The lived experiences of childbearing in a *basti*

Performing pregnancy and relationships in Jaipur, India

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Like the lives of women who constitute the core of this study, this work is the result of a combination of factors, a whole constituted of many smaller parts. I composed it on my computer, but without these women and their families there would have been nothing to type about. They allowed me into their lives, trusted me with their most personal stories, and shared their hopes and fears with me. For this I will be forever indebted.

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Transliteration and Usage

Customary English spellings for Hindi and Rajasthani words have been used. Common words such as Anganwadi and Pucca have not been italicized. All translations are mine except where mentioned otherwise.

Hindi and Rajasthani terms used

Anganwadi	The primary health and nutrition centre
Bahu	Daughter-in-law
Basti	Slum
Bhaari	Heavy
Bhabhi	Sister-in-law (brother's wife)
Chulha	Traditional wood burning stove
Dai	Traditional midwife
Devrani	Sister-in-law (younger brother-in-law's wife)
Girna	To fall
Halka	Light
Jauhar	Medieval Rajasthani custom
Jethani	Sister-in-law (older brother-in-law's wife)
Kachha Time	Raw stage
Karnewaala	One who provides care and support
Nanad	Sister-in-law (husband's sister)
Poora Time	Complete stage
Pucca	Permanent
Purdah	Religious and social practice of female seclusion prevalent among some Muslim and Hindu communities. It takes two forms: physical segregation of the sexes in the household and the requirement that women cover their bodies so as to cover their skin and conceal their form
Rajasthani	From Rajasthan or pertains to Rajasthan
Roti	Flat bread consumed in north India
Saas	Mother-in-law

Abbreviations

ANC	Antenatal Care
ANM	Assistant Nursing midwife
ASHA	Accredited Social Health Activist
IIHMR	Indian Institute of Health Management Research
IMR	Infant mortality rate
JSY	Jnani Suraksha Yojana
MDG	Millennium Development Goals
MMR	Maternal mortality rate
NHM	National Health Mission
OBC	Other Backward Classes
PHED	Public Health Engineering Department
SC	Scheduled Caste
ST	Scheduled Tribe
UA	Urban Agglomerates

Chapter 1: Introduction

India has been experiencing rapid socio-economic transformation in the past few decades. These transformations have of course permeated into every aspect of everyday life and have been significantly transforming how women lead their lives in cities, towns and villages across the country. While women's lives in India, especially the ones who are socio-economically vulnerable, continues to be arduous – right from high rates of infant mortality and female infanticide, poor nutritional and education levels, early marriage, high incidence of gender-based violence, to low autonomy and decision-making power in the household, low levels of female participation in the workforce and so on – leading to the country's labelling as "the most dangerous country for women" (Thomson Reuters Foundation, 2018), they have also been slowly but surely transforming. It is these transformations - that have been modifying gender norms, cultural values and everyday practices and in turn influencing women's health and well-being - I intend to bring to the fore. Specifically, I focus on transformations in women's health experiences and states - especially on childbearing experiences among women living in urban slums or *basti*s as they are referred to locally.

Women living in these *basti*s occupy a socio-economic milieu that is very different from the ones that their non-*basti* counterparts occupy. Not only are the *basti* women more likely to face structural socio-economic challenges such as poverty, nutritional deficiency, high disease rates, and water-sanitation insecurity, they are also less likely to be equipped to address these challenges due to low levels of autonomy, absence of traditional familial social security nets because of migration histories and strong adherence to cultural norms. This situation that the *basti* women find themselves in – somewhere 'between' rural and urban - has been aptly termed as "village in the city" (Zoe Matthews, Brookes, Stones, & Hossain, 2005).

Since the 1990s there was an increasing academic interest in the physical and emotional burden of ill-health faced by women in resource-poor contexts (Dixon-Mueller & Wasserheit, 1991). In the Indian context, the earliest studies utilized community-level studies to highlight the magnitude of ill-health borne by the women (Bang et al., 1989; Bhatia, 1995). These and most of the other early studies used measurable and clinically verifiable outcomes which have value in highlighting the disparities and allowing comparison over time and across communities, but are extremely narrow in definition and devoid of any contextualization. These studies paved the way for the next level of scholarship that utilized qualitative methods to examine specific disease

conditions embedded within the complex socio-cultural context of reproductive health. Most academic work in this area in the beginning was more exploratory, but gradually led to increasingly complex and analytical work where the focus was on examining, for example, how decision were made about seeking treatment, which kinds of healthcare were sought, how women visualized their diseased bodies, etc. It is within this body of scholarship that my research fits.

The aim of my research is to address this gap and unpack childbearing experiences qualitatively and embed them within the specific socio-economic context. I utilize ethnographic data to uncover how the 'doing of pregnancy' is being transformed at the micro-level. The main research questions that I set out to address are –

1. How are pregnancy and the pregnant body understood and conceptualized by women in Nagar *basti*?
2. How do these conceptualizations influence the performances of pregnancy in an impoverished environment such as Nagar basti?

There are several merits in examining reproductive health as embedded within the socio-cultural context. First and foremost, it allows for a better understanding of popular culture and norms which govern patterns of health behaviour. Secondly, it supports the creation of appropriate health policies and services. Thirdly, it brings to the fore micro-level factors and their significance in improving or hindering women's access to health and well-being. Such a research is especially pertinent given the rapid expansion of urban areas and urban slums (or *bastis*) in the country, which brings ever more women in the precarious situation of being a *basti* dweller.

In my research, I visualize pregnancy as a physiological as well as social process which brings about not only bodily changes but also changes in the social status of the mother as well as family dynamics within the household. I also view pregnancy as an active process which is deliberately performed by the woman everyday. She makes meanings, takes decisions, negotiates with the family to achieve what she believes is a healthy pregnancy and is good for her. As I unpack the tacit meanings and covert processes, I take the reader through the *basti* lanes and inside the homes of these women to understand what it means to be pregnant in the *basti* and how it plays out within the informal spaces of the everyday.

My central argument is that *basti* women, unlike their usual portrayal of helpless victims, are pragmatic in their approach when navigating through their socio-economic vulnerabilities during pregnancy. They strike up alliances, negotiate for autonomy, seek support and resist power dynamics and assert their agency as they go about their everyday routines and perform pregnancy

in a manner that they think is best for them, and demonstrating that they are not just bodies within structures. Nor are they solely agents actively constructing the structures. Rather they are at once both. I utilize the approach of embodiment to handle this relationship of individual pregnant bodies with the society.

Bryan Turner defines embodiment as -

> *"...not a static entity but a series of social processes taking place in the life course. Embodiment is a life process that requires the learning of body techniques such as walking, sitting, dancing, and eating. It is the ensemble of such corporal practices, which produce and give a body its place in everyday life. Embodiment is the mode by which human beings practically engage with and apprehend the world" (Turner, 2004 as cited in Neiterman, 2010).*

In other words, embodiment is a way by which a subject "learns to be in her world" *(Turner, 2004 as cited in Neiterman, 2010)*.

Within my research, I focus on the pregnant embodiment in Nagar *basti*, which involves how women learn to perform pregnancy by abiding by the popular norms and values to become a 'good mother' and a 'good daughter-in-law'. I also consider the pregnant women's family's role in constructing the pregnant embodiment. I locate these micro-level transformations within the overarching culture of medicalization of childbearing and childbirth in India brought on by the State's attempt to reduce maternal and infant deaths, brought in to focus by MDG 4 and 5 ("WHO | Millennium Development Goals 4 and 5," 2011). Thus, the availability of reproductive and newborn healthcare services for 'poor women' was thought of as the magic-bullet to improve the country's chances of achieving MDG 4 and 5. A spate of measures were introduced such as creation of a new cadre of healthcare workers called ASHA (Accredited Social Health Activist) and the Safe motherhood Scheme (JSY). The JSY provides cash incentives to women who opt for childbirth in public healthcare institutions and also for the ASHA who encourages and accompanies women to the healthcare institutions for delivery. As a result, there has been an overt institutionalization of childbearing and childbirth. It is within this context that the everyday practices of pregnancy take place.

Finally, just as there is no one idea of 'healthy pregnancy', there is no one pregnant embodiment or one way of 'doing pregnancy'. Even though the medicalized and State's discourses of pregnancy prescribe a singular manner of doing pregnancy the 'right' way, in reality it is performed in myriad ways. I therefore highlight the differences and variations in how pregnancy

is actively performed in *basti*s rather than describe 'the' way pregnancy is done by the urban poor. I analyse meaning-making processes that enable women to perceive their changing body, popular norms and medico-cultural knowledge and advice, which translates into the performance of pregnancy. Such a treatise would be helpful in understanding how intra-household decisions are made with respect to well-being during pregnancy which may have life-long repercussions not just for the health of women but also of infants.

Theoretically, my work lies within the sociology of health and illness, and I draw from the interactionist tradition which stresses on the meaning-making processes embedded within social interactions. Such an approach requires engagement with the personal narratives of women doing pregnancy to prise open the covert processes of meaning-making. Such an attempt would offer insights into how women make sense of their pregnancy, how they go about doing pregnancy, how it transforms their lives and their relationships. Methodologically, I therefore relied on in-depth narratives from women who were pregnant or had recently been pregnant. My participants were first-time mothers as well as mothers with multiple children, living in nuclear as well as extended households, were new-immigrants into the city as well as well established Jaipur residents, were Hindus as well as Muslims, and were homemakers as well as employed outside the house. Apart from women, I also conducted FGDs with some mothers-in-law whose daughters-in-law were or had recently been pregnant and men from the *basti* whose wives were or had recently been pregnant to gain a holistic insight into the popular values and meaning-making processes in the *basti*. I also interviewed Anganwadi staff, local medical personnel and government officials which helped me get acquainted with the medical and official narratives surrounding pregnancy prevalent in the area.

My research was based in a large heterogeneous slum cluster in Jaipur, the capital city of the north-western state of Rajasthan. Rajasthan has one of the poorest Human Development Indicators in the country which also affect women more severely. For example, according to the last census the female literacy rate is only 52%, while for the rest of the country it is 65% (UNDP India, 2009). Similarly the under-6 sex ratio in the state is an abysmal 883 females per 1000 males, while for the rest of the country it is 914 females per 1000 males (UNDP India, 2009), indicating at high levels of female infanticide and feticide in the state. The city of Jaipur was selected pragmatically due to its good rail and road connections with Delhi and the presence of a public health institute which served as my base in the field.

1. 1 Thesis outline

My thesis is organized into eight chapters. Following the introduction, I begin with a literature review in Chapter 2 where I bring the reader abreast with state of the art and the ongoing strands of discussions within the existing literature. I begin with an introduction about the ubiquitous *basti*s in urban India and then go on to initiate discussion about the lives of women in these *basti*s. I follow this discussion with an examination of the traditional *Rajasthani* household and its dynamics, beginning with a historical narrative and ending with what it means to begin one's married life in such a household as a young, daughter-in-law. I introduce the reader to the popular values, norms and customs prevalent in the traditional Rajasthani society and their implications for the childbearing woman. I end the chapter with an insight into the existing sociological investigation into women's health and childbearing.

In the third Chapter, I discuss the theoretical underpinnings of my work and explain some of the important concepts – such as embodiment and 'pregnancy as a performance'- that form the foundation of my work. I also take the reader through the methodology I followed to collect and analyse the primary data I collected in Nagar *basti* in Jaipur. Within this chapter, I also engage with my positionality and how I believe it affected the process of field work.

In the fourth Chapter, I introduce the reader to the field- the state of Rajasthan in north-west India, its capital city Jaipur and the Nagar *basti* where I collected my data. Because women's lives are firmly embedded with the specific *Rajasthani* cultural universe it is important to engage with what it means to be *Rajasthani* and how it drives decision-making and behavioural patterns. I also offer a detailed account of Nagar *basti* – its location, composition and infrastructure- and finally leading into the results of my research.

In Chapter five, the first part of my empirical section, I engage in meanings and meaning-making surrounding pregnancy and the pregnant body, in private and public. For ease of analysis, I categorize them into bodily and social transformations, and discuss how the pregnant embodiment is strongly influenced by the subjectivity of being a *bahu* of the household. I also take the example of two neighbours Renu and Hema who had both recently given birth but had been through drastically different circumstances resulting in two very different performances of pregnancy. I then also engage in a discussion of the cultural concepts of *seva* or 'care and service', and *sehen Shakti* or the power to endure, both of which are values that every *bahu* is expected to demonstrate while fulfilling her marital responsibilities. At the end of the Chapter, I discuss the overarching

transformation of the pregnancy experience within the last few decades and how it plays out within the intra-household micropolitics between members of different generations.

In Chapter six, I take the reader deeper into these household dynamics examining how they manifest into familial constellations and work politics. I use narratives from my interviews to analyse how women sometimes decide to separate from their extended marital families to form their own nuclear units wherein they can exercise more autonomy in the performance of pregnancy. But, this autonomy comes at a price and such a separation excludes the woman from receiving any care and support from the other female members of the marital household. Some women attempt to utilize their natal familial networks to receive care and support especially when their pregnancy is complicated. I also engage with the practices of pregnancy with respect to work, rest and food, and analyse how popular narratives and women's intersectional subjectivities drive decision-making in Nagar *basti*. In the end, I examine how pregnant women and their families choose medical institutions for pregnancy related examinations, ailments and delivery.

Finally, in Chapter seven I engage with the socio-cultural and physiological transformations taking place in the final weeks of pregnancy in terms of conducting oneself based on narratives of a 'good' mother and ensuring a quick and non-surgical delivery. I first discuss what an approaching delivery means for a woman in Nagar *basti* and how it translates into her performance of pregnancy. I also bring up the role of a mother-in-law during the pregnancy of her daughter-in-law, the various responsibilities and powers that she can exercise, and the rituals and customs that come under her purview. I then engage in perspectives about appropriate length of pregnancy and the psycho-social responses that they elicit among pregnant women and their families. I also bring forth the cultural symptom of *tenshun,* meaning a combination of negative emotions such as stress and anxiety that is commonly mentioned by women with reference to the upcoming delivery and the state of uncertainty. In the end, I examine popular narratives surrounding the mode of delivery and the *basti* women's relationship with medical institutions and personnel, and also suggest explanations for the *tenshun* commonly experienced by pregnant women.

In the final Chapter, I conclude my findings and summarize my research. I also bring forth some implications of my research and reflect on the limitations.

Chapter 2: Literature Review

Women residing in slums in urban India experience life in ways that are vastly different from their rural as well as urban middle-class counterparts. They face a range of social, financial and infrastructural constraints that influence their well-being in their everyday lives. During pregnancy, a crucial event in a woman's life, there are bodily as well as social transformations which also influence and are in turn influenced by her socio-economic milieu. As a result, they experience pregnancy very differently from women occupying other socio-economic positions. With this chapter, I intend to provide an insight into the existing literature on the lives of women residing in slums across north-India as well as on lived experiences of pregnancy. The Chapter begins with an introduction to India's urbanization trajectory and the accompanying expansion of slums across the country. It then gives a brief insight into the various kinds of deprivations that families living in slum settlements face. The next section focusses specifically on the intra-household lives of women and their interactions with other members of their family as well as of the slum. The last section introduces the event of pregnancy as discussed in south-Asian anthropological literature and it's place in the life of a woman in north-India. The ultimate aim of the chapter is to set the stage for an enquiry into how women experience the social-cultural and physical transformations that accompany pregnancy and accommodate them while living in an impoverished environment.

2.1 Urbanization in India

It is ironic how India, traditionally thought of as "rural", was the birthplace of the Indus valley civilization- South Asia's earliest urban society. The civilization (the site now located in Pakistan) flourished in the third millennium B.C. and was known for its well-organized urban settlements and sophisticated water-sanitation practices (Robbins Schug, Blevins, Cox, Gray, & Mushrif-Tripathy, 2013). Until the British conquest, India was comprised largely of self-sufficient, agrarian communities functioning more or less independently of the urban centers (M. Chatterjee, 2014). Under British rule (1858-1947), the country saw a new kind of urbanization - establishment of urban centers which served an economic or administrative function for the colonizers such as cantonments, mill towns, mining towns, port cities and seats of governments (M. Chatterjee, 2014). This was in stark contrast to urban centers in the west where cities were a product of economic development and this urbanization of the country under the British is believed to have disrupted

the existing rural-urban relations. By the time British relinquished power, only 17% of the total population lived in urban areas (M. Chatterjee, 2014).

The liberalization and trade deregulation[1] in the 1990s is believed to be responsible for the unbridled economic growth and the resultant accelerated urbanization of the last few decades (Deshpande & Sarkar, 1995; Kundu, 2011). Withdrawal of subsidies in agriculture, combined with advancements in information-technology and expansion of foreign as well as domestic investments pushed employment away from agriculture and accelerated rural-urban migration (M. Chatterjee, 2014; Kundu, 2011). There were also other factors contributing to expansion of urban population such as natural growth of urban population and reclassification of areas as urban (Tripathi, 2013). In 2011, the level of urbanization in the country reached 31% fand or the first time since India became an independent country, the urban population increased more than the rural population (M. Chatterjee, 2014; Registrar General & Census Commissioner of India, 2011).

Urbanization in India has been very heterogeneous. The percentage of population residing in urban areas varies vastly between the states, for instance from 48% in Tamil Nadu to 10% in Himachal Pradesh (M. Chatterjee, 2014). There are considerable variations within the states as well. In almost all the states there are districts with urbanization levels of less than 10% (M. Chatterjee, 2014). Further, most of the urban expansion has occurred in class I urban agglomerations (UA)/towns[2] with almost 70% of the total urban population residing in these UAs (P. Datta, 2006; Registrar General & Census Comissioner of India, 2011). The total number of class I UA/towns has also jumped from 394 in 2001 to 468 in 2011 (Registrar General & Census Comissioner of India, 2011) and this is attributed to the graduation of lower order towns[3] into class I categories (P. Datta, 2006). On the other hand, there have been very few new towns (Kundu, 2011) and the existing lower order towns have experienced a decreasing rate of urban population growth (Tripathi, 2013). Hence most of the urban population is concentrated in large cities (at the

[1] In response to the 1991 crisis, International Monetary Fund together with the World Bank recommended the Structural Adjustment Program (SAP) which entailed 'trade liberalization, devaluation, privatization and cut-back of government expenditure with the aim of 'boosting industrial production and exports' (Deshpande & Sarkar, 1995).

[2] "An Urban agglomeration (UA) is a continuous urban spread constituting a town and its adjoining outgrowths (OGs), or two or more physically contiguous towns together with or without outgrowths of such towns" (Registrar General & Census Comissioner of India, 2011). For example, Delhi UA. In the Indian census UAs are grouped on the basis of their population. The UAs/towns with population of more than 100,000 are categorized as Class I UAs/towns (Registrar General & Census Comissioner of India, 2011).

[3] Order of towns based on population size. "Class II: 50,000-1,00,000 population, Class III : 20,000-50,000, Class IV : 10,000- 20,000, Class V : 5,000-10,000, Class VI : less than 5000" (Registrar General & Census Comissioner of India, 2011).

"expense of smaller towns") contrary to the urbanization patterns in the west, making Indian urbanization "top-heavy" (M. Chatterjee, 2014).

India's urbanization trajectory has also been referred to as "lopsided" and "over-urbanization", since the rate of development did not coincide with the rate of urbanization (P. Datta, 2006; Kingsley Davis & Golden, 1954). It has also been referred to as "pseudo urbanization" and "dysfunctional urbanization" by Breese, and Moonis Raza & Amitabh Kundu because it has been driven by rural push, rather than urban pull (as cited in Datta, 2006) and was not accompanied by an expansion of economic base for the growing urban population (P. Datta, 2006). According to scholars, this has been mainly due to development of more capital intensive industries (Kundu, 2011). As a result, the new migrants pushed out of rural economies, have no choice but to get incorporated into the informal urban sector.

Even though prevalent discourses still paint cities as "engines of growth" (Nolan, 2005), the large metropolitan cities – Delhi, Mumbai, Kolkata and Chennai – are getting saturated in their capacities to generate new employment opportunities, driving up regional and interpersonal inequalities (P. Datta, 2006). Further, the urban planning has been "crisis-inducing, chaotic, irrelevant, incompetent and exclusionary", unable to provide inclusive housing and social infrastructure, turning urban areas into "spaces of contestation" (Bhan, 2013). As a result, a large section of the urban population are compelled to reside in the "informal city" where they live in derelict, cramped structures in squalid neighborhoods infested with stray animals and insects, and struggling with absent or crippled civic amenities (Mahadevia, 2009).

2.2 The "informal city"

A stark socio-economic divide can be seen in most Indian cities, with the affluent residing in gated enclaves and the economically disadvantaged in informal settlements[4] or slums which come up on pavements, areas along the railway lines, water pipelines, under bridges and other dilapidated areas (Karn & Harada, 2002). According to the latest census figures around 17% of the urban Indian population live in slums, that is around 65 million individuals (Registrar general & Census Commissioner of India, 2011). The actual figures, however, might be much higher because the census 2011 collected slum data from only the larger urban centers (Registrar general & Census Commissioner of India, 2011). Further, the government agencies often do not recognize colonies

[4] Despite some disagreement between different authors, the term 'informal settlements' is also used interchangeably in place of 'slum' (UN-Habitat, 2013).

that come up on fringe areas (such as construction sites), therefore making these estimates an inaccurate reflection of urban poor (S. Agarwal, 2011). For example, the government records in Indore city in India showed that 438 officially recognized slums existed in the city, but a separate mapping process discovered an additional 101 slums (S. Agarwal, 2011).

The definition of a 'slum' varies between organizations and countries. The UN- HABITAT for instance, defines a slum by its spatial, physical and social aspects, as a "contiguous settlement where the inhabitants are characterized as having inadequate housing and basic services" (UN-HABITAT Urban Secretariat and Shelter Branch, 2002). The report further elaborates on the characteristics of a slum, which are a combination of "insecure residential status, inadequate access to safe water, inadequate access to sanitation and other infrastructure, poor structural quality of housing, and overcrowding" (UN-HABITAT Urban Secretariat and Shelter Branch, 2002). In India, the central government defines slums as "a compact settlement of at least 20 households with a collection of poorly built tenements, mostly of temporary nature, crowded together usually with inadequate sanitary and drinking water facilities in unhygienic conditions" (Government of India, Ministry of Housing and Urban Poverty Alleviation, 2010). Various states within the country ascribe to additional criteria and technicalities based on local Slum Acts (Ministry of Housing and Urban Poverty Alleviation, Government of India, 2015). For example, the state of Rajasthan takes into account factors such as "… (buildings that are) detrimental to safety, health or morals.." (Department of Urban Development, Housing & Local Self Government, 2012). Colloquially too slums are referred to by various terms in different parts of the country such as *Jhuggi Jhompdi* in Delhi, *Jhopadpatti or Chawl* in Mumbai, *Ahata* in Kanpur, *Bustee* in Kolkata, *Cheri* in Chennai and *Keri* in Bangalore and *Katchi Basti* in Jaipur (literally translated as temporary village).

Slums in India are also characterized on the basis of their legal designation, which determines their access to public infrastructure. Communities designated or 'notified' as slums are recognized by the government and have a legal right to services such as water, electricity and sewers. Many settlements are slums *de facto*, but not *de jure* and are referred to as non-notified slums (Kit, Lüdeke, & Reckien, 2013). These settlements are slums that are not recognized by the government. 49% of urban slums in India are non-notified (Ministry of Statistics and Programme Implementation Government of India, 2010) and the conditions in such slums are much worse since they do not come under the purview of government agencies for the provision of civic amenities (S. Agarwal, 2011; Subbaraman, O 'brien, Shitole, Shitole, & Sawant, 2012). As a result slums even within the same city are extremely heterogeneous, with varying degrees of access to these

amenities (Goli, Arokiasamy, & Chattopadhayay, 2011). In the absence of government patronage, individual initiative of the residents, also referred to as "urban pioneering" by some scholars (Anand & Rademacher, 2011; C. Snell-Rood, 2013), helps them achieve access to amenities such as water and electricity. This is accomplished by investing in material and financial resources to improve the infrastructure and engaging in political patronage. This ultimately (and very gradually) transforms the status of slums from 'illegal' to 'legal' (Anand & Rademacher, 2011; C. Snell-Rood, 2013).

Although many residents of slum settlements are involved with informal, unstable occupations - such as cart pulling, rag-picking, domestic work in middle class households, construction labor and other such jobs - there is considerable variation in the socio-economic composition of slum settlements across India. As in the rest of the world, not all slum-residents are poor, neither do all poor households reside in slums (M. Davis, 2006). Srinivas Goli et al. (2011) found that in metropolitan cities like Mumbai and New Delhi a large section of the middle wealth quintile[5] population lived in urban slums[6]. Similarly, while in most Indian cities most of the socio-economically deprived so called scheduled castes (SC) and scheduled tribes (ST) end up residing in slums, in Mumbai the proportion of SCs, STs and non-SCs/STs living in slums do not vary (Goli et al., 2011). Emily Rains, Anirudh Krishna, & Erik Wibbels (2018) refer to this socio-economic and infrastructural heterogeneity between slums as the "slum continuum" and advocate for a more nuanced approach to understand the challenges of the communities residing in such settlements.

Although slums are not granted complete legitimacy by the civic authorities, they serve social, economic and political purposes by providing low-cost labor and votes for political candidates (McFarlane, 2008b). Marie- Caroline Saglio-Yatzimirsky & F. Landy (2014) describe how a slum resident is "despised, distrusted and feared by the Other" and ends up being ostracized. P. Chakrabarti (2008) and D. A. Ghertner (2012) examine the case of Delhi, where slum populations are construed as "nuisances" by the middle-class resident associations and this label gains legitimacy by entering popular and state discourses. The people residing in these settlements find themselves on the fringes of the society, disfranchised and marginalized and are often viewed

[5] Goli et al. (2011) used The Wealth index, comprised of 33 assets and housing characteristics, to classify households into "poor", "middle" and "rich" classes.

[6] This may be so because of middle class rural migrants not being able to find accommodation elsewhere and middle class urban residents opting to live in the slum due to its proximity to prominent areas of the city.

as “the problem” and “secondary category of citizens”, and not as residents in need of natural and social resources (McFarlane, 2008a; A. Roy, 2009). Hence local institutions provide piecemeal services to these settlements on a “case-to-case, *ad hoc*, or exceptional basis, without jeopardizing the overall structure of legality and property” (P. Chatterjee, 2004, p. 137). Arjun Appadurai (2001) refers to them as “citizens without a city” due to the insufficient access to crucial services such as education, health, and basic amenities like water, sanitation and drainage.

Only in the last few decades has the discourse been shifting to “slums as a solution” and to the problem of insufficient housing in urban centers (S. Jha, Rao, & Woolcock, 2005). Scholars are recognizing the political, economic and social entrepreneurship of slum communities (S. Jha et al., 2005; Kaye, 2013; Nijman, 2010). Slums like Dharavi in Mumbai have grown to become manufacturing hubs where personal and work space overlap to fuel economic production (Nijman, 2010). Communities residing in these settlements, overlooked by public services develop their own political institutions. These institutions could take different forms such as “traditional village institutions transplanted and adapted to the urban environment and novel leadership structures” to make up for the inadequacies of the State institutions (S. Jha et al., 2005).

2.3 Life in a *katchi basti*[7]

There exists extensive literature on urban slum settlements across the world. Various aspects of the lives of communities residing in these settlements have been discussed within different disciplines, such as urban policy, public health and nutrition, gender, human rights, urban ecology and human geography among others (Ali, 2010a; Baviskar, 2003; Birkenholtz, 2010; Goli et al., 2011; McFarlane, Desai, & Graham, 2014; McFarlane, Silver, & Truelove, 2016; Singh Parmar, n.d.; Subbaraman et al., 2012, 2013; Truelove, 2011). Usually, as argued by Ron Mahabir, A. Crooks, A. Croitoru & P. Agouris (2016), characteristics of these environments do not occur independently and represent multiple kinds of deprivations having various direct and indirect impacts on the communities residing in these settlements. In the same vein, B. Marx, T. Stoker, & T. Suri (2013) refer to slums as “poverty traps” with multiple far reaching effects which obstruct socio-economic progress of the households as well as the economy, rather than a transitory phase of fast-growing economies.

[7] Slum settlements as they are referred to in Jaipur.

There is also a vast body of literature discussing slum settlements and its residents in terms of social exclusion and how it leads to other forms of deprivations (Arimah, n.d.; Chakrabarti, 2008; Gandy, 2008; Mudege & Zulu, 2011; Sabina F. Rashid, 2009; Saglio-Yatzimirsky & Landy, 2014; A. Sen, 2000; Subbaraman et al., 2012). Many authors have also discussed at length the unsanitary conditions experienced by slum residents and its effects on their physical (water-borne infections, respiratory diseases, vector-borne infections) and psychological well-being (S. Agarwal, 2011; Ali, 2010b; Bhavsar, Hemant, & Kulkarni, 2012; Butala, Vanrooyen, & Patel, 2010; Moffat & Finnis, 2005; Sclar, Garau, & Carolini, 2005; Subbaraman et al., 2012). Subbaraman et al. (2012) in particular has written extensively about the non-existent solid waste management leading to creation of huge agglomerations of garbage in and around the settlements. In addition high population densities, of as many as 4-5 people living in houses of around 100 square feet[8], exacerbates the spread of diseases (Sabina F. Rashid, 2009). Many authors have also explored the conditions of settlements that come up on or adjacent to garbage dumps, across Asia, south America and Africa, comprising of communities that rely on garbage processing for their livelihoods (Bhavsar et al., 2012; McPherson, 2016). As mentioned by a resident (cited in (Sabina F. Rashid, 2009),*"bastees are where even dogs do not live … we live worse than animals …."*.

Scholars have also discussed the environmental vulnerability of slum settlements in terms of natural disasters, geo-hazards and climate-change related degradation. These settlements are usually located on urban fringe areas- along open drains, on wasteland, forest land and other low lying areas making them vulnerable to flooding, landslides, hurricanes etc. (Huq & Hossain, 2012; Jankowska, Weeks, & Engstrom, 2012; Pandey et al., 2018; Rubin, 2011) . There has recently been a push to discuss the vulnerability of these communities in totality by also examining their social vulnerability in terms of insecure land tenure and forced evictions especially in case of non-notified slums in India and other parts of the world (Baten, Ahmed, & Azad, 2011; Baviskar, 2003; Dercon & Krishnan, 2000; Jankowska et al., 2012; Mahadevia & Narayanan, 1999; Nakamura, 2014; A. Roy, 2004; Subbaraman et al., 2012). Shohei Nakamura (2014) also draws the association between insecure land tenure and low housing investment by the households, which also holds true for the Indian context where the notified slums are much better placed as compared to the non-notified slums with respect to the construction of *pucca* structures (National Sample Survey Office, 2013).

[8] 100 square feet = approximately 9 meter square

Slum residents, especially from non-notified settlement, also face blatant legal exclusion in terms of municipal provisions and access to official documents (Subbaraman et al., 2013, 2012). Inadequate access to water, sanitation and electricity experienced by slum households has been well documented by scholars from various disciplines (Karn & Harada, 2002; McFarlane, 2008a; McFarlane, Desai, & Graham, 2004; Truelove, 2011; Wutich & Bernard, 2006). In Rajasthan 66% of the non-notified slums are not provided with electricity (National Sample Survey Office, 2013). Similarly only around 9% of the non-notified slums in Rajasthan had a *pucca* road within the slum (National Sample Survey Office, 2013). Rameez Abbas & D. Varma (2014) describe how slum residents who are unable to establish tenure are in-turn unsuccessful in procuring documents such as ration card[9] which prevents them from gaining access to subsidized food and fuel under the public distribution system.

Slum settlements also often suffer from poor access to health and education services. It is well established that public medical and education facilities are not readily available in and around these settlements, as a result of which the residents often rely on private, expensive and often inferior facilities (Zoe Matthews et al., 2010; More, Bapat, et al., 2009; Stephens, 2011). The healthcare utilization is also very low. For example, in some slum clusters birthing practices are still being carried out at home by untrained birth attendants (Kumar, 2013). A large corpus of health and economic literature highlights how these deprivations combine with other forms of inequalities to create poor physical and mental health outcomes among the residents of these settlements in India (S. Agarwal, 2011; Siddharth Agarwal & Sangar, 2006; Bhavsar et al., 2012; Goli et al., 2011; H. S. Gupta & Baghel, 1999; Karn & Harada, 2002; Unger & Riley, 2007). D. Bradley, C. Stephens, T. Harpham, & Cairncross (1992) in their meta-analysis demonstrate that slum populations are at a distinct disadvantage, with respect to almost all respiratory, skin-borne and vector-borne diseases as well as life expectancy in general, as compared to the rest of the urban population and some rural communities. Studies also demonstrate that in terms of maternal and child health some urban poor fared much worse than even rural populations (Matthews et al. 2010, Urban Health Resource Centre, 2007) and Vaid, Mammen, Primrose, & Kang, 2007).

[9] Ration Card is a document issued by State governments and provide access to subsidized commodities at fair price shops under the Public Distribution System.

2.4 Being a woman in a *katchi basti*

A large body of transdisciplinary literature has illuminated various aspects of women's lives in *bastis*. Macro-analyses have described gendered inequalities in terms of access to water, sanitation, education and healthcare (S. Agarwal, 2011; Caruso, B. A., Sevilimedu, V., Fung, I. C., Patkar, A., & Baker, 2015; Chaplin, 2017; Kumar Karn & Harada, 2002; Subbaraman et al., 2012). Women living in *bastis* are less likely to attend the recommended antenatal services during pregnancy and significantly lower proportion have access to contraceptives as compared to their non-*basti* counterparts (Hazarika, 2010). They are also likely to be married before the legal age and bear more children than the non-*basti* women. Public health analyses have also explored the burden of ill-health borne by women in *bastis* in terms of morbidity and mortality (S. Agarwal, 2011; Bhanderi & Kannan, 2010; Das et al., 2015; Zoe Matthews et al., 2005; More, Bapat, et al., 2009; Padhi et al., 2015; Sabina F. Rashid, 2009; Sabina Faiz Rashid, 2007; Skordis-Worrall et al., 2011; Venkatesh, Umakantha, & Yuvaraj, 2005). Large proportion of *basti*-women suffer from gynaecological problems such as menstrual issues and vaginal discharge, but display low levels of treatment-seeking (M. Koenig, Jejeebhoy, Singh, & Sridhar, 1998). Nutritional deficiencies and infections are also common leading to high probability of adverse pregnancy outcomes (A. Fernandez, Mondkar, & Mathai, 2003).

On the other hand, scholars also critique the agenda set by the nation-state's concern with the poor female's reproductive body and term it a "tool of modern governance" (Arima Mishra & Roalkvam, 2014). The scholars claim that this has resulted in an extremely narrow focus on women's health. This focus was driven not by women's unique needs but rather by their crucial role in demographic transitions and was limited to fertility and later to reproductive health (Kielmann, 2002). This was further fuelled by the MDG's focus on maternal and child health (Arima Mishra & Roalkvam, 2014). As a result, policy and research focused on biomedical constructs such as fertility (McNay, Arokiasamy, & Cassen, 2003; Speizer, Nanda, Achyut, Pillai, & Guilkey, 2012), institutional deliveries (Siddharth Agarwal, Sethi, Srivastava, Jha, & Baqui, 2010; More, Alcock, et al., 2009), perinatal mortality[10] (Aggarwal, Pandey, & Bhattacharya, 2007; Vaid et al., 2007) and immunization (Angadi, Jose, Udgiri, Masali, & Sorganvi, 2013; Ghei,

[10] Perinatal mortality refers to the death of the baby between 22 completed weeks of pregnancy and seven days after birth.

Agarwal, Subramanyam, & Subramanian, 2010). The resultant National Health Mission (NHM)[11] has been critiqued for "institutionalization of motherhood" and its paternalistic/humanitarian view of poor women (Kielmann, 2002; Arima Mishra & Roalkvam, 2014) and to this day there is an increased focus on maternal and child health rather than holistic well-being.

There is, however, a small but growing body of literature that have ventured beyond the international and local health agendas, specifically from the disciplines of human geography and social anthropology and have emphasized on the subjective experience of life lived out by women in a *basti*. The focus then is on the everyday lived experiences of women's life with the ultimate aim of moving past the static binaries of haves/have-nots (Anand, 2011) and bring to the fore the micro-level transformations underway in the not so public domestic sphere (C. Snell-Rood, 2013). Feminist geographers, specifically, have sought to collapse the dichotomies to explore how women make life work "despite the odds" (Anand, 2011; Chandola, 2012; A. Datta, 2016; C. Snell-Rood, 2013). Maya Unnithan-Kumar further breaks down the rural-urban dichotomy and uses the concept of "rural cosmopolitanism" (Gidwani & Sivaramakrishnan, 2003) and "village in the city" notion (Matthews et al. 2005) to explain the rural-ness permeating life in *bastis* especially the ones occupied by new migrant communities (Unnithan-Kumar, 2015, p. 97).

Scholars from this school of thought have examined the lived experience of being, mentally and physically, covering various aspects of a woman's life course such as domestic violence (A. Datta, 2016; Magar, 2003), psychological distress due to the materialities of the *basti* (C. Snell-Rood, 2015; C. N. Snell-Rood, 2015; Truelove, 2011, 2016), drudgery of domestic work (B. D. Crow & Mcpike, 2009), nutrition (C. Snell-Rood, 2015; Vallianatos, 2010) and health and well-being (Marrow, 2013; M Unnithan-Kumar, Mcnay, & Castaldo, 2008) among others. The current research belongs to this body of work and intends to ethnographically examine the lived experience of pregnancy as it is performed by the women in a *basti* in Rajasthan. In the following discussion, I bring in more such scholarship, specifically grounded in the north-Indian Hindu kinship structures, to allow for a better understanding of the state of the art and the gaps in literature.

[11] NRHM is Indian government's maternal and child health programme introduced in 2005 to address morbidity and mortality among mothers and children to accelerate the achievemtn of the 4th and 5th Millennium Development Goals (MDG), targeting morbidity and mortality rates of children and women" (Arima Mishra & Roalkvam, 2014).

2.5 Inside the Family

Much has been written about the position of the north-Indian Hindu woman within the household and its transformation over the years, from the feminist account of female infanticide practices in Rajput clans in north-west India in the 19th century (Bhatnagar, Dube, & Dube, 2005) to gender politics surrounding eating and self-care practices among contemporary urban women (Snell-Rood, 2015). Anthropologist Usha Menon describes how scholarship on north-Indian Hindu women can be broadly divided into three schools of thought (Menon, 2002): the first, that portray women as passive victims devoid of any agency (Dhruvarajan, 1990); the second, that depict women as 'crypto-feminists' and covert rebels, perpetually using implicit subversion tactics (Raheja, 1994; Raheja & Gold, 1994); the third and the most recent, that represent them as "key actors, who use the resources available to them to construct for themselves meaningful and satisfying identities and lives" (Menon, 2002; Snell-Rood, 2015; Unnithan-Kumar, 2003a). Hence they are aware of their agency and make choices, which are sometimes used to resist and sometimes to reaffirm the status quo, quite like the "pragmatic women" described by M. Lock and K. Kaufert (M. M. Lock & Kaufert, 1998). This approach places the woman and her agency at the very center of everyday negotiations to navigate through an "intricate web of social relations and social hierarchy" negotiating the various forces exerted on her life (Tremayne, 2001, p. 9). The current study aligns with this approach to examine how pregnancy is understood, experienced and performed in households and how it interacts with the everyday practices of life in a *basti*.

2.5.1 The life-course

Historically, the home has never been a site of absolute "tranquility and obedience" (Bhatnagar et al., 2005, p. 60). Rather it has always witnessed negotiations of gender structures and power using tools of various kinds (Bhatnagar et al., 2005, p. 60). Many scholars have made ethnographic explorations into these negotiations and contestations within the family in both rural and urban Indian settings. The interactions between the power structures and the woman begin as early as *in-utero* when attempts are made to terminate the pregnancy if the fetus happens to be a female (Bhatnagar et al., 2005). This is the resultant of a deep-rooted cultural (and economic) preference for a male child (UNICEF, 2006), attributed to medieval aspirations of upward social mobility and purity/pollution distinctions which positioned women as the site of familial and social

purity/pollution[12] (Bhatnagar et al., 2005). Within India, which has one of the poorest sex ratios[13] globally (940/1000 males) and has 27-39 million "missing females", Rajasthan has one of the poorest sex ratios of 928 (Hesketh & Xing, 2006).

Even when female fetuses do survive, they often face discrimination within the households in terms of food allocation, access to healthcare and investment in education, and this disadvantage worsens when the resources are scarce (Bhatnagar et al., 2005). Especially in poor households childhood is severely curtailed and children stop receiving nurturance at sometimes as early as the age of three (Seymour, 1999a, p. 158). Especially girl children are expected to become physically self-reliant as quickly as possible, and take up caretaking of the younger siblings and labor intensive household chores – such as collecting firewood, fetching water, cooking, cleaning - while the mother works outside the house (Seymour, 1999a, p. 158, Bhatnagar et al., 2005, p. 6). The girls also often give up school to take up jobs to support the family income or substitute for a parent at work in times of illness (Bhatnagar et al., 2005, p. 6).

Girl children are brought up to be docile and submissive, and "take pride in sacrificing themselves for lineage pride" (Bhatnagar et al., 2005, p. 76). Traditional feminine behavior is expected to be "passive, docile, and shackled to domestic arrangements" (Marrow, 2013), driven by the Hindu moral principles of "duty, self-control, and service to others" (Menon, 2002). Young women are told to be "like water, which having no shape of its own can take the shape of the vessel into which it is poured" (Raheja, 1994, p. 57). P. Jeffery and R. Jeffery, in their ethnographic data from rural north India, describe how for young women the label of *azad* (free, independent) had a negative connotation and was used together with *besharam* (shameless, immodest) (Jeffery & Jeffery, 1994). The authors also describe how education for girls is perceived to be important for the "arranged marriage market" and not the labor market (Jeffery & Jeffery, 1994, pp. 150–151). Especially in rural north-India young women usually also have no say in the matters of marriage, often being completely unaware that their marriage was being arranged, and are expected to agree to whatever arrangement the men of the household decide (Jeffery & Jeffery, 1994, pp. 133–136). Self-chosen unions or 'love marriages' are widely disapproved and have only recently started to become common, but only in the large urban centers (Grover, 2009). 'Arranged marriages' or caste endogamous marriages (match within the caste), initiated and executed by the parents are still very

[12] Discussed at length in Chapter 4

[13] Number of females in the population per 1000 males.

much the norm (Grover, 2009). Sonia Grover also describes how even the poorest households attempt to organize a respectable dowry for their daughter's marriage in the form of cash and household items (Grover, 2009) often taking on sizeble loans. Literature and news reports have frequently covered how 'love marriages' that violate caste endogamy or clan exogamy norms, especially in traditional communities in north-India are ostracized and in some extreme cases even murdered (Gupta, 2014).

Lives of married women in Rajasthan, like of women from other regions of north India are tightly intertwined within constellations of kinship of affinal[14] and consanguineal families, and has been discussed from various perspectives. Some of the most prominent examples are Ursula Sharma's work on property rights and women's work in Himachal Pradesh and Punjab (Sharma, 1980); Susan Seymour's (1999) treatise on family life and childcare in Odisha (Seymour, 1999); Gloria Raheja & Anne Gold's analysis of speech practices as subversion tactics within patrilineal kinship in rural north India (Raheja & Gold, 1994); and more recently Maya Unnithan-Kumar's extensive account on kinship and access to healthcare among women in Rajasthan (Maya Unnithan-Kumar, 1999, 2010). After marriage, a woman is expected to move into the household of the husband and his kin, the *sasural* (house of the mother-in-law), which is segregated into "hierarchies of authority". Traditionally, "older members have authority over younger ones and males have authority over females" and so both men and women have authority in some bonds and simultaneously are subordinate in others, positioning the newly married woman at the lowest rung of the hierarchy (Seymour, 1999, p.272). The patrilineal and patrilocal kinship structures expect prioritization of the conjugal kin over the natal kin and expect the newly married woman to distance oneself from the natal kin while placing her in a subordinate position in the *sasural*. A. Raheja (1994) uses proverbs from Uttar Pradesh to describe these norms- "a proper wife feeds the household first, and saves only the leavings (food scrapings) for herself"[15].

Literature shows how traditionally the woman in the role of a wife is considered to be a threat to the solidarity within the patrilineal household. Additionally, intimacy between the wife and her husband is viewed as dangerous to the ties to his parents or siblings and the collective well-being of the extended family (Raheja, 1994, p. 62; Raheja & Gold, 1994, p. 73; Seymour, 1999a, p. 272; Sharma, 1978). She must hence follow a strict code of conduct in her *sasural* (Gjøstein,

[14] Affinal relationships arise out of marriage, for example in-laws. Consanguineal relationships on the other hand, are related by 'blood', for example parent-child and siblings.
[15] The eating order is a reflection of the social hierarchy.

2014, pp. 143–145). Traditionally, the wife must not address the husband or other older male affines directly and treat them with deference (Mandelbaum, 1986). As Sylivia Vatuk puts it, "(s)hyness of demeanour, avoidance of eye-contact with males, avoidance of loud speech and laughter (particularly in the presence of or within earshot of males), and the limitation of conversation with non-family males to necessary work-connected topics" as quoted by David Mandelbaum (Mandelbaum, 1986). Her conduct is guided by spatial separation or *purdah* (literally curtain) and vieling or *ghoonghat nikalna*[16] (Mandelbaum, 1986; Sharma, 1978). Spatial segregation traditionally entailed separate quarters for the men, such as an outer room or a cot in the courtyard where they perform their activities such as eating, sleeping, entertaining other men etc., while the women occupy the indoors performing their domestic tasks (Mandelbaum, 1986). Vieling is practiced by several communities across north India (by both Hindus and Muslims), although there may be minor variations (Mandelbaum, 1986; Sharma, 1978). The daughter-in-law (and not the daughter) uses the end of her Sari or a separate scarf to cover her head and most of her face in the presence of older kin males (including the husband) and all non-kin males (Mandelbaum, 1986; Sharma, 1978). Dagrun Kyte Gjøstein describes how fictive kinship transcends even caste groups which makes the woman the daughter-in-law of the entire conjugal village, necessatating vieling infront of the entire village (Gjøstein, 2014, p. 144) .

Traditionally, employment of women outside the house was prohibited and continues to evoke widespread disapproval among traditional communities (Jeffery & Jeffery, 1994, p. 137). It is however, different for the so-called 'low' caste and working class households, where economic subsistence takes precedence over patrilineal honour and most women are engaged in the family's economic activities or are employed outside the house (Seymour, 1999a, p. 145). Women in *bastis*, generally without sufficient education, usually have few opportuinities for paid emplyoment outside the house (Gjøstein, 2014, p. 136). Even when employed they either engage in low paying labor intensive informal jobs such as sorting garbage, domestic work in middle-class households, construction labour, selling fruits and vegetables or involved in caste-based occupations such as cleaning and washing the laundry, etc.

Whether or not she is employed outside the house, the daughter-in-law must usually be responsible for all domestic chores- such as cooking, cleaning, tending to the animals, washing

[16] The strict code of conduct does not apply to the daughter living with her family, even though she would be practicing it in her affinal family.

clothes, fetching water, collecting firewood, caring for the children and elderly, and other tasks- "working like a bull", taking orders from the older women in the household (Patel, 1999). The woman's numerous domestic responsibilities towards the members of her household is the *seva* (or service) that is expected of her, but isn't reciprocated (Snell-Rood, 2015). She is hence, expected to take care of the elderly and the sick, but when she herself falls sick, wait for the husband or mother-in-law to take notice and then initiate access to treatment (Vallianatos, 2010, p. 11). In extended households the chores get divided among the daughter-in-laws, the youngest one often bearing the heaviest burden (Gjøstein, 2014, pp. 145–146). As she grows older, bears sons and later herself becomes a mother-in-law her authority of household matters increases and the conventions of behaviour also get relaxed (Gjøstein, 2014). Well-being in such a context, as in other parts of south-Asia, is "relational", i.e. is heavily influenced by the woman's relationship within the family and the community (Snell-Rood, 2015).

Water fetching is central to a women's responsibilities as a wife, a daughter-in-law and a mother since it is indispensable for all the other domestic chores that she is responsible for. As in other parts of the world, women in India are the primary water drawers and managers in the household (Asaba, Fagan, Kabonesa, & Mugumya, 2013; B. Crow, 2001; Geere, Hunter, & Jagals, 2010; Kher, Aggarwal, & Punhani, 2016; Sorenson, Morssink, & Campos, 2011; Sultana, 2009). Initially thought of as a 'rural' problem due to the large distances involved, authors have only recently begun exploring the costs- in terms of health, energy and time- of water fetching in urban slums. Yaffa Truelove, for instance in her study based in the slums of New Delhi, discusses at length women's everyday experiences of fetching and managing the household's water and describes how these experiences "serve to re-enforce gendered and classed social differences" in the slum (Truelove, 2011). The author further describes how women endure "physical labour, gendered hardships and public shame" to access water and sanitation on an everyday basis (Truelove, 2011).

Water accessing activities leave the women with less time for paid employment, domestic chores, childcare, leisure and even sleep (Kher, Aggarwal, & Punhani, 2015; J. Roy & Crow, 2004; Sullivan, 2001; Truelove, 2011). Several studies conducted in slums across India report the total time spent on water fetching to be between one to more than two hours everyday (Bapat & Agarwal, 2003; Kher et al., 2015). Further, Jagriti Kher et al. in their study based in the slums of Delhi, found that in their sample collecting water was primarily the responsibility of young daughter-in-laws and children, making 4-6 trips everyday to the water point (Kher et al., 2015). This gendered bodily

cost of water fetching has been referred to as "drudgery" (Rosen & Vincent, 1999) and "water labor" (Truelove, 2011). Much has been also written about the conflicts (inter and intra household) and the related stress (physical and emotional) that these women go through while accessing water for their households (B. Crow & Sultana, 2002; Kher et al., 2015; Truelove, 2011).

In slums water access is also closely intertwined with sanitation and has special significance for India where the government is promoting toilet construction, but which ultimately go unused because of a combination of factors (Dutta, 2017). In the absence of toilets or sufficient water for the use and maintenance of toilets, sanitation is specifically problematic for women, more so for a new daughter-in-law, placed at the bottom of the social hierarchy. Newly married and pregnant women are also most likely to be disproportionately affected by an absence of sanitation facilities at home due to the increased shame and indignity attached to the visibility of their sanitation practices, as compared to adolescents and established adults (Hulland et al., 2015; Truelove, 2011). Further, she has the least ability in the household to request toilet construction as well as report incidences of open defecation related sexual harrassment (O'Reilly, 2016). In Jaipur almost half the slum households have no access to toilets (Population Foundation of India, 2012). Shrub forests and other vacant pieces of land located in the vicinity of these settlements are often used for open defecation (Kulkarni & O'Reilly, 2014) or as it is said colloquially 'going to the *jungle*'.

A growing number of studies have discussed the harassment and violence faced by women on an everyday basis (Hulland et al., 2015; O'Reilly, 2016; Truelove, 2011). Seema Kulkarni et al. in their study based in the slums of Jaipur found that the harassment took many forms such as men hiding behind trees or climbing water tanks to watch women defecating, taking pictures, passing offensive comments, masturbating in front of the women and even cases of rape (Kulkarni, O'Reilly, & Bhat, 2017). As a corollary, young married women are more likely to "discipline their bodies" to avoid going to relieve themselves at odd hours. They do this by regulating the urge to relieve in order to avoid facing emotional and physical violence by - arising early while it is still dark, limiting food and water intake and avoiding particular foods which they believe might result in the urge to relieve (O' Reilly, 2010; Truelove, 2011). Some scholars examining women's sanitation practices in eastern India, have also linked poor sanitation practices such as open defecation with adverse pregnancy outcomes such as pre-term birth and low birth-weight (Padhi et al., 2015). The authors also found that among the women from different life stages such as adolescents, newly married, pregnant and established adults, defecation was considered to be the most stressful by pregnant women and propose the term "sanitation insecurity" to refer to the

multidimensional concerns with respect to poor access to sanitation (Caruso et al., 2017; Hulland et al., 2015). Indian government's *Swachh Bharat Abhiyaan* (SBA) or Clean India Mission focuses specifically on new brides for sanitation promotion, calling it the "No Toilet, no Bride" campaign (Balasubramanian, 2017), although the campaign has been critiqued for further secluding women.

2.6 Childbearing

The foremost duty of a Hindu woman, according to popular narratives, is furthering the lineage of her husband by providing the family a *kul deepak* (literally the 'clan's hope', as commonly used in north Indian folk idioms) (Bhatnagar et al., 2005, p. 199). The staunchly patrilineal structures are associated with a tremendous pressure on her for "early and continuous childbearing", especially in the context of Rajasthan with both men and women perceiving women's lives as "being all about reproduction" (Maya Unnithan-Kumar, 2001, pp. 28–34). The author calls this the "burden of fertility" since the participants of her study – working class Rajasthani women residing in peri-urban areas- appear to have few options for fertility control, high vulnerability to reproductive tract infections, poor access to water, nutrition and appropriate healthcare along with the general constraints of poverty (Maya Unnithan-Kumar, 2001, p. 28). On the other hand, motherhood also ushers in increased authority of the woman in the household. Tulsi Patel refers to this as the "glory of motherhood" which makes her association with the conjugal household more stable and secure, and allows the woman to be more assertive in the household (Patel, 1999) .

Childbearing is at once biological, social and political and is influenced by the wider organizations and relationships in the society (Jeffery et al., 2004; Tremayne, 2001). There is a vast body of work on the biological doing of pregnancy, focusing on different aspects such as nutrition, physical activity and leisure during pregnancy. There is a considerable amount of literature and established debates on the biological or corporeal aspect of being a 'good' mother. The World Health Organization advises interventions with respect to nutrition and physical activity. Specifically "aerobic physical activity and strength conditioning exercise is recommended aimed at maintaining a good level of fitness throughout pregnancy" (World Health Organization, 2016, p. 15). The recommendation however comes with the disclaimer that the evidence on the interventions comes mainly from high income countries. The Indian government's Ministry of Health and Family Welfare has no opinions of its own according to its website (National Health Portal, 2015), and simply puts out physical activity recommendations for pregnant women advised by the U.S. Department of Health & Human Services on its website of the Office on Women's

Health i.e. at least 2 hours and 30 minutes of moderate-intensity aerobic activity a week (U.S. Department of Health & Human Services, 2018). Such an endeavor is not only unsuited for the concerns of an average Indian woman but might even be counterproductive for her level of nourishment and pre-pregnancy body weight. For example, according to S. Rao and her team, based on their study conducted in rural west India, women in agricultural communities have a high physical workload involving both domestic chores as well as agricultural labor (Rao et al., 2003). Using statistical data the team also discovered that physical activity of the mother during pregnancy had a negative impact on the maternal weight gain as well as birth weight of the baby (Rao et al., 2003).

Authors have also brought into focus the "invisible work" of pregnancy, via which a woman gradually learns to do pregnancy[17] physically by making adjustments to her bodily practices to accommodate the changing body (Neiterman, 2012). Elena Neiterman defines the "invisible work" of pregnancy as the bodily changes and the associated bodily adjustments that every woman continuously engages in during pregnancy, such as change in posture and sleeping position (Neiterman, 2012). There is also the social and cultural aspect in the 'doing' of pregnancy. The pregnant woman's social status undergoes a change and she must learn to do pregnancy in the 'right' way according to the prevalent norms and knowledges, for example eating 'right' and being a 'good' mother (Neiterman, 2012).

Sociological inquiry into the lived experiences of childbearing have been relatively well-described in Euro-American literature (Bailey, 1999; Hennekam, 2016; Neiterman, 2012; Rapp, 2001). Scholars have focused on bodily aspects of the transition (Haas et al., 2005); social aspects of the transition (Hennekam, 2016; Messias & DeJoseph, 2007) ; the intertwined nature of the bodily and social transition (Copelton, 2007); and still others have examined pregnancy as a process of embodiment wherein it is situated within the social context in which it is experienced (Neiterman, 2012). Embodiment here, as defined by Bryan Turner (2004) "is a life process that requires the learning of body techniques such as walking, sitting, dancing, and eating. It is the ensemble of such corporeal practices, which produce and give a body its place in everyday life…" (Neiterman, 2012). This last body of scholarship, as described by Elena Neiterman borrows the concept of 'performance' to examine the doing of Pregnancy (Neiterman, 2012), originally used

[17] Childbearing refers to the entire process of giving birth and encompasses conceiving, being pregnant and giving birth to a baby. Pregnancy refers specifically to the time between conception and delivery.

with respect to Gender by Candace West and DH Zimmerman (West & Zimmerman, 1987). The approach suggests "constant and active doing of Pregnancy" which involves learning to be pregnant, adapting to it and then constantly performing it (Neiterman, 2012). The approach of "pregnancy as a performance" allows for social and cultural meanings to be incorporated into the doing of pregnancy and accepts heterogeneity in the manner in which women perceive and negotiate pregnancy. Although based in a very different socio-economic milieu, the present study aligns with this approach to the inquiry of pregnancy with the aim of examining how the specific socio-economic context affects a woman's understanding of pregnancy and how that influences her performance of pregnancy. In doing so, the idea is not to describe 'the' way pregnancy is done in urban slums in north-India, but to explore the myriad ways in which pregnancy is experienced and negotiated by women.

