Pregnancy, Delivery & Family Planning

A study of health-seeking behaviour in Meopur village in Rajasthan, India

Master Thesis submitted to Department of Social Anthropology

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Pregnancy, Delivery & Family Planning
Abstract
The objective of this thesis is to present an interpretive account of how knowledge influences health seeking behaviour related to pregnancy, delivery, postpartum and family planning and how such knowledge affects the utilization of government health-services. This thesis builds on eight months of fieldwork I conducted in India in 2010, from January to July and one-month revisit in December. I lived in Meopur village for five of the eight months of fieldwork.

Villagers have a wide spectrum of ideas and practices to ensure fertility, and to protect mothers and their newborn babies against illness and malignant forces. This confirms that “Mother- and Child-health” has been and still is a major concern for the villagers in Meopur. During the last decade, Mother and Child health has also increasingly become a focus in the global agenda. United Nations Millennium development goal number 4 is to reduce infant and child mortality rate with two-thirds-, and goal number 5 is to reduce maternal-mortality ratio by three quarter between the years 1990 and 2015. The Indian government has introduced several health initiatives since 2005 whose goals are to reduce the risks of maternal and child mortality in India. This includes engaging local women to motivate new mothers to start breastfeeding right after delivery, to breastfeed exclusively for six month after delivery and to eat nutritious food during post partum. The government hopes to increase the number of women who give birth at hospitals and to make them responsible citizens, and to limit their family sizes through the use of contraceptives.

Governmental health workers introduce new knowledge and practices to the villagers, and desires to change what, from their perspective, is perceived as harmful practices performed by backwards and illiterate villagers. Practices which they see as potentially dangerous to mother and child. The villagers see these practices as necessary precautions to prevent severe risks of illness.

Different types of Knowledge concerning mother and child health are unequally distributed between healers, doctors, health workers and villagers, between grandmothers and new mothers and, of course, between individuals. How does this affect the villagers’ health seeking behaviour?
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Chapter 1
Introduction

Villagers in Meopur have a wide spectrum of ideas and practices to protect mothers and their babies against illness and malignant forces. This confirms that Mother and Child health has been - and still is - a major concern for the villagers. During the last decade, Mother and Child health has also increasingly become a focus for the global agenda. United Nations Millennium development goal number four is to reduce infant and child mortality rates by two-thirds, and goal number five is to reduce maternal mortality ratio by three quarters, between 1990 and 2015\(^1\). In 2005, the Indian government launched the National Rural Health Mission, with several new health-initiatives whose goals are to reduce maternal and child mortality in India. This includes engaging local women to motivate mother to start breastfeeding right after delivery, to breastfeed exclusively for six months after delivery, and to continue to eat nutritious food during postpartum. The government hopes to increase the number of women who give birth at hospitals. In addition, the government hopes to enable people to become responsible citizens, who follow official health advice, vaccinate their children and who plan and limit the size of their families, preferably to two children, by the use of contraceptives.

Governmental health workers introduce new knowledge and practices to the villagers, and works to change what - from their perspective - is perceived as harmful practices performed by backwards and illiterate villagers, practices they see as potentially dangerous to mother and child. The villagers however, see these practices as necessary precautions to prevent severe illness.

This thesis’ objective is to present an interpretive account of how knowledge influences health seeking behaviour related to pregnancy, delivery, postpartum and family planning, and how such knowledge affects the utilization of government health services. In the following part of the introduction I will first place my thesis within the field of anthropology, and in relation to similar studies from India and Rajasthan. Then I will provide an extensive discussion of how “Knowledge” is used for analytical purposes in this thesis.

\(^1\) In Rajasthan; Maternal Mortality Ratio (2007-2009) were 212 cases pr 1,00,000 birth(SRS, 2011a), Infant Mortality Rate (IMR), number of deaths of babies under one year of age per 1,000 live births. (2009) were estimated to be 65 in rural areas and 35 in urban areas in Rajasthan (SRS, 2011b)
This thesis builds on eight months of fieldwork I conducted in India in 2010, from January to July and a one-month revisit in December. I lived in Meopur village, in the state of Rajasthan in India, for five of the eight months of fieldwork.

**“Birth” in Anthropology**

This thesis falls under Medical anthropology and the subfield anthropology of birth. Prior to the middle of the 20th century anthropologist paid little attention to childbirth. This lack of attention could have been due to the fact that birth, to a large degree, is a female domain, or that birth was seen as a biological process and therefore of little interest to anthropologists (Hollen, 2003, p. 10). Several studies have been introduced to this field since then. In the book “Birth in Four Cultures”, Birgit Jordan (1978) shows that birth can be studied as a cultural system. She points out that it exists variations in the socio-cultural dimension and in practices among biomedical hospital deliveries in different countries as well as in societies practicing home delivery and midwifery. Hospitals differ to what extent they favour natural delivery, routine use of epidural, etc.

The number of anthropologists who have studied childbirth in India has been increasing. Community studies have situated delivery practices within the social, economical and cultural context of villages throughout India (Jeffery & Jeffery, 1989; Patel, Fertility behaviour: Population and Society in a Rajathan Village, 2006). Patricia and Roger Jeffery (1989), (1993) have written about the delivery-practices in a village in Bijnor district in Uttar Pradesh India. Jeffery (1993) emphasizes that variations in contextual factors provide women with different abilities to organize resources on their behalf at the time of birth. Factors such as socio-economical conditions, household organisation, women’s position in the household, others’ perceptions of birth, and perceptions of physiology and cosmology are important to take into account in an analysis of this subject. These factors influence women’s access to resources, including knowledge. Also social support, money, and various types of medical resources, determine their options (Jeffery & Jeffery, 1993). Maja Unnithan-Kumar(2001) has studied health-seeking behaviour related to child-bearing in a village in Jaipur in Rajasthan. She emphasises that there is a large difference in how high-, middle- and lower-caste women are treated in their meetings with public and private doctors, which also makes poor women from lower castes more fearful in their experiences with health personnel and biomedical technologies than upper and middle caste women (Unnithan-Kumar, 2001, p. 73). Another anthropologist who has studied childbirth is Tulsi Patel (2006). She has studied fertility behaviour in a village in Jodpur, Rajasthan. When Patel (2006) and Jeffery (1989) did their
field work, women in the villages gave birth at home, with assistance from relatives and traditional birth-attendants (Dai), and handled deliveries without anxiety. Expertise from trained health personnel at hospitals was only seen as necessary in emergency situations (Patel, Fertility behaviour: Population and Society in a Rajathan Village, 2006, p. 111). Similar to these studies, my study is also a community study. However, during the last five to 10 years an increased presence and utilization of government health services has occurred in Meopur and other villages. After 2005, a majority of women have given birth at hospitals. Due to this, there is also a significant difference between our studies.

Changes from home to hospital deliveries has also been a focus in the study of Cecilia van Hollen(2003) in her study of childbirth and modernity among urban and semi-rural women in Tamil Nadu. Many of these women said they gave birth at hospital because “These day we are modern” (Hollen, 2003, p. 209). Hollen shows it was common to equate education and good citizenship with the use of modern maternal health care services and family planning. Although Meopur is located at the other side of India it is equally true that many equate education and good citizenship with the utilization of government health facilities in this region(Nordfeldt & Roalkvam, 2010). The villagers in Meopur were seen by others as backwards, illiterate and resistant. In Meopur as elsewhere, there are both traditional elements as well as integration of new elements in knowledge and health-seeking behaviour, also related to pregnancy, delivery, postpartum and family planning. Knowledge of various kind influences their health seeking behaviour in this period. The way I use the term knowledge is elaborated bellow.

**Knowledge**

I have deliberately avoided using the term “Belief” to describe the ideas and practises that villagers in Meopur see as knowledge and it will not be used regarding knowledge held by healers, or government health workers. What people in other cultures regard as knowledge has often been called “belief” as opposed to western scientific knowledge, or the knowledge of the anthropologist (Good, 1994). “Belief” may have connotations of superstition and incorrect knowledge; hence, when it is used about lay- and popular-knowledge in foreign cultures it thereby simultaneously discredits their knowledge (Good, 1994, p. 39). Such use of the terms “belief” and “knowledge” has become increasingly problematic for medical anthropologists after the end of the colonial-time. In the last 60 years several anthropologists have re-thought how we should present “the others”, i.e, people living in cultures with ideas
and practices different from our own. An increasing self-reflection has created awareness that all “human knowledge is culturally shaped and constituted in relation to distinct forms of life and “social organisation” (Good, 1994, p. 21). Various knowledge traditions have distinct criteria for judging validity (Barth 2002). The western natural sciences, including western bio-medicine, have given priority to knowledge that can be tested by hypothetic-deductive method and to what is physically measurable, i.e., the body has been given priority over the soul. Several non-western medical traditions have a different epistemological background: they embrace holism, they view everything as connected; a dynamic and reciprocal interplay between the individual person and the universe. The soul (subtle body) is seen as just as real as the physical body (Schepar-Hughes & Lock, 1987). Ayurveda is one such tradition in India. This medical tradition has been more influential on how people in India, and Meopur, understand the body/soul, than the western- or biomedical-tradition. Byorn Good (1994) reminds us that “the language of medicine is not only a mirror of the empirical world, it is also a rich and cultural language linked to a highly specialized version of reality and of social relationships. “To be able to understand other cultures’ medical knowledge, we need to see it in relation to the semiotic field from which it originates (Good, 1994, p. 111).

Wikan (1992) reminds us that we must not forget to include the human endeavour; - the worries and concerns of those we study in our approach and analysis. Good (1994) emphasize that “meaning and knowledge are always in reference to a world constituted by human experience; formulated and apprehended through symbolic forms and distinctive interpretative practises”(Good, 1994, p. 177). I have used this as a guide-line, in my study and in my encounter with villagers in Meopur.

The term “popular knowledge” will be used to refer to villagers’ understanding of health and illness, but also to other types of knowledge the village possesses. Popular knowledge is not a fixed or static body of knowledge transferred from one generation to another, although it also includes knowledge transferred in this manner. The way I approach popular knowledge is inspired by Fredrik Barth (2002) in the article “SIDNEY MINTZ LECTURE 2000: An Anthropology of Knowledge.” Bart (2002) does not offer an essential/positive definition of what knowledge is. He is more interested in how we can pragmatically use it to improve our analysis. He conceptualizes knowledge as - “what a person uses to interpret and act in the world”. By this he means it is where people engage in such tasks that we should look for empirical manifestations of knowledge. Knowledge, in the sense Bart uses it, is not limited to
information, concepts or verbal taxonomies. It includes what a person experiences, sees and hears, and also embodies skills and feeling (attitudes). All are ways of understanding that we use to make up our experienced-based reality. Tulsi Patel (2006) emphasises that “Fertility behaviour is the outcome of knowledge - rational, evaluative, effectual or customary - which actors have about child rearing and child bearing” (Patel, Fertility behaviour: Population and Society in a Rajathana Village, 2006, p. 4)

According to Fredrik Barth (2002), the value of using the concept “knowledge” instead of “culture”, which frequently has been used by anthropologists, is that “knowledge” helps the anthropologists approach their material differently—in an improved or more adequate manner. “Culture” gives a connotation of a diffuse sharing of cultural ideas, practices and traditions among members in a society, while “knowledge” makes it easier to see the unequal distribution of such ideas and practices among the members in a society. In this way, the focus can instead be on how knowledge circulates in specific ways among members of a society. The process affecting these distributions can become the object of study, to help us understand how persons reflect and act as they do. (Barth, Sidney Mintz Lecture 2000: An Anthropology of Knowledge, 2002)

With this perspective, it is possible to see the variations between individuals within Meopur, what knowledge they have, and what knowledge influences their health seeking behaviour at the time of pregnancy, delivery, post-partum and family-planning. Villagers in Meopur accumulate knowledge through several types of relationships. Some knowledge is learned from elders, some in encounters with diverse types of experts, healers or health workers and doctors. Other types of knowledge are from their own or others’ experiences and observations which is shared through gossip and conversation in their interactions with other villagers and relatives.

When I approach the second part of my objective “how knowledge influences the utilisation of government health services in Meopur” (in chapters 4 and 5), I will outline the role of lay health workers, the availability of government health services and the strategies the Indian government uses to increase utilization of the health services, i.e., what Foucault has called “governmentality”. I will use Aiowa Ong(2007) division of “Technologies of Subjectivity” and “Technologies of subjection” in the analyse of the governmental strategies to increase
utilization of government health services. (Ong, Neoliberalism as exception: mutations in citizenship and sovereignty, 2007) I will also discuss the process of knowledge transferral. How knowledge is transferred from various “experts” and health-workers to villagers in Meopur and how this influences health-seeking behaviour. In his article “Guru and the Conjurer” Barth (1990) presents two different” ideal” models of transferring knowledge. Both bring status to the “expert” and validate his knowledge, but they create different effects in the society.

The Balinese Guru actively shares his knowledge, His medium is “words”, he teaches. He sees it as essential that his followers understand his message. The gurus teaching is explicit, and his students logically integrate it through a accumulative learning process. It is by making his pupils understand the information that the Guru brings about change. The Conjurer in New Guinea, however, increases the status of his knowledge by keeping it secret from others. He only shares parts of in the form of esoteric rituals, (not speech), performed during ceremonies and communication with dead ancestors, due to their higher status. It is through being present at ritual ceremonies his followers or the lay-people profits from his services. Barth says that the Conjure’s knowledge is characterized as “weak of abstraction and transportability”. In accordance with Barth I will focus on the process of knowledge transferral from healers and lay health-workers, to the villagers. How is knowledge validated? How is knowledge transferred, what ideas, does it enabling villagers in Meopur to make informed choices? What effect has it on villager’s health-seeking behaviour?

**Method**

The research this thesis is based upon the long tradition within Social Anthropology for using participant observation during extensive fieldwork in different cultures around the world. By positioning myself in a village in Rajasthan in India, I acquired knowledge through living, participating and observing the life of my host family and villagers. This strategy creates access and new opportunities for participating and observing different events, having contact with different people in the village, and having conversations (semi structured interviews), while at the same time making observations (Bernad, 2011, p. 257).

More importantly, living with a family in the village provides an opportunity to engage in people’s lives, share experiences and learn about their concerns and intentions. This manner of meeting people has been emphasised by Unni Wikan (1992) in the article “Beyond
the words: the power of resonance”. An active and emphatic involvement can help us understand what is at stake in a person’s life; it creates “resonance”, an understanding of the human endeavour among persons with different backgrounds (Wikan, 1992). To experience daily life in the village and to observe aspects such as facial expressions, body language, emotions, and interaction enhances the researcher’s sensitivity to situational factors and provides important supportive data for analysis (Patel, 2006, p. 11). Involvement is more natural and less intrusive to persons than pure observation and interviews (Stewart, 1998, p. 24).

**Host-family and village**

A NGO worker helped me to locate a host family in Meopur, the village where I conducted my research. Meopur had a population of 1,553 at the time of my fieldwork. The inhabitants were low-caste Hindus and Muslims divided into several caste-like groups. The family I stayed with were Jatav, a Hindu low-caste. The village will be described in detail in the next chapter. The family I lived with consisted of an elderly couple, their three married sons and their wives and children. Living with this family, I had good access to see the dynamic of a joint-family and to observe activities related to mother- and child-health in the village.
The family-tree above shows the composition of my host-family. Both personal names and the name of the village are replaced by pseudonyms in this thesis. Sensitive information has been left out or made anonymous.

Ambu, the wife of the youngest son, became a key-informant. Ambu was pregnant during my fieldwork. She had struggled for several years to get pregnant. The detailed narrative she gave of her struggle to conceive provide an insight into health-seeking behaviour, as well as an understanding of how important it is for a woman to get a child. The middle-son and his wife had a five months old daughter; thereby I got the opportunity to observe the care of small children within my host-family. The two daughters-in-law, Ambu and Rangini and the husbands of Rangini, were among the lay-health workers, who should inform, motivate and mobilize villagers to utilize government health services. Their roles and work will be further explained and discussed in chapter four.

Living with a host family in Meopur was a special experience, a 24 hour-a-day activity. Initially my host family was somewhat confused and unsure about my “role”; - was it all right to let me participate in the daily tasks related to household and agricultural? They let me participate because I insisted. After a week, Rangini got the opportunity to speak with my supervisor on phone. My supervisor told her it was favourable for me to participate in the daily-work; hearing this made Rangini very happy and relaxed –my participation was not an issue anymore. After my host-family became familiar with me, they performed their daily tasks as usual, which also increased the validity of the observation.

**Language and research assistance**

During preparation for my fieldwork, I learned some sentences in Hindu and I picked up more phrases during my field work. I also had a translator/ research assistants who assisted me during the majority of my field work. Since subjects such as pregnancy and delivery is, are subjects within the female-sphere, and also due to the strong division between sexes in the village, a - female - assistant was to be proffered. During my fieldwork, I had two different assistants, both females and Brahmins. There were no low-caste or Muslim females and few females among the applicants of assistant job. The assistant I chose came from a village nearby. She was educated with a Master-degree. She had an urban way of dressing (jeans), but she agreed to dress according to village standards when she worked as my research assistant. She did not like to ask the villagers about differences related to caste and religion.
Avoiding sensitive question related to caste differences, may have imposed some limitations on the material. But, not introducing such questions might also have made it easier to avoid faulty caste generalisations, and to see individual differences within castes as well as similarities between castes and religions, i.e a focus on the individuals experience and concern. My other research assistant, who assisted me for some weeks, had minimal English skills, but she had previously been a research assistant (for Cecilie Nordfeld). She did approach villagers in a humble and emphatic--manner. This approach encouraged people to share their experiences from their personal life.

**Research method in the field**

Many of the conversations we had with villagers were recorded and later transcribed by one of the assistants. By recording the conversations and semi-structured interviews it was possible to delay some of the translations, preserving the details and allowing people to speak without being uninterrupted. One limitation is that the translation of the recordings was directly into English. Therefore, I am not always able to provide the exact native term.

In addition to participating in the daily household-chores, I attended several celebrations, different health-events such as “Mother Child Health and Nutrition Day”, a sterilization camp, a hospital delivery and a Cooper T campaign-day. I also visited healers.

During my fieldwork, I also had many conversations and semi-structured interviews with a wide spectrum of villagers. Because knowledge is differently distributed, I tried to include a variety of people in the conversations. Because pregnancy, delivery and infant-care belong to the female-sphere, the majority of the conversations and interviews were with women, I tried to include women of all age groups; young girls, mothers, mothers-in-law, grandmothers, and even some great-grandmothers. We visited many of the villagers in their homes; some of them we visited several times. We attempted to include persons from all the different Hindu- and Muslim- castes in the village. Men were also interviewed, but to a lesser extent than women. This was also due to the strict gender-division in the village. I also talked with health workers at different levels, with persons in the health administration, members of the village council, healers, traditional birth attendants, members of non-governmental organisations.

I did not get the opportunity to observe a home delivery. This is a limitation to my fieldwork. However, many women of different ages told me about their experiences and practices related
to home delivery. I also visited women during their pregnancy, shortly after delivery. Some women I visited several times during the post partum period.

The majority of my fieldwork was done during the harvest and summer seasons. During my first trip I also experienced the beginning of the monsoon season. I revisited the village in December (One month). Thus I also got an opportunity to experience a part of the winter season. In this way, I was able to obtain a good impression of seasonal changes and the effects seasons have on diet, daily routines, agricultural work, resting periods after pregnancy, etc.

Studying a subject such as Mother and Child health can pose dilemmas; fx whether one should interfere in a situation or not. We (in one case Cecilia Nordfeld and Anita, in the other case Ragini and me) initiated two hospital-visits. We also paid for transportation and medicine. Here, our initiative obviously influenced the health-seeking behaviour of these two mothers who had recently given birth. But our involvement also caused these women to be more open and interested in sharing their experiences. Lack of money and anxiety for being alone at the hospital were reasons that prevented them from going to hospital. These visits enhanced my understanding and empathy for the villagers; the feeling of fear many villagers experience when being in the unfamiliar setting of the hospital. I also made me aware of the the importance of social support in such settings. So methodically correct or not, I felt it were a mutual benefit, (they and their baby recovered).

During my fieldwork, I tried to be as open as possible about who I was and the purpose of my study. The assistants helped me informed the villagers and the recorder was only used with consent from villagers. The role of the social-anthropoligist is often an unfamiliar to the native inhabitants and suspicions and unfounded rumours might arise(Berreman G. D., 1962). Some of the villagers in Meopur did indeed begin to speculate about the “real” purpose of my presence. These speculation originated in families mostly we had not yet visited. We decided to visit them and informed them about the purpose of my fieldwork, after this conversation they became trustful and relaxed; afterwards they called me to come and talk when I passed their houses.
Thesis Outline

Each of the chapters in this thesis addresses different aspects which I regard as important for the understanding of the health seeking behaviour.

Chapter 1 (this chapter) outlines the theoretical framework and method, and how I situated myself in the field.

Chapter 2 presents an outline of the economical, socio-cultural, context. Special attention is paid to women’s position in household and society.

Chapter 3 focus on how the popular medical knowledge villagers have (about mother- and child-health) influences their health seeking behaviour. This includes ideas and practices related to diet, spirit and cosmology/religion, The chapter presents a case; Ambu a young woman struggling to get pregnant. It illustrates how erratic the health-seeking behaviour can be.

Chapter 4 I this chapter I will provide an outline of governmental health-services and present the new schemes that have been introduced in Meopur. In this chapter I will also present and discuss the role of the lay health-workers in the village. Mother and child health and family planning will be focused.

Chapter 5 In this chapter I will look at how villagers evaluate, integrate and apply the health knowledge from different sources. Special attention will be paid to how the inhabitants regard the government health services, and how this affects their utilization of these services.

Chapter 2

Social and economic organization in Meopur village

The intention with this thesis is to analyze how knowledge influences health-seeking behaviour related to the health of mother and child in Meopur. To be able to achieve this, it is essential to have some knowledge about several aspects that influences the life of the villagers; such as geographical location and climate, religion, caste, economical condition, education and household organization.

Geographical location.
Meopur is located in Alwar, a district in the state of Rajasthan, in the north eastern part of India. The distance from Delhi is approximately 170 kilometres. In the past, the area of Meopur belonged to the historical region of Mewat. Mewat was located at both sides of the borders between Rajasthan and Haryana.

