CHAPTER 1
INTRODUCTION

During a rural camp with students of social work I visited Muthuvan tribal kudy\(^1\) at Marayoor in Idukki district, Kerala in the year 2005. However, it was not my first exposure to a tribal settlement. I have been to other non-Muthuvan tribal settlements along the tribal belts of Wayanad, which included the settlements of Paniyar, Adiyar, Kattunaykkkan and Kurichiar communities as part of work and camps. I have also briefly visited the Irular and Mudugar tribal areas of Attapady (Palakkad). But, in Marayoor, I observed a lifestyle that is different from the ones in the other tribal settlements of Kerala. In addition, the physical appearance of Muthuvan women and men is different too. Women are tall, thin and have a lighter skin. The Muthuvans do not have conventional tribal features like short, flat nose, and a small forehead. Further, their marriage practices and dormitory systems are also different from the ones of their counterparts in Wayanad and Attappady. Hence, I developed interest in learning more about the Muthuvan customs associated with marriage, menstruation, sexual and reproductive health in general and its relation with the dormitory system.

At Marayoor, while I was passing through the kudy, I noticed a small, beautiful hut made of grass. I asked a Muthuvan woman who was standing beside me, ‘What is the purpose of the hut’? She told me that the hut was called thinnaveedu\(^2\). It had been built for a young mother and her newborn baby. I became curious and enquired further about the thinnaveedu, and I also wanted to get a glimpse of the baby and the mother. However, the woman stopped me and said, ‘If you go there first, you will have to take bath before coming to our house. Therefore, you can come to our house first and visit the thinnaveedu later’. Accordingly, I learned that the Muthuvans consider child birth as pollution. This practice of isolating a woman with her newborn baby in a hut of mud and grass for twenty-one days after childbirth surprised me. The mother had to cook, wash and perform other household chores without any help, while taking care of the baby.

---

1 Kudy is the word used for hamlet in the Muthuvan language
2 The etymological meaning of the word thinnaveedu derives from the following two Tamil words: (a) thinna, meaning outer part of the house, that is, verandah and (b) veedu, meaning home. Thinnaveedu is the menstrual hut for Muthuvan women as well as a sleeping place for girls and unmarried women.

Note: The local words are italicized at the first instance in the document. Later, the usual style is followed while mentioning them at further instances.
In the Muthuvan culture, the taboos and restrictions related to sexual and reproductive practices do not seem to be in the spirit of the general practices of pollution and maternity care followed in the mainstream culture of Kerala. The traditional practices related to maternity care are mostly based on Ayurveda and its conventions in Kerala. Further, a woman after delivery is not typically allowed to comb her hair; she has to be on a diet and take oil bath for 90 days. On all these days, the mother takes rest, and her only task is to take care of the new born. Ayurveda talks about the 90 nerves in the body, and they are involved in the process of delivery. Therefore, they prescribe a rest period of 90 days (As per the conversation with an Ayurvedic doctor, Roselyn, Kottackal Arya Vaidyasala, Field notes 2009). My exposure to the culture of Muthuvan kudy and the mainstream culture of Kerala helped me recognize the differences between them. I wanted to explore further the above mentioned cultural differences that distinguish the conventions and practices of Muthuvans from the ones followed by the people of the mainstream culture. I was interested in understanding their practice of isolating a new mother with her baby from the community and the underlying ideology that prescribes the norms regarding their sexual and reproductive health practices.

Since my M. Phil. research work, I had an interest in the area of reproductive health. Therefore, when I decided to pursue my doctoral studies after receiving fellowship from the Indian Council of Medical Research for studying women’s concerns related to sexual and reproductive health, the specific context of the Muthuvan women in Idukki appealed to me as a possible focus area. The memories of Muthuvan thinnaveedu at Marayoor were clearly imprinted in my mind. I decided to understand more about the Muthuvans, where a woman addresses all aspects connected to menstruation, child birth, and its social impacts principally represented by the concept of ‘pollution’ (purity-impurity). As a woman, although I was proud to see the supposedly ‘non-literate’ Muthuvan women dealing with the aforementioned situations very well, I was equally concerned about the women’s health conditions and needs. The focus of the research, therefore, was to understand the instances of child birth in the thinnaveedu. Some research questions raised in my mind: How do they manage the complications or emergencies associated with child birth? Does the baby get adequate milk? How does the mother manage to meet her own nutritional needs, since under the pretext of pollution, the father too does not come to the thinnaveedu to see the baby and the mother? How do the women in the Muthuvan kudy perceive these age old practices? Are there any changes in attitudes, perceptions, and practices recently owing to the influence of modern institutions and practices on the people in the kudy? The above mentioned
thoughts, feelings, and questions slowly led me to learn more about the sexual and reproductive health practices of Muthuvans, who live in areas that are at a distance of several miles from the mainstream society and its institutions.

Another dimension of the study was added when I got pregnant, and it was during the last phase of my field work and data analysis stage that I gave birth to my second child. During the last stage of pregnancy, I was staying in the campus of Tata Institute of Social Sciences (TISS), Mumbai. The gestation period allowed me to compare my own situation with that of the young women and mothers in the Muthuvan kudy of Edamalakudy. Since I was staying in Mumbai, I had access to medical facilities and was able to take good care of myself by following a specific diet and moderate exercise routines. But, in spite of the precautions and modern medical care, I gave birth to my child in the seventh month of pregnancy, which raised certain questions in my mind. How did I have a premature delivery, despite seeking modern medical care? Interestingly, it was during the same period that Vasanthi from Ampalapadikudy was pregnant with her twin babies, and she continued to do all her daily chores during her pregnancy phase. She completed the tenure of nine months that I could not. When I compare her situation in Edamalakudy, which is at a distance of several miles from modern medical facilities, with mine in a big city such as Mumbai, the contrast becomes starker. The natural ways of maternity care and nurture in Edamalakudy seem to outsmart the typical ‘elite’ concepts and practices of sexual and reproductive health prevalent in metros, which are promoted and perpetuated by the urban, ‘civilized’ cultures, ‘high-tech, super-specialty’ health care systems, and the medical and insurance industries.

Therefore, this study attempts to understand the sexual and reproductive health practices of the Muthuvans in Edamalakudy and seeks to trace the traditional basis, roots, and the earlier status of these practices. The present study compares the practices of Muthuvans with those of their neighbourhood tribal groups such as Ulladan and Mannan of the same district. Further, the present situation associated with these practices in the Muthuvan kudy of Marayoor, which has a closer interaction with the outside cultures and where the changes are rapid, is compared with the situation in Edamalakudy that is completely isolated from the outside world in terms of its geographic location. This comparison has helped in understanding the differences and depth of the traditional practices that still exist in Edamalakudy.

Tribes are the most vulnerable and exploited communities in India. The continued repression of tribes since several decades has considerably secluded them from the mainstream. And, the
seclusion is not limited to a particular tribe or a place. It is a universal fact. They are labeled as encroachers and trespassers in their own forests, which affects the natural rhythm of their life attached to forest. Displacement from their natural location is common to the history of many tribal groups.

The Muthuvans reached Edamalakudy because they were displaced from their settlements owing to the construction of the Chenkulam reservoir. In addition to this transition, the alien social system subjugated them into a more complex life, and it also challenged their survival. Furthermore, the shift in the location may have affected their agricultural practices and resulted in change relating to the food pattern of Muthuvans. The construction of houses may have also changed depending on the availability of local materials in their new location. Proximity to rivers is another important aspect since it plays a significant role in the performance of rituals and other cultural practices. Sometimes, these cultural practices are challenged owing to the changes in location. Hence, we can see a tribe practicing the same ritual differently at two distinct locations on the basis of the availability of resources such as bamboo and mats. However, the Idukki district has abundant forest resources and therefore, the change in the location (i.e. from Chenkulam to Edamalakudy) has not greatly affected the cultural practices of the Muthuvans, although we can notice some changes in their agricultural practices.