The Euro-American literature, although offers conceptual approaches, has only limited application in the context of urban north-India. Even within a city, the lived experiences vary vastly from one individual to the next. Rashmi Bhatnagar et al., in their treatise on female infanticide in India, promulgate that the sociopsychology of childbearing is different for a rural woman working as agricultural labor as compared to an urban woman employed as an executive in a multinational firm (Bhatnagar et al., 2005, p. 6). The latter is increasingly more concerned about regulating fertility, childbirth and rearing issues; the former has several children so that at least some will survive the high infant mortality rate. She savors maternity for it offers an escape from her "bondage of drudgery" and is the only time when her well-being is the priority (Bhatnagar et al., 2005, p. 6; Patel, 1999). It is still different for an urban working-class woman residing in a slum, who is sort of in-between urban and rural. One who has better access to public and private healthcare services, but has weaker kin support networks; one who deals with less stringent social codes (Chandola, 2010), but with an additional responsibility of earning in addition to shouldering the domestic responsibilities. These are the women that the present study engages with in Nagar *Basti*, Jaipur.

Literature from ethno-physiology describes why understanding the cultural notions of health and disease are imperative. This has direct implications for the SDGs, specifically SDG 3 which aims to "ensure healthy lives and promote well-being for all" ("Sustainable Development Goals | UNDP," n.d.). How do we go about achieving health if there is ambiguitiy in the meaning of health and well-being? At a more local level, different ideas about health and disease have even more far-reaching effects. It directly influences the relationship between the health professional

and her patients, the acceptance of health interventions by an individual and her household, healthcare seeking behavior and the reporting of diseases. Mark Nichter, in his 1989 book on the intersection of anthropology and international health, brings into question the entities of 'public health' and 'tropical diseases' and brings to light how local (non-Western) perceptions of diseases and treatments are treated as "cultural barriers" in the international health and development discourses (Mark Nichter, 1989). As an example he compares the popular (western) nutritional recommendations for pregnant women that encourage "eating for two", with the dietary reduction for pregnant women in some communities in south India because of the preference for smaller babies for ease of delivery (Mark Nichter, 1989).

Within the Rajasthani context some scholars have attempted to explore different aspects of lived experiences of reproduction. Rashmi Dube Bhatnagar et al's analyis of the construction of reproduction in medieval Rajput society, describes how the male was posited "as the active principle (the seed, the producer) and female as the "passive principle" (land that is fallow unless tilled and sown) (Bhatnagar et al., 2005, p. 197). Maya Unnithan- Kumar has worked extensively on fertility, local kowledges of healing and childbirth practices in contemporary Rajasthan (Unnithan-Kumar, 2003, 2004, 2010, 2013). The author has shed light on the construction of fertility (and infertility) among the Rajasthani women in urban slums in Jaipur and provides an in-depth view of the significance of bearing a child and the stigma attached to the woman who is unable to do so (Unnithan, 2010). Infertility – or *banjhpan*, a term used only for women - is regarded as socially polluting and a kind of social death resulting in the woman being viewed as inauspicious and incomplete (Unnithan, 2010). Unnithan-Kumar also examines decision-making and negotiations within the household with respect to childbearing such as aspiring for a child, embracing or rejecting healthcare services during pregnancy and traditional beliefs such as in spirits and local healers in a basti in Jaipur (Unnithan-Kumar, 2003). According to her, "women's thinking, feeling and acting on fertility, reproduction and healthcare issues is a complex combination of their individual and community beliefs, their own knowledge and standing, the emotional universe of village and kin relationships, their individual physiology as well as their relation to poverty..." (Unnithan-Kumar, 2001, p. 30).

Sidsel Roalkvam, in her study based in rural Rajasthan, examines how women interact with the State's reproductive health services and policies (Roalkvam, 2012). She concludes that the paternalistic, top-down approach that the State has towards poor women results in the creation of policies that are blind to the existing hierarchies. This results in the birthing mothers' distrust in

the State's policies and interventions (Roalkvam, 2012). Tulsi Patel, in her work drawn from rural Rajasthan, examines women's agency through the life course, particularly with respect to decisions related to reproduction (Patel, 1999). She traces how childbirth and motherhood provides an escape to the new mother from work (both agricultural and domestic) and offers opportunities to relax while taking care of the baby (Patel, 1999). However as the child grows up and there are subsequent childbirths, there is reduced support from the household and the mother is expected to be proficient at fulfilling all the responsibilities that come with all her roles within the household, community and the larger kin network (Patel, 1999). She concludes that even within the rigid patrilineal structures, there exist domains where women can exert agency and negotiate, to manipulate decisions (Patel, 1999).

Patricia Jeffery, Roger Jefferey and Andrew Lyon, in their account of deliveries in rural north-India, examine the birthing experiences of women and the role of various actors such as the birthing mother, her mother-in-law, the traditional midwife and the natal kin during childbirth (Jeffery et al., 2004). The authors examine the interplay of local purity/pollution norms, caste and gender hierarchies to critique the maternal health policies and demonstrate the cultural specificity of childbirth, an aspect which has been grossly overlooked by the global and national public health discourses and interventions (Jeffery et al., 2004). The authors also conclude that the State's interventions would be unsuccessful in stemming the high maternal mortality rate if they continue to overlook the existing gender, caste and class hierarchies (Jeffery & Jeffery, 2010b).

Helen Vallianatos, in her doctoral dissertation based on ethnographic data from a slum in New Delhi, examines how working-class women interpret the cultural dietary norms of pregnancy (Vallianatos, 2010). She demonstrates how "reproductive histories, socio-economic status, and family structure" shape these food practices and in turn influence the health of both the mother and child (Vallianatos, 2010). Although the author does not explicit refer to embodiment, her approach unequivocally implies that the self is culturally constituted (Vallianatos, 2010). In general, the pregnancies in *bastis* are less stringently medicalized as compared to those in non-*basti*, urban communities. Women in *bastis* are also more likely to experience their first pregnancy earlier as compared to their non-*basti* urban counterparts. They are also more likely to engage with the State's mother and child health programme, follow the State prescribed routine examinations and seek services from public healthcare institutions.

Henrike Donner's study, located in middle-class urban Calcutta (now Kolkata), examines the construction of maternity in Hindu households and how it interacts with increasing

medicalization of reproduction (Donner, 2008). Although the women in focus in Donner's study belong to a very different socio-economic stratum as compared to the participants of the present study, there are some threads which are in common, such as their immense workload even during the last weeks of pregnancy. The 'work' incase of the former is referred to as "status production work", while in case of the latter it is more of "survival-orientated labor"(Donner, 2008).

Another unpublished work that is worth mentioning here is Synnove Knivestøen's master thesis, based on ethnographic data from a rural community in Rajasthan, where she examines how women during pregnancy, delivery and the post-delivery period were considered to be vulnerable to the 'evil-eye' and bad spirits (Knivestøen, 2012). As a result, an elaborate set of practices are employed to keep the woman, the unborn baby and the newborn safe and healthy. These practices range from dietary restrictions to other more elaborate practices such as religious rituals involving faith healers (Knivestøen, 2012). The author discovers that pregnant women made amends in their dietary patterns, in the form of restriction of certain food items, especially when there was a history of health problems such as miscarriage or sterility (Knivestøen, 2012). Although the delivery and post-delivery practices are examined in much detail, the study does not contribute much to the lived experiences of the transformations during pregnancy.

While these studies add volumes to the understanding of women's experiences of childbearing and childbirth in north-India, what appears to be missing is the focus on the period of pregnancy, especially in the context of accommodating it with the everyday workload such as-fetching and managing water, cooking, cleaning, washing, tending to the children and elderly, and going to work as well as its affect on social relations within the household. The present study intends to answer not whether the women address their reproductive conditions, but how they address them. Specifically, this study intends to examine the cultural interpretations of pregnancy among the working-class women in Jaipur and how these are accommodated within the everyday realities of being in the slum. The ultimate aim is to understand how women in a socio-economically impoverished environment understand and make sense of pregnancy and how that influences their performance of pregnancy.

Chapter 3: Theory and Methodology

The purpose of this research is to examine women's lived experiences of pregnancy in a *basti* (slum settlement) in Jaipur, to uncover the myriad ways in which pregnancy is done embedded within everyday social interactions. I attempt to describe the self-perceived world of the women going through pregnancy in Nagar *basti*, who continue to be an underrepresented category within Indian scholarship, using ethnographic data. The aim of such an endeavor is to bring to the fore how these women carry out everyday life, the popular cultures and the associated rituals and habits, as well as the popular meanings and conceptions surrounding a pregnant body and a 'healthy pregnancy'. Ultimately, I examine how these perceptions and conceptions affect the performance of pregnancy in Nagar *basti*.

In the first section of this chapter, I discuss the theoretical underpinnings of my research and touch upon the larger academic debates that it borrows from. In the second part of the chapter, I discuss the methodology, which guided the data collection and data analysis techniques. In the final section, I address my positionality within the research and how it affected my comprehension of the issue, experience in the field and approach to women's lived experiences of doing pregnancy.

3.1 Concepts and theoretical approach

In this section, I focus on the sociological concepts and approaches that I utilize to make sense of the lived experience of pregnant women in Nagar *basti* and introduce the reader to the scholars and scientists whose 'shoulders I stand upon'. The central theoretical feature of my research is to view pregnancy as an embodied experience firmly embedded within the social context of the woman.

3.1.1 Pregnancy as a socio-culturo-physiological process

While much of the literature on women's health essentializes the biological link between women's bodies and pregnancy, the sociological and feminist literature on pregnancy has focused on social transformation, self-identity and social construction of motherhood while placing less focus on the corporeality of the pregnant body (Bailey, 1999; Letherby, 1994; Marshall, 1991; Mcmohan, 1995). Even within feminist literature, some feminists consider the "body as discursively produced" by socio-cultural discourses (Butler, 1990), while others attempt to be specifically attentive to the materiality of the body – for, the knowledge and experiences are "lived through the body" (M. Lock, 1993; S. Sharma, Reimer-Kirkham, & Cochrane, 2009).

While it is essential to bring into focus the socio-cultural nature of childbearing, keeping out the 'body' excludes a vital aspect of the embodied experience. I therefore believe, as do several other researchers such as Neiterman (2010) and Rothman (1989), it to be essential to examine both the social and physiological nature of the transformation together to allow for a holistic examination of the lived-experience of pregnancy.

I follow in the footsteps of Ann Oakley who was probably one of the earliest advocates of childbearing as a "biological and cultural act" (Oakley, 1981) –

> *"Childbirth stands uncomfortably at the junction of the two worlds of nature and culture. A biological event, it is accomplished by social beings-women-who consequently possess a uniquely dual character"* (Oakley, 1979)

The author further suggests examining pregnancy in the "context of women's lives", rather than as an isolated event of "production of babies" (Neiterman, 2010). In a similar vein, I view the bodily experience of bearing a child as an inseparable component of the personal experiences of pregnancy playing out within a particular social context and with this study attempt to bring the embodied experience into the sociological examination of pregnancy.

3.1.2 The body in phenomenology

My research is firmly anchored within the social phenomenological approach. Social phenomenology was conceptualized by Alfred Schutz, based on Edmund Husserl's philosophy (Agger, 1993; Neiterman, 2010). Husserl identified the body as "a centre for all knowledge and experience; a primordial point of reference: the body inhabits and moves – not in the abstract, but in the concrete, necessarily embodied, and privileged ontological, spatial, and temporal presence of the here and now" (Waskul & Vannini, 2006). Phenomenologists focus on "embodied people who mindfully resolve pragmatic problems with intention and purpose in social encounters that are situated in broader social, cultural, and institutional milieus"(Waskul & Vannini, 2006) . They further seek to approach the body through "thick descriptions of lived experience that reveal meaning in the life-worlds of individuals and groups" (Waskul & Vannini, 2006). Meanings are believed to be anchored within the experiences playing out within the life-worlds. Such an

approach is also in harmony with the "looking-glass"[18] understanding of the body. Maurice Merleau-Ponty (1974) (cited by Waskul & Vannini, 2006, p. 8) further elaborates on this as-

> *"The enigma is that my body simultaneously sees and is seen. That which looks at all things can also look at itself and recognize, in what it sees, the "other side" of its power of looking. It sees itself seeing; it touches itself touching; it is visible and sensitive for itself.... There is a human body when, between seeing and the seen, between touching and the touched, between one eye and the other, between hand and hand, a blending of some sort takes place"*

In other words, the subject possesses a body that anchors her in the world corporeally and at the same time the subject experiences herself through "bodies of meaning" (Waskul & Vannini, 2006). Phenomenologists also think of a person as actively and constantly shaping as well as reproducing the world they occupy. Hence, the social world "is never externally defined, but exists via human interpretations, as both intersubjective and objective reality" (Agger, 1993) cited by (Neiterman, 2010, p. 41).

In my research, I also loosely borrow from the social constructionist perspective to examine how meanings are constructed to make sense of the social reality in the world of women living in Nagar *basti.* According to Peter Berger and T. Luckmann (1966), subjects objectify the world and "construct social institutions as real, existing before and after us" via social interactions (cited by (Neiterman, 2010, p. 43).

3.1.3 Embodiment

Irrespective of the underlying paradigm, 'the body' has increasingly been problematized within sociology, anthropology, psychology, cultural studies, critical theory and other areas of scholarship. The 'body', in the last few decades has also transformed from an object to an "experiencing agent" (Csordas, 1993, 1994) in scholarly work examining illness experience (Gordon, 1990; Ots, 1991) and healing (Csordas, 1990), body image (Csordas, 1994, p. 3) and

[18] The looking-glass body was first conceptualized by Cooley (1922) (cited by Neiterman, 2010, p. 45) and then later also developed further by Mead (1934) cited by (Neiterman, 2010, p. 45). According to this concept the process of reflexivity enables the embodiment of the looking-glass body. As described by Waskul "when we gaze upon bodies of others we necessarily interpret what we observe. Similarly, others imagine what we may be seeing and feeling, thus completing the reflections ofthe looking-glass. Obviously, this looking-glass body is not a direct reflection ofother's judgments - it is an imagined reflect built on the cues gleaned from others" (Waskul & Vannini, 2006).

political violence (Scheper-Hughes, 1992). Further, some scholars also allude to the transformation of 'the body' in literature, from a "fixed, material entity, existing prior to the mutability and flux of cultural change" to the idea of "the body as an epitome of this flux" (Csordas, 1994).

Thomas Csordas (1994) further proclaims that much of the literature that engages with 'the body' and embodiment can be categorized under the concept of the "analytical body". Such scholarship categorically focuses on "perception, practice, parts, processes or products" (Csordas, 1994, pp. 4–5).

> *"By perception I mean the cultural uses and conditioning of the five external senses plus proprioception (our sense of being in a body and oriented in space), as well what Kant (1978) called the inner sense of intuition or sensibility. Practice includes everything that falls under Mauss's (1950) classic notion of techniques of the body – swimming, dancing, etc. washing, ritual breathing in meditation, posture, the variations in batting stance among baseball players – in which the body is at once tool, agent, and object. Parts of our anatomy such as hair, face, genitals, limbs, or hands have long been of interest to anthropologists for the social and symbolic significance they bear. Bodily processes like breathing, blushing, menstruation, birth, sex, crying, and laughing are of interest in their cultural variation. Finally, a great deal of cultural meaning can be distilled form the treatment of body products such as blood, semen, sweat, tears, feces, urine and saliva."*

He further suggests that the 'paradigm of embodiment' could be used as a starting point to rethink "the nature of culture and our existential situation as cultural beings" (Csordas, 1994, p. 6), since it allows for a simultaneous examination of "culture and the self" (Csordas, 1990). Embodiment here is defined, as described by S. Wainwright & B. Turner, 2004, as

> *"a life process that requires the learning of body techniques such as walking, sitting, dancing, and eating. It is the ensemble of such corporal practices, which produce and give a body its place in everyday life ... Embodiment is the mode by which human beings practically engage with and apprehend the world."*

The approach of embodiment, as described by Csordas (1990) postulates that "the body is not an *object* to be studied in relation to culture, but is to be considered as the *subject* of culture, or in

other words as the existential ground of culture". In other words, the body "incorporates the social" or embodies the social structures actively and at the same time is an "active agent of social construction" or transforms the social (Gorringe, Haddow, Rafanell, Tulle, & Yuill, 2007). Turner (1989), as cited by Hugo Gorringe et al. (2007), further suggests that "people 'have' and 'are' bodies at the same time" which means that one's body is experienced "both phenomenologically and cognitively by ourselves and by others" (Gorringe et al., 2007). Thomas Csordas (1994, p. 10) further speaks of "lived experience" and "being-in-the-world" (from the phenomenological tradition) to refer to "temporally/historically informed sensory presence".

3.1.4 The pregnant body: a case of embodiment

Pregnant bodies, like all bodies, are real as well as socially constructed. They are also at once affected by the political, natural and cultural (Longhurst, 1996, p. 58). Borrowing from Foucault and his approach to embodiment allows "consideration of not only how discourses and practices create subjects but also how these practices construct certain sorts of bodies with particular kinds of power and (in)capacities" (Foucault, 1977) as cited by Robyn Longhurst (1996, p. 58). In other words, the pregnant body exists for the subject via a "web of cultural and social images of pregnant embodiment" (Longhurst, 1996, p. 68).

Pregnant bodies are also temporally and spatially differentiated (Longhurst, 1996, p. 59) making it essential to visualize pregnant bodies as "historically and culturally located". In other words, the meaning of being pregnant "shifts across time and space" (Longhurst, 1996, p. 60). Hence, even within a country there can be vast cultural differences in the way the pregnant body is culturally inscribed with meaning. This would also result in a different 'constructions' of the pregnant body even for the same subject from one pregnancy to the next.

Hence, the biological body and the socio-cultural representations are one and the same and cannot be separated. The pregnant embodiment can only be located within the complex web of nature and culture and at a specific temporal and spatial location. By conceptualizing pregnancy as embodiment, I try to examine how cultural understandings and meanings constitute pregnant bodies in Nagar *basti*. Other euro-american scholars who have examined pregnancy as an embodiment in other contexts include Lucy Bailey (2001), J. Davidson (2001), Robyn Longhurst (2001), Iris Young (1984).

The practice approach

Pierre Bourdieu positions embodiment within a "anthropological discourse of practice" and uses Marcel Mauss's postulation that "body is simultaneously both the original object upon which the work of culture is carried out, and the original tool with which that work is achieved" (Mauss, 1934, cited by Csordas, 1990). Pierre Bourdieu further describes the cyclic link between practices and the body. According to the author, "practices are incorporated within the body, only then to be regenerated through the embodied work and competence of the body" (S. P. Wainwright & Turner, 2003).

Practices included under the "practice idiom" could range from short-lived doings to long-term, stable patterns of activity (Rouse, 2007). Although there is no unified approach to practice theory, practices are usually conceptualized as "embodied, materially mediated arrays of human activity centrally organized around shared practical understanding" (Schatzki, 2001). Further, practice theorists typically believe that "bodies and activities are constituted within practices" (Schatzki, 2001, p. 11). There also exists the presumption that all activity is possible only due to the existence of shared skills and understanding (Schatzki, 2001, p. 12). In other words, the "social is a field of embodied, materially interwoven practices centrally organized around shared practical understandings" (Schatzki, 2001, p. 12). As a corollary, practice theorists conceive of phenomena such as institutions, structures, language and even individuals to be constituted within, embedded in or constituted of the field of practices and hence the only way to analyze them is via the field of practices (Schatzki, 2001, p. 12).

Pregnancy as performance

The underlying approach that I follow is to conceptualize pregnancy as a "performance", a concept that I borrow from Elena Neiterman (2010). According to this approach, pregnancy embodiment takes place by a conscious and active "doing of pregnancy" (Neiterman, 2012). The concept of "performance by doing" is originally attributed to Candace West & DH Zimmerman (1987) who utilized the concept to advance the "understanding of gender as a routine accomplishment embedded in everyday interaction". Just as the performance of gender is accomplished through a set of socially accepted, interactional and micro-political activities; pregnancy too is actively 'done' by women using established practices specific to that socio-cultural milieu. So even though the 'doing' is 'done' by the individuals, it is embedded within the interactional and institutional arenas. Other important aspects of performativity are the presence of "virtual or real others who

are presumed to be oriented to its production" (West & Zimmerman, 1987) and the repetition of "a sustained set of acts" (Butler, 1990, p. 15).

3.1.5 Lived experience in south-Asian studies

Any treatise that intends to conceptualize *women* must also engage with the problem of the "nature of subjectivity" and the subjecthood accorded to women. The postmodernist argument already challenges the Cartesian Subject/Object dichotomy and also the notion that an autonomous subject acts on a separate object to create a knowledge (Ong, 1967, pp. 225–226). Rather "knowledge, along with subjects and objects, is constituted collectively through forms and discourse" (Kumar, 1994, pp. 6–7). As Julia Kristeva puts it, "we are subjects in process, ceaselessly losing our identity, destabilized by fluctuations in our relations to the other, to whom we nevertheless remain bound by a kind of homeostasis" (Kristeva, 1987).

Nita Kumar further advises retaining the "notion of the subject" to allow for the existence of a consciousness and language, but proclaims, as do most engaging with south-Asian scholarship that knowledge is "plural and heterogeneous" (Kumar, 1994). Similarly, there are truths and not "the Truth". The author further, proposes a modified Foucauldian approach to further fashion the female subject (Kumar, 1994, p. 8). Such an approach discusses the "subject as constituted by discourse" but also one that is capable of resisting and creating other discourses (Kumar, 1994, p. 8). Such an approach is also commensurate with my feminist leanings and allow me to focus on the issues of women and how they assert their subjecthood and autonomy within the larger society. Women have for a long time been constituted by androcentric and patriarchal discourses and in my research, I focus specifically on bringing the 'peripheral' women-centric discourses to the center.

Additionally, to avoid inadvertently making the participants of my study the "object of my gaze" I follow in Nita Kumar's foorsteps who suggests looking at "hidden, subversive ways in which women exercise their agency even while outwardly part of a repressive normative order" (Oldenburg, 1991, as cited by Kumar, 1994, p. 4) in the process trying to create a womanhood that is specific to Nagar *basti*. While doing so, I try to be specifically aware of the intersectionality[19] prevalent in the seemingly homogenous *basti* women.

[19] Intersectionality was first coined by Kimberle Crenshaw for highlighting the struggles and experiences of black women and how it "fell between the cracks of both feminist and anti-racist discourses" hence necessitating an entirely new analytical framework that could tackle the complex phenomenon of intersectional experience (Crenshaw, 1989). According to the author, the intersectional experience of being a black woman "is greater than the sum of racism and

Intersectionality broadly refers to the "interaction of multiple identities and experiences of exclusion and subordination" (K. Davis, 2008). Other scholars have further elaborated on the approach since its first conceptualization. Floya Anthias & N. Yuval-Davis explain that the different categories of race, class and caste cannot be simply "tagged onto each other mechanically" as they are closely intertwined with each other and their specific intersections "produce specific effects" (Anthias & Yuval-Davis, 1983). In fact any two categories might "abrade, inflame, amplify, twist, negate, dampen and complicate each other" (Kessler & McKenna, 1978). Among the women in Nagar *basti*, for example, the axes of class, caste, religion and kinship (affinal/natal) are especially significant. For instance, a so-called 'upper caste', literate, Hindu woman wields more power as compared to a so-called 'lower caste', illiterate woman. However, the same 'upper caste' woman will be at a much lower social position within her extended family as compared to her mother-in-law or even older sister-in-law.

Recent conceptualizations of intersectionality think of it as having a more fluid, unstable characteristic. For example, C. West and S. Fenstermaker conceive of the intersection of identities in terms of a "doing, a more fluid coming together, of contingencies and discontinuities, clashes and neutralizations, in which positions, identities, and differences are made and unmade, claimed and rejected" (as cited by Valentine, 2007). Such a conceptualization avoids concrete categorization of an individual or group as "oppressed" or "oppressor". This is specifically pertinent, for an oppressor in a specific context may in fact be the oppressed in another context.

Leslie McCall particularly, proposes case-studies as the "most effective way of empirically researching the complexity of the way that the intersection of categories are experienced in subject's everyday lives" (McCall, 2005). She further suggests using an individual or a group or an event and then "working outward" to examine how the intersections of different identities are experienced. Such accounts would be able to unravel the multiple and simultaneous identities that are 'done' by individuals in specific contexts by, for example, weighing in or ignoring a particular identity to identify or "disidentify" oneself with a group (Valentine, 2007).

3.2 Methodology

When exploring meaning-making and social construction of social processes qualitative methodology is considered as the most apt form of inquiry. Specifically, research utilizing the

sexism". As a result, according to the author, analyses that did not acknowledge intersectionality could not comprehend of the different ways in which black women especially are discriminated against..

phenomenological approach broadly follows the basic steps of qualitative research. Amedeo Giorgi further describes in detail what the phenomenological method entails - "(1) collection of verbal data" – questions framed for collecting data are broad and open-ended, so that the subject has ample space to express her viewpoint extensively since a faithful and detailed description of the subject's experience and actions is desirable; (2) "reading of the data" – developing a holistic sense of the data is important before the analysis can be initiated; (3) "breaking of the data into some kind of parts"- since phenomenology focuses on meanings (Giorgi, 1997). Hence, depending on the discipline, the descriptions are divided into segregated units where each unit pertains to a specific meaning relevant for the study. The phenomenological method is "discovery-oriented", meaning the researcher needs to be open for the emergence of meanings from the data instead for looking for the presence or absence of a pre-specified criterion; (4) "organization and expression of the data from a disciplinary perspective" – which entails transformation of the subject's description of everyday life into a more discipline specific account; and finally (5) "synthesis or summary of the data for purposes to the scholarly community" – where the structure of the lived experience is finally described in disciplinary terms (Giorgi, 1997).

My research methodology followed a similar pattern as I went about examining how women in Nagar *basti* attached meaning to pregnancy and childbirth, and how they embodied and performed these meanings by everyday, micro-political activities. I used ethnographic methods to understand the complex social life worlds of my participants. I utilize the inherent virtues of ethnography such as open-endedness and flexibility to scrutinize the convoluted world of emotions, meanings, experiences and performances that make up the 'doing' of pregnancy. In the subsequent sections I take the reader through the methodology of my study. In the last section I reflect on my positionality and my personal subjecthood that affected my conceptualization of this research project.

3.2.1 Conceptualizing the problem

Because of my primary training in a medical field, health has been at the center of my interest in women's lives in the society. While working in a public hospital in Delhi I had the opportunity to come in close contact with people from the communities living in surrounding *basti*s. It also made me realize that most diseases that I was encountering in my department were closely intertwined with behavior and practices that in turn were embedded in their socio-economic context. To illustrate, I take the example of 'rampant childhood caries', a form of widespread tooth decay

wherein a young child develops caries on multiple teeth due to regular consumption of milk from a feeding bottle right before bedtime. Such cases are extremely tricky to handle because the patients are usually very young and milk teeth are not very easy to restore.

I realized that this condition had a strong socio-economic angle – children who belonged to socio-economically disadvantaged households and whose mothers were employed outside the home with no childcare support were more likely to develop this condition. On further inquiry, I discovered that this was because in the absence of the mother, the older siblings or other female kin would put the young child to sleep. To fasten the process and soothe the child a feeding bottle is often used. As a result, the milk sugars stay in the mouth for hours and lead to this extreme and aggressive form of tooth decay. To manage such a case, it was not sufficient to mechanically remove the decayed parts and fill them up, as is prescribed by dental science. Rather it was essential to understand the underlying practices and the socio-economic constraints behind the prevalence of such practices to avoid further deterioration of the situation.

When I turned towards public health and social epidemiology, placing disease and well-being within the complex scaffold of cultural and historical contexts became even more essential. I became particularly interested in the subcultures and popular discourses among women who continue to occupy a peripheral position within the still male-centered south-Asian scholarship. Even conventional epidemiological approaches – which were originally meant to address the social inequalities in health, end up reinforcing social hierarchies obfuscating our understanding of well-being and ailments. In my attempt to avoid reductionism in my research on the health of women, I followed what M.C. Inhorn and K.L.Whittle refer to as "feminist epidemiology" (Inhorn & Whittle, 2001). The scholars suggest (re)-contextualization and (re)-politicization of women's health and avoiding "biological essentialization of women as reproducers" (Inhorn & Whittle, 2001).

Driven by my research agenda and my academic interest of women-centered public health research I decided to use multiple qualitative methods. I talked to women at length, spent time at the *Anganwadi* centres [20], socializing with the local women and the slum health workers. Quantitative data was only collected as an adjunct to help me better understand the field and the

[20] Anganwadi centres are child and mother care centre in India and are part of the government's Integrated Child Development Services (ICDS) programme (Saxena & Srivastava, 2009). The centres provide basic health care to children under 6 years, pregnant and lactating women and adolescent girls. They also act as day care centres for young children and are an important center for the local women to socialize in an exclusively female environment. Other services provided by the Anganwadi centres are pre-school non-formal education, immunization, referrals services and health education.

women's health status in Nagar *basti*. The following sections offer an in-depth report of my time in the field.

3.2.2 Stepping into the field

My decision to choose Jaipur as the site of my field work was influenced by several factors. I wanted to choose a smaller urban center instead of the usual metropolitan cities of Delhi, Mumbai, Bangalore and Chennai. Small urban centers are relatively under researched and have different characteristics as compared to the larger metropolitan cities. In addition, the state of Rajasthan has one of the highest rural to urban population proportion in the country, which meant that Rajasthan was primarily a rural region. As a result, most communitites in Rajasthan continue to follow their traditional ways of livelihood. Even most urban dwellers continue to remain closely entwined in traditional networks and ways of doing things and this made it an interesting area for me.

Further, Rajasthani, the local language used by most traditional communities in Jaipur, is quite similar to Hindi, which is my mother tongue. This would preclude the need to use a translator. Jaipur city has also seen a doubling of its slum population in the last eight years, indicating at a rapid expansion of slum clusters and increase in new migrants in the slum communities (https://www.dnaindia.com/jaipur/report-slum-population-double-in-jaipur-in-eight-years-225-of-total-population-survey-2638965). New migrants are usually in a more precarious living situation as compared to migrants settled for several years. Since I specifically wanted to focus on women and families residing in *bastis*, it made Jaipur especially interesting to me. Lastly, I had close contacts at the health research institute in Jaipur, which I knew would be essential for laying the groundwork for my field research and enable me to complete the data collection within the allotted period of time. Hence, my decision to select Jaipur city was a pragmatic choice.

The fieldwork was spread over eight months, from August 2016 to March 2017. Indian Institute of Health Management Research, Jaipur was my gateway into the field. The Institute agreed to host me and offered me student accommodation and office space during my field research. My field supervisor, Prof. Nutan Jain also provided me access to their existing local research networks in the city, which enabled me to set up the first few key informant interviews with medical personnel in a local hospital and staff from a local NGO. This helped me plan my field research in terms of site selection as well as time and budget planning. The institute also supported me in recruiting research assistants for my assistance in the field for data collection.

3.2.3 Site selection

One of the first significant decisions that I had to make in the field was to decide on a site as my universe of study. Jaipur has several *basti* clusters – approximately 308 in number – of varying sizes, compositions, legal status and maturity. I first excluded all the smaller clusters since they usually do not have their own *Anganwadi* center. This was significant for me as *Anganwadi*s are at the frontline of the State's mother and child health services. It is where mothers, young children, community health workers (called *Anganwadi* workers[21]) and the ANM (Assistant Nursing Midwife responsible for vaccinations) interact regularly and discuss health (and sometimes non-health) issues. Also, the only way to locate women who were currently or recently pregnant was via the records maintained by the *Anganwadis*. Also, in a small *basti* I would have come across only very few currently and recently pregnant women. Small *basti*s also tend to be relatively homogenous comprising of households of the same caste.

I therefore selected the Nagar *basti* as my fieldwork site due to its large population size, heterogeneous nature and its unique location on the edge of the city adjacent to the Jhalana Forest. It can also be conveniently approached by 'Magic', one of the locally used modes of public transport which is a 4-wheeled vehicle with the brand name - Tata Magic. It plies on fixed routes like public buses and is supposed to seat 9 passengers, but drivers end up loading upto 14 people into a single vehicle. The Nagar *basti* comprises of smaller administrative units or *Teelas* each served by one or more *Anganwadi* centers, which became my gateways to the communities.

3.2.4 Sampling and methods

Once I arrived in Jaipur in August 2016, I began the process by conducting preliminary expert interviews which informed the site selection, interview guidelines, survey questionnaire and survey sampling. These first set of interviews were conducted with female doctors who had been working with women living in *basti*s for several years, as well as with the staff of a local NGO – Naya Sawera- which has been active in Jaipur in the area of mother and child health. From this local NGO I received a highly detailed map of the city marked with all the *basti* clusters. I also received from them a list published by the local government enlisting all the *basti*s along with their respective populations, the ward that it falls in and its legal status. Both these documents made it possible for me to make an informed decision about the selection of a *basti* for my field research.

[21] *Anganwadi* workers are usually women from the same geographical area and usually belong the similar socio-economic backgrounds as the families who use the *Anganwadi* services.

These initial interviews also guided the development of my interview guidelines and questionnaire (See Appendix).

After narrowing down on Nagar *basti*, I began interviewing community gatekeepers and key-informants such as the husband of the Municipal Councillor[22], a public health engineering department engineer and *Anganwadi* workers. Being able to interview government officials right at the beginning of my fieldwork allowed me to gain access into the *basti* and also gave me an insight into the prevalent issues in mother and child health in the area. It was then easier to seek an interview with the *Anganwadi* workers once I was armed with an implicit approval from the councillor. I thus sought the *Anganwadi* workers' support in familiarizing myself to the field, mapping the other *Anganwadi* centres[23] in Nagar *basti* and setting up introductory meetings with the staff at these centers. During these meetings I sought their mother and child health records[24] which I planned to use to locate the recently and currently pregnant women in their areas.

I then tested my unstructured interview guidelines and questionnaire in a neighboring *basti* and made final changes to the tools. I did not use this preliminary data in my research, but rather used the experience to improve the tools and establishing contacts. Then together with my research assistants, I began using the mother and child records of the *Anganwadi* to visit the women in Nagar *basti* to fill out the questionnaire. The purpose of the questionnaire was to understand the universe of study in terms of the family composition, socio-economic background, reproductive histories, migration histories and health status of women and their families. The survey also helped us single out interesting cases, which we wanted to include in our qualitative data collection.

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[22] Municipal councillors are the elected representatives representing a specific ward, which is the smallest administrative unit in urban areas. Municipal councillors together constitute the municipal council. The Municipal council is the legislative wing of the urban Government and it enjoys several legislative powers such as powers passing of resolutions, enacting of bye-laws and regulations, deliberations on local issues in the areas of education, public health, welfare, public safety and developmental work (*CHAPTER-III MUNICIPAL COUNCILLORS POWERS AND FUNCTIONS*, n.d.).

[23] Each *Anganwadi* centre is expected to serve a population of 1000 individuals. Nagar *basti* has 12 centers in all.

[24] These records are maintained manually in the form of thick notebooks recording the name, address, age and other details of pregnant women (such as weight, blood hemoglobin levels, data of last menstrual period, immunizations received, expected date of delivery) and children under the age of 6. These records were often not very up-to-date, meaning either some individuals in the are were not listed in it, or there were names in the record of individuals who had moved out of the *basti* temporarily or permanently or there were manual errors while entering by hand. My research assistants therefore had to often cross-check all the lists with the actual residents in the area by going door-to-door and then updating the lists. We then also shared these updated lists with the *Anganwadi* so that their records were then accurate and up-to-date.

Simultaneously, I visited the *Anganwadi*s everyday observing interactions, discussions and everyday activities (food distribution to the children under 6, immunization of women and children, and recording of weight). I introduced myself to the women who came to drop off or pick up their children or who came to seek the *Anganwadi* services. Currently and recently pregnant women who agreed to being interviewed were then interviewed by me either at the center or at their homes later. I interviewed 6 pregnant and 20 post-partum women (women who had given birth in the last year). With 2 of these women, I also conducted a second round of interviews to explore aspects that they highlighted in the first interview. In total 28 interviews were conducted with 26 women. I also conducted IDIs with 2 mothers-in-law and a local NGO worker living in the *basti*. All the interviews were recorded on my phone and were accompanied by written notes in my field diary. I extensively quote from these interviews in the empirical chapters. A detailed list of all the participants can be found in Appendix 1.

I also participated in several casual conversations over the course of eight months that I was in the field. These conversations were unplanned and happened at streets corners or parks or at the train station and other public places where I happened to meet someone with a story to tell. I also have one group interview, which was initially planned with one participant, but she was later joined by the other female kin in the household.

I also conducted focus-group discussions – 1 with pregnant women, another with women who had delivered in the past year, a third one with husbands of women who had delivered in the past year and a fourth one with mother-in-laws of women who had delivered in the past year. This was done to gain different perspectives on the locally popular ways of doing of pregnancy in Nagar *basti*. The interviews, FGDs and the survey were all happening simultaneously. There were some survey participants who were later also interviewed. All interviews were conducted in Hindi and later translated and transcribed into English.

3.2.4.1 Expert interviews

'Experts', as defined by Jochen Gläser and Grit Laudel, "are people who possess special knowledge of a social phenomenon which the interviewer is interested in" (Gläser & Laudel, 2009). In such interviews, the interviewees are utilized as sources of information, rather than "objects of study". This approach was introduced by Christel Hopf (2016). The 'experts' usually have an expert role in the specific social context under investigation and may or may not be trained professionals. These 'experts' by virtue of their position usually have easy access to information

about people, processes and phenomena in a specific setting by virtue of "learning and training" (Audenhove, 2017). This knowledge is otherwise difficult to obtain. According to the author, an explorative expert interview can be used "as first orientation in new fields" and can be utilized to prepare for the subsequent surveys or interviews (Audenhove, 2017).

During my field work, I first interviewed some people who I thought were 'experts' in the area of mother and child health in Jaipur – both medically and socially. Two of the medical experts were gynecologists – Dr. Gandhi who was working as a private practitioner near Nagar *basti,* and Dr. Meena who works as the head of the department of the gynecology department in the local government women's hospital. The 'social' experts were – Dr. Kashyap, the head of the department of the Preventive and Social Medicine department of the local medical college; and Mr. Maheshwari and Mrs Verma who work with the Naya Sawera NGO in the area of mother and child health among the urban poor. I also interviewed the local water expert- Ms Meena, Junior Engineer in public health engineering (PHED) department.

My interviews with Dr. Gandhi and Dr. Meena were among the first ones in Jaipur. They helped me understand the locally prevalent ideas of pregnancy and childbirth in the city generally. Both the interviews took place at their respective workplaces. Dr. Gandhi allowed me to record our discussion, but Dr. Meena did not and therefore I could only record it in the form of field notes. Since both the doctors practice very close to Nagar *basti* they had several experiences and anecdotes to share. Both had ample information on the commonly followed beliefs and practices, which offered me a preliminary snapshot of the issue I wanted to explore. Interacting with these two medically trained people also underlined the othering of the 'poor woman' that is common among medical personnel in India. Both the professionals seemed to view the *basti* women as unable to follow instructions and incapable of taking care of their health. I could visualize clearly how medics operate not in a vacuum but rather are firmly bound within the socio-cultural mores of the specific context. For example, I was discussing with Dr. Meena about how women handled domestic work during pregnancy and whether she thought that their hard work could be detrimental to their health. She responded that she thought that hard work could actually be beneficial and helped the women have a fixed schedule during the day and offered women the opportunity to get fresh air and exercise. This view coincided with the general opinion that a lot of the mother-in-laws had of their daughter-in-laws in the *basti* – that the rigors of domestic work keep women fit and healthy, and without it they would become lazy and unhealthy.

The other experts that I interviewed informed me about the more social aspects of doing pregnancy in the *basti*. Mr. Maheshwari and Mrs Verma from the NGO were especially very helpful since they had worked in Nagar *basti* before. She discussed at length the common Rajasthani myths that are followed during pregnancy and how she had been dealing with them in the field. The interview with Mrs. Verma helped me decide on Nagar *basti* for my fieldwork and enabled me to draw out a research plan for data collection and fine-tune my interview guidelines. Dr. Kashyap's interview also helped me conceptualize my research in terms of practicality.

Lastly, I also interviewed Ms Meena from the PHED department which directly controls water to the Nagar *basti*. This was done for two reasons- 1. It is an important government office in a city which lies on the edge of the Thar desert and where the public water supply brings water to homes for only 2-3 hours per day. It is located almost next door to the Municipal Councilor's office and is a site of frequent demonstrations in summers when the water supply frequently gets disrupted; 2. Water and sanitation are two of the most important issues for women in Nagar *basti*, as in *basti*s across India. They are the primary water collectors in the family and are the worst hit because of the absence of toilets. Ms. Meena's PHED department is responsible for controlling the water supply to the *basti* from the natural water reservoir located around 150 kms from Jaipur city and for supplying the various localities with water for an hour twice a day. This knowledge of the issues of water and sanitation systems of the *basti* were valuable for designing my interview guidelines and planning my data collection. For example, the information about water timings in the different parts of the *basti* helped me plan my visits because I was unlikely to meet respondents if I visited during water supply hours.

3.2.4.2 Key informant interviews

Key informant interviews are basically in-depth interviews with "people who know what is going on in the community" and have first-hand cultural information about the people and the issues under examination (UCLA center for health policy research, n.d.). The Sage encyclopedia describes key informants as "cultural brokers straddling two cultures and this role gives them a special vantage point in describing their culture" (Given, 2008). They can be a wide range of people such as community leaders, professionals, residents, or local business owners. The informants whom I interviewed were the Anganwadi staff from three different centers in Nagar *basti*. These personnel have this 'special vantage point' mentioned previously by virtue of their position as *basti* women themselves, as well as components of the State's health machinery simultaneously. They

interact with women everyday and therefore are privy to the locally prevalent cultural understanding. These interviews further helped me understand what aspects of pregnancy performance I wanted to focus on and what kind of answers I could aspect from my line of questioning.

I also interviewed Mr. Verma, the husband of the Municipal Councillor. Although Mrs. Verma is the elected official, all her official duties are undertaken by the husband[25]. He was my primary gatekeeper to the Nagar *basti* community. After I had introduced myself and my research to him I received his implicit approval to visit the *Anganwadi*s and seek information.

3.2.4.3 In-depth interviews

In-depth interviews have been described as "meaning-making partnership between interviewers and their respondents" (Hesse-Biber & Leavy, 2006, p. 145) conducted with the purpose of "gaining a detailed insight into the research issues from the perspective of the study participants themselves" (Hennink, Hutter, & Bailey, 2010, p. 116). Most of the interviews that I conducted with the women took place at their homes and some of them at the Anganwadi center. Both locations had its advantages and disadvantages. At the Anganwadi it was easier to have a conversation in private since it was an all female environment. It was also one that they were familiar with and it would culturally not seem inappropriate for a woman to have a long conversation with a strange woman at the center. Most women were also comfortable sitting and chatting in the courtyard of the center, which would have been difficult to achieve at other public spots such as parks. Leisure for women is not a familiar concept and therefore I utilized the time when women came to the center to either drop off their children or pick them up. The interviews were always preceeded by a verbal informed consent where I described the objectives of my research and shared insights into what I would be doing with the data collected.

Interviewing at home had its own issues. Women who were part of an extended household comprising of other female affinal kin were usually not very comfortable being an interviewee in front of the senior female family members. Most of my participants belonged to traditional families where the daughter-in-law was expected to be not heard and only seen, and always veiled. Even if they did agree to be interviewed at home, their responses would be short and not very detailed. Few

[25] This is a common practice in India wherein the women's quotas ensure their election into public office but these elected women end up serving as „proxies for their male family members or a male leader of their political party". This maybe due to limited professional experience of the female candidate or restrictions imposed by the local leaders (Upadhyaya, 2017). The Municipal Councilor was one such case.

of my interviews failed because of this issue and I therefore decided to not interview any women at home unless they were alone at home.

During the day, I had only had short timeslots wherein I could speak to my participants. The usual routine of most of participants was quite full. As a result, several interviews were conducted while my participants were also simultaneously managing chores such as feeding the child or cooking. From 13:00-15:00 most families would be having lunch so I would have to plan my interviews before or after it. Again, in the evening at around 17:00 women in the *basti,* the ones who did not have a toilet at home, would visit the nearby jungle to relieve themselves before starting to prepare the evening meal. I was also categorically advised by the Anganwadi staff as well as the research team at IIHMR to leave the *basti* by sundown as they deemed that it might be unsafe for a non-local woman. Hence, my window of opportunity to interview the participants was quite narrow. Most interviews were between 1-1.5 hours long. There were two interviews under 20 minutes and did not bring up a lot of information that I could use. I therefore excluded them. All the interviews were recorded on my phone and later transcribed in full.

Eight of my participants were pregnant at the time of the interviews while another 18 had given birth within the last year. In total these were 26 women, two of whom I interviewed also a second time. Out of the eight pregnant women, four were pregnant for the first time, two for the second time and another two for the third time. The women who had already delivered had varying number of children from one to four.

Apart from these, there were two elderly women who were the mothers-in-law (MIL) of women who had recently given birth and Ms. Anju who was the fieldworker of a local NGO. I decided to utilize Anju's experience as a case study because of her hybrid position as a NGO worker trained in the State's concept of pregnancy as well as a *basti* woman who has her own personal experiences of doing pregnancy several years ago. Apart from Anju and the two MILs, my participants were in the age group of 18- 30 years. Anju was 35 and the two MILs were between 55-65 years. Apart from these, while I was interviewing my respondents Heena and Radha (names changed), their MIL and landlady respectively joined in and added their insights to the questions that I was asking my participants. This is a very common cultural tendency and I sometimes found it tough to elicit responses solely from my participants without other older women in the household trying to take-over the conversation.

Almost all of my participants are Hindu except three, who are Muslims. Most of my participants had never been to school, eight of them have attended primary school and two have

attended secondary school. Many of the participants were originally from peri-urban or rural Rajasthan where education, especially of the girl child, is not a priority for most families. Even in most urban *basti*s girl children often do not complete schooling, although this is fast changing. Similarly, most of my participants had never worked outside home, but three were employed as domestic helps, one as an artisan and one as a primary teacher in a local school. Almost half of the sample were living in nuclear families and the other half with her in-laws. Even within the second half who were living with in-laws there were different kinds of familial constellations such as living with husband's parents or husband's parents and siblings or husband's parents and siblings and siblings families.

3.2.4.4 Focus group discussion

A focus group discussion (FGD) is useful method for identifying cultural norms or practices in a community. It is essentially an "interactive discussion between six-to-eight pre-selected participants, led by a trained moderator and focusing on a specific set of issues" (Hennink et al., 2010). FGDs can be valuable for uncovering subtle nuances as well as multiple facets of an issue by encouraging interaction within the group. The method utilizes the interaction within the group to present data and insights which would be inaccessible in a one-on-one interview.

Group dynamics hence play a central role in the effectiveness of FGDs and group composition should be considered with utmost care. Authors also suggest three main factors to consider when deciding the group composition- *homogeneity*, *familiarity* and *group size* (Hennink et al., 2010). Homogeneity: the participants should be from a similar socio-economic background, which ensures some shared experience of the topic. Group homogeneity would ensure an environment where the participants are comfortable to discuss their personal experiences. Familiarity: According to the authors, there may be different levels of familiarity within the group - from complete strangers to some familiarity such as that between neighbors to finally complete familiarity such as members of an existing group such as a counselling group (Hennink et al., 2010). There are advantages and disadvantages for each method, but a group of strangers is the preferred method to ensure that the participants have more freedom and less hesitation in sharing personal experiences. Scholars also advise having a group size of six to eight participants to ensure a variety of perspectives, sustenance of the discussion and sufficient opportunity for active participation. The discussion guide also demands considerable attention because it plays a key role in developing rapport, guiding the discussion and elicit a variety of perspectives.

I, with support from my research assistants, conducted four FGDs each comprising of a specific group- currently pregnant women; women who had given birth in the past year; husbands of women who were recently or currently pregnant; mother-in-laws of women who were recently or currently pregnant. The participants within a particular group were all from within the same *teelas* of the *basti.* Within each group, individuals were familiar with at least some of the other participants because they belonged to the same neighborhood.

In the currently pregnant group, I had seven participants. These were women who had come to the *Anganwadi* on immunization day to get vaccinated. The courtyard of the *Anganwadi* offered a safe space for the FGD where the participants felt comfortable and at home. Although confidentiality was sometimes problematic because there was often curious *Anganwadi* staff who wanted to participate or passersby who wanted to listen in. I would then have to politely tell them that it was a private discussion, and they could not be included.

In the recently pregnant group (women who had given birth in the past year), I had eight participants. This FGD also took place during an immunization day. This also took place in an *Anganwadi* courtyard, and the participants were somewhat familiar with some of the others. The discussion in this group also covered how the participants made sense of their pregnancy practices in light of the outcome of their pregnancy.

In the group of husbands, I had nine participants. This group was relatively tough to organize because most men were away at work during the day on weekdays and were not available in the *basti.* The prevalent cultural norms also made it inappropriate for a young woman to seek a meeting with unknown males. Hence, I enlisted the support of the research staff at IIHMR and requested a male colleague to initiate and guide the discussion on a Sunday, while I acted as the assistant. The local temple was the only public space, which also offered some privacy for the discussion. This discussion offered me an interesting insight of what men thought of the locally popular ways of doing pregnancy, which I would have completely missed by just speaking to women.

In the final group, which comprised of mothers-in-law of women who were recently or currently pregnant women, there were six participants in all. The women all belonged to the same neighborhood and were familiar with each other. This discussion was carried out in the home of one of the women. This FGD was invaluable for understanding the differences in the meanings and conceptualizations of pregnancy and childbearing between women from the current and the last generation.

These discussions mostly began with an introduction where I read out a statement explaining who we were and why we were conducting the discussions, followed by seeking their informed consent. This was followed by some introductory questions where I encouraged everyone to share some background details like how far along they were/or their wives/or daughters-in-law were in their pregnancy, or when had they delivered and what was the outcome. This was followed by my key-questions which focused on mainly-

i. Usual work routine at home
ii. Changes in roles and responsibilities
iii. Meanings of 'healthy' / 'unhealthy' practices during pregnancy
iv. If they could, what would they change in their own experience

My role during the discussions was limited to listening, allowing the discussion to take its own course and guide the discussion back on track if I felt that it was going off-track. I tried to generate discussion by posing open questions in an informal way. At the end, I concluded the discussion by thanking the participants for their time and insights and made myself available for any questions that anyone might have. I also organized for tea and a small snack for all the participants to thank them for their time.

Figure 1 Focus group discussion in progress at one of the Anganwadi centers

3.2.4.5 Survey

The survey was simultaneously carried out by me and my research assistants. I divided them into two teams – two per team and presented them with area-wise lists of all the women in a particular area who had delivered in the past year taken from the *Anganwadi* records. I provided the research assistants with a detailed day-wise schedule to ensure all the women in the sample could be covered within the stipulated time. Almost all the questionnaires were filled out by the research assistants who went from door-to-door, while I focused on spot-checking. This involved surprise checks at the interview site and observing the interview being carried out.

The questionnaire began with a statement about the research project and its objectives, followed by a statement of consent, which was supposed to be read out by the interviewer before the beginning of each interview[26]. The questionnaire itself was divided into seven sub-sections covering the following topics- respondent's background (age, education, religion, caste, marital history, migration history, employment); family structure; water facility and use (type of source used, water-timings, water-filling responsibilities); toilet facility (availability, location used for defecation in the absence of a toilet, challenges faced while accessing the jungle); reproductive history (health facility accessed, number of ANC visits, types of investigations carried out, experience of adverse pregnancy outcomes); health information (any chronic illnesses); housing characteristics (type of housing, type of fuel, below poverty-line card). The questionnaire can be found in the Appendix 4.

In the end, the participants were asked what they would change about their last pregnancy, if they could. The questionnaire was initially designed to be elaborate, with the idea that it would bolster the qualitative data. But, with time it was realized that a full-blown mixed-methods study would not be pragmatic given the limited time-frame. As a result, this data was not utilized in its entirety. However, I intend to publish it in the form of a paper. In the end 288 women were interviewed.

3.2.4.6 Spot observations

I also wanted to observe pregnant women and their interactions in public with minimal influence by an external agent (me). I therefore, also used non-participant observation to observe recently

[26] Getting the consent forms signed from the interviewee would not have gone down well with the community due to the inherent distrust of ‚officials' coming from outside and fraudulently getting legal papers signed, by taking advantage of the illiteracy of the poor people. As a result the information was read out to the interviewee and verbal consent was sought.

and currently pregnant women engaged in their everyday practices. Observation is defined as a research method "that enables researchers to systematically observe and record people's behavior, actions and interactions" (Hennink et al., 2010, p. 170). Others scholars define it as "the systematic, detailed observation of behavior and talk: watching and recording what people do and say" (Mays & Pope, 1995). Additionally, it also involves paying attention to and recording the location and setting to provide context to the examination. Observation can be very useful in obtaining a 'thick' description and uncovering silent social norms.

To achieve this, I selected three spots for observation where I expected to meet pregnant women. I chose three *Anganwadi* centres (that allowed me to sit on the premises and observe), water collection spots at the time of water supply and the waiting room of the local women's hospital. I did not engage with the women, rather just observed their interactions with others and made notes of my observations. Hence, I indulged in non-participant observation wherein I did not participate in the activities that I was observing.

Even though I did not engage with the women, it helped me familiarize with the *basti* and its social and physical landscapes. It also helped the women get familiar with me.

Table 1 Summary of data collected by different methods

Method	Tool	Participants	Total number
Expert interviews	Interview guidelines	Gynecologist (private practice near Nagar *basti*)	1
	Interview guidelines	Gynecologist from the local women's hospital	1
	Interview guidelines	Professor of Community Medicine from the local medical college	1
	Interview guidelines	Director and fieldworker from of a local NGO active in the area of mother and child health	2
Key informants interviews	Interview guidelines	Anganwadi staff	3
	Interview guidelines	Municipal Councillor's husband	1

	Interview guidelines	Junior engineer, PHED department	1
	Interview guidelines	Fieldworkers of an NGO in the *basti*	2
In-depth interviews	Interview guidelines	Pregnant women	8
	Interview guidelines	Women who had been pregnant recently	18
	Interview guidelines	MILs of women who had recently given birth	2
	Interview guidelines	Anju, the fieldworker from a local NGO	1
Focus groups	FGD guidelines	Pregnant women	7
	FGD guidelines	Women who had been pregnant recently	8
	FGD guidelines	Men whose wives have been pregnant recently	9
	FGD guidelines	Women whose daughters-in-law have been pregnant recently	6
Informal group discussions	None	Women belonging to one extended household	4
Survey	Questionnaire	Women who had been pregnant recently	288

3.2.5 Sampling

Sampling for IDIs: The main aim of the in-depth interviews (IDI) was to gain a deep insight into the popular perceptions and meanings associated with being pregnant and the processes via which these meanings are embodied. Hence, the sampling strategy I utilized to get a variety of perspectives on my research questions was purposive sampling. Purposive sampling is a type of non-probability sampling, wherein the idea is to select participants in a strategic or purposeful way so that they are most relevant to the questions being researched (Bryman, 2012). Because of its non-random approach it does not allow for generalization of the results to the entire community.

According to scholars, three types of cases are most efficient in purposive sampling and they are typical cases ("normal" for the particular community), "deviant" cases (unusual for the particular community), "negative" cases (which are exceptions for the particular community) (Devers & Frankel, 2000). Hence "outliers" which are traditionally excluded in quantitative studies are deliberately sought in qualitative research. Further, as the research progresses additionally cases might be included to support emerging aspects.

For selecting participants for IDIs I primarily utilized the *Anganwadi's* maternal health records. I also selected participants from my everyday interactions in the basti. The purpose of this selection was to select as "information rich" cases as possible (Devers & Frankel, 2000). The criteria I considered while selecting participants were- age, caste, religion, family structure, number of children and education status – to ensure a wide variety. The women selected from the *Anganwadi* records were first paid an introductory visit in which the informed consent was sought and questionnaire was filled. Then a convenient time slot was sought from the individual for the IDI. Sometimes this first step required multiple visits because some women would be away at their natal home, or be at work or preoccupied, and a second or a third visit were often required for the introduction. Then in the follow-up visit I would finally interview the women.

Sometimes there were issues, such as - the *Anganwadi* records were inaccurate, or it was difficult to trace the house because of the absence of a uniform numbering system in the *basti*, or the family had moved away or the home environment did not allow for effective interviewing (for example the in-laws did not allow a private conversation). There were also cases where the individuals refused to participate. In such scenarios I had to replace the selected participant with another one. I selected participants and conducted interviews till I believed my data had reached the point of saturation. Saturation is said to be achieved "when no new or relevant information emerges (Given, 2008, p. 195).

The inclusion criteria to delineate my sample universe was - 1. Rajasthani; 2. Currently pregnant or had been recently; 3. Could have a conversation with me without the presence of a female kin. I also fixed the cut-off date of the last delivery to September 2015 so that the participants could accurately recall their experiences.

Exclusion criteria: I did not select women whose last pregnancies had ended in a miscarriage to participate in the IDIs, FGDs or the survey. I frequently came across women with such experiences and did not include them in discussions about pregnancy to avoid bringing up painful memories. However, several of my participants have experienced loss of pregnancies in the

distant past. I also did not include women who had migrated from other states, such as West Bengal, Uttar Pradesh and Bihar, which had distinctly different socio-cultural milieus. I therefore selected only *Rajasthani* women even though there were also women in the *basti* who had migrated from other states. This was because recent migrants from these states brought with them the traditional practices and customs from their own cultures. Since I was specifically focusing on the *Rajasthani* way of doing pregnancy, I had to exclude women from other cultural backgrounds.

Sampling for the survey: The purpose of the survey was to describe the population of Nagar *basti* in terms of demographics, migration histories, household characteristics and reproductive histories, and conduct some community level statistical analyses[27]. I used simple random sampling to select participants from the maternal health records from all the *Anganwadis*. I compiled a list of all women whose expected date of delivery was between September 2015 and September 2016. That meant only women whose pregnancy journeys had recently completed - either successfully or unsuccessfully – were considered. I then divided this list into two groups- 'normal' and 'abnormal' outcomes, where 'abnormal' referred to the final outcome of pregnancy which was divergent from the 'normal outcomes' meaning low birth-weight baby, pre-term birth, miscarriage, still-birth or neonatal death (deaths among live births during the first 28 completed days of life). There were a total of 148 cases of 'abnormal' pregnancy outcome that fit the study criteria. I then used a random number generator to select a sample of 148 participants from the 'normal' group as well to reach a sample size of 296. The survey was then carried out by me and my research assistants, but finally only 288 participants could be covered.