Fig. 1. Map of India and the location of Rajasthan and Meopur

**The ecological setting of Meopur.**
The landscape of Meopur is semi-arid. There are significant seasonal changes in climate and temperatures during a year. Four main seasons influence the rhythm of village-life in this area. March - April is the harvest for the major crops (mustard, wheat and oats). This period is characterized by intensive work. The temperatures increase gradually during this period. From May to June it is summer, the hottest period of the year. The median temperatures are 41 °C. during the days and 28 °C. during the nights. According to a local newspaper, the temperature lingered just below 50 °C. for a long period during my fieldwork. Summer is the season for lady-fingers, bitter guard, cucumber, watermelon and sweetmelon. However, the majority of the agricultural fields are left to rest uncultivated during this period. The heat is seen as dangerous to the health in the middle of the day, between 12 pm and 4 pm. In this period villagers tried to avoid being in the sun and they rest if possible. They cover their heads to avoid heat-stroke. The heat inside the houses is unbearable, so villagers sleeps outside during the night. The rainy season starts in July and lasts to October. The rain provides relief from the heat. When the rain comes, the villagers begin ploughing and seeding the agricultural fields and the landscape grows green again. The roads easily get muddy and the rain water might create holes, so work to repair roads is also necessary during this period of the year. There is an increase of insects. Kerosene is poured in stagnant water pits to prevent mosquitoes from breeding, and to further prevent outbreaks of malaria. The winter season lasts from November to February. Day temperature is pleasant but temperatures during the nights can drop below 8° C. Villagers then sleep inside, due to the low temperature they sleep with their winter-clothes. Jackets and warm head -shawls are kept on during the night. It is also common that two people of the same gender share blankets to stay warm during the night. In the cold mornings and evenings villagers group together around a fire in
their courtyard. Crop watering is a major task during this period. It is also the harvest season for sesame and lentils.

Outline of the village
The map below shows the outline and major characteristics of Meopur. The map is constructed partly from observations during my field work, and partly by viewing a satellite picture on Google map.

Almost all families owned smaller or larger patches of fields located some distance from their houses.
People from the same caste were usually relatives and it was common that relatives lived close to each other. In the densest cluster of houses, located in the centre of the village, a majority of the service-castes lived, in this cluster there also lived a few Meo-families. In the rest of the village it was most Meo-families. There were some houses located in the fields; belonged to Meo- Jatav- and Fakir-families who had relatives living in the central parts of the village.

**Material development in Meopur**

The distance from Meopur to the nearest city is 12 km. Meopur is easily accessible; located near the main road. Public and private busses leave for the city every five minutes during the day. The fee is 10 Rs public busses and 5 Rs for truck transport. Local truck drives stop at the bus bay, to offer people transport. The trucks have six passenger seats, but since the floor and the outside are utilized, they often transport is around twenty passengers. On the way from the city to Meopur, there are several villages like Meopur; clusters of houses surrounded by a
patchwork of fields. These villages differ in composition of castes and religion. Larger villages often include many castes. Small villages with populations below 2,000 usually have a more limited number of castes.

Despite the relative central location of Meopur, the material development in Meopur was low compared to the city and many of the villages in the area. The majority of houses in Meopur were made of bricks. Only one house in the entire village had a toilet facility. Villagers go to the fields to defecate. This is more problematic for the villagers during the summer than during the winter. In the winter villagers can easily hide in the high crops near the houses during the day. In the summer there is no crop in which to hide. Women wake up before the men in the morning and go to the fields before sun has risen, which during the summer is between 5:00 am and 5:30 am. In this way they avoid being seen by the men. At other times they will often choose to wait until dusk around 9:30 pm, when it gets dark, otherwise they will have to walk to more distant fields. Bath rooms were uncommon. Men usually take baths in the open courtyard. Women usually made an improvising shelter in the courtyard. Sometimes they took bathes within a room they used for living, which often has a drain.

The electrical supply of the village is irregular and has large breaks. This limits both the functionality and the time electrical devices can be used. It is not possible to store food in a refrigerator. Villagers cannot depend on electrical cooking-plates for cooking. Due to the sinking groundwater level, electrical driven bore-wells have become necessary. Bore-wells are expensive, so poor families without wells have to obtain water from other villagers. As electricity is unstable, women in many families without water-wells are often in a hurry to gather water when electricity is available. Sometimes this causes disputes with the well owners.

**Population, religion and caste in Meopur**

Caste is a central part of the social stratification in Meopur as elsewhere in India. Case might refer to both, varna - and jati. Varna is the classification of caste as in Hindu sacred scripture\(^2\). Jati refers to birth ascribed groups, associated with a traditional occupation and rank in society. If not otherwise is mentioned, caste, is used referring to jati. The term “caste” will be used both referring to Hindus and Muslims in Meopur. Caste is not founded in the Koran.

\(^2\) Twice born castes: Brahmin; the priests and people of learning. Kshatria; the rulers and worriers, Vaisya; the traders.

Once born castes: Shudra ; all cultivators, occupational and serving castes, and also those previously seen as Untouchables (Gupta, 1974, p. 22)
but it is common with similar divisions among Muslims in India (Berreman G. D., 1972). Only one of the Muslim caste in Meopur referred to a division called “Quom”. Quom is related to the geographical origins of the ancestors and their claimed relations to the prophet (Berreman G. D., 1972). The rest of them had converted from Hinduism. The relationship between castes in Meopur will be further illustrated below.

The population in Meopur was 1,553 at the time of my fieldwork. The Muslim-castes living in Meopur are: Meo, Sakka, Mirasi, Miya and Fakir, The Hindu castes are Jatav, Kumar and periodically Lohar. Meo is the dominant caste in Meopur. They were the traditional landowners in the village. The Meo-caste still own the majority of land. The Meo-caste still have a dominant position in the village which is reflected in the patterns of their relationship with other castes. They had been and still were the main recipients of both agricultural and ritual services from several of the other castes, although less than in the past Meo are officially categorized by the government under the category “Other backward class”. By the time I came to Meopur, I had heard about the “backwardness” of the Meos several times. I had heard about the Meo from people in the health system, from people working in NGOs, and from several people we interviewed for the position of research assistant. The backwardness of the Meo was usually described in social rather than material development. The Meo were said to be illiterate, uneducated, dirty, resistant and non-complying in relation to the government health program.

People employed at administrative levels in the District Government Health Services often referred to some castes as “good citizens”. These were the castes that make use of government health services i.e., those who used contraceptives and limited their number of children, gave birth at hospital, took vaccines, etc. Meo caste were specifically mentioned as backwards. They had many children, difficult to convince to utilize government health services and were illiterate.

According to Aggarwal (1966), Meo, until the time of partition, manage to draw upon an advantage of a double identity as both Muslims and Hindu, Kshatrias. After the partition, Meo were not able to hold on to this dual identity. Hindu regard Meo as Muslim (Aggarwal, 1966). This also implied a loss in status as illustrated above.

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3 The strong connection between modernity and citizenship and utilization of government health services in India has also been written about by Cecilia Van Hollen (2003) and Nordfeld and Roalkvam (2010).
Before the partition of India, Meo had Jajman relationships or patron-client relationships with the service castes. Land reforms distributed land to tenants from the services, and paid employment in town has also become common. This has, to some extent, reduced, but did not destroy, the dominant position of the Meo caste in Meopur.

The Mirasi offer services to the Meo caste during marriage. The Mirasi in Meopur distribute weddings cards and invites relatives of the bride and groom to meals. At the time of Lagan, the wedding ceremony, they go with the bride’s family to the groom’s family. According to Majaram(Mayaram, 2003, p. 44), Mirasis have a role as poet-historians, who preserved the Meos history in songs and poems, these were preformed during celebrations of the Meo caste.

The traditional work of Sakka was water carriers, but this service ended when bore wells became available. They had also offered services for high-caste, Rajputs in their neighbour village. The traditional work of the Kumhar-caste are pottery-makers. They still make clay pots and perform ritual services to both Hindus and Muslims during marriage and other celebrations. Lohar is a nomadic caste that comes periodically to Meopur, to offer their traditional services as blacksmiths.

Jatav have traditionally worked as shoe-cobblers. Due to their work with leather, which is seen as an unclean substance, they have been regarded as Dalits (previously untouchables). Members of the Jatav-caste have collectively attempted to strengthen their position in society through sanskritization. Sanskritization is a particular form of social change, where a caste adapts the customs of a higher caste, and makes a claim of belonging to a higher Varna (Srinivas, 1956). In Meopur, all Jatav have stopped performing their traditional occupation, and adopted vegetarianism. The Jatav caste have stopped accepting cooked food, water and tea from the Meo caste as they have in the past. This is a change that followed the partition of India, and also involves other Hindu castes that previously accepted food from the Meo (Aggarwal, 1966). Meat eating is looked down upon by the Brahmin caste, as it is seen as polluting. Giving and receiving cooked food and water among Hindus is known as an indicator of caste hierarchy. The giver is generally seen as higher than the receiver in rank and purity. According to Marriott (1976) a person’s nature is seen as “transmittable substance.”

Such transactions transfer and reproduce part of the “nature “of the giver. Castes who do not exchange might indicate differences in nature or antagonism (Marriott, 1976). Jatavs in

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4 Coded substance- includes both ritual purity, action (karma), moral (dharma) vital engery
Meopur said it was because the Meo eat meat that they did not accept water or food from them. Jatav is today categorized by the government as Schedule caste.

Miya (Faqir) said they belonged to Sayyed, a group of Muslims who trace their origins to Mekka and Medina and said they were the highest caste in the Muslim hierarchy. The Miya caste did not see the Meos as proper Muslims, since they originally were Hindus before they converted under the Mughal period. Miya said their high caste status was not recognized within the village. When Meos commented on the ranking of castes, they claimed Miya was mostly fakirs. Fakir was regarded as a very low caste, since they had assisted with funeral rites. Muslims castes did not accept water and food cooked in water from those they regard as lower castes, including Jatav. Neighbours who did not accept food or water from each other could still visit or attend parts of a function. Their youths have friends of the same gender across castes and religion.

There were three mosques in Meopur. Praying in the Mosque were restricted to Muslim men. Muslim women prayed at home. Hindus used one shelf in their home as an alter with pictures of gods and saints. In the middle of the village, close to one of the mosques, there is a shrine devoted the goddess of Sitala mata, the goddess of pox diseases. The village also had a shrine devoted to Sayyid baba, a Muslim saint. In Meopur, worship at the Sitala mata or the Sayyid baba shrines was not restricted by caste or religion. There were some cross-religious participation of both Hindu and Muslim, although the majority of attendants usually were of their respective religion. In some high caste villages in the area low castes are not allowed inside the temples.

**Health-facilities in Meopur.**

One local aliphatic “doctor” had a shop-like clinic in the neighbouring village. He was not educated as doctor but as a lab technician. In Meopur there was four Maulvies, or Muslim healers. They came from Meo and Muslim service castes such as the Sakka. No Hindu healers lived in Meopur, but Hindus sometimes went to the Maulvies when ill. There were more similarities than differences in ideas and practises of Hindus and Muslims in Meopur related

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5 According to Aggarwal (1966), the Meo caste converted to Islam during the Delhi Sultanate (1206-1526).

6 In the past they had accepted the 2m-long white sheets that had covered the corpse.
to cause health and prevention of illness. As I will return to in the next chapter, there were also more similarities than differences in popular medical knowledge and practices at times of pregnancy, delivery and post partum, despite caste and religion; however, there were some differences in religious celebrations after the birth of a child between Hindu and Muslim.

Villagers in Meopur generally interacted without problem but caste distinction became evident when conflicts arose. Once, water and electricity problems caused a violent fight between a Hindu family and a Meo family. More than 100 villagers went out into the streets and caste counsels were held afterwards on street corners, where men of the same caste gathered to discuss the events. Conflicts were preferred to be solved within the village which gave the Meo an advantage. Politicians also gathered villagers’ caste vices. A Panchayat is a village counsel, the smallest democratic political unit, is shared by three villages. Villagers elected a Panch, a member of the village counsel, for each 300 inhabitants, and one Sarpanch as the head of the village counsel for the three villages. Panchayat members told that villagers voted for people from their own caste during elections of Panch and Sarpanch. This left small castes with few possibilities of influencing village policy. Higher political positions were allegedly more dependent upon the candidate’s ability to pay for the position.

Economy
There has been two major redistributions of land in Meopur. The first redistribution was after the Independence and partition into India and Pakistan in 1947. The land owned by those who fled the area was mainly given to the remaining relatives. The second redistribution was in 1974, under the rule of Indira Ghandi. The government gave tenants, who did not previously own land, approximately 3.10 acre of land, parts of it waste land. Since 1974, several Jatav families have increased the size of their private owned land by inheritance and/or buying. Among the other service-castes of Kumar, Miya/Faqir, Mirasi and Sakka, several who had received land later sold it, or it has been divided among their sons. Among families from the Meo caste, there was a great variation in the size of their land/property. The Meos with large amounts of agricultural land leased out parts of it to the land-less and minor landowners. Usually, the landlords pay for the seed, water and tractors, while the tenants do all the work and usually receive 1/5 of the crop. During the harvest season (wheat and mustard) many of the villagers in Meopur work for large land-owners. They receive 100 Rs to 150 Rs
per day. Families without bore-wells usually pay 1/4 to 1/3 of their crop for water. It was also common to pay 1/3 of the crop for tractor ploughing and threshing.

Some men worked only within agriculture. However, it was also common among all the castes that the men had other occupations. The most common occupation among the men was as drivers or in construction (building houses), but some worked in factories, breaking stone, threshing and ploughing for others, tailoring or in small shops or services. Monthly salaries ranged from 3,000 Rs to 7,000 Rs, but could be less due to irregular work. There was currently only one man in the village who was employed in a government job. The teachers and the nurse who worked in the village came from the city. NREGA (National Rural Employment Guaranty Act,) had periodic projects of building roads in the village, where both women and men could work and earn 100 Rs per day.

Women performed much of the agricultural work. Few women had any form of paid employment, as the possibilities for such work were few. During the harvest season, some women worked on other’s land. Some old widows worked as traditional birth attendants, Dai, out of a necessity to earn a living. The demand for their services had decreased since many women went to hospital for delivery. Some women did some tailoring work for other village women, and the women in the Kumar families helped with the decoration painting of terracotta pots. Mirrasi women also performed work related to Meo weddings. The government engaged local women in the village health care. This will be described in chapter four.

**Exchange economy**
In addition to a money economy there was also an exchange economy in the village. It was possible to pay with wheat in the small shops in the village and it was also common to pay with gifts for the services of healers, Dais, and for traditional services of castes in the village. Many healers did not require payment but gifts were given, which included wheat, sweets, cloth and other items, as well as money. Some Meo families gave a yearly share of wheat to the Mullah for his services, which also included healing. The payment to Dai depended upon the gender of the child. One elderly woman from the Sakka worked as a Dai for her own caste and the Meo caste. She received 10 rupees and some wheat for assisting the delivery of a girl. If the baby was a boy she would receive additional money and one or two pair of clothes at the celebration of Hakika.
The Kumars made the majority of their income from their traditional occupation, pottery. They had a special role in several ceremonies both for Hindus and Muslims in Meopur and for Rajputs in the closest neighbouring village. The day before weddings Muslims and Hindu perform a worship of the potter wheel (chak pujna). They dance to the rhythm of drums from their house to the house of the Kumar family, to pick up clay pots. Kumars receives 2½ kg rice. Kumar receives more money and two pair of clothes at the time of gauna, when the bride moves to her husband. Rajputs from the neighbouring village went to the Kumar family at religious celebrations, such as ganguar puja. Clay statues of Shiv, Parvaty and Ganesh were made by the Kumar. The Kumars generally were given money, rice, wheat, sweets, and clothes. At the time of harvest, people mostly used wheat as payment for pots, 3 kg for a small pot and 5 kg for a large pot. The Kumar earned double during the hot harvest and summer months. Mirasi also received both money and clothing for the services they rendered during marriages.

Education
According to a survey done by the ANM and health workers in Meopur, illiteracy is significantly higher among women than men. 88.4% of married women between the ages of 15 to 45 years were illiterate; among married men in this age group, the illiteracy rate is 32.8% or 83 out of 258 men. The number of illiterate men in Meopur is low compared to two neighbouring villages where the illiteracy rate of men is close to 80%. Only 10 men were educated at a collage level, 58 had quit school between grades 1-5, 49 between grades 6-8 and 58 between grades 9-12 class (Eligible couple survey) . Several new schools had opened in the village during the last decade. Some specifically focused on increasing the education level among girls. Others were interested in providing Muslim children with the knowledge of Urdu and Koran. More children were undertaking higher education than their parents, and most girls attended school. The government school had class grades from 1-8. The school had 170 pupils; 81 girls and 89 boys. A NGO- (Non-governmental organization) driven school for girls opened 10 years ago, with classes from preschool to fifth grade. It had 60 pupils and was free of cost, inclusive school material. The NGO was interested in raising the education level among girls. A Madrassa, Muslim school, had opened two year ago, with support from the

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7 Rice is seen as an expensive luxury; it is not grown in the area but usually imported from south India.
government. It had classes up to fifth grade and had subjects such as Urdu, Koran and English in addition to Hindu and other general subjects. After fifth grade, pupils were able to continue at a government or private school. There was no religious or gender criteria, but the majority of pupils were Muslim boys. An Urdu and Koran girls’ school, free of cost, was opened two years ago by a female teacher from Delhi. She wished to teach girls about their religion and have them read the Koran. The times of these classes did not interfere with the other schools.

Several children went to a private school, in the neighbouring village. This school was more expensive than the government school. One mother said the reason why she sends her child to private school was that her children had not learned to read or write due to poor teaching at the government years. Another parents told they had had changed their child’s school after the teacher punished their oldest son with a cane. Although the education level was rising among both Hindu and Muslim children, some Muslims told it were little use for educating above eighth grade, due to the prospects of future jobs. Education is seen as costly, if a child shows little interest in villagers think it is better that the child contributes to the common good of the family in other ways. School children are expected to help at home. Girls usually care for younger children. They also perform household tasks and help their mother in the fields after school. Education does not free them from such expectations. When a girl moves to her husband’s village after marriage her schooling is usually discontinued. Several girls continue to stay with their parents some years after marriage and then some of them continue school until they move.

**Women’s position within the Household**

Neither boys nor girls take part in the decision about whom they will marry. This decision is left to the elders. Before an engagement is made Hindus visit a Brahmin astrologer to make birth horoscopes and these are compared to ensure that the girl and boy are a compatible match. For Hindus, astrology also determines fortunate and unfortunate dates for the wedding ceremony. Meo and the other Muslim did not compare birth horoscopes and arranged weddings all year except during “muharam”, the first month in the Islamic calendar.
The girl’s physical beauty was supposed to be left out from the negotiation. The decision should be made on the basis that she is from a good family and the boy and his family are not allowed to see the girl. “If they see the girl it will be like a cattle market.” one Muslim mother told. This had also been the norm among Hindus.

Having brothers was important. A Jatav woman told that she would never marry her son to a girl who did not have a brother. The bond between brother and sister are symbolized in several celebrations. A brother also takes over the life long obligation of gift giving to his sisters and the member of her family-in-law, upon the death of their parent.

Both Hindu and Muslim are caste-endogamous. The bride and groom were from the same caste. It is always the girl who moves from her parental village (Pihar) to her husband and family-in-law’s village (Susural) after marriage. Before marriage, a woman belonged to her father’s linage, after marriage to her husband’s linage. Meo practices a gotra (clan) system similar to Hindus, such as Rajputs(Aggarwal, 1966).Marriage practices such as cross-cousin and parallel cousins are common among some Muslims in India and among Hindus in South India. It is not common among Hindus or Muslims in Meopur. Meo regards cousin marriage as incestuous (Aggarwal, 1966). Fakirs said they are allowed to marry cousins, but underlined that it was common in Pakistan and not practiced in their family. Sibling sets marriages were common among both Muslims and Hindus in Meopur. Two or more sisters from one family are sometimes married to an equal number of brothers in another family. Such an arrangement was described as a means of cost reduction of the wedding expenses, such as two weddings for the price of one.

Both Muslim and Hindu marriages include several ceremonies. The majority was the same despite religious differences. The main difference was that Muslims performed Nika – the couple had to agree to the marriage in front of a mullah. Celebrations last seven to nine days and more than one hundred guests came to eat and celebrate. By arranging sibling-set marriages, expenses of food, party tent, music and gifts can be saved. There might be several years’ age difference between siblings. The oldest sister will then usually be married around the age of 15 to 18 years. The youngest sister can be eight years old, or even younger. However, the day of the wedding and the date when a

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8 The legal age of marriage in India is 18 for girls and 21 for boys.
woman moves in with her husband is usually not the same. The oldest sister usually moves first, while her younger sister continues to live with her parents for a period that can last up to several years. Many young girls in the village are married, but have not moved from their parents to their husbands yet. They do not carry the bridal jewellery and their marriage is not mentioned to school teachers or the ANM. Typically, spouses are close in age. Often, the boy is a few years older but there were also examples where the boy was a few years younger than the girl.

Hindu and Muslim parents see it as their duty to ensure a good marriage for their children. They give considerable values as a dowry, such as gifts and money from the bride’s family to the groom’s family at the time of their daughter’s marriage. Gift-giving from the bride’s family to the groom’s family also continues after marriage. This is also seen as a gifts of Dan, which transfer inauspiciousness (Raheja 1988); see chapter three. Muslims parents of the groom spend considerable amounts in Mehar on the bride’s jewellery, in their sons’ marriages. The Mehar is given to the bride, not her birth family. If the couple gets divorced the Mehar belongs to the bride. The dowry in both cases belongs to the husband and his family. The most important piece of the jewellery for Muslim women was the Hansali, a necklace. It symbolizes a Muslim woman’s status as married and was essential. In addition, the Mehar often included different types of a necklace called “gulliband”, rings, toe rings, bracelets (kada and bangles), anklets, hand jewellery, etc. In Hindu marriages the Mangal sutra necklace symbolizes marriage, and also other jewellery is given such as toe rings, bangles, etc. Hindu do not give jewellery as Mehar see as a guaranty for divorce. The jewellery given in Mehar by the Meo caste was substantially larger than that of other castes. How much money the parents spends in dowry and Mehar depended upon their ability and caste. Wealthy families gave more than poor. Honour and pride is invested in such giving and their status was reflected in the giving. The Meo caste usually gave significantly more in dowry than the Muslim service castes. The total cost could be more than 500,000 Rs. Items usually given in dowry included: closet, string cot, a big storage box, sewing machine, TV, refrigerator with freezer, air cooler\(^9\) or fans, pots, pans, motorbikes, money, jewellery, homemade decoration items, and clothes for all members of the in-law family. The jewellery given could be of gold or silver. Some gave one half of a kg in silver and others as much as

\(^9\) Air cooler is a box with a fan; water circulates and falls down in front of the fan, the air is saturated with moisture and feels colder.
two kg divided in jewellery. More affluent families gave gold jewellery, double beds instead of string cots and a car or tractor instead of motorbike. Among poor Muslim families from the service castes, the dowry could be limited to some pots, a storage box, a bed and 2,000 Rupees. The obligation of the girl’s parents to give to their daughter and her in-law family starts at her marriage and lasts throughout life. The responsibility of gift giving will later be taken over by her brothers.