The isolated life of Muthuvans as a result of staying inside the forest has limited their interaction with the other communities. The Muthuvans rarely go out, and the outsiders hardly come into the kudy. Hence, they are able to preserve their culture without tremendous changes. After independence, the constitution has made definite provisions for the protection and welfare of tribes. Every five-year plan targets the total welfare of tribes and puts special emphasis on their health care and education by allocating funds.

According to the 2001 Census, the population of Scheduled Tribes in the country is 8.43 crores, which is 8.2% of the total population of the country. Kerala has 1.1% of ST population of the total Indian ST Population, and with regard to the total tribal population of India, it has 0.43 percent. The sex ratio of the total ST population is 1021, and it is significantly higher than that of the national average (978) for the total ST (Census 2001). In the context of Muthuvans, the sex ratio is 976, and the sex ratio among children below 6 years of age is 943. The education level of Muthuvans is very low in comparison with the other tribal groups of Kerala. The number of school dropouts is the highest among Muthuvans. Only 5.6% of Muthuvans have attained the matriculation level of education. Further, 61.1% of the children go to school. A study conducted
by the Department of Tribal Development (2011) on Muthuvans focuses on their marriage with outsiders, that is, marriage with a non-Muthuvian. Six non-Muthuvian men have married Muthuvian women; whereas among other tribes, it is 157 in Malarayan, 57 in Mannan, and 43 in Ulladan and Urali tribes, respectively. Inter-caste marriages are restricted among the Muthuvans. There are stringent norms with regard to marriage among the Muthuvans. They are a matrilineal community, and the women have own the land. However, their education status and other social status are less in comparison with that of the larger population living outside the forest.

**Background of the Study**

The government is implementing various programmes for the development of tribes such as Rural Employment Schemes, free food supply, and medical supply. These government policies and programmes have brought changes in the life of Muthuvans, and it has influenced their culture too. Although the changes have some positive influence, they are quite challenging in many other respects. The challenges are explained differently by people from various disciplines. According to environmentalists, forests are being destroyed through the new concrete housing policies. With regard to health professionals, owing to their background in modern medicine, they are worried about the home deliveries that take place in the Muthuvan community and the rituals associated with delivery and menstruation. The local people who have business relations with the Muthuvans are simply concerned about making more profit. The locals give high-yielding cardamom, plants and vegetables, seeds, manure, and pesticides to Muthuvans and force them to cultivate those on their land such that they are able to get maximum profit. They are not concerned about the health hazards caused by the pollution of chemical flooding of the ‘virgin’ forests of Edamalakudy. The ignorance of Muthuvans is exploited by the middle men in business.

Development programmes seemingly brought in many advantages such as education and employment into the life of the indigenous people, and they appear to have helped in building their self-esteem. But, at the same time, one cannot ignore the fact that these interventions brought in some disadvantages that is clear from the changes that have occurred in their culture. These development programmes significantly impacted the culture and traditional practices of the indigenous people.

In general, people who have secluded themselves from the mainstream society may have reservations and face difficulties in adapting to the culture of the ‘outsiders’. At the same time, the younger generations in such isolated communities are restricted by their elders from any
spontaneous inclinations they may have for the ‘new’ ways and styles of living. The youngsters are deeply rooted into their traditional culture, with stories of pain of punishment connected to the taboos. Therefore, the younger generation is often caught up in a dilemma between the grip of ‘tradition’ and the lure of ‘modernity’. What is important is that most tribes shape their lives and determine their choices that are in contrast with the aggressive-consumerist value systems of conglomerate capitalism. With regard to the Indigenous people, their surroundings are more important. For example, the indigenous people around the world consider that their land is an important asset for their survival, and they do not want to use it for profit (Mathai 2011). A letter allegedly written by the Chief of Seattle to the then American president is a testimony to the great respect of the native American people towards nature and the earth, as realities to be approached with reverence rather than as properties to be bought and sold. The letter gives us some glimpses of the world view of the native or indigenous populations around the world: ‘The earth does not belong to man, man belongs to the earth. All things are connected like the blood that unites us all….Man did not weave the web of life; he is merely a strand in it. If we sell you our land, remember that the air is precious to us, that the air shares its spirit with all the life that it supports. The wind that gave our grandfather his first breath also received his last sigh. The wind also gives our children the spirit of life’ (ibid). On the basis of my interactions with the Muthuvans of Edamalakudy, it became clear that land, air, soil, and water in the daily life interactions are natural and perennial. They do not want to hold on to these resources and reserve those for themselves. They treat the natural elements as part of their life and a part of a single habitat. Palanivel, a research participant, told me, ‘In this forest, an elephant, a bison, and a Muthuvan are equal, and we live together’. Such a cultural ethos makes them closely attached to their soil and the forest. The settlement of Muthuvans in Edamalakudy is completely covered by dense forests from all sides. Therefore, interaction with the outside world is limited. Hence, Muthuvans still uphold their age old ‘traditions’ and practices. An outside institution or an agency that approaches them is initially seen with suspicion. They would prefer to withdraw rather than come forward to embrace any new thing; they may accept it eventually, but the acceptance takes time.

Modern conveniences and facilities in Edamalakudy are increasing and eventually making people's life comfortable. In the kudys3, there are evidences of erosion of many aspects of their traditional culture. It is observed that the government is implementing the same programmes planned for the general populations among the tribal people without understanding the tribal

---

3 Plural form of the word kudy
wisdom and making necessary adaptations and re-articulations. It is important to preserve the tribal wisdom and ethnomedical practices. Further, the government needs to understand the impact of modern medicine on the Muthuvans by keeping in mind their cultural context.

The broader understanding of the concept of health and related practices is different in various cultures, and it helps to understand the tribal health culture empathetically. By focusing on various cultural groups, Kleinman (1975) reports that culturally constructed health and related beliefs result in a wide range of unique patterns of health-seeking-and- maintenance behaviours in different societies, and he concludes that illness and health care are directly woven into the cultural fabric. For example, among the Chinese, the concept of health is yin-yang (hot and cold) balance in the body, and its imbalance results in illness (Torsh, Ma 2000). The Muthuvans have a similar understanding of the concept of health. Therefore, this study on the Muthuvan women, particularly on reproductive and sexual health, is thus placed within the wider context of various understandings of and approaches to the concept and practice of health, invariably culture-specific and context-specific. The study attempts to analyze the important studies in the areas of health culture, health 'traditions' and systems, the concepts of body, reproductive age, reproductive and sexual rights, and the meaning’s of motherhood and related concepts and considerations.

In order to discuss this point further, let us take the case of Muthuvans ancient ethnomedical practices. This system had elaborate methods, although not documented systematically, to address most ailments and general health conditions. Once the modern medicines entered their daily lives, especially the allopathic 'tradition', the ethnomedicinal 'traditions' of the Muthuvans took a lower position for themselves and for the ‘outsiders’ who come into contact with them, especially the government officials. I recall my own experience of getting a firsthand experience of the intuitive tribal wisdom. As mentioned earlier, when I was in the final phase of fieldwork, I was pregnant with my second child. During the initial months of pregnancy I was unaware of the fact that I had conceived, and I continued my normal work routine in the field. One day, an old lady in Marayoor asked me, ‘Are you pregnant’? I replied very confidently, ‘No’. After a month of this episode, I learned that I was pregnant. I wondered so as to how that woman's native wisdom operated and recognized the condition of my body. This study tries to understand the sexual and reproductive health practices of Muthuvan women from an actor perspective.
Thesis Layout

Chapter I set the background of the study. The picture of the Muthuvan kudys in Edamalakudy in Idukki district is provided in this chapter. Further, it reviews theoretical and empirical literature in the area of health, and different dimensions and perspectives on health are dealt with. Different sexual and reproductive health practices in the various contexts and the associated taboos are explored in this section of the thesis. The concepts of Scheduled Tribe, 'modernisation', and health and related culture are explored here. An attempt has been made to understand the concept of health from the sociological, psychological, and anthropological perspectives. In addition, I have attempted to understand the various health systems available in our country. Attempts have also been made to understand how different scholars have commented on a woman's body and self-image by focusing more on the aspect of motherhood.

