etc
- Preparations regarding giving birth

**How did you realize that you were pregnant? When did you realize you were pregnant?**

Can you give a more detailed description regarding this? Do you have some more examples regarding this? Can you say anything more regarding this?

What did you think then? How did you react? Have you experienced this by yourself?

**Can you tell me something about your childbearing, did it affect your daily life somehow?**

- Behavioural precautions / practice
- Dietary precautions

Can you give a more detailed description regarding this? Do you have some more examples regarding this? Can you say anything more regarding this?

What did you think then? How did you react? Have you experienced this by yourself?

**Can you tell me if you made some preparations to have a normal/easy birth?**

How did you realize that your delivery started?

- Behavioural precautions/ practice
- Dietary precautions
- Where were you living at the time of delivery
- Where did you deliver?
- Who was with you during the delivery?
- Who assisted you?

Can you give a more detailed description regarding this? Do you have some more examples regarding this? Can you say anything more regarding this?

What did you think then? How did you react? Have you experienced this by yourself?

**Can you tell me something about the period after delivery?**

- Behavioural precautions/ practice
- Dietary precautions
- Where did you live?
- Who nursed the baby?

Can you give a more detailed description regarding this? Do you have some more examples regarding this? Can you say anything more regarding this?

What did you think then? How did you react? Have you experienced this by yourself?

**Can you tell me something about your breastfeeding/ lactating practice?**

- How long did you breastfeed?
- When did you start to breastfeed/ how soon?
- Did you give colostrums feeding?
- Was breast milk the first thing you gave your baby? (or something else?)
- Dietary precautions

Can you give a more detailed description regarding this? Do you have some more examples regarding this? Can you say anything more regarding this?

What did you think then? How did you react? Have you experienced this by yourself?

**Can you tell me something regarding how nursed the baby?**

- Practices?
- Who nursed the baby the first time after delivery?

Can you give a more detailed description regarding this? Do you have some more examples regarding this? Can you say anything more regarding this?

What did you think then? How did you react? Have you experienced this by yourself?

**I do not have any more questions; do you have anything else you want to tell me before we end the interview?**

*Finally I will write down or record my immediate impressions I have regarding to the interview, this will give me valuable background to use during analyses.*



## 9.8 THE STORY OF 'SELVI' A RURAL HINDU WOMEN

Below is a short novel that describes in general terms the women I meet during my stay in Kancheepuram. I have used my findings to invent the story, and I know it is risky to generalize, but I will take the chance.

Look whom is coming down the dust track! It's Selvi a 20 year rural Hindu woman who lives here in Tamil Nadu. She looks very exhausted in her advanced pregnancy. She is expecting her second child within a month, and she probably yearns that the pregnancy will soon end. She is married two years, and lives together with her husband in the nearby rural village. The extended family also consists of her husbands elderly parent's and his brother with his wife and their children, a total number of eight persons. The village consists of fifty households', and the main source of income among the men is agriculture. Selvi herself is 'just a housewife', and has finished school after six years, at an age of twelve years.

Today she is on her way to the village health nurse for an antenatal check up. She tries to go every month as the health personnel recommended, but sometimes her mother in law thinks it's unnecessary, and then she continues with household work instead. She really does not know why she has to go to for these check-ups, but she has heard it has something to do with the growth of her baby. Sometimes she even gets an injection, she does not remember why, but that doesn't matter, it's western medicine, so it must be good. On the other hand she does not like the black tablets they want her to take. The elderly women in the village have told her they are too 'hot', so she will definitely avoid them. She is hot enough! Don't the skilled health personnel know that she is in a hot state during her pregnancy, and if she takes even more 'hot' tablets she will risk losing her baby? That undesirable experience she already has had. Last year she gave birth to a stillborn baby boy, just before she was going to celebrate 'Seemantham'. What a sad memory.

She had followed all the advice from her mother in law and the rest of the elderly women in the village. She had avoided hard household work, and also avoided of water, since she didn't want to get sick or bring coldness to the baby. Sometimes even her mother in law shared her heavy household duties with her. She slept on the left side, she is sure about that. Avoided travel by bus, solar eclipses, and the hardest of all, to remember all food restrictions. In the beginning it was no problem since she had had morning sickness and vomiting, but later on!

She couldn't eat fruits such as papaya, mango, guava, jackfruit or pineapple since they cause abortion. She also kept to strict vegetarian food even if she yearned for chicken or mutton. Her wish for a fair skinned baby made it easy to avoid all black items such as black grapes and coffee. Her neighbours even recommended *saffron for a fair baby*, that's why she started to eat 'the red flower' in the sixth month of her pregnancy, and she would continue until delivery time.

Selvi was convinced that the evils have caught her baby! Also the elders in her village were of the same conviction. Everybody knows that evils are very attracted to pregnant women since the women send out a special smell. She had avoided going outside during the evenings and night time, and she had protected herself with herbal leaves and coral, but anyway! It must have happened during midday, at 12.30. She was told to stay inside and rest after lunch, and avoid all kinds of household work, but one day she just has to leave the house since a big snake had entered her house. The more that she thinks about it, it must have happened that day! Shortly after she started get labour pains, and delivered a son at home with assistance of the dai in the village. No, she does not want to think more about it! Soon it's time for her traditional pregnancy ritual called 'Seemantham' in Tamil. Every pregnant woman is celebrated in her ninth month of pregnancy. All people in the village will celebrate and honour her with food and gifts.

The day after she will leave her husband's house and return to her relatives and her parent's house to stay there until delivery and the first months afterwards. She aches already! At her parent's house she is allowed to rest and she will have some more food. Her mother and her sisters will follow her to the hospital to deliver this time. She feels a little bit afraid of this, to be alone at the hospital, and nobody that cares about her, but anyway, she will manage. Then she will become a mother, and the other women will respect her a little bit more! The first time she is restricted to stay inside her parent's house, since she and the baby are very polluted and unclean. They are also very vulnerable and attractive for evils, so her mother has promised to perform all kinds of different rituals to protect her and her baby. Of course they will perform 'vately', and also put black and red string around the baby's waist, wrist's and neck, and of course put a black kohl dot in the baby's forehead. The worst problem is the celebrating relatives. Think if they bring the evil eye with them when they enter the house, God help us! But it will certainly help if we perform some blessings for the baby.

An elderly woman is already asked to come and help her with the daily herbal baths and another woman will give massage to herself and her baby. After eleven days they will also give the baby it's name and she is already looking forward to this. She will of course breast feed her baby. The elderly women have told her not to give the first milk, but the health personnel told her to do so, and she thinks she will follow this advice. Her mother in law will of course give the newborn baby some honey for 'sweet voice', and donkey milk as protection against sickness. She will agree to this since she also has had this as a child, and she is strong and healthy, and has a nice voice. She is a little bit worried about giving a cold to the baby and just has to remember to dress herself in warm clothes and avoid all kinds of cold items. Oh dear, we cannot delay her, she is already late and her mother in law is probably already annoyed. She moves away from us, but she will always stay in my mind.

Kristina