Sampling for FGDs: Selecting participants for FGDs was rather tricky because of logistics and communication gaps. It was very difficult to select a group and then coordinate with them on the time, date and place. *Basti* households do not have phone connections and most families had one cellphone, which belonged to the main earning member who has to go out of the house everyday. Most women did not have personal cellphones. Further, in most households most women have their hands quite full with domestic chores and many would find reasons to not turn up at the last moment. Hence, I relied on convenience sampling to select participants for FGDs.

I first sought permission for a place for the FGD. Once I secured that, I selected a day on which it would be easier to gather participants – Immunization days for recent and currently

[27] In the beginning, one additional sub-research question was to examine the statistical association between poor water and sanitation practices and experience of abnormal or adverse pregnancy outcome. However, during my field research I realized that such a mixed-methods approach would be difficult to achieve in the stipulated time-frame.

pregnant women, a meeting day of a local NGO for the mothers-in-law and a Sunday for the men. Then on the selected day I brought together participants who were available right then, who agreed to participate and fulfilled the criteria for the particular group.

3.2.6 Data analysis

3.2.6.1 Transcription and Translation

Once I had completed data collection, I started translating and transcribing the interviews and discussions directly from Hindi to English. For the IDIs I did verbatim transcripts, but for FGDs I transcribed only sections which were on topic. In most FGDs there were long discussions about issues which were not relevant to the study and these I did not transcribe to save on time and effort. While transcribing I retained some colloquial phrases and words, which I thought would be essential during interpretation and for which I could not come with an exact English substitute. I wanted the final manuscript to reflect the cultural dimensions and therefore the work is littered with colloquial terms. A list of all the colloquial terms with their English translation has been placed at the beginning of this thesis. I also anonymized the transcripts and replaced all names with Pseudonyms.

3.2.6.2 Coding

Once all the transcripts were ready I uploaded them on Atlas.ti Version 7.5.18. I then started with the process of open-coding. Open-coding is a line-by-line inductive coding of data (Holton, 2007). During the process I tried to remain as open as possible and included concepts which I thought were even remotely significant for my analysis. The aim is to encourage the emergence of patterns and allow the researcher to see which direction the data is pointing to. Such a line-by-line open coding minimizes the risk of missing an important concept. Several of these inductive codes were processes and explanations that I had not anticipated, but were, nevertheless, significant for the interpretation. This first step resulted in a large number of codes – 153 in total. I then compared my indicators, renamed some of them and added prefixes to denote a hierarchy in the codes. I also combined some of them to create new categories. By the end of this process, I had reduced my codes to 134. I then arranged my codes into categories and sub-categories to allow for analysis. I also maintained a codebook where I described how I had defined each code in my analysis.

3.2.7 Reflecting on my positionality

Reflexivity and reflection on one's positionality is being increasingly considered as a crucial aspect of the process of knowledge generation via qualitative research. I borrow Roni Berger's definition of reflexivity (which she in turn borrowed from other scholars) – "the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (R. Berger, 2015). Positionality is the researcher's specific characteristics such as age, gender, ethnicity, migration status, class, ideologies, linguistic tradition and affiliations (political, academic, religious) and others, which influence the research in several ways. According to the author, the positioning of a researcher can affect her access to the field, influence the researcher-researched relationship, as well as the construction and the presentation of the research (R. Berger, 2015).

I was at once an insider as well as outsider in Jaipur. To give the reader a short background- I was born and brought up in Delhi in a Hindu family. I do not wear any markers of a married Hindu woman and therefore come across as 'young and unmarried' to most Indians who don't know me. I also come across as urban and privileged because of the kind of Hindi I speak, which is very different from Hindi spoken in traditional, rural communities. From early on I was conscious of my half-insider, half-outsider position vis-à-vis my participants. My positionality as a north-Indian, seemingly unmarried, seemingly young, 'modern', English speaking, educated and privileged woman influenced how I approached the field and how the field addressed me. I was encroaching upon the everyday spaces and lives of my respondents, taking up their time and enquiring about very confidential and sensitive issues without offering anything in return. Yet, the *basti* almost always accommodated my intrusive questioning quite graciously.

Even thought I was also cognizant of my appearance in the field, I did stand out in the basti. During data collection, I always had my glasses on and was carrying interview materials in my hands such as papers or a pencil. I was also often accompanied by my research assistants or the local *Anganwadi* staff. I was therefore often viewed in the *basti* as an educated, government health official conducting the census. I wore inexpensive, locally stitched *salwar kameez* which is commonly worn in urban India but is still different from women's clothing in traditional *basti* households where women often wear *ghaghra* or *sarees*. I also always travelled by public transport.

Even though I was an 'outsider' in the *basti*, my 'insider' status as a north-Indian Hindu did make my access to the field relatively uncomplicated. I had some existing contacts in the local

health institute, who agreed to host and support me. My affiliation to a German University also created an image of 'credibility' in the eyes of the teaching staff of the University as well as the 'experts' I consulted to access the field. Due to my 'urban' and 'modern' look, most of the people I approached in the *basti* took me seriously and believed that I was in some position of authority even though most did not quite understand why I was conducting interviews in the *basti*. I was however, careful to not exploit this apparent position of authority.

I had a head start into the issue and was well-equipped to understand the tacit expressions and subtle gestures of my participants. Since I also belonged to 'north-Indian culture' and spoke Hindi, it was usually relatively straightforward for me to build a rapport and trust with the people I met in the field. My experiences from my years in India offered me a tacit understanding of the inner lives of women. Even if I had never lived in a *basti*, I had interacted with many women who lived in *bastis*, in my personal and private life in the past. Having been trained in social science research methodology, I was better prepared to handle sensitive and taboo discussions with my participants.

Having also already worked in the public healthcare system in Delhi in the past, I was aware of the systems, practices and endemic issues in public health establishments. I therefore possessed the ability to unpack my participants' responses and understand 'between-the-lines' even when indirect comments were made. Being a woman also made it 'normal' for me to enter an *Anganwadi* centre and request the staff for cooperation, something which would have been very difficult for a male researcher to accomplish.

At the same time, I was also clearly an outsider. I was very easy to spot in the *basti* and my participants were always very keenly aware of my 'alien status'. Young women are not expected to wander or loiter around. Most *basti* women from relatively well-off households take pride in declaring that they don't step out of the house. Even if they do, women will have a purpose or a chore to accomplish and would return home as soon as possible. Loitering or wandering or walking around is not 'meant' for women. I was therefore often enquired if my family was okay with me loitering around or how much was I being paid to justify the loitering that I was expected to do.

It was also difficult for me to explain to most of my participants what I was doing. Most of my participants from the *basti* had not completed school and several had never been to one. Doctoral studies was almost always confused with a 'medical doctor' and I was usually unsuccessful in explaining the different levels of higher education or that the fieldwork was part of

my own research project. I was also often confused with the government officials who collect data for the census, since I was too going from house-to-house and asking questions with authority.

My participants also often asked me about my marital status. Since I don't look "married" in the traditional north-Indian sense, many would assume I was unmarried and living with my natal family. My child-free status also obviously created 'otherness' and it did strike as odd to some participants that I was enquiring about the extremely personal experiences of conceiving and contraception when I myself was seemed to be unmarried and therefore, according to most participants, unknowledgeable about sexual relationships. Even when I did assure my participants that I was married, I knew that my marriage was extremely unconventional by Indian standards. It was not an 'arranged' marriage, but rather a 'love' marriage, meaning me and my husband had found each other rather that our parents looking for a match for us. We also belonged to different cultures – I from north-India and he from the eastern part of the country. This meant although both our families were Hindu, our mother-tongues, cultures and castes were quite different. This otherness, did make the familiar 'alien' in the field, but also gave me the opportunity to start afresh.

Power relations and my responsibilities towards my participants: All throughout my study I have also been keenly conscious of the power imbalance between my participants and myself, as well as the authority I possessed in the *basti*. I therefore explicitly tried to create an equitable relationship between myself and my participants. Before all my interviews I sought an informed consent and made it clear that I would not be able to offer financial help of any kind. During all my interactions I also offered the participants a chance to ask me questions that they had (personal, professional or related to the issues of the *basti*) making the interaction a two-way flow of information. Several participants sought health-related information and advice such as the availability of a certain medicine in public health establishments or regarding options of private healthcare centres. I was also often asked about how one could apply for financial benefits from the state or for an official document. Sometimes when discussing health and well-being my participants would bring their hospital records and request me to go through to them to determine if everything was alright.

For most of these requests I tried to direct my participants to the appropriate authorities where their queries could be answered. Some queries, such as specialists in the vicinity or dates of admissions to private schools, could be answered via a quick internet research and this I tried to do as often as I could. After the FGDs I also did short informational sessions on basic hygiene and nutrition which I thought might be helpful for the young mothers.

I also continue to be in touch with my research assistants and one of the NGO fieldworkers who was one of the gatekeepers into the community. I visited India again in 2018 for a personal visit and met with my research assistants again. I also visited some of my participants and checked on how they were doing. While analysing and writing my research I tried to bring to the fore the voices of the women to highlight their experiences rather than allowing my subjectivity to colour the processes that I was trying to examine.

Chapter 4: Research context

As discussed previously, childbearing and childbirth are not merely biological, but also socio-cultural and political processes firmly embedded within the local context of women. Therefore, to be able to examine perceptions and meaning-making surrounding pregnancy it is imperative to first unpack the 'field' and explore the *Rajasthani* ethno-culture. I selected Jaipur – the capital and one of the largest urban agglomerates in the state of Rajasthan - as the site for my research. Within Jaipur, I chose Nagar *basti*, one of the larger and more heterogeneous slums of the city, for data collection. This chapter intends to introduce Rajasthan and its capital city to the reader so as to enable contextualization of the research and set the stage for the subsequent empirical chapters. Although urban slum settlements in Rajasthan are comparable with settlements in other Indian cities, there are characteristics which are unique to Rajasthan and its people. I begin this chapter with a discussion about Rajasthan's historical origin from several distinct princely states in the medieval era to its present-day consolidated structure. The section also provides an insight into the structure of society with a special focus on Rajputs, one of the most prominent caste groups in the area. This is followed by a discussion on Jaipur city and its contemporary urban concerns. In the last section, I discuss the Nagar kachhi Basti, specifically with respect to the socio-economic background of the various communities residing in the settlement and their everyday living conditions.

4.1 State of Rajasthan

Rajasthan lies on the north-western border of the country adjoining Pakistan on the west and bound by the Indian states of Punjab and Haryana in the north; Uttar Pradesh and Madhya Pradesh in the west; and the state of Gujarat in the south. The state is the largest in the country by area and the eight largest by population according to the latest Census figures (Registrar General and Census Commissioner of India, 2015). Thar Desert meets the central Indian plains in Rajasthan giving the area an arid landscape, with barren sandy slopes covering almost 60 % of the state area with some humid areas in the southern and the eastern part of the state (Swain, Kalamkar, & Ojha, 2012) . The eastern plains are relatively densely populated as compared to the north-western desert areas and the south-western hilly tracts.

Rajasthan – literally 'abode of Kings' – took shape politically and territorially only after independence from British colonial rule in 1947. For centuries the area was ruled by Rajput clans,

a warrior caste[28] supposed to be of Scythian[29] descent that rose to prominence around the 9th century (Bhatt & Bhargava, 2006, p.44). The entire territory, covering present day Rajasthan and some adjoining areas, was divided among numerous Rajput clans. Each clan and its territory were headed by a ruler and there were constant conquests for new territories since the arid lands did not lend themselves well to settled agriculture (Unnithan-kumar, 1997, pp. 47-48).

Figure 2 Location of Jaipur and Rajasthan

The invading Mughals[30] took advantage of this discord and after initial attempts in the 13th and the 14th century, established the Mughal Empire in the 16th century, following which a large part of present day Rajasthan and surrounding states came under Mughal rule. In early 18th century the

[28] India's caste system is a "social structure that divides different groups into ranked categories" (Elwes and Brown, 2014). The Castes are hereditary and endogamous, emerging out of traditional occupational roles. The Members of "higher" castes have a greater social status than individuals of a "lower" caste and often reflects in the economic status. Although discrimination by caste is prohibited by Indian law, caste identities continue to remain central, especially when it comes to matters like marriage (Elwes and Brown, 2014).

[29] Scythian people are considered to be nomadic people, originally of Iranian stock, who migrated out of central Asia. They were "feared and admired for their prowess in war and, in particular, for their horsemanship." ("Scythian | ancient people | Britannica.com," n.d.)

[30] "Muslim dynasty of Turkic-Mongol origin that ruled most of northern India from the early 16th to the mid-18th century" ("Mughal dynasty | History, Map, & Facts | Britannica.com," n.d.)

Mughal Empire started declining after which the various Rajput kingdoms fell into disarray once again (Bhatt & Bhargava, 2006, p. 26). The fortresses and palaces belonging to different Rajput kingdoms (and in various stages of disuse) continues to dot the landscape today - some abandoned ruins, some still occupied by the royal descendants and others converted into luxury hotels.

By early 19th century British had made inroads into the Indian subcontinent and took advantage of the disunited Rajput clans to sign treaties of alliance with almost all of them (Bhatt & Bhargava, 2006, pp. 18-19). They categorized the various Rajput kingdoms as princely states and brought them together under their indirect control, referring to them as *Rajputana* or 'home of Rajputs'. During British rule (from 1818-1947) these states retained control over their internal affairs but other external matters like defence and foreign affairs passed on into the hands of the colonial state (Maya Unnithan-Kumar, 2000) . It was only after the departure of the British in 1947 that the 19 Rajput princely states were consolidated politically to form present day Rajasthan (Singh et al., 1998, pp. XVI-XVII).

Like other ethno-cultural regions of India, Rajasthan is distinct in its language, culture and social structure with several sub-ethnic groups. Several dialects are spoken across Rajasthan which together form the Rajasthani language. Ethnographers have been able to identify five distinct eco-cultural regions within the state, based on the ecological and linguistic features, each region with its own hierarchy of castes (Singh et al., 1998). The communities of Rajasthan were surveyed for the first time in 1985 by the People of India project under the Anthropological Survey of India and more than 200 different communities were identified (Singh et al., 1998, p. XVII). The state is predominantly occupied by Hindus of various castes contributing to around 88 % of the entire population (Registrar General and Census Commissioner of India, 2011). Islam, Sikhism, Jainism and Christianity are other minority religions in the order of prevalence (Registrar General and Census Commissioner of India, 2011).

Rajputs have been historically dominant as rulers and have largely been able to retain their status as class elites (Robbins, 1998; Maya Unnithan-Kumar, 2000). They have also exerted considerable influence on the culture of the region, so much so that Rajput history is conflated with the history of Rajasthan. The so-called lower-caste communities remain grossly underrepresented in the historical accounts and their identity continues to be grounded in their association with the Rajputs (Maya Unnithan-Kumar, 2000).

4.2.1 The Rajput

A treatise on Rajasthan is incomplete without at least a brief introduction to Rajput clans. Rajput literally means 'son of a king' and this is the basis of a shared belief among members of the community that all of them are descendants of kings (Harlan, 1992). Even present day Rajput communities living all over Rajasthan or even in different parts of the country and the world remain acutely conscious of their genealogy and other aspects of their family's heritage (Harlan, 1992). They were warring clans originally from central Asia, who lived off the peasants they conquered and engaged in constant aggression for territorial expansion (Maya Unnithan-Kumar, 1997). Within the Rajput community, all clans believe themselves to have descended from three main kinship units which play a significant role in the construction of their identity, traditions and customs.

There were also different classes of Rajput – the royalty, the nobles and the ordinary Rajput (Harlan, 1992). It is believed that the practice of primogeniture has been responsible for this wherein the eldest son succeeded the father and the younger sons were supposed to seek out new kingdoms to conquer or enter into the service of another king as a noble. Over generations, some of the youngest sons had to resort to cultivation and became the 'ruled'. On the other hand, non-Rajput households that were loyal to the king received landholdings which brought along power and prestige, and elevated them to the stature of Rajput (also referred to as Rajputization) (Bhatnagar et al., 2005). According to Singer (1964) Rajputization or the adoption of 'the kingly or martial lifestyle' (as cited in Bhatnagar, Dube, & Dube, 2005, p. 69) could be aspired to by families from any community. Rajputization was also often initiated by violent acquisition of land and capital and establishing power. This would then be followed by creating associations with elite Rajputs by marrying off a daughter into an established Rajput clan in exchange for a huge dowry, adopting oppressive women-related practices characteristic of Rajput clans and enlisting the services of priests to compose a family genealogy that would associate them with ritual purity (Bhatnagar et al., 2005). Hence, the Rajput category was relatively fluid and was affected by processes of upward and downward social mobility, and this has led post-colonial sociologists to challenge the 'caste' label ascribed to Rajputs.

The erstwhile Rajput state had a male dominated political and social structure, at the core of which lay the Rajput code of conduct and honor. Women along with the children required protection and were the embodiment of men's honor. Patrilineal kinship translated in power and men's right to claim the inheritance of land, while women occupied an inferior position in the natal

as well as marital families and could not inherit property. Clan exogamy allowed royal lineages to expand kinship ties with other landholding families this formed the basis of their power. Polygamy further allowed the ruling clans to widen its affinal ties and expand its military power. Marriage alliances were also made as a 'token of submission' after a battle and the daughters of a defeated king were offered to the victor, and this was often an indicator of the ruler's status (Sreenivasan, 2007). As a rule, daughters were always 'married up', but a daughter-in-law could be taken from lower clans. As a corollary, female infanticide enjoyed social sanction especially among the royal clans at the top of the hierarchy, who preferred to kill their infant daughters to avoid the indignity of marrying them off to lower clans (Bhatnagar et al., 2005; Maya Unnithan-Kumar, 1997).

Rajasthan has one of the highest rural to urban ratios in the country and most communitites occupy quite a traditional socio-cultural milieu. Within popular culture the primary responsibility of the ideal Rajput woman was to preserve honor, chastity and loyalty to the husband and the clan, the most extreme forms of which were *Sati* and *Jauhar* widely practiced in aristocratic families (Maya Unnithan-Kumar, 2000). *Sati* was considered to be the ultimate sacrifice wherein the woman immolated herself on the funeral pyre of her husband and *Jauhar* was the mass immolation of the royal women to escape capture in case of military defeat. Committing of *Sati* was considered an extension of a devoted wife's duties towards the husband and enhanced the status and honour of the wife (post-humously), and her kin. Anti-*Sati* legislations stamped out the practice in much of modern India, but it still enjoys social sanction in some communities in rural Rajasthan where the last Sati attempt occurred in as recent as 2009 (Divya, 2009). Veneration of the site where Sati was committed is still a tradition in many parts of Rajasthan and Madhya Pradesh with multiple Sati temples, fables and folktales glorifying and deifying the women who committed Sati.

Another Rajput custom which was more widely practiced was the *Purdah* - literally meaning 'curtain' – which refers to the spatial seclusion of married women (Maya Unnithan-Kumar, 2000). It is still practiced in some form or the other, the most common being the use of a veil to cover one's face from all male members of the household except the husband, a practice that is still widespread in rural as well as urban Rajasthan. Complete *Purdah* would entail complete seclusion of married women in separate women's quarters – called *Zanana* - so that women would remain unseen by men except their husbands and close relatives. They would generally remain indoors, not even worshipping in the local temple or participating in festivals, unless it was done in the *Zanana*. These practices symbolized prestige and high status, which could not be afforded by working class families. In such families, women's labor is required for income generating

activities outside the house such as in cultivation or animal rearing. As a result, even powerful non-Rajput communities came to practice *Purdah* to display their elevated social standing. In other words, upward social mobility of a community was strongly associated with increased constraints on women (Bhatnagar et al., 2005; Maya Unnithan-Kumar, 1997).

As mentioned, among the working classes, *Purdah* wasn't financially viable and the labour of women had considerable value, even though the means of production such as land was still controlled by men (Maya Unnithan-Kumar, 2000). To this day most Rajput and even non- Rajput households in Rajasthan follow some form of *Purdah*, although not as rigid as having a separate *Zanana* for the women. These institutions and its processes continue to be used by Rajput women to define their identity and by Rajput men to differentiate themselves from non-Rajputs. Even today, most contemporary upper-caste households continue to bring up their daughters with the ideals of husband devotion and sacrifice.

Many erstwhile ruling families continued stay politically active post- Independence and some of them even got elected into political office due to their influence within the community. Although after the Indian independence royal families lost the power to collect taxes from the larger community, they are still referred to with their royal titles of 'Maharaja' and most of them have maintained their wealth and prestige. Descendants of some of the royal Rajput families continue to occupy their traditional palaces living among people whom they once ruled. They are still treated with deference within the community, although most of them have now had to take up other occupations.

4.2.2 Other communities

Apart from the Rajputs, the other caste group that has traditionally been very prominent is the Jats. Traditionally tenant farmers, they form the largest caste group in Rajasthan and were at the center of peasant movements in the years leading up to the Independence (Sisson, 1959). Post-independence Jat elites have been successful in attaining political power and they continue to be prominent in contemporary politics.

Rajasthan also has numerous nomadic and semi-nomadic communities making up around 3.5 million of the total state population of around 68 million (Thomas, 2016). The area has also traditionally been a part of the "animal-breeding centre of northern India" with several communities specializing in herding livestock (Robbins, 1998). These nomadic and semi-nomadic communities are either pastoralists – such as the *Raika* who are camel and sheep breeders – or

'non pastoral' providing services to the settled population – such as the artisan communities of *Lohar* and *Sikligar,* the singing and dancing *Kalbelia* and the *Banjara* who were traditionally long-distance goods carriers (Motzafi-Haller, 2012). These communities have a long history of marginalization. During British colonization these nomadic communities were labelled "born criminals" under the Criminal Tribes Act (1871) and treated with suspicion by the larger community as well as the state. Even Independence could not bring about any considerable improvement in the social status of these communities (Motzafi-Haller, 2012). Modernization and development further grossly affected their traditional livelihoods and most members continue to live on the margins of the society (Motzafi-Haller, 2012).

The so-called 'tribal' communities - such as the *Bhils* and the *Meenas* - are also an important part of the Rajasthani society and constitute around 13% of the state's population (Directorate of Census Operations Rajasthan, 2011c). These communities are thought to be the original inhabitants of the Aravalli hills and today are concentrated in the southern part of the state. Some of these communities have traditionally relied on hunting and food gathering, but now have taken to small scale agriculture or seasonal urban migration. Many of these nomadic and tribal communities, because of the loss of their traditional livelihoods and being absorbed by the rapidly expanding cities, have resorted to living in *basti*s in urban centres like Jaipur where they take up informal employment.

4.3 Contemporary Rajasthan

Till the 1970s, Rajasthan lagged behind the rest of the country with respect to industry and per capita income but has experienced rapid advancement in the last few decades. This has been attributed to the Five-Year plans[31], discovery of mineral deposits in the state, large scale hydro-electric works and extension of the Rajasthan canal to the western border of the state and other factors (Adams & Bumb, 1973). The state is still largely rural with more than 75% of its population residing in rural areas made up mostly by small and middle- holding agro pastoralists (Directorate of Census Operations Rajasthan, 2011b; Robbins, 1998). Agriculture and allied activities are the primary sources of livelihood for around 65 % of the total population and most of it is dependent on the Monsoons (Swain et al., 2012).

[31] Five-Year plans were a central project of India's first Prime Minister Jawaharlal Nehru. This economic policy was part of what was termed as "Nehruvian socialism" which were introduce with the intention of reconstructing the Indian economy after the losses of the WWII and the Partition ("The end of Five-Year Plans", 2017) . The plans ran from 1951 to 2017.

Small-scale livestock rearing is also commonly practiced even by many marginal households. Several urban households residing in slum settlements rear goats, chicken and even cattle to supplement the household income. This could also be seen among the a few earliest settlers of the Nagar *basti* who live in the older areas of the *basti* and could occupy relatively larger pieces of land. Although economic and political transition has been steadily narrowing the inter-caste professional differences, many communities continue to engage in their traditional specialized occupation (Köhler-Rollefson, 1992; Robbins, 1998). For example, pastoralist castes such as the *Raika* and *Sindhi* continue to dominate in camel breeding and supply.

Rajasthan has also seen a steady rise in urban population as well as total number of urban areas. The big, million plus cities - namely Jaipur city, Churu, Sawai Madhopur and Kota – attract the major chunk of the migrants from within the State. Like in other Indian states, rural to urban migration has contributed significantly to this rise in population and this contribution has been steadily increasing, with Jaipur district leading in the rate of urbanization. With improvement in transport and communications, migration is also increasingly becoming an important livelihood strategy for rural communities especially in the arid areas (Human Development Resource Centre, 2004).

The rapid expansion of urban centres has been accompanied by deterioration in the quality of life of rural as well as urban dwellers. Most rural communities have been experiencing a gradual depletion of resources such as community grazing lands, village forests and woodlands, and community ponds and animal watering points (Jodha, 1985). Further, incessant ground water harvesting, rampant mining (legal and illegal) and demand for infrastructure have further led to land degradation and increased risk of desertification (Chauhan, 2010). Some areas in western Rajasthan such as Bijolia, one of the richest in India with respect to mineral deposits, have seen a rapid expansion of wasteland associated with mining (almost 675 % in the last 20 years) (Chauhan, 2010).

As a result, several rural communities have lost their means of livelihood. For instance Paul Robbins (1998) describes the increased nomadism of erstwhile semi-nomadic *Raikas* in western Rajasthan due to increased demand for agricultural land and intensification of agriculture, followed by breakdown of local institutions and change in land use patterns and eventually a decline in available grazing land and frequent water shortages. Similarly *Bhil* communities who have traditionally relied on subsistence farming and gathering forest produce, have taken to seasonal migration to urban centres for unskilled low-wage labour work (Mosse, Gupta, Mehta, & Shah,

2002). Jeffrey Snodgrass (2004) similarly describes how semi-nomadic *Bhats* – traditionally employed as village entertainers, genealogists and praise-singers – have taken to entertaining tourists at five-star hotels.

The 1990s' infrastructural development also gave a considerable boost to the growing tourism industry and Rajasthan was transformed into a 'heritage' tourism destination (Weisgrau & Henderson, 2007, pp. xxviii–xxxii). It was actively marketed as the 'authentic' and 'traditional' Indian state and as a result gradually emerged as India's top tourist destination for international as well as domestic tourists with Jaipur being among the most visited sites within Rajasthan (Weisgrau & Henderson, 2007, pp. xxviii–xxxii). Gradually, Rajasthan came to account for around one-third of India's tourism revenue as the 'sand dunes, palaces, forts and elephants' characteristic of Rajasthan, became conflated with the culture and history of India (Weisgrau & Henderson, 2007, p. xxviii). On one hand, palaces turned five-star hotels offered the experience of the ancient royal culture at exorbitant rates, on the other hand the quality of life of the average Rajasthani household continues to fall below Indian standards (Weisgrau & Henderson, 2007, p. xxvi).

The rapid urbanisation has not brought about much transformation of the socio-political milieu of the society. Feudal patriarchal Rajput formations continue to heavily influence the wider populace of the State. This can be exemplified by Rajasthan's poor sex ratio of 926 females to 1000 males as compared to the Indian average of 940, resultant of rampant sex selective abortions, female infanticide and neglect of the female child (UNDP India, 2009). The female literacy rate is also an abysmal 52% while the corresponding figure for India is 65% and for males in Rajasthan is 80% (UNDP India, 2009). The state is part of the Empowered Action Group (EAG)[32] with seven other states – namely Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttaranchal and Uttar Pradesh - that trail behind in demographic transition and have the poorest child and infant mortality rates in the country. Rajasthan, along with the neighbouring states of Haryana and Uttar Pradesh is also notorious for its *Khap Panchayats*, caste-based all male village councils that are in-charge of dispute resolution. The disputes may be related to property or inter-caste or inter-religion matters and much has been written about their evolution into quasi-judicial

[32] The Empowered Action Group were constituted by the Govt. of India under the Ministry of Health and Family Welfare in 2001 with the aim of reinforcing the population stabilising efforts of the eight states lagging behind the Indian norm. According to Kumar and Singh (2016) the EAG states account for 61% of India's poor while accommodating only 46% of the country's population and have the worst health outcomes in the country. The EAG states have displayed marginal improved in the latest Census ("CENSUS: A nation of 1.21 billion", 2011).

bodies, prescribing and enforcing diktats based on medieval customs. Because these councils often enjoy the support of the local political elite, they operate with impunity despite often inciting crimes such as 'honor killings'[33].

Further, Rajasthan is also one of the poorest performers in terms of health indicators in the country, such as morbidity and mortality rates, maternal and child health care access as well as utilization, delivery care, immunizations, nutritional status of children as well as adults and access to family planning methods. For example, according to the National Family Health Survey - 4 (NFHS) the Under 5 mortality rate[34] for India is 50, while that of Rajasthan is 51 (International Institute for Population Sciences (IIPS), 2017). Similarly the percentage of mothers who received all recommended types of antenatal care was 21% for India and 10% for Rajasthan and percentage of children receiving postnatal care from a skilled provider within the first 2 days of birth was 24% for India and 22% for Rajasthan (International Institute for Population Sciences (IIPS), 2017). Further, complete Immunization coverage was 62% for India and 55% for Rajasthan and the percentage of births with birth weight under 2.5 kg was 18% for India and 21 % for Rajasthan (International Institute for Population Sciences (IIPS), 2017). The state also an outlier within the national level data since the indicators for the rest of the country improved, while that of Rajasthan worsened between NFHS - 1 (1992-93) and NFHS - 3 (2005-06).

4.3.1 Jaipur

Jaipur is the tenth largest city in India and the capital of Rajasthan. It is considered to be one of the oldest planned cities of the country and was apparently based on an ancient architectural manual (Jawaid, Pipralia, & Kumar, 2016). It was founded in 1727 by Sawai Jai Singh II, the ruler of the kingdom of Amber, to accommodate the then burgeoning population (of around 50,000) and to serve as a commercial hub for the region (Jawaid et al., 2016). Jaipur was constructed as a walled

[33] 'Honour killings are acts of violence perpetrated upon a woman and sometimes even a man, "when an honor code is believed to have been broken and perceived shame is brought upon the family" (Meetoo & Mirza, 2007). Honor killings have been documented in many parts of South Asia and Africa. These so called honor killings can be acarried out by the the community and as well as family members such as mothers, brothers, uncles and cousins (Meetoo & Mirza, 2007). Especially in the Indian context, 'honor' takes on casteist color, wherein a family, clan, caste or even an entire community can lose honor by the inappropriate conduct of the woman. In such a context, extreme subordination of women was justified to preserve patrilineal purity and this form of gender discrimination is referred to as Brahmanical Patriarchy (Chakravarty, 1993).

[34] Under 5 mortality rate (U5MR) is expressed as a rate per 1000 live births and indicates at the probability of dying before reaching the age of 5 years.

city covering just 6.7 square km, integrating contemporary Mughal architectural concepts with traditional planning guidelines while adapting to the terrain and local ecology (Jawaid et al., 2016). Over the years, it became a hub for commerce, trade, local handicraft industries and tourism.

By the early 19th century, the city started expanding beyond the city walls and modern infrastructure was laid down. The establishment of a railway line especially, accelerated the expansion of the city. In the last quarter of the 19th century the old city was painted pink – considered to be the colour of hospitality – to welcome the Prince of Wales to the city (Jawaid, Sharma, Pipralia, & Kumar, 2017). As a result, the city earned the epithet of 'The Pink city' and the walled zone continues to have pink external walls. To this day, the original walled area has been able to accommodate vehicular traffic and commercial expansion making it the only 18th century city in the country to do so (Jawaid et al., 2016).

At the time of India's independence from colonial Britain and the associated partition of the country, there was a massive movement of people in both directions of the new border and it brought thousands of new residents into the city as refugees. There was also an influx of rural migrants in search of employment opportunities in the growing real estate construction industry, pushed away from agriculture by frequent droughts. Many were also attracted by the growing tourism industry in Jaipur. This resulted in the development of a dual economy within the city,; on one hand a 'traditional' city preserved to offer a glimpse of the royal history and on the other a crowded city dotted with informal settlements and encroachments (Weisgrau & Henderson, 2007). For administrative purposes the city is divided into the inner area (including the historic walled city) administered by Jaipur Municipal Corporation (JMC) and the outer city (consisting of the suburbs and various satellite towns) administered by Jaipur Development Authority (JDA). These administrative bodies were established in 1970, after which the first Master Plan for Jaipur city was implemented, followed by the establishment of the second Master Plan in 1995 (Jawaid et al., 2017). However, these plans proved ineffective in regulating the unfettered urbanisation and the situation has only grown graver. Since 1971 the population of Jaipur city has been experiencing a growth of 50% in almost every decade, while housing grew by only around 39% (Jawaid et al., 2017). The urban development was mostly steered by the real estate developers, and public infrastructure tries to catch up and retrofit the civic amenities.

Even though Jaipur has expanded way beyond the old city limits enveloping large swathes of forests and cultivated land, the infrastructure is grossly insufficient for the growing population (See Figure 3 Urban growth pattern of Jaipur (Gupta, 2011)). The city has been receiving considerable economic investment for the past few years due to its strategic location close to the National Capital Region of New Delhi.

The resultant mushrooming of malls, commercial spaces, highways and other infrastructure, along with frequent droughts lead to significant rural to urban migration rates, which are one of the highest in the country. As a result, Jaipur Municipal Corporation accounts for the largest slum population in Rajasthan, which is around 29% of the total population of slum dwellers in the state (Siddharth Agarwal & Sangar, 2006). Ironically Jaipur city - whose original plan was lauded and even replicated by smaller towns across the State – was ranked 20 in the quality of urban governance, out of 21 cities of India by the Annual survey of India's City-Systems in 2015 (Janaagraha Centre for Citizenship and Democracy, 2017).

Jaipur is currently home to around three million people, with some parts of the historic centre having a population density of over 58,000 persons per square km (Participatory Research in Asia, 2014). The corresponding figure for the whole district of Jaipur is 595 persons per square km (Directorate of Census Operations Rajasthan, 2011a). Rapid population growth in the last few decades has put tremendous pressure on the infrastructure exacerbating the

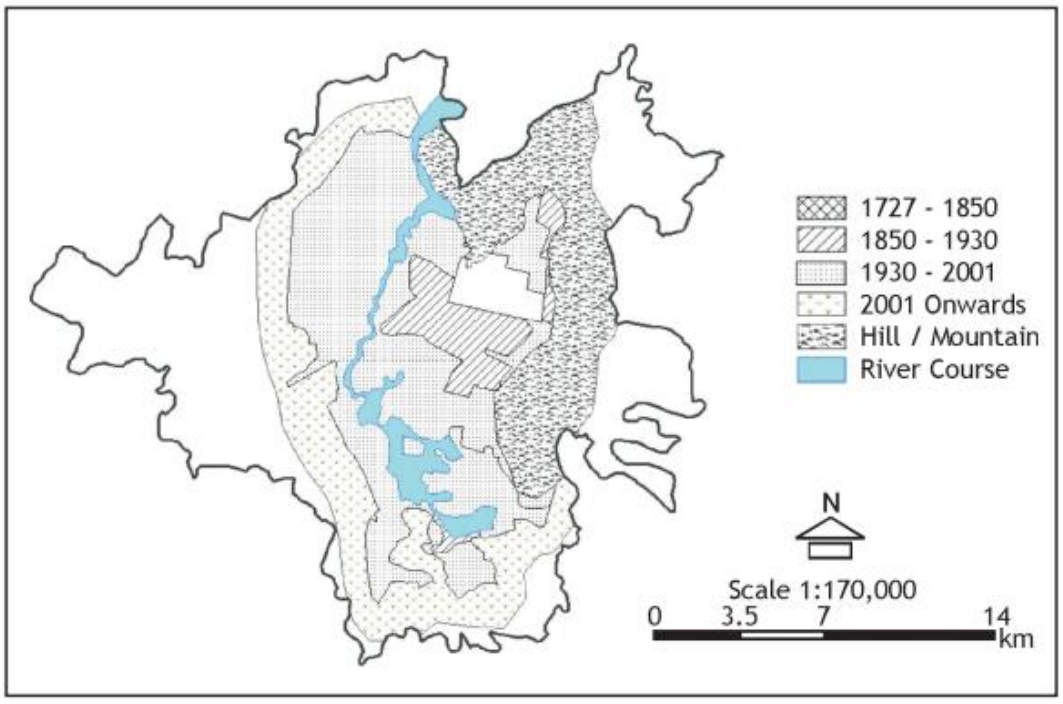

Figure 3 Urban growth pattern of Jaipur (Gupta, 2011)

disparities in access to various amenities. Like most other Indian cities, Jaipur has been struggling to provide the basic amenities of housing, transport, garbage disposal, water, sanitation and other facilities to all of its residents.

Rapid transformation in land use to provide for residential and commercial units has also led to widespread loss of forest cover, soil cover and surface water channels, in turn hampering groundwater recharge and affecting the level of the underground aquifers. Indiscriminate extraction has also concentrated salts and heavy metals in the ground water degrading its quality and making it unfit for human consumption. The sewer system also covers around only half of the population of Jaipur (K. Roberts, Reiner, & Gray, 2013). The sewage generated each day vastly exceeds the treatment capacity of the sewage plants but the exact status of the functioning of these plants is unclear. Residents falling outside of the network either rely on septic tanks or leach pits, both of which are more expensive to construct and maintain as compared to the sewer systems. Households with insecure land tenures often find the toilet costs prohibitive.

The past few decades have also seen a rise in the slum population. The first ever survey of slum areas was conducted in 1971, which identified 109 slum settlements in the city and compelled the authorities to initiate the process of resettlement of slum residents. However, not much could be accomplished. Today, more than 10% of all Jaipur residents live in informal settlements or slums or *basti*s most of which are largely concentrated around the eastern foothills and other un-utilized areas (Registrar General & Census Commissioner, 2011). The exact number of slum settlements is ambiguous, but recent NGO assessments report that around 80,000 households comprising of approximately 400,000 individuals live in 238 listed or notified slums (192 under JMC and 46 under JDA) and 59 non-notified or unlisted slums (Participatory Research in Asia, 2014).

The infrastructure situation in the slum settlements is even more grim as almost half of the households in Jaipur slums do not have access to definite water sources and are dependent on public taps, neighbors or private sellers for their everyday water needs (Participatory Research in Asia, 2014). Even for the households that are connected to the centralized water supply network, the water supply in the city is intermittent and is available for around 90-120 minutes per day. The Public Health Engineering Department's metering system is also problematic, since around 60 % of the meters are non-functional and tariffs are based on the average consumption based on past readings rather than the actual consumption by the household (K. Roberts et al., 2013). The situation of sanitation is also abysmal and most *basti* households without a toilet resort to open defecation along roads, railway tracks and drains (Population Foundation of India, 2012).

According to the latest Census figures around 39% of the population of the district of Jaipur continue to rely on open defecation (Directorate of Census Operations Rajasthan, 2011a).

The health status of the urban poor, households that are most likely to reside in slum settlements, is also far worse than the rest of the population of the region (S. Agarwal, 2011). For example, under-5 mortality rate, percentage of children completely immunized, percentage of under-5 children who were stunted, percentage of mothers with at least three antenatal visits and percentage of births assisted by health personnel were all much worse for the poorest urban quartile as compared to the rest of the urban population in Rajasthan (S. Agarwal, 2011).

In 2012, Rajasthan Government announced its intention to make Jaipur 'slum-free'. The Rajasthan Slum Development policy was framed to implement this proposal by converting large slum settlements into 'modern residential colonies' (The Hindu, 2012). However, till March 2017 residents of 10 out of the 308 slums are in the process of being rehabilitated while the status of the rest of the slums remains uncertain (Thomas, 2017). Jaipur was also one of the first cities to be accepted within the Smart Cities Mission (SCM) of the Government of India under the Ministry of Urban Development (MoUD). The MoUD intends to develop a foundation for 100 smart cities between 2015 and 2020, with the aim of improving living conditions and attaining higher economic growth in the selected cities. SCM proposes inclusive and transparent 'city improvement (retrofitting), city renewal (redevelopment) and city extension (greenfield development)' (Smart Cities Council India, 2015). With an over emphasis on the so-called 'smart' principles, it remains to be seen how it would be operationalized in Jaipur.

4.4 Nagar *kachhi basti*

The Slums or *kachhi basti* – literally meaning temporary settlement, as they are called colloquially - provide low-cost housing opportunities in the city. Nagar *Basti* (not its real name) is located on the eastern fringe of the city bounded by the Jaipur-Delhi Highway on one side and isolated hills of the Aravalli range on the other side. The *basti* is located on land officially designated as 'forest area' and comes under the jurisdiction of Rajasthan Forest Department. The *basti* has a steep incline in places and is a maze of narrow winding lanes, extending between temporary and permanent housing structures. The exact population of the settlement is unclear. While government reports peg the population at around 10,000 individuals, local NGOs claim that the actual population is likely to be more than 20,000. A recent newspaper article reports the number of households in the settlement to be around 5000 (Avanindra Mishra, 2017). For administrative purposes the settlement

is divided into seven units called *Teela*s (literally meaning ‘hill’), numbered from one to seven. The settlement originated with *Teela* one and elderly women often narrate tales of the times when the settlement comprised of a few houses among the scrub forests. As more families moved to the *basti*, new structures were built and gradually the basti grew into subsequent *Teela*s.

According to residents of the settlement, the slum originated around 1980. Most of the slum residents are migrants from other parts of Rajasthan or even other States such as Uttar Pradesh and West Bengal who moved to the city in search of better livelihoods. Initially it was comprised of rural migrants working as laborers at a housing board construction site in the vicinity. At the time, the area was covered with vegetation, thorny trees and shrubs characteristic of the desert. The early migrants constructed temporary structures in the scrub forests. In the initial years of the settlement, land was in abundance and newcomers took up new areas. The settlers did not have rights to the land.

Gradually it attracted families from farther away who migrated to the city for new opportunities. As a result, the settlement grew exponentially, clearing up more and more scrub forests. New migrants could just occupy a vacant piece of land and build a temporary construction. Gradually more permanent features would be added to the structure, turning it into a *pucca* structure. According to the residents, a few years ago the Forest Department constructed a low wall at the far end of the slum to limit its expansion into the forest and construction beyond the wall was prohibited. The houses did not extend beyond the wall, but it has been breached at multiple places to provide easy access into the scrub forest. This forest is used by the *basti* residents for multiple purposes. Garbage from the households is dumped along the wall and the remaining foliage provides firewood to the households that cannot afford gas cooking stoves. The forest is also used as a play-area by the children and for socializing by men of all age groups, for

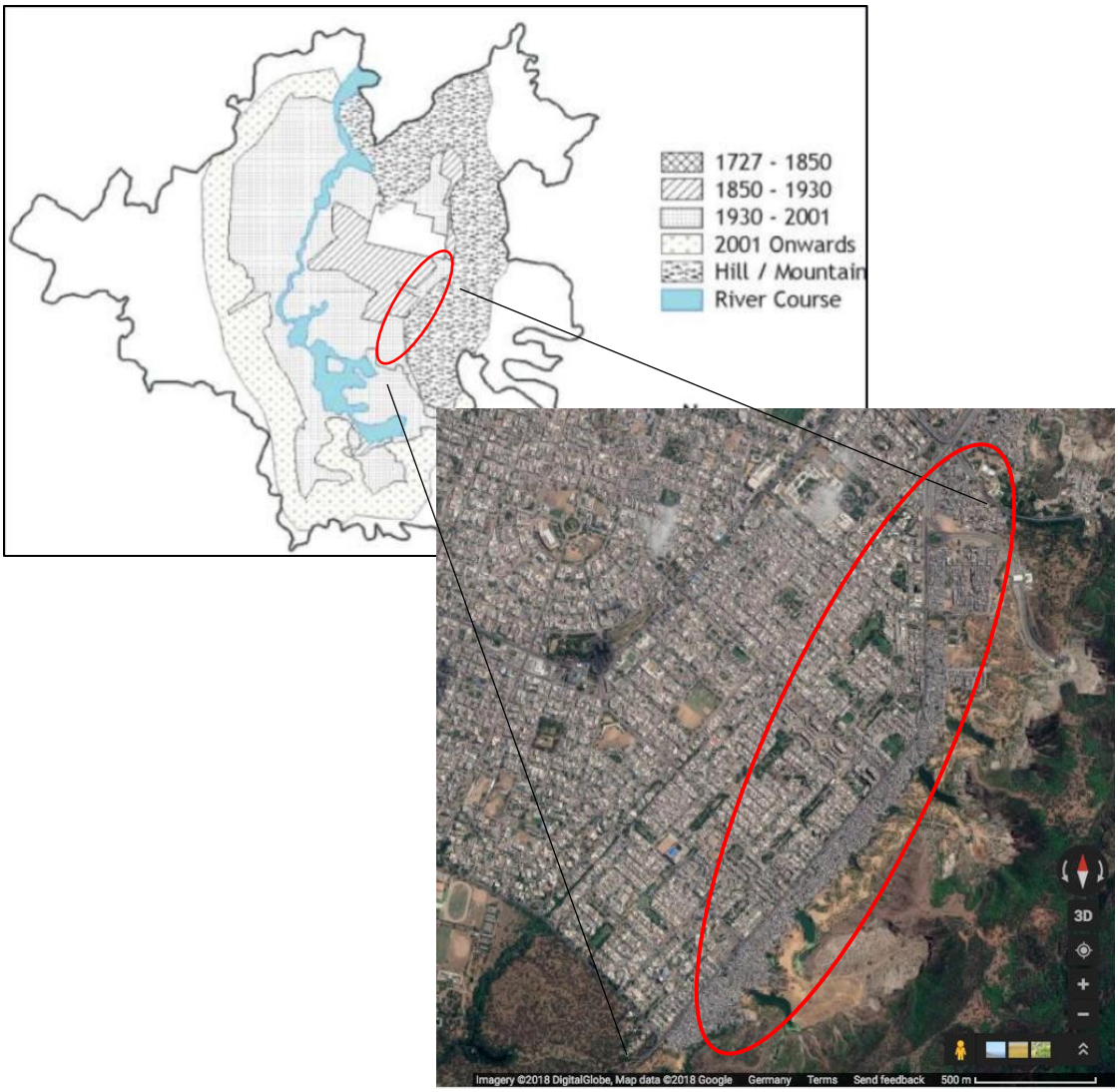

Figure 4 Location of Nagar basti in Jaipur

alcohol consumption, playing cards or just loitering. Most importantly, the scrub forest also provides a relatively isolated spot for the men, women and children to defecate.

Over the years, land has become scanty and it is increasingly difficult for new migrants to find a piece of land to build on. This has given the early settlers an opportunity to let their houses out on rent or even sell them off even though their land has not been legally bought or owned but rather occupied. According to residents, house purchase deals can be executed on stamped paper at a whole range of prices depending on distance from the main road, water connection, availability of toilet, type of roof and other factors. Some houses belong to the second or even the third generation of the initial settlers, whereas others have been through multiple dealings of sale and

rent despite the absence of any land ownership in the *basti*. Because such property deals fall outside the legal system, the tenants, usually new migrants and also the more vulnerable households, have no legal rights or protections as tenants.

Today the *basti* is quite diverse in terms of religion, ethnicity and caste but is highly segregated. Most families tend to take up houses in the vicinity of others from their social background. New urban migrants also often follow friends or family who migrated from their own village and seek houses in their vicinity. As a result, the settlement is largely heterogeneous, made up of small and relatively homogenous clusters divided on the basis of caste, religion and region where they migrated from.

Figure 5 Far end of Nagar basti leading into sand dunes and bush forest

The residents engage in diverse occupations, from informal employments – such as wage labor, domestic work, factory work, rickshaw driving, mechanic, carpenter, plumber – to government employment – as a nurse, sweeper, security guard – and even small businesses selling groceries, meat, poultry and cosmetics among other things. There are also some cottage industries within the slum such as pottery and embroidered garments. There are also several small businesses on the main road which serve the residents, such as shops selling groceries, terracotta items, jewellery,

apparel, vegetables, second hand cell-phones and paraphernalia, and other items of everyday need. Some older households in *Teela* one even rear cattle for milk.

Most households comprise of joint-family arrangements with multiple generations living together and sharing a hearth, while the nuclear family is relatively less common. There are also rooms occupied by temporary migrants, single men working in the city with families in a nearby village. Like the socio-cultural background of the residents, the housing structures of the residents are quite varied. The houses in the settlement are *pucca*, *kachha* and *semi-pucca*. *Teela* one which comprises of the initial settlement has relatively larger, *pucca* houses built in the traditional rural Rajasthani fashion with a central courtyard with two or three rooms around the courtyard, occupied by a large household. Some of these have added floors to accommodate the subsequent generation. *Teela* seven is the most recent addition to the settlement and has more *kachha* and *semi-pucca* houses. Most of these are little more than a single room with a sheet roof occupied by the entire family and used for all purposes. There is a clear socio-economic and caste divide within the slum with the older, better-off and relatively 'upper' caste households occupying *pucca* houses along the road, while the poorer and relatively 'lower' caste households occupy the single-roomed houses at the far end along the forest wall.

Most of the *basti* households are relatively traditional as compared to the average urban non-*basti* household. This phenomenon, sometimes referred to as the "village in the city" (Zoë Matthews, Ramakrishna, Mahendra, Kilaru, & Ganapathy, 2005) can be explained by the strong kinship ties between the recent migrants and their extended families in rural areas leading to retention of cultural restrictions and traditional ways of living. The reproductive behaviors of women in the *basti* are also often guided by the conventional norms, despite their proximity to urban healthcare services and employment opportunities. Most *basti* women are also married off early, begin their reproductive career sooner, have more children and have a less medicalized childbearing experience as compared to their non-*basti* urban counterparts. Some descriptive data about the *basti* residents is available in Appendix 2.

4.4.1 Infrastructure in Nagar *basti*

Like other slum settlements across the country, development of civic amenities in the *basti* has been very slow and remains lacking in many respects. The 'illegal' status of the slum has hindered the residents from demanding better services and most live under the constant fear of slum demolition. The uneven topography has made the task even more complex. Most areas have no

functioning drains and wastewater from the households flows onto the streets. During the monsoons large sections of the streets are inundated and the houses in the low-lying areas get flooded. Water is supplied on the main road, twice a day for an hour each. Some of the households have water connections within the house via PVC pipelines that draw water from the main pipeline running along the road. Others who cannot afford it or reside at an elevation manually fetch water from the main road. Toilets are also available in only some of the houses and regularly used by even fewer households. Sewage connection has not been extended into the settlement due to which the residents have had to rely on pit toilets, most of which are not regularly used due to the fear of it getting filled up.

The settlement is served by 11 *Anganwadi* centres (AWC), which serve as the basic health and education center for babies and children up to 6 years and childbearing and breast-feeding women. Each *teela* has atleast one AWC, with the larger *teela*s having two. These centers are the first point of contact for women who conceive. The staff is responsible for recording the details of every new case of confirmed pregnancy and then advise the woman about the mandatory examinations and nutritional supplements. The closest public women's hospital is located around 4 kilometers away but can take up to 50 minutes to reach by public transport. For other ailments *basti* residents also frequent Satellite Hospital, another public hospital located around 2 kilometers away. Apart from these, there's also a primary healthcare center in the vicinity. There are also several private clinics – allopathic, homeopathic, ayurvedic and others - and hospitals around the *basti* which are sometimes preferred by the residents because of their shorter waiting times and the more efficient management.

4.5 Conclusion

Nagar *basti* is one of the largest *bastis* in Jaipur providing residence to thousands of households. Despite being located minutes away from world renowned heritage sites, these households live in cramped structures with limited resources. The lives of most families are stongly influenced by the distinct ethno-culture prevalent in the region which informs every aspect of their lives, including how pregnancy is done. Women's perceptions, understanding and meaning-making surrounding pregnancy are all heavily coloured by this context resulting in multiple, specific ways of performing pregnancy. With this chapters I intended to set the stage with contextual landscape of urban Rajasthan to allow for a better understanding of the various actors and their interactions within the 'everyday'.

Chapter 5: The pregnancy experience: experiencing the transformation and transformation of the experience

Conception brings about numerous transformations in the life of a woman. These transformations are not just physical and physiological but also social, and bring about an evolution within the relationships between the woman and herself as well as with others. These transformations are also highly culture specific and can be examined only by taking into account the context in which they play out. Within the context of north-Indian patrilineal kinship the experience of this transformation is heavily influenced by core cultural values and rooted within the familial as well as the larger community wide structures of caste, gender norms, class and religion.

The women whose life stories became the basis of this dissertation live in a cultural universe that is uniquely and traditionally *Rajasthani* and its core values continue to guide their lives (and those of men) in Nagar *basti*. But this is not to say that these experiences are static in time or uniform throughout the region. The pregnancy experience itself has been rapidly transforming owing to the increasing opportunities of social and spatial mobility for most women and their families. The experience of pregnancy has also been transforming with the changing relationship of the women with the State by way of the national maternal health programs targeting the 'poor woman and her child', and the associated medicalization of the experience. In this chapter, I attempt to address the first research question - How are pregnancy and the pregnant body understood and conceptualized by women in Nagar *basti*? The chapter intends to discuss how women and the people around them acknowledge and understand pregnancy, and how that influences women's experiences of this transformation in the context of a *basti* community in Jaipur. In section 5.2, I examine the cultural interpretations of the womb and how the body is named as 'pregnant'. In the section 5.3, I focus on the experience of the visibility of pregnancy and how the pregnant body is viewed in Nagar *basti*. In this section, I also explore the local understandings of the different stages of pregnancy. In section 5.4, I focus on the social transformations experienced by pregnant women in their households and their notions of care and support. While discussing all these themes I focus on the relatively short-term socio-physiological and emotional transformations that women and their families go through, within an overarching long-term transformation of the pregnancy experience in Rajasthan and other parts of the country.

5.1 The meanings surrounding pregnancy in Nagar *basti*

Much has been written about the 'poor *basti* woman' who has little control over or knowledge about her own reproductive health processes (Aggarwal et al., 2007; Hazarika, 2010; Zoe Matthews et al., 2005; McNay et al., 2003; More, Bapat, et al., 2009; Skordis-Worrall et al., 2011). The dominant international and national health discourses often characterize women in *basti*s as helpless and vulnerable, suffering through numerous pregnancies (much of the colonial, orientalist and even western feminist narratives represent a unified view of the repressed "Indian woman" although this is gradually changing [Gayatri Chakravorty Spivak, 1985; Mohanty, 1984]). Further due to a rather positivist view of health and illness, statistical data takes centre stage when examining women's health states (Kielmann, 2002). In an attempt to quantify, generalize and compare health, the examination of women's health experiences is usually reduced to aggregate data sets of "behaviour outcomes" such as number of antenatal visits or immunizations received[35] (Kielmann, 2002).

But pregnancy, like all other health conditions, is perceived and acted upon in a manner that is determined by a complex combination of factors such as social status, past experiences, caste affiliations, kin networks, individual beliefs and local knowledges. Hence, there is a wide variation in how women *do* pregnancy depending on their social position, the meanings attached to the transformations and their interactions with people around them. There exists multiplicity in the experiences of pregnancy in even apparently homogenous groups. Not only do no two women have identical pregnancy experiences; no two pregnancy experiences of the same woman are identical. In the following sections I turn to ethnographic material that I collected from Nagar *Basti* to elaborate on the local perceptions of pregnancy and the pregnant body and how they influence women's performance of pregnancy, with the aim of bringing to the fore the myriad ways in which women performance pregnancy in their own voices.

5.1.1 Pregnancy as a natural duty

Most women in Rajasthan occupy a cultural universe, which is specific to north-India. To a large extent the sense of identity and selfhood is drawn from their involvement in domesticity in large extended families. Self-development is thought to be achieved through immersing one-self in social

[35] Although such attempts have their advantages, they obscure the historical, cultural and socio-economic variations within and across regions. Moreover, models and frameworks suggested by health scientists to understand reproductive health behavior tend to be Eurocentric (for instance focusing on individual couples rather than the micro-politics within the extended joint family) and hence ill-suited for the analysis of health and illness in non-Western contexts (Kielmann, 2002).

and familial relationships. Duty and service towards family members, self-discipline and deferred gratifications have historically been considered as desirable virtues (Menon, 2014, p. 5). But this is not to say that there is 'a' unitary female *Rajasthani* subjectivity or 'a' static culture. Rather as Gloria Raheja and Anne Gold argue, everyday practices indicate at polyvalent subjectivities and discourses (Raheja & Gold, 1994). In the same vein, I assert that there is multiplicity in the way meanings are attached to the pregnant body leading to multiple ways of doing pregnancy.

According to traditional north-Indian kinship norms, after marriage women are expected to begin bearing children as soon as possible, a process that fortifies the women's position and elevates her status in the conjugal household (Mandelbaum, 1974; Patel, 1999; Raheja & Gold, 1994; Maya Unnithan-Kumar, 2001). As often described in literature, childbearing and motherhood in much of the subcontinent - as in Nagar *basti* - is an essential stage of a woman's life and is a "mark of her success" (Mandelbaum, 1974, p. 16). For most women self-development is unequivocally grounded in domesticity and conjugality, and childbearing is placed at the very centre of domestic life (Menon, 2014, p. 5). In Usha Menon's study of Hindus in Odisha, both men as well as women described that they are "born into this world to build families" (Menon, 2014, p. 5). Hence procreation, rearing and nurturing children are moral responsibilities (Menon, 2014, p. 5), and pregnancy is believed to be 'natural' and universal.