The next section begins with sexual and reproductive health, its history, and its changing contours in the last century. Different studies in India and abroad in the area of reproductive health are considered in order to analyse the trajectory of family planning programmes and the challenges it poses on the sexual and reproductive health. The studies that focus on young mothers and the key events in a woman's life are also explored with a special emphasis. Further, a woman's autonomy in the area of sexual and reproductive health is discussed as one major area of interest in this chapter. The Muthuvans and studies related to their 'traditional' culture are also explored.

Chapter II describes the research procedures. This chapter brings out the rationale of this study. The concepts used by me in the study are clarified in this section. The concept map gives a picture of the interconnectivity among different concepts, which again were facts that needed to be verified in the field. Research objectives and research questions are outlined in this chapter. The insider approach in the context of ethnography is explained. The methods for data collection, the ways through which the field was approached and access to participants was obtained, and the analysis process are explained in this chapter. I have further explained the research paradigm that has been followed for the purpose of this research. Ethics and limitations of the study are also mentioned. The challenges as an outsider, the process of getting into their culture, and the position I have taken in the study are also described in this chapter. I have provided the details of the site, the state and district map with illustrations, and a social map of the Edamalakudy (given in the Appendix). My initial work in the field and the phases of field work are also recapitulated.

Chapter III explores the life of Muthuvans inside the forest. It mainly introduces the location of the kudy and its structure. The main locations of study are Andavankudy and Ampalapadikudy.
The structure of these two kudys of Edamalakudy area is explained. This chapter also traces the family system, death rituals, institution of marriage, the other customs, and practices that exist in their culture generally. Muthuvan practices such as the dormitory system, *panchayam* for the legal aspects and the *ooruvilakku* as punishment are also described. The other aspects that are discussed here include the food habits, agricultural practices and the associated festivals, their patterns of building houses and their dress patterns. Rituals and ceremonies associated with their life, their dialect and education level are further mentioned. This descriptive chapter provides a picture of Muthuvans who live in the Edamalakudy forest area.

Chapter IV narrates the growth of a Muthuvan girl amidst the cultural characteristics of the Muthuvan community. Among these are the characteristic *poonukettu*, *kondakettu*, *thalemuttu*; clan lineage and marriage are the significant practices that are explained, and their relation with sexual and reproductive health is interpreted. Adherence to the cultural norms moulds the identity of a Muthuvan girl. The relevance of kondakettu, thalemuttu, marriage and the other events in the life of a woman in the area of sexual and reproductive health is traced here.

Chapter V mainly focuses on the practices related to delivery, motherhood, beliefs and taboos in the system. Further, this chapter traces the trajectory of change in their existing sexual and reproductive practices vis-a-vis Sanskritisation. The concept of purity and pollution is explored. The challenges faced by the Muthuvans while responding to this shift are analysed. The entry points of 'modernity' into their culture, the role of government policies and programmes in their culture, and their perceptions towards them are also explained in this chapter. The changes occurring owing to the influence of the outside world and the role of education and media are also a part of the focus of analysis. How the role and gender status change owing to the external exposure is analyzed, and its impact on the sexual and reproductive health is traced. Further, the role of allopathic medicines in their lives and the utilization of the modern medicinal system are also explored. Marriage and its associated issues with regard to the clan system, exogamy, consanguineous union, and the ooruvilakku that are associated with marriages with outside communities, are discussed in this chapter.

---

4 A meeting of concerned representatives to solve the problems of the kudy
5 Ooruvilakku refers to total isolation imposed on a man, woman or a family for violating the rules of the kudy.
6 Carrying babies on the back with the support of a cloth knot.
7 It is a hair style followed by the Muthuvan women. The first tying up of hair by the girl is celebrated as a ritual called kondakettu
8 Cloth knot over the head - a ritual which mark the menarche of a girl
Chapter VI explores the personal and social facets related to the Muthuvan women, the changes in or responses based on their perceptions relating to sexual and reproductive practices rooted deep into their culture and 'tradition'. Adaptation strategies and the role of external influences in this process are also noted. Moreover, the changes in their attitudes and inclinations toward food and related habits and how these changes affect the health of women have been shared. The role of artifacts in the kudy and how the older generation interprets the new trends in their community are the areas that are addressed in detail in this chapter. The present study, therefore, explores how the different types of changes introduced by 'modernity' affect the sexual and reproductive health of the Muthuvan women.

Chapter VII titled conclusion and it sums up the thesis. This chapter presents the challenges and explains the major arguments raised by this study in the analysis of each chapter. With regard to the larger context and the intent of the present study, the concept of sexual and reproductive health and the other related concepts need to be thoroughly understood and addressed.

**Literature Review**

This section explains the concepts associated with sexual and reproductive health and the relevant theories. Therefore, the key concepts from the studies related to this area are also described. In order to understand the relevant concepts and theories, one needs to understand perspectives that have been developed by the different scholars through their long-term involvement in issues of sexual and reproductive health. Therefore, an attempt has been made to share the different perspectives on reproductive and sexual health debates. The context of negotiation between the external exposures, the local reproductive and sexual health practices, the response of tribal women to these external factors are the key focus areas of this study. Therefore, the concepts related to the factors of social change and structuralism, motherhood, arguments related to tribal sexual and reproductive health, and the cultural aspects of health are explored in this section of the thesis.

By venturing into the lives of the tribes, this study opens up a wide range of issues related to sexual and reproductive health in one of the unique social groups of the country. The study hopes to shed light on the actual sexual and reproductive health practices of the Muthuvans, especially after the introduction of other medicinal systems and practices in their kudy. These changes in the tribal community affect women in crucial ways and have serious consequences. It has been observed that in a study conducted by Health Department, (DMO 2006) several tribal women are
reluctant to embrace the indigenous health practices since they are caught between contemporary and local practices and are lured by different newer possibilities, which are totally unknown to the older generations.

History and definitions of sexual and reproductive health from different perspectives and the scholarly arguments have been incorporated to comprehend the layers of inquiry. Some of the questions addressed in this section are as follows: How do the community interactions and their daily life practices relate to the health behaviour? What are the adaptation strategies in the context of the dynamics of sexual and reproductive health and how do people who are part of the change respond to it? Further, analysis has been made to understand how the culture preserves traditional knowledge and how the research was carried out in those areas. Different cultural aspects, perceptions and concepts on sexual and reproductive health of diverse cultures are also elucidated. Muthuvans belong to the tribal community and therefore, it is important to understand about the tribe and studies conducted in tribal people of Kerala.

**Scheduled Tribes**

Article 366 (25) of the Constitution of India (Ministry of law and Justice 1988) refers to Scheduled Tribes as communities who are scheduled in accordance with the Article 342 of the Constitution. This Article says that only those communities that have been declared by the President through an initial public notification or through a subsequent amending Act of the Parliament will be considered Scheduled Tribes. The list of Scheduled Tribes is State/UT specific and a community declared as a Scheduled Tribe in a State need not be one in another State/UT. The essential characteristics that were first laid down by the Lokur Committee, for a community to be identified as Scheduled Tribes are as follows: indications of primitive traits, distinctive culture, shyness of contact with the community, a stagnant or declining population, extremely low literacy, and a subsistence level of economy (Joshi 2004). Geographical isolation, pre-agriculture level of technology and ‘backwardness’ are the criteria for grading tribes.