After the bride has moved in with her husband she will return and stay one night at her parents’ home. This is called “vida”. When she goes back she will be given sweets, money and gifts for herself, husband and family. Such a return is practiced among both Hindu and Muslims, but may be skipped if her in-laws cannot manage without her help in the house and fields. Obligatory gift-giving to daughter and sisters is related to both yearly celebrations and life events, such as after the birth of a son. This and the dangers of such gifts during pregnancy will be further explained in the next chapter.

It was common that the girl cries at the last celebration, called gauna or chalu karna. This is when her husband and his relatives come to get her and she has to move to her husband’s village. Marriage involves a greater change in her life than in the life of the husband, as she has to move to her husband’s village, her sasural, and begin living with her new family in-law. It might be scary to have to move in with a strange family, but the tears are said to show the love of her parents and her sadness upon leaving them.

The most common living arrangement is joint and extended families. Elder sons and their families would sometimes separate their households from the parents after several years of family service, though such separation is often limited. It might involve an economic separation, or a separate cooking arrangement. Often the couple continues to live next door to the parents and share the same courtyard.

Most married couples disposed one room where they lived together with their children. There was not much space and little privacy in the sense of being alone. Privacy was seen more as a division between men, on the one hand, and women and children on the other. When a woman moves to her husband’s house, she takes on a new role as bahu, i.e., a wife and daughter-in-law. There is little interaction between a married woman and her husband during the day. The bahu is supposed to show respect towards her mother-in-law, act submissive, perform household tasks, help with agricultural works and do as her mother-in-law tells her to do. She is the lowest in the family hierarchy. Respect, status and hierarchy are generally
reflected in sitting, eating, veiling and speech patterns. The men or elders will sit highest. A married woman will not sit down if someone to whom she should pay respect stays. This includes the mother-in-law or elder sisters-in-law. Guests, men and elders are usually served food first.

A woman who is married into the village always covers her face with a veil in front of men elder than her husband, including her elder brothers-in-law and their father-in-law. However, a newly married bahu will, in addition, cover her face when only women are present in the first period of approximately six months after she moves in with her husband. Village women can glance underneath the veil to see her face and then gives the new bahu a few rupees. When someone looks under the veil, the new bahu are supposed to look shyly down, this is normal behaviour. A good bahu is supposed to act shy or show sharam, and even more. This is important in the first period after the marriage as she just has entered into a sexual relationship with her husband. After the first period of approximately six months, bahu continues to wear a veil that covers their hair, but does not walk about with it in front of their face when only women and younger men are present. In Islam, covering the head is a religious practice, but the particular pattern of veiling practiced in Meopur is called ghoongath, and also means a of showing respect and sharam (shame, shyness) towards the elder men. It is practiced along similar rules by both Hindus and Muslims in Meopur.

In a group of women, those who have already been married some years and have children speak more freely than those who have only been married a few years. A lowered voice is also a sign of respect. When married women, who have lived in the village for some time, greet other women on the road or converse inside the house and no men are present, they speak with loud, strong voices. However, at places such as at the bus stand, next to the tea stall where are men gathered, or when passing men on the road their voices are lowered to whispering. Their veil is pulled down with an automatic reflex-like gesture. On the bus stand located by the tea stall, women about to travel also shy away from the men’s gazes by hiding behind one of the trucks. The few times a woman had to speak with elder men it was always from behind her veil.

As mentioned above, a woman was not expected to wear her veil for men younger than her husband, and young boys in the family were permitted to join in with women at certain times, such as evenings when the women were singing and dancing. Adult married men would keep a respectful distance by not entering the room.

The veiling norm of a married woman only matters in the Susural. When a woman is in the city or natal village, she is not supposed to cover her face. In their natal village, the women
again took on the role of the pure daughter. To pull her veil down in front of men in her natal village was seen as wrong and shameful. Anything which indicated her sexual relationship with her husband is shameful in her natal village. When I accompanied Ragini, from my host family, to her pihar paternal village, she removed the bindi, the red mark married Hindu women apply to their forehead. She explained she felt sharam. Both Hindu and Muslim women felt it was sharam to visit their natal village when they were visibly pregnant. But there were exceptions, such as if a woman had to attend a sibling’s marriage, if she was mistreated by her husband, or if her in-laws were unable to provide her with a separate room after delivery or due to lack of social support from her in-laws at time of delivery. In such situations, a woman could go despite feeling ashamed. The fact that the married women in Meopur came from different villages, and the existence of local variation, might also mean the degree of shame felt by women could have some variations. In what situations sharam is felt varies throughout different localities in India. Some places it is even normal for a women to give birth to her first child in their natal village (Hollen, 2003, p. 95).

A woman increases her status within the family when she has children, especially sons, and with time and when she becomes a mother-in-law she is entitled to more respect. Women unable to bear children or who do not give birth to a boy might face blame by her in-law family. However, the in-law family would usually pay for several visits to doctors and healers before such steps were taken. Among Muslims, a husband could take a second wife if the first was barren. In this way, divorce could be avoided but it was not a desired situation and was seldom done. I only heard about two women to whom this happened. Divorces happened but were not common. If a woman was not treated well by her husband and family in-law, more often she returned to her parents and stayed there for some time, in some cases up to a year or two. Negotiating between the families happened before she returned. It is not common among either Muslim or Hindu woman to inherit from their parents; their share is given in dowry and gifts. However, there were some exceptions. One Meo widow had moved back to Meopur with her sons and was given land by her brother. It was more common, though, that widows continued to live in their in-laws’ village, and raise their children there. Old widows usually depended upon their sons to provide for them.
Women’s work at home and in the agricultural fields

The majority of women in Meopur perform a large part of the agricultural work, in addition to household tasks, and are generally hard working. There are individual differences in the amount of work due to factors such as: whether a woman lives in a joint, extended or separate household; the amount of land a family owns or leases; and the number of animals their family possesses.

Daughters-in-law generally do more both in the house and of the heavy agricultural work. They rest less than their mothers-in-law. Small babies might be brought to the field at times such as the harvest season. There the baby might rest on a string cot while the mother works. More often they are looked after by their grandmother, great grandmother or an older sister. Girls might begin to take care of their sisters from around age seven, but elders are seldom far away and disciplines the girl if she does not take proper care of a child. Mothers might take some short break in their work to breast feed, but there is seldom time to rest until finishing the dishes from the evening meal.

Women fill pots and buckets with water before the electricity is turned off, usually around 6 am and 7 am. Families need enough water to wash themselves and for their drinking and that of the buffalos, and for washing clothes and dishes. Any person who is at home will hurry to refill the buckets when the electricity is turned back on for short periods. In families without wells, women run with clay pots on their heads, to get water when electricity returns. In the early morning women sweep the courtyard for garbage, and the rooms, which usually are full of sand. Buffalo and cows are milked, given fodder and watered both in the morning and in the evening. Women make and serve milk-tea to all family members, when the husband awakens in the morning, and when the husband returns home from work in the evening. Women cook and serve hot meals twice a day, usually between 8 am and 10:30 am and 19:00 pm and 21:00 pm. Leftover bread (roti) might be eaten between the meals, with a mix of crusted garlic, chili and salt. In the morning, women collect the buffalo and cow dung into a large bowl, which is carried to a sunny spot either by their house or some distance away. There, dung is mixed with water and shaped into round bricks called Oplas. After drying, Oplas are burned when food is cooked on the “chula”, a clay stove in the courtyard.

Women’s work in agriculture depends on the season. They might saw, replant, apply chemical insecticides, and harvest. The harvest is accomplished with a sickle. During the main harvest season of mustard, wheat and oats, women often go to the field early in the morning and work
until late in the evening. Men generally do the work where a tractor is needed, such as ploughing, using the threshing machine to separate the grain from the husk and the straw, and chopping the wheat straws into small pieces (tula), which is used as a cattle forage. Nothing is wasted. What is not used for forage is dried and used as firewood. Women perform the cleaning, storing and processing of grain and vegetables. In addition to looking after and harvest a variety of crops, the women also grow greenery for the buffalo regardless of season, which is brought in from the fields in the morning. Women carry big loads of greenery on their heads. After reaching home with the greenery, they chopped it on a hand-driven machine before it can feed the buffalo. During the summer, they make clay stoves, and repair and build walls made of clay and dung in the courtyard. During the winter, they water the crops during the days, and make sure that the earthen walls, which are made by tractor to direct the water, are intact.

The majority of women of all the castes were involved in some agricultural work; this made them more mobile than women in some other villages in Rajasthan, where women from land-owning high-castes such as Charan and Rajputs observe purdo. Purdo is a customary seclusion of women within the house or courtyard (Patel, 2006, p. 39). The agricultural fields were often located some distance from the house. When women walked to the field, they could meet another woman outside a house, on the road or in the field. Interaction and conversation was also common among neighbours and relatives. Women from different castes and religions shared information and discussed everything about daily life. They informed each other about health seeking issues. They talked about visits to hospitals, but also about healers who had successfully cured their relatives from an illness, or had failed to do so. Success stories seemed to matter far more than the religious background of their health seeking behaviour.
Chapter 3
Popular knowledge and health seeking behaviour

This chapter begins by offering the reader a glimpse into villagers’ health-seeking behaviour through the case of Ambu, a young woman who, in her efforts to conceive, sought help from many doctors and healers.

In the analysis that follows, the popular medical knowledge will be analysed in light of diet, Astrology, Spirits, Nazar, Pollution, Dan and Religion. This chapter will provide a detailed account of popular knowledge of risks, prevention and spiritual-cures (goddesses and Evil-eye), in relationship to mother-child health; preventing and curing illnesses.

“Health” may be understood as experiencing a meaningful, fulfilling and happy life. Infertility may not necessarily be regarded as an “illness” in our western/modern society. However, for a woman in India – as will be shown in the following case of Ambu – it is indeed a matter of health and well-being. This case shows that precious time and money – as well as a willingness to experience many hardships – will be “offered” to fix the problem of infertility.

The Case of Ambu
Ambu was 23 years old at the time of my fieldwork. She was the youngest daughter-in-law in my host family.

Ambu grew up in a poor family but had completed eight years of school. This implies that she is rather well-educated relative to other women in the village.

When the father of her husband first visited her family to consider the possibility of an engagement, he asked about her grades and if she would like to apply for the job as a Sahyogini. She got married to her husband when she was 18. He was two years younger than she was. Their wish was to have a child as soon as possible after their marriage.

However, time passed and she did not conceive. Gradually, her parents-in-law displayed an increasingly negative attitude towards her. Her inability to conceive gave rise to abusive behaviour from her parents-in-law. Her sister-in-law also made comments that upset her. Her

10 Sahyogini is a lay health worker the government of India has introduced, to assist the work of improving mother and child health. Her role will be further elaborated in the next chapter.
parents-in-laws exerted pressure on her husband to re-marry, but he did not give in to that pressure; he “stood his ground”. Having his confidence and loyalty was of crucial importance to her. Still, she suffered from not being able to give her husband and his family a child. Her sister-in-law, although she was a hard working woman, could take small rests to breastfeed her baby when they worked in the field during the day and when caring for her children in the evening. For Ambu, who was still barren, there was little relief from work and she received little empathy.

Once when Ambu was ill her in-laws still expected her to work. Her mother and brother came to visit her and told her father-in-law they would take her to the hospital. He agreed, but her family-members decided to bring Ambu to their home, to make sure she would be able to rest. Some villagers created rumours that she had run away with someone. Ambu’s father-in-law told us, that this had made him very angry, although he knew Ambu was with her parents. He told that he had gone to the police station. There, he filed a court case against Ambu, falsely accusing her of stealing the family’s jewellery. He did this so that she would return to Meopur. When Ambu returned to the village, he went to the police station and withdrew the case he had filed against her.

Ambu told me about her many visits to doctors and healers. I will provide an abbreviated narrative of some of these visits.

The first time she visited a doctor was six months after her marriage. She went to a female doctor together with her mother-in-law. The doctor told her she was one month pregnant, and asked her to come back every tenth day. Ambu states:

The doctor told me that my uterus was very weak I returned to the hospital after ten days. While I was there, my menstruation started. After the doctor had taken a sonography\textsuperscript{11}, she told me my uterus was not able to hold a baby longer than for one and one-half months. I followed this doctor’s treatment for a period of two to three months. After that I quit, because my period returned. When I asked her to explain why my period had returned, she told me I had to continue with the tablets until my uterus was stable. I decided to end the treatment.

\textsuperscript{11} Ultrasound image
The next doctor I visited said I had a tumour in my uterus. At that time, it was two months since I have had my period. I believed I was pregnant. But two months later my menstruation came back, and lasted for eight to ten days which was considerably longer than usual.

After this, we saw an advertisement in a newspaper for a female doctor offering her services. The next day we went to her clinic. She also claimed I had a tumour in my uterus. She asked me to take a new sonography because she was not able to interpret the former ones.

Ambu told me that all of the doctors she visited required a new sonography to be able to diagnose and treat her. She had taken five to six sonographies at different clinics, and all the doctors gave different diagnoses with regards to what caused her infertility. The diagnoses she got were a swelling in her uterus, a tumour in her uterus, that her ovaries could not make proper eggs and that her uterus was still not ready for pregnancy. The doctors prescribed many medicines to treat her infertility-problem but none was successful. Usually doctors give little information about the medicines they prescribe to their patients. Ambu did not know what medicines she had been given from this doctors. After many unsuccessful cures, she turned to traditional healers.

Ambu told:

We were not at ease with the doctors’ explanations and their unsuccessful attempts cure my infertility, so my parents-in-law brought me to healers instead. Some healers said my problem began in my childhood when I walked upon a grave of a Mohamedan (Muslim). When a small child dies, Mohamedans bury them at all kind of places, both inside and outside their house. A person who walks on a grave can get this type of problems, they became unable to conceive. It may also result in headache, stomach pain and vomiting. Sometimes the spirit of the deceased enters the body of a person who accidently happened to walk on the grave-site.

One women healer told me this was the cause of my problem. She also demanded I stop working with pregnant women. I adhered to her treatment for six months. She said that I should trust her, her treatment would “give” me a child. She gave me some wheat seed called “fool”. After two months, I got my period again. I went back to this woman-healer. She started blaming me for not following her advice, even though I had. I got angry and disappointed and quit the treatment.
Then I went to Akbarpur to see a male healer. He also gave me some wheat seed and some tabeeze. He requested 500 Rs. for the “medicines”. He told me not to eat any food white in colour. I intuitively felt that this person was a “fake” and ended the consultations. Like this, I went on visiting many healers and received one treatment after another. But still the dream of holding my baby in my arms, was as remote as ever.

In the village, all of the women had given Ambu advice concerning whom she should consult. Some said one healer was the best for in treating this type of problem, others said another doctor or healer was better. It was very confusing. But she visited the healers villagers recommended. Ambu told she visited 25 -30 healers after such recommendations, her parents in-law talked abusive to her, and she felt very sad. One day during a polio-campaign Ambu and her niece went from house to house in the village distributing the polio-droplets to children. She got into a conversation with a Muslim woman (Mew). The woman told her about a female-healer living in her sister-in-law’s natal village. She told Ambu about a female relative of hers who had gotten pregnant after being treated by this healer. When Ambu came back to her house, she told her in-laws about this healer. Her sister-in-law was willing to accompany her. They went to see the healer the following Saturday.

Ambu tells that the healer immediately reassured her that she would have a baby; she would become pregnant very soon. When Ambu asked the healer about the cause of her problem the healer just said “Do not worry about that. You need a child and I guarantee that you will get one”. They never talked about the cause of her infertility problem again. She asked Ambu how long she had been married and how she had heard about her. Ambu told me “I was pregnant after the first day of her treatment, but I ate pearl millet. On my previous visit, she had told me not to eat pearl millet, but I had not followed her advice; that’s why I got my menstruation again. When I came back the next time, she said: “You did not follow what I told you”. She gave me more medicines and I followed her prescriptions carefully. One month later, I was pregnant again. I continued to follow her treatment. My sister-in-law usually accompanied me to the women because the she lives in my sister-in-law’s pihar (paternal village)”. Upon asking Ambu what she thought about the healer she replied, “The healer is marvellous, a god-like woman! I am really impressed by her. Before we went to her we spent so much money at different doctors, all in vain.”

12 Ambu did this work for the government because she is the ASHA Sayoghini in the village – see chapter 4.
Ambu had to follow some basic rules. The healer told Ambu not to visit pregnant women or to accompany women to the hospital at the time of their delivery. She also forbade Ambu to visit women in the last month of their pregnancy and during the first month after delivery. This is contrary to her work with ASHA, but she decided to follow the healer’s advice. Ambu was told only to eat food that had been prepared at home – even food brought from relatives outside the household was forbidden. After seven months of pregnancy, she could not leave her saseral (conjugal village) except for her monthly visits to get treatment. The healer gave Ambu ayurvedic medicine, iron syrup and tablets\textsuperscript{13}. She told Ambu not to drink tea or eat pearl millet, pickled jaggery, mango and some other foods categorized as having a heating effect on the body. In addition to food characterized as hot, she should avoid some sour food (as, for example, crude mango). Ambu said “I have a hot nature - that’s why she forbids me to eat hot things.”

Ambu told us about her treatment from the woman-healer. “The woman-healer has a book in Urdu. She reads one or two pages from the book and then she tells me to point out some words in that book, just two or three words. Then she recites a special worship using these words as a basis. This is called “utraxa”. She also gave me some “tabeez”. She gave me one tabeez to wear around my neck and another one to fasten around my waist to protect my child. She also gave me some tabeez for bathing and drinking and some ayurvedic syrups. I have visited her monthly during the last five months of my pregnancy. She confirmed my pregnancy by taking urine-sample. She provides medicines for only one month a time. I receive new medicines on each visit and she changes the tabeez around my neck and stomach. Around my stomach, I wear a red thread with a small black cloth. Inside this cloth is a very thin and small silver plate with some Urdu letters. Many people come to her home to get treatment. She gives some medicine to all of them such as “tabeez”.

Together with my assistant and Ragini, Ambu’s sister-in-law (JM), I visited Ambu’s successful healer. She was Muslim and approximately 35-40 years old. Her deceased father had trained her in ayurvedic medicine and astrology before he died. She had opened a clinic at home where she received patients at specific times during the week. All the patients were allowed to be inside her room at the same time. Both the patients and the healer sat on the

\textsuperscript{13} Some of the tablets she received were Femina Plus tablets produced by Maharshi Badri. \textbf{Indication:} Useful in leucorrhoeal illness, backache, pain in lower abdomen, anaemia, loss of appetite, general debility, vertigo, irregular menstrual cycles, amenorrhoea, dysmenorrhoea, menorrhagia, sleeplessness and improves health & beauty of ladies.
floor. In front of the healer was a small altar. On the wall were several pictures of the saint Baba (Hindu saint), a picture of a mosque, one poster with some Arabic/Urdu letters, and an illustration which showed the inner organs of the human body. She had a book where the patients – one at the time – were asked to put their pinkie finger on some lines (two different places) on a page. They were also asked to state their name. Then she counted using her finger joints before she decided which pages to read from the book.

By doing this, she could tell about the past and the future of the patient. Among the patients was one girl who arrived with her husband, and she struggled to get pregnant. Another girl suffered from chronic stomach pain. The healer read from the book then she told the women with stomach pain to consult a medical doctor. One man came by with his mentally disabled son, and the woman healer scratched with a knife on the floor in front of the child. Another man had a cow that would not give milk; he brought some jaggery and the healer blessed the jaggery. The man would later give it to his cow.

In the case of Ambu, we have seen some of the treatments Ambu were given by various healers, it should be mentioned that there is several types of healers, and also herbalist in the area. Villagers discuss what type of healers or doctor is good for different illness. Villagers frequently shares information about healers and doctors who have successfully cured someone with same kinds of problem. Such information has a strong influence on health seeking behaviour. Often the final answer to what have caused an illness is reviled by the cure. Illness is a time of suffering, it creates speculations about the cause and try and error to find a cure. In the end Ambus mother-in-law and sister in-law were convinced, a spirit had cased Ambus problem to conceive, But Ambu emphasized that the healer preformed exorcism on all woman, to ensure that if a spirit caused the problem it left, and that the healer combined a variety of treatments. Below I will show how the healer’s advices are similar to the popular knowledge of village.

**Diet**

The dietary-restrictions and herbal medicines the healer gave Ambu were based on the Ayurvedic medical tradition. Dietary restrictions and use of herbs are essential in Ayurvedic medicine.
Ayurveda originated in India, in the sixth century BCE and is a well established medical tradition India (Morgan, 1994, p. 9). Ambu’s healer was trained in Ayurveda by her father, but several universities and colleges also provide education in Ayurvedic medicine and Unani Islamic humeral medicine. Due to their long history in India, these traditions have been much more influential on popular medical knowledge than the western allopathic medical tradition. The popular medical knowledge is rooted in these traditions. Naturally, the amount of knowledge, vocabulary and details varies between lay and professional healers/doctors.

The villagers in Meopur recognize the importance of food in sustaining and promoting health and in curing illnesses. Like Ambu’s healer (learned Ajurvedic medicine by her father), Meopur inhabitants classify food and illnesses into categories of “hot”(garam) and “cold”(thanda). The categories “hot” and “cold” do not refer to the actual temperature of the food but is metaphors referring to the effect the food has on the body (by influencing the balance of the humours) (Good, 1994, p. 103). In Ayurvedic medical tradition, the Sanskrit term Dosha refers to humour. Although Doshas in Ayurveda has hot and cold properties, it is more complex. In Ayurveda, “Tridosha” (the three doshas) consist of Vata (wind) with cold and dry qualities, Pita (bile) with hot and fat qualities, and Kapha (phlegm) with cold and fat qualities (Svaboda, 2000). Food is used for balancing these humours in the body.