5.1.1.1 The first-time mother

In many communities in north-India even today, women are in their late teens when their marriage is arranged and they are initiated into conjugality and motherhood[36]. According to Patricia Jeffery and Roger Jeffery, who examined female autonomy in rural Uttar Pradesh, the timing of marriage was dependent on the girl's apparent physical maturity (Jeffery & Jeffery, 1994). Parents failing to marry off the daughters on time feared being subjected to taunting and gossiping (Jeffery & Jeffery, 1994). Also, marriage, quite like childbearing, is usually not thought of as a choice (Jeffery & Jeffery, 1994).

Even though most women are just stepping out of adolescence when they move to their conjugal homes, sexual intimacy and conception of a child are not topics that are discussed within the family. Women who participated in my study, for example, had all experienced their first

[36] Despite the legal age of marriage in India being 18 years, Rajasthan has one of the highest child marriage rates in the country (Young Lives & National Commission for Protection of child rights, 2017). Across much of the country, the parents' initiate marriage enquiries for both men and women once they are thought to come of age.

pregnancy between the ages of 16 and 21 years. Although the mother-daughter relation can be a source of significant emotional and financial support for some married woman, the topic of sexual initiation and contraception are associated with *sharam* (shame or modesty)[37] and hence usually not touched upon by either party before marriage. The impurity attached to female reproductive events of menstruation and childbirth by extension denigrates female sexuality, which is viewed as "polluting" and usually not acknowledged (Thompson, 1985).

According to Maya Unnithan's anthropological treatise on home-birth in rural Rajasthan, even during childbirth the woman is attended to by her affinal and natal kin, while her mother remains outside the room because of *sharam* (Maya Unnithan-Kumar, 2002). Jeffery and Jeffery, in their examination of childbirth in rural north-India, describe how unmarried girls are prevented from even coming anywhere near the room while a woman undergoes labour because they are not expected to learn about these matters of *sharam* before they get married (Jeffery, Jeffery, & Lyon, 1989, Chapter 1). When asked if there had been a discussion on these topics with their mothers, the usual response of my participants was, "Ofcourse not! Don't I have any *sharam*?" Women are expected to be natural mothers and learn with experience, just as their mothers did before them. The notion of conception and pregnancy as 'normal and something that everyone goes through' also contributes to this lack of conversation surrounding these issues.

Examining the pregnancy experiences of women in the medicalized culture of Canada, Elena Neiterman describes how lifestyles are often reorganized in preparation of the pregnancy to abide by the established norms of a 'good mother' *before* conception (Neiterman, 2012). Unlike women in the euro-american context (Neiterman, 2012) and in privileged communities in urban India, there is no period of (mental, emotional and physical) preparation by way of self-education by reading relevant material or 'preparing' the body by way of diets and nutritional supplements. Among the women whom I spoke to in Nagar *basti*, there is no apparent stage of preparation or planning. The society's view of women as 'mothers' and their lives being 'all about reproduction' translates into expecting motherhood to come naturally to all women. All women are believed to be born to be 'wife-mothers' and generally learn as they go.

[37] The concept of *sharam* (shame/modesty) is common across parts of the subcontinent and the world . According to Abraham, Bedouins - as described by Lila Abu-Lughod - practice a similar form of modesty (*hasham*) where sexuality is denied as a form of deference (Abraham, 2010).

Some participants refer to this lack of initiation or information as being in the "hands of God", indicating that they had little role to play. The concept is also frequently ascribed to other events and predicaments where one believes they have little control such as one's future.

> *"At 15 I was already pregnant. I myself didn't know what was happening to me. No one discussed anything with me, I didn't know anything. I have no idea how I managed to handle myself. Nobody told me what to eat, what not to eat, nothing…I was just in the hands of God."*
>
> *(Anju, 32 year old mother of three)*

According to Anju, she was also the oldest of her siblings and too young to understand anything at the time of her marriage. After marriage she left her natal village to live in the city with her husband's family. When she got pregnant, she did not know how to take care of herself. Nor was she guided by the older women in the family or taken to a health centre. She was expected to fulfil all her household responsibilities as usual. Even if she felt unwell, she kept working around the house to avoid getting reprimanded by the family members. She describes how she felt lonely and depressed during her first pregnancy. On some days she took pain medication twice a day to relive her body aches, but even then she was not taken to see a doctor. Anju believes that all the "tension and stress" during her first pregnancy affected her baby, who was born with severe physical and mental deformities. She now works as a fieldworker in the *basti* for a local NGO and advises women on basic reproductive, maternal and child health.

As reported by R. Ramasubban and B.R. Singh (2005), based on women's pregnancy narratives in the slums of Mumbai, the conjugal kin might be "lukewarm, indifferent or even hostile to a woman's needs during pregnancy" (Ramasubban & Rishyasringa Singh, 2008). But being almost cut off from their natal kin back in the village, the social system in the conjugal household plays a significant role in maternal well-being and healthcare-seeking behaviour (Ramasubban & Rishyasringa Singh, 2008). Heena, a young mother of three children, was equally uninformed during her first pregnancy but had more supportive female kin in the conjugal household.

> *"Heena: Actually my saas (MIL) was related to my natal family. She had grown to like me and wanted me as her daughter-in-law. So she said to my mother, 'I want her to be my daughter-in-law. Let's formalize it or you will marry her off elsewhere. Don't send her to our house for 2 years, if you like.'*
> *I was so young that I didn't even used to get my periods then. Even when they brought me here after 2 years of the wedding, I still wasn't an adult.*
> *Researcher: How old were you?*

Heena: I was around 16, when I started coming here. I did not use to understand these things. Some things were explained to me by my sister and my nanad (husband's sister). I was so scared the first time, I almost got a fever.
Researcher: What did they explain to you?
Heena: (laughs in embarrassment) How do I tell you? My nanad told me that one should dress up and go to the husband. Things like that. But even then I was so scared and in a bad condition. Then soon after, I got pregnant with my elder daughter.
(Heena, 20 year old mother of three)

According to Heena, she was unprepared for conjugality when she was married and sent to her husband's family. In the first two years after marriage, she continued to stay in her parent's house and only visited her husband's family now and then. Such a practice is common in Rajasthan, where consummation of marriage is delayed till the bride attains physical maturity. Her sister and sister-in-law indirectly made some suggestions to her about the consummation of marriage, but according to her she still did not "understand these things". According to Heena, when she first started living with her husband's family, she was terrified of even being in the same room as her husband and told her MIL that she was unwell, hoping to delay intimacy with her husband. Her MIL in turn asked Heena's husband to delay consummation till she felt better. When a few months later Heena conceived her first child at the age of 16, her MIL guided her by explaining to her what she should and should not be doing during pregnancy. Heena's interview describes her under-preparedness for sexual initiation and her first conception, and underlines her dependency on her mother-in-law and sister-in-law to help her navigate through conjugality, conception and pregnancy.

However, it is not to imply that all women have a "passive-defeatist" approach (Mandelbaum, 1974, p. 22) towards the experience of pregnancy throughout their fertility career. Women gradually learn to delay or avoid pregnancy, decipher its signs and 'manage' their bodies to ensure a good outcome. For guidance related to matters of reproductive health such as sexual intimacy, contraception and conception women often turn to other females from their own generation. Their peers are perhaps the only source of information for the women in the natal home, comprising of *bhabhis* (sister-in-laws) as well as visiting married sisters. In the conjugal home the *dewarani* (younger brother-in law's wife), *jethani* (older brother-in law's wife) and *nanad* (husband's sister) form the peer group for a married woman. Patrilocality and village exogamy impede the sustenance of childhood female friendships and in the conjugal family non-kin

relationships are detrimental to the image of a modest *bahu*[38]. For most women the kin peer group within the family serves as a source of social support and guidance. The women within the household closely interact with each other throughout the day as they undertake their domestic chores such as fetching water and go about managing their bodily functions such as going out for open defecation. As a result, they also closely experience each other's everyday changes, reproductive milestones as well as interactions with healthcare professionals, and together gather knowledge from every pregnancy that plays out in the household.

5.1.1.2 Conceiving the Womb

Omission of any kind of an initiation towards learning about and doing pregnancy can also be the result of dominant gender ideologies in the region which ascribe the primary role in reproduction to the husband. The conception of a baby is interpreted as the result of the husband (actively) sowing his 'seed' to perpetuate his lineage. The woman is assigned a secondary position, since her womb is believed to play a passive role of the 'field'[39]. Conception is considered to be the process where the husband's 'seed' gets sown in the fertile 'field' of the woman. Hence the event of conception is viewed as the result of an action done by the husband, where it is sufficient for the woman to just be present at her fertile best. The conception is also described in passive terms – in Rajasthani, pregnancy is *caught (lagna)* much like one *catches* a cold. Hence, most women remain alienated from their own role in procreation, until they actually experience it[40].

Within the *Rajasthani* consciousness, the womb also transforms after the woman becomes pregnant. As in some other regions in the subcontinent (Mark Nichter, 1989, Chapter 1), *Rajasthani*s traditionally conceive of the uterus as an organ which can open and close[41]. It is

[38] Friendship is conventionally thought of as a relationship category exclusively between males in conventional north-Indian culture (Gjøstein, 2014)

[39] In popular Rajasthani narratives, there is no mention of the female egg, while the womb is commonly mentioned. To my knowledge, there is no term for female egg in colloquial Rajasthani. The cultural interpretations of conception among the women in Jaipur using the seed-field analogy are also common in other parts of South Asia and the Indian subcontinent, as well as the religious texts of Ramayana and Dharmashastra as discussed by Nichter (1989, Chapter 1) (Rothman, 1989).

[40] I was struck by the extent of this alienation when I was once off-handedly asked by one of my research assistants about how conception actually took place. My research assistant belonged to a rather traditional *Rajasthani* family but had a Bachelors degree in sociology from the local University. While training my assistants for quantitative data collection I discussed several concepts on maternal and reproductive health, but I assumed that they were all aware of the process of sexual intercourse and conception since they were all between the ages of 20 and 25. I then undertook a short session where I then explained to them the biology behind conception.

[41] Referred to as the "mechanics of the uterus" (Mark Nichter, 1989, p. 12).

frequently believed that the uterus 'opens' to allow menstruation and then gradually closes and remains so during the rest of the cycle. Therefore, it is believed that pregnancy is possible only in the five days following menstruation since the 'mouth of the uterus' is open at the time to allow the male "seed" to enter the uterus[42]. When a woman conceives, the nature of the uterus is also believed to undergo change- from an organ which expels 'impure blood' to a vessel which retains the foetus inside the body. Its behaviour changes accordingly, from opening and closing every month to remaining closed for the duration of the pregnancy. The uterus is then believed to open again during childbirth[43] to allow the baby to be delivered.

5.1.1.3 Recognizing and labelling the pregnancy

Women often speak humorously of the times when they first conceived and were unable to tell the signs. Stories of women not realizing that they were pregnant or mistaking their pregnancy for stomach infections well into the second trimester are common. Nutrition deficiencies are rampant in slum settlements, making irregular menstrual cycles and bouts of weakness, the first signs of pregnancy, common phenomena. This also indicates that many women in Nagar *basti* were unable to make the connection between sexual intimacy and pregnancy. Disregarding the first signs can also probably be attributed to the popular Hindu femininity ideals that advocate the principles of duty and self-control which further contributes to the young women trying to conceal and deemphasize episodes of ill-health. *Sehen-shakti* or literally 'power to endure' is another virtue essential to the image of a good wife and *bahu,* further encourages women to underplay discomfort and pain. Hence, the initial signs of pregnancy often go unnoticed by the woman and her family members.

> *"When it was the 2nd month, I had started getting repelled by food smells and I couldn't eat. I told my daughter's father, "I have lost my appetite, bring me medicines for stomach worms". Then my Saas (MIL) said, "That won't be necessary. She is about to have a baby". That's how I got to know."*
>
> *(Radha, 25 year old mother of three)*

[42] This is is especially significant since many women reported to be commonly using the rhythm method to postpone or prevent pregnancy and the cultural interpretations of the functioning of the uterus seem to be at odds with the objective of preventing pregnancy.

[43] More on this in chapter 6

Hence, Radha associated loss of appetite with stomach ailments that were common in the *basti* and her household. Had her MIL not intervened, Radha would have probably self-medicated and taken medicines that are detrimental when consumed during pregnancy.

For many women the recognition of the signs and the subsequent acknowledgement of the body as pregnant, especially during the first pregnancy, is often initiated by the MIL. In such a scenario, there is no opportunity for the woman to decide how and when (and if) to announce her pregnancy to the family. Rather, the naming the body as 'pregnant' often happens simultaneously for the woman as well as the family. On the contrary Elena Neiterman's participants, mostly middle-income Canadian women, chose when and whom to disclose the news to, sometimes postponing to inform the family till they themselves had digested the news (Neiterman, 2010, Chapter 5). Also, unlike Neiterman's participants, who almost always relied on a biomedical confirmation before labelling themselves as pregnant even if they could read the signs, in Nagar *basti* the confirmation of pregnancy by the MIL is often enough for the social labelling of the woman as pregnant.

Radha was the eldest among her siblings and her husband was the oldest among his. Therefore, Radha had not had the opportunity to observe other pregnancies in her natal or conjugal household and did not know of the signs of pregnancy that she had to look out for. In Nagar *basti* – as in much of rural India- the *saas* is the first one to recognize the signs exhibited by her *bahu* - such as nausea, vomiting and unusual food aversions – especially during the first pregnancy. Often she is the first one to declare the DIL's pregnancy, reiterating her seniority among the other women in the household and setting the tone for the manner in which the pregnancy would be handled[44]. Since childbearing is exclusively the women's domain, the MIL is usually responsible for decision-making with respect to all pregnancies in the household. Radha also describes how she felt when she heard about it from her *saas*. Becoming pregnant indicates at the sexuality of the female body, a notion that Radha found embarrassing especially because it was spoken out aloud in the presence of her other family members. She denied it and refused to believe her MIL, until the vomiting episodes got worse and then she had to visit a doctor. Radha's MIL then directed her son to take Radha to the hospital so that her pregnancy could be confirmed.

[44] Pregnancy and childbirth are purely female domains and the MIL being the senior-most (and most reproductively experienced) woman in the household has a lot of say in each pregnancy occurring in the household. She often is the one to make several important decisions such as - the place of birth, choice of medical institution, number of check-ups and whether or not an apparent illness is serious or requires special attention.

5.2 The Pregnant body in public

As seen across most traditional communities in India, in most *Rajasthani* families the *saas* usually continues to lay down the roadmap for practices and processes that must be followed during pregnancy. On one hand, there is a pressure on new *bahu*s for early pregnancy so as to establish themselves as fertile, but on the other hand the event proclaims the woman as a sexual being and underscores her sexual relationship with her husband. Most women, therefore, associate the initial declaration with feelings of embarrassment and *sharam* (shame). *Sharam*, which can be understood as feelings of shame that indicate modesty, is considered to be one of the foremost characteristics of an ideal *bahu*. According to Radha, she was so embarrassed when she first heard the news from her Saas that she didn't believe it and outrightly denied it to herself and to the others, therefore postponing her pregnant status.

> *"My Saas just observed me eating and declared, "she's become pregnant". So everyone in the house started asking, "Bhabhi (sister-in-law), are you pregnant?" I said, "no, no, that's not true. There's nothing like that"*
>
> *(Radha, 25 year old mother of three)*

Few days later when Radha's aversion to food and weakness got worse, she finally agreed to visit a doctor for the confirmation of pregnancy. Hence, she attempts to avoid the embarrassment by dismissing the notion that she might be pregnant. The news of pregnancy is therefore concealed, sometimes even ignored and not flaunted, even with kin. Many participants describe how they kept the news from the women in the neighborhood for as long as it was possible, and only confirm the news when the pregnancy becomes apparent, and questions are posed by the neighbors. However, such a delay in the recognition of pregnancy could result in inadvertent damage to the developing fetus, for example by indulging in excessively heavy physical activities or delay in medical attention in case of a critical pregnancy.

The proclamation of sexuality by the visibly pregnant body is countered by displaying an increased degree of modesty. This is attempted by avoiding leaving the house unless absolutely necessary and adjusting the *dupatta*[45] or the free end of a saree so that it covers the belly. These emotions of shame and embarrassment because of a visibly pregnant body can also be discerned among the urban privileged women, although it is much more muted. In this group, there might be no limitation of mobility, but women are still expected to wear loose fitting clothes and use

[45] Loose piece of cloth draped around the shoulders to cover the chest.

scarves/*dupattas* to mask the large belly or at least attempt to do so. Wearing tight clothes when the pregnancy is visible would be considered shameful and almost unthinkable. Within and outside the family, pregnancy is also referred to with euphemisms and never directly, the most commonly used phrase being *pet se* (being with the belly).

The visibility of pregnancy also complicates everyday activities which required being in the public eye such as going to the *jungle* for open defecation. Defecation in itself is an activity that generates embarrassment and shame for women, but this embarrassment is alleviated by the *ghoonghat* (veil) that obscures the face of the woman preventing her from getting recognized when she walks to and from the jungle. A visibly pregnant body however marks her, making her recognizable by the people of her community, despite the *ghoonghat*. Participants often mention waking up early to visit the jungle so as to avoid encountering non-kin males of their community on their way to the *jungle*. Other activities such as water fetching or walking the child to school are often given up once the pregnancy becomes visible. Once apparent, these activities are altogether avoided if that is possible. Among the women from the so called disadvantaged castes issues of *sharam* during pregnancy appear to be less crucial. The visibility of pregnancy does not place constraints on their mobility and they often continue with paid and domestic work outside the house until childbirth. In such household concerns of survival are more serious than those of *sharam*.

Feelings of *sharam* (shame/embarrassment) generated by the visibility of pregnancy create a dilemma for women with respect to visits to the *peehar* (natal home). Traditionally, in many north-Indian communities married women continue to maintain a close relationship with her natal kin. It offers the possibility of bodily rest and emotional support much needed during pregnancy. She gets a respite from the drudgery of household chores and freely consumes foods that might not be available to her at the affinal home. In some communities in the subcontinent, it is even the norm for the woman to spend the last few weeks of her pregnancy in her *peehar* and return to the *sasural* (conjugal home) after the delivery. However, among many communities in Nagar *basti,* pregnancy and childbirth are the responsibility of the affinal kin. In such communities all signs of a sexual relationship with her husband are considered to bring about feelings of *sharam* for the woman, especially in the natal home. For instance, using the *ghoonghat* in one's natal village is considered inappropriate since it is a sign of conjugality and sexual maturity. Similarly Synnove Knivestøen (2012) in her master's thesis describes how her field assistant removes her *bindi* (red mark worn on the forehead by married women) when visiting her natal village in southern Rajasthan because it is a sign of conjugality and invokes *sharam*. According to one of my

participants, Guddi, who lives in her husband's household along with her parents-in-law, brother-in-law and sister-in-law and her natal family live in a village nearby-

> *"One would obviously feel embarrassed if one would take this big stomach in front of everyone. Not with my mother..what is there to hide from the mother… but my father and older brother"*
>
> *(Guddi, 24 year old mother of two)*

> *"When I was pregnant, I didn't go my Naani's (grandmother) place. I used to think, 'oh my god, what will my mama (Maternal Uncle) and everyone else think. Just look at her!' I used to get such an embarrassing feeling.. Now my kids are grown up, now there is no such tension. Earlier I used feel, 'no, I don't want to step outside'".*
>
> *(Heena, 20 year old mother of three)*

According to the participants, it is not prohibited for the woman to visit her *peehar*, but it is avoided unless absolutely necessary. The feelings of *sharam* counter the appeal of receiving care and support in the natal family. However, some participants also mention spending a few months of their pregnancy in their *peehar*. This only happened when the affinal home was considered incapable of providing the pregnant woman with the care that she needed, such as in case of the couple living separately from the husband's kin. In such a scenario, the need for an older female kin who could advise and take care of the woman during her pregnancy outweighs the embarrassment that she might feel because of the visibility of her pregnancy.

5.3 Perceived vulnerability of the Pregnant Body

The pregnant body is also culturally considered to be vulnerable because it is in a 'hot' state[46]. Here, the 'hot' does not refer to the actual temperature but rather to the characteristics (Nag, 1994; Pool, 1987). Pregnancy, along with menstruation, is considered to be a 'hot state' due to excessive 'heat' in the womb which makes women vulnerable to 'hot' food and 'hot' diseases. It is believed that this heat needs to be managed accordingly, depending on the stage of pregnancy. According to popular beliefs, in the first and the second trimester the 'heat' is supposed to be countered to

[46] In India, the hot-cold ethno-physiological model of explanation comes from the ancient science of Ayurveda, the indigenous healing system first recorded in the Hindu religious texts 5000 years ago (Nag, 1994; M Nichter & Nichter, 1983; Vallianatos, 2010). According to the Ayurvedic paradigm, the body is governed by 5 basic elements - space, air, fire, water and earth - which have to be maintained in balance to achieve health and well-being. Although the average person does not have a profound understanding of the Ayurvedic paradigm the 'hot-cold' concept is used across India to categorize health states, foods and diseases into hot and cold.

prevent miscarriage and other 'hot' complications by avoiding 'hot' foods and consuming 'cold' foods[47]. This changes towards the end of the pregnancy when the body needs to be 'heated up' to allow for an easy delivery and this is done by consuming 'hot' foods.

As also discussed in other medical anthropological literature, this understanding of the female body and pregnancy directly influences the pregnancy practices such as dietary habits and healthcare seeking behaviour (Nag, 1994; M Nichter & Nichter, 1983; Pool, 1987). In Rajasthan and other parts of north-India foods rich in protein and fat such as meat, eggs, nuts (such as walnut, peanut, cashews, and almonds), spices (such as pepper, cardamom, cumin and cinnamon), foods growing underground (such as garlic, ginger, onion) and some fruits and vegetables are considered 'hot' (Vallianatos, 2010). On the other hand most fruits and vegetables with high water content – such as cucumber, carrot, apple, pomegranate, melon etc.- along with rice, wheat and cow milk are considered to be cold foods (Vallianatos, 2010). Naturally, this has direct implications on the choice of foods prescribed to the woman within the household and its effect on her health status. This has been discussed more elaborately in Chapter 6.

The woman's pregnant status is also considered to make her vulnerable to *oonpar ki hawa* (evil winds). In popular *Rajasthani* discourses (among both Hindus as well as Muslims) *oonpar ki hawa* is believed to be the harbinger of evil spirits, which are especially dangerous for the pregnant and recently delivered woman, because of their ambivalent state and their association to the unborn/newly born baby. Remarkably, men are not considered to be susceptible to the evil winds. Stories about pregnant women becoming afflicted with *oonpar ki hawa* followed by miscarriage are common. In all such stories the women develop unexplainable, untreatable illnesses such as fever, loss of appetite and seizures, finally resulting in the loss of the unborn baby or birth defects[48]. To avoid such an affliction, women are forbidden from venturing out alone after dark as evil spirits are considered to be especially active during night time. If stepping out is unavoidable such as in case of an urge to relieve oneself, they are accompanied by the *saas* or other older female kin. The susceptibility of the woman ends only when purification rituals are performed a few weeks after the delivery allowing her to take up the household chores again. Interestingly, this vulnerable status

[47] A detailed treatise on 'hot' and 'cold' foods, as believed in different parts of the country, can be found in 'Poor and Pregnant in New Delhi, India (Vallianatos, 2010).

[48] *Oonpar ki hawa* is also commonly used to explain infertility among women in the Rajasthani context and a detailed examination of the topic has been undertaken by (Maya Unnithan-Kumar, 2010).

does not usually translate into care, support or rest that a pregnant woman can expect to receive in her conjugal household.

5.4 Interpreting the transforming body

The interpretation of bodily transformation during pregnancy among the residents of Nagar *basti* can be better understood by examining the stages that are used by the women to describe their pregnancy. Biomedical literature divides pregnancy into three trimesters of three months each (the first, the second and the third), whereas in the Rajasthani worldview pregnancy comprises of two main stages divided by a middle stage – *Kaccha time, Beech ka time* and the *poora time*.

5.4.1 *Kaccha* time (raw or unripe stage)

According to the *Rajasthani* world view, this is the first stage of pregnancy when the unborn baby is still under-developed and hence prone to miscarriage (locally known as *girna*, literally- falling, or *kharaab hona*, literally- getting spoilt). The absence of a physical sign of pregnancy i.e. a growing belly is a characteristic of this stage. The temporal boundaries of this stage are not clearly defined but it broadly corresponds to the first three-four months. The months of pregnancy are counted from first day of the last menstrual period and then a month is complete on the same date of the next month. For instance, the menstruation for a woman begins on the 10th of January after which she conceives, 10th of February will be counted as the first month, 10th March as the second and so on and so forth. 10th of October will be considered as the expected date of completion of pregnancy. This closely coincides with the method of Expected Delivery Date (EDD) calculation prescribed by the National Rural Health Mission of the Govt. of India, the only difference being that another seven days are added to the nine months (National Rural Health Mission, n.d.). The latter is also the globally accepted method of EDD calculation.

Most women define the *kachha* time as the first three-four months and view the pregnancy at this stage as fragile and vulnerable to external influences. This perception coincides with the findings in medical literature where the risk of miscarriage goes down as the pregnancy progresses (García-Enguídanos, Calle, Valero, Luna, & Domínguez-Rojas, 2002). Many participants associate this stage with considerable discomfort in terms of nausea, vomiting, tiredness, loss of appetite and

aversion to food. These physical ailments are thought to be a normal aspect of pregnancy and there is no equivalent term for morning sickness[49] in *Rajasthani*.

Since the discomfort is not viewed as abnormal, there is usually no attempt to alleviate it or seek medical advice for it. All medications belonging to the modern medical system, sometimes even prescribed nutritional supplements, are also considered to increase the 'heat' of the body which may affect the baby or even 'spoil it' leading to miscarriage. One of the participants, who had recently given birth to her second son, recalls that she would take some *Chai* to relieve the nausea and dizziness (the subcontinent's version of spiced milk tea commonly containing spices such as cardamom, cinnamon, ginger, cloves or pepper, believed to produce a warming effect and aid in digestion). Although tea is naturally considered 'hot' she would try to minimize the 'heat' by allowing the temperature of the tea to cool down.

> *"I used to have some tea for the dizziness. Ideally one shouldn't have too much of tea or other hot drinks. So I used to let it cool down and then drink it. Then gradually I stopped having tea as well. I wasn't even allowed to take any medicines, because it is said that the medicines also make the body hotter"*
>
> *(Guddi, 24 year old mother of two)*

Therefore, over the counter medications for common problems such as fever, cold, indigestion, pain etc. are strongly disapproved and strictly avoided during pregnancy. Seeking medical advice for more severe ailments such as back and waist pain is also very uncommon. Rather it is believed that these problems arise because the body is still not used to the baby and that they would get better as the pregnancy progresses and the body 'healed'. The only sign that elicits panic and warrants a visit to a doctor is vaginal bleeding.

There is also a strong belief, mostly among the younger daughter-in-law's (DILs) though, that because the developing baby is vulnerable, heavy work that involves excessive exertion on the body of the woman should be avoided during this time. The premise for this belief is that uterus is thought to have an open-close mechanism- it opens during menstruation and remains so for a few days. It is believed that if the woman conceives during those days, the uterus then closes to retain the developing baby inside. Heavy work during the first trimester or the *kaccha time* before the uterus has closed completely can lead to a miscarriage or the 'falling of the baby'. Lifting heavy

[49] Nausea and vomiting during pregnancy is commonly referred to as morning sickness and is said to be very common in early pregnancy. It has no negative effects on the unborn baby and normally gets resolves by the 16-20 week of the pregnancy (NHS, n.d.).

containers of water is the most common task that is considered risky by the participants, although this perception does not always translate into practice. Many women narrated experiences of self or neighbours or relatives regarding the loss of their pregnancy because of carrying heavy containers of water. Guddi's first pregnancy had ended in a miscarriage which she believed happened because she lifted a heavy bucket of water.

> *Guddi: When one picks up a heavy load, it puts pressure on the body and the baby can get spoilt (bachha kharaab ho sakta hai). It had also happened to me. I had been pregnant for one and half months and I lifted a bucket of water. I developed pain in the belly that day and had to go to the doctor. I lost that baby (kharaab ho gaya tha). If one exerts too much, then all that affects the body (agar hum zor lagate hain, toh wazan shareer par hee padta hai). If something is too heavy then one should take the help of someone else.*
> *Researcher: Did the doctor tell you that it happened because of the heavy weight?*
> *Guddi: That's how it is. What can the doctor say…they only know what we tell them. They don't know what exactly happened at home.*

Not only does Guddi directly draw the association between heavy exertion and loss of pregnancy. She also suggests that she understands her body well and has only limited dependence on doctors and medical science. This view contrasts the experience of women in the Euro-American context and the urban non-poor context where the reliance on medical personnel is complete- from the tracking of ovulation to the initial labelling of pregnancy, to mother-and-child healthcare well after the delivery.

Some older women also share this opinion about the vulnerability of the pregnant woman during the *kachcha* stage and agree that 'excessively heavy work' should be avoided during this stage but their definition of 'excessively heavy work' is vastly different from that of the younger women currently going through pregnancy. For these older women, 'excessively heavy work' was associated with rural farm activities that were common before the older generation had migrated to Nagar *basti*. These older women had either themselves performed strenuous farm activities[50]- such as working in the fields, managing cattle, working hand-pumps for water, grinding wheat by hand-operated mill, collecting firewood and carrying it on the head- or had seen their mothers do so in the village. However, many younger DILs currently going through their reproductive career categorized several domestic chores- such as kneading flour to prepare dough, washing clothes by

[50] Discussed in detail in chapter 6

hand and carrying wet clothes out to dry, carrying buckets of water from a public tap for the household's consumption- as heavy work.

5.4.2 *Beechh ka* time (the middle stage)

Once the *kachha* time is crossed, for the *Rajasthani* woman, the chances of the pregnancy leading to a successful conclusion increase manifold. The woman then enters the *Beechh ka time* which roughly extends up to the end of the eighth month of pregnancy. In this period the pregnancy is thought to have passed the danger of miscarriage and the baby is expected to survive the long journey to the final delivery. If the pregnancy has crossed the *kachha* time without any major problems, then it is believed that the mouth of the uterus has closed and is likely to remain so till the end. Since it is considered to be a relatively safe period the restrictions of heavy load, if any, are lifted and the woman is expected to fulfil all work-related responsibilities.

During this stage the belly also starts growing which brings about the public labelling of the growing body as 'pregnant'. As also seen in the Euro-American context, when the pregnancy starts showing pregnant women become "public bodies" (Neiterman, 2010; Warren & Brewis, 2004). The pregnant woman and her MIL are commonly advised by female members of the neighbourhood and extended kin on anecdotal information about 'what is good during pregnancy'. It is believed that the role of the woman in this stage is to provide a favourable environment for the growing baby, who is believed to have a tendency to get 'stuck' or 'fixed' in one spot within the womb which can hinder its growth. The woman's foremost responsibility then is to keep the baby moving and turning in the womb by abiding by the local pregnancy-related recommendations of *hilna doolna* (keep moving, working around the house) [51].

Delivery in this stage is thought to be an abnormal event and most women know of examples, personal or anecdotal, where the delivery happened before the ninth month with different outcomes – some babies survived and others did not. The babies who get delivered in this period are usually referred to as the 'seventh month one' (*satmaasa*) or the 'eight month one' (*athmaasa*) depending on the length of the pregnancy. It is strongly believed by women of all castes and both religions that the 'eighth month ones' do not survive. The reason they give for this is that the process of formation of the baby wasn't complete because of which it was unable to survive the outside world. However, surprisingly, the 'seventh month ones' are believed to survive. When

[51] Discussed in detail in Chapter 6

asked about the reason for this, one of the participants responded that this was due to the sacred nature of the number seven[52].

An important ceremony is performed in most households, for the pregnant woman and her baby, during this period. In this ceremony, the seventh month of pregnancy is commemorated where offerings are made to God in the form of seven pieces of sweets, seven different kinds of cereal, water from seven different wells and seven different leaves among other things. It marks the safe completion of seven months of pregnancy with the hope that the outcome will be favourable for the mother as well as the child. The ceremony, attended by female kin and other women from the neighbourhood, is the formal social acknowledgement of the soon-to-arrive baby and the families (both natal and conjugal) start ritualistically preparing the woman for childbirth. She is presented with fruits, nuts (which are traditionally considered to be 'hot' and beneficial for a smooth delivery) and, new clothing for herself and the baby. For the young women experiencing their first pregnancy, it is one of the few opportunities to receive attention and adoration in the conjugal family. This ceremony of the 'worshipping of the seventh month' is viewed as a sign of appreciation for the soon-to-be mother and is organized by conjugal households with varying extent of ceremonial display depending on the socio-economic status and intra-familial relationships.

Like most other decisions pertaining to childbearing, the decision to perform the seventh month ceremony comes under the purview of the MIL. Some of my participants who were estranged from the extended family and lived only with their husbands, lament on how no such ceremony was performed for them. According to 30 yr old Seema, "Nothing like that was done for me because my *saas* (MIL) didn't have any interest in spending any money on me. Nor was she excited about grandkids." Hence women in Nagar *basti* attach a lot of significance to this ceremony of 'worshipping the seventh month' and the enthusiasm with which it is celebrated – indicated by the number of people invited, arrangements made and gifts bought for the *bahu*- is commonly taken as an indicator of the acceptance she enjoys in the household.

5.4.3 *Poora* time (completion stage)

The *poora* time is believed to extend from the beginning of the ninth month of pregnancy up to the delivery. In the Rajasthani worldview, this is the final month of pregnancy and the baby is almost

[52] The number seven appears frequently in mythological and religious texts. In the Hindu worldview, human beings are believed to have seven lives and a Hindu marriage ceremony involves the couple circling the fire seven times. There are many such examples of notions of sacredness and luck attached to the number seven.

completely developed, ready to leave the womb. In the words of one participant - *"matka pake ga, toh phootega"* – translating into "when the earthen pot is fully baked, it will obviously break", indicating that the baby that is getting 'baked' in the womb, will break out once it is ready. Hence deliveries in the ninth month are thought to happen because the process of development of the baby was complete. The women do not distinguish between the beginning or the end of the month- the baby is believed to be ready when she enters the ninth month (*poora lagna*). Due to the high incidence of preterm birth in the community, delivery at any time within this period is considered 'normal' and even desirable. Because the baby is believed to be completely formed as the pregnancy enters the ninth month, sexual intercourse is strongly disapproved when a woman nears this stage. According to the women, the man's 'seed' can harm the developing child and one of the participants associated an ailment in her newborn baby because of intercourse around the *poora* time.

Once the pregnant woman enters the *poora* time, she is expected to conduct herself so as to enable the baby to move 'downwards' in the womb. Here again, it is important that 'mouth' of the uterus opens to allow for a quick and uncomplicated delivery. Hence, it is commonly believed that increase in the intensity of certain kinds of physical activities (activities that require squatting on the floor such as cleaning the floor with a piece of cloth) would loosen up the baby in the belly and aid in pushing it downwards towards the birth canal. It is also believed that further 'heating up' the body will allow for the baby to exit the womb easily. Hence 'hot' things (especially the ones rich in calories and fat) which were restricted during the first two stages are now advised whereas 'cool' materials (such as water-rich fruits and vegetables) are avoided.

5.5 The social transformation

The improvement of the Hindu woman's social status because of pregnancy has been well established within cultural anthropology (Bloom, Wypij, & Gupta, 2001; Monica D. Gupta, 1995). It is believed that pregnancy drastically improves the position of the young *bahu* (DIL) within the family and provides a solution to all her woes. As a new bride she is socially at the lowest status in the household, isolated within a strong network of the husband's kin and far away from her natal support system. The prospect of motherhood proves her self-worth by fulfilling her duty of providing the family and the clan with an offspring, especially if it is a son. Hence, her status changes drastically from being a new *bahu* to that of a mother. "Motherliness" is a crucial aspect

of a Hindu woman's identity (Kakar, 1978) and pregnancy affirms the possibility of achieving this ideal[53].

5.5.1 *Bahu* as a mother

Traditionally, mothers are socially revered and respected for their central role in furthering the life cycle of the entire clan. Religious, mythological and popular discourses are abounding with representations of the venerated 'Mother'. The most revered of Hindu goddesses - Lakshmi (Goddess of Prosperity), Saraswati (Goddess of Learning), Parvati (Goddess of Benevolence), the Sacred Cow (embodiment of the entire cosmos and the provider of substances that are ritually pure)(Korom, 2000) and even the Earth - are all representations of the nurturing mother. Sudhir Kakar describes how the Indian male ideology (both Hindu as well as Muslim) constructs and deifies Mothers as the ever-present, benign provider who shower tenderness and protection onto the child (Kakar, 1978). Pregnancy thus indicates at the possibility of attaining such a pedestal by the woman who progresses from being treated as a 'guest' who does not belong in the natal family to a newcomer bride occupying the lowest rung in the unfamiliar conjugal family, to finally being on the threshold of fulfilling her ritual responsibilities and the feminine ideals that are honoured universally. On the other hand, infertility is feared widely (by both Hindus and Muslims) and is compared to a social death, and women who are unable to procreate are considered as incomplete and face social ostracization.

Even though the change in self-perception and the associated transformation in identity happens almost abruptly for the woman, its translation into the social realities within the Rajasthani households, that I interacted with during my fieldwork, is much more gradual. In other words the recognition of the woman as pregnant within the household happens over weeks, as the chances of the pregnancy being successful increase. Most women describe how there was no immediate change in their relationships or the way they were treated within the household. They would often continue with the usual work schedules, household chores, food habits and daily routines. For most, only when the pregnancy became advanced and 'visible' was the woman acknowledged as

[53] Contrary to the contemporary ideals of femininity among certain western communities, motherliness is the central component of womanhood for most communities in the subcontinent. This is also associated with exhibition of maternal excesses and absolute indulgence in child rearing practices resulting in a prolonged infancy and dependency of the child on her mother as compared to her western counterparts. Within the Hindu moral codes, mothering a son essential for the parents and the family to achieve salvation since 'wives who produce children are the root of religion and salvation' (Kakar, 1978, p. 77).

'pregnant'. Especially in the case of women living in *bastis* the invisible stage of pregnancy could be quite long due to inadequate nutrition. Hence, often there is a significant time lag between the determination of pregnancy and her being treated as 'pregnant' by the family.

This delay in the labelling of the woman as 'pregnant' can probably be attributed to the high prevalence of miscarriage in the community. In my fieldwork in Nagar *basti*, I found that almost 25% of the survey participants had experienced at least one miscarriage[54], some even multiple. The socio-economic realities of poverty and depravation negatively affect the physical and mental well-being of women possibily playing a role in the high rate of pregnancy loss among the families in Nagar *basti*. Harsh living conditions such as those of a slum necessitate a utilitarian approach thus ensuring that care and support are imparted to the pregnant woman only when it is sure to be beneficial and bring about results. As a result the labelling as 'pregnant' is put off till the chances of loss of pregnancy decrease. In contrast, in the Euro-American context the family usually labels and treats the woman as pregnant as soon as the information is shared with them. Elena Neiterman, in her doctoral dissertation based on the medicalized pregnancy experience of Canadian women, examines how a biomedical confirmation (by personnel or tool) is important for the body to be labelled as 'pregnant' by the woman herself and such a label brings about a change in the behaviour meted out by family members as soon as it is announced (Neiterman, 2010, Chapter 5). Hence in the Canadian context the determination of pregnancy coincides with being socially labelled and treated as 'pregnant'.

Traditionally, the wellbeing of the woman also now gains prominence within the family. Literature describes that she is made to rest between chores and the older female kin urge her to eat well (Kakar, 1978, p. 77). However, the actual everyday practices of pregnancy are informed by multiple interacting forces- such as gender ideologies, class structures, and caste affiliations - and are therefore extremely heterogeneous in the *basti*. It is also influenced heavily by intra-household micro-politics as well as national politics – such as those that influence the local health policies, for instance. Women who live in nuclear families, for example, have no peers who would take up the chores in their place and therefore must continue to fulfil all their responsibilities even though she might enjoy more autonomy in a nuclear family as compared to a large extended family. The gender ideologies and clear division of labour within the household allow the men to evade

[54] The global estimates for the prevalence of miscarriage (or spontaneous abortion) are between 11-16% (Everett, 1997), where miscarriage is defined as the loss of pregnancy before the completion of 22 weeks (World Health Organisation, 2012).

chores in most households. Hence, some women continue to handle independently, all the chores and responsibilities of the household simply because there is no other choice.

On the other hand, an extended household might sometimes offer opportunities for the young *bahu* to seek help from the older *bahu*s or young unmarried siblings of the husband. In this manner she might be able to avoid the heavier the chores, ask for help for some tasks from the other *bahu*s, seek companionship when going out to the jungle to defecate and exchange or compare pregnancy experiences – with the understanding that she herself would also return the favour when the others go through pregnancies or sicknesses. However, this is not always the case. Many women in extended households, where the relationships are not as cohesive, continue to be responsible for all the chores without any opportunities for care or support.

5.5.1.1 A tale of two neighbours

Hema and her husband belong to the caste group referred to as *harijans*, traditionally thought to be at the lowest rung of Hindu caste society, and are recent migrants to the city. They live with their four children in an one room rented accomodation with no water or toilet facilities. The one-room serves as living quarters for six of them where they sleep, eat, cook, play, do homework and rest. Her parents are no more and her husband's mother and married siblings live in their ancestral village. Ever since they migrated to the city five years ago, they have moved houses several times[55]. She and her husband were both employed as cleaners, he in a private company and she in a school. Hema, however, had to quit her job during the final weeks of her last pregnancy. Hema's husband's job as a cleaner keeps him out of the house from early morning to late evening. Hence, from Hema's perspective, all the household chores - such as cleaning, washing, fetching water, cooking, taking care of all the children - are tasks that she does for herself and her children, since she's the one present at home during the entire day. Since the husband is away, he isn't affected if the chores aren't performed.

> *"The household is dependent entirely on the woman. The man is involved in earning and he leaves for work in the morning. Whether she takes care of it or ignore it, the household is in the hands of the woman. If I don't do the chores, my household will be at loss, right? I am the one who is at home, so I will suffer and my children will suffer.*

[55] The house owners in *bastis* are not bound by legal rental agreements, hence eviction rates are high leading to high tenant turnover.

When I was pregnant, our relatives living nearby would fight with him saying, 'don't make her carry heavy loads. If something goes wrong tomorrow, you will be at loss'. But it didn't bother him. When my elder daughter was born and I had an operation, he fetched water at that time 2-3 times. Now, he doesn't fetch even a single vessel."

(Hema, 26 year old mother of four)

In the past she has lost two of her children in infancy and one child in the first trimester of pregnancy. During the delivery of her third child, she fell unconscious and doctors told the husband that they would have to perform a cesarean section. Her husband also agreed for the doctor to perform surgical sterilization on her during the procedure[56]. According to Hema, she thought that the sterilization surgery had been performed on her and she stopped using contraception. One year later, after missing menstruation for 5 months, she went to the doctor and discovered that she was pregnant again. It is still unclear to her whether the surgery wasn't performed or it was performed but was a failure. She decided to go through the pregnancy.

During her last pregnancy, she continued to work as a cleaner in a school uptil the 8th month along with being responsible for all domestic chores and child-rearing responsibilities. Once her belly became big and she started showing , her employers asked her to stop working because as a cleaner she was required to go up and down the stairs of the school building several times during the day. She would wake up early morning fetch water, go to the jungle, make tea and prepare food (bread and vegetables) for the husband to take along, then ready the older two children for school and then leave for work dropping her 2 year old daughter at the Anganwadi center. She would come home in the afternoon and take care of her remaining responsibilities such as serving lunch to her children, cleaning the house, washing utensils, doing the laundry, all while taking care of her 18 month old daughter. Hema's oldest daughter (7 year old) helped her with some of the tasks such as dragging the water bucket from the public tap or taking care of the younger two when the mother wanted to go to the jungle to relieve herself.

Hema recalls that her last pregnancy was very difficult- she frequently suffered from lose motions, body ache and could not eat or drink anyrthing. Right before her delivery she was so weak that she had to be given intravenous fluids. She did not receive any support from her husband with respect to the household chores, even though their neighbours reprimanded him when they saw Hema fetching water in the final weeks of her pregnancy. Once her baby is an year old she hopes

[56] The Indian government, under the National Health Mission offers financial compensation to couples who undergo permanent sterilization procedures. It is common medical practice within the Indian public healthcare system to offer permanent sterilization procedures such as tubal ligation as part of the cesarean section procedure.

to go back to her cleaning job, but worries that her oldest daughter might have to quit school to take care of her three younger siblings. On the day of the interview she was worried how she would cook for her children, since the husband hadn't left her any money. In the future, Hema hopes to educate her younger children and earn enough so that she can marry them off.

On the opposite end of the spectrum is 22 year old Renu, recent mother to her first child, who lives with her extended conjugal family. She is also a recent migrant to the city, but Renu's husband is a second generation resident of the *basti*. His family has been living in the *basti* since the very beginning and he was born here. They belong to the locally dominant Rajput caste and live in their own house with multiple rooms around a central courtyard, one of which has been let out on rent. Her husband is the oldest sibling and has just set up a small shop selling clothes. His younger siblings, a brother and a sister, attend the local university. Although they belong to the traditional Rajput caste, they are relatively 'modern' by local standards. Her MIL works in a beauty salon and is usually away for the greater part of the day.

Renu's first pregnancy ended in a miscarriage and hence her family was extra careful during her second pregnancy. As soon as her second pregnancy was confirmed in the second month, her family took extra precautions like not letting her perform chores that involved exertion. She recalls how excited everyone in the family was because it would be the first grandchild of the family. Her SIL helped her with work, allowing her to rest between chores. If she felt an aversion towards cooked food, her family brought her fruits and yoghurt. Buttermilk, which is traditionally thought of as 'cooling' and hence avoided during pregnancy, was also given to her because her MIL thought that it would be difficult for the body to accept it after pregnancy if it is completely restricted for 9 months. Her pregnancy also made her crave for sweet foods and her family made sure to provide her with food articles that she had the desire for. At the end of the seventh month of her pregnancy, a religious ceremony was organized in the house for her and her parents participated by sending presents (clothing for the entire family, including the to-be born baby) to her conjugal household. She recalls that the doctors decided to deliver the baby via caesarean section because it was too big (around 3750 grams). Renu's MIL even helped Renu bathe and change her clothes during the first 10 days after her delivery. When the child turns one year old, Renu plans to join her MIL and learn beauty salon work. During work hours she would leave her baby with her married sister who lives in the neighbourhood. Although her husband wishes that she would stay home, take care of the children and contribute in their education, her MIL feels that going out to work she would see and learn new things which would be good for Renu.

To summarize, the experience of pregnancy is intimately intertwined with the unique socio-economic position of the woman within a specific moral *Rajasthani* universe. Living in a nuclear family, being employed outside the house, higher parity – all characteristics which are commonly presumed to improve the status and autonomy of the woman in the household do not function linearly or independently of each other. Rather they interact with each other and can be detrimental or beneficial for the women in different contexts. Even though living in an extended family and not being employed outside the house is usually associated with lower levels of autonomy for the DIL, in the case of Renu and Hema it was quite the opposite. Although Renu lived in a large extended household where she was at the bottom of the social status ladder, had recently migrated from her natal village and was not involved in employment outside the house, she was in a far better situation than Hema. She received support from her in-laws, care from her husband and all her pregnancy related needs were taken care of. Her MIL even encourage her to defy the local dietary advisory of avoiding buttermilk consumption during pregnancy because she was worried that her body might reject it when she would resume consuming it after pregnancy. On the other hand, Hema earned almost as much as her husband and lived with her immediate nuclear family but received very limited support and care during her pregnancy. Hence, varied constellations of power and autonomy resulted in a whole spectrum of intra-household micro-dynamics which in turn strongly influence the doing of pregnancy in convoluted ways and this translates into every woman undertaking a very unique path of pregnancy transformation which further leads to multiple ways of *doing* pregnancy.

5.6 Enduring pain and expecting care during pregnancy- *Seva* (service and care) and *sehen shakti* (power to endure)

According to classical Hindu traditions, a pregnant woman is supposed to be protected and meted out care, roughly translated as *Seva* or service and care (Kakar, 1978, p. 77; Mark Nichter, 1981). But the concept of *Seva* is highly fluid and it's exact nature depends on the provider and the receiver. Conventionally, married women are expected to be the 'providers of *seva*'- by cultivating and exhibiting responsibility towards the husband's kin by taking over the responsibilities of nurturing, cleaning and over-all upkeep with deference (C. N. Snell-Rood, 2015). This caregiving and service gradually leads to acceptance and increased authority in the family as well as entitlement to receiving care at a later stage in life (Menon, 2002; C. N. Snell-Rood, 2015). The rest of the conjugal family – the husband, children, parents-in-law, sister and brother-in-law – are

all 'receivers' by virtue of their specific position in the kin network. The younger children – deserve nurturing, protection and care since they are not adults yet. The husbands deserve service and respect since they are the head of the households and to be considered as the lord or God (*Parmeshvar*) by the woman. Finally, the parents-in-law are to be revered by virtue of their seniority and having played their role in furthering the family[57]. The SIL is also expected to receive *seva* because when she gets married and moves to her conjugal family, she would not be able to receive it anymore. In the conjugal household, women are almost never– atleast till they are the *bahu*- in the position of the receiver of *seva*. The position of the daughter-in-law is one of the most neglected ones in the Hindu kinship network, and is well established in literature (M D Gupta, 1995; C. N. Snell-Rood, 2015, p. 48). Many participants recall their experiences of their maidenhood when they received *seva* from their mothers – "there was buffalo milk twice a day for me". However, in her conjugal household only ill-health, pregnancy and childbirth may offer the *bahu* an opportunity to receive *seva*.

Usha Menon also highlights the significance of the 'performance' of this service, indicating that the physical doing has to be accompanied by a "desire to please" and the acceptance of an inferior position in the household (Menon, 2014, p. 186). In both Hindu and Muslim traditions this "living for others" is viewed as spiritual, providing the doer with moral power (Menon, 2002; C. N. Snell-Rood, 2015, p. 58). In Menon's analysis of the so called 'upper caste' newly married Hindu women in Odisha, for a new *bahu* it begins by understanding the tastes and preferences of each member of the household and serving them with sincerity, to later - after gaining seniority over decades- taking over the management of household affairs (Menon, 2014). Among the so called 'low caste' communities residing in *bastis,* such as the ones examined by Claire Snell-Rood in New Delhi, women aim to achieve higher moral power by fulfilling their duty towards their husband's kin by "living for others", despite the additional burdens of poverty (C. N. Snell-Rood, 2015). This path to assimilation into the conjugal family for these women includes all the caring and nurturing responsibilities – such as cleaning, washing, cooking, serving, feeding, massaging and tending to the old and sick – within an environment of socio-economic poverty and deprivation. But Usha Menon argues that the concepts of service and living for others should not be viewed as just subservience. Rather these notions emanate out of the culturally defined means for women to

[57] Usha Menon describes reverential practices among the young Hindu wives in eastern India such as "massaging their feet daily, drinking the water used to wash their feet before taking food herself, as well as eating out of the metal plate previously used by either of her husband's parents" (Menon, 2014, p. 131)

refine oneself (Menon, 2002). According to the author, the other critical prerequisite of self-refinement is self-control. It is believed that service to the kin – which can be challenging work – is thought to enable the woman to develop self-control ultimately bringing the woman closer towards a "selfless ideal" and superior moral power (Menon, 2002b, Snell-Rood, 2015a, p. 48).
I suggest that this self-control also has a physical component - *Sahan Shakti* (literally, power to endure). Within these traditional narratives, overlooking and enduring physical pain without complaining while continuing serving the family, is a quality that young *bahu*s are expected to possess. Again, this is not viewed as 'suffering' but rather a 'power' that only women possess, which enables them to selflessly serve the family. According to Usha Menon, women utilize these tactics of denial and endurance as a way of relinquishing their "attachment to their individual needs"[58] (Menon, 2002). In Claire Snell-Rood's study, women residing in the *bastis* of Delhi, commonly "swallowed pain" and "small hurts" demonstrating their selflessness (C. N. Snell-Rood, 2015, p. 48). Hence *Sehen Shakti* (the power to endure) enables a woman to selflessly serve or provide *seva* to her conjugal family and gradually earn moral power which then places her in a higher position in the household once she is older and has a *bahu* of her own.

The association of enduring pain and physical suffering, with spiritual growth and a favorable rebirth in the moral Hindu universe has been well established (Pugh, 1991; Thrane, 2010). The suffering and sacrificing mother has been glorified in mythological as well as nationalist discourses (Van Hollen, 2003). Cecilia Van Hollen, in her study in south India, describes how enduring pain and suffering is considered to be a necessary aspect of motherhood. However, in case of bodily ailments, these behavioral norms make it difficult for women to express their pain or bring it to the attention of the older female kin who are in charge of initiating treatment for the younger *bahus*, especially in the presence of the male kin. Expressing pain and ailments of reproductive or sexual nature (such as menstrual cramps, vaginal discharge and sexually transmitted infections) is perceived as even more shameful and is therefore usually endured[59]. Patricia Jeffery and Roger Jeffery describe how on the day of her delivery Muni- the protagonist of their first chapter- finishes her chores for the day, serves dinner to her family, washes the dishes

[58] Nonattachment and overcoming one's desires are Hindu ideals as preached by the Bhagvad Gita - the religious texts that are central to the Hindu philosophy.
[59] The under reporting of female urinary tract infections and sexually transmitted infections is well established in epidemiological literature (M. Koenig et al., 1998; Newmann et al., 2000)

and then informs her MIL that she is about to deliver, although her labour pains began in the afternoon (Jeffery et al., 1989, Chapter 1).

On the other hand, *Seva* (care and service) expected from men is of a more generalized kind. The central responsibility of a married man is to financially provide for the family. Traditionally they are expected to be present, but emotionally distant and aloof (Kakar, 1978, p. 131). Sudhir Kakar describes the father figure's position as that of "preoccupied authority" (Kakar, 1978, p. 131), while the mother is responsible for everyday nurturing, feeding and socializing the child. According to the author, the traditional father does not actively demonstrate care and affection to the child because of the larger good of the extended joint family (Kakar, 2007). According to this logic the father must be restrained towards his own child to avoid the destruction of the large extended family into nuclear units (Kakar, 2007). Also the gendered division of parental obligations dictates that child rearing and socialization be under the purview of the mother (Kakar, 2007). Similarly, providing care to the old and sick are traditionally thought to be womanly obligations, while being "ritually purer" men are absolved from such expectations (Menon, 2014, p. 4).

Between the married couple, service is also mostly one-sided. In Nagar *basti*, as in other parts of north-India, wives are expected to display respect and deference to the husband and even refrain from using their husband's name in public or private. Often the husbands are referred to as 'the father of *name of their child'[60]. According to traditional norms of conduct, women are expected to demonstrate modesty towards the husband in public and avoid unveiling, addressing him directly or even facing him (Gold, 1997). In Ann Gold's examination of rural Rajasthani women, women would employ "modes of self-effacement" while speaking to the husband such as- "turning her head away, whispering, speaking obliquely in the third person, or pointedly addressing someone else in the room with a message intended for him" (Gold, 1997). Such an environment is also necessary by the logic of the extended joint family as excessive adoration between the couple might threaten its cohesion.

[60] In the context of north India, using one's given name implies superiority by age or status (Vatuk, 1969). Hence other devices are utilized such as the caste, occupation, place of origin and teknonymy (Eg- Krishna's mother) (Vatuk, 1969). In Nagar *basti,* the participants with whom I had developed some familiarity, referred to their husband's in conversations with me as 'your *bhaiya* (elder brother)'.

5.6.1 Women's narratives of *Seva* (service and care) and *Sehen Shakti* (power to endure)

Although popular accounts indicate at a one-sided display of *Seva* and *Sehen Shakti*, it is not to say that women approve of this service asymmetry and don't expect reciprocity, or close affectionate couple relationships do not exist in private. When discussing about sharing of household chores during pregnancy (in a group discussion), women sometimes describe the absence of reciprocity from their husbands with exasperation and displeasure – "He generally has tea in bed. I heat water and bring it for him for rinsing his mouth and then I bring him tea"; "What help can I expect from him, I even fill his bottle with water for him to carry to the jungle (to wash after relieving himself)"; "He is not even aware of the route to the kitchen". When one woman recalled that her husband cooked food for a few days when she delivered, the others joked about how lucky she was and wished "that everyone had a husband like her". These comments indicate that women expect care and attention from the family especially during pregnancy. However, this expectation of care cannot be made explicit lest they be viewed as self-absorbed or self-indulgent (Menon, 2014, p. 136).

In Nagar *basti* when women are the receivers of care there is an explicit avoidance of the term *seva* (care and service) probably because it is culturally unnatural for young DILs to receive *seva*. Instead, they refer to only *karna* (to perform or to do or to provide) and *karnewaala*[61] (the provider). In other words, the women talk of having a 'provider' who provides care or rather (in most cases) lament about the absence of a provider (*karnewaala).* Here, it is interesting to note that even though '*Karnewaala*' is a masculine term (unlike 'provider' –which is a gender-neutral term), the young *bahu*s are referring to expectations of support and care from the female kin.

Women also believe the intrinsic female *Sahan Shakti* is also on the decline due to modernity. In Nagar *basti*, Anju (35 year old mother of three) recalls how she would "keep crying from within" when she would be scolded for committing a mistake and would keep working despite aches and pains when she was a new *bahu*. According to Anju, elderly women who grew up in villages had more *sahan shakti* because of "better food and drinks"-

[61] *Karnewaale* (literally do-ers) are members of the household who can be relied upon for care and support. A large family does not always translate into *karnewaale*. Rather whether or not one receives care and support in times of need depends on intra-household dynamics and subjectivities.