The Scheduled Tribe (ST) population in India accounts for 8.2% of the total population of which 0.2% of ST population resides in Kerala (Census 2011). With regard to the state of Kerala, they constitute a minor percentage of the total population. Therefore, they are not big ‘vote bank’ for the politicians. Hence, the cultural understanding and the programmes keeping the context as a primary concern are not in the agenda of the government. A study conducted by CDS (2005) shows the Human Development Indicators (HDI) of the ST population continues to be much
lower than the rest of the population in terms of all parameters such as education, income, and health status. In addition, the problem becomes more complex since these deprived sections of the society also suffer from geographical and cultural exclusion, which are not reflected in the Human Development Report.

Further, the tribes are deprived of access to benefits enjoyed by the mainstream society owing to their social, geographical, economic, and cultural factors. This leaves the tribal women in a disadvantageous situation. The Human Development Report on Kerala clearly indicates the fact that marginalisation is aggravated by the low levels of education and awareness among the people.

It was not the tribal identity of Muthuvans, but the reproductive health practices followed by the Muthuvans that fascinated me to conduct this study. Hence, the tribal identity is not a major focus of this study. Nevertheless, the study discusses the tribal features, as the State treats them as scheduled tribes. The mainstream studies on tribal health are of primarily of the following two types: (1) general health studies that cover the health status or any prevalent issue in a particular community and (2) the orientation of medical anthropology and emphasis on health culture of a particular community. But, the studies conducted in Kerala mainly focused on the general culture and the associated issues of tribes.

**Studies on Tribes in Kerala**

The pioneer ethnographic notes on tribal life are of Edgar Thurston (1909). His ‘Caste and Tribes of Southern India’ has seven volumes, and he made a systematic and detailed survey of the entire south India. This monumental study gives an account of Muthuvan's way of life, social culture, and agricultural practices. Another study is by Iyer (1968) titled ‘the Cochin Tribes and Castes’, and it has four volumes. In this work, he has explored the history of Muthuvans, their arrival to Kerala from Tamil Nadu, and their culture and religious life. Luiz’s (1962) study of the 48 communities of Kerala included the tribal groups. He gives detailed descriptions of the Muthuvan's lives, their culture, and the changing pattern of their social life in the context of social and economic changes.

M Kunhaman's (1989) study covered the hill tribes of various regions of Kerala. This study focused on the social, economic, and development aspects of hill tribes. This study brings out the various development-related achievements of tribes and changes in the pattern of leadership among some of the tribal groups. However, this study does not cover Muthuvan or any other
tribes in the Southern part of Kerala. A classic ethnographic study of the Cholanaikans, a primitive tribe of Kerala, by Bhanu (1986), describes their life style, material culture, and food-gathering techniques.

Furthermore, studies on the livelihood of Muthuvans were carried by Damu (2003), and it highlighted the Muthuvans’ relationship with the ecosystem and their role in the conservation of forest and wild life in the Idukki district of Kerala. He further explained that the Muthuvans were guides to many UK-based planters who came to Idukki district for tea plantations. The Muthuvans took a major role in finding short routes to reach major cities through forests and made *kuthirachal* to Cochin from Tata Tea Ltd, Munnar during the British rule. Kannan and Thevan, two Muthuvans were guides for these route mapping exercises to the British, and as a token of gratitude, the East India Company named their plantation as Kannan Devan Tea Plantations. Kumar (2005) studied the role of *chavadi* in a Muthuvan life cycle. His study confirms the multiple roles and functions of chavadi in making a male child a mature member of the community. Further, he explains that these dormitory systems enable one to understand the rituals, rites, and also how each member participates in them. It provides an avenue to be community conscious and to incorporate their feelings and actions, thereby making them responsible to the community. The practice is explained by the Muthuvans, as a technique to confirm familial obligations during periods of scarcity and to hold on to the notion of their settlement as a collectivity. Kumar explains such features of Muthuvan social organisation make their chavadi distinct from that of Murias *ghotuls* as described by Elwin (1947) and Oraon’s *dumkuria* described by Roy (2006).

The studies on Muthuvans show their association with nature and its role in their culture. Their cooperation of living, sharing, and divergence in cultural practices are highlighted in the studies. Muthuvan have different social institutions such as chavadi compared to the other tribes of Idukki. This divergence in their practices has attracted researchers. But, their secluded and isolated life inside the interior forest does not provide easy access to conduct a study.

---

9 Horse way
10 Dormitory, a sleeping place for boys which is considered as a vital place in the kudy
11 Mixed dormitory, for boys and girls in Muria tribal community
12 Mixed dormitory, for boys and girls in Oraon tribal community
Traditional Health Culture and Changes in the Contemporary Period

Every community has its own culture. Hence, understanding the way of each community's sexual and reproductive health practices is complex. And, in the context of an indigenous group, it becomes more difficult. At the same time, India has diverse medical knowledge from health systems and practices, including the multiple indigenous systems of medicine like Ayurveda and ethnomedicine. The wide variety of medical knowledge is related to religious practices and shamanism. One can see these diverse practices even in the area of sexual and reproductive health of an indigenous community.

Several people have opted for folk and ethnomedicine to treat various ailments in their lives. In the domain of sexual and reproductive health too, there exists a plethora of such cultural-specific beliefs. Hollen (2003:189) described even in the interior places, one can see the partial shift to allopathic medicine, such that they become 'shifting constructive parts that are constantly being put together in new ways at multiple levels of the “local”'.

The marginalised circumstances of the tribal women demand special attention from social scientists, policy makers, and health practitioners, so as to make a sincere effort to understand the situation of the tribal populations. The indigenous practices related to reproductive and sexual health among tribes vary from one community to another. Some of these practices may have adverse effect on proper health but some surely do enrich the health of women and children. The good practices are worth replicating in the mainstream communities by considering the rich tribal wisdom and the wealth of their experiences that are precious gifts to the entire humanity. But, these ancient 'traditions' and practices have been facing constant challenges owing to the impact of policies that came along with development and urbanisation and were accompanied by globalisation (Kohily, Nayak 2008). Such drastic changes make the tribal people vulnerable in many respects: in terms of livelihood, shifting or totally disappearing agricultural practices, and changes in food habits. Every indigenous community has its body of 'tradition' and its own organic process of evolution. Globalisation refers to the expansion of a universal culture at the expense of all other cultures. Local cultures are self sustaining. But as far as they are forced to integrate into the mainstream, they become dependent and helpless.

Development is visualised in terms of a progressive movement towards technologically and institutionally more complex and integrated forms of 'modern' society. This process is set in motion and maintained through the increasing involvement in commodity markets and through a series of interventions involving the transfer of technology, knowledge, resources, and
organisational forms from the more 'developed' world or sector of a country to the less 'developed' parts. In this way, a traditional society starts to make negotiations with the external boundaries, and it is negotiating with the often designated 'social and cultural obstacles to change', and its economic and social patterns acquire the accoutrement of 'modernity' (Long 2001). All forms of external intervention enter the existing worlds of the individuals and social groups, and in this way, they are mediated and transformed by these same actors and structures.

Sociologists define ‘modernity’ in the context of social solidarity, industrialization, and globalisation. It is the impact of these contexts due to which there are changes occurring in the local culture. In this study, the external intervention has been focused in the context of change entering into a Muthuvan kudy. Therefore, this study aims to provide explanations and interrelations between phenomenon appearing in the Muthuvan world and their response to it as actors.

**Health and Related Culture**

The process of initiation into one’s culture in the context of a community is all the more evident and important in the case of indigenous and ethnic cultures. Every group and society has a distinct culture with relevant history. Moreover, the culture of an ethnic group changes drastically even while the same ethnicity persists. A study conducted in Manipur reports (Maheo 2004) that the identification with an ethnic group “name” is more important than the culture of a group; the name persists as a symbol even though the culture has exchanged.

When a child grows up in a community, it assimilates various facets of day-to-day life, including the values of the community. Through this process of socialization, health culture as an entire way of life becomes internal to the individual, an integral part of the personality, providing the framework for organizing one’s actions and expectations, and directing health actions or health behaviour in accordance with the value and norms of particular community (Garro CL 2000). Thus, health culture becomes the basic desiring or stimulating force behind an individual’s health behaviour.