The Ayurvedic medical system has a holistic perspective on health. Every human being is seen to have an inborn constitution, prakriti, which remains unchanged through life. The changeable actual condition is called “Vikriti”. Vikriti expresses actual balance/imbalance between the humours (health/sickness) (Svaboda, 2000, p. 23). Physical substances, energies, mind, thoughts, emotions and spirit play a role in the increase and decrease of the three doshas. The correct balance of the doshas (i.e., health) is influenced by factors from all five areas (Svaboda, 2000). Season and environment influence both the properties (pitta, vata and kaha) of vegetables and fruits and the vikriti of human beings. Different types of food have different properties, and diets are used to create a healthy balance; to keep or restore health.

**Season and diet**

Creating a good balance of vikriti implies changes in diets according to season.

There are variations in the classification of food as hot and cold by people in various parts of India. Vallianatos (2006) has made a table, which compares several anthropologists and Bihar, while it is seen as cold in Gujarat and Uttar Pradesh (Vallianatos, 2006, p. 119). Food
items are seen as taking on properties of the seasons. Charaka – an Ayurvedic physician who lived in the second century AD – distinguished between winter rice (shali)/summer-rice/60 days rice (shashtika ) and autumn rice (vrihi). According to Charaka, both winter and summer rice have cold properties, while autumn-rice was categorized as hot, because bile (pitta) dominated phlegm and wind in this season. It has a sour aftertaste and is heavy to digest. Rice grown during this season was seen to aggravate bile (Morgan: 1994:81). There are several local variations in India of food categorizing. The food categorization in Meopur village does not necessarily apply everywhere else.

Villagers in Meopur said food categorized as hot was beneficial to eat in the winter and food categorized as cold beneficial to eat in the summer. Food was used to restore the balance in the body. “Hot” food they consider beneficial to eat in the winter includes:

Meat, eggs, mango, sesame oil. Dishes such as roti-bread – kicheri and -dahlia when they are made with pearl-millet, sweet-potato, bathua paranta (white goosefoot-leafs baked in wheat bread fried in oil), jaggery, sweets made from carrot and ladoo

Food categorized as cold and beneficial to eat in the summer includes:

Oats in soured milk, yogurt, roti-bread made from wheat, peas/vegetable-curry, cold water and cold drinks

Villagers paid most attention to such dietary restrictions at times of illness, which were assumed to be caused by imbalances.

In Meopur, villagers recognized symptoms such as pimples, boils, ulcers, measles, typhoid and pox diseases as signs of too much accumulated “heat” in the body. When a boy got pimples during the summer, it was seen as caused by “heat” in his body because he had eaten mangoes (mangos are very “hot”). Villagers in Meopur also saw “hot” food as increasing menstrual menstruation- and postpartum bleedings, and increase the risk of spontaneous abortion.

Nag (1994) has noted similar conceptualisation of food several places in India, but with some local variations. Many places “hot” food were seen to create such symptoms, and potentially induce abortion (Nag, 1994)
When I began to have cold symptoms in the winter, instead of giving me vegetables and wheat-roti, as the others ate, I was given roti made of pearl millet-flour and jaggery. They also rubbed my hands with sesame oil. Food was important both in the understanding of how illnesses developed and in curing the disease. They paid attention to how different factors/food worked in combinations, or “added” to each other. Seasonal factors and food-properties could affect people differently as their personal constitutions differed.

**Individual constitution and life period changes of women**
Ambu referred to her individual constitution (nature) saying, “I already have a hot constitution”, when explaining how eating pearl millet caused her to miscarry. As mentioned before, each person has their own specific natural constitution (prakriti) from birth.

Age also influences the balance of doshas in the body. People of fertile age are seen as having more heat in their body than children and elderly people. The female body is usually seen as being more “hot” than the male body. On a monthly cycle, a woman’s body is seen to contain mostly heat in the days preceding the menstruation cycle. Villagers perceived prolonged periods of menstruation as a sign of extra accumulated heat, which was then released. One woman mentioned that she thought western medicine was very hot since she had experienced longer menstruation than usual after she had taken it. The balance within a woman’s body is also seen to undergo changes during periods of pregnancy and birth. The pregnant female body accumulates heat, since there is no heat released through menstruation. As shown in the case of Ambu, too much heat was seen to increase the risk of spontaneous abortion; it increases the risk because the body would release heat through bleeding. The healer, therefore, told Ambu to refrain from such food.

Even though several villagers shared this knowledge, they agreed that under normal circumstances it was not seen as necessary for a pregnant woman to avoid hot food. I asked several women in Meopur about their dietary practices during pregnancy and post partum period. Most of the pregnant and previously pregnant women I spoke to had not made any dietary changes during their pregnancy – they ate the same food as they had eaten prior to pregnancy. I observed that dietary precautions were followed most strictly when a health-problem had occurred, i.e., during illness, when they had problems getting pregnant or after having experienced a spontaneous abortion. Critical periods also included the time after birth or sterilization.
Helen Vallianatos’ (2006) study of dietary practices of poor and pregnant women in New Delhi revealed an almost universal agreement among the women that “hot” food should be avoided during pregnancy. Of the pregnant women, 77% claimed “cold” food was beneficial. Also, reproduction histories, economical status, religious affiliation and cravings and aversions were factors that influenced their diet during pregnancy (Vallianatos, 2006, p. 124)

Ambu’s case illustrated how dietary precautions during pregnancy became very important due to her problematic reproductive history. She did not cook separate food for herself, but refrained from drinking tea and eating food seen as particularly hot such as mango, jaggery, pearl millet, pickles and other foods categorized as “hot”. Making separate food for herself would have been difficult as she lived in a joint family. She was busy with farm or household work most of the day. Food was cooked for all family members at the same time.

Vallianatos (2006) writes that, particularly during the first trimester and during the hot-season, women saw it as risky to eat hot food. (Vallianatos, 2006, pp. 123-124) This illustrates how several factors are seen as adding on to each other and increasing the risk of experiencing a health-problem. Personal constitution, season and diet, are take into consideration.

**Black tea and diet after delivery**

After delivery, the female body becomes colder due to a period of bleeding. The villagers regard this period as critical. Dietary restriction is the norm even if no complications have occurred. The precautions are seen as necessary to avoid illness for both the mother and infant. Food considered hard to digest is avoided as the digestive ability of the woman is perceived as weakened. Hot food is considered as particularly hard to digest, and also some specific cold foods were avoided. During the first three or more days after delivery many women received only black tea. Special precautions were taken during the first three to 15 days after delivery – a period in which it was necessary to clean the mother’s womb, stimulate digestion and prevent illness. Villagers believed the mother had to become internally clean. Villagers normally drink tea with milk, but the black tea given to mothers after birth was without milk. Tea together with an easily digestible food is given for a period of eight to 15 days after delivery. The older generation followed these precautions even more carefully; they solely took black tea for seven to eight days.
Some women in the village ate a few biscuits during the first three days after giving birth.

After three days, or after the first bath by the mother, the mothers were served lapsi/dahlia. Lapsi is a sweet porridge made of wheat flour (semolina) mixed with a little bit of ghee and sugar. The mother was not allowed to eat roti, the round and flat bread made from stone-ground wheat flour (which villagers eat together with curry or vegetable), as this was seen as hard to digest, and was postponed until the mother's digestion was supposed to be normal again. It was said that the mother risked stomach pain for rest of her life if she did not adhere to the proper restriction of her diet. The villagers also mentioned that roti could make the baby ill because the mother’s milk was bad. Roti was avoided for a minimum of 15 days after delivery and then gradually reintroduced into the diet. After 45 days, the mother could eat as normal. Milk and ghee were also seen as creating problems and would be avoided the first few weeks and then slowly reintroduced into the diet again.

The special tea and food are prepared by the other women in the family during this post-natal period. Due to pollution from post partum-bleeding, the woman is not allowed to cook food for herself or others. Rangini and a few elderly persons explained that the tea prevented tetanus in addition to indigestion. The tea is usually made by elder female relatives who learned it from their mothers-in-law or Dais. The two recipes for black tea below were given by a woman in the village (I cannot rule out the possibility of other variations):

Recipe 1.

Hirero; Ghee and sugar was added to the tea.

Recipe 2 (given by an old Muslim woman)

In addition to the ingredients above, jaggery, carom capsicum seeds and copper was added. They said that carom capsicum seeds was added because it is beneficial to the digestion.

Copper was said to protect against tetanus. Copper was added by putting a copper ring in the hot tea (with the rest of the ingredients). All ingredients were boiled for at least 10 minutes.

Rangini and the Muslim woman referred to the use of copper as a homeopathic treatment. Different but similar tea recipes have been noted elsewhere. In Bijnor, the tea given to mothers contained jaggeri, ajwan (carom capsicum) and dried ginger (Jeffery & Jeffery, 1989). Some of the elders connected the restriction of avoiding milk and ghee the first days after delivery to avoiding tetanus. The elders who mentioned this linked the tetanus

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14 Post-partum bleeding is seen as polluted.

15 Bishop weed seeds also called Aijwan in India.
vaccination to the later changes in dietary practices (less strict diets). One of the elderly women said that at the time when she gave birth, they had to drink only black tea for seven to eight days (or until the first bath) after delivery. Women would also follow this diet of black tea and easily digestible food after a miscarriage.

**Breastfeeding and the diet of the infant during the first days after delivery**

Currently, the first bath of the new mother was given on the third day after delivery. After the first bath, the mother would begin to breast feed her baby. Until then, the infant was given gutti (water boiled with jaggery or sugar). Guti was sometimes given on a piece of cotton, on which the baby suckled. The government had previously informed some of the women and Dais about the danger of the cotton getting stuck in the throat of the baby. Those aware of this danger gave the gutti with a teaspoon. When we asked mothers why they did not breast feed the infant before the first bath (three days after the delivery), the most common answer was that the breast milk was not produced until after the bath. This was established knowledge and they did not question it. A few women said it was because the first milk was of bad quality as it had been collecting in the breast during the nine months of pregnancy. It was only during the first three days after delivery that it was common practise to give the baby gutti. Later, the mothers usually breast fed their babies. Some of the mothers were unable to breast feed because they produced no milk. In such situations, it was common to give the baby buffalo milk. Some gave milk tea. Cow or goat milk might have been regarded as equally suitable as buffalo milk, but most villagers owned only buffaloes, so buffalo milk was the natural choice (easily accessible and with no extra costs). These mothers often allowed the baby to relax and suckle their nipple after finishing bottle feeding.

It was recognized that babies became calm and felt comfortable by suckling the nipple. Sometimes the aunt or grandmother of a baby would let the baby suckle their nipple to make it stop crying.

**Astrology**

The healer who treated Ambu learned astrology\textsuperscript{16} from her father. We saw that Ambu’s healers used astrology as a diagnostic device combined with Ayurveda. Astrology is used in

\textsuperscript{16} Astrology classes are available at schools and Universities in India.
counselling both among Hindus and Muslim\textsuperscript{17} in India. It is a rather common belief that astrologers can predict events, assess vulnerability to spirits, and impact the balances of the doshas. Muslim healers trained in astrology usually call themselves Maulvies, “learned man”, rather than astrologers (Plugh, 1983, p. 137). We saw that Ambu’s healer asked her patients to point at some lines in a book. Muslim healers usually do not make an individual horoscope themselves, as do some Hindu high caste astrologers. Instead, they use existing horoscopes in almanacs written in Urdu. It is common practice for a Muslim astrologer to use some election device, i.e., to ask the patient (client) to make a seemingly accidental choice (Plugh, 1983, p. 137).

When Ambu selected the lines, the healer could interpret Ambu’s future and past from an astrology book. Hence, she could give Ambu a guarantee that she would have a child. The constellation of planets at time of birth is, among Hindus, seen as reflecting a person’s karmic-code, a code that is generated from moral action in a previous lives. Muslim astrologers see the person’s nature reflected in the constellation of the planets, which is due to Allah’s will, not Karma from previous life (Plugh, 1983, p. 138). In Meopur, villagers did not usually mention that planets, karma or sin caused illness, except that at time of an eclipse a person’s action would have stronger effects. The action of a pregnant woman or her husband could cause disabilities for the child. For example, if they cut wood the child could be born with a harelip. Astrology might be used to predict auspicious and inauspicious events in a person’s life, as well as auspicious and inauspicious days for specific activities (Raheja, 1988, p. 38). The consultations with astrologers for auspicious dates in Meopur seemed to be less frequent – and of less importance than in several other districts in India such as Uttar-Pradesh described by anthropologist Raheja in Uttarpradesh (Raheja, 1988, p. 42). This might be differences die to caste, and also because no Brahmin astrologer lived in Meopur. As mentioned in chapter one Hindus, but not Muslims, in Meopur consulted Brahmin astrologers before marriage and to compare birth horoscope and find an auspicious day for marriage.

Vedanga Jyotisha, an ancient text of vedic Astrology, provides an outline how specific planets and panet-constellations have an influence on the doshas; - vata, pitta or kapha, and the connection between the physical body, subtle body and causal body (Frawly, 2007, p. 23) Anthropologist Cecilie Nordfeldt (2005) has shown that women in Gharwal-Himalaya linked vulnerability to spirits to the planetary constellation at time of birth; a woman with strong

\textsuperscript{17} It should be noted that astrology is controversial within Islam.
planets was seen as being less at risk for possession than women with weak planets (Nordfelt, 2005) But in Meopur, and also Garwal, villagers, instead of referring to planets, usually mentioned the importance of diet, evil spirit (but), Nazar, goddess or pollution as crucial for their fate and health. This will be illustrated below.

**Spirit and Nazar (evil eye)**

As exemplified in the case of Ambu, healers may point to a link between health problems (and healing) and the realm of spirits. In Meopur, “spirits” and “Nazar” were central concepts or forces/phenomena in popular medical knowledge. Both Hindu and Muslims sought cures during illness and blessing and protection in general, and particularly in connection to important events or phases of life, such as pregnancy, birth and post partum.

In vedic astrology and ayurveda, the conceptualization of the body includes not just the physical body but also a subtle invisible body. They refer to a subtle body, which is not seen as less real, but as belonging to a higher level of reality. The subtle body includes the vital energy or prana. A person can experience his subtle body “in dreams, visions, inspiration and directly through death” (Frawly, 2007, p. 16). This subtle level influences the physical level. I will try to shed some light on – or convey a brief outline of – the villagers’ popular knowledge of illness caused by spirits and Nazar, their experiences of the effects and how they seek protection and cures from it.

**The “nature” of spirits**

In the villagers’ popular medical knowledge spirits are seen as able to cause several problems related to mother and child health, such as barrenness, miscarriage, post partum illness and cot death. Also other illnesses such as diarrhoea, headaches, etc. (but not colds) afflicting people in general can, according to their view, evolve into more serious conditions if not treated by a spiritual healer.

The spirits villagers in Meopur usually spoke about were the spirits of persons that once lived. They were deceased relatives, neighbours or other people who once lived in the village. Spirits is common part of popular knowledge in Rajasthan. According to Tulsi Pattel (2006)
villagers in Morga, Rajasthan told that when a person dies he becomes a “jiv”, a spirit or soul for eleven days, until the funeral rite is preformed. If it the jiv refuses to attain gati (the final funeral ritual) it becomes either a pittar (house god) or a ghost (bhut). A pittar usually has a place of worship in the house. It is helpfull, and brings luck for the household and sometimes larger community (Patel, 2006, p. 147). According to Unnitan-Kumar (2003b) a woman in jaipur, attributed her pregnancy to help from a dead relative spirit, when she became pregnant after a long time with struggle (Unnithan-Kumar, 2003b). The spirits continues to have human characteristics and temper. But factors such as the age of death, the degree of satisfaction the person had in life, and whether the person died a good or a bad death determines if the dead person’s spirit becomes helpful or evil. Adults who died unhappy and childless were considered a particular danger as they often become evil spirits (Lambert, 1997, p. 267; Patel, 2006, p. 147; Unnithan-Kumar, 2003b) According to popular knowledge, people who die in a states of pollution, such as during childbirth, often are seen to become evil spirits (bhut) (Lambert, 1997, p. 267).

In Meopur, the evil spirits (Bhut) the villagers talked about usually died childless – by suicide, murder or accident. Both Hindus and Muslims in Meopur had relative’s spirits as house-gods. It was common practise for women to sing particular songs for their relative’s spirits at times of celebrations. During one celebration Hindus celebrate after the birth of a boy– Koa-puja (well worship) ceremony – I observed a woman who became possessed by her dead brother-in-law, who had the status of a house-god. The possessed woman was shaking. Both the woman and the spectators interpreted the possession in a positive way; they believed the brother in-law was happy and wanted to see the baby.

Villagers and healers perceive dead infants and small children as a separate category of spirits based on the characteristics of their nature. As we saw in Ambu’s case, healers and villagers agreed that the spirit who caused Ambu’s problem of conceiving was the spirit of an infant or most likely a Muslim. Dying at such a young age, these young children long to go back to the comfort of their mother’s womb. If a woman steps on a grave belonging to such a small child, its spirit enters the woman’s womb and the woman will be unable to conceive. The entering of a child’s spirit does not depend upon the religious affiliation of the child or his family. It is more likely – due to the different burial practice – that a Muslim child will enter the womb. While Hindus cremate the dead, Muslims bury them. Muslim adults were buried at the village

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18 Menstrual blood is seen as very dirty, this will be explained further below.
cemetery, but small children were buried in their private courtyard or field. In one Muslim
family in the village two small children had drowned in the well and both were buried under a
tree in the courtyard. Ragini discussed the potential dangers for people who did not know that
the children were buried there with the dead children’s grandmother.

**Villagers’ experiences with spirits**

Popular knowledge about spirits are shaped by villagers own experiences and villagers
exchange of such experiences. To villagers in Meopur, as with the villagers Nordfeld (2005)
studied in Gharwal- Himalaya, spirits is part of daily life, and can create real effects in the
world (Nordfeldt 2005) Villagers can experience spirits in several ways; in unfortunate ways
such as causing illness (Ambu), or accidents and in positive ways, as in the case just
mentioned – a dead relative coming back to participate in a celebration. Good spirits might be
helpful and bring fortune. Bad spirits could cause accidents, and misfortune. It could make a
person act immoral. Spirits were also heard, seen and/or felt. Several women in the village
spoke about spirits who had threatened them, some told a spirit had told they would never
have a son, another had experience a spirit who appeared at night as a big black and pressed
her down. They also told about spirits who “disguised” themselves by taking on the shape of,
for example, their mother-in-law or an animal. Although appearing in different forms, the
spirit was usually interpreted to be a specific person; a relative or one who previously lived in
the village. Spirits could also be encountered in dreams. One person told they had felt hands
pressing around their neck upon awakening 19. Illness-narratives sometimes began with “I
awakened with fear…” indicating that spirits may be at work. Villagers said that many spirits
gathered by the well on the fields at night and that they could hear their voices. Therefore,
there was not one single way to experience the presence of a spirit. Spirits were not seen as
something extraordinary, rather as a natural phenomenon, although belonging to the subtle
realm. Most of the villagers had experienced the presence of a spirit in one way or another –
often it was a part of their medical narratives, which they shared with each others.

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19 Se Hufford(2005) “ Sleep paralysis an spiritual experience” Hufford has studied peoples strong feeling of
“reality” during similar experiences in other cultures, including USA,
Attracting spirits

A person could be possessed by a spirit in different ways due to different causes – both accidental such as by stepping on a grave, but they could also be attracted by white food or fright.

Spirits who leave the possessed person does not disappear. It will search for another body as a host. For this reason, Rangini refused to let my assistant and me visit the woman who healed Ambu on a Saturday, the day she performed exorcism. Rangini said it was too dangerous, as possession may occur when a person is in the vicinity of a dead person.

It is more likely to happen if the deceased person was an unhappy person, or if he suffered an abrupt and painful death.

Certain circumstances are more likely to attract spirits, for example, white coloured food. After having eaten white food, it is regarded as necessary to wash the mouth with water before leaving the house. The danger of spirits with a craving for white food is shown in the narrative of Sumati, a grand-mother (one of her sons died in cot death and another was spontaneously aborted):

I gave birth to three children, all boys; one boy died when he was just 12 days. (.)That day I cooked rice and the rest of that rice we kept under the bed of my child. Maybe a spirit came and ate my child with the rice. Another child died in my uterus. That day I ate kheer which is made by rice and milk (sweet rice porridge). The Elders told us that we should not go out without drinking water after eating white things. But after eating kheer, I forgot to drink water and I went to the field. A spirit killed my child. After this I did not get any more children.

We saw that also one of the healers Ambu visited, advised Ambu to avoid food white in colour, this was seen as attracting spirits. A frightened person was also seen as vulnerable to evil spirit. I was told that it was a sound precaution not to be afraid of seeing possessed persons.

Nazar

Nazar, or “evil-eye”, was an integral part of the popular medical knowledge among villagers in Meopur. The idea behind Nazar is that the gaze from a person harbouring emotions of jealousy, desire or adornment, can cause harm and illness, even if it is not intended.
Favourable or enviable situations or things can cause “Nazar”, for example, a person dressed in nice new clothes or a new born baby. A new born baby can create jealousy in people who desire a child, or people might adore a baby and, hence, “put the baby at risk”. Small babies were, therefore, seen as extra vulnerable; when they got sick they were often diagnosed with “Nazar” by the Maulvie. If villagers in Meopur experienced a lack of energy or a sudden unexplainable sadness, they thought of Nazar as a possible cause, but realized that it could also be symptoms from other illnesses (food causing diarrhea, weight loss, etc).

Nazar was also a theme in some of the songs I recorded (sung by women in the village). According to Devdutt Pattanaik (2011), the evil eye is related to the idea of the subtle body which can be seen as an energy shield (Aura) protecting our physical and mental health. A person may feel energized looking at a beautiful person with a positive and healthy aura, but he/she draw energy from the person who is looked on. It causes the person who is looked on to feel drained, tired and sick. (Pattanaik, 2011).