"The food and drink also matters. Earlier the water was also pure and now it isn't the same[62]. Yesterday's water is equal to today's ghee (clarified butter). So because of that also, these days the women and girls don't have enough sahan shakti, that they can tolerate things. What does one get these days, only sabzi-roti (vegetables and bread)… even that if one gets on time then one is very lucky."

The MIL of another participant, in a conversation, also mentions that the mothers these days are weak, because of the tainted food and injections required during pregnancy. They in turn give birth to weak babies, according to her. Although these narratives were usually prevalent among the relatively older women (middle aged and elderly), these associations between weak female bodies with poor quality of diet and the medicalized nature of pregnancy in the urban context are quite common. The comparison here is with the rural context, where the diet is believed to be better[63] and childbearing is much less medicalized. Cecilia Van Hollen discovered similar critiques of modernity within the narratives of childbearing in south India (Van Hollen, 2003).

For the pregnant women residing in Nagar *basti*, expectations of care during pregnancy take on generalized and subtle forms. As discussed before, the first pregnancy- which usually occurs within the first year or two of marriage- heralds a stage of status transformation for the woman. Also as described earlier, the transformation is drawn out and delayed, quite unlike the pregnancy announcements among the urban middle-class or in the Euro-American milieu. The new wife who has been working towards getting integrated within the family begins to expect covert and indirect displays of appreciation, attention and approval. A piece of advice given by the MIL on restricting certain food item or posture, directing the SIL to help the woman with a heavy bucket of water, allowing some rest, suggesting the husband to get her examined at the hospital and bring food items that she has cravings for, are enough to be viewed as 'care' by the woman. For women like Renu, who lives in a joint family household and who gave birth to the first grandchild of the household, there are numerous 'providers of care' *(karnewaale)* at home. She also fondly recalls

[62] Here she refers to the ritual purity of water which is not associated with its physical purity. In traditional Brahmanical Hinduism water (especially from rivers) is considered to be pure and further purifies whatever it touches. Bathing in a river (especially the 'Holy Ganges') is believed to cleanse the sins of a person and bestow her with auspiciousness. *Ghee* (clarified butter) is considered to be "the most distilled essence" of the Holy cow and believed to have purifying properties even more powerful than that of water (K. Fernandez, 2011).

[63] Because of better availability (perceived) of vegetables and cereals grown locally as well as milk and milk products – such as butter, ghee, buttermilk, yoghurt- obtained from livestock. Milk and milk products are consumed in relative abundance and considered to be essential for health, but these vanish from the family's diet when they migrate to urban areas.

the rituals that were performed for her in her conjugal home - the seventh month ritual and the post-delivery purification ritual. According to her, her pregnancy was exactly how she expected it to be.

Anju's first pregnancy however, was very different. She laments that she was criticized by her MIL if she followed the doctor's instructions of avoiding heavy chores and resting frequently, because according to the MIL "we have also given birth to children and we didn't even see the face of a doctor". To avoid criticism, she diligently fulfilled all her responsibilities.

> *"I used to keep working around the house. If I was unwell, nobody would take me to the doctor. I used to take combiflam (pain relief medicine) twice a day. I used to be under a lot of stress and tension. I used to feel alone. My child's father (the husband) also didn't used to understand me. If I would make a mistake, someone would reprimand me, and it would just keep festering inside me."*
>
> *(Anju, 35 year old mother of three)*

Clearly, Anju expected support from her husband which would have helped her to negotiate better conditions for herself. She feels that all the physical and mental stress that she went through affected her unborn child (Anju's first born has a severe form of intellectual and physical disability). According to her, there were no providers *(karnewaala)* for her. However, the situation was very different during her subsequent pregnancies, as she grew "smarter" and started working with a local NGO, as we shall see in the next Chapter.

Rekha, 20 year old new mother, handled the absence of a *karnewaala* differently. She had a conflict with her *saas* over her pregnancy. Her *saas* had young children of her own and didn't want Rekha to have a child yet, but rather wanted her to work as domestic help and earn for the family. Rekha and her husband, on the other hand, wanted to go through with the pregnancy, which then resulted in a conflict. They then decided to move out and rented a small, one-room accommodation nearby. Rekha used to suffer from a lot of nausea, vomiting and weakness throughout her pregnancy. Although her husband tried to support her, he would have to leave for work and she would have no one at home for help or support. They decided that she would visit her natal home for a few days, so that her mother could take care of her. She recalls,

> *"Sometimes I would stay there for 2 months, then come back here for 15 days and then go back again. That way I could get some rest. The doctor said, 'it is important to give her milk'. And here my Saas never used to bring me milk. And when my husband used to get it, she used to start a fight. She wouldn't give me anything to eat, just plain roti (bread). The roti used to make me vomit. In the village my mother keeps*

a buffalo. I used to have milk there as well as yoghurt and buttermilk. You get everything in the village. That's why I used to go to the village.

Rekha had the complete and open support of her husband, which would have been difficult in an extended family situation. When she became unwell during her pregnancy, he suggested that she stay with her parents so that she could receive care, support and rest, which he was unable to provide. He would take Rekha on his motorcycle and drop her at her natal home in the village and then also come to pick her up when she wanted to return. Rekha overlooked the embarrassment of visiting one's natal village with a visibly pregnant belly and readily sought parental support and care.

Hence, women in Nagar *basti* display a range of responses towards the existing structures of domination. Neither are they 'victims' –passive, demure and unable to act- nor are they 'rebels' –subverting at every opportunity. I, as many other scholars of South-Asian studies, view her as an agent who "may both resist her oppression and also be an agent in her own coercion" depending on her circumstances (Jeffery & Jeffery, 1994; Kumar, 1994, Chapter Introduction). In the words of Douglas Haynes and Gyan Prakash, "one can observe omnipresent tension and contradictions between hegemony and autonomy in consciousness, between submission and resistance in practice" (Haynes & Prakash, 1991, pp. 10–13 as quoted in Jeffery & Jeffery, 1994). The objective is to look for and bring to the fore subtle ways in which women "exercise their agency" in performing pregnancy "even while outwardly part of a repressive normative order" (Kumar, 1994, p. 4).

5.7 Transformation of the experience

Examining the physical and social transformation of the individual during pregnancy also demands a discussion of the long-term transformation of the entire experience. Young mothers conceiving for the first time narrate vastly different experiences as compared to their mothers and mothers-in-law. More and more young women are attending higher secondary schools and seeking waged employment outside the house. In urban colonies such as Nagar *basti*, women have greater proximity (as compared to small towns and villages) to a wide array of public as well as private health services. Life in an urban context also offers more opportunities for conjugal intimacy and cooperation between the couple (Maya Unnithan-Kumar, 2003). Given their greater social and spatial mobility, some women have greater control over their reproductive identities and may even sometimes take decisions unbeknownst to the family.

The pregnancy experience – how it is learnt, performed and even talked about- has also been transforming rapidly due to the biomedical turn of childbearing. In Nagar *basti,* as in the rest of the country (and the world), the local *knowledges* of childbearing are being challenged by new "techno-medical imports" (Roalkvam, 2012) leading to increased *medicalization*[64] of the process (Neiterman, 2010; Van Hollen, 2003). Although the degree of medicalization of pregnancy and birth in rural and peri-urban India is not yet as comprehensive as in metropolitan cities or in the industrialized world, the experiences in Nagar *basti* are rapidly transforming.

Due to a greater choice of public and private healthcare in the vicinity, and the Indian government's drive to incentivize institutional deliveries, home-births have become quite uncommon in Nagar *Basti*. Even if a delivery does take place at home, it is now usually conducted by a trained midwife rather than a traditional *dai*[65]. Most births happen in hospitals (public and private) attended by medical personnel. Even though these hospitals do not always guarantee quality healthcare (Hulton, Matthews, & Stones, 2007), they symbolize modernity and high social status. Hence, in some ways the aspiration of being viewed as 'modern', 'educated' and 'urban' is also intensifying the shift towards medicalization of pregnancy. The English terms '*sonography'* (referring to Ultrasound) and '*operation'* (referring to Cesarean section) frequently feature in everyday speech of women experiencing pregnancy and their families. Many women possess the state-issued 'Mother and Child Card' (Appendix 5: Maternal and child health card) provided upon registration with a health institution and could list off the number of tests they had undergone, such as blood and urine examination. Women also often keep track of their menstrual cycle and sometimes seek to investigate when the cycle is delayed. The preferred first line of investigation is the readily available home pregnancy test kit. Medical personnel are also being increasingly consulted and their prescriptions being followed for complications encountered by the mother-to-be.

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[64] Medicalization has been defined as a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (Conrad, 1992). Peter Conrad defined it as having three levels- (1) the conceptual level, when medical vocabulary has been adopted to define a problem as medical; (2) the institutional level, when organizations approach a problem as medical; and (3) at the level of interactions where the problem is defined and/or treated as medical in the context of provider-patient communication. In the Euro-American context it began with the advancement of the biomedical discourse and medical science's attempt to acquire political and professional hegemony (Neiterman, 2010). For discussion see Chapter 2.

[65] *Dai*s are usually women belonging to the so-called 'low castes' who follow traditional systems of maternal and newborn care to conduct deliveries at the pregnant women's house. They usually have received no formal (medical) training in healthcare. For a detailed account a home delivery in rural north-India managed by a *dai*, see (Jeffery et al., 1989).

As a result, most women's experience of childbearing is a hybrid of local customs and traditional conceptions of pregnancy, mixed with formal Indian medical traditions such as *Ayurveda* and *Unani*, interspersed with biomedical practices based on 'western' scientific principles. As many scholars of anthropology of Rajasthan such as Helen Lambert (1997), Jeffery G. Snodgrass (2004) and Maya Unnithan (2010) have examined, an individual may simultaneously access a variety of treatment options - such as herbal medicines, pilgrimage to a shrine, spirit exorcism and a visit to a local public health centre – depending on popular conceptions attached to the particular affliction she is suffering from.

But these transformations in childbearing and childbirth practices are not being imbibed uniformly or without any resistance. Many women, especially older ones who are past their reproductive age, believe that excessive biomedical intervention is detrimental and leading to 'weaker bodies'. According to Neetu's *saas*, a frail 50 year old lady whom I met when I visited their home to interview Neetu -

> *"Nowadays people are not like what they used to be earlier. Today she (Neetu) got an injection for which we were charged Rs 100 (approximately 1€ and 20 cents). All the pregnancies are happening with injections. Because of this even the babies are weak. Earlier the babies used to be very strong. When my granddaughter climbs this hill, she gets tired and dizzy in just a few minutes. When we were her age, we could easily climb up the hill and play all day, up and down the hill. We would just run and go up and then run down."*
>
> *(Neetu's MIL)*

Neetu's *saas* was referring to the common biomedical practice of administering Progesterone[66] injections during pregnancy in case of certain complications, especially among women who had experienced a miscarriage in the past, with the aim of delaying labour. Many participants mentioned been prescribed these injections and many from the older generation viewed these 'children from injections' as weaker than what children used to be. According to Neetu's *saas*, the bodies of women and children are being affected by this intervention of 'modern' medicine. According to another elderly lady, "I have had 4 children, and I had never even seen a hospital. The sickle that was used in the field, was used to cut the umbilical cord. And today they say you should get a tetanus injection or this will happen, that will happen".

[66] Progesterone is a type of female hormone that is administered via a syringe, if the body is producing insufficient amounts. It is administered during pregnancy to delay labour when there is a risk of preterm labour.

Maya Unnithan-Kumar (2003b) and Cecilia Van Hollen (2003) discovered similar narratives among mostly elderly participants, in rural north and south India respectively, who believed that modernity was having a degrading effect on women's bodies. Within these narratives, associations are made between biomedical interventions and weak bodies. These biomedical practices often contradict the locally prevalent narratives of pregnancy as 'natural' and 'normal' and are therefore often viewed with suspicion and sometimes even outrightly rejected. For example, the popular belief that western medicine causes 'heating up' of the body and therefore is potentially harmful during pregnancy. On the other hand, acceptance of biomedical terminology and advisories is often utilized by the younger women to assert their modernity or improvement in socio-economic status. It is within this socio-cultural and biomedical context that the experience of childbearing plays out in the Nagar *basti*.

5.8 Conclusion

As discussed in the previous chapter, childbearing is at once social, biological and political. Through this chapter, I attempt to unravel these strands which make up the everyday experiences of pregnancy in Nagar *basti*. The objective of this chapter is to put forth the popular narratives pertaining to childbearing in Nagar *basti*. I focus on local interpretations of physiological process of conception and the understandings of bodily and emotional and social transformations that women go through during pregnancy. To do so, I focus on lived-experiences – personal narratives, interviews and anecdotal information- to eventually weave together the experience of child-bearing within the background of caste, poverty and gender. The narratives indicate that in Nagar *basti*, pregnancy is viewed as a 'normal', necessary and inevitable stage of a woman's life, and hence usually warrants no initiation or discussion in the natal or conjugal family. There is no apparent stage of bodily or emotional 'preparation' before attempting conception. Young women, especially during their first-pregnancy, are also often unable to recognize the signs of conception. Rather, conception is often recognized by the mother-in-law who also sets the tone of how the pregnancy would be handled in the family. At least during the first pregnancy, especially women living in extended families in Nagar *basti* are often alienated from decision- making regarding self-care- such as resting, food choices, choice of medical institution for check-ups etc. But this changes over the years as women advance in their reproductive career, gradually enjoy more autonomy as gain valuable experiences from their own pregnancies as well as those of relatives and neighbours.

The pregnant body, in Nagar *basti* and some other parts of north-India, is traditionally viewed as vulnerable - warranting protection from harmful foods and evil spirits. However, in Nagar *basti* often these beliefs about 'vulnerability' usually do not translate into any unusual treatment at home with regards to special foods, more leisure, sharing of household responsibilities or emotional support. I suggest that socio-economic limitations associated with living in poverty contributes to this 'indifference', since urban-privileged *Rajasthanis* experience pregnancy vastly differently.

But this does not indicate that women do not expect care and support from their kin. On the contrary, my data shows that women demand care and support and sometimes even take bold steps such as separating from the extending household or going to stay with the natal family despite the fears of shame and embarrassment in the wider community. Through my participants' experiences I also observe that the social transformation of a woman from a new DIL to a soon-to-be-mother usually happens gradually over months. Only after the pregnancy is 'visible' and close to completion is she treated as 'pregnant' by the family. In most households, there exists a lag between the confirmation of pregnancy by a health personnel and her social treatment as 'pregnant'. Finally, I also examine the long-term transformation of the experience of pregnancy among the residents of Nagar *basti* and how it intertwines with young women's aspirations. To conclude, this chapter highlights what becoming 'pregnant' means in Nagar *basti* and tries to draw contrasts and parallels between the subjectivities of women and their pregnancy experiences. In this manner, this chapter acts as a prelude to the following chapter on the everyday doing of pregnancy in Nagar *basti*.

Chapter 6 - Being a *bahu* and performing pregnancy

The experience of childbearing is a physiological, psychological, socio-cutural and political episode- one that is undergoing a gradual transformation in Nagar *basti*. The local systems of knowledge, however, continue to heavily influence the behaviours surrounding the everyday doing of pregnancy. In this chapter, I dig deeper into the everyday practices during pregnancy – such as domestic responsibilities, self-care, healthcare and eating habits- with the aim of unearthing the embodied experiences of pregnancy among women in the *basti*. While doing so I do not dissociate with the everyday context within which these practices are performed. The idea ultimately is not to deduce the manner in which pregnancy is done within poor urban households in Jaipur, but rather the variety of ways in which pregnancy is understood, dealt with and performed by women even within a seemingly homogenous community. This chapter focuses primarily on Research Question 2- How do the conceptualizations of pregnancy and the pregnant body influence the performances of pregnancy in an impoverished environment such as Nagar *basti*?

The first section examines the relationships, hierarchies and power dynamics within north-Indian households within which pregnancy is suspected, confirmed and then carried out by the *bahu* (daughter-in-law). I also look at the role of the natal ties, which are usually portrayed as weak and ineffective, in buoying the women through the crises that they face in their lives in the *basti*. In the second section, I examine women's work responsibilities and how they interact with the changing bodily and emotional needs of pregnancy. I discuss women's understandings of their bodies and popular norms surrounding the changing body as well as how they go about achieving or rejecting those norms. In the third section I put forth women's ideas of self-care and rest during pregnancy and their significance in deciding how pregnancy is performed. In section 6.4, I bring up medicalization of the process of child-bearing and how women interact with the changing nature of the healthcare system. In section 6.5, I examine the culinary practices of the pregnant woman and its potential repercussions for the developing foetus. Throughout these sections I highlight the heterogeneity in the manner in which women perform pregnancy.

6.1 Micropolitics of household chores

Much has been written about household gender roles pertaining to domestic responsibilities in traditional north-Indian households. Even within this seemingly distinct division of roles, responsibilities and power, there are domains within which older women of the household wield authority and control – such as childbirth, marriage rituals and domestic chores, among others

(Jeffery et al., 1989; Raheja & Gold, 1994). Within these domains, the hierarchies among the women of a household shape the various relationships of female cooperation and exploitation within the family (Monica D. Gupta, 1995; Jeffery et al., 1989; Patel, 1999; C. N. Snell-Rood, 2015). These complex intersectional hierarchies are produced by social differences such as age and kin relationship- the older, patrikin, agnates[67] occupy higher positions. In such a context, the most arduous tasks fall on the shoulders of the youngest *bahu* (daughter-in-law) (Monica D. Gupta, 1995; Jeffery et al., 1989). But how does this affect the *bahu*'s everyday doing of pregnancy? How does she negotiate with her physical, psychological and social transformations of pregnancy within this context of low social status, heavy work responsibilities and poverty? I examine the informal intra-household transactions and politics to answer these questions.

6.1.1 Going separate *(alag hona)* versus having someone who supports *(karnewaala)*

The complex constellation of powers within the members of an extended household – often comprising of three generations and multiple sets of married pairs- is, however, difficult to sustain over a long period of time. Fissions often arise between married brothers or *bahus* or between *bahu* and *saas*. Such situations may result in the separation of a married couple from the larger unit or the breakdown of the larger unit into smaller nuclear households. Some women begin their married life as a *bahu* in an extended family and later separate to establish her own household, provided they can gain the support of their husbands. Many households in Nagar *basti* comprise of the traditional north-Indian joint family type where the married men and their families, reside with the men's parents, grandparents and unmarried siblings. However, nuclear families are becoming increasingly common. Especially for the urban poor, due to meagre land and other property to share and pass on to the next generation, there is little benefit in remaining financially joint (Seymour, 1999a, p. 146). In my study, approximately 53% of the families were joint extended households and the remaining 47% were nuclear units.

The decision to separate from the extended family is often a tough one. Even though sometimes precarious, familial relationships are considered to be central to an individual's social reputation, sense of self and well-being. Claire Snell-Rood refers to this as "relational well-being" which, especially in the south-Asian context, is dependent upon integrating within the family and

[67] Agnate is a person descended from the same male ancestor as another specified or implied person, especially through the male line. On the other hand, affine is a relationship by marriage.

keeping it together (C. N. Snell-Rood, 2015). The interpersonal relationships and the work/service that the *bahu* puts into them is believed to provide her with a purpose and fulfilment in life (Menon & Shweder, 1998, p. 160). However, women in Nagar *basti* do not always conform to the culturally prescribed "symbols and systems" (C. N. Snell-Rood, 2015). Rather, there appears to be wide diversity in the manner in which they engage with familial relationships.

Pregnancy sometimes strengthens the couple and brings about changes in the power dynamics of the household, which might also result in the breaking away of the pair to establish their own household. However, setting up a separate nuclear household would also preclude the couple from familial support (financial, everyday labour-related and moral). For most, there is a trade-off - more autonomy in the household (to work, live, spend and save by choice) but at the cost of familial support and *karnewaale*[68]. Separating from the larger family thus has repercussions for the social, physical as well as mental well-being of the individuals residing in *bastis*.

The process of separation is often long, arduous and usually not amicable. It may begin with some resistance to the authority of the *saas*, followed by altercations, rising tensions and demands for separation, and finally the husband may decide to back his wife resulting in the decision to establish a new household. Usually the process extends over years, but sometimes it maybe as short as a few weeks. Almost all couples in my study, who had separated from the extended household, after separation sought new accommodation on rent in Nagar *basti* itself but in a different area. For 20 year old Rekha, separation happened within the first six months of marriage.

According to Rekha, she became pregnant against her *saas*'s wishes. Since her *saas* had small children of her own, she wanted Rekha to delay pregnancy and earn for the family by working as a domestic help.

> *"After I got married, I accidently conceived. My Saas said, 'Get it aborted'. I said, 'I will not get it done'. My husband also wanted the child and stood by me. He said, 'we will not get it aborted. Let it happen'. You tell me, is it a good thing to get it removed? The first baby should not be aborted.*

[68] *Karnewaale* (literally do-ers/providers) are usually family members who can be relied upon for care and support. A large family does not usually translate into many *karnewaale*. Rather receiving care and support in times of need depends on intra-household dynamics. It is interesting to note that although *Karnewaala* is a masculine term, women use it to refer to female kin who could provide care and support in adverse times- such as ill-health. Men are usually not expected to be providing care and support to the pregnant wife.

My saas started complaining, 'she doesn't obey us'. She actually wanted me to go to work in others' houses, wash clothes and earn money. I used to do all the work at home - washing clothes, sweeping, mopping, the utensils, vegetables, roti (bread), everything. But the doctor had strictly advised me against heavy work and heavy loads. Now if one goes out to work, one has to do all kinds of work, heavy as well as light. So I said, 'My condition is not well, how can I go?' So we decided to get separated."

(Rekha, 20 year old mother of one)

The separation of the household gave Rekha the autonomy to continue with the pregnancy, consume foods that she craved for, give up chores when she felt unwell and seek the help of her husband with household work. Even though she lost the support of familial relationships and financial security of her conjugal household, Rekha managed to offset this loss by seeking the support of her natal family.

"My health was in a bad condition during pregnacy, I didn't feel like working at all. I felt like sleeping the entire day. If I would sleep in the morning, I wouldn't realize whether it is night or day. My condition was so bad. I couldn't eat for days. As soon as I would eat, I'd vomit.
My husband said, 'if you are unable to work, don't do it. Go to your mother's house and she would be able to look after you. And come back whenever you feel like it. Call me and I will come to pick you up.'
At my mother's I could get some rest. Sometimes I would stay there for 2 months, then would come back for 15 days and then go back again.
Here my saas didn't give me anything to eat, just roti (bread). When I used to have roti, I used to vomit. My mother keeps a buffalo in the village. I used to have milk, yoghurt, buttermilk, rabdi (milk and cereal) you get everything in the village. That's why I used to go to the village.
The doctor said, 'it is important to give her milk'. And here my Saas never used to bring me milk. And when my husband used to get it, she used to start a fight."

According to Rekha, her husband helped her with household chores such as washing clothes or fetching water, but according to her, this was only possible because they lived separately. For the first few days after her delivery, Rekha's husband bathed her and the baby, cooked for them, washed her clothes and even used a bedpan to help Rekha relieve herself in the house (since they do not have a toilet). In the face of odds, Rekha's husband became a *karnewaala* even though taking up 'traditionally female responsibilities' is usually accompanied by the risk of being ridiculed by kin and neighbours. Hence, although Rekha lamented upon the separation and the

indifference of her in-laws, the separation from the extended family had enabled her to receive care and support- support with nutrition, emotional support and support with pregnancy related ailments- from her husband and natal family. These support systems would not have been effective had they continued living in the extended family.

For 30 year old Seema, however, it was difficult to separate because of financial reasons despite rising tensions. Seema and her husband both work as domestic helps. They have three children and till a few months ago used to live with the husband's parents and married younger brother and his wife. The household did not have a sewage connection and the toilet they had is connected to a septic pit which required regular emptying (with considerable financial costs and manual labor). As a result, her in-laws established that the toilet be used in case of emergency only- for example late at night or when someone was sick. For hygiene and safety reasons Seema and her oldest daughter disliked going out to the jungle to defecate. According to Seema, altercations were common in their household and both the *bahus* endured a lot of misbehaviour. Seema endured all the "tensions" and only recently moved to her separate household when they had enough money to rent another house in the same area.

> *"In this new house I have a toilet and everything. This was the reason for changing the house. I was very troubled. I had no other problems, just the lack of toilet. Then the behaviour of my Saas was also such. I mean it was very bad towards us. That's why I decided to move out.*
> *She is the kind of Saas that one sees in Movies. She has never liked me. She was never bothered during my pregnancy. Because I conceived on the very first night, she claimed that I got pregnant while still in the peehar (natal village) and that my unborn child was not their's. Forget about bringing me fruits, she hasn't even ever offered me a glass of water. I wasn't allowed to use the toilet even when there was an emergency during my pregnancy.*
> *So during my last pregnancy I had an argument and left the house. I stayed with my sister for a few days and then as soon as the 9th month began I went to my mother. My mother and my sister took good care of me and fed me well."*
>
> *(Seema, 30 year old mother of three)*

Despite all problems that she faced, Seema was unable to set up a separate household for a long time mostly because of the support (financial and everyday labour-related support) provided by the joint household. She shouldered all the 'tensions' during her pregnancies and was only able to move out after her fertility career was over. This was when her oldest daughter was almost nine and was beginning to help her around the house.

Hence, both Rekha and Seema women deal with power asymmetries and the resultant frictions in the household in different ways. When there were no *karnewaale* - or people who could provide them with care and support - during pregnancy they relied on their natal kin, specifically their mothers and sisters, to accomplish self-care- specifically resting more and fulfilling their dietary aspirations. But the support of the husband and his agreement to move out is central to the decision of separation.

6.1.2 *Peehar* (natal family/home) support

Traditionally, marriages in Rajasthan - as in other parts of north-India- follow the rules of kin exogamy as well as village exogamy[69] (Monica D. Gupta, 1995; Vatuk, n.d.). Hence marriage matches are sought in a different village. In urban north-India, however, it is common for families to look for marital matches for their daughters within the same city, but in another locality. As described by Sonia Grover (2017) in her treatise on Marriage and Kinship among the "urban poor" in New Delhi, marriage alliances by Nagar *basti* households are also usually sought within the city. Among Nagar *basti* households, daughters are married into families in *bastis* in other parts of Jaipur or sometimes into families in other colonies of Nagar *basti* but never within the same colony of Nagar *basti*. Boys and girls who have grown up in the same colony are believed to be in a brother-sister like relationship and hence such an alliance would be incestuous. Among the women that I interacted with, *peehars* (for around 70% of the participants) were either in other *bastis* within Jaipur (around 30-60 minutes away) or villages surrounding Jaipur (for around 30% of the participants) such as Bharatpur, Dausa, Jhotwaara all of which were a few hours away. As in Sonia Grover's participants in New Delhi (Grover, 2017), it is very uncommon for urban Nagar basti households to look for marriage alliances for their city-bred daughters in the village. The explanation for this being that the rural lifestyle would be completely foreign to them and they might be unable to cope with it.

Culturally, marriage is perceived as a gift of a virgin "from one kin group to another", locally termed as *kanyadan* (gift of a virgin) (Vatuk, n.d.). The marriage marks the beginning of an asymmetrical relationship between the "bride-givers" and the "bride-takers" with the former being established as "socially and ritually inferior" to the later (Dyson & Moore, 1983; Vatuk, n.d.). This

[69] Within a village, fictive kinship is believed to exist between all residents, irrespective of whether an actual kinship relation exist (Vatuk, 1969). Hence, after marriage a woman must leave her natal village (*peehar*) to live in her husband's household in the marital village (*sasural*).

inferiority of the wife-givers is expressed in the form of "deference, hospitality and gift-giving", which they are expected to perform at the wedding and lasting throughout their lifetimes at ritual occasions and festivals (Vatuk, n.d.). The marriage also transfers her allegiance from the natal family to her marital family including the products of her labour and fertility (Vatuk, n.d.). Despite this transference, the author argues, the bond between the woman and her natal family is sustained throughout the lifetime by gift-giving at every meeting and ceremony in the form of cash and clothing.

Apart from material and financial presents, the natal family also provides emotional support and refuge in times of hardship such as marital discord and illnesses. Many scholars of Indology have focussed on the significance of parental support for a married woman. In Sonia Grover's analysis of marriages among the "urban poor" in New Delhi, she examines how women commonly seek parental refuge at the time of marital problems which strengthens her position and enables her to "renegotiate her domestic arrangements in the event of a conflict" (Grover, 2017, Chapter 2). Similarly Patricia Jeffery et al., in their study in rural Uttar Pradesh, observed that women sought refuge in their natal homes also when medical treatment was refused in the affinal household or when recuperating from an illness or in case of domestic violence (Jeffery et al., 1989).

Pregnancy, being a prominent milestone for both families, is one such event, which necessitates not just material gifts in the form of ornaments, clothes, food stuffs and utensils, but also emotional support and care to the pregnant woman. In the *Rajasthani* context, notions of *sharam* (shame and embarrassment) prevent the woman from visiting her *peehar* during pregnancy, especially in the advanced months, although she might be in great need of emotional support and would benefit greatly from visiting her natal family. Women usually avoid visiting the natal village after the pregnancy becomes conspicuous. Neither do her parents visit her in the *sasural*, until after the delivery. In the seventh-month ritual, as described in Chapter 5, performed in the seventh month of pregnancy the natal family are expected to provide gifts to their daughter, daughter's unborn child and the daughter's family in the form of clothing and food items- such as sweets, nuts and fruits. But even these presents are usually sent with a brother or an uncle or the father who engages with the menfolk of the household and returns without meeting the woman.

In such a context the only means of receiving some emotional support and care during pregnancy in the *sasural* is when she suffers from a serious medical condition that necessitates rest and performing manual household work is severely restricted. Usually, the labelling of the condition by a medical personnel is essential for it to be considered serious, for example a doctor

describing the baby as positioned 'low' in the belly or forewarning the family about the high chance of miscarriage and prescribing bed-rest. Some participants had a prior history of miscarriage and as a result of that were allowed to follow the doctor's recommendations. It is essential for the *saas* to be in accordance with the *bahu*'s need for care and support[70]. In such cases the *saas* can decide to seek the support of the natal family to provide a *karnewaala* - an ad-hoc carer and replacement for the pregnant *bahu.* The natal family then usually sends an unmarried, or in some cases a married, daughter to live with the sister in her *sasural* to care for her and take over her household work for a few weeks[71]. This situation affords the pregnant woman some rest from her otherwise arduous schedule and allows her a small window of opportunity to fulfil her pregnancy cravings and urges such as preference or avoidance of a certain food items. Such arrangements are usually seen when either the woman and her husband live as a nuclear family or the women lives in a joint household but the other women in the household don't wish to or are unable to take over her responsibilities.

In my sample, such arrangements were rare and only organized when the pregnant woman suffered from serious medical complications with high risk of miscarriage. For example, Amita and her husband lived separately from the extended family, and as a result during her pregnancy she had no *karnewaala* to care for her.

> *"I couldn't do anything special for myself during pregnancy. I couldn't even digest a roti (bread). I could just eat one roti in the morning. I used to have so much gas and burning sensation in the stomach that I could hardly eat anything for the first 3 months. I was repulsed by the smell of the food, cooking fuel, roti, everything. I could just consume a cold roti. I used to eat Roti cooked on a chulha (traditional firewood hearth) the night before. I couldn't eat the roti cooked on the stove. I used to get one roti from my sister's house cooked on the chulha.*

[70] Due to this power dynamic it is common practice during gynaecological appointments for medical personnel to counsel and advise the accompanying *saas* on her *bahu*'s condition to ensure that the medical recommendations would be taken seriously and adhered to.

[71] Remlinger examines how, in the north- Indian context, the bride's sister occupies the lowest position within the extended kin on both sides of a marital bond (Remlinger, 1991). The author suggests that the reason behind this is her association via the bride, unlike other relations who are associated via the groom. For example- there exist several terms for a bride's affinal sister-in-laws, depending on their status and social position within the household which in turn is related to the position that her husband occupied in the household. So the wife of older brother-in-law (*jeth*) is *jethani* and the wife of the younger brother-in-law (*dewar*) is *dewarani*. However, the groom's affinal sister-in-law (or bride's sister) is referred to with only a single term *saali,* a term which is also used as an insult in other contexts (Remlinger, 1991). Semantics indicate at the relative insignificance of the position and the basis for such a practice of seeking a younger sister of the bride as an ad hoc carer and worker in the household.

For the first 3 months of my pregnancy I was just lying on the bed all the time, because of the vomiting. Then when the 4th month began, it became alright. Then when the ninth month began, I asked the daughter of my sister to come and help me. She did all the work for me."

Amita's parents had passed away, leaving behind only her, her married brother (who still lives in the natal village) and her sister (who also lives in Nagar *basti*). According to her "*Only when the mother and father are alive, does someone bother about you in the Peehar. Now I go there, only when it is absolutely essential".* Amita's sister lived close by in Nagar *basti* and she turned to her for support during pregnancy. Not only did the sister give Amita advice about taking care of herself during pregnancy, giving her suggestions to deal with her pregnancy sickness, but also sent her *roti* cooked on the *chulha,* which Mamta found more palatable than the *roti* that she herself cooked on her cooking stove. Towards the end of Amita's pregnancy, when her belly had grown to become big and she could not fulfil her household work, she asked her sister to send her adolescent daughter to help with work. In this manner, natal kin compensates for the absence of carers in the marital kin during pregnancy.

For 22 year old Rekha, going through her first pregnancy, it was difficult to receive support from natal kin because of the geographical distance between Nagar *basti* and her natal village. Rekha and Jeetu separated from Jeetu's extended family during Rekha's pregnancy and were not on good terms with them. Rekha had a difficult pregnancy and was advised to rest more and avoid exertion. She also had severe pregnancy sickness and developed an aversion to most food items. Jeetu realized that he would not be able to take care of her wife and suggested that she visit her natal village and stay with her parents for a few weeks.

"I would stay with my parents for 2 months, then come back here for 15 days and then go back again. That's how I did it.
Here when I consumed Roti, I would vomit. I couldn't eat for days, how would I be able to walk, you tell me? If I would see food being cooked, I would go and vomit. My condition was so bad. I didn't feel like working at all. I felt like sleeping the entire day. If I would sleep in the morning, I wouldn't realize whether it is night or day. My condition was so bad.
My husband suggested that I go to my Mother's place so that she is able to look after me. My mother keeps a buffalo. So I used to have milk, yoghurt, buttermilk and rabdi (a kind of cereal in milk). You get everything in the village."

Because there were no other younger female kin who could be sent to Nagar *basti* to stay with Rekha, her mother fulfilled her need for a carer or *karnewaala* during her pregnancy by hosting her and caring for her in her natal home. Notions of *sharam* (embarrassment) produced by the visibility of pregnancy in the natal village were put aside and endured by Rekha to receive the much needed care and support.

In scenarios where the woman is not permitted by the parents-in-laws to visit the natal village, the mother may attempt to support her daughter via phone by calling up the *saas* to make requests on her daughter's behalf. Often when the *bahu* is still new in the household, it is considered inappropriate for her to directly make demands or express a need to her *saas*. Instead, requests are made to the husband or sometimes to one's mother who then pass it on to the *saas*. For example, an elderly woman in an FGD commented-

> *"I already took my bahu to the hospital twice. Then she called up her mother and her mother called me up to say, 'Behenji (sister), please take her to the hospital'. I said, 'Behenji (sister), instead of calling you up, she could have directly asked me.'*
>
> *Bahu could have just told me directly. I am the one who has to take her to the hospital. These are things that I don't like."*

Tim Dyson & Mick Moore (1983) and Gloria Raheja & Anne Gold (1994) contend that although strong post-marital bonds with natal kin might seem contradictory to the traditional kinship paradigms which "present a homogenous picture of north Indian women as estranged from their natal kin", close ties are actually quite common within a variety of kin ties that women continue to nurture and invest in post marriage (Grover, 2009, p. 68).

However, these requests usually do not go down well with the affinal family. Expressing the desire to visit one's natal home or complaining to one's mother implies (to the wider community) that the *bahu* is not well-looked after in the marital home. In her detailed monograph based in the slums of New Delhi, Sonia Grover describes how close marital-bonds between the woman and her natal kin can be a source of resentment and conflict among the husband's kin (Grover, 2017). Among families living in the resettlement colony in New Delhi where Grover conducted her fieldwork, a "married woman's constant visits to her natal home are questioned" and the woman is suspected to not being interested in "building her marriage" (Grover, 2009, pp. 66–67). While some of Grover's male participants contend that excessive involvement of the wife's natal kin resulted in frequent conflicts between the husband, wife and the husband's agnates,

I contend that natal support during pregnancy in the form of emotional care, guidance and support- in person or over the phone - provides a crucial element in the *doing* of pregnancy in Nagar *basti*. Women who don't have female kin (natal or affinal) to take over the role of a *karnewaala* - to provide care, support and resting opportunities for the pregnant woman – encounter a very challenging situation. As Anju, one of my key informants narrates-

> *"If there are any problems in the pregnancy then the in-laws would ask for someone to be sent from the natal household of the woman. If one has nobody (for example in a nuclear family), then the husband will take care. If the husband also doesn't do it, then the poor woman has a problem. Then she alone will suffer. When one has nobody, then she has God.*
> *There's a lady in my neighbourhood and she has a very weak uterus. Her uterus could not bear the weight of the growing baby and twice she became pregnant, but then delivered in the 7th month and lost the baby on both occasions. So I spoke to the husband and said, 'If you have a sister or she has a sister, call them over for help. Because she needs bed rest'. They didn't have anyone. So I told him, 'brother, if you want to propagate your family and have an heir, you will have to care for her. Just care for her like a mother would, for 9 months'. Now they have a child. The husband cared for her. Times are changing"*
>
> *(35 year old Anju, fieldworker of a local NGO)*

This quote illustrates the significance of the support offered by natal kin in times of physical and emotional vulnerability experienced during pregnancy. For Anju's neighbour, pregnancy was a difficult time because she did not have any female kin to take over her domestic responsibilities and take care of her. In this dire situation her husband had to be motivated to step in and care for her 'like a mother', so she could have some rest. Hence, according to Anju, the husband temporarily took on the role of the mother- highlighting the significance of the mother as carer and supporter in the lives of women in the north-Indian context during pregnancy. The quote also indicates at the transformations that intra-household relationships are growing through.

6.1.3 The nature of women's work: the daily grind

Whether an individual decides to separate or continue living within the conjugal household, there are a range of household chores that need to be performed. In Nagar *basti*, with the average family size being around seven[72] there is considerable work around the house. In most households, the women's day begins with waking up at dawn to fetch water[73]. In Nagar *basti* it is usually done by attaching a rubber pipe to the public taps on the street to bring water into the premises and then filling the various containers such as earthen pots, old paint cans, cement/plastics tanks etc. In households that are too far away from the street taps, women (and sometimes both men and women) make several rounds and carry water on their heads or against their waists in earthen pots or plastic vessels. This water is then emptied into larger containers at home and then more water is fetched in this way.

Figure 6 Women queuing for water at 5 AM

When enough water is secured for the day, the women go to the jungle to relieve themselves. Subsequently, the bedding (sheets etc. used for sleeping on the floor) is cleared away and the daughter-in-law prepares tea for the household and starts kneading flour for the afternoon meal (usually a meal of vegetables and *roti*). Breakfast usually comprises of tea and sometimes a few biscuits. Water

[72] As shown by my survey

[73] In Nagar Basti, the colonies are supplied with water by the Public Health Engineering Department (PHED) for an hour in the morning and another 30 mins in the evening. The timings vary from one colony to the next and have been fixed by the PHED (between 4:00 – 9:00 AM and 5:00-7:00 PM). The financially stronger, well-established households located near the road have water connections inside the house, while the socio-economically weaker households located away from the road must physically carry water from the main road in buckets and other containers. Traditionally earthen pots were used that were locally produced, cheap and easily replaced. However, in the *basti*, people favour more durable and less heavier plastic and metal containers. In most households it is common to see an array of water containers like bottles, old cans (of paint and other chemicals), plastic buckets, canisters, etc. Further, getting a water connection involves significant expenditure since the household is expected to pay for all the material (such as metal pipes and joints) as well as manual labour required to extend the water line from the public pipe to the household. In my study, in around 54% of the households water is fetched from outside the house, while around 46% of the households have water connections on the premises.

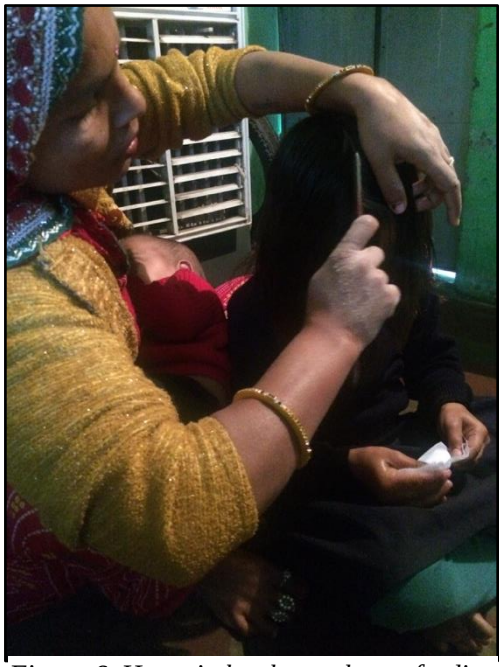

Figure 6 Hema in her home, breastfeeding her newborn infant, while getting her oldest daughter ready for school and also talking to me. She was also cooking roti for her children on the side, as can be deciphered from the flour on her hands.

is heated on the gas stove or firewood for bathing and washing. Simultaneously older children are woken up, bathed, dressed and often walked to school. Meanwhile the husband leaves for work. Preparations for lunch are also made on the side comprising of *roti* and vegetables or lentils. Thereafter the cleaning of the house commences.

Cleaning the house comprises of using a broom to sweep away dust and waste, followed by mopping the floor with a wet cloth and throwing the trash out in the street or taking it to a garbage dump nearby. In most communities in India, cleanliness of the house is believed to be essential for the prosperity of the household. It is believed that a "tidy house attracts deities, who bring fortune" (Lüthi, 2010)[74]. In slums it is common to find households living in the midst of open drains, open defecation and garbage dumps, but the inside of the house is meticulously swept and mopped multiple times a day. Since the household chores are the responsibility of women, the cleanliness of the house is considered to be a reflection of the competency of the women of the house. During my fieldwork when I visited women in the morning when the sweeping had not yet been performed, the participants were often embarrassed and lest they be judged as lazy would often provide explanations to justify the state of the house. In most households in Nagar *basti,* waste is swept outside and onto the street or into the open drain. Most participants took some pride in describing how they swept the house twice or even thrice a day to keep it clean.

[74] Like several other aspects of domestic life in the sub-continent maintenance of the house is also guided by the caste system and the associated norms of ritual purity/impurity. These ideas and interpretations of cleanliness and hygiene guide the everyday cleanliness practices (Lüthi, 2010). Physical 'dirt' as arising out of sewage, garbage, pollution and other processes are thought to be less threatening than the ritual 'dirt' as associated with the so-called 'low castes'. Hence in the words of Milner Murray, the concepts of cleanliness and purity are not completely congruent with the Western Germ Theory of Disease (Murray, 1987). For example, the waters of river Ganga are thought to be purifying for the body and soul, and many worshippers bathe in, worship and even consume it, despite high levels of chemical and biological pollutants in the water. In the same vein, the presence of a toilet in the house (because of it is association with faeces) is thought to be more ritually polluting than open defecation nearby.

After cleaning, other chores are taken care of such as tidying up the house, washing clothes by hand, putting them out in the Sun to dry, feeding and caring for babies and other work. In the afternoon children are collected from the school or the bus stop and then lunch (and the first meal of the day) is consumed. There after the utensils are washed and put away. During summers the temperatures across much of India crosses 40 degrees celsius and it is common for people (especially children and elderly) to take short siestas. Women in Nagar *basti* often spend their afternoons doing additional work such as mending torn clothes, grinding spices on stone, tightening the strings of the string bed, fetching vegetables or groceries from the local stores and other such chores. In the evening dried clothes are taken inside and put away, children sent to tuition centres or out to play, followed by beginning of preparation of the evening meal. In households which lack toilets, another round to the jungle is made by women before nightfall to avoid toilet-related emergencies in the night. Late in the evening, usually when the husband returns from work, bread is prepared and food is consumed (often after 9:00 PM). Finally before retiring, the bedding is laid out for family members on the floor or string beds.

6.2 Working during pregnancy

In joint households with multiple *bahu*s, the chores tend to get distributed between the *bahus* as do the child-rearing responsibilities (Seymour, 1999a). Tasks sometimes also get shared between the *bahu* and the *saas*, but the tougher chores remain the *bahu*'s responsibility. Despite often being physically arduous, there appears to be a consensus, among all men and most women, that household workload in cities is insignificant and not very strenuous as compared to the village. This is mainly because of change in livelihoods – which requires no agricultural labour or animal rearing or firewood collection- and easy availability of processed foods (such as wheat flour, butter, etc) which eliminates the need to perform arduous tasks such as manual wheat grinding and butter production at home. The popular cultural norms of a 'hard working *bahu*' dictate that young women often underplay the manual workload that they handle and the older women often expect the *bahu*s to handle all the tasks just like they had done in the past. My participants often commented, "of course, I do everything myself. How much work is there anyway?" or "All the work inside the house is done by us, whether it is heavy or light. Who else will do it if not me?"

As discussed in previous sections, during pregnancy the *saas* (MIL) and the *nanad* (SIL) are the primary *karnewaale*[75] for a pregnant woman in joint households. They sometimes take over

[75] Someone who provides care and support (See Chapter 5)

or assist the woman with some heavy household tasks especially towards the end of pregnancy. In my sample, this engagement of the *saas* and *nanad* usually happened only when the pregnant woman had a history of miscarriage in the past and was advised caution by a doctor. In some other households the pregnant women, despite being advised by doctors to rest, continue to be responsible for the household chores because culturally it is unacceptable behaviour for a *bahu* to be resting in bed during the day. Hence, women often continue with the same everyday work routine and activities usually until labour[76]. Many women share how they felt overwhelmed by work and wished they had received more support during pregnancy.

The presence of *karnewaale*, as discussed in the previous sections and in Chapter 5, depends on several factors such as the family size, intra-familial power relationships and socio-economic constraints. The kind of support that women receive from the *karnewaale* with her household tasks also depends on how the tasks are viewed by the family members. In the next section, I discuss how different kinds of tasks are perceived which in turn influences whether the particular task is encouraged or restricted during pregnancy.

6.2.1 Heavy versus light work

Among women in Nagar *basti*, the nature of physical work is frequently categorized as *bhaari* (heavy) or *halka* (light). *Bhaari* work includes chores that involve heavy loads or significant amount of physical exertion. Some tasks are intrinsically considered to be heavy such as fetching water, carrying a bucket full of wet clothes, carrying firewood on the head. Manual grinding of wheat to get flour on a locally made stone mill is also commonly categorized as a heavy work, although the manual mills are rarely found in urban households. The easy availability of packed flour and urban households' conscious move towards 'modernity' has all but made the stone mill a relic of the past. Nevertheless, it is still commonly brought up especially by the older women who have experienced rural life and the stone mill, and believe that all other household tasks are incomparable to the heavy physical effort required to work the mill.

On the other hand, *halka* (light) work includes chores that do not involve a lot of physical exertion. All other tasks such as sweeping, mopping, cooking, washing utensils, hanging up the laundry, shopping for groceries, taking care of children and elderly etc. are categorized as light

[76] But as discussed in Chapter 5, it is not to say that women do not expect care or support with household tasks during pregnancy.

work. There are still other chores which have an ambiguous status and fall in the middle- such as kneading flour for bread and washing clothes. Since both these tasks are performed manually while squatting on the floor, they can be quite strenuous especially in the case of large households.

Heavy tasks, because of the physical exertion involved, are culturally considered to be detrimental during pregnancy. This view was confirmed by men, women (both *saas* and *bahu*), local medical personnel and health workers. Most believe that manual lifting of heavy weights would exert pressure on the pregnant belly and push the developing baby out, leading to miscarriage or *girna* (literally, falling of the baby). This is believed to be especially common during the first 3-4 months of pregnancy, that is the *kachha* (raw) time when the baby has not yet fixed itself in the womb, or in the ninth month, that is the *poora* (full) time when the baby is almost complete. Many people promptly narrate incidences to validate this notion.

"When I was pregnant with my elder child, I carried two buckets at the same time. I was in the 9th month then. So the baby was pushed downwards and I developed pains. I had to rush to the hospital and was operated upon to get the baby out."

(Kavita, 23 year old mother of two)

Figure 7 Manual stone-mill. Wheat grains are dropped from the top and the upper wheel is manually rotated to get flour

Many women also attribute their miscarriages (which are quite common in Nagar *basti*) to manual lifting of heavy loads. This view coincides with literature from the field of Gynaecology and Obstetrics - heavy physical work and especially lifting heavy loads is medically considered to increase the risk of suffering from miscarriage and low birth-weight (MacDonald et al., 2013)[77]. The local medical personnel in Jaipur also advise pregnant women to avoid lifting heavy weights, especially buckets of water and wet clothes.

However, it does not mean that all women abandon heavy work during pregnancy or all families advise the pregnant *bahu* to avoid it. Rather, there is a wide variation in the way these

[77] The relationship between high physical exertion such as manual lifting of heavy weights and maternal and/or fetal health is influenced by several complex biochemical mechanisms. Some of these are "venous insufficiency, excessive intraabdominal pressure, ligament laxity, and increased demands on the musculoskeletal system because of fetal load" (MacDonald et al., 2013).

cultural understandings are translated into practice. Among the medical personnel, discourses of 'illiterate women' who don't follow instructions are common. Most medical personnel belong to the privileged classes who usually view the issue from a paternalistic approach.

On the contrary, I contend that pregnant women indulge in hard manual work not because they don't know better or are unable to understand the advice but rather because they believe it to have advantages. For women who go through pregnancy, dealing with "heavy" work during pregnancy is a complex issue. Even though it is associated with an increased risk of miscarriage and preterm birth, medically and culturally, certain amount of hard manual work during pregnancy is also considered locally to be essential for the baby to move around in the belly. In the absence of physical work, it is commonly believed, that the baby would remain 'stuck' at one position and not slip out easily at the time of birth resulting in a long and difficult labour or even a caesarean section. Lack of hard work during pregnancy is also believed to prolong labour as one participant describes how her neighbour suffered with labour pains for three whole days before being operated upon because she kept "lying around" during her pregnancy. Women often use a common idiom to explain this association, which can be translated as "reaping the fruits of one's hard work". In other words, the type of labour that the woman undergoes is directly attributed to her efforts and hard work during pregnancy. As a result, the kind of labour one undergoes is to some extent considered the responsibility of the woman herself and a difficult labour is often translated as an indication of a 'lazy person'.

High incidence of caesarean section births among the non-slum women are also viewed as the result of a leisurely (lazy) lifestyle. Among my participants, references were often made to the "women who live in bungalows", who often employ women living in Nagar *basti* as domestic help in their houses and therefore have no work to do which results in caesarean sections. These discourses reflected a kind of class critique where the implication was that the women living in bungalows were 'weak' and 'lazy', given all the 'resting' they did.

This discourse was used by the women in Nagar *basti* in two disparate ways- first, some women underline their divergence from the 'lazy resting woman' approach to pregnancy by working hard, to ensure an easy labour and establish their vitality and worth in the household. Some participants describe how they pushed themselves to work hard with the aim of having a 'normal' delivery. For instance, 20 year old mother of three, Heena describes how she was nervous about the delivery during her first pregnancy. Upon her grandmother's advice she put in long hours of hard work doing chores at home with the hope that it would lead to a smooth labour. Heena

ultimately had a difficult 12 hour long labour with the doctor describing her as "critical", having lost a lot of blood. When asked about why she believed she had a difficult labour she said,

> *"Heena: My condition became that bad because I took too much tension/stress. I didn't even eat much, so the condition became even worse. The doctor had told my Saas that I might not survive. My family members had started crying.*
> *Researcher: So what was the reason for your stress?*
> *Heena: It was my very first delivery (…) Thinking about the delivery- how will I manage, what will happen, things like that.*

Heena strongly continues to believe that hard manual work is necessary to achieve an easy labour, even though it did not work out well on her case. Instead, she blames the stress for her complicated delivery.

Second, in some other households the 'resting' approach is encouraged by the *saas* (by following doctors' manual work-related precautions, abiding by food aversions, taking time to rest in bed during the day). In this way pregnancy is done like the 'bungalow women' to imply 'modernity' and higher social status. In my sample only a small minority fell into this category. Apart from these, there were also some women who would have liked to do pregnancy by the 'resting' approach but couldn't because they were in a nuclear family and there were no other women to take over the work or their in-laws of did not approve of the approach.

Hard work is also preferred over rest during pregnancy, I contend, because many women believe that the harmful effects of heavy work can be reversed by medical personnel. On the other hand, from the perspective of the pregnant women, there appeared to be no possibility of reversal of the harm done by resting.

> *"When I was pregnant with my elder son, I suffered from loose motions and vomiting during the entire 9 months. Because of the pressure exerted during vomiting the baby slid downwards. I had to go to the doctor 2-3 times during my pregnancy, to get it pushed back up… I had to get the head pushed upwards."*
> *(Sushila, 32 year old mother of two, a FGD participant)*

> *"It happened in our neighborhood. There was a girl whose baby was placed low in the abdomen. She couldn't do any work. Even if she would work a little, she had to go to the doctor to get it pushed back upwards. That's how it is. It moves downwards with the pressure of the weight."*
> *(Komal, 21 year old soon to-be mother, a FGD participant)*

Hence, according to Komal and Sushila, even if heavy work pushed the baby down it could always be pushed back in. "Pushing it in" appeared to be a common method. Here, I presume women refer to Progesterone injections that are frequently prescribed by doctors to prevent premature delivery. However, if the baby got 'stuck' because of lack of heavy work during pregnancy, my participants believed that there would be no way to mitigate a caesarean section. Further, heavy manual labour is believed to be problematic only for women whose babies lie 'low' in their bellies near the exit path, although the reason for this 'low' positioning is not known by the women.

6.2.1.1 The (G)olden days of heavy work

Another interesting aspect about the nature of work, that I gleaned from my interactions with women in Nagar *basti* is that there also appears to be a variance in what is considered to be "heavy" and "light" among the members of the household. Older women who had lived in rural areas in the past, almost unanimously agreed that domestic work was no longer hard. According to them, life in the *basti* had none of the drudgery of village life - there was no manual agricultural labour work, animal rearing if at all practised was on a much smaller scale, medical facilities were much closer and numerous, and due to easy accessibility of technology much of the food processing work was no longer needed (such as grinding wheat into flour, churning buttermilk to get butter, etc). Cecilia Van Hollen (2003) in her study in semi-rural south India encountered similar narratives of "those days" when women toiled in the fields right up to their delivery. Most of these older women associate their 'normal' delivery (the commonly used term for non-caesarean delivery) with the hard manual work that they had to engage in in the village. According to the *saas* of one of the participants,

> *"Women, who just keep lying around after eating and don't work, have a difficult labour. Some are in the habit of working around the house. In their case the path of the baby remains open. But now the times are different".*

The lady is referring to the birth canal, which is believed to open up with hard work. Hence, hard manual work is believed to be essential for the health of the baby and the opening of the 'path' of the baby, ensuring a 'normal' birth. According to the *saas* of another participant,

> *"I had seven children. The day I delivered, I carried bricks on my head and the baby happened in the evening. I delivered all the children while I was working. I didn't stay at home even a single day. I did all the labour work, mixing concrete and everything. And nothing happened to me."*

Hence, according to these narratives, the ease of delivery via the birth canal was directly the result of heavy manual work, making them not just beneficial but rather necessary for a pregnant woman. These narratives become consequential because the *saas* have considerable influence over how pregnancy is done within the household, usually even more than the prospective mother herself. As a result, some MILs did not advise their *bahus* to avoid heavy tasks, because to them none of the tasks in an urban household seemed to be hard (when compared with those of a rural household).

This underrating and underestimating of women's physical domestic workloads was also seen in other studies in north-India [such as those of (Jeffery et al., 1989)] as also in other paid work in most occupational categories across the world (Cohen & Huffman, 2003). Within the north-Indian context, men (elderly and young) and women (the elderly and even some of the younger ones) downplay the domestic work undertaken by the *bahus*. "Real work is what men do" (Jeffery et al., 1989), while women are believed to play the supporting role. In a FGD conducted with some men from Nagar *basti*, it was tough to discuss women's manual workload in the household during pregnancy since many did not agree that there was much work undertaken by women in the house.

> *"When the woman thinks, 'I should do the work', then she is able to do all the work. But some women, when they become pregnant, think 'I just want to keep lying in the house all day and not work at all. My husband should do the work. My MIL and FIL should do the work. I will just lie on the bed'. Some women are in the habit of doing that" (Others laugh).*
>
> *(32 year old male FGD participant)*

> *"Researcher: So what kind of work do they not do during pregnancy?*
> *Participant: They don't do anything except eating." (Others laugh)*
>
> *(37 year old male FGD participant)*

Patricia Jeffery et al. (1989a, p. 56) came across similar narratives in rural Uttar Pradesh where they were told that women only consumed without making any financial contributions to the household. The women respond to this abnegation in two broad ways. First, by conceding to it to some extent, for example 32 year old Santosh (in her 3rd trimester) believes that "The husband's responsibility is to earn and my responsibility is to manage the household. I don't like

asking him for help with the chores". Second, by expressing discontent, for example 23 year old Pinky (in her second trimester) responds to questions about husband's help in household chores as "What will he do to help me? He even asks me to fill the bottle for him to carry for washing after defecation. He just gives orders- 'Pinky bring water! Pinky bring Soap'". Hence, the perceptions about the nature of household work as well as its division within the household varies significantly from one household to the next and so do their understandings about the benefits/harmful effects of heavy manual work during pregnancy.