Health culture of a community needs to be understood by placing health in the broader spectrum of culture of a particular society or community. Culture is the repository of all rituals, norms, symbols, beliefs, images, and other mechanisms that any group of people use to interpret, assign meaning to, and develop a sense of what the world is all about. Culture is the means by which people receive, organise, rationalise, situate, and understand themselves and their particular
experiences in the world (Smith 1996). ‘Much of what culture imparts, people learn early in life’ (Saleeby 1994), which begins in infancy. Cultural learning occurs through stories, narratives, interpretations, and myths that both transfer the meaning of any culture from one generation to another and reinforce the meaning for the adults (Burawoy 2004). As a result, much of the meanings in people’s lives grow out of their relationships or lack thereof, starting with their parents and other members of their culture.

Emphasizing the cultural dimension of health, the World Health Organization (WHO) describes health system as ‘a set of cultural beliefs about health and illness that forms the basis for health-seeking and health-promoting behaviour, the institutional arrangements within which that behaviour occurs, and the socio-economic, political, and physical context for those beliefs and institutions’ (WHO 1978). Health has been defined by WHO as a ‘state of complete physical, mental, and social well-being and not merely the absence of any disease or infirmity, in the entire way of life’. This definition of WHO does not include the beliefs and norms of a social system and therefore, the cultural aspects of health do not form part of the discussion. As the characteristics of health attributes are ascertained from the axiom of culture and manifest as the dynamics of health culture in the complex social system and require a holistic or wider frame of reference. The circle of health and culture determines the essence of health culture and its axis overrules the given situation wherein human beings or the community lives.

This broader understanding of the concept of health and related practices as something different from culture to culture helps to look at the tribal health culture from an actors’ perspective. The culturally constructed health and health beliefs result in a wide range of unique patterns in health-seeking-and-maintenance behaviours, concluding that the illness and health care are directly woven into the cultural fabric (Kleinman 1975). In each community, they have their cultural beliefs and practices; it is important to understand and consider these beliefs and practices before implementing any programmes for them.

According to Sen (2001), health is among the most important conditions of human life and a critically significant constituent of human capabilities. Any conception of social justice demands the need for fair distribution and efficient formation of human capabilities in which health is a must factor. Hence, the freedom and capabilities exercised by us depend on our health achievement. Sen’s position is further clarified in the ‘Argumentative Indian’ in which he claims that, the expansion of women’s capability enhances their freedom and well-being (Sen 2005). The government programmes focus on increasing women's autonomy to achieve certain level of
development. Kleinman's (1975) argument becomes relevant here, that the cultural practice varies and culturally constructed health and beliefs result in unique patterns of health-seeking behaviour. The study of the perceptions of tribal mothers particularly on reproductive and sexual health is thus placed within the wider context of various understandings and approaches to the concept and practice of health. This is invariably culture-specific and context-specific, thereby examining the important studies in the areas of health culture, health traditions/systems, concept of body, adolescence, reproductive and sexual rights, and meaning attached with motherhood and related concepts and considerations.

**Health from Different Perspectives**

The concept of health is shaped by different paradigms or frameworks and also depends on how changes happen within these paradigms. Here, one can examine the following three different perspectives on health: psychology, sociology, and anthropology. The disciplines of psychology, sociology, and anthropology inform us that human beings are not passive objects shaped by the external world but are active subjects who construct their social reality by giving meaning to the reality around. They interact with one another within their distinct contexts and create their own reality. Their experience of reality is subjective, and it is individually and socially formed and guided by intersecting political, economic, and cultural experiences. Understanding the sexual and reproductive practices of indigenous community is a difficult task without understanding the perspectives of different disciplines. However, when one looks at sexual and reproductive health through the lenses of various disciplines, it gives more scope for understanding the linkages of the health culture of that community and helps in bringing out the complexities involved with it.

**Sociological Perspective:** In spite of the growing interaction between medicine and social sciences, medical specialists often fail to realize that the sociological view of illness is different from the medical view of illness. For a physician, illness is deviance from a biological norm of health and feeling of well-being. Normally, they define a person as ill when his or her symptoms or complaints or the findings of a physical examination or tests indicate an abnormality. In contrast, the sociological view of illness is much broader because sociologists view illness as deviant social state brought about by disruption of normal behaviour through disease, which is a biological state.
The Cartesian dualism creates the split between the concrete physical body and the abstract emotional being (Kim 1971). The body is a scientifically observable entity, locating pathology in the body, making disease concrete, and thus identifying a single agent as the specific cause of disease which is rational because such measurable observations lead to framing of universal laws. Social, cultural, economic, and structural factors that arise from human interactions and different community contexts are complex and cannot be directly observed or scientifically measured (ibid). These dimensions of illness are most often ignored in the biomedical system since the body and its scientific treatment become the focus of their research and practice.

Sociology goes beyond examining the society in which individuals live, the way they interact, the rules and norms for interaction and exchange, and the hierarchies and other social factors that play a role in the human experiences. Svedberg (2006) argues that within a certain social structure, social relations prevail, which are maintained, and reproduced through coercive forces. Good health would then refer to not only the physical and emotional well-being but also to access and control over the basic material and non-material resources that sustain and promote life in order to enjoy a high level of satisfaction.

Structure restricts control over resources in the hands of a few powerful sections of the society, and the production, distribution, and consumption of medicines serve to perpetuate these inequalities through the processes of labeling, monitoring, prescribing, and medicalisation (Purdy 2006). This perspective is thus concerned with the social production of illness. It is argued that the illness of a patient cannot be understood without understanding the historical, social, and cultural context of the individual (Schattschneider 1960 p.68 as cited in Outshoorn 1990). But, in the context of India, the status of medical sociology is only emerging. Minocha (1974:1) argues that not much thought had been given to explore the links between medicine and society. She laments the facts that 'the present sociologists in India have more or less neglected sociology of medicine as a field of study'. However in early period, many authors explained how sociological concepts like sanskritisation (Srinivas, 1956), universalisation, and parochialisation (Marriot 1955) and stigma (Goffman 1961) are useful to explain sociological aspects of medicine (Minocha 1974). The larger thrust of sociology or social anthropology was on village studies in the sixties and seventies in India, and research on various aspects of health and medicine were

---

13 The qualities of our experience (modes of thought) seems to differ dramatically from the qualities of material bodies (modes of extension)
part of those studies. But, in the later periods, many foreign anthropologists and sociologists came to India and well explored the area of health and medicine. In an indigenous community, the sociological basis of health is determined through their social system. Their interactions with each other and the approach to the external phenomenon are different. Therefore, understanding sociological perspectives of health becomes relevant here.

**Psychological Perspective:** Psychology contributes to the field of health by emphasizing the role of emotional and personality factors in the physiological manifestation of disease. It is interesting to find out connections between the ‘psycho’ and the ‘soma’ in tracing the origin of diseases. Psychological factors such as stress, availability of social and family support, personality traits, past experiences, meaning and value attached to different conditions, appraisal mechanisms, coping mechanisms, severity of symptoms, and threshold and adaptation levels play a role in the manner in which an individual experiences health and illness (Svedberg et al. 2006). Psychological aspects of health are relevant in understanding the characteristics of individuals, their coping mechanisms in different situations, and personality traits, especially in an indigenous community. It is important to explore the individual’s personal response and feelings on different practices and norms that exist in the community.

**Anthropological Perspective:** Anthropology questions the existence of essential truths, and the ones that are asserted to be true are analyzed and treated as the product of power relations. Knowledge is, therefore, a construction and cannot be universal but is dependent on cultural contexts (Joshi 2004). Anthropology is concerned with examining how diverse cultures ascribe meaning to different health statuses, what is considered as normal or abnormal, what treatment method is followed, and what are believed to be the causes of different illnesses.