Protection and treatment of Nazar and Spirit
In the case of Ambu, at the beginning of this chapter, the healer gave Ambu tabeez; some to put in the bathing and drinking water, some to wear around her neck and waist. These Tabeez medicines were pieces of papers with text; the written text was usually Quran verses or special words written in Urdu20. It was common practice for healers to prescribe this type of medicine. The Moulvies in Meopur also gave patients tabeez to cure illness such as diarrhoea if they thought the diarrhoea was caused by spirits or Nazar. The Maulvi would first whisper a prayer and then blow his breath on the patient’s face – from the head downwards. Then he makes tabeez using a yellow marker-pen, he cuts the paper into strips, which then are folded into the size of a tablet.

The patient should put these tabeezzi in his drinking water three times a day for three days. The Maulvie followed the same procedure with three tabeez for bathing. The patient should have these tabeez in his/her bathing water each day for three days. After three days, the patient would be well. Tabeez was also prescribed for protection against Nazar and spirits .The patient would put tabeez inside a necklace with a cylindrical tabeez-locket to store the paper. In Meopur such necklaces were worn by many Hindus and Muslims of both sexes. One of the Moulvies in Meopur explained that when he treated diseases and possession he preformed “Ayat”, a special type of Islamic prayer. With the Ayats he could cure many diseases. Not all

20 Hindu mantra can be prescribed as tabeez by Hindu healers.
people could perform Ayat. The Molvi used a special method for praying with an Ayat continuously for up to 21 days. He had a book with 1,024 Ayats. He would not share more of his knowledge; it was a secret knowledge.

Healers such as maulvies were seen as experts in cures and preventions involving spirits and Nazar, but the villagers themselves also had some procedures for prevention; they did not always consult an expert. In the post partum period it was common for a mother to keep a knife in the bed beside her and the baby as a protection against spirits. If the women left the house, she would take the knife with her. Women with a knife were also a common sight at the hospitals. Wheat-grain was also seen as a protection against spirits.

As a protection against Nazar, a black mark could be drawn on the baby’s forehead, or somewhere on the face of the woman. Black eyeliner underneath the eyes was also seen as protection and was painted on both babies and adults. Few used it daily; it was more common when they wore new or particularly nice clothes. In a few families, the babies also carried a black thread around their waist as protection.

As endorsing a baby can give it Nazar, women called babies names such as kali and kalo, meaning black – (white skin was seen as beautiful and signalled status, black insinuated ugly) and women used to slap small babies on the cheek when they talked to them and gave them attention. An old woman told that because three of her children died when she gave birth inside the house, she had been advised to give birth outside and to make a hole in the ear of the baby immediately after delivery; that would save her child from evil spirits.

A necklace called “chand suraj” is given to a Hindu baby. It is believed to protect the baby against the evil eye. When the child gets older the risk of the evil eye decreases; then the bracelet can be given to younger brothers or sisters or another relative. Villagers could also do rituals at home to avoid Nazar. Circling a red chilli around the head of a person and afterwards putting it in the fire could diagnose and sometimes remove Nazar, but going to a healer was seen as the best cure/protection. It was the healer who was the specialist, villagers was often unsure if they preformed the ritual right. Women who had experienced the death of an child would also pray to gods/goddesses or Allah and saints.

So far we have seen how Diet, Astrology, Spirits, and Nazar are part of villager popular Medical knowledge. In the remaining part I will turn to aspects related substances, that are seen as potentially dangerous: Menstrual blood and postpartum blood, and inauspiciousness
transferred through gift of Dan. Purity and worship can be seen as moral-tradition of medicine, to please and not insult gods and spirits, (Shweder, 2008).

**The danger of menstrual - and postpartum pollution**

The reason why Ambu was told to stay away from women one month after birth can be seen in relationship to the dangers associated with post partum bleeding, which like menstrual bleeding, is seen as a very impure substance that is disliked by gods and attracts evil spirits. Both during menstruation and in the period of post partum bleeding, the woman is seen as unclean or polluted. Neither Hindu nor Muslim women can perform any religious prayer – or attend any type of religions celebration – during menstruation or the first 45 days after delivery. Reading of the Koran is also strictly forbidden.

The pollution is seen as easily transferable through contact between persons, so the new mother is provided with a separate room at the time of delivery where she stays secluded. The ideal length of the period of seclusion is 45 days. After this period she regains ritual purity, marked by a purification bath.

During the unclean period, women and infants would (ideally) have the privilege of complete rest, while the mother-in-law or another female relative provides for her needs. However, the actual period of seclusion and rest varies from woman to woman according to how well the family can function without her work. Some women stated they returned to work eight to fifteen days after giving birth. In relation to religious ceremonies and worship, the new mother is always considered “impure” for 45 days. In addition to being prevented from making food in this period, she is also prevented from gathering water. When home-delivery was common, the family called on an elderly woman for help, In some castes, this was done by the mother-in-law, or a widowed relative. Some widows from a lower Muslim-caste had also assisted some of the Meos at the time of delivery, and with work related to removal of the pollution after delivery – such as cutting the umbilical cord and burying the placenta. The low-caste woman would also wash the clothes and the delivery room.

A woman who performs this work will be contaminated by pollution and ritual impure. She can transfer her pollution to other people. Therefore, some of those who assisted delivery

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21 Some places in India there are specific castes who work as dai (traditional birth attendant); this was not the case in Meopur. The work was done by widows out of necessity, and they attended mostly to relatives of the same or higher caste, but not of a different religion. They did not like to be referred to as dai.
(Dai) told they refused to wash dirty clothes. Contact with menstruation and post partum blood was also seen to cause illness. Once when Ragini’s husband was sick with diarrhoea, they spoke about the possibility that it may have been caused by some menstruation clothes near the well.

Because of the danger this postpartum blood, Ambu’s healer asked Ambu to stay away from women the month after their delivery.

**Pregnant women and their vulnerability to gifts of Dan,**

The healer told Ambu not to go outside the village, visit her birth family or receive food from relatives outside her household. Raheja(1988), who did fieldwork among the Pashanu in a village in Uttar Pradesh, has describes similar practices and precautions; she registered that the mothers-in-law used to tell their pregnant daughters-in-law not to receive or eat any food sent from their birth-family during pregnancy. This was because this food was Dan, containing inauspiciousness. While daughters under normal circumstances can receive such gifts, during pregnancy, they were seen as week (kamjor) and not able to withstand the danger this food contained. Also, visits to their natal- village posed a danger because of the obligation of the daughters to receive gifts which contain inauspiciousness (Raheja, 1988, p. 93). Raheja has described the tradition of gifts as Dan; Dan are gifts from the family of the bride to the family of the groom. Gifts of Dan differ from transactions of water and cooked food, which in most places in India are connected to contamination and ritual impurity; gifts of Dan can transfer inauspiciousness or evil from the giver to the receiver but not ritual impurity (Raheja, 1988, p. 33). In the marriage ritual, the bride’s nature goes through a transformation; it becomes similar to the nature in her husband’s family, she no longer belongs to her birth-line, and does not share their nature anymore.

There are particular rules for gifts and transactions between the bride’s family and the groom’s family. The rules in Meopur were similar to the rules Raheja has described (in
According to the tradition, Ambu’s family-in-law would not accept water or kacca food (cooked in water), from Ambu’s side family.

The first gifts of Dan – to the grooms family – are the gift of a virgin, and the Dowry at time of wedding. Marriage is the beginning of a life-long relationship where gifts of Dan will be given from the bride’s natal-family to her husband and family-in-law on several yearly celebrations and other life-event celebrations (Raheja, 1988).

Gifts of Dan included cloths, sweets, money or other items given as Dan. The norm in Meopur was that a daughter should never leave empty handed when she had visited her birth home.

Ambu’s father-in-law told he gave gifts to his daughters and their families on Makar Sakranti, which was celebrated 14 of January; he gave jaggery, clothes and also usually donated cows. Also on Feez or “saavan ki tokari”, he brought gifts of clothes, money and about 5 kg of a sweet called Jallebi (which the daughters distributed among relatives in their village).

At “bhaia dhoi”, married daughters come back to their native village to give “ticka” on their brothers forehead. When she leaves, she would be given money and clothes. Ambu’s father-in-law said that his obligations of gift-giving were the main reason why he would not give land to his two youngest sons before he died.

Ambu’s parental family had not brought any such gifts, because Ambu had not yet given birth to a child. The parental families of both of Ambu’s sisters-in-law gave such gifts, which were distributed in the family.

Ambu’s father-in-law complained about Ambu’s family because they had not brought any gifts yet, while he brought 10 kg (clothes and sweets) to his married daughters several times a year (according to traditional on special days of celebration).

It was also common to store unopened gifts of clothes, etc. to be given to daughters at a later time (at times of special celebrations). Gifts given by the daughters-in-law’s family were often given to visiting daughters. My impression was that, in Meopor, gifts of Dan were generally highly appreciated by the family who received it; clothes and sweets are “luxuries” – very appreciated items (due to the scarce economy).

**Worship**

The primary ritual worship-events in Meopur are connected to Sayid Baba, and Sitala Mata.
**Sitala Mata**
In Meopur there was a shrine for the goddess Sitala Mata. She was seen as the goddess of seven kinds of pox-diseases. She is worshiped in several places in India.

In Meopur, all Hindus worshiped her, also some of the Muslims worshiped the goddess. They said she provided protection from pox-diseases and typhoid. A yearly celebration Sitala-ashtami was held for the goddess. The goddess was considered to be hot-tempered, so she needed to be cooled down. Heat made the goddess angry. The house had to be made cold on the day of the festival, through ritual washing. All the participants had to take full baths, and it is forbidden to cook anything on the stove that day. The heat will make the goddess angry which could cause an outbreak of illness. Food offered to the goddess as well as for the villagers must be prepared the day before the festival. The goddess received five dishes.

The old women performed the worship. Women of all ages sang songs to honour the goddess.

Despite the festival, villagers could be afflicted by the diseases the festival was supposed to protect against. Anthropologists such as Helen Lambert(1997) have noted that worship is more related to an auspicious outcome of the illness, than to complete protection (Lambert, 1997). When afflicted with pox disease or typhoid, villagers in Meopur usually treated the disease at home without consulting a doctor. Three leaves from the neem-tree were put into the right hand of the sick child. It was seen as crucial that the food given to the patient was “hot”, in the sense of having a heating effect on the body, and pearl millet (hot) was seen as good. In addition, black tea containing a variety of herbs such as long pepper or papal, cardamom and tulsi, was given to the patient. Food seen as having a cooling effect on the body was avoided. The heating food and tea was seen to help the disease leave the body. If the illness did not “come out”, the situation would become critical; some villagers said the illness would change character and could resemble tuberculosis. When the illness was over, they would go to the Sitala Mata shrine. They would bring some cold food similar to during the festival and perform puja for the goddess. Villagers knew that when one child was afflicted all children in the family could get the disease and sought precautions through prayers. Among Muslims in Meopur who did not worship the goddess, several still followed the same diet when illness occurred.

**Sayyid baba**
The common belief is that the nature of one person can be transferred through water and cooked food. By offering food as prashad to the gods in “Puja” ritual, the food “digested” by the good brings...
auspiciousness to the person who eats it. Puja can be done individually, or in ceremonies for one caste or for the whole village.

Muslim worship at the Sayyid Baba shrine was also spoken of as Puja. Sayyid Baba was said to have been a particularly good-natured man. He is also worshiped elsewhere in Rajasthan (2003b). Before the rainy season, wheat and money were collected from all the nearby villages and sold on the market. The money from this sale was used to buy rice and sugar to make Ganji, a sweet rice-dish which was offered to the saint, and also distributed to all people who prayed for rain. Then according to the villagers, rain would indeed come.

Individual prayers were also said to the saint, sometimes the person praying made a promise that a later gift would be given if the prayer was fulfilled. If his promise was not fulfilled – when the person received what he prayed for – the spirit could get angry and cause problems; manifested as unfortunate events or illness. One of the Muslim women believed that the saint had possessed her because she had not kept a promise of offering a religious cloth.

**Rituals after the birth of a boy.**

The wife’s parental family brings gifts when she becomes mother. Significantly more gifts are given if the baby is a boy than if it is a girl. When a baby boy is born, the grandmother of the newborn child (the mother-in-law of the mother who has just given birth), or a Dai hits a metal-plate, so everyone knows that a boy has been born. The women gather and sing songs. Large celebrations are held one and one-half months after the birth of a boy when the mother has regained her ritual cleanliness after the delivery.

Hindu families celebrate koa–puja (well-worship). Previously, Meo-Muslims also celebrated the Hindu ritual of well-worship after the birth of a boy (Mayaram, 2003). But to day Muslim families celebrate Hakika after the birth of a boy.

In the celebration of koa puja (worship of the well), the primary ritual worship is performed by the baby’s mother. Women gather and sing outside her room while she changes into a new yellow sari. The mother holds leaves on her head and a necklace of ten rupees around her neck. A drummer plays and the women dance in the streets while following the mother to the well. When they reach the well, the mother performs puja. She offers wheat-seeds and turmeric powder to the well, and prays for good luck and a blessed life for the child. After this ceremony, gifts are given from the family of the baby’s mother to the family of the baby’s father, which includes both money and cloth and are given to all family-members.
Like in all celebrations, the final distribution happens when the guests have left. The husbands in the family pass gifts of cloth (as Dan) to all the married sisters who have attended the ceremony; no daughter should leave the village empty handed.

Muslims celebrate Hakika. The day before this celebration they slaughter a goat and distribute the meat together with rice to all Muslims in the village. Prayers are held for the good luck of the child. The next day a Maulvi come. Prayers are held for good luck of the child. The babies mothers side give the baby a jola, jewellery in gold to baby. They also give cloth to all member of the father’s family (as dan).

Performance of rituals is necessary to ensure good luck and health. A Muslim grandmother told that in the end it was Allah that was the source of the good health of all her family members. To follow various ritual obligations is therefore seen as important.

Chapter 4. Government health services in Meopur

We have seen that villagers have a wide variety of ideas and practises to improve fertility, complete a successful pregnancy and to protect the mother and child against illnesses and malignant forces. In his chapter, I will give a presentation of the government’s health services and the role and work performed by the Auxiliary Nurse Midwife (ANM) and the other public lay health-workers in the effort to improve mother- and child-health in Meopur.

The lay health-workers are persons living in the village. They do not have formal health education but the government gives them a short period of training. The lay-health-workers in Meopur include: an ASHA-Sahyogini, an Anganwadi Worker, an Anganwadi-Helper and a Jan Mangal couple. The lay health-workers were involved in various tasks related to facilitate and increase the use of public health services.

This chapter begins with a short account of the planning and implementation of various public health-schemes in Meopur and Rajasthan. Next I give outline of the work the lay-health-workers in Meopur; do to inform, motivate and mobilizes the villagers to use the government health services and convince them to follow the public-health advices.
In Meopur the “ASHA Sayoghooni” and the wife in the “Jan Mangal-couple” (titles of public lay health-workers) were sisters-in-law and; both were members of my host family and important sources of information for me- as this paper reflects.

**Planned and actual implementation of various health-initiatives in Meopur, Rajasthan and India.**

To understand how the role of the lay health-workers are shaped - both by what they have been taught or told to teach - as well as their personal background - , i.e. both their intentional role and their actual role - requires detailed observation. This is also important in order to understand how they - lay health-workers - influence the health-seeking behaviour of the inhabitants.

I will start by giving a short historical background for the introduction of the new health-schemes and their devolvement, in Rajasthan. The outline is not intended to give a complete outline of the government’s health initiatives in Rajasthan, but performed in order to facilitate the readers understanding of the government’s health initiatives in Meopur.

It should be noted that it exist a discrepancy between the time the schemes were introduced by the Indian government and the actual implementation in many villages, including Meopur. It is also likely to be some variation between Meopur and other villages. Some of the schemes which date back to 1975 and 1990 had recently been introduced in Meopur. Some planned initiatives were still incompletely implemented in Meopur. The discrepancy may remind the reader, that implementation-process of health programs often is an long and time-consuming possess - for several reasons; it requires human resources, economical founding ,and planning (Lyengar, Lyengar, & Gupta, 2009).

**The introduction of health initiatives**

The government of India proclaimed the Integrated Child Development Service Scheme (ICDS) in 1975: This program aim to provide nutrition to children from 0-6 years of age and further referral of severely undernourished children and stimulating sound activities for

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22 Se "Maternal Health: A case Study of Rajasthan” for the progress of planned and Implemented health initiatives Rajasthan.(Lyengar, Lyengar, & Gupta, 2009)
preschool children. The government would provide an Angawadi centre, a courtyard shelter with preschool activities for children between 3-6 years old; Where also a daily nutritious hot meal would be served. An Anganwadi worker and an Anganwadi helper (Sahayoka) –would be selected among the village/local-women to do this work. The Anganwadi Worker has the responsibility for the daily preschool-activities and the Anganwadi helper will assist in the care for children, keeping the Anganwadi Center clean and prepare the daily nutritious hot meal. The Anganwadi worker would also work with improving the nutrition, weighing and registration of infants and children, and distribute supplementary nutritious flour called “puchahar”, and refer undernourished children. In the state of Rajasthan also a third worker “Sahyogini” was connected to the Anganwadi centre to assist in the work of nutrition; this work is coordinated the with ANM (Ministry of Woman and Child Development,n.d.) The ICDS scheme also included that the Axillaries Nurse Midwife should provide immunization/vaccine.

In 1991 Rajasthan - as the only state in India - initiated a community based “contraceptive program”. A volunteer local husband-wife couple was selected as Jan Mangal Couple (JMC). The JMC would contribute to curb the birth-rate; this was also seen as a way to improve the health of mother and child and thereby also the welfare of the whole family. The JMC-couple should inform the villagers about health-risks related to short intervals between deliveries, the risks of pregnancy in very young or old age and the risks related to many deliveries. They would motivate villagers to limit their number of children, preferably to two. The JMC gets a supply of condoms and birth-control pills to distribute free of cost to villagers. This supply is given to them by the Axillary Nurse Midwife.

JMC is a married couple, the intention is that in this way the wife can attend to women and the husband to men, and they will be able to coordinate their work. A Jan Mangal couple should be selected in every village with more than 1000 inhabitants. (SIHFW, 2008b)

In 1992-1997 under the “Child Survival and Safe Motherhood Program”, a training program for Dais, (traditional birth attendants) were initiated. One Dai in every villages would go through a 6-days training-program offered by the government.. The Dai was also supposed to be provided with a safe “delivery-kit”.(Lyengar, Lyengar, & Gupta, 2009)
In April 2005 the government of India launched the National Rural Health Mission (2005-2012). A comprehensive health initiative intended to provide effective health-care for the rural population. NRHM aims for a radical improvement in the general health-status and a substantial reduction of mother/child deaths; a concrete measure taken to reach goal 4 and 5 of “the millennium development goal”. The NRHM integrates several vertical Health programs. It aims both to improve the infrastructure, and it to facilitate access and utilization of health services. Rajasthan was one out of 18 states that were given special attention due to weak public-health indicators (NRHM, 2005).

The NRHM schemes include:

An introduction of a monthly “health day” in every village (1000 + in population). Health-activities on this day includes: vaccination, giving nutrition food, and pregnancy-checks. The work is done by the Auxiliary Nurse Midwife, in cooperation with lay-health workers in the village.

Another key component under NRHM was the introduction of a new lay health-worker an “Accredited Social Health Activist” ASHA. The ASHA acts as a mediator between the public-health-system and the local health-workers. The ASHA were selected among the women married into the village. She should be between 21 -45 years old and have completed 8 years of school.. The ASHA would undertake 23 day training (NRHM, 2005). In Rajasthan the position as ASHA were given to the Sahyogini, - the “third” health-worker at the Anganwadi center to avoid a duplication of roles. ASHA is therefore called ASHA – Sahyogini in Rajasthan. The role of the ASHA-Sahyogini is to create awareness and counsel villagers about nutrition , a healthy life, safe delivery at hospital, sanitation, contraception and other health services. The ASHA – Sahyogini will mobilize villagers for utilization of health-services such as vaccination during the Mother Child Health and Nutrition day and accompany woman to hospital at the time of delivery. (NRHM-Rajasthan, ASHA, n.d)

The ASHA–Sahyogini are responsible for arranging a monthly meeting in the “Village Health and Sanitation Comity” (VHSC): This comity is also new under NRHM. It consists of a panchayat member, the ANM and lay health workers, a school teacher, a member from a member of “Self Help” (micro-financed)-group and representatives from other organizations in the village (NRHM-Rajasthan, 2012).

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23 Village council
A key aim for NRHM is to increase hospital-delivery, ante- and post-natal care and to implement the Joyana Suraksha Yojana (JSY) scheme. In the JSY scheme the government grants an amount of 1400 Rs to all women giving birth at hospital. If they go alone they will also get 300 Rs to cover transportation-costs. The deliveries are supposed to be free of charge; caesarean section, medicines and everything needed to keep mother and child healthy for the first 30 days after delivery included (free). If the ASHA- Sahyoginy arrange the transportation and accompany the woman to the hospital she receives money to pay for the transportation and 200Rs for “herself”; 100 Rs of this amount are regarded as payment for having ensured that the woman giving birth has received 3 tetanus vaccines during pregnancy and got 2 pregnancy-controls. The other 100 Rs, also include payment for five postnatal checks, within 42 days after delivery. The Jan Mangal can also accompany the woman about to deliver to hospital; she will then receive 200 Rs (SIHFW, 2008a)

**The implementation of health services in Meopur – illustrating the importance of lay health-workers**

In 1998 the ANM began to work in Meopur and two neighbour villages. At this time there were no lay health workers in the village and she had to go from door-to-door with vaccines. The Auxiliary Nurse Midwive’s experience in 1998 illustrates the important role the engagement of the local lay health-workers has in bridging trust –between the public health-system and villagers.

The Auxiliary Nurse Midwife was a Christian. She belonged to another social-class. In her family everybody was either doctors or nurses. She came from a different state in India and spoke a different dialect. She had never been in a village before. She was ordered to work in the village by the government. In the beginning she faced problems understanding villagers and to make herself understood. She lived in the city and came to village only to work. In several ways she differed socio-culturally from the villagers. This is not unusual for nurses and doctors who attend to villagers.