6.2.2 Standing versus sitting chores

According to women in Nagar *basti*, tasks in the household are also categorized as tasks which are performed standing such as filling water in a vessel with a pipe in contrast to tasks which are performed while squatting on the floor. In the *basti,* most households have limited pieces of furniture. Most households only have wooden beds where eating, sleeping, watching television and any other activity which requires sitting is done. During the interviews I conducted in people's homes, I was usually invited to sit on the bed and the participant would sit next to me. Some other households do not have beds and usually spread out their bedding on the floor just before retiring at night and put it away during the day. Most of the domestic tasks such as cooking, kneading the dough, washing clothes, mopping the floor with a wet cloth are all performed on the floor while squatting on ones' haunches. In these households, while interviewing I would position myself in the manner the participant was sitting- either on the floor or squatting on the haunches.

Squatting is believed to ease the baby's movement towards its natural exit and hence considered to be advantageous for women during pregnancy. According to 20 year old mother of three, Heena, she was advised by her grandmother to work while squatting and avoid using a *palta* (Figure 7 - small, low stool on which one can sit to perform chores on the floor. Usually just a few inches high).

> *"Heena:I used to keep working the entire time during my pregnancies- washing the clothes of everyone, mopping the floor while squatting. Two of my kids were about to get delivered before the expected date. The doctors said, 'she has done too much work'. Then they pushed them back in with the help of an injection and asked my family members to make me sleep with a pillow under my feet and said, 'Do bed rest'.*
> *Then my nanad (husband's sister) asked me to start using a Palta. But when I used a Palta while working, my daughter was pushed up here in the chest.*

Then my Daadi (grandmother) told me, "One shouldn't sit like this, one should squat (ukdu). Then one gets a normal delivery, because of sitting ukdu".
If I sit like this for washing clothes, then it is the right way, then there would be a normal delivery. If one takes a palta, then the doctors will prescribe an operation. That's the thing. So I started working very hard, while sitting ukdu. I used to think 'I hope my delivery is normal'".

In Nagar *basti* as in other parts of Jaipur a delivery is called 'normal' (using the English term) when the baby is born via the vaginal route. In case the delivery happens via a Caesarean section it is referred to as 'operation' (using the English word). This conversation highlights the contradictions in perceptions even among women of the same household. According to Heena, she was anxious about her delivery and therefore worked hard to ensure that her delivery would be 'normal'. But too much of hard work had resulted in her baby being pushed low in her belly and had to pushed back in by the doctors. Her sister-in-law then advised her to use a stool while squatting, to prevent the baby from getting pushed out before the expected date of delivery. But, Heena believes that the use of a stool resulted in her baby being pushed too high up near the chest area. According to her, she inferred this because at the time she lost her appetite, was unable to eat food and would vomit frequently. On the other hand, the older generation of women, most of whom had experienced tougher lifestyles in their youth usually believe that women today do not work hard enough required for a 'normal' delivery. Hence Heena's grandmother advised her to squat while working and not use a stool so that her baby would be pushed downwards resulting in a normal delivery. After experiencing three pregnancies, Heena believes that she now understands how to properly 'do pregnancy'. According to her, like many other women in Nagar *basti*, avoiding hard work or easing the exertion of squatting would result in the doctors advising a caesarean section.

Figure 8 Palta (low stool) commonly used in rural and basti households for ease of sitting on the floor while performing chores

This analysis contradicts the '*basti* woman as a helpless victim' narrative popular among health personnel and both local and international development agencies implementing safe motherhood initiatives. On the contrary, Heena, like many other women in Nagar *basti*, attempt to continuously manage/regulate their pregnancy outcomes by indulging in activities that they think are beneficial for them. This also concurs with the

underlying approach of this research that pregnancy is actively and constantly performed by women.

6.3 To rest or not to rest

In case of critical pregnancy related problems such as growth problems in the developing foetus, high blood pressure, risk of preterm labour, etc., where activity is expected to worsen the situation, it is common for medical professionals to prescribe bed-rest to the pregnant woman[78]. Also referred to as 'bed-rest' in common parlance by the women in Nagar *basti*- it can range from advising frequent periods of bed-rest during the day, to complete restriction of physical activity along with strict bed rest throughout the day, to bed-rest under medical observation in a medical establishment. Within my data, collected from Nagar basti, 33% of the women interviewed were advised bed-rest by their doctors. In the context of Nagar *basti,* it offers an opportunity for pregnant women to rest during the day, which is usually elusive when one is still a young *bahu*. Being prescribed bed-rest by a doctor might also create a setting where the pregnancy related complications tend to be taken more seriously by the *saas* and by extension the rest of the family members.

Such a prescription, however, does not ensure that the woman would still be permitted or willing to rest in bed during the day. Within the local narratives bed-rest symbolizes a bio-medical, 'upper-class' and 'modern' approach to pregnancy. As a result, it is antithetical to the locally prevalent approach towards maternity, which advocates the ideology that strong babies and uncomplicated labour require hard work. Following such a prescription, thus, involves a number of impediments. Firstly- according to many women and men, bed-rest can be detrimental to both the developing baby and the mother. Especially when undertaken after the midday meal it is believed to cause the baby to stick to one part of the belly preventing it from moving around. This is believed to hamper its growth and its passage through the birth canal at the time of delivery. Hence, often such an advice for bed-rest is not conferred with a lot of importance and sometimes even completely ignored by the family.

Secondly, many older women deem it to be unnecessary since during their reproductive years, medical examination or opinion was not sought during pregnancy. Pregnancy was not considered to be a medical condition necessitating registration at the local medical centre or

[78] Although recent studies based in the Euro-American context have denied any significant effect of advising bed-rest to improve pregnancy outcomes (Meher, Abalos, & Carroli, 2007), it is still commonly advised by Indian medical personnel where the average physical work load handled by an individual is usually higher than her Euro-American counterparts.

requiring any changes in the usual work schedule. Hence, for example, during 35 year old Anju's first pregnancy, her *saas* strongly objected when Anju wanted to follow the doctor's recommendations for bed-rest during her first pregnancy. She felt that Anju was trying to escape her duties. Fearing a conflict, Anju continued performing her usual work responsibilities in the household even when she experienced discomfort and continued to do so till the very end of her pregnancy.

Thirdly, undertaking bed-rest during the day is culturally incongruent with the position of a young *bahu.* If attempted, she faces the risk of being labelled as 'lazy' or 'ill-mannered'. Just as Patricia Jeffery et al.'s informant exclaimed, "Call it necessity or whatever you like, it isn't good to sit idle in front of your *saas*" (Jeffery et al., 1989, p. 85), many participants of my study found the thought of resting in bed during the day uncomfortable, fearing how it would be perceived by others[79]. This perspective is deeply entrenched and this "looking-glass process of embodiment[80]" prevents many women from following the doctor's recommendations. According to Dennis Waskul & P. Vannini (2006), the performance of an individual is a reflection of what she believes that people around her see when they look at her. "Even though this looking-glass body is not a direct reflection of other's judgments - it is an imagined reflect built on the cues gleaned from others" (Waskul & Vannini, 2006) and in the case of women in Nagar *basti* – as among Elena Neiterman's sample of pregnant women in Canada (Neiterman, 2010) - it plays a powerful role in decision-making about how pregnancy should be performed.

These narratives of bed-rest as a 'modern', 'upper-class' and 'lazy' approach to pregnancy was also used by some women to criticize and dissociate themselves from such views (but with

[79] In Nagar basti most houses are sparsely furnished. Almost activities are performed on the floor, including sleeping for many couples. In most households that I interacted with, the only piece of furniture was a wooden (or string) bed for the parents to sleep on, while the younger couples and children slept on the floor. In some of the more settled households all the couples had wooden beds to sleep on which are sometimes shared with small children. During the interviews, while I was always offered a seat on the bed, the women whom I interveiwed- mostly the young *bahu* - almost always found it embarrassing to even sit on the bed in the presence of the parents-in-law . They would keep standing next to bed, rejecting my request to take a seat. When I would insist on sitting on the floor, so that we could both sit together for the interview, it further perturbed my hosts. Myself an 'educated', 'modern' and 'urban' female guest was perceived as worthy of a seat on the bed, but not the household's *bahu*. The purpose of describing this anecdote is to demonstrate that resting on the bed is not just a physical activity but rather associated with the status of the person attempting it.

[80] The notion of the looking-glass self, as suggested by Charles H. Cooley (1922), argues that "the process shaping the self, revolved around inter-subjectivity, seeing ourselves as we imagine others see us".

some envy towards women who could achieve bed-rest) and project themselves as 'traditional' and 'hardworking'. According to one FGD participant-

> "*I have a sister-in-law who was married into a good family (referring to high financial status). During her first pregnancy, she was not made to work. She just kept sitting around and she didn't do any work*. She was just fed on the bed. *But then she faced so many problems. At the time of delivery, she was taken to a private hospital, but her case was so serious that they refused to take her. Then finally she was taken to the government Hospital. She even lost consciousness. It was a very difficult delivery."*

In this manner, any adverse events during delivery of a woman who had undertaken bed-rest are often directly attributed to bed-rest. Hence most women knew of neighbours or relatives who complied with the doctor's recommendations of bed-rest and as a result, they believed, suffered during delivery- either had a long, complicated delivery or had to undergo a caesarean section.

6.5 Eating for two?: Dietary practices during pregnancy

The nutritional demand, in women's bodies, unquestionably increases during pregnancy. According to the World Health Organization (WHO, 1985) the increased energy requirements is estimated to be around 300 kcal per day. The guidelines for Indian women suggests an additional 350 kcal per day – through fats, carbohydrates and proteins- along with other micronutrients such as Calcium, Iron, Folic Acid, Iodine, Vitamin A, B_{12} and C (National Institute of Nutrition, 2011). To make up for the increased demand, the guidelines advice an increase in the frequency and quantity of food to attain an optimal weight gain of approximately 10 kg during pregnancy (National Institute of Nutrition, 2011).

Pregnant women in the context of several industrialized nations have traditionally been encouraged to "eat for two" to make up for the increased nutritional demands during pregnancy (Vallianatos, 2010, Chapter 5). In such contexts, the major concerns with respect to food-intake during pregnancy, as examined by Elena Neiterman (2010, p. 107) are- (1) consumption of foods that might be harmful or (2) over-consumption of food leading to excess weight gain. On the contrary, in the context of developing countries insufficient increase in nutritional intake is the major concern. According to Poppit et al. 1994, as quoted by Helen Vallianatos (2010, p. 89), who compared pregnancy among women living in the Netherlands, Sweden, Scotland, England, the Philippines, Thailand and Gambia there was a wide range of weight gain from as high as 14 kg in Sweden to a low of 6.4 kg in Gambia. In India women on an average gain only around 7 kg during

a full-term pregnancy (which is just about half of "the minimum recommended gain for underweight women in the United States, for whom national guidelines recommend gaining between 12.5 and 18 kg during pregnancy") (Coffey, 2015). Helen Vallianatos' study, which examined the diets of low-income women in Delhi, also found that that especially the low-income women were consuming far less than the Indian recommended dietary allowances of 2,500 kcal/day[81] (Vallianatos, 2010). Even in Nagar *basti,* although most pregnant women appeared to be under-weight, but gaining sufficient weight during pregnancy was not a concern for any of the participants or their family members. In the following section, I offer narratives from my interviews in Nagar *basti* to uncover the meanings and associations attached with food and eating during pregnancy among the women in Nagar *basti*.

6.5.1 *Bahu*: "the culinary victim"

Among both Hindus and Muslims, food traditions and practices – such as sharing and exchanging- constitute their "social and moral duties" (Vallianatos, 2010, p. 6)[82]. Intra-household food practices in much of the Indian subcontinent are closely intertwined with the power relations within the family. Who feeds whom, in which order, how much and what kind of foods, all have powerful symbolic meanings. The hearth is largely controlled by the women, supervised by the senior-most female, usually the mother-in-law. When food is served, the older male and patrikin[83] members enjoy precedence over the younger, female and matrikin members over the household. Very young children escape these regulations and are fed first and their taste preferences are paid attention to. But as they grow older, they become socialized into the traditional roles of men and women.

[81] Studies conducted among poor women estimate the average daily consumption to be between 1337 kcal/day to 2110 kcal/ day.

[82] Food transactions are guided by "class and caste affiliations of both giver and receiver" and the giving of food symbolizes attempts to earn social honour by feeding the poor (such as in the case of Muslims on Eid) or transference of "inauspiciousness" by atoning one's sins (such as in the case of Hindus where the receiver "assimilates this inauspiciousness") (Raheja, 1988, Chapter 4; Vallianatos, 2010, p. 7). In Hindu thought, according to (Khare, 1976) as quoted by Appadurai, "Men and gods are co-producers of food, the one by his technology and labor (the necessary conditions) and the other by providing rainfall and an auspicious ecological situation (the sufficient conditions)" (Arjun Appadurai, 1981). Therefore, food becomes the "fundamental link between men and gods" having moral and social consequences (Arjun Appadurai, 1981). As a corollary, the food transactions are guided by a set of traditional notions - about the nature of food ("hot" or "cold"), the hierarchy among the providers and acceptors, and the context in which it is served (for the family, for guests, for a wedding feast or for a death). Within most traditional families, the everyday food practices are embedded within a "complex ritual calendar of festivals" where different social contexts call for specific kinds of food (Arjun Appadurai, 1981).

[83] One related on the father's side, as compared to Matrikin, who are relations from the mother's side of the family.

In both north as well as south India the new daughter-in-law occupies the "worst stage of a female lifecycle" and becomes what Arjun Appadurai terms as "the culinary victim of her husband's household" (Arjun Appadurai, 1981). To elaborate, she is expected to take over the most labour-intensive jobs of the kitchen and, master the complex culinary codes and preferences of the household. At the same time the young daughter-in-law is fed meagrely, at the end after everyone has eaten and alone. Even within the husband-wife bond, according to the traditional paradigm, the wife is the "provider of sexual and culinary services" to the husband. She is expected to "cook and serve, he eats and criticizes" (Arjun Appadurai, 1981).

In her study, Monica Gupta asserts that decreased autonomy combined with the stresses of childbearing contribute to high age-specific death rates among women in the childbearing years (Monica D. Gupta, 1995). She demonstrates this by using data from women in the financially progressive region of Punjab who were generally found to be adequately nourished "except during the peak reproductive years" (Monica D. Gupta, 1995). This was explained by the unchanged nutritional consumption during periods of high nutritional requirements brought about by pregnancy and lactation. The scholar further proposes that the mothers' nutritional needs remain unmet most importantly because of her poor social status and autonomy in the household which result in her needs being neglected (Monica D. Gupta, 1995). Comparing north-Indian societies with the 18th and 19th century peasant societies in northern Europe, Gupta asserts that even though the latter were also strongly patriarchal with the woman's position in the household being subservient, she had considerable autonomy in running the household (Monica D. Gupta, 1995)[84]. In Nagar *basti* as well as in most traditional communities in north-India, rigid patriarchal values ensure that *bahu,* irrespective of pregnancy status, occupies the lowest rung in the extended family. As a result, the type and quantity of foodstuffs available to the *bahu* is influenced and controlled directly by the *saas*.

[84] Due to a strong emphasis on conjugal bonds rather than on the intergenerational patrikin bonds, women in peasant communities in 18th century Europe were hence better placed to meet their health and nutrition needs. On the contrary within north-Indian societies, as described by Gupta, the patrikin bonds within the extended household (both intra-generational and inter-generational) enjoy a far stronger emphasis than the conjugal bond between the woman and her husband and this the strength of the intergenerational which exacerbate the marginalization of the young married woman in her conjugal household (Monica D. Gupta, 1995).

6.5.2 Cultural perceptions about food consumption during pregnancy

As discussed in Chapter 5, within the *basti*, pregnancy is not preceded by any changes in the dietary habits of women. Unlike Elena Neiterman's Canadian participants there is no "preparation" or expectations for the women to "detox" their bodies through "special diets and make them suitable for pregnancy by taking prenatal vitamins and folic acid" (Neiterman, 2010, p. 66). Pregnancy is viewed as a "natural", fundamental and inevitable stage of every woman's life, a process that women are believed to be born to undergo. In other words, women's bodies are believed to be made for birthing and hence require no special diet or nutritional supplements. However, once pregnancy is established, the dietary habits generally align with the traditional and cultural norms of food consumption during pregnancy most of which are grounded in Ayurveda and Unani medical systems (Vallianatos, 2010). These cultural norms, however, do not play out in a vacuum but rather interact closely with the socio-economic context of the household and traditional beliefs prevalent within the region.

Hot and cold foods: Much research has elaborated on the food restrictions followed by pregnant women in different parts of the country (Hutter, 1996; Jeffery et al., 1989; M Nichter & Nichter, 1983). As discussed in Chapter 5, pregnancy, and also menstruation, is considered to be a 'hot' condition. Here 'hot' does not refer to the literal temperature or spice but rather the nature of the condition[85]. This 'heat' during pregnancy is believed to be due to "excessive heat production within the womb" (Vallianatos, 2010, Chapter 6; Van Hollen, 2003). Consuming "hot" foods in such a condition is believed to result in miscarriage. As a result, 'hot' foods are considered to be detrimental up until the 9th month milestone (after which it is encouraged). 'Cold' foods on the other hand, are considered to be beneficial during pregnancy up until the 9th month milestone (after which it might cool down the womb and delay delivery), even though there is considerable ambiguity across regions in what is considered "hot" and what is considered "cold" by nature.

Avoidance of "hot" foods is the most commonly followed dietary restriction in Nagar *basti* and it drastically reduces the nutritional diversity and often also the total calories consumed within

[85] Hot-cold concepts can be found in several cultures in South America, Africa and Asia. The two main traditional medical systems of India – Ayurveda (based on Hindu sacred texts) and Unani (traditional Islamic medicine) – both refer to the hot and cold nature of certain foods and body conditions. According to Moni Nag (1994), the local perceptions of hot and cold foods might not always correspond to the Ayurvedic classifications but rather than on the perceptions that people have about their effects on the human body. This often leads to some ambiguity in what is considered beneficial and what is thought to be detrimental during pregnancy. For a detailed account of Ayurveda and Unani medicine refer to Helen Vallianatos (2010, Chapter 6).

the already basic diet[86]. Most common foods avoided during the pregnancy due to their 'hot' nature, are high calorie foods such as jaggery, ghee (clarified butter), tea, meat, eggs, coconut, almonds, whole lentils, peanuts and other nuts. Fried and spicy foods available in the markets are also considered 'hot' and are discouraged during pregnancy. However, at the stage of completion of pregnancy or '*poora lagna*' these 'hot' foods are encouraged, to further 'heat up' the womb and induce labour and accelerate the birthing process. According to one of my respondents, Heena, "*At the end of the 8th month, I used to have ghee (clarified butter) mixed with milk, grated coconut and sugar*." Heena was given this concoction with the aim of heating up the womb and resulting in opening up of its mouth to ease delivery.

White-layer forming foods: Another set of foods that are considered to be detrimental to the ease of delivery are white foods which are believed to get deposited (*oolan*) on the baby, hampering its easy passage out of the birth canal. Buttermilk, yoghurt, milk, banana are such foods which are all usually avoided during pregnancy. According to Rekha, "*This is because it gets deposited on the baby (oolan)…this white thing on the baby. Then the child doesn't slip easily. It gets jammed and then an operation has to be done."* These notions about the foods can sometimes be seriously detrimental to the health of pregnant women who have been leading impoverished lives and are going through the additional burden of pregnancy. Especially because all the foods deemed inappropriate for pregnant women are foods rich in nutrition. The local medical and NGO staff have been attempting to break down food taboos and improve pregnancy outcomes. According to Naaya, a fieldworker of a local NGO working to improve the health of pregnant women in the area,

> *"Our NGO also started providing different foodstuffs to eat for pregnant women like fruits, coconut water and sometimes buttermilk. The women keep saying, 'my mother-in-law has asked me not to drink it'. I would say 'I will speak to your mother-in-law'. Then I carefully talk to the mother-in-law, I also listen to what she has to say, and also listen to what the bahu has to say. And during the group meetings, I would say 'here you can drink buttermilk. No one will get to know'. And to the mother-in-law I would explain, 'Aunty, nothing will happen. Those were the olden times when you would have to make buttermilk in a pitcher. These days everything happens with*

[86] Typically two meals are consumed within most households in Nagar basti. In the morning a cup of chai (tea with milk) is consumed, sometimes with biscuits or rusk (wheat biscuits). Lunch and dinner comprise of chappati (round, unleavened bread) eaten with vegetable curry or pulses. Occasionally rice might replace chappati. Most Hindu families are vegetarian and even among non-vegetarian families eggs and meat are not consumed very frequently. Fruits are a rarity and are not consumed regularly. They were viewed as an indulgence bought upon for example the doctor's advice for a convalescing family member or for a particular medical condition.

machines. So whatever you feed, if the child has to be delivered by operation, it will have to be delivered by operation. There's nothing you can do about it.'"

The excerpt illustrates the associations made between buttermilk - and other white food-stuffs such as milk, yoghurt and bananas- with a complicated delivery leading to a higher probability of cesaerean operation. The statements also indicate at the power structures within the family which prevent the *bahu* from independently taking decisions about her own diet during pregnancy.
To take the example of Rekha, who has recently given birth to her first child, to describe these intra-household power structures-

"*During my pregnancy the doctor had said, 'it is important to give her milk'. And here my Saas (mother-in-law) never used to bring me milk. And when my husband used to get it, she used to start a fight. I was just given regular food, but when I used to have chappati (traditional round, flat bread), I used to vomit. My mother keeps a buffalo in the village. I used to have milk there, yoghurt, buttermilk, rabdi (buttermilk drink), you get everything in the village. That's why I used to go to the village.*

Rekha describes that even despite doctor's insistence and her strong aversion to *roti*s, she was not provided with milk to drink. She believes that this was not just because of the food taboo, but also because her mother-in-law resented her getting pregnant against her mother-in-law's wishes. In such a scenario, Rekha then sought the support of her maternal family in the village and went off to live with them for extended time periods. Providing for the dietary requirements of the pregnant daughter-in-law, and taking into account her food aversions and cravings is a form of care provision or *seva* that most new daughter-in-laws are deprived of (as discussed in section 6.1).

On the other hand, ignoring her dietary needs and preferences is an approach commonly encountered to reinforce the power structures within the family and the *bahu*'s low status within the affinal household. According to 35 year old and mother of three, Anju -

"*When I was pregnant, nobody got me anything special to eat. Not even once did anyone ask me, 'is there anything special you feel like having'? I used to just eat the usual sabzi (vegetable) and roti. I ate whatever everyone ate. There was no difference in my food habits."*

Hence, Anju feels that she wasn't cared for by her in-laws during her first pregnancy, a time of which she has only bad memories. Anju believes that with age, more experience in motherhood and with her increasing contributions to the household income she 'changed'. During her last pregnancy, she was working as a fieldworker with a local NGO where she conducts meetings with

women in the same slums to encourage them to access healthcare for their reproductive needs. She believes that because of her work she understands things better and has grown more mature.

> *"At 15, I already had my first pregnancy. I myself didn't know what was happening to me. Then in my last pregnancy I took care of myself, ate well, and got all the examinations done. I had started understanding things. I was 23 then. Then I thought, 'Anju has changed, she will not simply obey what you say'. When one's brain is smaller, the thoughts are also smaller. As one grows up, one starts understanding better."*

Some women who did not, or could not, practice food aversions or cravings perpetuated the narrative of "the strong, traditional woman who doesn't fuss about food". Within this narrative, being selective about food, rejecting what is available or seeking what is unavailable, is viewed as being vain and pretentious, traits that are deemed to be incongruent with the position of the *bahu*. According to 25 year old Aruna- who lives in a nuclear family after being rejected by her in-laws- becoming pregnant did not bring about any change in her affinal kin. They still disliked her, didn't enquire about her health or supported her in any way during the pregnancy.

> *"Aruna: See, nobody told me anything. I do what I know and what I think is right. Neither do I go to others to ask for things. I just eat what I have and what I cook at home. I eat whatever is available. I don't do like, 'I won't eat this or I won't eat that'.*
> *Researcher: did you eat anything special?*
> *Aruna: No. Like some people crave for different things during pregnancy. I don't do that. I just eat whatever I cook. I eat everything."*

Aruna describes her unhappiness with the lack of support from her affinal kin which led her to become strong and independent. She declares that she doesn't practice food cravings or aversions and refers to it as a sensation which one can choose to ignore.

Hence in Nagar *basti,* as in other parts of the country, food imbues multiple meanings, a phenomenon termed as "gastro-politics" (Appadurai,1981). As discussed, food and practices surrounding it are often used as tools to perpetuate the power dynamics or to subvert the hierarchies within the household or as in Aruna's case to present a moral high-ground.

6.5.3 "Too much food can crush the baby"

Many scholars have explored the phenomenon of "eating down " during pregnancy due to the preference of a small baby for ease of delivery (Jeffery et al., 1989; Nag, 1994; M Nichter & Nichter, 1983). In Mark Nichter & Mimi Nichter's study conducted in south India, women thought

it was advisable to reduce food during pregnancy or consume the same quantity of food as before. Majority of participants also expressed a preference for a small baby (M Nichter & Nichter, 1983). In Nagar *basti* the respondents do not express a preference for small babies as such but commonly advise against eating "too much". According to Anju, *"people say, if you eat too much, you will crush the child. Eat in small quantities. Others say, 'oh, she eats too much. There will be some problem.'"* The notion that the growing foetus and food consumed occupy the same space in the woman's belly and hence compete for space results in the belief that too much food can harm the baby by crushing or burying the child in the belly and lead to ailments such as stomach ache, gas or loose motions. Digestive ailments such as gas formation are fairly common during pregnancy (due to hormonal changes) and this is viewed as a sign that too much food has been consumed. Hence, many women in Nagar *basti* prefer to eat less during pregnancy even though they might already be underweight.

I contend that women in the *basti* end up eating less, not just because too much food is presumed to crush the baby and hamper its growth in the belly, but also because of the unequal feeding relationships, wherein seeking more food or a larger portion by the daughter-in-law is considered dishonourable or even misbehaviour and does not conform to the traditional role of a daughter-in-law. She is expected to perform service or *seva* towards her affinal kin in the form of cooking and serving them food (Arjun Appadurai, 1981; C. Snell-Rood, 2015). Her role as a subservient 'carer' also directs that she eat last and whatever is left (Arjun Appadurai, 1981) without expecting to be served in return. Some scholars argue that *bahu*s, by "sublimating their own physical desires" and putting others' needs first, display their "moral superiority" and devotion in an attempt to gradually gain higher status (Menon & Shweder, 1998, p. 183; C. Snell-Rood, 2015). Susan Wadley offers the example of fasting/religious vows or *vrats* performed by women with the same intent (Wadley, 1983). Usha Menon and Richard Shweder also describe how the self-abnegation, which might be viewed as "deprivation" in a western perspective, but among their Hindu participants was a way to cumulate "moral authority" and by the time she is senior "no man in the family equals her in moral stature" (Menon & Shweder, 1998, p. 184). As a result, insufficient weight gain was not perceived as a concern by any of my study participants.

6.4 Dealing with health care system

Even though pregnancy is normalized among the families living in Nagar *basti* and many *saas* are still of the opinion that pregnancy-related health events require no medical intervention,

pregnancies are becoming increasingly 'medicalized'. As discussed in chapter 5, the performance of pregnancy is rapidly transforming – most pregnancies are registered with some medical facility, women attend antenatal examinations[87], sometimes seek treatment for serious pregnancy complications such as bleeding, and usually prefer hospital delivery as compared to delivering at home. Even though the women still underplay their general health complaints (especially of non-reproductive nature), visiting a medical facility at least once to seek prescriptions for an ailment during pregnancy or attend a routine antenatal check-up is considered 'normal' and even essential. Maya Unnithan-Kumar, in her anthropological work based in peri-urban and rural Rajasthan, also reports widespread use of faith healers, 'indigenous' specialists (such as Ayurvedic and Unani practitioners) and traditional midwives for reproductive health complaints such as menstrual disorders, vaginal discharge, inability to conceive and suspected miscarriages among others (Maya Unnithan-Kumar, 2002, 2003, 2004a). My participants, mostly urban young women, did not bring up faith healers or 'indigenous' practitioners in their narratives.

When pregnancy is suspected, women in Nagar *basti* usually visit the maternity hospital located around 5 km away, where pregnancy is confirmed, followed by registration and receiving a Mother and Child Protection Card - official document recording the personal data of the woman (Appendix). The woman then receives counselling regarding antenatal check-up (ANC) visits. Government of India's National Health Mission (NHM) prescribes a set of guidelines including a range of tests that each pregnant woman is expected to undergo free of charge and a minimum number of visits that each pregnant woman is expected to make to a public health facility. Apart from these visits, the woman is also expected to register herself at the local Anganwadi in her area. The Anganwadi worker and the ASHA together are supposed to offer regular weight monitoring of the pregnant woman, complementary nutrition in the third trimester, referral services and accompanying the pregnant women to the hospital during delivery or other emergencies (Kapil, 2002). Not all women in Nagar *basti* follow all the guidelines put forth by the National Health Mission, but almost all have had at least one check-up visit.

[87] According to the NHM guidelines every pregnant woman is expected to undergo at least 3 ANC visits at the Maternity hospital during which she would be undergoing several examinations including urine examination for Sugar and Albumin, blood examination for Haemoglobin, blood pressure, weight gain monitoring, abdominal examination, tetanus toxoid immunization, Iron-Folic Acid supplements and Ultrasound examination.

The national government sponsored Janani Suraksha Yojana (JSY)[88], which provides cash incentives to women who deliver in a medical facility, has been a major contributor in this increasingly medicalized childbearing experiences (A. Gupta et al., 2018). The objective of the program is to reimburse out-of-pocket expenditure incurred during delivery, post-delivery care including transport to and from the medical facility for delivery (Roalkvam, 2012). The ultimate aim of the scheme is to bring down the mortality rate among the mother and child during the perinatal period (Lim et al., 2010). To avail the financial benefits, the woman should have had the prescribed three ANC visits to the local hospital where she is registered.

The JSY and the larger National Health Mission, under which the JSY functions, have been debated intensively from many perspectives. The development discourses discuss the State's perception of development as a 'welfare activity' and the government's viewing of the poor women in particular in a humanitarian light (Arima Mishra & Roalkvam, 2014). The discourse also views the JSY as a "market-like structure" which "regulates female citizenship" and where the "key agent of change is not the health system (the supply side), but rather the individual pregnant and birthing woman (the demand side)" (Roalkvam, 2012). Sidsel Roalkvam also suggests that the program, like other similar interventions, projects a complex political issue as a purely scientific or technical issue which can be solved by transparent, objectively measurable indicators (Roalkvam, 2012). The medicalization critique laments the "medical gaze" which views the pregnant woman as a patient and shifts the control away from the mother (Van Hollen, 2003). Epidemiological literature has focused on the impact of the program on maternal and child health outcomes such as maternal and neonatal mortality (Lim et al., 2010). Although such literature allows impact assessment of the program based on the objectively defined indicators, it offers little insight into the actual experience of the beneficiaries.

[88] Launched in 2005, JSY (translated as safe motherhood scheme) is one of the largest conditional cash transfer programs in the world and reached 9.5 million beneficiaries in 2010 (Lim et al., 2010). In the basti, JSY is implemented by the Accredited Social Health Activist (ASHA), the community-level health worker. According to the guidelines, ASHA is responsible for identifying pregnant women and "should provide or help women to receive at least three antenatal care visits, arrange immunization of the newborn baby, do a postnatal checkup, and counsel for initiation and continuation of breastfeeding" (Lim et al., 2010). After the delivery in a government or accredited private health care institution the mothers in the high-focus states (which includes Rajasthan) receive 1000 Indian Rupees (approximately 12 €) in urban areas and 1400 Indian Rupees (approximately 17 €) in rural areas. The ASHA also receives an incentive of 200 Rupees (approximately 2.5 €) in urban areas and 600 Rupees (approximately 7.5 €) in rural areas for every in-facility delivery assisted.

Anthropological literature fills this lacunae by examining the demand side experiences – of pregnant and birthing women availing the program (Chaturvedi, De Costa, & Raven, 2015; Arima Mishra & Roalkvam, 2014). Arima Mishra and Sidsel Roalkvam explore how the women, although use the "language of tonics, injections and check-ups" to participate in the "discourse of modern medicine", but have become increasingly alienated from their own childbearing processes which have now become institutionalized (Arima Mishra & Roalkvam, 2014). The authors have also criticized the Program's 'one size fits all' approach which focuses on narrowly defined outcomes (Roalkvam, 2012). Several studies have also identified several structural problems in the delivery of care such as- poor quality of care offered, execution of unnecessary practices, misbehavior of staff (Chaturvedi et al., 2015; Roalkvam, 2012) and pressurizing for permanent or temporary sterilization (Hollen, 1998).

In this section, I examine how women in Nagar *basti* interact with public and private maternal health services. While doing so I align myself with scholars mentioned above and maintain that reproductive health and rights cannot be separated from the larger socio-economic context and power structures of the society (Roalkvam, 2012). Using ethnographic data, I intend to explore how the various health agents and agencies- the Anganwadi, the Maternity hospital, ASHA and private hospitals - are perceived and engaged with at the household and community level. I do this to display how women's concerns for childbirth and child survival, their roles and responsibilities within the household, and their notions of health and well-being interact with the various parts of the public and private health machinery to affect each individual differently.

6.4.1 The Hospital as the protector

Women in Nagar *basti* increasingly have access to a wide variety of healthcare providers– public and private hospitals based on modern medical science, local clinics offering modern medicine, clinics offering indigenous medical sciences such as Ayurveda and Unani, and faith healers and exorcists. Women, like Cecilia Van Hollen's participants from south-India (Van Hollen, 2003), rely on both biomedical knowledge and technology (for instance for pregnancy confirmation), as well as non-biomedical / popular notions and perceptions of health and the body. The State's fervent thrust on 'maternal health' and its promotion via electronic media and state health employees - such as Anganwadi workers and hospital staff - have made the government's safe motherhood scheme distinctly visible in the rural as well as urban areas. As my key informant Anju describes, *"No matter which channel you watch, every 5 minutes there is an advertisement about*

the pregnant woman. Now everyone has become aware". In Nagar *basti*, most women rely on the public maternity hospital - for confirmation of pregnancy, registration, examinations (blood, urine, and ultrasound) as well as delivery - and the local Anganwadi - for immunization, Iron Folic Acid supplements and weight monitoring. Not only are these services free of cost but also the documentation demonstrating that at least three ANC visits were made, is a prerequisite for availing the JSY cash transfer at the time of childbirth.

In Nagar *basti*, the healthcare machinery is viewed as the 'protector', especially during childbirth (Arima Mishra & Roalkvam, 2014). According to 20 year old Anushka, going through her first pregnancy-

> *"Researcher: Where do you plan to get your delivery done? Have you thought about it?*
> *Anushka: Not at home. We will get it done outside, in a hospital. Because there can be some problems, since it is the first delivery. It is not right to get it done at home. The doctors were also telling us to get it done outside. If not in the hospital, then where else? There are facilities there. And it was the first child, what if there was a problem..?"*

According to Anushka's *saas*-

> *"The facilities that one can get in the hospital, one cannot receive at home. At home, they (traditional birth attendants) will do whatever they feel like. What if one dies? In the hospital, government provides for everything. It becomes their responsibility."*

Many men and women perceive the hospitals as their savior from the dangers of death during childbirth. According to Anushka's *saas*, "*these tests and infections ... all these things were not there in our times".* In other words, modern dangers such as "infections" required modern remedies which could be provided by modern health facilities. These dangers were perceived to be beyond the scope of traditional birth attendants, the *dai*, who have traditionally been responsible for conducting home deliveries. This goes against Maya Unnithan-Kumar's findings among the new migrants residing in KN *basti* in Jaipur who preferred the first-order births to take place at home and then subsequent ones in a medical facility (Maya Unnithan-Kumar, 2015).

Access to the NHM's services – such as cash incentives, free hospital deliveries, iron-folic acid supplements, ASHA's counselling, weight monitoring etc. – also "inscribes citizenship status" (Arima Mishra & Roalkvam, 2014) on the *basti* women's bodies. Being marginalized in most aspects of socio-cultural and politico-economic life in the *basti*, the NHM views women as the

primary stakeholders and offers the (often only) opportunity for political membership. As a result, participating in the NHM's activities is locally viewed as a sign of progress. During my interaction with women, they proudly displayed documentation (often a combination of registration cards, examination results, payment receipts) accrued over months of medical facility visits to illustrate their participation in modernity and citizenship. Maya Unnithan-Kumar takes the example of the Ultrasound scan the use of which has expanded rapidly in Rajasthan, as in other parts of the country, in the last decade and is now increasingly at the centre of a 'modern' pregnancy experience (Maya Unnithan-Kumar, 2004a, 2010). She further asserts that the *basti* women's interactions and expectations with the scan are very different from that of a woman based in the Euro-American context. The former is more concerned about the social security and improvement of social status brought on by the confirmation of pregnancy (Maya Unnithan-Kumar, 2010), while for the latter it is an essential part of pregnancy where the baby is introduced to the parents and "personhood" is conferred to it (Kroløkke, 2010). Even though the *basti* woman is not invited to get involved in her scanning process and is often offered no explanation about what is playing out on the screen (which is often turned away from her, unlike in the euro-american context), the scan is still extremely sought after. The author suggests that the reasons for this are that the scans are essential to ensure that the baby is "alive" which the sonographer "like God" bestows on the parents; they are non-expensive and non-invasive; and can be easily accommodated with non-biomedical notions of the pregnancy such as faith-healing (Maya Unnithan-Kumar, 2004a).

6.4.2 Private preference

Indian's preference for private health services has been well documented (Jeffery & Jeffery, 2010a; Radwan, 2005; Rani & Bonu, 2003). Despite all the promotion of public facilities by the State, private facilities continue to remain popular among the urban poor. According to Manju Rani and S. Bonu's pan India study, rural women in several states prefer private practitioners for gynaecological symptoms (Rani & Bonu, 2003). In the poor states, the dysfunctional public sector fails to fulfil the health needs of the people and the private sector is the only option, while in the relatively richer states the population prefers private facilities even though public ones are available (Radwan, 2005). I Gupta et al., in their study based in Delhi, also found that even though government hospitals are subsidised for the most economically vulnerable households, they are utilized mostly by the middle and high income groups, while the poorest households utilized mainly private facilities (I. Gupta & Dasgupta, 2000). As described by Ergler, Sakdapolrak, Bohle, &

Kearns (2011) among *basti* residents in Chennai, south India, private hospitals are considered to be more effective and have better facilities. According to one of their respondents people believe that they were getting cured faster, because they were paying more (Ergler et al., 2011).

Similarly, many families residing in Nagar *basti* prefer private medical facilities despite their limited financial resources since they are perceived to be of better quality. For example, according to 30 year old Seema, who had recently given birth to her third child-

> *"If one has the money then private or else in public. One of my nephew's wife is pregnant and I said to them, 'If possible go to a government hospital. Everything gets handled well there.' First they said, 'No, we have enough money. We will get it done in private.' But then they went and asked the charges- Rs 21,000 (approx. € 261) for normal and Rs 50,000 (approx. €622) for caesarean. Now they have decided to go to a government one. Sonography in private is Rs 1100 (approx. € 14), whereas it is free in government hospitals."*

Even though Seema advised her nephew and his wife on the advantages of public medical facilities and shared her positive childbirth experiences at the public hospital, the family still wanted to get their *bahu* delivered in a private hospital. Only after the costs were inquired and they were considered to be prohibitively expensive, did the family settle for a public hospital. Similarly, medicines purchased from a medicine store are perceived to be more effective than the generic pharmaceuticals provided free of cost at public healthcare facilities. According to Seema –

> *"I have a sister and she had twins, a boy and a girl. Now the girl has some slight problem with her legs, they are bent and she can't walk normally. But the son is fine and there's no problem with him. She has been advised to give calcium supplements to the children because both the kids are deficient in calcium. So she says, 'I will give the government supply supplements to the son and the private expensive ones to the daughter.'"*

Though both her children were diagnosed with calcium deficiency, she reasoned that her daughter was in a more serious condition and required better quality drugs. This indicates at the effectiveness associated with private[89] high-cost services as well as medicines. Personnel in private facilities are

[89] 'Private' is commonly used by people (also while speaking Hindi) to refer to services which are perceived to be of better quality because they require payment as compared to the free, but 'unreliable' government services. During my interactions participants frequently exhibited predilection towards 'private' schools for their children despite several public schools in the neighbourhood; 'private' sewer cleaners for the cleaning blocked *basti* drains when government cleaners don't respond; 'private' toilet construction when the government toilet construction

also usually believed to be more attentive and polite to the patients than their government counterparts. Getting scolded and shouted at by government hospital staff had been experienced by many of my participants.

For many families residing in Nagar *basti* selecting a private hospital for their *bahu'*s delivery is also a means to project a high social status. Due to high user charges, these services are not affordable by everyone and therefore access to them is viewed as a sign of high socioeconomic status. Only when the prices turned out to be prohibitively expensive did they resort to a public hospital.

However, Seema's own pregnancy experiences were drastically different-

> *"One of my employers works at the accounts department in J. K. Lone (public women's hospital), I wash clothes at her place. She said, 'Everything will be alright. Even if there is an operation, I will get everything managed well'. She stayed with me during the entire delivery. She was a big help for me.*
> *So you can say, I followed her views. I took her advice on every issue because she is older and she works there, she has a lot of experience dealing with doctors, etc. She said, 'there is nothing to worry about. I am there with you, beta (term of endearment for a child). No matter what happens I will handle it'. I'm so thankful to God. Even the nurse that I was allotted was so good. She really supported me all throughout, giving me courage."*

Seema's experience with public medical facilities was extremely satisfying. However, no other participants reported such positive experiences. I suggest that her experiences were largely affected by the moral support and reassurance received from her employer. Her employer, who also worked at the hospital, had knowledge about the workings of the systems and had her own networks among the hospital staff which contributed greatly to make Seema's experience pleasant. The doctors spent time in offering her explanations about her condition, she was treated well because she was known to a staff member, she did not have to worry about malpractice and constantly received reassurance for her employer. Like Margaret Lock and Patricia Kaufert's "Pragmatic women" (M. M. Lock & Kaufert, 1998, Chapter 1), Seema examined the pros and cons and weighed them against her options and took a pragmatic decision based on what she thought would be best for her.

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subsidies do not reach the family; even 'private' Aadhar card application when the household is unable to apply for an Aadhar card by regular government centres.

In a way, she also utilized her networks to achieve a 'private' treatment at a public hospital. She exemplifies that women in *bastis* are not just "passive vessels, simply acting in culturally determined ways with little possibility for reflection on their own condition" (M. M. Lock & Kaufert, 1998, Chapter 1).

6.4.3 "If it's an urgent problem, I go to private"

Another justification offered for using expensive private services is that they offer urgent resolution of the problem. Nagar *basti* has one private medical centre located less than a kilometre away and several small clinics on the main road whose clientele is made up primarily of Nagar *basti* residents. Even though private hospitals charge consultation fees and one is expected to buy medicines from a pharmaceutical store, they are sometimes preferred over government hospitals (with no consultation fees and free medicines) for urgent (but not too grave) ailments. These medical facilities can usually be accessed without spending too much time. As 25 year old Aruna, in her third trimester describes-

> *"Aruna: During my pregnancy, I have had the problem of gas formation in the stomach. So I have visited both private and government hospital. If there's too much problem, then I go to private here in Raamganj.*
> *Researcher: Why is that?*
> *Aruna: Actually government one has a lot of crowds and your turn never comes, and you might not be able to see the doctor at all. In a private one, one pays and gets examined by the doctor. In government hospitals, if you can pay a bribe to the guard, then he will let you go in. I keep standing in the queue, but some people pay the guard. Some people have connections with the hospital staff and they are allowed to go in. One who doesn't have connections, they helplessly keep waiting in the queue. That's why I go to private."*

For Aruna, who lives with her husband and 2 year old daughter, the time required to get oneself examined by a doctor in a government hospital, inefficiently managed patient flows and the corruption of the non-medical staff were problematic issues. Her husband is a priest in the local temple and conducts his temple duties from early morning till noon. Aruna especially laments making her 2 year old daughter wait in the long queues at the hospital for hours. Hence, she often chooses to visit the private hospital in the vicinity for her pregnancy-related digestion problems. Relatively high user charges in this hospital ensures shorter patient queues and the assurance that the visit would culminate in examination by medical staff. On the other hand, visiting a government hospital in Jaipur can often take up a few hours with no guarantee that the patient would be seeing

medical personnel that day. It is common for a patient to spend a considerable amount of time being directed from one queue to another- first general registration, then the particular department, then for a test. Often a patient might have to go around the hospital waiting in different queues, and in the end be told that the doctor's shift has ended and they might have to return the next day. Like Aruna, many pregnant women in Nagar *basti* use a combination of facilities- public hospitals for the ANCs and delivery, and private hospitals and clinics for other ailments. In the process, Aruna saves time and effort even though it involves extra costs.

Private hospitals are also often the only recourse when childbearing deviates (or is perceived to deviate) from the normative maternity approved by the NHM and the State. For example, Heena's (20 year old, mother of three) first pregnancy happened when she was still in her mid-teenage. The legal age of marriage for women in India is 18 years, even though child marriage rates in the country remain significant[90]. The State's version of approved maternity, therefore, necessitates the mother to be older than 18[91]. Even though by law, medical personnel cannot reject a patient on the grounds of her age or parity, underage patients are frequently reprimanded in government facilities for marrying and carrying young. According to Heena –

> *"Heena: During my first pregnancy I was so thin, like I would just die. I was in a very bad condition during those days. The doctor in the private hospital had told my saas 'there would be a legal case if you take her to government hospital.' So I was taken to the private hospital for my first 2 deliveries.*
> *Researcher: Because you were underage?*
> *Heena: Yes. Only when I was pregnant with my youngest son did I become an adult. He was delivered in a government hospital, otherwise the first 2 happened in a private hospital."*

[90] Child marriage rates among women in some districts in Rajasthan are as high as 47% despite the Government's ban on child marriages (UNICEF, 2018).

[91] Even the erstwhile eligibility guidelines (uptil 2013) to avail the State sponsored JSY cash transfer in high-performing states (with better human development indicators) necessitated the mother to be 19 year or older and could only be availed for up to 2 live births and only if the delivery happened in a government or private accredited health facility. In low-performing states such as Rajasthan financial assistance for institutional delivery is available to all pregnant women regardless of age and parity, but only for deliveries undertaken in a government or private accredited health facility (Ministry of Health and Family Welfare, 2013). Deliveries that did not fall within the eligibility guidelines – such as those undertaken at home, or for the 3rd birth or when the mother was under 19 years – were all excluded from the scheme even though they might be the most vulnerable. The eligibility criteria was changed in 2013 to include all women irrespective of age and parity (Ministry of Health and Family Welfare, 2013).

Because legally Heena was still a minor at the time of her first and second delivery, Heena's in-laws preferred to consult a private hospital instead of a government facility. There the family was further discouraged by the doctor against visiting a government facility by (falsely) citing legal repercussions that they might have to face. The family therefore decided to continue consulting the private hospital for her first two deliveries. It is common for legally "under age" pregnant women to lie about their age in public hospitals to avoid getting reprimanded. In this manner, the State's guidelines which aim at reducing child marriage result in a narrow definition of maternity and end up excluding the most vulnerable of women.

During her third pregnancy, Heena legally became an adult and could finally without fear of admonishment access public health facilities. According to her they were told by the doctors at the private hospital that her baby is *ulta* (reverse position) which could refer to both upside down or front to the back. They were also told that because of the baby's *ulta* position the delivery would be 'complicated' and would have to be performed surgically via a Caesarean section. Fearing a complicated surgery and high delivery costs the family then decided to go to a government hospital. Ultimately, Heena underwent her third delivery in a government hospital and did not require a surgery. Hence, women and their families negotiate through the pluralistic health system pragmatically, availing what they believe is best for them. Institutional deliveries are increasingly becoming the norm resulting in reduced mortality rates. However, the lived childbirth experience of women in government hospitals still remains under-examined.

Much has been written about the 'slum woman's' relationship with the State health machinery in general and for gynecological needs in particular. As discussed, socio-economically marginalized communities in India generally prefer expensive private healthcare facilities over free (or less expensive) public healthcare services (Ergler et al., 2011; I. Gupta & Dasgupta, 2000). The reasons for this are multiple and complex, such as – overcrowding in the outpatient departments, poor infrastructure, inconvenient opening hours, waiting time, perceived effectiveness of the treatment provided (Ergler et al., 2011; I. Gupta & Dasgupta, 2000). Further, socio-economic inequalities – of class, caste and gender- between the hospital staff and the women from *bastis* seeking treatment, result in gross power asymmetries within the patient-provider relationship, which in turn affect the quality of patient-staff interactions (Chattopadhyay, Mishra, & Jacob, 2017; Dey et al., 2017). Patricia Jeffery and Roger Jeffery in their paper based on their study in rural north-India observed the public healthcare staff in the area and described them as "rude and inattentive to their duties even in an emergency" (Jeffery & Jeffery, 2010a). They also described

how they constantly underlined their superiority over uneducated village women (Jeffery & Jeffery, 2010a). They also mentioned that "they would chide women publicly for their inadequate mothering and poor hygiene practices, they would ignore patients rather than disengage from chatting with their colleagues (and us), they would talk patients down rather than listen to their narratives."

My interaction with the head of the department of a local public hospital highlighted how medical professionals are also products of the socio-cultural milieu and do not function in an objective medical vaccum. When discussing women's heavy work routines even in the final stages of pregnancy, Dr Meena, who's primary clientele in the hospital are *basti* women, vehemently agreed that heavy work has a positive effect on ease of delivery, even though it does not have a scientific backing and may actually be detrimental to women with a difficult pregnancy. Dr. Meena also claimed that a tight schedule of *basti* women of waking up at 5 AM to fetch water for the household keeps them "active and on their feet" and without which the women would go lazy. Such narratives were also common among the mothers-in-law and potray the young women as uninformed and lazy who need the pressure of work to keep them organized, disciplined and in shape. These narratives also highlight the disalignment between the medical personnel and the people they are expected to cater to.

6.4.4 Navigating through the medical system

In the area of maternal and child health, the excessive and narrow focus on institutional delivery, driven by the MDGs, has contributed towards reducing the notion of a successful childbirth as "survival of the infant and the mother" (Chattopadhyay et al., 2017), placing almost no importance on the quality of the delivery. A growing body of literature has been trying to highlight this gap and emphasizes specifically on women's lived experiences in public healthcare facilities especially during childbirth (Chattopadhyay et al., 2017; Dey et al., 2017; P. Jha et al., 2016; Raj et al., 2017; G. Sen, Reddy, & Iyer, 2018) . Studies suggests rampant mistreatment experienced by women such as "direct abuse (physical, sexual or verbal), discrimination, failure to meet professional standards of care (non-consensual or non-confidential care, neglect or abandonment, and in- adequate or poor quality medical resources), and non- supportive care" (Dey et al., 2017). Gita Sen et al. (2018) also report the rampant use of unnecessary procedures such as episiotomy (cut at the perineal site), lack of privacy and disallowing of companionship during childbirth. The discrimination and disrespect

faced by socio-economically marginalized groups are so widespread and normalized that it is often not recognized as mistreatment (G. Sen et al., 2018).

Among the women in Nagar *basti* as well, there seemed to be a strong preference for private maternal health facilities despite the high economic costs involved. The most common reasons given by *basti* residents for preferring private hospitals over public ones are – shorter patient queues, less bureaucratic processes and better staff behavior. Sometimes a combination of hospitals are utilized – public hospital for antenatal care and private hospital for delivery. The birthing context in Nagar *basti* is vastly different from the childbirth experiences among the privileged communities in urban centers as well as from those of traditional communities in rural India. The *basti* women's experiences are also different from those of their mothers and mother-in-laws. In the succeeding sections, I try to explore how women in Nagar *basti* fulfill their healthcare needs towards the end of their pregnancy and how these experiences are shaped by their unique socio-economic contexts. I turn to the experiences of two of my respondents, Radha and Seema, to illustrate women's perceptions and expectations with respect to healthcare during childbirth and how these assist them in deciding the institution for their delivery.

26 year old Radha, who migrated to Nagar *basti* two years ago, recently gave birth to her second child in a private hospital. Her sister-in-law's maternal experience as well as an uncomfortable encounter with a doctor influenced Radha's perceptions about government hospitals.

> *"In my sister-in-law's case, when her pains started she went to the hospital in the morning. But she was asked to go back home and come back at 5 PM. They said, 'the delivery won't happen anytime soon', even though she was in a lot of pain. Then she delivered at 3 PM only. So seeing her I didn't want to go to the doctor.*
> *[…] When I was carrying my son, I went to the doctor for medicines. When I am pregnant, I am in a very bad condition. I am unable to eat and then there is some problem with my nerves and I am unable to stand. […] So when I went to the doctor, he said, 'you will have even more problems'.*
> *When my labour began we went to the government hospital and got registered. The staff told me to get admitted. By then my water was flowing, but my pains had gone. There were 2-3 other women there who were in a lot of pain and were not able to deliver their baby. I got scared looking at them. I was getting troubled. Then I thought, till the time my pains won't get stronger, the doctor won't give me the injection to further the labour. So I didn't even wait for the doctor to examine me. I said to the Anganwadi didi (local healthcare worker from the basti who usually accompanies the delivering woman to the hospital) who was accompanying me,*

'Didi, I am not getting any pains. Let's go to a private hospital'. Then I went to Vinayak hospital. I had to spend 12,000 Rupees (approx. 148 €)."

Radha lives in a rented accommodation with her husband and three children and does not have other female kin in Jaipur. Her husband works as manual labour at a construction site, while Radha is a homemaker. In the past, Radha had not had positive experiences with the public maternal health institutions. When her sister-in-law went into labor and wanted to get herself admitted to the hospital, she was asked to return later, but her delivery happened before the estimated time. During Radha's last pregnancy, when she visited the hospital, she was told that her condition would become even worse. As a result, she was scared and anxious for her own delivery, even though she had been through childbirth twice before. She had so little trust in the public hospital that she decided to get herself discharged from the maternity ward while she was in labor and get herself admitted to a private hospital. She preferred to pay a large sum of money (more than the monthly income of her household) and forgo the financial incentive paid by the State to women who undergo deliveries in public facilities.

Radha's example highlights some pertinent issues and faults within the financial incentive scheme. Radha defies the commonly held narrative of the 'poor *basti* woman' and took charge of the decision-making even while she was in labor. The discomfort of the women around her in the maternity ward made her anxious and she knew that her pleas for medication to further the labor would not be heard. Hence, without waiting for the doctor to examine her, she requested the health worker from the *basti*- who was accompanying her- to take her to the private facility nearby. Radha, also possessed the knowledge that till her labor pains are not stronger, she wouldn't receive any attention or intervention from the medical staff. She wanted to fasten the process and wanted her intentions be heard by the staff, which wouldn't be possible in the public hospital. She hence decided to act on it even without waiting to consult with her husband.

On the other hand is Seema, works as a washerwoman in middle-class homes in the neighborhood and lives with her in-laws. Her family have been in Nagar *basti* for decades and live in their own two-storied house. She narrates her experience of her third delivery which happened a few months ago.

"*There's a lady who works in the accounts department at J. K. Lone (public hospital), I wash clothes at her place. She said to me, 'everything will be alright, eat everything without worry.{…} Even if there is an operation, I will get everything managed well.' She stayed with me during the entire delivery. She was a big help for me.*

So you can say, I followed her views. I took her advice on every issue. Because one, she is older and second, since she works there, she has a lot of experience dealing with doctors.
In the beginning we didn't know there would be an operation. It happened because my blood pressure shot up and the baby went unconscious. The doctor discussed everything clearly and said that either the baby or the mother might lose their life if we continue the normal delivery. So my Saas who was sitting outside took the decision and said, "we want both to be safe. We don't have a problem with an operation."

For Seema, the experience of a public hospital was drastically different from that of Radha's. She had the support of an 'insider' who guided her throughout her pregnancy and ensured that Seema was looked after well at the hospital. As she went into labour and developed complications, her employer- who also worked at the same hospital- ensured that they received a clear explanation of the problem. While she was in the maternity ward her family sat outside and took the decision of going ahead with a C-section based on the doctor's advice. She also had female kin at home (her MIL and the wife of her brother-in-law), who supported her and took over her responsibilities while she recuperated from her surgery. As a result, Seema was so satisfied with her experience at the public hospital that she is now a strong advocate for public hospitals in her family.

Hence, even within Nagar *basti*, women's experiences with the healthcare system are diverse. An individual's specific socio-economic constellation determines her choice of facility for childbirth and her experience within a medical institution. Even when reproductive healthcare services are largely profit-driven and impersonal, women in Nagar *basti* learn to take charge, negotiate and take from the system what they believe would be best for them.

6.6 Conclusion

I first examine the intra-household micropolitics to analyse how the everyday doing of pregnancy is intertwined with the domestic activities such as managing relationships, handling chores, eating, resting and seeking healthcare. The change in household dyamics brought on by the pregnancy sometimes leads to breaking down of the large extended family constellation into smaller nuclear units which might not necessarily be positive for the pregnant woman. I use narratives from my participants to demonstrate how women sometimes benefit from and sometime loose out when they decide to separate from their extended marital household.

I also examine in detail women's domestic work and how it is perceived and categorized within the *basti* worldview. Perceptions about the different kinds of domestic work (heavy, light,

sitting chores, standing chores) then influence whether a certain chore is encouraged or restricted during a specific stage of pregnancy. Popular norms and traditional knowledge combine with bio-medical information gleaned from health personnel, family members and acquaintances, to influence women's pregnancy practices. But my participants' accounts also highlight that these perceptions are not uniform among the sexes and age-groups within the *basti*.