Fabrega (1974:189) defines medical anthropology as an inquiry that will be defined as one that elucidates the factors, mechanisms, and processes that play a role on or influence the way in which individuals and groups are affected by and respond to illness, disease, and examines these problems with an emphasis on patterns of behaviour.

According to him, neither concepts nor methods or aims are critical, but rather the content of the work that is performed. Thus, medical anthropologist’s major areas of concern are society’s beliefs, concept, and curative measures of illness and they explain how people cope with a disease and what solution they offer to overcome this situation, in the general context of their culture. Individual and contextual factors thus interact to determine experiences. Social conditions or structures, on the one hand, provide choices to individuals, while on the other hand,
restrict physical and social movement. An individual lives within these community structures, cultures, and his/her experience (of health) is shaped and guided accordingly.

Good (1994) argues that, in spite of the many advances in medical diagnosis and therapy, the notion that the medical science mirrors nature rests on the culturally specific distinction between knowledge and belief. It is important to look at, how language activities and social practices actively contribute to the construction of scientific knowledge. In this philosophical climate, medical anthropologists face the task of investigating how cultures with their unique forms of social practice of 'illness behaviour', the activities of diagnostic and healing specialists, and healing rites formulate reality in distinctive ways. Good (ibid) claims that biomedicine provides straightforward, objective depictions of the natural order, an empirical order of biological universals, external to culture, no longer seem tenable and must be submitted to critical analysis. And, for this, the empiricist theory of medical language with its focus on representation is not enough. Therefore, there must be ways to alternatives. Fabrega (1974) and Good (1994) emphasize on the cultural background such as beliefs and practices that are important to determine one's health and illness.

**Different Alternative Health Systems and Perspectives on Health and Illness**

Allopathy (bio-medicine) is considered the ‘modern medicine’ and at times, the only scientific branch of health science. Since our approaches and attitudes to health are majorly shaped and influenced by this system of health that relies heavily on analytical atomization through clinical experimentation procedures, one needs to take a rather critical stand on allopathy and use its parameters to evaluate the indigenous health practices of the tribal communities. The tribal worldview and their health culture are oriented towards a synthetic and holistic process. Therefore, a study on health practices needs a broader understanding of alternative health systems. As relevant to the geographical context of the present study, that is, Kerala (India), a brief understanding of three alternative health systems and their vision of health are taken into consideration here.

**Ayurveda:** The term Ayurveda means science of life. It deals elaborately with measures for healthy living during the entire span of life and its various phases (Subramanyan, 2004). Ayurveda conceives the human being as a conglomeration of three aspects (vata, pitta, and kapha), seven basic tissues (rasa, rakta, mansa, asthi, majja, and sukra) and the waste products of the body that include faeces, urine, and sweat. And, the balanced condensation of the five basic
elements *panchamahabhutas*, namely, earth, water, fire, air, and vacuum (ether) as the basic constituents of all forms of matter in the universe is advocated (ibid). Ayurveda incorporates both the preventive and curative aspects of life echoing WHO’s concept of health from a holistic perspective.

According to Ayurveda, health and sickness depend on the presence or absence of a balanced state of the total body matrix, and disturbance in the natural equilibrium by both intrinsic and extrinsic factors can cause disease. Ayurveda also follows the homeostasis of four bodily humours, that is, blood, phlegm, yellow bile, and black bile, which is explained by Good in the anthropological context (Good 1994) that is each culture, has a unique way of practice and concepts. The essence of Ayurveda lies in the fact that diagnosis is always done considering a patient as a complete person and not in parts (Subramanyan 2004). Indigenous communities have the similar type of beliefs and concepts that is connected to water, soil, and fire.

**Homoeopathy:** This system originated in Germany and has been recognized as one of the popular alternative systems of health in India at large and plays an important role in providing health care to a large number of people. Homeopathy involves treating diseases with remedies, prescribed in minute doses, which are capable of producing symptoms similar to the concerned disease when taken by healthy people. It is based on the natural law of healing, ‘likes are cured by likes’ (Jaggy 1976). Homoeopathy is a system of treatment based on demonstrable laws and principles. It treats all aspects like mental, emotional, and physical nature of the person who happens to be suffering with any disease or infirmity (ibid). Homeopathy regards each patient as a unique individual, and it aims at the individual’s total being or the whole system. The physician’s interest here is the long-term well-being of the patient and not just the alleviation of the patient’s present symptoms.

**Siddha:** Siddha system is one of the oldest systems of medicine in India. It is largely therapeutic in nature. It is very similar to Ayurveda; it also considers human body to be composed of five basic elements of nature and three humours, seven basic tissues, and waste products of the body. Food is considered to be the basic building material of human body, which gets processed in to humours, body tissues, and waste products. Siddha also upholds the concept of salvation in this life on earth itself. The exponents of this system consider that the achievement of this state is possible by medicines and meditation (website www.indianmedicine.nic.in accessed on 11/11/2007). The traditional system of Ayurveda and indigenous medicine has some conceptual linkages, and one can observe this around the country.
'Heat' is a core concept in both classical Greek and Islamic physiology and medicine. In order to understand the concept, it is necessary to recognise that heating serves as a model of transformation that is central to theories of digestion (Good 1994:103). He further argues an anthropological hermeneutics requires not only a mapping of symbolic elements from one system to another or a pairing up of sentences but also a comparison of the situated practices through which knowledge is produced and elaborated.

These traditional systems of medicine are considered holistic in nature. They take a multifactorial, multilevel view of human illnesses by considering a particular disease as a result of disturbances owing to a combination of physical, psychological, social, and spiritual factors (Zollman, Vickers 1999). Traditional health practitioners define life as ‘the union of body, senses, mind, and souls, and they describe positive health as blending of physical, mental, social, moral, and spiritual welfare’, which definitely fits into the WHO definition of health as physical, mental, and social well-being (Foster 1983). As described by the WHO, these diversified streams of alternative medicines have not actually become alternatives in many of the developing countries, where a large proportion of population still rely on witch doctors and similar practitioners (including untrained traditional birth attendants) for their primary health care needs (WHO 1996).

Indigenous people have their own knowledge regarding health and illness that may be associated with fire and soil. Shamanism and various kinds of prayers are also prevalent among the tribal communities. The aboriginal people of Canada have been undergoing a cultural revival in more recent decades. As a result of the residential school system and other government policies aimed at assimilation, aboriginal communities experienced a significant loss of cultural knowledge in general and healing knowledge in particular. Many of these aboriginal people who endured the worst through the residential system had limited or no exposure to traditional languages and healing practices, along with a myriad of other customs and values (Wilson et al. 2011). The compulsion of acquiring a particular system by shifting from one's own to other affects the formation of human beings identity and leads to erosion of knowledge and cultural practices.

**Women's Body and Health**

Sexuality is the individual experience and expression of a sexual being or it is how people experience and express as sexual beings. Biologically, sexuality encompasses sexual intercourse and sexual contact in all its forms. Sociologically, it covers the cultural, political, legal, and philosophical facets, and it also includes the moral, ethical, and religious aspects. Foucault (1980) argues the concept of what activities and sensations are sexual is historically as well as culturally
determined, and it is therefore, part of the changing discourse. The sexual meanings are social and cultural constructs, they are made subjective only after cultural and social mediation.

The natural and universal fact of sex differences is not to be confounded with behaviour, roles, and tasks attributed to either female or male sex. Feminine and masculine characteristics are largely learnt gender constructs. By comparing three cultures, Mead (1935) came to the conclusion that masculinity and femininity have much less to do with born differences, and that besides a biological sex, there is a socio-cultural sex. While observing that female subordination is universal and looking beyond the biological differences between women and men to find an explanation, Ortner (1974) located the problem of ‘sexual asymmetry’ at the level of cultural ideologies and symbolism.

An intermeshing of ‘sex’ and ‘gender’ in relations between women and men occurs through interaction between the culturally determined ideas that people hold about the destiny of men and women (gender ideology) and the division of labour and related to this is the control over economic resources. Thus, ideas legitimize and perpetuate the division of labour, and reciprocally, the existing division of labour reinforces the gender ideology (Postel 1990). The discourse on sex and gender is important for consideration of the ideology regarding motherhood in different cultures.