Distrust in health-workers was common many places in India for several years after the “emergency-period” under Indira Gandhi; 1975-1977. At the time of emergency the Indian government’s main focused were “population stabilisation” Due to the fear of over-population the government made use of force to get people sterilized. (Unnithan-Kumar,
2003, p. 183). Several Muslims lower-class and low-caste Hindu communities had very negative experiences during this period; some Muslims even feared that the state planned their extermination. The way sterilization-“campaigns” was conducted created a long-distrust between villagers and the government. (Pinto, 2008; Unnithan-Kumar, 2003; Jeffery, Jeffery, & Jeffery, 2008)

The first ANM in Meopur told that villagers initially met her with distrust. Villagers had hidden their children inside their houses when the ANM came with vaccine (at that time she went from door to door with vaccination). The lay health-workers in Meopur also told me that villagers had been sceptical. Not only Muslims, also the low caste Hindus were distrustful-. Rangini - who today is Jan Mangal,- told she had hidden her children inside her house when the Axillary Nurse came. Her mother-in-law had instructed her to do so. Some feared that the polio drops distributed by the government (ANM) was a trick to destroy the fertility of their children.

To gain villagers trust, the ANM had contacted the former Sarpanch, the head of the village council. He was a local person trusted by the villagers. The Sarpanch went to villagers’ houses and explained that vaccination was good. This helped the ANM to gain the trust of the villagers.

Engaging local people to mediate between non-local (professional) public health-workers and villagers seems to have a good trust-enhancing effect; The Sarpanch and the lay-health worker are from the same village. Villagers are familiar with them. They share the same dialect and life-conditions. The other villagers view the lay health workers first and foremost as a “villager” (one of us). They use appropriate family-terms when they speak to them not “madame”; a word they use when they speak to nurses or doctors who are seen as above them in rank.

Since the lay health-workers are local persons, who live in the same village, share the same language and have similar social background, it is easier for villagers to trust them. From several observations and interviews I learned that villagers in Meopur often were sceptical to strangers. Many were unsure and fearful in unfamiliar settings, such as at the hospital, (this will be illustrated by examples in chapter 5). That the lay health-workers also knew the Auxiliary Nurse Midwife and the procedures at the hospital during sterilization camps, delivery, at times of illness etc. Hence, her company made villagers feel more comfortable and safer than when meeting “strangers”; unknown people in unfamiliar settings.
The Implementation of the various lay-health workers in Meopur

The Anganwadi worker and the Anganwadi Helper were introduced in Meopur in 2001. The Anganwadi Worker was from the Meo caste and educated to 6th class. The Anganwadi Helper was from the Kumar caste and illiterate.

“The Sahyogini” were established in Meopur in 2004 The first Sahyogini was Ambu - the youngest daughter in my host family. The Sahyogini had to be educated up to the 8 class and few women in the village qualified. A short time after she moved to Meopur the ASHA scheme came and she became Asha-Sahyogini.

The first Jan Mangal Couple began working in Meopur 2007. The ANM in Meopur had selected Vikram; the oldest of the married sons in my host family, and his wife Ragini as JMC. The ANM selected Ragini because she was an intelligent, active and engaged woman. Ragini had also been very helpful to the ANM earlier. The ANM felt she knew Ragini and was sure she would do a good job. The ANM told me that she had wanted Ragini as ASHA, but that it had not been possible since the ASHA position requires a minimum of 8 years of education and Ragini was illiterate. Rangini was able to write her name but nothing more. Ragini’s husband had some education; this had enabled the ANM to select Ragini as Jan Mangal. Ragini’s husband would help her to fill the forms.

The government had also provided birth-attendant training for one elderly woman in 2005. This woman was an old widow who sometimes assisted deliveries. First the ANM had asked another old widow who also had assisted deliveries; this woman told me that she had not accepted it because her son disliked her delivery-assistance. The woman who had been trained told she did it because every village had to send one woman. Right after she had been trained the majority of women in the village started to go to the hospital at the time of delivery, due to the introduction of the JSY scheme.

The JSY scheme was introduced in 2005. This lead to a major change in delivery practises. Before 2005 almost all deliveries were at home. Now, the majority of villagers went to hospital at the time of delivery.
The monthly health-day –“Mother Child Health and Nutrition Day (MCHN)”, were at the Anganwadi Centre in Meopur. The Anganwadi centre was a small room, approximately 10 square meters. It had a door facing directly out toward the streets. It was not used as a day care centre for children. The government paid rent -200Rs -to the owner in Meopur. The Anganwadi worker said it was not enough for larger room. During the MCHN day, the ANM stayed at the Anganwadi Centre. At the time of my fieldwork it were the Anganwadi worker and Jan Mangal wife who went from house to house and mobilized mothers with babies and pregnant women to come to the Anganwadi centre for vaccination. Women were given three tetanus vaccines during pregnancy, and children BCG, DPT1, DPT2, DPT3, Polio and measles vaccines on these health- days. Disposable syringes where used when vaccinating. Vitamin A and iron were also given. The ANM measured the blood pressure of the pregnant women. Tuberculous patients got medicines these healt-days. The ANM also took blood samples from women with fever during the rainy season; tests for malaria were also performed. The Anganwadi worker, distributed nutritious flour, pushahar, during these MCHM days.

Polio-campaigns were held several times during a year. The lay-health workers went from house-to-house and gave oral polio vaccines to children.

The lay-health workers also motivated – and accompanied village women - to public health services offered outside the village. The model below show some of the health

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24 In some other villages government has provided the building of Anganwadi center or building affiliated with schools, so had larger space could provide this function. The ANM im Meopur hoped that the government would provide a building in Meopur.
At time of delivery the first referral unit were the Community Health Centre (CHC), 8 km from Meopur. Since the CHC did not have facilities for managing complicated deliveries it was common that women was referred to the district hospital in the city if a risk factors were present. This included first-time deliveries, young or old age and delayed pregnancies. At the District Hospital they were better equipped to handle complication. They could perform caesarean section and give blood-transfusions. In the District Hospital a “Sick Newborn Care Unit “which has been established - the bulk of the cost to establish this unit came from “ Norwegian Partnership Initiative” (NIPI). In cooperation with NIPI. An ”Yashooda” “- a lay-health-post has also recently been established at the district hospital and at the Community Health Center. One of the tasks of an Yashooda is to motivate mothers to stay at least 48 hours at the hospital after giving birth and not to delay breastfeeding “the sooner the better”. Usually villagers from Meopur left CHC few hours after delivery. Those who deliver at the district hospital were encouraged to stay up to tree day.

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25 More detailed description of services at different levels is the public health system is available at: http://nrhmrajasthan.nic.in/Programmes.htm
Sterilization camps were arranged monthly at the CHC. The sterilizations were performed by a mobile team who arrived at the date of the camp. Women came from all the surrounding villages on this day. It was crowded both in the courtyard, and the halls. The delivery-room at the CHC was utilized for check-ups, the corridors was utilized for injection and for resting after the operation. The women are accompanied by Jan Mangal or other lay health-workers such as the local ASHA. Government arrange free transportation, and the respective health worker follows the women back home. Lay health workers explain how to take medicines and what food to eat. The woman who has undertaken sterilization receives a 600 Rs check as compensation/reward. Copper T is also offered at the CHC.

During my fieldwork there was a Copper -T campaign located at the Sub-Centre. It was sponsored by an NGO, otherwise it is more common to go to the CHC to insert Copper T. At one day monthly it was possible for those who missed vaccination during the Mother Child Health and Nutrition day to take these at the Sub-Centre. It was more common that villager in Meopur delayed the vaccines to next MCHM day in the village.

**Influence of personal factors and life situation-factors on the works performed by the lay health-worker.**

There were variations in how active the different lay health-workers in the village were. In Meopur, the Jan Mangal woman was very active. She also performed some of the ASHA’s tasks. In another village under the same ANM, the ASHA was the most active person, also in regard to family-planning. Personal variations such as age, gender, personality, and position in the family are important in the role/work as lay health-worker. Their relationship with other villagers cannot be separated from their role and their life-circumstances influence the result of their work. Variations in performance might occur; much of the motivation is done in informal settings, such as when the JMW meets a woman on her way to the field. Below, I will show how some of the personal characteristic of the ASHA and Jan Mangal influenced their work at the time of my fieldwork.

The government has as a criteria that the couple must live in the village, have credibility within the community and be willing to work as volunteers. It is also a criteria that the Jan
Mangal Couple are between 25 and 35 years of age and that they are functionally literate (WHO India, 2004, s. 98). State Institute of Health and Family Welfare in Rajasthan has recommended in their evaluation of the Jan Mangal Program that couples above 35 years of age should be replaced immediately and that those between 31 and 35 should be considered for replacement. They base their argument on the assumption that it will be better with a young JMC because young couples lack the courage to talk to senior persons about contraceptive methods or ask “embarrassing” questions. In Meopur, the Jan Mangal was above the age-criteria, but several other personal factors out-weighed this “lack”

Ragini was 38 years old. Despite the fact that she had exceeded the age criteria for JMC, her age turned out to be more of an advantage than a disadvantage in many situations. Ragini did not have small children. Her daughter was 21 years old and able to take care of the buffaloes, do, housework and work in the field. Ragini had also separated her household from her parents-in-law. Together, these factors gave her flexibility and made it easier for her to be active. For women with small children and separate households it might be more difficult to find time free from child care, house- and fieldwork. In joint households, other women may provide assistance looking after her children. Still, the activity of young daughters-in-law may, in joint households, be restricting in several ways. Ambu, who worked as ASHA, was initially optimistic. Her mother-in-law and Ragini had accompanied her in her work in the village. However, later, several factors had interfered with her work. She received complaints from her sister-in-law, Basthi, because Basthi had to do more house- and field work when Ambu did “ASHA work.” The mother-in-law also began to demand that Ambu should work more at home and in the field. Due to Ambu’s pregnancy problem, the healer had requested that Ambu should stay away from pregnant women in the period before and after delivery, nor should she leave the village. Therefore, in practice, Ambu had resigned several aspects of her tasks as ASHA. These restrictions made her work difficult to accomplish and, as it was the beginning of her child-caring period, her personal life-situation were likely to inhibits her activities in the years to come. When I spoke to Ambu, she said that when her household became separated from her parents-in-law, she would again become active. However, from the conversation with other members in the family, this did not seem to be a likely prospect. Her parents-in-law were unwilling to separate the land to their two youngest sons. Because the two other sons had separated cooking, it was not likely the parents-in-law would allow/appreciate that Ambu and her husband separated their cooking.
Ragini talked to mothers-in-law and husbands about diet and gave diet-advice. During my field work, she told mothers-in-law several times what they should give their daughters-in-law something to eat after birth. As we saw in chapter three woman in postpartum do not cook them self, due to postpartum pollution. Due to her age, Rangini was able to speak more freely to parents-in-law, as well to the wife’s husbands, since many of them were younger than she was. Hence, she was able to negotiate between family members. This would have been difficult for a younger ASHA or JMW. As illustrated in chapter one, younger women are expected to show a higher degree of respect, act submissive and with sharam in their meeting with elder people and as women they are not supposed to talk to men older than their husband.

When we asked women if they had considered sterilization or Copper T, the most common answer was that the parents-in-law or husband wanted did not permit them to do so. In such cases the, JMW was able to talk to the mother-in-law and often also to the husband. As JMW, Ragini, was active and took the initiative to talk about family planning. She told village women that they could receive a supply of condoms and birth control pills if they came to her house.

During my field work, Ragini and the Anganwadi worker shared the task of mobilizing mothers and children to attend the vaccination day. Rangini accompanied the ASHA during polio-campaign. She, followed women to sterilization camps, and several times she had accompanied woman to hospital at time of delivery. Rangini’s support surpassed the tasks she should perform according to the government schemes (JMW- and ASHA-work). Village women came to her to get advice or assistance with all kinds of health problems. She sometimes accompanied sick women to several government services, and sometimes she followed them to private doctors or healers.

During my stay, a Muslim mother-in-law came to Rangini’s house because her daughter-in-law was weak and sick. Ragini accompanied them to the city, to the private clinic where the wife of her husband’s boss worked as a doctor. She also followed a Muslim mother-in-law and bahu to visit the healer in her pihar (to the healer who treated Ambu for bareness). Ragini also provided help to women who struggled to conceive or were ill. This gave her an advantage in her work as Jan Mangal. Her engagement, together with her personal
qualities and life circumstances, gave her ability to mediate between several family members and flexibility in her work – she could be there “in time of need”, i.e. advantages that “age” can’t easily disqualify and which were highly appreciated in the community. Stressing the age-factor as the State Institute of Family Welfare (SIFW) does – may if strictly applied - exclude well-qualified people. Among those who came to Rangini for regular supplies condoms were younger female relatives; a “health-seeking behaviour” who according to SIFW (SIHFW, 2008b, p. 15)should be “particularly difficult”.

**Role-models and Family Planning.**

The government has stressed in its program that the government workers themselves should conform to the small family norm and preferably be able to pose as role-models. Both the Auxiliary Nurse Midwife and the Jan Mangal wife made use of their own experience as examples when they talked to villagers about family planning. Most women in the village did not see it as an option to undergo sterilization without consent of their husband and parents-in-law. The Jan Mangal wife was a living example that women had the ability to take independent actions; to form their own life. Rangini and her husband had three children, two boys and one girl when she opted for sterilization. Both her parents-in-law and her husband had initially reacted with anger to her choice. When they failed to convince her, the parents-in-law began to pressure her husband to stop her plan. He had beaten her. She did it without his permission. Afterwards, her husband admitted that she had made the right decision and supported her. Although Ragini was uneducated, she and her husband were among the few villagers with children undertaking an education at the university level. Her 21-year old daughter and 18-year old son were both undertaking bachelor degrees at the university in the city. Hence, the Jan Mangal Couple had limited their number of children and invested in their education. The ANM was an example that illustrated sterilization also could be undertaken without sons. The ANM chose sterilization after the birth of two daughters. Because the government has decided to exclude people having more than two children from access to government jobs, she had to get sterilized to keep her job. Both the ANM and the Jan Mangal often used themselves as examples during conversations and motivation of villagers.

**Lay health workers information and motivation**
There was a difference in types of knowledge between ANM, ASHA and the Jan Mangal, but the knowledge they transferred to villagers was pretty much the same. During mobilization, it was common to call villagers to come, not to explain first. But it was emphasized that vaccines was good and prevented illness. Also economical arguments were used.

The Anganwadi-helper said she told villagers that after tetanus vaccines they did not have to worry if the child got a cut. She said she explained to villagers that it was a free service from the government, and it was better to take one injection now, than pay for several injections at the time of illness. The ANM also said that they informed villagers that they had to take three tetanus vaccines during pregnancy, which was necessary to receive the JSY money. In this way, she said, also those who did not view vaccination as necessary to prevent illness came to the Anganwadi Centre. Both ANM-worker and the ASHA explained to me how vaccinations worked, referring to immunization and specific diseases. Rangini was reluctant to answer this question and told me to ask the ASHA, although she knew it helped for tetanus, polio, measles and some other illness.

When the ANM spoke to a woman after delivery, she recommended easily digestible food, such as fruits of papaya and a fruit called chiko. She also recommended that lapsi, which is seen as good by the villagers, was given right away and not after a week. To drink milk was good. Rangini repeated these advices to villagers. She also explained that to start breastfeeding immediately after delivery was good and told them that she had breast fed her youngest son immediately after birth - against the will of her mother-in-law - and that he had been in good health. Why it was good was seldom explained to the villager. Health advices had a moral - human based - component. One should follow them because it was best for the mother and the child.

Ambu had previously followed women to the hospital at times of delivery, Rangini also did this work. Rangini had knowledge about the hospital facility, how to register, where to get medicines, did remember to ask for information about how to take medicines etc. This - as I will show in the next chapter - were important knowledge for those who were unfamiliar with the hospitals. In the next chapter, I will also illustrate the effect of ANM and lay health-workers recommendations concerning diet and vaccination.

Trust and confidentiality.
As I will show below, confidentiality and trust in the lay health-workers can give women courage and opportunity to take action in matters concerning family planning despite lack of family-support. Both the JMW and ANM found it preferable that a woman had the support of her family-in-law in relation to contraceptives and family planning. They would help the women to convince them, but they also supported women who took the decision into their own hands, and provided them with support and confidentiality. At a Copper T camp, I observed one Muslim woman who wanted to insert a Copper T without her family-in-law’s knowledge.

When we asked Hindu- and Muslim-women about contraception, the will/wish of the husband and parents-in-law was stressed. The interdependence in relation to work and economy provides parent-in-law with power and possibility for negative sanctions. In addition to social and economic sanctions, a woman risk verbal abuse or corporal punishment. Several women informed their husbands but not their parents-in-law. Copper T was among the contraceptive easiest for women to do secretly. Sterilization is almost impossible to keep secret. The woman is still drugged when she returns home and her body needs time to recover afterwards. While she recovers, she is dependent upon a female relative’s cooperation to help with work in the household and farm. Condom use requires cooperation with the husband. However, both birth control pills and Copper T was possible for a woman to take without others’ consent. JMW stressed that operation and condoms were much safer that Copper T and oral pills because the body sometimes took time to adjust to the Copper T and several woman had side effects of white discharge.

The problems with the pill was that it was not supposed to be used by breastfeeding women as it affected the breast-milk, and that the pill caused bleeding if it was not taken regularly. Some women had difficulties in understanding that it had to be taken at the same time every day. Condoms and pills might be difficult to hide in the room the couple share with children; JMW said some women had hidden them in the field. Another problem JMW mentioned was periods without a supply of pills given by the government.

For the women who decide to take action into their own hands, it is crucial to be able to trust the ANM and other lay health-workers to maintain confidentiality. Both the ANM and the JM were aware of this and it had also been a subject during their training. Their direct knowledge about the particular village-woman and the involvement or non-involvement of members of
her family-in-law in the decision making, enabled them to act with sensitivity. Still, they told about an episode when a supervisor came to the village to check the validity of their registrations. He lacked the knowledge about the particular circumstances of women and had confronted a woman who secretly had inserted a Copper T. Her family-in-law was not informed. Due to fear of reprisal, she refused and told the supervisor that she had not inserted a Copper T, but the damage was already done. Consequently, the health-workers had to face suspicions of false registration. The woman had been severely beaten by her husband, and mistreated by her family-in-law after the supervisor left. The JMW and the other lay health-workers in the village were able to attend to villagers in a discreet manner, because they see villagers during informal meetings in the field, passing on the road, or villagers who come by their house during the day. This stands in contrast to other health consultations where there usually are no privacy during consultation. At both public- and private doctors, it is common that a queue stands around the doctor’s desk and waits during the doctor’s consultation with other patients. When the ANM is in the village during the Mother and Child Health and Nutrition Day (MCHN), many people are inside the Anganwadi Centre at the same time. Healers also usually have all patients in the room at the same time. The lay health-workers might be able to provide confidentiality due to informal contact with villagers. The informal setting; the private atmosphere when a lay health-worker meets a woman face-to-face – is favourable to break the barrier against talking about sensitive subjects like the use of contraceptives.

The Jan Mangal Couple in Meopur spent more time doing their work in the beginning than they did “now” i.e when I did my fieldwork. When villagers got to know them and their work, many people came to their house to get their regular supply of condoms or birth-control pills. As with other large families, it is common that many people meet in Jan Mangal Couple’s home. Jan Mangal distributed the condoms and pills in a very discreet manner. Trust has to be mutual. If the Jan Mangal had deceived a villager in the interest of the state, the villagers trust in her would be damaged.

**Strategies of health workers and potential influence of trust**

Above I have illustrated some aspects of the role of the lay health-workers in Meopur. In the same way as the individual personality may influence the role and work of the lay health worker, different strategies may be used and have potential for affecting the villagers’ trust in
the lay health workers. The other example is from the Copper T campaign in Chotipur where Dagrun Kyte Gjostein did observation during her field work.

JMW (Rangini) and I went to the Copper-T campaign at the sub centre (the sub centre gives health-services to 3 villages including Meopur) in the neighbouring village. Inside the sub centre, the ANM, two other nurses and the ASHA from another village were present. No women from Meopur were going to obtain a Copper T that day. Then two village women entered the sub centre. They wanted some information about Copper T. The ANM took up a round plate. The top was made of glass. The plate was a model of the female reproductive organs viewed from the inside. The ANM took a Copper T from her supply. She inserted it into the “uterus”/plate. Through the glass top it was possible to see how the T shape made it easy for the Copper T to enter and to stay inside the uterus without falling out. The ANM pointed and explained while the women watched. After the women had left, the ANM showed the model plate to JMW(Rangini). She looked carefully while the ANM explained. The ANM gave the model and the Copper T to Rangini and said she could use it in her work in Meopur to demonstrate for the village women how Copper T worked. The next day a woman came to the Rangini’s house to get condoms. Inside the room, the Rangini picked up the model and the Copper T she had been given by the ANM. She inserted the Copper T into the plate, pointed and explained its use to the woman.

Copper T camp, near Chotipur: holding back information
The ANM in Chotipur had to get five women to take Copper T at the day of the Cooper T campaign, to be able to reach her minimum target. Due to this she told the ASHA’s to bring five women, if they did not do it they would not receive their salary. In this village, several women in the elder generation had previously experienced side-effects after using Copper T, and the women’s fear of side effects from Copper T prevailed. ANM told the ASHAs to tell the women that it was an IUD injection, and not to mention the word” Copper T”, by doing so the ASHA got five women to come for Copper T at the day of the Copper T campaign. The ASHA felt uncomfortable doing this. These women were interested in contraceptives for spacing, but not in Cooper T. The day after, the women got to know that it was a Copper T that had been inserted. They went to the Anganwadi-centre and demanded that the Copper - T’s. should be removed.(Gjøstein, 2012)
The example shows that ANMs use different strategies. The ANM who covered Meopur applied an open, educative, and pedagogical method. This can have positive effects in the long-run, as it also contributes to building trust in the relationship between the villagers and health workers. In Chotipur, a high caste, dominates in the village. Distrust in health workers might not have been as low as it initially was in Meopur. However, in Meopur - and also in other villages especially with low-caste and Muslims not too many years ago there was a deep distrust towards the government’s health workers. Trust between villagers and health-workers is essential for a health-system to function in a proper way. It takes time to build trust, and unfortunately it can easily be broken. Manipulation and holding back information- not to say direct lies seldom pays off in the long run. Unnithan-Kumar’s study among poor women in Jaipur, illustrates that public health programs which focus on controlling fertility easily leads to distrust and avoidance of government health services (Unnithan-Kumar, 2003)

Technologies of Subjectivity and Technologies of subjection

To offer free health service is not seen as enough to ensure that the services are utilized by all layers/groups of the population. The Indian government has, therefore, also made use of several strategies or “technologies” which is well within what Foucault (2000) has termed “governmentality” i.e. knowledge and practises made used of, systematically and pragmatically, to regulate every day conduct - (cited, in Ong 2007, p.4). In the following part I will use Aiowha Ong’s (2007) division of the governmental strategies into “Technologies of subjectivity” and “Technologies of Subjection” (Ong, Neoliberalism as exception: mutations in citizenship and sovereignty, 2007, p. 6) to illustrate some of the governmental strategies the government of India make use of to regulate health-seeking behaviour. Technology of subjectivities refers to an array of knowledge and expert systems to induce self-animation and self-government (Ong 2007). It desires to shape peoples’ attitudes and knowledge so that they will behave in a way that corresponds with the wishes of the state.