Food and resting habits are also highly political issues within the household, for women are expected to not bring too much attention to themselves and not seek special treatment. Complaining about ill-health and seeking care does not align with the traditional narratives of women as strong and natural birth-givers. This often prevents women from indulging in self-care such as seeking special kinds of food or bed-rest during the day or even healthcare. This starkly contrasts with the urban priviledged narratives of self-care when women are expected to take special care of themselves and the unborn child by doing things differently.

In the final section, I examine the relationship between the pregnant *basti* woman and healthcare institutions. My data shows that women share complex relationships with hospitals. On one hand, some view them as saviours who can ensure a safe childbirth and salvage the situation in case of any medical complications. On the other hand, there is also considerable amount of distrust and wariness making women dread medical intervention. Women navigate through these complex situations pragmatically, sometimes abiding by the advice and other times resisting and overruling it with whatever resources are available to them.

Chapter 7 - Looking forward to the baby/ delivery

> *"In the afternoon her labour was beginning, but she told no one until she had finished her work. She prepared the evening meal, served it to her husband and toddler daughter, and scoured the dishes at the hand-pump outside her house. Several days ago she had tidied her house, removing from under the bed items which might be contaminated by the birth, and set aside some old rags for cleaning up once the baby was born. Now she quietly informed her mother-in-law whose house abuts her own, and retires inside."* (Jeffery et al., 1989, p. 2)

This section from Patricia Jeffery et al's pioneering work on the experience of pregnancy in a rural north-Indian agrarian community illustrates the intersection of women's experiences of childbirth and household chores that still holds true for many traditional communities in India. Although childbirth in Nagar *basti* is relatively modern, with most families opting for institutional delivery, the socio-cultural milieu is still strongly traditional. The childbirth is still traditionally women's domain, particularly the affinal kin.

While many studies have explored the event of birth from various perspectives, the anthropological examination of the preparation for this event has not been theorized very well. It is assumed that women living in slums, far removed from the highly medicalized cultures of the urban privileged communities, continue to widely prefer home births. On the contrary, as discussed in the previous chapters, women in Nagar basti increasingly prefer hospital births. In this chapter I intend to take the reader through the final stage of pregnancy (the third trimester) when the woman as well as the family start preparing for childbirth, as experienced by women in Nagar *basti*. Engaging with the lived experience of preparing for childbirth allows one to have an insight into the local worldviews which guide the 'doing of pregnancy' in the specific context of the Nagar *basti*. The aim is to uncover meanings, perceptions, preferences and concerns of women which often tend to get over-looked, but which play a fundamental role in defining practices.

7.1 The approaching delivery

As discussed in Chapter 5, women in Nagar *basti* begin calculating the duration of pregnancy from the first day of the last menstrual period and add nine months to it to ascertain the date of delivery. This aligns with the method of calculating the expected date of delivery by medical professionals ("Calculating a Due Date | Johns Hopkins Medicine," n.d.). In this latter method, however, an additional seven days are added to estimate the date of delivery. This results into a total of 280 days or 40 weeks, while according to the Nagar *basti* method of calculation the total duration of

pregnancy amounts to around 274 days. For example, if the last menstrual period began on the 1st of January, then the 1st of October would be considered as the end of pregnancy. A health professional, however, would further add seven days and fix 8th of October as the date of delivery. The completion of the eighth month of pregnancy and beginning of the ninth month, counted from the first day of the last menstrual period, is referred to as '*poora time lagna*' or 'entering into the complete stage' (also discussed in Chapter 5). To the Rajasthani worldview, the baby is considered to be almost fully formed in the '*poora*' (complete) stage and ready for birth. Considering the high prevalence of pre-term birth in *basti* communities in India, this stage is accompanied by a relief within the family that the baby would now survive.

This in turn results in several shifts in the way pregnancy is performed in the final weeks. In the advanced stages, the visibility of pregnancy modifies the way the woman herself, her family and the larger society views her. The focus on the 'visible stage' of pregnancy – in the society as well as academia- has been attributed to the shifting focus on the "product" of the pregnancy (the baby)- the "visible, touchable and scientifically-measured result"-, rather than the "work involved" or the process of being pregnant[92] (Neiterman, 2010, p. 26; Rothman, 1989). Although relatively less medicalized, popular discourses in Nagar *basti* also tend to focus on the result of pregnancy- the event of delivery and the future baby.

In the *basti*, the visible stage of pregnancy also demands recognition because of its association with higher chances of a successful outcome. In the third trimester, even if labor pains develop before the completion of full-term, the chances of the baby surviving are quite high[93] (Tucker & McGuire, 2004). Popular perceptions in Nagar *basti* also align with this notion. As a result, pregnancy is announced to people outside of the family and acknowledged publically usually

[92] Rothman, in her influential work on kinship and patriarchy in the American context, refers to the invisibility of the 'invisible stage of pregnancy' in academia as well as the larger society (Neiterman, 2010, p. 26; Rothman, 1989). According to Rothman, this focus on the "product" or pregnancy rather than the process of being pregnant was due to the shift towards a "mechanized and technocratic model of pregnancy and birth" in the euro-American context (Neiterman, 2010, p. 26; Rothman, 1989). This "mechanical process of babies production", she continues, seemed to her to be the reason why the "emotional, invisible and immeasurable experiences of expectant mothers" is usually ignored. However, even in the less medicalized context of rural/peri-urban India, narratives tend to focus on the product. Hence, I maintain that this insignificance associated with women's physical, psychological and emotional work of child-bearing is rather a much older matter and is a manifestation of the patriarchal kinship system in which "women bear the children *of* men" (Rothman, 1989).

[93] According to medical literature with progressing pregnancy, the risk of pregnancy loss decreases (van den Berg, van Maarle, van Wely, & Goddijn, 2012).

after the seventh-month milestone is reached. The following sections focus on how this acknowledgement plays out and how it affects the 'doing' of pregnancy.

7.1.1 The mother-in-law's role

Literature is rife with studies on the influence that the mother-in-law (MIL) has on the health and well-being of the *basti* woman. The seventh month of pregnancy is marked by the 'seventh month ceremony' or *saatva poojna* (also discussed in Chapter 5) where offerings are made to God in the form of rituals to ensure a safe delivery. As Seema, who has just had her 3rd child, mentions, "There's the relief that the baby is still healthy and one prays to God to keep the baby healthy. Because some women have a baby at seven months and that can be deadly". This last stage of pregnancy also endows the woman with the special status of "pregnant" and heralds a significant change in the way the pregnant individual and her pregnancy is viewed by the family and even the individual herself.

Since childbirth in most traditional Indian communities is exclusively the domain of women, the mother-in-law enjoys considerable clout in decision-making surrounding the event. Decisions about how, when and whether to have the 'seventh month ceremony', for example, is entirely the *saas*'s (mother-in-law) decision. For 25 year old Aruna, who is pregnant with her second child, there was no such ceremony.

> *"My saas is no more. My jethani and nanad (wives of husband's brothers) don't speak to me, although they live nearby. You know how it is..ups and downs keep happening within the family. In today's world, sometime people don't care. Before marriage I wished, I would get a nice sasural (affinal household), where people would take care of me. But then one can't force someone to take care of you. During the first pregnancy I went to my Peehar (natal home) so that somebody could take care of me."*
>
> *(Aruna, 25 year old, pregnant and mother of a 2 year old)*

The seventh month ceremony therefore, symbolizes appreciation, adoration and care showered by the in-laws onto the pregnant woman and is one of the first such instances for a new bride in her affinal family. The ceremony, attended by female members of the kin and neighborhood also acts as a formal announcement and acknowledgement of the pregnancy in the society. The pregnant woman for whom the ceremony is performed receives presents in the form of sweets made up of milk products and other food stuffs considered healthy such as fruits and nuts. She also receives presents from her natal family in the form of clothes for herself (for after her delivery) and the

soon-to-be-born baby to prepare her for the next stage. Women like Aruna, for whom no rituals were performed, often feel left-out and uncared for.

Once the seventh-month milestone is crossed, the pregnant woman as well as the house needs to be prepared for the upcoming delivery. According to Roger Jeffery's account (Jeffery et al., 1989, p. 2)(on the first page of this chapter), Munni, who lives in a nuclear household makes these arrangements herself – such as tidying up the house, arranging for pieces of cloth that would be required by the mid-wife and removing things from around the bed which might get "contaminated" during the delivery (Jeffery et al., 1989, p. 2). In Jeffery's accounts, the *saas* also decides when to call the midwife and undertakes the monitoring of labour (Jeffery et al., 1989, p. 108). In Nagar *basti*, deliveries at home are rare, but other arrangements for the upcoming delivery are required which come under the *saas*'s purview. An area or room is designated in the house which would be used only by the new mother and her baby upon returning from the hospital after delivery. The mother and the baby are expected to remain in this room, in which they are fed and where they also receive visitors. Other areas of the house are avoided by the woman, especially the kitchen, to avoid contaminating others[94].

The pregnant woman's body is also prepared for the impending childbirth, also under the purview of the *saas*. As discussed in Chapter 6, in the final stages of pregnancy 'hot' and 'fat rich' foods are advised to the woman to 'heat' up the body further to initiate labour, lubricate the birth canal and open up the mouth of the uterus to ensure a smooth labour. Foods such as hot milk, jaggery, ghee (clarified butter), almonds, cashews, raisins, eggs, sesame seeds etc, which are prohibited in the early stages of pregnancy because of their 'heating' properties are thought to bring about labour and miscarriage, are encouraged in the final stages. In extended households the *saas* decides if and when and what kind of hot food to give to her daughter-in-law. For example, 19 year old Heena, who recently delivered her third child, describes the foods that she was given in the final weeks of her pregnancy.

> *"Heena: And in the 7th month, I used to have ghee mixed with milk and grated coconut with sugar.*

[94] Childbirth is considered to be polluting and the mother and the child both polluted as well as vulnerable due to the event are kept segregated from the rest of the family members lest they should contaminate others (Jeffery et al., 1989). During this polluted stage the new mother is prohibited from doing any housework including cooking. Most households even prohibit the new mother from entering the kitchen. To counter this pollution, a ritual is performed at 40 days or a month and a half, after which the new mother is considered clean and allowed to par take in the usual domestic activities of the household.

Researcher: Why?
Heena: So that the delivery is normal. They also gave me Tilli ka tel (sesame oil) during my first delivery.

Oil and butter in the last few days of pregnancy are thought to lubricate the birth canal, making it easier for the baby to slip out and thus resulting in a quick delivery. The delivery is also viewed as an event which is exhausting and 'weakening' for the woman. These foods, also rich in energy, are hence considered to be essential to help the woman withstand the upcoming delivery.

After the seventh month is crossed, the family as well as the woman herself begin to acknowledge the pregnancy more explicitly. Discussions are also initiated about the logistics of the delivery- where should it take place, institutional or at home and which kind of institution (public or private). The mother-in-law also often sets the path for the pregnancy with respect to issues such as what kind of health facility to consult and when and whether medical examinations are required. In Meenakshi's family, for example, the deliveries of all the 3 daughters-in-law happened at home conducted by a local trained mid-wife.

"We followed what our saas told us to do. She used to tell us, 'see, I used to work. There is nothing to worry about. Handle your kids, get your work done and then you can rest.' The biggest thing is that we didn't have to go to the hospital. Our deliveries happened here at home only, normally. None of us had had any such problems. This small girl was also born at home."

(Meenakshi, 38 year old mother of two)

Even though rare in urban communities, deliveries at home still happen in Nagar *basti*. In Meenakshi's joint family, all deliveries happened at home because their *saas* believed that childbirth did not require medical attention. According to Meenakshi, it was the right decision and she continues to advise heavy work and home delivery to her younger neighbours.

Some participants also described how it was their mother-in-law who took the decision of going for a C-section in the hospital when the childbirth became too complicated and the doctors told the family that attempting a normal delivery might be risky. For example, 30 year old Seema, who just gave birth to her third child describes her delivery experience-

"In the beginning we didn't know there would be an operation. It happened because during the delivery my blood pressure shot up and the baby became unconscious. So the doctor made everything clear and said that either the baby or the mother might lose their life if we continue the normal delivery. Then my Saas were sitting

outside, took the decision and said, 'we want both to be safe. We don't have a problem with an operation.'"

Hence, often the mothers-in-law in Nagar *basti* hold a high degree of decision-making powers in the childbearing experience of their daughters-in-law. As also in the case of weddings, women in most communities across the country are considered as the custodians of cultural knowledge and their opinions in the matter are therefore valued as well as followed. For the mother-in-law as well, a pregnancy of her daughter-in-law is one of the few events in the household where she plays the role of a primary decision-maker, which can be both advantageous as well as problematic.

7.1.2 A delayed delivery

As described in the previous chapters, the ninth month from the first day of the last menstrual period is considered as the expected date of delivery or *'poora time'* by most women in Nagar *basti*. By this date the baby is expected to be completely formed and ready to be born. Every day beyond this '*poora time'* is referred to as '*din upar'* or 'days beyond the stage of completion' is a period of anxiety in the household (even though medically seven more days are added to the end of the ninth month to estimate the date of delivery). In a discussion, 19 year old Heena and her MIL describe how a 'delayed' delivery was dealt with in their household-

MIL: When her pregnancy crossed the 9 months, I gave her Arandi oil (Castor oil[95]) in the night. With that the delivery happens normally.
Heena: […] it is a kind of oil that you get in the medical store. It is mixed with hot milk and consumed. I consumed it at the time of all 3 kids. If, for example, I consume it at 9 PM, I will be in the hospital by 11 PM.
MIL: I made her drink it at the time of all 3 kids.
Heena: […] Yes. With it the delivery happens quickly. This kid was positioned the wrong way, but then he became upright at the time of delivery.
Researcher: But how did you know about it?
MIL: Our older kinswomen all know about this.

[95] Castor oil (in German – Rizinusöl) has been used for inducing labor since the ancient Egyptian times (Hall, Mckenna, & Griffiths, 2011) and it's use has also been recorded in the middle-east region (Gilad, Hochner, Savitsky, Porat, & Hochner-Celnikier, 2018). Although its use in public healthcare facilities in India is very limited, especially due to the availability of other injectable drugs for inducing labor pains, it is still commonly used in traditional households and by traditional midwives despite limited research on its efficacy. In India, as in most other countries, castor oil is common available over-the-counter for use as a laxative and as a haircare product.

Heena's labour was thought to be delayed during her last pregnancy. The responsibility of taking action, again, falls under the purview of the MIL. She decides whether the pregnancy is delayed enough to require an intervention and also chooses the course of action. Castor seed oil is commonly preferred by the older women in Nagar *basti*, if *ghee* (clarified butter) mixed in hot milk fails to bring about labor pains. Castor oil is also sometimes thought to correct the position of the baby and thus enabling a quick delivery and is usually only consumed under the directions of the mother-in-law.

To summarize, the *saas* plays a significant role in all the pregnancies playing out in her household. She often draws from her own experiences and the experiences of other kinswomen and sets the course of the pregnancy taking decisions about, for example, whether a bodily ailment is serious enough to warrant medical attention, what kind of medical institution to visit etc. For a daughter-in-law, an 'experienced' *saas* in the household can be advantageous, especially in traditional communities in households with limited socio-economic resources. The *saas* can be the source of traditional knowledge and guidance to the new daughter-in-law as she navigates her pregnancy in the affinal household. The *saas* can also delegate the more arduous tasks to other household members if she believes that the pregnant daughter-in-law requires support. But this is not always the case. Several women felt that they did not receive the support during their pregnancy and were uncared for by their affinal kin. In several cases, pregnant women received no respite from hard domestic work and were not guided by their older affinal kinswomen during their pregnancy.

On the other hand, it can also be difficult for a pregnant daughter-in-law to take decisions about her own pregnancy if it goes against the wishes and advice of her *saas*. The daughter-in-law is expected to abide by the beliefs and values of the household, which can sometimes affect the woman's expectations from her pregnancy. For example, women often have to request their *saas* (or nudge the husband or even their own mothers into requesting the *saas*) to take them to the hospital in case of physical discomfort. Women in nuclear families, although lament the absence of female kin who could provide them with care during their pregnancy, then are free to take these decisions around child-birth themselves. It is in such as domestic environment that pregnancies are performed in Nagar *basti*.

7.2 Working after the seventh month

Once the seventh month milestone is crossed, the chances of successful completion of pregnancy are believed to increase. Her pregnancy is also recognized in the family and in the community and her body is bestowed with the special status. As a result, there is a change in the way the pregnant woman is expected to conduct herself. According to my respondents, she is expected to exercise caution while conducting household chores that involve lifting heavy weights- such as carrying a bucket of water or wet clothes. As Darshana, 20 year old mother of one, explains-

> *Darshana: One can fetch water till the 7-8th month but when you enter the 'poora time' (the 'complete stage') then we stop fetching water.*
> *Researcher: What exactly do you mean by entering the complete stage?*
> *Darshana: When the ninth month begins, then one stops fetching water.*
> *Researcher: What is the reason behind this?*
> *Darshana: Because of the heavy load we stop filling water. If we carry loads that are too heavy, then the pressure is exerted onto the baby.*
> *Researcher: So did anyone tell you about it?*
> *Darshana: Everyone says so, that very heavy loads should not be lifted.*

In Nagar *basti* water is either carried on the head or against the waist. Some women who use buckets also carry it in their hands with the handle. The physical pressure from the weight of the vessel, it is believed, can harm the baby. The exact month when this precaution sets in might vary from one household to the next, but usually after the seventh month lifting of heavy loads is avoided. It is interesting to note that it is only in the last few weeks of pregnancy that the baby is viewed as an entity that can be hurt by the physical pressure of heavy water containers. As mentioned in Chapter 5, the 'mouth' of the uterus is believed to gradually open towards the end of the pregnancy. Lifting heavy weights in such a situation, according to many in Nagar *basti*, can result in the baby being pushed out before the pregnancy is complete and hence should be avoided. On the contrary, as mentioned in the previous chapters, during the middle stages of pregnancy many households believe that hard work including lifting water vessels are an essential part of pregnancy to ensure a non-cesarean delivery.

However, not all women in the *basti* have the socio-economic capability to abide by these restrictions. For example, Hema, mother of four and living in a rented room with her nuclear family, received little support from her husband with water fetching even in the final stages of her pregnancy.

"When I was pregnant with my younger daughter, our relatives living in the neighborhood would see me fetching water from the public tap, they would scold my husband saying, 'don't make her carry heavy loads. If something goes wrong, you will be at fault'. But he didn't fetch even a single vessel. My elder daughter can hardly lift a vessel. She would still drag the filled vessel and bring it to the door and then I would pull it inside the house, slowly. When my elder daughter was born and I had an operation, he fetched water a fewtimes at that time. In the morning also I would fight and keep screaming at him, only then would he fetch water before leaving for work. I was helpless (majboor) and no one was understanding my helplessness (majboori)"

One can gauge from Seema's account that she expected her husband to acknowledge her special status as "pregnant" and support her with the heavy task of water fetching in the final stages of her pregnancy. When this did not happen, she continued to bear the burden of all the domestic work along with her job as a cleaner in a local school.

The 'shame' of visible pregnancy

This restriction on carrying vessels of water and other tasks that involve leaving the house in the final weeks of pregnancy is also perhaps associated with the visibility of pregnancy in this stage. The pregnant belly indicates feminine sexuality and is a source of shame and embarrassment (Jeffery et al., 1989), and is expected to be concealed by a *shawl* or *dupatta* wrapped around the upper body or the lose end of the *sari*. Jeffery's respondents in a rural Uttar Pradesh referred to the pregnant belly in the final stages of pregnancy as "like a pitcher" and "like a drum strapped to the belly" and also associated it with shame (Jeffery et al., 1989). Women are therefore not expected to be in public spaces with a full pregnant belly, unless they have no other option. The pregnant body in the advanced stages is also deemed to be especially vulnerable to the 'evil eye' (Kant, 2014) or *'upar ki hawa'* or 'evil winds' as they are referred to in Nagar *basti* (Maya Unnithan-Kumar, 2004b). As a pregnant woman in one of the focus group discussions explains,

"The elderly people also say that a pregnant woman should not be taken out of the house at odd times or go alone. It might affect her or the baby. She might even lose her baby. There might be problems especially around poora time (full term) or a few days short of the due date. The elderly people don't let us go out during that time."

It is therefore common for women to be asked to avoid stepping out of the house during advanced pregnancy, especially alone. Chores such as walking the older child to school or going to the market to buy vegetables are also delegated to other members, if there are others who can take over the

role of *karnewaala* (one who provides care and support). In households that don't have toilets, female relatives also accompany the woman to the *jungle,* to avoid leaving the woman alone. However, not all women in the *basti* are able to abide by the notions of shame and still step out throughout their pregnancy to fetch water, fuel, take the household garbage to the dumping ground, drop their children to school and go to work. As the reader will discover from the accounts of my participants, women also continue to go to the jungle alone to relieve themselves.

Tasks for 'pushing out the baby'

There are however, other tasks that are encouraged especially in the final weeks of pregnancy. Tasks which require squatting on the floor - such as mopping the floor with a wet cloth and sweeping the floor with a broom - are encouraged. This is believed to push the baby towards the mouth of the uterus resulting in a 'normal' delivery. Although working while squatting is encouraged throughout the pregnancy, it is deemed to be even more significant as delivery approaches. Squatting is also commonly advised by traditional mid-wives as a method to accelerate delivery once the labour has begun. Several scholars have documented it's prevalence and preference in home deliveries in north as well as south India (Jeffery et al., 1989; Zoë Matthews et al., 2005).

While the medical science has been exploring squatting as a possible position for accelerating deliveries *after* labour sets in (Golay, Vedam, & Sorger, 1993, Russell, 1982), women with poor obstetric histories are strongly advised against it during pregnancy. According to Dr. Gandhi, a gynecologist practicing in the Nagar *basti* area,

Figure 7 Woman sweeping the floor while squatting

> *"If someone has had abortions or complications and the cervix is loose, in such a case we will obviously say, 'don't squat', 'sit on a stool or a chair', 'sit at a height so that you don't feel stressed down there'. But in normal cases, it is fine".*

Seema, mother of three, also received the same instructions from her Gynecologist when she visited the hospital during her pregnancy,

> *"When I went to see a doctor, they clearly restricted me from carrying heavy loads. They also advised me against doing work while squatting (baithne waala kaam).*

'Don't squat for long periods, keep getting up for breaks'. They said that I could do the 'standing' chores (khade rehne waala kaam) if I wanted to."

In my interviews, on the other hand, I discovered that the use of squatting - especially in the weeks preceding the expected date of delivery - as a tool to ensure a quick labor, was widespread in Nagar *basti*.

The women also often face the repercussions of squatting and working too much during the last trimester of pregnancy. Heena, the mother of three, described her pregnancies-

"While I was pregnant with the other 2 children I did a lot of squatting work - washing the clothes of everyone, mopping the floor while sitting down- so my children were about to get delivered before the expected date (mahine se pehle). Then the doctor had to give me an injection to push them back in and asked me to sleep with a pillow under my feet".

Experiences like Heena's can be commonly heard in Nagar *basti*. I believe the possible risk of a pre-term birth is counteracted by the lure of a quick and uncomplicated delivery and the approval of the older affinal kin. According to the local belief system (as also discussed previously) hard domestic work is essential for a health pregnancy and a non-cesarean delivery.

7.2.1 Paid work in the advanced stage

Elena Neiterman, in her work on the pregnancy experiences of women in Canada, reports that most of her participants "worked until very late in their pregnancies" (Neiterman, 2010). They were all working in the formal sector as "academics, professionals, administrative assistants, educators, care providers, bookkeepers, nurses, receptionists, social workers and waitresses" (Neiterman, 2010). Women who have physically challenging tasks could mostly negotiate with their employers to temporarily shift them onto lighter tasks. In one case, the obstetrician of a pregnant woman provided her with an official letter that she could present to her employer and get herself excused from handling the more physically exerting tasks (Neiterman, 2010).

In contrast, most Nagar *basti* residents are engaged in the informal sector[96] in occupations that are physically arduous. They work as housemaids, washerwomen, rag-pickers, as masseurs in beauty parlours and as janitors in schools and colleges (Chapter 4). None of these occupations are

[96] Informal sector can be understood as all kinds of income-generating economic activities that are not authorized or regulated by the State (Castells & Portes, 1989).

protected by the maternity-leave bill of India [97] (Rajagopalan & Tabarrok, 2019). Most of the participants who I engaged with, reported working till the last stages of their pregnancy, despite their work being physically fatiguing. Hema, mother of four and living in a nuclear household, was employed in a school as a cleaner. Hema and her husband are both illiterate and moved to the city in search of employment. She describes her experience during her last pregnancy as –

> *"I used to work as a cleaner in the school. Sweeping, mopping, tying the laces of small children, taking care when someone wets or soils their pants. I used to work on the 5th floor. Then my madam and sir (her supervisors) started asking me to go on leave. She said, 'if you stay alive, then you can do all the work you want. But we will be accountable if something happens to you. Who will take the responsibility? The school children are mischievous, what if someone pushes or something?' That is why I quit work.*
>
> *Now we live in a rented apartment and pay Rs.1500 as rent (~ €19). What can one do? One is unable to save. One can only eat. We have four children and I have also stopped earning. What can one do with one person's salary?"*

According to Hema, she used to earn around INR 4000 per month (~ € 50) for 10 hours of work per day (7 AM to 5 PM) and is naturally not covered by the national maternity-leave bill. Since her husband also works as a cleaner in the informal sector and earns a similar amount, she could not quit work or reduce her work hours/workload during her pregnancy. In the advanced stages of her pregnancy (in the 8th month), after it became too difficult for her to climb stairs and the visibility of her pregnancy made her employers worry about the repercussions, should a mishap take place. She was then forced to quit working at the behest of her employers, even though she wanted to continue working.

Hema also describes how her house does not have a toilet and she would regularly use the toilet at school. This was another reason why she did not want to discontinue her employment at the school, since she would then no longer have access to the toilet at school and would have to

[97] The Maternity Benefit Act of India originally provided maternity benefit of 12 weeks, out of which up to six weeks could be claimed before delivery. After an amendment in 2017, it was extended to 26 weeks – eight of which could be claimed before delivery. However, Shruti Rajagopalan and Alexander Tabarrok refer to such legislations as "phantom legislation" because they cannot have the desired effect (Rajagopalan & Tabarrok, 2019). They explain that first, a majority of women in India are not part of the labor force (70 percent). Secondly, even those who are within the labour force mostly work in the unorganized sector, where they are either self-employed or are part of organizations that employ under 10 emplyees, to which the maternity act doesn't apply. Hence, considering that 30 percent of the workers in the organized sector are female, then approximately 2 % of the entire labor force are potential beneficiaries of the act (Rajagopalan & Tabarrok, 2019).

resort to going to the jungle like the other *basti* women[98]. The jungle that the people of Nagar *basti* use for defecation, is around 5 minutes away from Hema's rented room and women prefer the far end of the jungle due to its perceived safety from peeping eyes. Hema describes that after quitting her job in the 8th month of her pregnancy, it became difficult for her to relieve herself. She would wait for darkness to fall.

> *"I used to keep waiting for it to turn dark. I couldn't walk too far. Here, around the corner, a rickshaw is parked. How can a woman go alone at night? I would just go behind it and relieve myself quickly."*

Hema now looks forward to her youngest son turning 1 year old when she can start working again. Hence, for women like Hema in Nagar *basti,* deciding if and when to go on maternity leave is not a straightforward decision and is influenced by multiple aspects.

24-year-old Guddi, on the other hand, had a different experience. She, her husband and two young children live in an extended family with the parents, sister and brother of her husband. Her husband works as an automobile mechanic. They live in their own house and have several earning members. Guddi herself is educated and used to teach in small informal school in the slum. She had a miscarriage after her first child, which the doctor said was due to the lifting of heave vessels of water. As a result, during her third pregnancy was very careful.

> *"At the time of the next pregnancy, I went to see a doctor and he said that the baby is positioned very low in the abdomen and advised me to stop doing everything. They just prescribed bed-rest for 3-4 months."*

Guddi then quit her job at the school and started giving coaching classes to the children in her neighborhood from the comfort of her home. These she could continue teaching right until her delivery.

Similarly, Seema, who works as a washerwoman (i.e. washing clothes by hand on the floor) and recently gave birth to her third child via C-section, describes how during the final stages of her pregnancy she reduced her workload upon the doctor's advice. According to Seema, her pregnancies were always complicated and therefore she thought it was prudent to follow the doctor's advice. During the final stages of her pregnancy instead of washing clothes at four houses,

[98] Most families that live on rent in Nagar *basti* do not have access to a toilet, even if one is present on the premises. The landlords often keep the toilet locked, or use it as a storeroom for their belongings or reserve it for their own personal use if they happen to live in the vicinity.

she reduced the number to two and also started carrying some food with her to work. She also stopped lifting buckets with wet clothes at her employers' homes. However, Seema, like Guddi, could make changes in their existing employment situations and ease their workloads because they were both living with their affinal families and therefore were somewhat financially stable, unlike Hema who was dependent on her job as a cleaner in a school, not only as a means of livelihood but also for toilet use.

Hence, women in Nagar *basti* negotiate with paid work and their antenatal bodily requirements in different ways. These women, by virtue of their vulnerable socio-economic as well as physiological situation, are the most deserving candidates for protection under the maternity-leave bill of India. However, none of my participants were covered under the bill due to their employment in the informal sector. In the absence of State support, the women try to remain employed as long as possible during pregnancy. Women in nuclear households, although can exercise more autonomy over their pregnancy practices, usually are unable to afford rest periods due to financial pressures and the requirement to keep earning. On the other hand, women living with the affinal family with multiple earning members, are sometimes in a better position to abide my doctors' prescription of rest and restriction of physical activity.

7.2.2 Sexual intimacy in the advanced stage

The perceived vulnerability of the pregnant body in the final stages of pregnancy also has implications for the couple's sexual intimacy. Pregnancy, like menstruation, is perceived to be a condition which increases the "*garmi*" or "heat" of the female body. In this context, "heat" does not refer to the physical temperature but rather its internal characteristics[99]. This "heat" is considered to gradually increase with the progression of pregnancy and finally culminate into childbirth. Mark Nichter and Mimi Nichter, from their data collected in south-India, report how the female body during pregnancy is likened to the process of ripening of a fruit (referring to the rapid transformation) (M Nichter & Nichter, 1983). The female body is then believed to "cool down" once the delivery has taken place (M Nichter & Nichter, 1983, p. 42). Too much "heat", it is commonly believed, (for example by consuming "hot" foods in the first or second trimester) can lead to miscarriage. But in the final stages, this increasing "heat" is encouraged to allow for ease

[99] The hot-cold conceptual framework of substances, illnesses and bodily conditions is fundamental to Ayurveda and popular folk traditions across the country and many other parts of the world (Lambert, 1997; M Nichter & Nichter, 1983). For further reading (Pool, 1987).

of delivery[100]. This is commonly achieved by encouraging the consumption of "hot" foods such as milk with ghee (clarified butter) or sesame oil, especially in the last few days of pregnancy.

During these stages of heightened "heat", sexual interaction between the husband and wife are strongly discouraged. Mark Nichter reports how, according to popular beliefs in south-India, not only the menstruating woman but also her menstrual blood is considered to be "heating" and could cause the "drying up" of a man's semen should sexual interaction take place (Mark Nichter, 1989, p. 8). Maya Unnithan also reports similar findings from rural Rajasthan where sexual intercourse is prohibited for 7-8 days during menstruation (Maya Unnithan-Kumar, 2004b, p. 117). Similarly, in Nagar *basti* sexual intercourse in the final stages of pregnancy, when the "heat" of the female body is supposed to be at its peak, is prohibited. During my interviews, my participants had unambiguous opinions about the appropriateness of sexual intimacy during the advanced months of pregnancy. According to Heena, for example,

> "*See, you know how husbands are. The problem is that the semen might enter the mouth of the baby. Husbands still ask for 'it' in the beginning, like 3rd or 4th or 5th month. If it is in the 7th or the 8th month, then it is risky. Then the husbands shouldn't ask for it."*

This excerpt for Heena's interview implies that there might be differences in the opinions of men and women. When inquired about the repercussions of sexual intercourse during the last few weeks of pregnancy, she was unable to explain when asked what would happen if the semen enters the mouth of the baby, but there were similar narratives from other women about "dirty water" being gulped by the baby which is considered to be detrimental for the baby's health. Anju, fieldworker from the local NGO, also refers to the issue of "dirty water entering the baby's mouth" which could lead to "spreading of poison in the baby".

Mark Nichter's ethnographic data collected in south-India can be useful in making sense of the notions of "dirty water" (Mark Nichter, 1989, pp. 42–43). According to his respondents, it is believed that there is an accumulation of excess toxins in the pregnant body because of absence of menstruation (which is thought to expel these toxins). The male sperm, a "foreign substance in the female body" is also referred to as "toxic" (Mark Nichter, 1989, pp. 42–43).

[100] Maya Unnithan and Patricia Jeffery et al. in their ethnographic accounts of childbirth in traditional communities in north-India describe how midwives conducting the delivery try to „heat up" the delivering mother further by giving her hot tea to drink and keeping her covered with quilts (Jeffery et al., 1989; Maya Unnithan-Kumar, 2004a).

Older women, in Nagar *basti* as well, unambiguously believe that sexual intercourse in the final stages of pregnancy can be risky. As the MIL of a pregnant woman describes-

> *"Researcher: Did you advise her anything, any precautions?*
> *MIL: Yes, I advised her regarding my son, I would say, 'just be careful'. I would just say indirectly. If I would say directly, she would have been very embarrassed. I would just say indirectly, 'stay a little careful while sleeping with my son around, or you would face problems'. When I was pregnant, my older sister-in-law had given me this advice. She said, 'Vimla, be careful when you are around your husband. Now you are almost at the completion of your pregnancy. Sleep separately.' Now this is knowledge of the villagers, I don't know much about the knowledge of literate people."*

Vimla did not know much about the problems that one could face, but her notions about a complete prohibition of sexual intimacy around the final days of pregnancy was also echoed by other older women. Again, it is interesting to note that, as with heavy physical work, sexual intimacy is considered to be detrimental for the developing baby only in the advanced stages of pregnancy. In other words, only when the baby is close to completion is it considered to be vulnerable to external forces.

Another aspect of the visibly pregnant body, that is universally noted by ethnographers studying Indian cultures, is the transition of her identity from a mere 'daughter-in-law' to 'mother'. At the core of this identity are the emotional expression of "tenderness, nurturing and protectiveness"[101] towards the unborn child (Kakar, 1978, pp. 77–79). Sudhir Kakar also discusses the all-encompassing nature of this "motherliness" towards the baby growing inside her "perceived as her savior, instrumental in winning for its mother the love and acceptance of those around her" (Kakar, 1978, pp. 77–79). In such a scenario, there is little space for sexuality or sexualization of the pregnant body[102].

7.3 Fearing the unknown: the delivery

[101] In Euro-American contexts, women also experience a transition of identity and body-image – in Elena Neiterman's words switch in the function of body as sexualized/attractive and (therefore) slim to maternal/productive and (therefore) big" (Neiterman, 2010, p. 131). However this transformation is not usually all-encompassing and, as Iris Young (2005) mentions, it is accompanied by a fear of loss of identity as "she would never be the same again" (Young, 2005).

[102] Again, this is starkly in contrast to the western worldviews. Neiterman's thesis on the experience of pregnancy in urban Canada discusses the recent shift in the public attitudes towards the pregnant body referring to the expansion of the market for products specifically for the pregnant body (clothing, lingerie, make-up) (Neiterman, 2010, pp. 118–120). Pregnant bellies are no longer expected to be hidden, but rather celebrated.

> *"The anticipation of birth itself, in spite of the primitive medical facilities available, does not seem to provoke strong anxiety or fears of dying since she knows her own parents, the all-powerful protectors, will be constantly at her side during labour. Once having given birth, the new mother can bask in her delight in her child and also in her satisfaction with herself, all of this taking place in a circle of greatly pleased and highly approving close kin."*
>
> (Kakar, 1978, p. 77)

Sudhir Kakar's influential psycho-analytic work on Hindu society based on anthropological data describes how women despite having limited access to essential health services did not seem to be anxious about the upcoming childbirth (Kakar, 1978). The author's description of the soon-to-be mother fits in well with the image of the "strong woman who has the power to quietly endure everything". Kakar's treatise although ground-breaking for its time, does not coincide in its entirety with the realities in Nagar *basti*. In present day Nagar *basti*, the upcoming delivery brings out a different set of emotions. As the expected date of delivery inches closer, women in Nagar *basti* often speak about anxiety and fear surrounding childbirth. This fear and anxiety were associated not just with the outcome of delivery (the baby) but rather also, and more strongly, with the actual process of delivery. The term '*tenshun*' or tension was frequently mentioned to describe this fear and anxiety when discussing the upcoming delivery.

7.3.1 *Tenshun (tension)* about the upcoming delivery

Tension or *tenshun*, as pronounced by women in Nagar *basti*, is an all-encompassing term which can be used to describe a range of anxieties and worries, and has been recorded by several scholars (Mark Nichter, 1981; C. N. Snell-Rood, 2015; Weaver, 2017). In the south Asian context, '*tenshun*' or tension is often referred to as a cultural syndrome[103] or an 'idiom of distress'- a cultural manner of expressing distress or suffering (Mark Nichter, 1981). *Tenshun* can be used to refer to several issues from "everyday hassles to infrequent grave events" – from issues like running out of cooking gas to more grave anxieties like lack of food and having to sell off land to marry a daughter (Sabina Faiz Rashid, 2007; Weaver, 2017). It was also used by the women living in a slum settlement in Delhi in Claire Snell-Rood's study on well-being among women, to describe the stress of maintaining familial relationships and domestic conflicts in abject poverty (C. N. Snell-Rood,

[103] Weaver also mentions the examples of other cultural syndromes prevalent in other parts of the world. For example *susto*, or fright, which is "one of the earliest-identified cultural syndromes found throughout Latin America" and *reflechi twop*, a "syndrome of rumination without finding a solution to problems" recorded in Haiti (Weaver, 2017). The expression has also been recorded in several linguistic groups across the country (Weaver, 2017).

2015). Lesley Jo Weavers's participants describe the psychological features of *tenshun* as feeling troubled or upset, irritated, restless, worried and rumination (thinking too much) (Weaver, 2017).

Interestingly, although the word *tenshun* is derived from the English word 'tension', its usage and meaning do not coincide with the English term. Weaver (2017) describes how *tenshun* is something that one can *give to* others or something that can be *given by* someone/something. In Nagar *basti* and elsewhere, *tenshun* is described by the respondents as an ailment in itself and is also considered to cause other bodily ailments such as "weakness, dizziness, fever, headaches, body aches, palpitations, gastric pain", lack of appetite, being unable to sleep and the 'feeling of high blood pressure' (Sabina Faiz Rashid, 2007; Weaver, 2017). Weaver also discovered, in her study among Diabetes patients, that *tenshun* was closely associated to clinical symptoms of depression and anxiety and may actually predict clinical diagnosis of both the diseases (Weaver, 2017). In Bangladesh, *tenshun* has also been thought to cause gynecological symptoms such as vaginal discharge, which in turn causes more *tenshun*, which is further considered to worsen the condition (Sabina Faiz Rashid, 2007). To my knowledge, the cultural symptom of *tenshun* has not yet been explored in the context of the pregnancy experience.

7.3.2 *Tenshun* for a quick and 'normal'[104] delivery

My participants commonly mentioned *tenshun* to describe the fear and anxiety they felt when thinking about the upcoming delivery- specifically about the process of childbirth. Despite abject poverty, temporary housing which was at risk of demolition, erratic and informal employment, and a complete absence of civic amenities like sanitation, water and cooking-gas, the women did not mention *tenshun* with respect to raising the child in the slum environment. Neither did the *basti* women express concerns about the health of the future baby. During discussions, the sex of the future baby was also discussed with anticipation and hope[105], but never *tenshun*. The process of childbirth, however, almost always elicited *tenshun* especially in the first-time mothers.

Heena, 20-year-old mother of three, from a Muslim family living with her affinal family experienced a lot of *tenshun* during her first two pregnancies. According to Heena, she had not yet attained adulthood when she was married off to her husband. At 16 years of age, she conceived her

[104] Vaginal delivery is referred to as 'normal' delivery, colloquially, as opposed to Caesarean deliveries which are referred to as simply 'operation'.

[105] None of the pregnant women I interviewed knew the sex of the future baby. Under the PNDT Act (1994) it is prohibited by law to use technologies to determine the sex of the child ("Sex Selection & Abortion: India | Law Library of Congress," n.d.). This was done to curb rampant female feticide and to improve the sex ratio in the country.

first child.

> *"Researcher: What was the reason for your tension?*
> *Heena: It was my very first delivery that is why I had the tension. I was thinking 'what will happen to me?', 'how will I manage everything?' things like that.*
> *Researcher: Like how will you raise your child?*
> *Heena: No, thinking about the delivery.*
> *Researcher: So you were scared about the delivery?*
> *Heena: Yes, exactly, nothing else. I have seen it for my elder sister. She was in a very bad condition. Because of that I had the fear inside me. I was wishing for the delivery to be quick. And then I used to get scared when somebody used to say, 'this can happen and that can happen' that would scare me. So that fear stayed inside of me. And as a result, I didn't even have any blood."*
> *[…] I have become like this only now (have put on weight), otherwise I was even thinner than you, like I would just die. I was in a very bad condition. I used to be very scared.*
> *[…] Then my grandmother told me, 'Beta (child), one should squat and work. Then one gets a normal delivery'. Then I started working very hard, while squatting… like very hard. I used to think 'I hope my delivery is normal'. Washing everyone's clothes, mopping the floor while sitting down, so my children were about to get delivered before the expected date. Then the doctor pushed them back in with an injection and asked the family to make me sleep with a pillow under my feet and said, "Put her on bed-rest".*
> *[…]Also I didn't eat much and took a lot of tenshun because of the first delivery, thinking about what will happen. So because of that tenshun my condition became that bad. Because I didn't even eat much the condition became even worse. The doctor had told my Saas (mother-in-law) that I won't survive."*

When Heena first got pregnant she was still a teenager and had not had a lot of experience with medical establishments. She was thin and weak and was also told that she did not have enough blood. Her older sister, apparently, was in a very bad condition at the time of her delivery which instilled a lot of fear inside Heena. It was this anxiety about the childbirth process that made her push herself to work harder during pregnancy with the aim of ensuring a "quick" and "normal" delivery which did not bring good results and she was ultimately advised bed-rest.

According to Heena, the fear and *tenshun* because of the upcoming pregnancy resulted in bodily effects such as not having a lot of blood and loss of appetite which resulted in her being in a bad condition during childbirth. By her own admission, her condition was so grave that she was not expected to live through the childbirth. The relationship between *tenshun* and childbirth seems

to be cyclic. The thought of childbirth often causes *tenshun* among the *basti* women and *tenshun* during pregnancy is believed to affect childbirth.

Stories of ill-treatment during delivery[106] at the hands of health personnel are common in Nagar *basti*. Most women whom I interacted with, knew of someone or had themselves been at the receiving end of mistreatment at the hands of medical staff during labour. Being scolded by staff for not following instructions, not being attended to on time, not providing detailed information and inadequate pain relief in the maternity wards are common complaints by the women of Nagar *basti*. A participant reported that when she entered labour, she was taken to the maternity-ward of the local public hospital, where she was terrified of the screams of women in labour. As a result, she requested to be brought back home.

Other scholars report the use of abusive/bad language, being slapped/beaten during delivery, not seeking consent prior to treatment, lack of control/autonomy and discriminatory behavior (Raj et al., 2017). Perceptions of childbirth are strongly associated with the perceived degree of control, awareness and relaxation experienced during delivery (Bryanton, Gagnon, Johnston, & Hatem, 2008). The caste, class and, sometimes, religious affiliations of the *basti* women - that place them at the lowermost rungs of society - also result in an extremely unequal patient-staff relationship, with low degrees of autonomy and ultimately leading to negative perceptions of childbirth. Fear of ill-treatment at the hands of the maternity-ward staff is now increasingly being viewed as a primary barrier to the use of medical institutions during childbirth especially among women from disadvantaged communities (Dey et al., 2017; Raj et al., 2017; G. Sen et al., 2018).

To summarize, mistreatment during delivery is pervasive in the public health institutions in India. This results in widespread negative perceptions about childbirth, especially due to almost a complete absence of opportunities of gaining information from health personnel. This is in contrast to the birthing context in industrialized nations where women are active participants in their own

[106] In the last decade a renewed focus on women's experiences of childbirth has resulted in a new and evolving line of enquiry which focuses on the quality of obstetric care especially in non-industrialized nations (G. Sen et al., 2018). Several scholars have highlighted the disrespect and abuse (D&A) experienced by women in the labour room (also termed as "obstetric violence" or "mistreatment") (Chattopadhyay et al., 2017; Raj et al., 2017; G. Sen et al., 2018). Most commonly reported D&A reported in the Indian context are rampant episiotomies – surgical cutting of the vagina- often without anaesthesia; physical and verbal violence by staff – such as slapping and verbal abuse; disrespectful treatment; neglect ; inadequate pain relief ; and failure to meet professional standards of care (non-consensual) (Chattopadhyay et al., 2017; Raj et al., 2017; G. Sen et al., 2018). Studies suggest that mistreatment is mostly meted out by the staff-nurses (rather than doctors) and possibly stems from their desire to exercise power over their less-advantaged clients (Raj et al., 2017).

labour. For example, for Heena, her sister's unpleasant childbirth experience was her only source of information that informed her maternal expectations regarding labour and delivery. It was also the root of the deep fear and *tenshun* she experienced during her pregnancy. This is perhaps the primary reason of widespread *tenshun* experienced by pregnant women in Nagar *basti* and their wish for a 'quick' and 'normal' delivery.

7.3.3 The dreaded operation – another cause of '*tenshun*'

A Caesarean-section (or C-section)[107] or 'operation', as referred to by the people in Nagar *basti*, is another common childbirth experience that is associated with *tenshun*. All of my participants, men and women, young and old, expressed negative emotions about it and none of the women preferred it as their mode of delivery. 24-year-old Guddi, who recently gave birth to her second son and lives with her extended family, describes her experience-

> *Guddi: The doctors said that the baby will happen by operation. Since then I was just crying about it and worried but then in the end, it was a normal delivery.*
> *I was so scared, I just started crying. Then I told this Sahayka didi in the Anganwadi (health worker in the local community health centre), she pacified me and asked me to get another sonography done to be sure, 'don't worry, everything will be fine'. aI would obviously be scared if I would have to undergo an operation.*
> *[…] There was this lady next to me in the hospital who had had an operation done. I was so scared just seeing her condition. She could not do anything independently. Ladies who go through a normal delivery, they can start being independent in a few days. Ladies who go through an operation can't do anything for a month and a half to 2 months. One has to be careful about lifting loads, because one receives stitches and the uterus hangs low (shareer neecha rehta hai). She can't even eat freely. Ones with a normal delivery can start eating normal food…after 5-6 days one can do everything by one's self.*

Like Guddi, almost all women that I spoke to in Nagar *basti*, perceived C-section as undesirable. It elicits strong feelings of *tenshun* and anxiety. If advised by their doctor, women often switch to a different medical institution in the hope (and search) of a different prognosis.

The reasons for this distaste for the surgical process are several. Primarily, the most remarkable feature is that the procedure is never discussed in terms of the comfort or pain (or an absence thereof), but rather as a serious surgery with a long recuperation period. Childbirth, in the

[107] Cesarean delivery (C-section) is a surgical procedure used to deliver a baby through incisions in the abdomen and uterus ("C-section - Mayo Clinic," n.d.).

basti, is not viewed as something which *should* or *could* be painless. Hence a pain-free delivery is never aspired for and is not attractive for most women in the *basti*. In the Indian moral universe, going through the pain and suffering during childbirth is the path to "self-refinement" and "feminine power" which can ultimately result in elevating the social status of the daughter-in-law in the household (Menon, 2002; Van Hollen, 2003). Motherhood is valorised and valued, and central to this notion is the "woman's ability to suffer nobly the pain of childbirth", this pain being "an important ingredient in women's self-conception of the powers of motherhood" (Van Hollen, 2003). In fact, contrary to popular childbirth experiences in more medicalized contexts, Cicilia Van Hollen's participants from south India often insisted for oxytocin-injections[108] during labour which amplify uterine contractions and also the resultant pain (Van Hollen, 2003). The same study also reports a traditional midwife's opinion, "when you are grinding, it is only if you go on grinding and grinding that you will get a good paste. Like that, without pain how will you deliver a baby?" (Van Hollen, 2003). In contrast, in more medicalized contexts pain management is an important aspect of childbirth planning and women routinely opt for analgesics (for pain management) and sometimes even elective C-sections.

Secondly, C-section is associated with a long period of recuperation in which several precautions are prescribed by doctors especially with respect to the food and work habits. These precautions are directly dependent upon the availability of *karnewaale* or caregivers in the household- i.e kinswomen who can take over the domestic chores. For example, Seema expresses this concern in the following manner-

> *The problem is that in some households there is no one else to take care. For people who have someone who can take care, it's fine for them. After the delivery there are problems for another 6 months. […] There will also be stitches. Now you tell me, the stomach receives such a big tear, you tell me, won't it be a big problem?*
> *A normal delivery is better because, one can eat anything and don't have to bother much. And when there is an operation, no matter what one eats, there would be gas formation or something else happens. One can't lift heavy loads. One is just reduced to half a life. […] When this big operation is conducted, the women's life is destroyed. Now see, I am sitting at home today. Why am I sitting at home? For a year, year and a*

[108] Oxytocin is a naturally produced hormone, the levels of which surge during childbirth and produce contractions in the muscles of the uterus (Bell, Erickson, & Carter, 2014). The World Health Organization recommends the use of Oxytocin in the case of slow labour progression ("WHO recommendation on the use of oxytocin alone for treatment of delay in labour | RHL," n.d.).

half, I can't go to work. Neither can I lift heavy loads. The stitches are weak, they can break. So the woman's life is ruined.

Seema's concerns are echoed by several women in the *basti*. Most of these women are employed in the unorganized sector with tough working conditions and no maternity support. They are also often single-handedly responsible for all household chores. Hence, it is essential to have a body which can withstand the physical pressures of living in a *basti.* With stitches, neither would she be able to work in the house to serve her family, nor would she able to take up employment which entails heavy physical work to financially support her family. As Usha Menon describes, "service to the household", according to the Hindu worldview, is a culturally defined method to self-refinement and an eventual improvement of the social status in the household (Menon, 2002). With stitches the woman is hence unable to fulfil her duties and believed to just be "reduced to half a life". This is in stark contrast with perceptions surrounding C-section in the more privileged communities in India and the industrialized nations. In these more-medicalized contexts, the rates of elective C-section are rather, on the rise.

Finally, the prognosis of a C-section brings about feelings of *tenshun* and anxiety also because being advised a C-section is often believed locally, to be an indication that not enough hard work was performed during the pregnancy. As discussed in previous chapters, heavy physical work is thought to be essential for a 'normal' delivery. By this association, women who are advised a C-section are commonly viewed in society as 'lazy' – because they tried to avoid hard manual work- or 'weak' – because their bodies are not suited for the hard work of childbirth. As a result, during interviews women who have been through a C-section often offered possible explanations, justifying why they believed a C-section was necessary in their case. For example- "the umbilical cord was wrapped around the baby's neck. That is why they had to do an operation" or "the baby was in the wrong position. That is why they advised an operation".

However, interestingly, often this negative perception of C-section reversed after a woman had actually been through both modes of delivery and could compare the two experiences. For example, Seema, mother of three has had both normal as well as Cesarean deliveries. She describes her experience as follows-

"M: Your first two deliveries happened normally and this last one surgically, so how was your experience?
R: Didi, (embarrassed laugh), actually as compared to normal, I found this last delivery more comfortable. Because there was so much pain during the first 2

deliveries. I was very troubled. As compared to that, during the last time I just didn't get to know anything. Of course later on there was some pain in the stitches. But I found this delivery more comfortable.
[…] Yes before the surgery, one obviously thinks, 'what will happen during the surgery'? But I'm so thankful to God that even the nurse that I was allotted was so good. […] So when that operation was done, I wasn't conscious. Of course for 3-4 days there was a lot of pain, but other than that I thought this one to be much more comfortable as compared to the normal delivery.

Seema seemed embarrassed to admit that she actually found the surgical delivery more comfortable. Other respondents who had been through both types of deliveries also shared similar perceptions. But for the vast majority of women the prognosis of C-section is usually accompanied with strong feelings of anxiety and *tenshun*, which can be detrimental to the physical and mental health of women in the final stages of pregnancy.

7.4 Conclusion

In conclusion, I would like to highlight the diversity in women's lived-experiences of the final stages of pregnancy. I demonstrate how with the approaching delivery and the increasing visibility of the pregnancy, the material practices of doing pregnancy change. Activities and body postures, which were previously encouraged, are in the final weeks considered to be detrimental for the now certain infant. There are also changes in dietary habits, focused towards ensuring a 'normal' delivery. Childbirth, like other domestic events such as weddings, fall exclusively in the domain of the women of the family and in joint families the MIL enjoys considerable decision-making powers in the pregnancy of her daughters-in-law, which can be a double-edged sword.

Women employed outside the house, despite being engaged in physically arduous tasks, often continue to work till the very end of their pregnancy, sometimes even defying the advice of healthcare personnel. Difficult financial conditions and absence of maternal protection laws in the unorganized sector mean that women often are unable to quit working till the very last day of their pregnancy. Others sometimes switch to easier tasks such as teaching children at home, instead of going to the local school to teach, as in the case of Komal, or avoiding lifting buckets of wet clothes and reducing the laundry load to only 2 houses instead of the usual 4, as in the case of Seema.

In the third section, I explore the emotion of *tenshun* – which is originally derived from the English word 'tension', but its usage and meaning has a distinct meaning for Hindi speakers in north-India. *Tenshun* has been described by scholars as a cultural syndrome which loosely means

being troubled, upset and restless. Studies have also found it to be closely associated with clinical depression and used commonly by individuals suffering from gynaecological symptoms such as vaginal discharge. I found that the women in Nagar *basti* commonly felt *tenshun* when thinking about the upcoming pregnancy. Their primary concern was the process of childbirth – all hopes in Nagar *basti* revolve around a quick and 'normal'(meaning vaginal) pregnancy.

Contrary to the birthing contexts in the industrialized nations and the privileged urban communities in India, pain management and the notion of elective C-section seemed to be absent among the women in Nagar *basti*. Pain and suffering are considered to be essential components of childbirth and important stepping-stones for attaining a higher social status in the family. A C-section would withhold this recognition, which makes it an extremely undesirable option for the women in the *basti*. When C-section is advised by the doctor due to a medical condition, it is commonly considered to be the result of non-compliance of the locally approved practices of doing pregnancy i.e. mopping/sweeping the floor while squatting on the floor, performing the hard manual chores, avoiding foods which can cause the baby to stick in the stomach and resting too much. C-sections are also associated with a long convalescence which might be tough for women who don't have female kin to take over their domestic responsibilities temporarily. As a result, C-sections are dreaded by all women and are a source of great *tenshun* among the women of Nagar *basti*.

Chapter 8 - Discussion and Conclusion

The objective of my research project was to examine the various ways by which women in a specific disadvantaged community 'did' pregnancy. The underlying aim was to explore how social and physical processes are intertwined together to create a pregnant embodiment, and to demonstrate that pregnancy and childbirth are not just physiological events but also intrinsically socio-cultural. As a result, they are acted upon by socio-cultural meanings and processes resulting in very different pregnancy experiences even within a seemingly homogenous community. Using ethnographic data, I draw upon the experiences of women and their family members to unpack how the physiological and socio-cultural changes interact to produce myriad ways in which women 'do' pregnancy.

To undertake this examination I use the concept of 'performance', first put forth to describe the 'doing' of Gender by Candace West and D.H. Zimmerman (1987). I contend, like others before me such as Elena Neitermann and Robyn Longhurst, that pregnancy is actively and constantly 'performed' by women as they negotiate the everyday social contexts in a *basti* in north-India. To explore the pregnancy performance, I borrow the concept of 'embodiment' as described by Thomas Csordas who postulates that "the body is not an *object* to be studied in relation to culture, but is to be considered as the *subject* of culture, or in other words as the existential ground of culture" (Csordas, 1990). Hence, an individual body is affected by the socio-cultural influences and at the same time it actively participates in the social construction of the body. My study therefore focuses on the micropolitics of a very specific everyday doing of pregnancy located within the complex web of nature and culture at a very specific temporal and spatial location.

In general, and most importantly, my thesis demonstrates how pregnancy is constantly and actively performed. It is not a passive experience that *happens to* an individual, but rather is actively *done*. The women who participated in my study continuously learnt how to do pregnancy in a socially acceptable fashion from their interactions with others around them and gradually with the changing body altered how they performed the everyday activities such as eating, sweeping the floor, washing clothes, fetching water for the family, going out to drop children to school, resting, caring for the elderly and seeking medical advice. The embodiment of pregnancy is thus, a continuous negotiation of the body within the social as well physical world of the individual.

I also demonstrate that sometimes the locally popular meanings and interpretations of a 'positive pregnancy experience' are vastly different from those prevalent in other contexts such as

privileged urban communities in Indian cities and communities in more industrialized nations as well as the State's ideas enshrined within the national maternal health policies and programmes. In the context of India, such a research is especially pertinent because the State views the poor woman's pregnant body in a humanitarian light and expects it to fulfil its reproductive functions via a State defined way of pregnancy (Arima Mishra & Roalkvam, 2014). Within such a State-society relationship, all other ways of doing pregnancy which diverge from the State's prescribed pregnancy practices are then deemed inappropriate. My study therefore highlights the diversity in the *doing* of pregnancy, thus advocating for flexibility in the State's treatment of pregnant individuals.