Discourses have perceived the human body differently and rather narrowly, as for instance, by Marx as the economic body, by Freud as the sexual body, in scientific and medical discourse as the mechanical body, by modern day reproductive scientists and biologists as the hormonal body, in population discourse as the fertile body and so on, rather than body as a whole, constituting an individual self (Gupta 2000). Here her arguments clearly show the importance of examining the system as a whole.

Feminist studies have used various theories based on private-public, nature-culture, and particularistic-universalistic contrasts to provide a framework to study and explain the disparities in gender relations, which is a characteristic feature of most of the societies. Ideas about women (and men), which include perceptions of women’s bodies, women’s nature, and the roles of women and men in society, have significantly influenced the position of women in different societies. These ideas as a part of certain ideologies are connected to their cultural context of origin or emergence. The culture and ideologies emanating from them influence and reinforce mutually. Gupta argues that (ibid) the Western approach to natural sciences, a connection is made
between women and nature, and a woman’s anatomy is used to explain gender differences and promote the idea of inferiority of women to men. Medical science, as a force of implicit social control plays an important role in the construction of ideas on women’s nature and in the definition of health and sickness in general.

Usually, in most of the conventional communities, women are considered as an object of procreation and vehicle for upbringing children. The situation is not very different among tribes. In some of the indigenous communities, women are not allowed to talk to men outside the family, and girls are restricted from going to school after menarche (Iyer 1968). A woman is treated as inferior to her husband and other male members in the family. Women are refrained from entering the main agricultural occupation and are considered unhygienic during menstruation and also during the postnatal period (Ruddick 1997). Isolation, restricted options, and social devaluation can make motherhood appear grim even for the economically privileged women.

According to Rich (1977), the institution of motherhood is often oppressive where as the experience of motherhood has so much capacity for beauty and could be positive and empowering. She emphasizes the two-fold nature of motherhood, that is, the biological capacity of every woman to bear children, on the one hand, and on the other hand, patriarchy as an institution, which aims to use this capacity of women for the benefit of men. She argues that motherhood, as an institution, is maintained through heterosexuality and through the expropriation of women’s bodies by men. Further she explains, the right of women to decide about their own bodies and their sexuality is for her an important condition to weaken and breakdown the institution of motherhood.

Anthropologist Rosaldo (1980) argues that instead of seeking general explanations for current forms of motherhood and fatherhood, one should look for the meaning people give in certain socio-cultural contexts to the relations between parents and children and between men and women. On the one hand, European and North American conceptualizations overemphasize the ambivalent and negative aspects of motherhood (motherhood as a source of oppression and powerlessness); on the other hand, the Asian and African notions of motherhood present it as an undeniable source of respect, joy, and freedom. Both conceptualizations tend to have class and ethnic biases. The fact that it is women who are generally responsible for the upbringing and care of children gives them a certain intimacy with their children and also creates a strong mutual bond. This gives them some kind of informal power within the family (ibid). The ideas concerning motherhood within a society influence the content and form that women give to their
lives. Motherhood shapes not only the relationship of a woman with her children but also the relationship between her and the father of her children. It influences, above all, the manner in which women see themselves and the possibilities they have to develop in other areas, that is, the place that motherhood has in women’s lives, the meaning of the father and the mother, the resulting division of roles, and the possibilities that society offers to women to participate in activities besides motherhood (Gupta 2000). The norms, values, and practices regarding motherhood manifest themselves in varying ways in different societies and ethnic cultures. These norms, values, and practices are linked with marriage, family, the home, children, and work. Moore (1988) argues the concept of ‘women’ is constructed through these different constellations of ideas, and individual women subsequently construct themselves through the culturally given definitions of womanhood, which thereby emerge even if the construction proceeds through conflict and contradiction. The result is a definition of woman that is dependent on the concept of mother and on the activities and associations connected to it.

**Sexual and Reproductive Health**

'Reproduction' is defined by the Oxford English Dictionary as the action or the process of forming or creating or bringing into existence again. The sociological meaning of human reproduction, however, has been broadened to cover reproductive processes, which include fertility, reproductive pathologies, and reproductive technologies. Sexual health includes the ability to acknowledge, accept, and take pleasure in the feelings associated with one’s body (sexual subjectivity). It also involves being able to make active decisions about one’s body and to control, shape, and change one’s sexual practice (sexual agency) (Brooks-Gunn & Paikoff 1997; Martin 1996). Body is perceived differently in each culture. Therefore, the concept of body change varies according to place, community and person. The sexuality is attached with body and its pleasure, that also varies based on the perception of one's body.

Reproductive health is related to sexual health particularly and to sexuality in general. In the past programmes and policies, the issues related to sexual health were carefully skirted. Any matter connected to sex and sexuality was taboo owing to its political and cultural sensitivity. Many reproductive and sexual health needs were not addressed, and many social groups were neglected (Panchauri 1994); several distortions happened in the implemented programmes since it ignored the linkages between family planning and sexuality.
As outlined by the International Conference on Population and Development (ICPD 1994) definition, Sexual and Reproductive Health (SRH) is not merely about reproduction; SRH must be viewed as the following three interconnected domains: universal rights, women's empowerment, and health service provision. Firstly, SRH promotes a universal understanding that it is a basic human right to be fulfilled by all governments. Secondly, SRH seeks to address the underlying causes of gender inequality and inequity to promote women’s empowerment. Thirdly, the provision of universal access, utilization, and quality of SRH services addresses issues of sexual and reproductive ill-health, and possibly death. The three concepts of rights, women’s empowerment, equality, and services must work in unison in order for individuals to achieve healthy sexual and reproductive lives. The first over-arching concept of SRH is premised on a rights-based approach. This means that everyone is entitled to the rights and freedoms set out by the Universal Declaration of Human Rights, which includes the right to health and education without distinction based on race, sex and religion. Universal reproductive and sexual rights must be supported and upheld by governmental policies and laws, specifically the right for couples and individuals to decide if, when, and how many children they would like to have; as well as access to information to enable them to make these choices; the right to attain the highest standard of sexual and reproductive health; and the right to make SRH decisions without discrimination, coercion, or violence (ICPD; Programme of Action, 7.3, 1994).

The second concept of SRH, women’s empowerment, is based on the fact that norms, values, and laws create an environment that influences the extent of women’s equality and power within a society (ICPD 1994). In addition to addressing the issues related to the gender discrimination, facilitating universal education and enhancing empowerment of women gains the attention of ICPD. It also recognizes the fact that the involvement of men is an essential part of protecting women's SRH health. Therefore, while promoting women’s empowerment and addressing issues of equality, and equity, relationships must not only be viewed in the context of those between men and women but also with regard to the individual and wider community. Attitudes and norms surrounding sexuality and gender carry profound meanings in every society or culture.

Education plays an important role in sexual and reproductive health; it contributes to reduction in fertility and morbidity and at the same time, it contributes towards empowerment of women. Education helps to postpone the age of marriage and to increase a child’s survival possibilities (Caldwell 2005). Practices and norms surrounding sexuality and gender carry profound meanings in every community. The dynamics of knowledge, power, and decision-making in sexual
relationships, between service providers and clients, the residing area and between community leaders and citizens affect an individual’s reproductive and sexual health status.

SRH is also addressing factors that may inhibit an individual from accessing and utilizing these services. This may include ensuring widespread information of services and methods of family planning and safe sex, affordability, confidentiality, convenience, treatment of service providers, and availability of supplies.