Strategies of subjectivity, includes when the lay and government health workers provide information about diet advices, particularly among young children, pregnant women and
woman in post partum. It is also includes a learning of risks, and what is good citizenship. The Dai who had been given training by the government told me that she had learned that she should not assist women who were young, old or first time delivery, they had taught her that these were “risk deliveries”, so she should not assist them, rather explain to the woman it were a dangerous situation and tell to go to the hospital. The other lay health workers had also learned this. When a daughter of one of the woman in the village had died under a hospital delivery, Rangini told other women that it happened because the women was very young, and that deliveries at an young age are dangerous. The lay health workers also recommend a gap of three years between births to reduce the risk of anemia (lack of blood). Use of role models, can also be seen as a strategy of subjectivity. Rangini, used herself as an example; both in relation to family planning and breast-feeding. Lay health-workers tell villagers about benefits with small families. ’ Having few children enables the parent to take better care of their children and they can invest more in their children’s education and increase the welfare of the family. The ANM told me that she motivated the parents to think of the future of their children by saying “If you dye having many sons, the land will be divided among them, and they will become poor”. Rangini also stressed that she knew how important family planning was for the country. Hench, the lay- health workers and the ANM not only give information they also promote good- citizen-ship and moral. And in this way do what the (Nordfeldt & Roalkvam, 2010)

Technologies of subjection are a political strategy to regulate population for optimal productivity (Ong, 2006)The government hope to change behaviour through various types of laws, incentives and disincentives that will influence a person’s choice. Rather than changing attitudes or knowledge directly. Extreme “technologies of subjection” implies direct physical force. As I have mentioned earlier the Indian government utilized such strategies under the emergency in 1975-1977. Since then, family planning has merged together with a comprehensive health and welfare system. Force is no longer used, but techniques of subjection are still used by the government today.

For example, the government has, in order to make people limit their number of children, introduced “The law of the two child norm” in several states after 1993. This law disqualifies everybody who has more than two children to be elected as Panch or Sarpanch in the

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village counsels. This law became effective in Rajasthan on November 27, 1995 (Visaria, Acharya, & Raj, 2006). In 2002, the law was extended and include government servants. The law declares that “Appointing authority shall have right to retire a Government servant in public interest, if he/she has more than three children on or after 1st June, 2002” (Finance Department Rajasthan, 2007). Although this - as mentioned before - give preference to role models, the “role-models” may also be “subjected to be role-models” (to keep their job etc.).

Techniques of subjection also include rewards for good behaviour. This might include the JSY money given to women who give birth at a hospital. Although the incentives sometimes are called “compensation for expenses”, some villagers choose hospital-delivery mainly due to the “JSY- money “given Therefore it can be seen as “a technique of subjection”. I will be discussed this in the next chapter.

In this chapter I have shown that using lay health workers can seen as a strategy to restore and build trust between the public health- system and villagers. Villagers may trust lay health-workers’ recommendations. But the aspect of social-support might be equally important; that they will be looked after and guided by the lay health-worker in a hospital setting. This will be further elaborated in the next chapter. Lay health workers’ has and important roles in bridging trust between the State and the government. Villager’s evaluation of government health services are shaped by what they learn from personal experience and conversations with other villagers and relatives. This will be illustrated in the following chapter.

Chapter 5

Knowledge, and villagers utilization of government services

Information and knowledge transferred from the government through ANM and the lay health workers in the village, does not come in a vacuum. Villagers do not lack knowledge but have another type of knowledge. In this chapter I will look at how villagers integrate knowledge from the state and from the lay health workers with the knowledge they already have, and

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how it effects their health seeking behaviour. As Barth (2002) emphasize in the article "Sidney Mintz lecture2000: “An Anthropology of Knowledge” person has knowledge from several sources, much of it comes from what a person has experiences or heard from others. I have tried to include several types of knowledge that circulates among the inhabitans in Meopur village and which influences their utilization of government health services. Also aspects such as trust, social-relationship and technologies of subjectivity and subjection is taken into the analyse .I will now continue to analyze the health seeking behavior of villagers related to the government health programs presented in the previous chapter; nutrition, breast feeding, vaccination, hospital delivery and family planning

**Diet, the problem of mutually exclusive advices**

Studies done by Neicher (1996) from India, have shown that nutritional advices from health personnel such as to drink milk; often were interpreted as balancing the heating effect of allopathic medicine (Nichter & Nichter, 1996, p. 216). Allopathic medicines were interpreted according to properties such as colour and taste which indicate their cooling or heating qualities(Nichter & Nichter, 1996, p. 221) My observations in Meopur were similar (see also Nordfeldt & Roaldkvam 2010). For villagers to understand a diet advice that aims to increase the nutritional intake during post partum, advice has to be transferred together with knowledge ; fx."food consists of specific nutritious elements in the forms of carbohydrates, proteins, fat, vitamins and minerals - elements you have to incorporate in the diet". In chapter three we saw that villagers in Meopur categories all food into hot and cold, and easy and hard to digest. Their diet knowledge was transferred from elders, healers or other village women - at times of illnesses such knowledge got extra attention . Few questioned this knowledge, villagers accumulate such knowledge from many sources/ situations, and integrates in their knowledge. The ANM and lay health-workers recommended papaya, chiko-fruit and lapsi and told the mothers to eat some easily digestible food immediately after delivery and continue to do so during the postpartum period. However, since this contradicted previous knowledge about diet, such advices would be rejected/not applied.

The Popular medical knowledge of the villagers can, to some extent, be seen as having a great syncretic ability, an ability to combine several kinds of treatments and diets,.Healing and allopathic medicine may be combined as illustrated in the case of Ambu in chapter three . It was common that villagers sought help from both doctors and healers, this was not seen as problematic. Rejection of diet advices from the government might be due the confusion it
creates because it sometimes seems to be in direct opposition to previous knowledge. In chapter one we saw that postpartum and times of illness, both were periods during which diet were seen as especially important.

The case below illustrates the concern, worries and confusion of a Muslim grandmother, when her twelve days old grandson was sick. The grandmother wonder if her grandson had become sick due to the food the mother had eaten; but she also considers other possible causes for her grandson:

Rangini (the Jan Mangal), Cecilie Nordfeldt my research assistant and I went to visit a family with a sick baby. Inside the room, Devrani, the mother of the baby-boy, was resting on the string cot with the baby in front of her. The baby had fever and - had developed a rash all over his body it had started the previous evening. The day after delivery the ANM advised the mother to drink milk, eat some fruits and a small amount of food - instead of just drinking black tea. Devrani had followed the dietary-advice from the ANM and also breastfeed the baby right after delivery. Now the baby was sick. Devrani struggled to breastfeed him.

Rangini asked the mother-in-law why she refused her daughter-in-law to drink milk

“I don’t know, some say we should not give milk to the mother after delivery, she should just drink black tea. You say milk is better than tea. This is why I am confused. Apart from this, I do not have any issues against giving milk to her. When I gave birth, my mother-in-law forbade us to stay in fan air (wind). My daughter-in-law has slept in fan air. She has also been drinking milk. This is not good. Old people taught us these precautions, so they must have some meaning. We should follow them. This is why I am feeling scared. The baby is ill. He is only twelve days old today. I did not protest, therefore my daughter-in-law is in this position now. She does not listen carefully to me when I am talking. We do not allow women to eat chapatti and milk the first two weeks after delivery. It can be harmful for the baby’s stomach. The mother can drink tea. Last evening the baby did not have fever. But the mother slept in the wind from the fan together with the baby,- so the baby have fever.”

The grandmother is worried about her grandson, the major concern is his health. Trying to make sense of why the baby is ill, the grandmother switches from explanations such as “diet” to “wind”. Devrani and her sister –in-law had taken the sick baby to the Maulvi (Muslim
healer), who lived nearby. He had said the baby suffered from Nazar and he had provided some nakkas for him (paper medicine with Urdu writing on it) These had been given to the baby with water). They had also visited the local “doctor”, who was educated as a lab technician. He gave them some liquid medicine, they did not know what was. None of the treatments helped. We convinced the mother and mother-in-law to bring the baby to the Sick Newborn Care Unit at the government hospital We accompanied them There the doctors treated the baby for an allergic reaction caused by new cloth. The baby got well. Rangini stayed one night at the hospital with the mother and child.

While the illness, in this case, was not directly related to diet, the example illustrates the worries of a grandmother. She felt she had not been clear enough ;telling her daughter to keep the traditional diet restriction,.She also felt that her daughter-in-law had not paid attention to her advices,. Still she were not sure about the cause of the illness, since none of the treatment had not helped. This case illustrate the contrast/difference between new and old dietary advices , and how confusing and difficult it can be for both the young and old generation in a joint family.Similar doubt/confusion I also sensed in other similar cases

**Vaccination, when new advices were not in conflict with elders**

While “dietary restrictions” were problematic mainly because they contradicted the diet precaution villagers saw as necessary to prevent illness; vaccination, was less problematic. Vaccine -coverage had been steadily increasing in Meopur during the last 5-10 years. It was above 80%. As I showed in the previous chapter ASHA and ANM had knowledge of antibodies. But they gave no detailed explanation to the villagers.Trust seemed to be the key factor for the increase. Some women told they had gone for vaccination because they had been called by the lay health worker, but they had not reflected over of how vaccine “works” in body, they were too occupied with agricultural work.

The government had painted health-messages on some of the houses in the village, these” said”: “take to two drops, and don’t worry about polio” another said “take vaccines - get rid of illness”. Several villager said that they took vaccination because it was good; other knew that vaccines worked against some illnesses fx. Tetanus and polio.

In work-intensive periods such as the harvest season taking vaccine got less priority. People were occupied with agricultural work.
A few villagers who did not come for vaccination on other days told they were afraid of side effects, such as pain, fever. This is a common side-effect with the DPT-vaccine, and the AMN usually informed about this, saying it was normal and distributed paracet. But some told that because they child had cried for a whole day, they did not go to get vaccination the next time they were called upon..

**Deliveries, villagers view on JSY money and birth technologies**
As mentioned in the previous chapter, the introduction of JSY- money created a change in delivery-practises. Since its introduction in 2005 the majority of woman had chosen hospital-delivery. However, there were still some women who gave birth at home, or other places than the government-hospital. Villagers decision of where to go for delivery were usually a decision based on what they had experienced - or seen or heard from others (Barth, Sidney Mintz Lecture 2000: An Anthropology of Knowledge, 2002). Villagers evaluated various aspects with hospital-delivery from their own and others experiences. Their evaluation included economical factors, facilities at the hospital, availability of trained personal, technologies to solve complications such as caesarean section, episiotomy, injections and skills of the birth attendants. They also considered aspects such as sharam (shame), feelings of security and social support. Below I refer some of the concerns, mentioned when women explained why they were in favour of home-delivery or hospital delivery. Mother-in-law and daughter in-law sometimes had different opinions, but there were no clear generation tendency; sometimes it was the mother who preferred hospital delivery – sometimes it was the mother-in-law.

**JSY money and payment at hospital: normal delivery and complications**
Some women said that their most important reason for choosing hospital-delivery was “the-JSY money”. Others emphasised that hospital-delivery was safer due to its facility. Although the majority of villagers saw the JSY money as positive, it was also seen as problematic due to “hidden” expenses to doctor and nurses.

A mother-in-law to a woman who had delivered at hospital said: “After the delivery they also demanded some money, 500 for the doctor and 500 for the nurse. If they were not given the
money, they would not discharge the mother from the hospital. This is the reason why I do not like hospital-delivery. Poor people go to the hospital because they think the government will pay them some money and the money will help them, but they have to pay for renting transportation, doctor and nurse and the delivery gets more expensive.”

Among the women who had delivered at a hospital there was a considerable variety in how much money they had paid. A few said they did not have to pay anything. The majority of the women had paid 500 Rs or more to doctors and nurses. Some told they had to pay extra money to the nurse because they gave birth to a boy. Traditionally Dais are paid more money if the baby born is a boy. Villagers said they had heard that nurses sometimes refused to assist the delivery if they did not pay them money first.

As mentioned in the previous chapter, families receive money for transportation directly, if they are not accompanied by the ASHA. When families became aware of the fact, that they could receive more money by going alone, the demand for assistance from lay-health workers decreased. Some viewed this as an opportunity to save expenses. The result is often a more risky form of transportation. In one of the poor families, the husband had borrowed a motor bike to take his wife to the hospital at the time of delivery.

**Expenses related to complications**

In the previous chapter it was mentioned that according to the JSY scheme all cost related to hospital deliveries, including caesarean-section and medicines, are supposed to be free of charge (SIHFW, 2008a). However, it still often involves considerable expenses for the family if a complication occurs. According to Rangini said it usually took longer time for a woman to recover from caesarean-section, sometimes six months, and it could be difficult to take a bath and cleanse the wound.

At the hospital we talked to two women. The caesarean-section was free, but medicine expenses were a considerable burden for both families. Both women had had a caesarean-section and both they and their babies were ill.

One of the women had been to the government-hospital three times after her delivery. “Doctors gave an injection, cut my stomach and the baby came out. The whole procedure took only between 5 to 10 minutes. That was fine –and I felt well. After the operation, they shifted me to another ward. The doctor told me to rest and I fall asleep. In the night I got
fever. My family (accompanying her) went to the doctor’s office to get medicine. He refused.” Her baby had a problem passing urine and she had problems with her blood pressure and the stretches after the caesarean. She had many re-hospitalizations and had spent most of the two last months in hospital. “We don’t have money, so we have to borrow money from our relatives. My medicines cost us 120 Rs a day. My husband stays with me. He had to leave his job.”

The other family had spent 11,000 Rs in medicine at a hospital and 2,000 Rs in the village. The monthly salary of the husband was, in comparison, 4,000 Rs.

The majority of the villagers in Meopur viewed the JSY-money as positive; it had considerable influence on their decision to go to the hospital at the time of delivery. Villagers shared narratives about expenses at times of illness and delivery, about the price of medicines, payment to doctors and nurses, as well as of items, services, and dowry and other expenses. Cost and expenses were subjects of great interest. The majority of villagers were aware of the fact that they had to pay hidden expenses at hospital. They received the JSY money first after the delivery. The majority of villagers did not have much money. But the hidden expenses were most problematic for the poorest families, who were not able to give payment in advance; hence this delay had more influence on the health seeking behaviour of the poorest families. Extra expenditures in medicine due to complication, is a large burden for a family. Still: - I heard several stories were villagers had used considerable money in medical treatment for a woman or child. Obvious health matters to them, and they are willing to make substantial sacrifices to keep the family in good health.

**Risk, safety and technologies at the hospital.**

Conceptualization of risk and safety concerning birth differed among the villagers. Primarily, villagers agreed that the facilities at the hospital were positive, and several emphasised that in hospital everything was done in time. However, several villagers were sceptical to caesarean section and episiotomy.

**Risk deliveries; caesarian section vs skill to “turn it into a normal delivery”**

In the book “Birth in four culture”, Birgit Jordan (1978) writes that attribution of superiority of technology is a tendency for any stable system, not only systems that are technologically highly developed. Dona Juana, a Mayan birth-attendant, argued that doctors did not have
knowledge of the technique of turning the baby in utero, and that this method was superior to caesarean section (Jordan, Birth in Four Cultures: a crosscultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States, 1978, p. 69). Jordan emphasizes that such claims to technical superiority often are based on pragmatic experience and careful observations and should not be dismissed but taken seriously by incorporating the technique of turning the baby in utero into medical practices.

Also in Meopur, several women mentioned this skill, which some traditional birth-attendants had. Information about Dais or birth attendants with such skills was shared between relatives and neighbours within Meopur. Sometimes they went to the woman’s natal village if they knew about a skilled birth-attendant there, even though this - as explained in chapter one, otherwise was associated with sharam. There were several cases where women had left the government hospital when the doctor told them that they needed a caesarean section.

Karuna, a Muslim woman who had just given birth at home, told she wanted to go to a hospital for delivery but her mother-in-law had called a Dai from a neighbouring village. Karuna’s mother-in-law explained she was afraid to let Karuna give birth at a hospital because her oldest daughter-in-law had gone to the hospital before two deliveries both times the doctor told her that she needed a caesarean section. Both times they left the hospital and went to Haryana (a different district) to a Dai. The mother-in-law said “Someone in the village told me about this Dai, she is a retired nurse and a relative. She helped my bahu to have a normal delivery. That is the reason why I believe more in Dais than in doctors.”

Three other women told similar stories. In one case, the woman had first taken an ultrasonography at the government hospital. She had been told that her child had died inside her womb. Her family decided to leave the government hospital. They went to a private hospital recommended by a relative, as the birth attendant had skills to do it as a normal birth. There the woman delivered a living and healthy boy.

The use of technologies at hospital, were particularly questioned because it was applied in situations where it did not appear to be necessary. Nanda, a mother-in-law in Meopur, mentioned as one the reasons she thought home delivery was safer:

“Often they try to make a normal delivery into an operation. They always make a cut. I have seen this several times. They did it before a delivery, but they also do it after a delivery. First time I saw it I thought they did it so the baby could come out easily. But
they did it after a delivery too and in a case of a normal delivery; then I was not able to understand anymore.”

Villagers usually applied the English term “operation” for sterilization, Caesarean section, and episiotomy. In this case it is likely that the woman had observed episiotomy.

In Mepur, one of the old widows who assisted births also knew how to turn the baby in the uterus. She told she had learned to turn babies in utero by observing how it was done on a cow. Later she tried it on a woman and then through practice she became an “expert”. She had helped several women to have a normal delivery. Her daughter-in-law emphasized that because of these skills, her mother-in-law did good work, and should not stop helping women, but washing of clothes she should not do. Her husband still feared pollution from her work.

The old widow had been an elected member of the panchayat. Indian Dais have - in much of literature - been described in terms of “lack of qualifications”, as “cord cutters and removers of pollution”(Hollen, 2003). The above examples show that there are differences in skills and experiences and that villagers often share knowledge about birth-attendants with specific skills at times of complication/emergency. The assistance of Dais resulting in a safe normal delivery in cases where the alternative was a caesarean-section at hospital - might have increased the positive value of Dais.

This knowledge spreads through informal social networks – but is not equally distributed. In Meopur mostly Muslims - and the majority Meos - referred to skilled Dais. Dais, usually assisted members of their own caste, and some of the lower caste Muslims also assisted Meo women - but not Hindus. This indicates that there were, a larger difference between Muslims and Hindus in access to this type of assistance, than with healers. The exchange of such information seemed wide-spread among the Meos than among other castes in Meopur. Still knowledge also crossed caste-barriers.

**Induced labour – a change in women’s perception of delivery-pain**

Several anthropologist have described the frequent, (somewhere almost runite) use of oxytocin to induce labour at hospitals in India(Jeffery, Dasb, Dasguta, & Jeffery, 2007; Hollen, 2003).Cecilia Van Hollen (2003) writes about women in Tamil Nadu who get oxytocin to induce labour. Oxytocin increases contractions, which also result in increased pain. Hollen writes that some of the Tamil Nadu-women said that oxytocin increased Pain, and their Sakti (power) and modernity ;others women said that oxytocin - and “the forces of
modernity” depleted their Sakti (Hollen, 2003). In Tulsi Patel (2006) study among women in a village in Rajasthan a view of “pain” during delivery as a “natural burden”. And that deliveries were handled without anxiety. Tulsi Patel (2006) also stress that:

“The experience of pain is highly conditioned by the mediation of cultural and social practices. Pain is both a fact and a value. Pain as a fact acquires different values in different cultures. Pain is understood, experienced and responded to customarily. The socially-defined perception of pain and its appropriation at the subjective level plays a crucial role in understanding and controlling it or in relenting under it.”


At the CHC; I observed a woman who was given two injections at the time of delivery; one to induce labour, another to enlarge the vaginal opening. Both the Jan Mangal and other women in Meopur confirmed that it was standard to give two injections. Some women said because the delivery and placenta was taken care of “faster” in the hospital, it was less painful; they regard it as positive and safer. The citing below shows how a Hindu woman in Meopur, compared hospital deliveries with deliveries with home.

“When I gave birth to my first two children at home the Dai (traditional birth attendant) did not come on time. Both times I had already given birth when she arrived. My husband went to her house when my labor-pain started, but she was not at home so she did not arrive in time to assist the births. Such situations can be very dangerous. I was only 16 or 17 at the time. At such a young age giving birth may be very critical. The Dai never pulls the placenta from the stomach. She always tries to push it from the stomach side. This is often very painful often and may last half an hour or more. In hospital they do it very fast. Therefore I consider a hospital delivery is safer and better than a home delivery”.

Some Muslims had a similar view; when a mother in –law said “We receive money when a child is born at hospital, so we prefer hospital birth. Her daughter in law added “In the hospital they have trained personal present. To give birth there is less painful than to give birth at home.”
The emphasis these mothers have on danger, lack of facilities and pain in home deliveries is in contrast to what Tulsi Patel (Patel 2006) describes as a “matter-of course attitude” to birth and the evaluation of labor pain as a “necessary evil” expressed by the mothers in the village. These differences in attitude concerning danger and pain related to delivery might be seen in relation to changes in delivery-practices accompanying Janani Suraksha Yojana (JSy) scheme. When there are alternatives and the estimation of enduring “pain” might somehow lose its heroic value.

The availability of personnel and facilities

Vasha, the daughter-in-law of Nanda was positive towards the hospital-delivery:

“Hospital delivery is best, the hospital has all kinds of facilities so you do not have to be afraid if a dangerous situation occurs. Sometimes women who do not go to hospital at the times of delivery and die due to the lack of facilities. During home deliveries, we have to wait before the Dai give the baby a bath, or sometime she refuses to bath the baby and a family-member has to do it. In the hospital we have to do nothing - everything is done in time. The baby even gets an injection at the time of birth so the baby and the mother will be healthy and relaxed.”