In chapter five, I examine how pregnancy is understood and interpreted in Nagar basti, how the physical and social transformations accompany the event are closely intertwined and how the twin concepts of *seva* (service) and *sehen-shakti* (power to endure) play an important role in the pregnant embodiment. My thesis demonstrates how pregnancy is viewed by most people in the *basti* communities as a 'natural' consequence of marriage which does not require any specific preparation or medical intervention, unlike their urban and more privileged counterparts.

I also discuss how in the local universe, pregnancy is divided into three main (and unequal) stages of *kachha* time (the raw stage), *beech ka* time (the middle stage) and the *poora* time (the stage of completion). I further explore how the doing of pregnancy changes along with the transforming body as it progresses from one stage to the next. The raw stage which corresponds roughly with the first trimester is associated with a higher probability of miscarriage. In the *beech ka* time or middle stage of pregnancy, which roughly lasts from the fourth month to the end of the eight month, is considered locally to be generally safer with the chances of miscarriage being much lesser as compared to the previous stage. Here the primary responsibility of the woman is to ensure a favourable environment for the growing baby, in other words keep the baby moving within the belly so as to avoid it getting stuck in one place, which is thought to lead to difficult deliveries. The *poora time* or the stage of completion begins at the beginning of the ninth month. Locally women believe the baby to be ready for birth once the *poora* stage is reached and deliveries even in the beginning of the ninth month are considered 'normal'. In this stage, the main motive of pregnancy practices is to loosen the baby in the belly and aid in its downward journey through the birth canal. These include long periods of work while squatting on the floor on the hunches and eating foods that are believed to 'heat up' the body such as those with high calorie content like jaggery, dried coconut and nuts. Hence, defying the popular narratives of the 'poor, unknowledgeable basti

woman', my participants utilized their own framework of understanding pregnancy. Some women also used this understanding of pregnancy to achieve outcomes that they desired, putting into use the popular knowledge that had been handed down from their female kin. This understanding of the three stages of pregnancy closely guided the *doing* of pregnancy in Nagar basti. It dictated what should be eaten, what should be avoided, what kind of chores should be done and when, whether to rest or not, and whether it was okay to engage in coitus. It also helped women make sense of their physical signs and what was happening inside their bodies, in the absence of other sources of information. More importantly, it indicated to the women and their families when the pregnancy was complete, refuting popular notions about the basti women not being in control of their bodies.

I then utilize my participants' narratives to discuss the twin concepts of *seva* (service and care) and *sehen shakti* (power to endure). Women are considered to be able to go through the responsibilities of care-giving and service towards the affinal family because of their inherent power to endure (*sehen shakti*). It is commonly believed that young married women aren't in the social position to expect service and care in return, even in times of sickness. However, in my study most women in Nagar *basti* seemed to clearly expect care especially during the final stages of pregnancy or in case of a difficult pregnancy. Many of my participants also lamented the absence of a care-provider referring to unfulfilled expectations of care and support in times of need. Some participants even decided to separate from the joint family unit to set up a new household with their husbands in the hope of receiving more care and support from their partners, as well as autonomy in the doing of pregnancy.

In chapter six, I utilize participants' narratives to explain how complex intra-household micropolitics strongly influence the pregnancy experience and create a whole range of ways in which women experience pregnancy in Nagar *basti*. I also examine how the roles and responsibilities of the young daughter-in-law within her marital household combines with the subjecthood of pregnancy. I also demonstrate how women despite their limited means negotiate and rearrange their lives to achieve their desired outcomes. My study also shows how the natal family continues to plan an important role in the lives of women living in Nagar *basti* – women often moved to their natal households for a few days or even weeks when they were in the need of a caretaker; others also requested their sister sor the daughter of a sister to move in with them as a caretaker. Hence, in the absence of other kinds of support, these women were actively pursuing other forms of support available to them.

I also explore the concepts of *heavy* work and *light* work within the households in the *basti*. 'Heavy' chores were sometimes considered to be detrimental for pregnant women specially around the beginning and end of the pregnancy, but what was interesting was that the definition of 'heavy' and 'light' varied from one person to the next. Women from the older generation usually did not find any of the chores within the urban households as 'heavy' since their ideas of 'heavy' chores were based on the work that they handled in their youth in rural areas. By comparison, the chores in an urban household, according to most elderly women, was 'light'. Similarly, men did not think of most household chores as 'heavy' even though most of them did not handle these chores at all. My study demonstrates how women in Nagar *basti* utilized these popular ideas of *heavy* and *light* work to achieve the pregnancy outcomes they desired.

I next explore the *basti* women's relationship with the State's mother and child health program. The medicalization of pregnancy among the women in the *basti* is not yet as pervasive as among privileged communities in urban India or among the women in the more industrialized nations. But most of my participants were involved in the State's mother and child program, although up to different degrees. Some attended the three antenatal visits to the hospital as prescribed by the State, were registered with the local *Anganwadi* centre, had undergone all the basic tests, as well as underwent childbirth in a medical institution. There were still others who did not get themselves registered with the local mother and child centres and opted for delivery at home. My work demonstrates the variations in the levels of medicalization the women engaged in and how they made sense of technology alien to them. My study also engages in the decision-making behind these patterns. My participants took pragmatic decisions, carefully weighing the pros and cons, and utilizing the resources at their disposal to navigate through the complex processes of the health system, depending on their bodily condition, quite like Margaret Lock and Patricia Kaufert's pragmatic women (M. Lock & Kaufert, 1998). Even the participants who chose to deliver at home and and preferred the less medicalized path, did so not because they did not understand the benfits of modern medicine, as commonly thought by healthcare personnel, but rather because the familiarity of their homes provided them with more autonomy and comfort. The midwife who would perform the delivery at home, would also be familiar and being from the same community would 'listen' to the woman and the other women at home.

I also explore *basti* women's relationship with medical staff at hospitals and clinics that these women visit. The relationship is characterized by a sharp asymmetry in socio-economic status and deep distrust between the women and the medical staff. Such a situation prevents any real

opportunities for the women to have an open and in-depth discussion about what they could expect from their childbirth experience. Unlike pregnancy experiences in more industrialized countries, or even in more priviledged urban communities in India, the quality of the childbirth experience is not an aspect that is cared about by the medical personnel in public hospitals. Therefore, some women in Nagar *basti* tend to prefer private hospitals, if they have the financial means for it, because as paying customers they feel they will have more autonomy and perceive the services to be of better quality as compared to public hospitals.

In the seventh chapter, I focus on the final weeks of pregnancy popularly referred to as the '*poora time*', roughly commencing around the ninth month of pregnancy. I first focus on the role of the mother-in-law (locally referred to as the *saas*) in ushering this stage of the daughter-in-law's pregnancy. The *saas* organizes the seventh-month ritual which socially labels the woman as pregnant and marks the beginning of the preparation for the impending childbirth and soon-to-arrive baby. The ritual involves religious worship for the safety of the mother-child and gift-giving to the mother in the form of fruits and nuts as well as clothes for her and the baby. The enthusiasm with which it is celebrated is directly associated to the acceptance and approval enjoyed by the daughter-in-law. The *saas* also handles the preparation for the upcoming baby. In some households a separate room or an area is allotted to the woman where she and the new baby must remain for the first few days.

In the last few days, leading up to the delivery the woman's body is also prepared for childbirth by providing her with foods considered to ease the slippage of the baby into the birth canal. Again, this is initiated by the *saas* who possesses this knowledge about which foods are beneficial and how they must be consumed and in what quantity to ensure maximum effectiveness. She also takes charge when the pregnancy is believed to have the crossed the due date and the labour seems to have been delayed. In such a scenario, local remedies are commonly used at home to initiate labour pains. The *saas* usually is also the primary decision-maker when deciding about childbirth and where it would take place – at home, in a private or public institution. Hence, living in a household with the *saas* can be on one hand beneficial for women experiencing pregnancy for the first time on the other hand it can also sharply reduce the autonomy that a woman can exercise over the performance of her own pregnancy.

I then discuss the perceptions surrounding physical work in the final weeks leading up to the delivery. The developing baby is now considered an entity that can be affected by lifting of heavy weights. Many participants shared anecdotal experiences of neighbours or relatives who

underwent premature delivery after lifting a heavy bucket of water or a pile of clothes. Working outside home is also avoided specially because of the visibility of the pregnancy. Most women in the *basti* are employed in the informal sector which offers no maternity leaves for the pregnant woman. Hence, many women in the *basti* who are employed outside their homes and have the financial capability, quit work in the final weeks. There are still others who are unable to quit due to financial responsibilities and continue to work till the very end of their pregnancy.

I then focus on the negative perceptions that most first-time mothers have of childbirth. With little access to scientific information and little opportunities for discussion with medical professionals, most *basti* women rely on experiences of female kin to picture what they could expect from their delivery. Pain management during childbirth is not commonly known or even desired by the women due to the commonly held perception that the gift of the child is achieved by hard-work and struggle that the woman must go through. As a result, all my participants, especially the ones who were undergoing their first pregnancy, were terrified of childbirth. All of them wished for the labour to be short and non-caesarean.

I then delve into the expression of '*tenshun*' (derived from the English term 'tension', but used in a different manner) and examine how a seemingly common term obscures a wide range of negative emotions specifically in the context of childbearing by the women in Nagar *basti*. It is a commonly used to express the emotion experienced when thinking of the upcoming delivery and to my knowledge, this is the first study to examine the cultural syndrome of 'Tenshun' in the context of pregnancy. *Tenshun* has been discussed by several scholars in various geographical contexts and among other linguistic groups as well. Studies based in Bangladesh, south India and other areas of north-India have examined the use of *tenshun* to describe the emotions felt when facing different kinds of issues ranging from everyday domestic hassles to infrequent serious problems. The term is used to denote the negative feelings of stress, anxiety and rumination.

Scholars have also discovered that it is not just a psychological emotion, but has been found to be associated with bodily manifestations such as weakness, dizziness, fever, headaches, body aches, palpitations, gastric pain, lack of appetite, inability to sleep (Sabina Faiz Rashid, 2007; Weaver, 2017)(Sabina Faiz Rashid, 2007; Weaver, 2017). *Tenshun* was also found to predict clinical symptoms of depression and in some contexts gynaecological symptoms such as vaginal discharge (Sabina Faiz Rashid, 2007; Weaver, 2017). It is interesting that in the works of other scholars as well as in my research the cultural ailment of *tenshun* is usually experienced by women. In Nagar *basti* it is most commonly used by women for their anxieties about domestic conflicts and

financial pressures in an environment of abject poverty. It is also often heard in the context of an upcoming delivery.

Among my participants *tenshun* was the most commonly reported emotion when asked about how they were feeling about the upcoming delivery. Their central anxiety was the unpredictability of the process which could go on for several hours, could be extremely painful, might involve surgical interventions and involved health professionals with whom most women did not share a very good rapport. Most women in the *basti,* especially the first-time mothers, based their expectations of childbirth on anecdotal information received from other female kin who had experienced childbirth before. Most of my participants shared that during their pregnancy they had extremely negative perceptions about the upcoming delivery and they prayed to God that it was short and non-surgical.

The possibility of a Caesarean section is another major source of *tenshun* for pregnant women in Nagar *basti*. Unlike some pregnant women in more industrialized contexts or in privileged communities in urban India, pain management is not a theme that is discussed within the couple or with the gynaecologist. The popular understanding is that the fruits of the delivery can be enjoyed only through hard work. In other words, pain, struggle and endurance were an essential aspect of childbirth, and pain-free delivery is usually not desirable.

8.1 Implications for healthcare service delivery and health outcomes

This study highlights several pertinent issues which have direct and indirect implications for healthcare services in India especially those catering to basti communities. While promoting women and mostly poor women to take up facility-based antenatal and perinatal services, the Indian government, as governments of other LMICs as well, have focused on the demand-side of the services, while not paying much attention to the supply-side, such as quality of services, infrastructure, training of staff, access to drugs and other aspects of quality of care. One important aspect that emerged quite strongly in my study is the service provider – patient relationship. In the context of my study participants, this relationship was not akin to the service provider – client relationship prevalent in more priviledged communities. In case of women living in *bastis*, their position in the outside world at the intersection of class, caste and gender axes, continues to place them at a severely disadvantaged position within the healthcare facilities. Service providers, who are often from more priviledged castes and class groups, usually don't view these women as clients deserving good quality and respectful treatment, but rather as 'poor', 'illiterate', 'helpless'

beneficiaries of State-sponsored services. Service providers' perceptions of patients living in *bastis* coincides with how middle-class urban India views *basti*-dwellers. In my interactions with gynaecologists working in Jaipur's public hospitals, it was clear that the patients were not thought of as equal, but rather as the 'other' who did not have the capacity to understand their bodies or follow instructions.

Medical education and training of health personnel is also partly to blame for creating such a disharmony. Health providers are trained to view illnesses and medical conditions as purely biological states. However, women seeking health care are not just biological creatures, but a combination of their physiological, social and cultural selves. The treatments and medical care therefore, that is meted out to young pregnant women is devoid of contextualization and usually there is little or no engagement with the social and cultural aspects of the patient or the disease, viewing women as just physical beings.

Needless to say, such a view of women and and their health is grossly insufficient in promoting well-being. A healthcare personnel advising a pregnant woman from Nagar basti to eat bananas, for example, will have to understand that the woman might find it difficult to follow this advice, not because she doesn't want to have a healthy pregnancy, but because her position at the lowest rung of the social hierarchy of the household might prevent her from requesting someone in the household to buy bananas for her to consume. She might also be advised by the older women in the household to avoid white foods, as they are commonly thought to 'stick to the baby' making delivery difficult. Some neighbours might also scare her about bananas, explaining to her that too many calories might result in a baby that is too large, hence resulting in a difficult delivery. Hence, medical training needs to be refined to encompass the different selves of an individual to ensure that the service providers are equipped with the right tools to promote holistic health and well-being.

In the context of India, healthcare personnel providing antenatal and perinatal services also need to address the challenge that most pregnant women are underprepared especially during their first pregnancies. Unlike their German counterparts, for example, who can choose to receive *preparatory courses* before the delivery (Vorbereitungskurse) and then courses for *recovery after the delivery* (Rückbildungskurse), most Indian women and especially those from non-priviledged communities, receive most of their information from their female kin. This makes the services provided by healthcare personnel during the antenatal and perinatal periods all the more crucial.

It is even more important for the health providers to 'do' healthcare well for *basti* dwellers, most of whom are likely to be new migrants. Not only are rural sensibilities and cultural universes quite different from urban ones, recently migrated families also often leave behind their networks, connections and relatives with little or no possibilities of support in times of need. As migration is not just an Indian but rather a global phenomenon, it is imperative that the health and well-being of the new migrants, especially women, is addressed in a holistic manner[109].

8.2 SDGs and health of women

Creating systems and structures more conducive for the health and well-being of women, especially as they embark on their reproductive journeys is crucial for the achievement of the SDG 3 – "Ensure healthy lives and promote well-being for all at all ages" (United Nations, 2015). Globally, there has been considerable improvement in the maternal and child health indicators since the turn of the century (Graham et al., 2020). However, without addressing key weaknesses in the current health system structures it would be difficult to progress further. Gains achieved in the area of maternal and newborn health as in other areas of health, are also at a risk of being overturned by health systems shocks, such as disease outbreaks like the ongoing COVID-19 pandemic. Investment in RMNCH was already decreasing before the pandemic (Pitt, Bath, Binyaruka, Borghi, & Álvarez, 2021) and now with increased pressure on government and household budgets, it is all the more relevant that funds are not diverted away.

8.3 Contribution to literature

The purpose of this study was to uncover the myriad ways in which pregnancy is performed in a specific impoverished urban community in north-India. The research contributes to sociological and ethno-physiological literature by bringing the bodily experience into the centre of the examination of pregnancy. I use the concept of embodiment, like others such as Neitermann and Bailey, to demonstrate how the physical and social transformations are closely intertwined and are played out within social interactions (Bailey, 1999; Neiterman, 2010). Hence, the pregnancy experience is specific to the socio-cultural context resulting in different types of pregnancies even within the same household.

[109] Examining how migrants in Germany approach and experience maternal health services might be an interesting area of research.

I also treat pregnancy as a 'performance', much like Gender, which is actively 'done' everyday (West & Zimmerman, 1987). I demonstrate how women make meanings out of their changing physical and social body, constantly renegotiate within their specific contexts and utilize whatever resources are at their disposal to perform pregnancy in a way that they believe is appropriate. However, being at the bottom of the social ladder within their marital households, the women do not always have the power to 'do' pregnancy the way they would have liked to 'do' it.

I also contribute to public health and pregnancy literature by bringing to the fore experiences of individuals who are marginalized within the society by way of being *basti* dwellers and then are further marginalized within the *bastis* because of their gender. Further, most works on pregnancy and childbirth among marginalized communities in the Indian context are based within positivist, biomedical traditions focussed at improving mortality and morbidity rates. Many of these works treat childbearing as a purely physiological event and group the various aspects of the sociological process transformation under 'socio-cultural factors'. I demonstrate in my study how the sociological and the physiological transformations go hand-in-hand in the perfromance of pregnancy and play a decisive role in the health outcomes of both the mother and the child.

I also focus on the ideas and meanings of a 'healthy' pregnancy within the specific context of Nagar *basti* and how they might often be different from the State's idea of a 'healthy' pregnancy. In this way my research underscores the women's extremely asymmetrical relationship with the local medical facilities and how it influences their experiences of pregnancy. I believe that a sociological inquiry into women's well-being is central to the country's attempts towards reducing deaths and ill-health during childbearing.

8.4 Limitations and areas for future research

As with all pieces of scholarship, my research also has limitations and shortcomings. In my study, the focus of examination was the period from the conception up until the final delivery, including their perceptions about the upcoming childbirth. I did not explore women's experiences of the actual delivery, which I believe will uncover a whole other set of issues which definitely warrant examination. Post-partum or after delivery is also an area which has been under theorized qualitatively and is bound to throw up issues pertinent to the well-being of women and children.

Even though I tried to select a sample of women who belonged to different age groups, castes, migrations histories and religion, some biases may have crept into the sample. I was able to interview women who possessed a certain degree of autonomy in the household which allowed me

to have a private conversation with them. I had to exclude participants whom I began to interview but we were intruded upon by the family members such as the mother-in-law or sister-in-law. This was a culturally accepted practice as the daughter-in-law is not expected to hold private or personal views and often the household members wanted to ensure that nothing unfavourable was shared with an outsider i.e. myself.

Additionally, because many women did not own cell phones I usually got in touch with them at the Anganwadi center or at their home through the Anganwadi records. I therefore must have missed women who do not receive any services from the Anganwadi or were missed by the Anganwadi staff and therefore do not feature in the Anganwadi records. These are likely to be women who are daily-wage workers and are usually at work during the opening hours of the Anganwadi.

Finally, during my interaction with participants in the field I often encountered situations where I was treated as a maternal and reproductive health technical expert, and asked questions about problems that the women were experiencing. As a trained public health professional, I could answer their questions but I felt there was a need for a comprehensive discussion on *basti*-specific maternal and reproductive health issues, considering most of the women within the community did not have access to technical knowledge in the form of print material, websites or medical guidance. If I had the opportunity to re-do the field research, I would have incorporated a module on health and hygiene topics for the women where they could have participated in dicussions at length.

Appendix 1: Participant characteristics

Table 2 In-depth interview participants

	Name (Anonymized)	Age	Status	Education	Employment	Religion	Family status
1	Payal	18	First pregnancy	Primary	No	Hindu SC	Joint
2	Kavita	24	Second pregnancy	None	No	Hindu OBC	Nuclear
3	Seema	30	Third pregnancy	Primary	Domestic Help	Hindu OBC	Joint
4	Anushka	20	First pregnancy	None	No	Hindu SC	Joint
5	Gulshan	30	Postpartum 3 children	None	No	Muslim	Nuclear
6	Hema	26	Postpartum 4 children	None	Cleaner in a school	Hindu SC	Nuclear
7	Guddi	24	Postpartum 2 children	Secondary	Teacher	Hindu SC	Joint
8	Santosh	36	Postpartum 3 children	None	No	Hindu	Nuclear
9	Yashika	26	Postpartum 2 children	None	No	Hindu SC	Joint
10	Chandrakala	27	Postpartum 2 children	None	Artisan	Hindu SC	Nuclear
11	Mohsina	23	Second pregnancy	Primary	No	Muslim	Joint
12	Heena	19	Postpartum 3 children	None	No	Muslim	Joint
13	Savita	19	First pregnancy	None	No	Hindu SC	Joint
14	Saroj	24	Postpartum 1 child	None	No	Hindu SC	Nuclear
15	Komal	21	Postpartum 1 child	Secondary	No	Hindu SC	Joint
16	Sangeeta	24	Postpartum 2 children	None	No	Hindu SC	Nuclear

17	Lalita	30	Postpartum 2 children	Primary	No	Hindu SC	Joint
18	Radha	26	Postpartum 3 children	Primary	No	Hindu SC	Nuclear
19	Rekha	24	Postpartum 1 child	Primary	No	Hindu OBC	Nuclear
20	Asha	22	Postpartum 2 children	Primary	No	Hindu SC	Joint
21	Darshana	20	Postpartum 1 child	Primary	No	Hindu SC	Nuclear
22	Mamta	28	Postpartum 2 children	Primary	No	Hindu	Nuclear
23	Jaya	22	Postpartum 1 child	Primary	No	Hindu SC	Joint
24	Aruna	25	Third pregnancy	Primary	No	Hindu	Nuclear
25	Renu	22	Postpartum 2 children	Primary	No	Hindu SC	Nuclear
26	Aarti	19	First pregnancy	Primary	No	Hindu	Joint
27	Anju	35	3 children	Primary	Fieldworker	Hindu	Joint
28	Neetu's mother-in-law	61					
29	Anushka's mother-in-law	58					

Table 3 Expert interview participants

	Name	**Position**
1	Dr. Mrs. Amita Kashyap	Head of Department, Preventive and Social Medicine, SMS Hospital
2	Dr. Mrs. Meena	Head of Department, Gynaecology/Obstetrics, Women’s Hospital
3	Ms. Verma and Mr. Maheshwari	Peer worker and Coordinator, Naya Savera NGO
4	Dr. Mrs. Gandhi	Private Gynaecologist
5	Ms. Mona	Junior Engineer, Public Health Engineering Department

Table 4 Key-informant interview participants

	Name	**Position**
1	Mrs. Malti	Anganwadi worker - Anganwadi centre Teela 1
2	Mrs. Kailashi	ASHA worker- Anganwadi centre Teela 5
3	Mrs. Mithilesh	Anganwadi Helper- Anganwadi centre Teela 7
4	Mr Verma	Husband of Municipal Councillor

Table 5 Focus-group discussion participants

	Type of FGD	**Participants**
1	Currently pregnant	7
2	Recently pregnant (who had given birth in the past year)	8
3	Husbands of women who either had recently given birth or were currently pregnant	9
4	Mothers-in-law of women who either had recently given birth or were currently pregnant	6

Appendix 2 : Characteristics of survey participants

Table 6 Religion of participants

Religion	
Hindu	66%
Muslim	34%

Table 7 Age of participants

Age of participants	
18-20 years	11%
21-25 years	62%
26-30 years	23%
31-35 years	3%
36-40 years	1%

Table 8 Family structure of participants

Family structure	
Joint	53%
Nuclear	47%

Table 9 Family size

Number of family members	
3 and <3	41
4 - 6	85
7 - 9	50
10 and >10	62

Table 10 Caste affiliations

Caste affiliations	
General	11%
Scheduled Caste (SC)	34%
Scheduled Tribe (ST)	10%
Other Backward Classes (OBC)	45%

Table 11 Level of education

Education level attained	
Had never been to school	30%
Primary	30%
Secondary	30%
Senior Secondary	4%
College	6%

Table 12 Migration status

State of origin of participants	
Rajasthan	86%
Gujarat	3%
Odisha	2%
Uttar Pradesh	7%
Delhi	2%

Table 13 Occupation of participants

Occupation		
1	Not employed outside the house	91%
2	Domestic help	5%
3	Small shop/business	1%
4	Artisan	1%
5	Daily wage labourer	1%
6	Salaried (private/government)	1%
7	Garbage collection/sorting	1%

Table 14 Reproductive history

Outcome of the last pregnancy	
Normal	55%
Low birth weight	35%
Miscarriage	7%
Still birth	1%
Pre-term birth	1%
Neonatal death	1%

Table 15 Whether ANC sought by participants

Antenatal care during last pregnancy		
No	2.5%	
Yes	97.5%	
	Public facility	69%
	Private facility	31%

Appendix 3 : Interview guidelines

Interview Guide (for pregnant and post-partum women)

1. Respondent's background-
Age, age at marriage, caste, occupation, husband's occupation, migration history, pregnancy history

2. Family composition
Family members and family structure

3. Family's experience of living in cluster
i. Relationship with neighbours (inter-caste/inter-religion relations)
ii. Perception of life in the city (rural vs urban)
iii. Atmosphere in your area? (safety, security, solidarity)
iv. Change in civic amenities in the past 2 years (Swach Bharat Abhyan)?
v. Role of actors/institutions in bringing about this change?

4. Details about pregnancy-
a. How was it discovered?
b. How was it announced?
c. Family's response?

5. Meaning of "healthy pregnancy"?
a. How can it be achieved?
b. If can not be acheieved, then ?

6. Typical daily routine-
a. Changes after pregnancy?
b. Changes after visible pregnancy?
c. Water collection practices?
d. Going to the jungle?

7. Knowledge about female body-
a. How is the baby carried inside?
b. Health baby?

8. Delivery
a. Feelings about upcoming delivery?
b. Choice of institution?
c. Past experiences?

9. Advice for other pregnant women

Appendix 4 : Questionnaire

Household questionnaire for Post-partum women

Identity		
1	Serial no.	
2	Name of slum	
3	Slum code	
4	Household ID	
5	Name of respondent	
6	Name of respondent's husband	
7	Respondent ID	
8	Pregnancy outcome	Normal ……..….1 Low birth weight …….....…2 Pre-term birth ……..……...3 Miscarriage ……..…..……4 Still-birth …..……..…….....5 Neo-natal death ……..……6
9	Date of outcome	D D M M Y Y Y Y
10	Date of interview	D D M M Y Y Y Y
11	Name of interviewer	
12	Result of interview	Complete.....1 Incomplete.....2 Refused.....3 Other.....8

SECTION 1: Respondent's Background

101.	How long have you been continuously living in this slum?	0- 2 years ……..…… 1 3-4 years ……..……2 5-10 years …….....3 11 or more years.....4 Visitor..... ..…….……5 Since Birth ……..…….....6 Don't remember ……..9	
102.	Where did you live before moving to this slum?	…… State, city, village, town, other village	
103.	How old are you?	Age (in completed years)	**If gives exact age go to 107**

104.	How old is your eldest child?	Age (in completed years) ☐☐	
105.	How many years after your marriage or gauna was your first child born?	…………………………	
106.	How old were you when you got married?	Age (in completed years) ☐☐	
107.	Have you ever been to school?	Yes .... ……………………………..1 No . . . .………………………0	**If 0 go to 109**
108.	What is the highest level of education attained by you?	Primary (1-6) ……………………..…..1 Secondary (7-10).................................2 Higher secondary (11-12)…...………..3 Graduation ……….……………..……4 Other (specify) ………………………..8	
109.	What is your religion?	Hindu……..…………………....……1 Muslim……………………………......2 Sikh……………………………………3 Christian……..…………..…………...…4 Other……………………………...….5 Don't know……………..………….....8	
110.	What caste do you belong to?	General ………………………………..1 Scheduled caste……………....………...2 Scheduled tribes (ST)....……………..…3 Other backward classes (OBC)... …….4 Don't know ……..………..…..……9	
111.	What is your family structure?	Joint …………………..……………...1 Nuclear ………………………………2	
112.	Are you involved in any kind of employment?	Yes. . . ..…..….…..1 No . . . . ………….……..……0	**If 0 go to 116**
113.a	What is your main occupation?	Domestic help (cleaning/cooking).......... 1 Small shop/business……………….....…2 Skilled/ semi-skilled artisan……………..3 Daily wage labourer ……….…………4 Big shop/business………………………5 Salaried (Private/Govt)…...……………..7 Garbage collection/sorting………………8	
113.b	How many hours in a day do you work?	hours ☐☐ Morning: ….. to …. Afternoon: ..… to …. Evening: … . to ….	
114.	Upto which month of your pregnancy did you work?	Worked upto month………………………….. Other (specify)................................8	

115.	What were the financial losses that you incurred during your maternity leave?	No losses.....0 Monthly/daily salary ..... No. of months of maternity leave.....	
116.	What is the main occupation of your husband?	Domestic help (cleaning/cooking)..... 1 Small shop/business……...…2 Skilled/ semi-skilled artisan..……..... 3 Daily wage labourer ....…….……....4 Big shop/business;……...…5 Salaried (Private/Govt)……..……..7 Garbage collection/sorting…….....…8	
117.	Do you consume Tobacco in any form ?	No ……..……..…….. 0 Bidi …….……..…… 1 Pan masala /Gutka /other forms of chewing tobacco ……..… 2 Other ……..…..8	
118.	Did you consume Tobacco in any form during your Pregnancy?	No ……..…. 0 Bidi …….……..…. 1 Pan masala /Gutka /other forms of chewing tobacco ……... ……..2 Other……..……8	

SECTION 2: Information about the other family members

201.	How many family members live together in your household, including you?	Total number of family members	

Age group	female	Male
Infant (0-1yrs)		
Children (1-12 yrs)		
Adolescents (12-18 yrs)		
Unmarried adults (18-60 yrs)		
Married adults (18-60 yrs)		
Senior citizens (above 60 yrs)		

SECTION 3: Water facility and use

301.	Presently, what is the main source of water for the members of your household? (multiple responses possible)	Piped into the house……A Personal pipe outside the house ……..……B Public tap…….……..……C Public tank .....…….....……D Borewell ……..…….....…E Tanker tr……..……..…G Other…….……X	
	Note 1- If only one source is used go to 303		

302.	Please state the sources for each use of water.	Drinking …… Cooking ……..……..…….. Washing clothes …… Cleaning the house.…….. Bathing /washing the body …... Rearing animals …… Other (specify) …….	
303	During Summers what was the main source of water for members of your household?	Piped into the house……A Personal pipe outside the house ……..……B Public tap……..……..……C Public tank **……**…….…..…….....……D Borewell **……**…….…….....…E Tanker truck…….……..…G Other……X	
	Note 2- If only one source is used go to 305.a		
304	If more than one source used in Summers, please state sources for each use of water.	Drinking …… Cooking ……..……..…….. Washing clothes …… Cleaning the house.…….. Bathing /washing the body …... Rearing animals …… Other (specify) …….	
305.a	Which containers do you use to fill and store water for your household ?	Bucket …….....……A Old paint bucket ……..…B Jerrycan …..……..…..……....C Old oil jerrycan……..…….....D Earthen pot .....……..…E Metal pot…….....F Camper.....G Old soft drink bottle……...H Water tank (volume…….……..).....I Water tank (filled with vessels).....J Direct into water tank (with pipe) (volume…..)...K Others……....X	
305.b	During Summers, which containers did you use to fill and store water for your household ?	Bucket …….....……A Old paint bucket ……..…B Jerrycan …..……..…..……....C Old oil jerrycan……..…….....D Earthen pot .....……..…E Metal pot…….....F	Lak[;k fy[ksa

		Camper.....G Old soft drink bottle……...H Water tank (volume…….……..).....I Water tank (filled with vessels).....J Direct into water tank (with pipe) (volume…..)...K Others……....X	
	Note 3- If water is available via pipe inside the house throughout the year, go to 308a.		
306.a	Presently how long does it usually take to go there, and come back in one trip? (Excluding waiting time)	≤10 min …….……1 11-30 mins……..…… 2 31-60 mins……..……..…….. ..3 >60 mins …….. 4 Not applicable ……88	
306.b	In Summers, how long did it usually take to go there, and come back in one trip? (Excluding waiting time)	≤10 min …….……1 11-30 mins..…… 2 31-60 mins..……..…….. ..3 >60 mins ……..…….. 4 Not aplicable…….……88	
307.a	Presently, how long do you usually have to wait at the water point?	No waiting time…….... 1 11-30 mins..…… 2 31-60 mins..……..…….. ..3 >60 mins ……..…….. 4 Not aplicable…….……88	
307.b	During Summers, how long did you usually have to wait at the water point?	No waiting time 11-30 mins..…… 2 31-60 mins..……..…….. ..3 >60 mins ……..…….. 4 Not aplicable…….……88	
308.a	Presently, how many times is water collected in a day (from all sources)?	1st Source ……times 2nd Source ……times	
308.b	During Summers, how many times was water collected in a day (from all sources)?	1st Source ……times 2nd Source ……times	
309.a	Presently, how many trips/rounds to the water source are made currently in a day (from all sources)?	1st Source ……times 2nd Source ……times	
309.b	During Summers, how many trips to the water source were made in a day (from all sources)?	1st Source ……times 2nd Source ……times	
310.a	Presently, who is primarily responsible for fetching/filling water for the household? (If response is children, also mention age)	Respondent……..…… 1 Husband...…….....…..2 Daughter……....3 Son…….…… ..4 Mother-in-law……..….. 5 Other (specify)……..……8	

310.b	During Summers, who was primarily responsible for fetching/filling water for the household? (If response is children, also mention age)	Respondent……..…… 1 Husband...…….....…..2 Daughter……....3 Son…….…… ..4 Mother-in-law……..….. 5 Other (specify)……..……8	
311.	Who is responsible for helping with the water related chores, if this person needs assistance or can not fulfil the water duties (due to ill-health, other responsibilities, etc)?	No one……..0 Respondent……..…… 1 Husband...…….....…..2 Daughter……....3 Son…….…… ..4 Mother-in-law……..….. 5 Other (specify)……..……8	
312.a	Presently, what time is the water supply available?	Morning…… to …… Afternoon……..to……. Evening…….to……..	
312.b	During Summers, what time was the water available?	Morning…… to …… Afternoon……..to……. Evening…….to……..	
313.	Are these timings suitable to you and your family?	Yes…….……..… 1 No (justify)……...……0	
314.a	On an average, how many days in a week was water from the main source available to your household during the last one month?	……days	If available all 7 days, go to 314b.
314.a i	What did you do on the rest of the days?	…….……..……..…… …….……..……..……	
314.b	During Summers, on an average, how many days in a week was water from the main source usually available to your household?	……days	If available all 7 days, go to 315a.
314.b .i	What did you do on the rest of the days?	…….……..……..……	
315.a	What water related contributions, in kind and cash, does your household have monthly? (Multiple responses possible)	Nothing …….……..……..…..Z Fixed monthly charge……A Metered connection…..……..B Per bucket charge…….……...…..C Water tanker ……..…....D Others (specify).....X	If Z go to 316. a
315.b	How much does your household usually pay per month for the water (for all purposes and sources)?	Rs……	

316.a	During Summers, what water related contributions, in kind and cash, does your household have monthly? (Multiple responses possible)	Nothing ……..……..……..…..Z Fixed monthly charge……A Metered connection…..……..B Per bucket charge……..…..C Water tanker ……..…...D Others (specify).....X	**If Z go to 317**
316.b	During Summers, how much did your household pay per month for the water (for all purposes and sources)?	Rs…….	
317.	What were the total initial water related expenses for your household ? (includes connection fee, initial contribution and own expenditures for materials etc) (Multiple responses possible)	Nothing……..…...Z Connection fee/Initial contribution ……..…...A Building materials, sand, cement, stone etc…...B Pipes, taps, etc **……**……...…...C Water meter ……..……..……...…..D Contribution with own labour ……..…..E Hire labour……...…..…..F Other(specify)……...…….. X Don't know……..…..Y	**If Z go to 319**
318.	What were the total initial water related expenses for your household ? (includes connection fee, initial contribution and own expenditures for materials etc)	Rupees……	
319.	Did your household experience any major interruptions/breakdowns in the water supply from the main source during the last one year? (for example breakdown of water pipeline, non availability of tanker truck)	No ……..……..……...0 Yes(specify)……1 Don't know……..……..…..…9	**If 0 or 9 go to 321**
320.	During these interruptions/breakdown, how many days was water not available from the main source?	Total number of days:…….	
321.	Does your household treat the water to make it safer to drink?	Never ……..……..……..…..0 Sometimes……...……1 Often……..……..……..... 2 Regularly……..… 3	**If 0 go to 323**
322.	What does your household do to make the water safer to drink?	Boil the water…..……..……..……...A Alum…….……..……....B Bleach/chlorine.....C Sieve/cloth……..……....D Water filter……..……..……..E Other (specify)……..……..…..... X	
Note 4: If filling/fetching water is some other family member's responsibility go to 332. **;fn ikuh Hkjuk fdlh vU; lnL; dh ftEesnkjh gS r® 332 ij Tkka, A**			
323.a	Were there any changes in your water related duties during your most recent pregnancy?	No change…… 0 Change in 1st trimester……...1 Change in 2nd trimester……..... 2 Change in 3rd trimester……..…3 Other (specify).....8	**If 0 go to 324 a**

323.b	What were these changes?	Was assisted by family member during water collection ……1 Was assisted by other women from the neighborhood during water collection ……2 Was not expected to collect water at all during Pregnancy ……3 Chose another water source during pregnancy……4 Others(specify)…….....8	
324.a	Have you ever experienced bodily discomfort (for example backache, tiredness, etc) while collecting water in the past one year?	Never ……..... 0 Sometimes ……. 1 Often ……... 2 Regularly ……. 3	**If 0 go to 325**
324.b	What kind of bodily discomfort did you experience? (multiple responses possible)	Backache …….....A Tiredness ……B Aching of other parts of body (specify)…….…….C Other (specify) ……..……..……X	
325.	What kind of physical issues have you experienced while collecting water in the past one year? (multiple responses possible)	None…….……..Z Walking long distances…….……..A Slippery/uneven lanes…….……....B Waking up at odd …….……..C Carrying heavy loads of water…….……..D Insects ……..E Stray animals…….……..…..F Other.(specify) ……...……..X	
Note 5: If water is available inside the house around the year, go to 331.			
326.	Have you ever experienced arguments/verbal fights while collecting water, in the past 1 year, especially during your pregnancy?	Never …….…….... 0 Sometimes ……..…….. 1 Often…….……... 2 Regularly…….… 3	**If 1,2, 3 specify**
327.	Have you ever experienced pushing/shoving while collecting water, in the past 1 year?	Never…….……..... 0 Sometimes ……..…….. 1 Often…….……... 2 Regularly ..…….… 3	**If 1,2, 3 specify**
328.	Have you ever experienced the fear of pushing/shoving while collecting water, in the past 1 year?	Never…….……..... 0 Sometimes……..…….. 1 Often…….……... 2 Regularly…….… 3	**If 1,2, 3 specify**
329.	Have you ever experienced harassment while collecting water in the past 1 year?	Never…….……..... 0 Sometimes ……..…….. 1 Often…….……... 2 Regularly..…….… 3	**If 1,2, 3 specify**
330.	Have you ever experienced the fear of harassment while collecting water in the past 1 year?	Never…….……..... 0 Sometimes……..…….. 1 Often…….……... 2 Regularly..…….… 3	**If 1,2, 3 specify**

331.	Have you ever had to forego your other chores or daily routine for collecting water in the past 1 year? Which activities did you most often forego? (Multiple responses are possible)	Never ……..…….....Z Foregoing sleep……..…….A Foregoing other household chores…….....B Going to work……..…....C Going to health institution……..……D Other (specify)…….X	
332.	Has it ever happened in the past 1 year, that you could not collect enough water for your household needs for the day?	Never…….…….... 0 Sometimes……..…….. 1 Often……..……... 2 Regularly..……..… 3	**If 1,2, 3 specify** **If 0 go to 401 a**
333.	What did you do to manage the water needs of the family on such a day, when sufficient water could not be collected? (Multiple responses are possible)	Did not wash clothes……..……..…A Did not wash hands ……..…..……..B Did not bathe……...…..…..……...…C Use ash/sand to clean utensils ……..D Did not clean the house……E Other (specify)**……**……..…….8	

SECTION 4: Sanitation

Now I will ask you a number of questions regarding your household's toilet facilities.

401.a	Does your house have a toilet facility? If toilet is present on premises, ask to see the toilet. Observe and mark the kind of facility	No toilet **……**……...…0 Flush to piped sewer system.…….. 1 Flush to septic tank…….....2 Open pit….. …… 3 Other (specify)…….....……..….8	**If 0 go to 402 b**
401.b	Is this toilet personal or shared?	Personal…….……1 Shared.……..……..……2	
402.a	*If toilet is present in the house*, do the adult males of the household usually use this toilet?	Never…….…….... 0 Sometimes……..…….. 1 Often……..……... 2 Regularly..……..… 3	→Reasons ……... ……... **If 3 go to 403.a**
402.b	Where do the adult males of your household go for defecation?	Open field (Public) …… 1 Jungle/hill ….…….....2 Road side…….3 Behind the house…….. 4 On polythene or paper for later disposal……..**…**5 Other (specify) ……..……..8	
403.a	*If toilet is present in the house*, do the older children of the household usually use this toilet?	Never…….…….... 0 Sometimes……..…….. 1 Often……..……... 2 Regularly..……..… 3 No other children in the household … 4	→Reasons ……... ……... ……. **If 3 or 4 go to 404**

403.b	Where do the older children of your household usually go for defecation? vkerkSj ij vkids ifjokj ds cMs+ cPps 'kkSp ds fy, dgkj tkrs gS\	Open field (Public) ……. 1 Jungle/hill …..…….....2 Road side…….3 Behind the house…….. 4 On polythene or paper for later disposal……...5 Other (specify) ……..……..8	
404. a	*If toilet is present in the house*, do you usually use this toilet?	Never…….…….... 0 Sometimes……..…….. 1 Often…….…..……... 2 Regularly..…… 3	→ Reasons dkj.k ……... ……... …… If 3 go to 405 a
404.b	Where do you usually go for defecation?	Open field (Public) ……. 1 Jungle/hill …..…….....2 Road side…….3 Behind the house…….. 4 On polythene or paper for later disposal……...5 Other (specify) ……..……..8	
405.a	*If employed*, is a toilet facility available to you during your work hours?	Toilet available .....…..…..…….. 1 Toilet unavailable .....……..… 0	**;fn 0] r® u®V 4 ij Tkka,**
405.b	*If employed*, where do you usually go if you have to use the toilet during work hours?	Open defecation……...…..1 Controlling the urge…….…..2 Other (specify)……..……8	
406.	Usually how long does it take to walk to and back from the open defecation spot ?	……..minutes	
407.	When are you able to access the sanitation spot ?	Whenever required……...…...1 Only when dark …..……..….2 Only when someone is accompanying .....3 Only early morning……4 Other arrangements (specify)…..……..……..….. 8	
408.	Do you usually go to the spot alone or are you accompanied by someone?	Alone ……..……..……..…1 Accompanied by family member…….…….… 2 Accompanied by other women from the neighborhood …3 Other arrangements..(specify)…….....8	
409.a	Did your choice of toilet facility change in any way during your most recent pregnancy?	Yes (specify)…….…… 1 No …….…….....0	**If 0 go to 410**
409.b	In which month of your pregnancy did you change the sanitation spot?	1st Trimester……..…….…….....1 2nd Trimester……..…….. 2 3rd Trimester…….…….….. 3 Other (specify)……..……...……...8	

410.a	Did your toilet habits change in any way during your most recent pregnancy? (for example going more frequent, not being allowed to go out alone,etc)	Yes (specify) ……..…. 1 No …….……....0	**If 0 go to 411**
410.b	In which month of your pregnancy did you change your sanitation habits?	1-3 ……..……...….1 4 & 6 …….. 2 7&9 …….. 3 Other (specify)…..……..……..……8	
411.	Did your choice of toilet facility change in any way during the post-partum period immediately after your most recent pregnancy?	Yes (specify) ……..…. 1 No …….……....0	
412.	Did your toilet habits change in any way during the post-partum period immediately after your most recent pregnancy?	Yes (specify) ……..…. 1 No …….……....0	
413.	Have you ever had to postpone going to the toilet, due to inability to access toilet in the past 1 year?	Never…….……..... 0 Sometimes……..…….…….. 1 Often…….…..……..... 2 Regularly..……..…. 3	**If 0 go to 415 a**
414.	What was the most common reason?	Wanted to wait for darkness to fall …… 1 Did not have anyone to accompany ……. 2 Other reason(specify)…… 8	
415.a	Have you ever limited your food habits (eat less so that you don't have to visit the toilet) because of inability to access toilet facility, in the past 1 year?	Never…….……..... 0 Sometimes……..…….…….. 1 Often…….…..……..... 2 Regularly..……..…. 3	**If 0 go to 416**
415.b	How did you limit your food habits? (Example: skipping a meal, eating lesser than needed)	Specify…….……..…… …….……..…….. …….……..……..	
416.	What are the challenges that you have faced in the past 1 year while accessing the defecation spot?	Did not face any challenges…….…… Z Being seen by people…….……..... A Restrictions on when to go out….. ……...…… B Embarrassment…….……...…..C Males (peeping, following, teasing, drunkards)……..D Fences / physical barriers……..……..…E	

	(Multiple responses possible)	Lack of space……..……..……...F Lack of privacy…….. ……..…….....G Lack of safety…….. H Distance……..……...…… I Rain (getting wet, mud, feces)…… J Difficulties due to ill-health..…….....….K Post-natal problems…….……...L Ghosts…….…….....M Night / darkness…….…… N Others (specify)..……...……....X	
417	Have you ever experienced physical problems while accessing the sanitation spot in the past 1 year ?	Walking long distances……...Z Walking to geographically treacherous landscape…….…...A Controlling the urge to defecate **……**….B Waking up very early in the ……D Insects…….…….....E Stray animals **….**……F Other (specify)……..……..……....X	**If 0 go to 419**
418.	How often did you face these problems?	Never…….…….... 0 Sometimes……..…….. 1 Often…….…..…….... 2 Regularly..……..… 3	
419.	Have you ever experienced arguments/verbal fights while accessing the defecation spot, in the past 1 year?	Never…….…….... 0 Sometimes……..…….. 1 Often…….…..…….... 2 Regularly..……..… 3 Specify……..	
420.	Have you ever experienced physical violence while accessing the defecation spot, in the past 1 year?	Never…….…….... 0 Sometimes……..…….. 1 Often…….…..…….... 2 Regularly..……..… 3 Specify……..	
421.	Have you ever experienced the fear of physical violence while accessing the defecation spot, in the past 1 year, especially during your pregnancy?	Never…….…….... 0 Sometimes……..…….. 1 Often…….…..…….... 2 Regularly..……..… 3 Specify……..	
422.	Have you ever experienced harassment while accessing the defecation spot in the past 1 year?	Never…….…….... 0 Sometimes……..…….. 1 Often…….…..…….... 2 Regularly..……..… 3 Specify……..	
423.	Have you ever experienced the fear of harassment while accessing the defecation spot in the past 1 year, especially during your pregnancy?	Never…….…….... 0 Sometimes……..…….. 1 Often…….…..…….... 2 Regularly..……..… 3 Specify……..	

SECTION 5:Maternal and reproductive health

Now I would like to ask about all the pregnancies you have had during your life. Some of these questions are very personal.

501	Women use different methods of protection during menstrual period. What do you use?	Nothing…….……..…….……0 Cloth.……..…….…..1 Locally prepared napkins…….……..….2 Commercially available sanitary napkins…..…….3 Other(specify)……..……..……8	
502	Would you be able to tell me how many times have you experienced pregnancy(successful as well as unsuccessful) including the most recent one?	☐	
503	Did you and your husband want this child?	Yes . . . . . ……. . . . . …... . …. 1 No. . . . . ……... . . . . . …. 0	**If 1 go to 505**
504	Did you want to have a child later on, or did you not want any children at all?	Did not want a child at the time ……..... . .. 1 Did not want a child at all……..... 2 Other (specify)…….……..…..8	
505	Were you using any Family Planning methods when you conceived your child?	Yes . . . . . ……. . . . . …... . …. 1 No. . . . . ……... . . . . . …. 0	
506	Did you receive antenatal care during this pregnancy?	Yes . . . . . ……. . . . . …... . …. 1 No. . . . . ……... . . . . . …. 0	**If 0 go to 511**
507	From where did you seek antenatal care for this pregnancy?	Govt. Hospital ..... 1 Govt. Health centre.. …….. 2 Private hospital……. ……. 3 Private clinic... …… . …….. …….. . … 4 Other(specify)…..…….……...…….. 8	
508	How many months pregnant were you when you first received antenatal care for this pregnancy?	……..months	
509	How many times did you receive antenatal care during this pregnancy?	☐	
510	As part of your antenatal care during this pregnancy, were any of the following done at least once?		

	YES	NO
Was your blood pressure measured?	1	0
Did you give a urine sample?	1	0
Did you give a blood sample?	1	0
Was an ultrasound done?	1	0

		Was your abdomen examined?	1	0	
		Did you consume any iron tablets or iron syrup?	1	0	
511	Did you receive any supplementary nutrition from the Anganwadi centre during last pregnancy?	Yes . . . . . 1 No. 0			
512	Were you advised any special precautions by a health personnel during your last pregnancy? (for example: special diet, bed rest)	No. . . . . Z Special Diet. . . . . A Bed Rest. . . . . B Medications. . . . . C Other (specify). X			
513	Did you take special precautions of any kind during your last pregnancy? (for example: special diet, bed rest, delegation of domestic responsibilities)	Yes . . . . . 1 No. 0			
514.a	Have you ever experienced any of the following?		Yes	No	
		Low birth weight child	1	0	
		Still birth	1	0	
		Pre-term birth	1	0	
		Spontaneous Abortion	1	0	
		Induced abortion	1	0	
515	During the last 12 months, have you experienced any abnormal genital discharge?	Yes . . . . . 1 No. 0			**If 0 go to 517 a**
516	Did you seek treatment for the same?	Yes . . . . . 1 No. 0			
517.a	During the last 12 months, have you experienced a genital sore or ulcer?	Yes . . . . . 1 No. 0			**If 0 go to 518 a**
517.b	Did you seek treatment for the same?	Yes . . . . . 1 No. 0			
518.a	During the last 12 months, have you ever experienced burning while passing urine?	Yes . . . . . 1 No. 0			If 0 go to 519
518.b	Did you seek treatment for the same?	Yes . . . . . 1 No. 0			
519	Are you currently suffering from any other gynecological ailment?	Yes . . . . . 1 No. 0			

520	Sometimes a husband is annoyed or angered by things that his wife does. In your opinion, is a husband justified in hitting or beating his wife in the following situations:		Yes	No	
		If she goes out without telling him?	1	0	
		If she neglects the house or the children?	1	0	
		If she argues with him?	1	0	
		If she refuses to have sex with him?	1	0	
		If she doesn't cook food properly?	1	0	
		If he suspects her of being unfaithful?	1	0	
		If she shows disrespect for in-laws?	1	0	

SECTION 6: Anthropometric and health information (observe from health center reports)

601.	Were you under long-term medication for any chronic ailment before pregnancy? (Example Diabetes, Hypertension)	Yes . . . . . 1 No. 0	
602.	Did you suffer from any pregnancy related disorders during the most recent pregnancy such as Gestational diabetes mellitus or high blood pressure?	Yes . . . . . 1 No. 0	
603.	Weight at first ANC (in kg)	……	
604.	Weight at third ANC (in kg)	……	
605.	Hemoglobin level during pregnancy (in %)	…… %	

SECTION 7:Household characteristics

701.	What are the total number of rooms available for your family members?	☐☐ Courtyard present……..……..1 Courtyard not present..……..……... 0	
702.	What type of fuel does your household mainly use for cooking?	LPG. . . . . 1 Kerosene . ……..……... 2 Coal . . . . . 3 Wood. . . . . 4 Animal dung . ……...……..……5 Other (specify)……...……..8	
703.	Main Material of the floor (Record observation)	Earth/sand . . . . . 1 Ceramic tiles ……2 Cement.. . . . . 3 Unfinished floor ……..……..……4 Other (specify)…….....…….....8	
704.	Main material of the roof (Record observation)	Plastic sheet……..……..…. 1 Wood/Plank…… . . . .……..…2 Metal sheet …… . . . . ……..… 3	

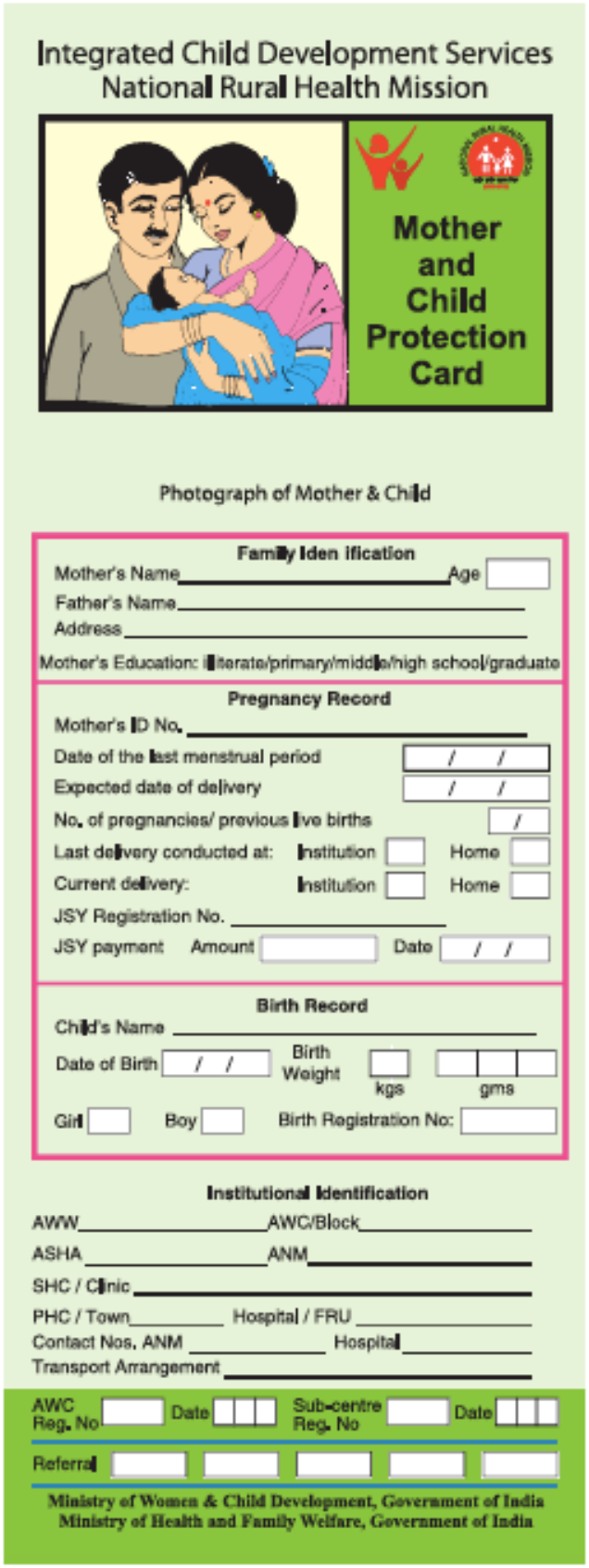
		Cement sheet…….....4 Concrete. . . . . ……..…..5 Other(specify).. ……....8	
705.	Does your family have a BPL card?	Yes . . . . . ……. . . . . ….... . …. 1 No. . . . . ……... . . . . . ….. 0	
706.	Which of the following amenities does your household have?		

	Yes	No
a. Electricity	1	0
b. Mobilephone	1	0
c Cycle	1	0
d. Motorcycle or motor scooter	1	0
e. Television	1	0
f. Refrigerator	1	0
g. Bank account	1	0

707.	Does your household rear any animals?			
		Yes	No	
	a. Dog	1	0	
	b. Goat	1	0	
	c. Cow	1	0	
	d. Buffalo	1	0	
	e. Pigs	1	0	
	f. Chicken	1	0	
708.	Does your household have a water pump?	Yes, we use it ……..……..……1 No..……..……..…….0 Yes but don't have to use it…….2 Yes but does not work ….……..….3		
709 a	Please show me where your family members most often wash their hands. Observe and mark. (Multiple options possible)	Outside the house……1 Designated space in the house……...…2 Washing sink ……3		
709 b	What kind of water is used for washing hands?	Running water is used ……..……1 Stored water is used …..……..……..……2		
709 c	What is used to wash hands with?	Soap or detergent (bar, liquid, powder)……..…1 Ash, mud, sand **.**.....……..…..…...2 Nothing……..……..……..0		
801.	According to you, how could your pregnancy been made better?	…… ……... …….. …….. …….. …….. …….. ……..		

Appendix 5: Maternal and child health card

Issued to pregnant women upon their first registration at a public health facility



Integrated Child Development Services
National Rural Health Mission

Mother and Child Protection Card

Photograph of Mother & Child

Family Identification

Mother's Name _____ Age ____

Father's Name _____

Address _____

Mother's Education: illiterate/primary/middle/high school/graduate

Pregnancy Record

Mother's ID No. _____

Date of the last menstrual period ___/___/___

Expected date of delivery ___/___/___

No. of pregnancies/ previous live births ___/

Last delivery conducted at: Institution ___ Home ___

Current delivery: Institution ___ Home ___

JSY Registration No. _____

JSY payment Amount _____ Date ___/___/___

Birth Record

Child's Name _____

Date of Birth ___/___/___ Birth Weight ___ kgs ___ gms

Girl ___ Boy ___ Birth Registration No: _____

Institutional Identification

AWW _____ AWC/Block _____

ASHA _____ ANM _____

SHC / Clinic _____

PHC / Town _____ Hospital / FRU _____

Contact Nos. ANM _____ Hospital _____

Transport Arrangement _____

AWC Reg. No ___ Date ___ Sub-centre Reg. No ___ Date ___

Referral ___ ___ ___ ___ ___

Ministry of Women & Child Development, Government of India
Ministry of Health and Family Welfare, Government of India

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