Some births are assisted only by mother-in-laws or family-members. Several women told me that the Dai was called only after the delivery; to cut the umbilical cord (this brings “pollution) The help women got from their mothers-in-law varied-. One woman told me that her mother-in-law that had gone to the field to work instead of assisting with the birth. Others had a mother-in-law that helped with everything, receiving the baby, cutting cord and washing the baby. Some women said that during home-delivery everybody thought they knew how to do things best. Women argued and forgot to give attention to the mother. The importance of social relationship will be further elaborated below.

Social relationships at times of delivery

Unnithan-Kumar (2001) studied women’s reproductive health-seeking behaviour in a village in Jaipur district in Rajasthan. Unnithan-Kumar has emphasized a need to modify the focus, Indian health-planners and health-policy makers have, on the importance of education in relation to Rajasthani women’s health seeking behaviour. She argued that emotional states
and personal relationships are important in decision making about who will assist during delivery and are crucial for understanding the health-seeking behaviour. Intimate relationships often mattered more than expertise in selecting a woman to assist at the time of delivery. Hospital deliveries were still uncommon at the time of her field work (Unnithan-Kumar, 2001, p. 29). According to Brigitte Jordan (1978), the importance of human companionship is even more important for women who give birth in unfamiliar surroundings or when under stress. Emotional factors influence physiological factors, Sometimes - also in delivery-situations - emotional support/lack of support can lead to arrest of labour and fatal distress (Jordan, Birth in Four Cultures: a crosscultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States, 1978, pp. 46-48).

In Meopur, there were also variations in who was supported at times of delivery. The availability of someone to assist during home delivery varied among the women and also castes. The few elderly women who sometimes worked as a Dai, did not see themselves as Dai in the sense of occupation but had started to do this work after they had been widowed to earn some money They mostly assisted relatives. Low caste Muslims would help women from the Meo-caste but not from the Jatav-caste. Jatav had - before the introduction of the JSY scheme - been assisted by an old widowed relative in another village. In the Kumar family, the mother-in-law did it all, including the cord-cutting. In general, women who had separated their household from their parents-in-law seemed to have a less guaranty for assistance by her mother-in-law, both in home- and hospital-deliveries, especially if they had separated households without the approval from their parents-in-law. Sometimes men worked outside Meopur. In such situations, the assistance of ASHA or Jan Mangal to accompany the women to hospital was of special importance.

Rangini’s neighbour lived “separate” and her husband worked away from the village. She was clear in her preference to deliver at home. She feared bad treatment by the hospital staff due to what she had heard from other women. Still, at the time of delivery, there was no one willing to assist her at home. She went to a hospital together with Rangini and the government trained Dai.

Sometimes, women who lacked support went to the hospital with relatives from their birth-village, despite that this usually is associated with sharam.

Some families had little experience with a hospitals. They felt safer accompanied by relatives or lay health-workers. In one case, a woman and her husband cancelled the transportation they
had called for going to the hospital while the chauffeur waited in the garden. They called a Dai because the lay health-worker was not home. They still had to pay the chauffeur 300 rupees.

**Sharam**
During delivery at a hospital, a woman risks that a male doctor would see her during the delivery. To be seen by a man involved shame (sharam). There was, to a large degree, an agreement that - under special circumstances - situations which involved sharam to some extent could be “understood”/exused... The fact that the majority of the women in the village during the last years had given birth at a hospital shows that many families have made an exception and risked shame by assistance of a male doctor at the time of delivery. The ANM emphasized that it sometimes was challenging to convince villagers to deliver at a hospital since it was a possibility that a male doctor would assist at the time of delivery. Several men had said to the ANM that they would not allow their wife to give birth at the hospital if a male doctor assisted the delivery, but if the doctor was female it was okay. The ANM tried to explain that the doctor should be seen as a God who tried to save the life of their wife and child, not a man. The concept of sharam, was often mentioned in connection with hospital delivery.; as a negative aspect with such deliveries

Nanda, mother-in-law of Varsha, said: “If we think in view of facilities the hospital is better than home. But if we think about the” safety of the ladies”, home is better than hospital because at the hospital doctors are mainly men. We never want a man to see our women, but this is impossible to avoid at the time of delivery if the doctor is a man. During home-delivery only ladies will be permitted inside enter the “delivery-room”:

A pregnant daughter in-law in the Kumar family also mentioned sharam related to a man at the hospital. She was going to give birth at home. She also mentioned the importance of having relatives and people she knew around her. Her mother-in-law had assisted with many deliveries and was experienced.
Social support during hospital stays

Many women said they were afraid of being at the hospital - their reasons were not always further explained. Many say that they felt more comfortable at home where they were surrounded by neighbours and relatives. Some women said that women in the village had told them that they had been hit - or talked to in a derogative “abusive” way when they screamed due to pain during delivery. Similar stories have also been noted by other anthropologists.

In Jaipur, Unnithan-Kumar (2003) noted a widespread fear that public hospitals would perform sterilization without consent at times of delivery (Unnithan-Kumar, 2003). We asked a Muslim woman with five children, if the nurse had talked abusively to her or put pressure on her to get sterilized at the time of delivery. The woman said no, but she added that the nurse did not know how many children she had. Rangini, who was present, commented that it was probably because she had been accompanied by her brother, that “otherwise, every time I go with a woman, they ask how many children she has, and if she has more than two they try to force her to have an operation” Rangini’s comment illustrates that that social support from a trusted person might be seen as crucial in a hospital setting.

The way patients are received can be an experience that discourage them to stay. Both times I was with women from the village at the district-hospital a uniformed guard was among the first people we met. The first time we (Rangini, the mother-in-law of the “mother” and I) went to the hospital - accompanying, a mother and her sick baby; this guard told the mother-in-law not to enter the Sick Newborn Care Unit. He did so in an authoritative manner. He did not paying respect to the older women - nor offering her a place to sit. She sat down on the floor. The guard reacted immediately when I sat down beside her - he hurried to offer me - but not her - a better place to sit (in a separate room with chairs). I stayed with her.

In the other case, we came to the district hospital with a woman who was sick during the first week after delivery. We had to register in one building and walk over to another at some distance. There we were met by a uniformed guard who asked why the woman was there. The woman told him that she was sick. The guard said she was at the wrong place and told her to go back to the building where they do the registrations. It was my assistant that convinced the guard that the woman had been referred to the doctor, then the woman was allowed to pass the guard and go to the doctor.

A Yashooda - working at the district hospital - receives women who come to the hospital to give birth. Then the reception and guidance are hopefully much better. It is important that
family members who accompany them feel comfortable. The way they are received can determine whether they stay or not. The mother-in-law was obviously in distress; she pointed at the fan and said it was due to winds (wind might indicate evil spirits) that she was afraid to stay at the hospital. Rangini (JMW) stayed with the woman who had the sick baby that night. In the other case we accompanied a woman to hospital, I observed this woman’s anxiety, when the doctor wanted to admit her for three days, She started to cry - she was afraid to be left alone at the hospital. Her family comforted her and said they would take her home –which they did, They also bought the medicines prescribed.

It was a common sight that a women carried a knives as protection against spirits at the hospital - also at the delivery-unit. However, fear of spirits and pollution was seldom mentioned by villagers who argued that home delivery was better than hospital, For this reason, it will not be further elaborated. The importance of social support, on the other hand, - as illustrate above - were often emphasized. To be accompanied by a lay health-worker can be vital for those villagers who are most fear-full for hospital, and for women with little support from relatives.

That fact that some women about to give birth leave the hospital when they are told they need a caesarean-section, indicates a mistrust to the hospital staff’s judgement as well as knowledge about alternatives - “alternative” knowledge gained through a active exchange of information in the social network (family, other women, lay health-workers) Since most of the women are illiterate –oral information far outweigh written information.

**Family planning**

In the previous chapter I showed how JMW and other lay health-workers might function as a technique of subjectivity” i.e. by using themselves as examples. Government also uses propaganda through different media. The text below is from a song the JMW and her friend had learned from a TV commercial.

“The king eats a lots of sweats. He bath in hot water. He baths with flowers. But he has a lot of sons. Please do sterilization. Then all of you can eat good food. The king drinks good drinks. King, please don’t have more children. Get sterilized, then you

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can live happily. If you have more children it will create problem for you. You will not be able to take proper care of your kids. “

Media has contributed significantly in shaping an image of the modern and good citizen as opposed to the backwards and illiterate, through the use a variety of slogans (Nordfeldt & Roalkvam, 2010). In media also demographers and right-wing politicians has repeatedly focused on the high birth-rate among Muslims, to such an extent that it has become common knowledge that Muslim gives birth to more children than Hindus (Jeffery 2005). Muslims are depicted as resistant due to religion as well as backwardness.

The ANM and JMW said that the use of contraceptives had increased significantly in Meopur during the last decade, both among Hindus and Muslims. Some of the Muslims who did not use contraceptives claimed that it was “against the Koran”. Some said it was their own choice. Reference to religion was not common among the Hindus, who almost exclusively established their arguments within the frame of the joint-family. The way Muslims answers when asked about family-planning may strengthen the image of them as dogmatic or resistant. However both among the Hindus and Muslims several had performed sterilization or made use of other contraceptives or had considered it.

When we asked women in Meopur if they had considered family planning, both Hindu- and Muslim-women stressed the wishes of their husband and parents-in-law had an decisive impact. The fertility behaviour among Muslims and Hindus in Meopur did not differ radically from each other. There were both Hindus and Muslims with many children who would not sterilize, as well as women from both religions who had undertaken sterilization after three children.

According to the JMW, Muslims had a tendency to use “Koran-argument” when it was something they did not want to do. Muslims had previously used the Koran as argumentation against vaccination, but now, Muslims came for vaccines.

Muslim women who had time and interest to talk, often showed that they had considered several factors before making a decision. Religion was not necessarily the decisive factor. This is illustrated in the case below:

One day, on our way back from the field, my assistant and I stopped and talked with two Muslim sisters-in-law, Ahisha and Mamuli who lived together in a joint family. Ahisha had
undertaken sterilization. Mamuli was pregnant; she was already a mother to three sons and three daughters and felt she had enough children;

“I am scared to take the sterilization operations, earlier I took a Copper T but it failed. Three months later I ended up like this (pregnant). I used a Copper T but I suffered from white discharge so I removed it. Some women destroy their uterus after using Copper T, so I think it is very dangerous. That is why I am so scared. In reality sterilization is not allowed in our Koran. It is a sin and we got punished from doing this. But now people are aware about sterilization. If they want to become a happy family they have to keep their family small in size.”

Mamuli felt she had enough children, and stressed that she and other women were aware and knew about the benefits of a small family. The way she expressed this were similar to the slogans used by the state (Nordfeldt & Roalkvam, 2010). Mamuli mentioned several concerns; fear for sterilization operation. Religious punishment. Previously, she had experienced side-effects from Copper T and had heard about even more serious side-effects. As with the women from Chotipur (Gjøstein, 2012), fear and experices of side-effects was the major reason why she did not use any prevention. Women like these might appreciate contraceptive alternatives without side-effects (or bad “rumours”).

Personal experiences such as illness during pregnancy and difficult deliveries were factors that increased women’s wish for sterilization. Nassim, a Muslim woman had one daughter and one son, she said “No, I do not want more children. I will go for sterilization. I think two children are ok. I cannot handle more children. If we have only two children we can give them good education, food and clothes. During both my deliveries I got much pain. This time I was sick all the time during my pregnancy. At the time of my delivery, after I had given birth, I felt that I too was as borne again.. I don’t want to get pregnant again.”

When it was not due to illness, sterilization were usually unthinkable without having two sons firs. Ragini, told there generally was considerable pressure from the older generation. She used herself as an example, (se chapter 4). Even Rangini’s sister-in-law, Basthi, who had two daughters and one son, did not view sterilization as an option:
“This is not in my hand, my husband and parents-in-law want one more boy. They usually dislike girls and want only boys. But the girls are God’s gifts to me. My family in-law would not allow me to take an "operation."

Another Hindu (Jatav) woman, Kamilesh, had three daughters and one son told:

“Yes, I have thought about sterilization, but they (family-in-law) would cut my leg off if I did it without their consent”.

These examples show that the split between those who choose sterilization and those who do not – crosses division of castes or religion. This also applies to the Muslims in the village. It is common to wish for at least two or three sons, as this makes the family less vulnerable if something fatal happens to one son. Almost none in the village had privileges such as a pension. They depend on their sons and daughters-in-law to care for them when they get old. Sterilization after one son is seen as risky. The mother-in-law of Basthi, Ambu and Ragini had given birth to six boys, one died in infancy, two as young adults. Such experiences were not uncommon. Some deaths were caused by disease, others by accidents. Rangini told that only during the last 3 years 10 small children had drowned in the small wells families have for buffaloes to drink. Such experiences or knowledge of others who have lost a child are likely to influence a person’s view on what number of sons is desirable.

Tulsi Patel (2006, p. 165), who did fieldwork in Rajasthan, has argued that in addition to an optimal number of sons, advance in age and attaining status as parents-in-law also was important factors for ending fertility. In Meopur, the optimum number of sons seemed to overshadow the two others. Three women were pregnant at the same time as their daughter or daughter-in-law. Sometimes I mistook a mother for being the grandmother of her child. In these cases, all said they wanted one more son.

Not many families in Meopur wished many girls, but they tried to achieve their ideal number of sons, usually two. Kamilesh was a woman in a “such” a family. She gave birth to a daughter before the harvest season. “Maybe next time I will give birth to a boy; then they will care for me,” she said. Even if the woman feels tired of having children, if the next child
is a boy her in-laws are pleased, her status will increase and perhaps she will receive the care she is longing for.

A Muslim woman who was sterilized during my field work had two boys and one girl. This is the ideal minimum for most of the villagers.

Government employees’ situations are different from the situations of the majority of the villagers in Meopur. Government employees are subjected to the law of the two-child norm, so they have to limit their number of children to keep their job. However, a Government employee is also given security in old age through pension and his family will receive the family pension if the government employee dies. The law of the two-children norm is likely to exclude most of the young fertile couples in Meopur from a position in the panchayat by the end of their reproductive carrier. According to the JMC, villagers had not protested against the law. JMC emphasized that the law was quite new and those who had more than two children before the law was introduced were exempted from the law.

Several studies of the effects of the two-children norm have shown that the law has a potential for adverse effects and tends to exclude already vulnerable groups such as poor women from panchayat, while more powerful people might find ways to circumvent the law. The law has caused episodes such as sending away a wife pregnant with the third child to the parental village for period of two years. Some men divorced their wife to marry a second woman in order to have more children (Rao, 2003; Visaria, Acharya, & Raj, 2006). It has also led to sex selective abortion (Buch, 2005). Sex-selective abortion is forbidden by law in India (Government of India, 2003). Research has shown that sex-selective abortions are more common among better educated people, higher caste and land-owning families (Bhatia, 2010).

None of the villagers in Meopur mentioned political ambition or personal- or spousal-ambitions or government-work as reasons for limiting their number of children. A study done by Nirmala Buch (2005) suggests that “long-term familial security” far outweighed political aspiration - in Rajasthan and other states where the law has been introduced - and that the law seems to create many unintended negative effects, but little of the intended effect (Buch, 2005). Although government picture of the good citizen had been internalized the negative sanctioning from the family in-law a woman faced, and the need for security in old age, had stronger influences on women’s decision.
The last five- to ten- years, several major changes have occurred in the health-seeking behaviour of villagers in Meopur, as well as in other villages in rural Rajasthan. After the government of India launched the National Rural Heath Mission in 2005, there has been an increased presence and utilization of government health services; especially in Delivery-practises. In Meopur this has changed from almost exclusively home-deliveries to a majority of hospital deliveries. Hospital deliveries in Rural Rajasthan have nearly doubled in the same period; – from 22.5 % in 2002-2004 to 40.7% in 2007-2008 (Govt. of India, 2008). During the last 10 years the vaccination cover in Meopur has increased significantly, after the introduction of various lay-health workers. In rural Rajasthan; full immunisation –of children more than doubled in the same period, from 18% in 2002-2004 to 46.7% in 2007-2008 (Govt. of India, 2008)

Today, women –and their families, have to make decision related to mother-and child health, based on other criteria’s, information and types of knowledge, than in the past. The introduction of hospital delivery has contributed to a changes in how women experiences “birth”; the risks and pain related to deliveries are no longer met with a “matter of cores” attitudes,” as it was when Tulsi Patel did her fieldwork in a village in Rajasthan (2006, p. 118) Due these changes my study inquires into a “new dimension” compared with previous community studies done within the field of anthropology of birth and health practices in modern, rural India.

The focus of this thesis has been on how knowledge influences health seeking behaviour related to pregnancy, delivery, postpartum and family planning; with a special focus on how such knowledge affects the utilization of government health services. It has illustrated that several types of knowledge - circulates among the villagers in Meopur- and effect health seeking behaviour in various ways.
I have used Barth (2002) concept of knowledge as - “what a person uses to interpret and act in the world”. Barth not only includes information, concepts or verbal taxonomies, he also includes experiences, embodies skills and feeling (attitudes) etc.

In chapter 3 we saw how villager’s popular medical knowledge includes both recommendation and advices from elders, but also the sharing of experiences and observations through gossip and conversation with other villagers and relatives.

Popular knowledge villagers has related to diet, spirit, astrology etc. can partially be understood in relation to Medical traditions, such as Ayurveda, with has a long history in India. But at the same time it is based on personal experiences and through sharing of such experiences. Such knowledge are -real -to the villagers, “they are experienced creating real effects in the world” (Nordfelt, 2005).

Not only spirit or illness experiences is shared and circulates within the village, also experiences related to side effects of copper-t, about hidden expenses at hospitals, abusive nurses, et cetera. This types of knowledge also influences health seeking behaviour in Meopur.

Skills of the–Dais who know how to turn the baby inside the uterus, are now evaluated in contrast to new technology. This skill were evaluated by many villagers as superior to technology –of caesarean section. This skill gave status to dai’s , with this specific knowledge. Several villagers had left the government -hospital when the doctor told they need sectarian section.

The case of Ambu, illustrated that illness, is not only is physical, but also- social suffering. , not only does a barren woman often face abuse from her parents in law, but also threat of divorce and lack of care in old age. Suffering, can be a strong drive force in health seeking behaviour.

I have given special attention to the transferral of knowledge from government- and lay-health workers, healers, and doctors, and the effect of these: Barth (1990) has suggested this focus using his ideal types of knowledge transferral - “guru” and the “conjurer”.

The knowledge provided by doctor at the hospitals is just like that provided by the healers; it is minimal and remains to some extent “esoteric”. The case of Ambu also illustrated a central feature in how villager’s judge validity related to different “experts” explanations of the cause
of illness. Villagers use “successful cure” – both bodily experience and sharing of such experiences - as a criteria of judging the validity of different types of medical treatment; villagers tend to attribute successful treatment with specific healers- or –doctors, and also dais. The sharing of these success-histories among villagers has a significantly impact on their health seeking behaviour. At times of prolonged illness a pattern of visiting, multiple healers and doctor, is typical. The patient will usually not endure a long lasting relationship as the guru has to his students. Even when someone settles with a particular doctor or a healer (as Ambu did), the relationship does not last longer than the illness.

The limited transferral of knowledge from doctor and healers is despite the fact that the Indian Ayurvedic, and allopathic medical tradition, are highly abstracted traditions –.making them, as emphasized by Barth, “easy to transference”. The similarities between popular knowledge and advices given by healer, still makes the healers advices, easier to integrate logically.

Diet advices provided by the government – through the ANM and Lay health workers are transferred in the form of “words”, but the way it is done, does not enable villagers, to validate it in relation to the body of medical knowledge it belongs to, i.e nutrition, vitamins etc. Villagers interpret such –advices- in relation their popular knowledge-classifying –it into hot and cold. Because the Public health advices, given to woman after delivery contradict with popular knowledge they create confusion, and are often rejected.

Committed Mothers-in-law, who rejects this advices, does so out of fear that it will harm the baby or mother. When health -recommendations are not contradicted by popular knowledge or socio-economical factors, such as in vaccination, villagers follow public health advices in a larger extent.

The change in vaccination has taken place, despite a lack of transfer of knowledge about antibodies from health workers. It has not been a “natural” demand for vaccines. To make villagers utilize these services has demanded an engagement of local-persons to – bridge trust, to provide information, and to motivate; even then it is necessary that lay health workers go to their home bring them on the vaccination day.

To illustrate the process of how knowledge and information is transferred by the government and how this contributes to changes in health seeking behavior. I have seen it as useful to
introduce other concepts, than those used by Barth. By using Ong’s (2007) division of “technologies of subjectivity” and “Technologies of subjection” the focus is drawn to the different strategies the government uses to increase the utilization of government health services; to make them “good citizens” who internalize public health advices, and becomes self regulating individuals. It also draws the focus to other strategies, which effects health seeking behavior through regulation of laws, incentives and disincentives. Through a change in circumstances factors example; economical rewards, access to job, et cetera.

We have seen that government make use of “role models”- those who can make use themselves as examples to follow as “good-citizen” and that advice from the ANM and lay health worker might be framed as moral obligation. The lay health workers also transfer information of incentives and disincentives, such as that it is necessary to take vaccines to receive money given by JSY.

The effect of these, much be seen in relation to other social-and economical factors. Villagers in Meopur, underscored knew -small families are happy family families. But at the same time, they are equally aware that sons, bring both an immediate rise in status, and security in old age.

I have shown that trust and social-support, is important aspects influencing utilization of health services. It might be discussed if trust and social-support is “Knowledge”, but when it is seen in relation to what villagers has heard from others, such as the histories of forced sterilization, uncaring health personnel, nurses who demand payment in advance, and also an unfamiliar setting at the hospital; Resonance – i.e an emphatic approach (Wikan, 1992), makes it easy to understand the feeling of fear, many women mentioned in relation to hospital-deliveries. The emphasise woman gave on the importance of social support; it might be based on the knowledge -that there is less risk for unpleasant experience surrounded by supporting relatives or- a trusted woman from the village such as the lay-health worker. Emotion might be seen as both a person reaction -towards the world, and also a form of embodied knowledge about the world.
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