**Sexual and Reproductive Health: Historical Perspective**

An English pastor Thomas Robert Malthus articulated the idea of population problem being a serious impediment to development. Malthus proposed that population growth needed to be curtailed if food scarcity was to be avoided. Malthus claimed that food production increases at an arithmetic rate \((1, 2, 3, 4, 5, \ldots)\), but number of people doubles at a geometrical rate \((1, 2, 4, 8, 16, \ldots)\). This is known as the Malthus Law of Nature (Malthus 1798). This idea gained attention of modern thinkers and in India, Malthusian Leagues were established in Madras and Bombay in the 1920s. Further, neo-Malthusian thinkers also came up with this trajectory of the history of reproductive health. The important landmark in this history is the medicalisation of child birth. The history of medicalisation of child birth is not only the story of specific therapies and outcomes but also the story of a set of meanings attached to and the mediation of relationships among women's reproductive practices, the hospital, and the medical profession (Hodges 2006). The second problematic issue is the social history of reproduction and how the diverse groups invested reproductive practices with often contradictory sets of meanings (including medical and scientific meanings), and how these groups understood the reform of reproductive practices as a linchpin of greater social, political, and hygienic changes. By the mid of the nineteenth century, attempts to train women in midwifery started in different parts of India. These schemes were designed mainly for traditional birth attendants or *dais* into modern midwives (ibid). The concept of population was further established in India through the family planning programme that was introduced in 1952. Thus, contraception or volitional acts of restricting reproduction may be considered a contested ground for the clergy (who decry all forms of restrictions), political forces (who prefer population control), and women (who would prefer the autonomy to choose on their own) (ibid). This longstanding triangular contest to a great extent settled after the 1994 Cairo conference. The term mother and child health programme was shifted to reproductive health. The mother and child health concentrated on events like pregnancy delivery and child health. It stressed on reducing maternal and infant mortality rate. The term reproductive health looks at all
matters related to reproductive health of all within the age of 15 to 45 and includes both sexes. Further, some arguments related to sexual health were raised by the members. They argued sexual health should be combined with reproductive health since it is not a separate element. Hence, the term sexual and reproductive health was coined.

Foucault’s notion of bio-power and the formation of docile bodies in regulating populations are examined in the context of the family planning programme in India. Malthusian principles have always dominated most debates surrounding population. Neo-Malthusian thinkers suggest that human interventions can put a check on population growth through birth control. Each five-year plan presented and provided programmes for family limitation and population control. This was considered to be an important strategy to reduce birth rates to a great extent in order to stabilise the population growth at a certain level and to improve the national economy. When the Family Planning Programme was initiated by India in 1952, it was one of the first few independent countries to initiate a National Family Planning programme based on neo-Malthusian views (Patel 2010). Srinivasan (1995) classified the Family Planning Programme into six phases. The initial approach adopted by the government was a clinical approach and based on this, many family planning clinics were opened throughout the country. It offered contraceptive services, condoms, diaphragms, and vasectomy for men to reduce the birth rate. The next approach was the extension approach in which the family planning workers were asked to visit homes in order to motivate couples to adopt family planning methods. Further, this programme was under the health department, called high intensity (HITTS) approach. In this phase, the department gave more emphasis on vasectomy to reduce the birth rate. The next phase was during India’s national emergency, and various coercive tactics were used to control the fertility levels mainly through the increased number of vasectomies. The fifth phase is called the recoil and recovery phase. In this phase, programmes were formulated by considering long-term policy goals and the targets for family-welfare programmes, and a greater emphasis was laid on spacing method and child survival programmes. These programmes were implemented through all the sub-centres and primary health centres in rural areas (ibid). After 1995, the initiation is termed as reproductive and child health (RCH) approach. Permanent sterilization (tubectomy) of women began to rise steadily and became a dominant method of family planning during the subsequent years. It is a permanent sterilisation programme. Further, many welfare programmes were introduced by the Government for mother and child, which also emphasised men’s reproductive health (Hodges 2005). The National Health Policy (NPP), outlined in 2000, has been considered by many as a
landmark document that reflects the post International Conference on Population and Development (ICPD) and which show a shift from population control to women's reproductive health.

**Studies in the Area of Sexual and Reproductive Health**

Social anthropological research or qualitative research is increasingly being acknowledged by medical scientists and public health specialists in India, since it attempts to understand the cultural aspects and perceptions. Medical anthropology's precise contribution in the field of public health is more pronounced in recent times. Further, a multidisciplinary approach is increasingly acknowledged in all fields of research.

Research on women’s sexual and reproductive health began with the pioneering work of Bang and Bang in 1989, which brought the impetus for such issues of concern in the context of South Asia (Bang and Bang 1989). The study highlighted both the magnitude of the problem and the negligence. ICPD and its recognition of a holistic understanding of population health resulted in an increased number of research studies, and those showed high levels of reproductive tract infections and other gynaecological morbidities among women from urban and rural India (SEWA-rural 1994). A few studies (Bang and Bang 1994; Patel 1994) conducted on women’s reproductive problems in tribal and rural areas had shown that women often use the services of traditional health practitioners in case of white discharge. Women’s etiology of weakness is better understood by traditional healers, while doctors trained in biomedicine were found unable to understand the social and cultural background of illness.

An anthropological hermeneutics requires not only the mapping of symbolic elements from one system to another or a pairing up of sentences but the comparison of situated practices through which knowledge is produced and elaborated (Mishra 2010). Among the Sinhala, the most effective, utilized referential frameworks evoked the image of the womb as a flower. “Poetic expression is commonplace in the Sinhala culture and the image of a flower is pervasive in Sinhala poetry as a symbol of fertility, a symbol utilised in the ritual marking of a girl's first menstruation. After the image of flower was introduced, eventually being asked a question such as ‘when in the month is the bud most ready for the bloom of conception?’” (Nichter 1996:22). The urgency to get the girl married immediately after she starts menstruating is not merely because she is treated as a burden but also because of the belief that once the girl starts menstruating, she can reproduce. Therefore, if she is not married soon, the father is held guilty
of killing the seeds that could have been fertilized. Jeffery and Jeffery (1989) argues in their study on a rural community in North India that a father is forced to arrange the marriage of his daughter since he believe once a girl has passed the ‘marriageable age’, it is very difficult to find a husband for her.

Apart from the disastrous demographic consequences, the early marriage of girls has severe implications on their health. The awareness of their own body is limited. Many adolescents have not even developed the vocabulary to describe any part of the anatomy between the navel and the knees (Potts 1979). Various studies (ICMR 1991) have shown that the capacity for reproduction is not synchronous with menarche and puberty. Full sexual maturity and stability in growth as opposed to the mere development of reproductive capacity is not earlier than 18 years in girls, and among the deprived, undernourished communities, it is not earlier than 19 years.

The Malay\footnote{Refers to politically dominant ethnic group which professes Islam, habitually speaks Malay language, and conforms to Malay customs (defined by the constitution of Malaysia)} believe that conception can take place only when both parents’ bodies are in a cool state, and it is an event that occurs once a month but it is not affected by the women’s menstrual cycle. It can only happen on “the days the seeds fall”, which occurs on any one of nine days in each Islamic month. A Malay father’s strong and intimate tie to his unborn child begins with conception, a conception which occurs long before the ‘day the seeds fall’ for his wife. For 40 days before the start of his wife’s pregnancy, the husband carries their child within his own body, where it receives its most truly human qualities (Laderman 1987). A study on (Conklin 1996) Wari Indians, who live in the rain forest of the Western Brazil, believe that babies come only from repeated sexual encounters which means that a pregnancy cannot be regarded as a simple slip-up, an unintended ‘mistake’. In western biomedical models of conception, once a sperm meets with an egg, the foetal’s body begins to develop through more or less automatic biological processes. The Wari woman speaks of her children as ‘flesh of my husband’, and she speaks of her husband ‘flesh of my children’. The idea that semen builds foetal’s bodies means that couples should have sex often during pregnancy, and failure to do so, endangers the foetus. Wari babies can have multiple fathers; any man who has sex with a pregnant woman contributes semen to form the fetus’s body and can claim biological paternity.
The underlying belief that blood from birth is defiling has been reported in a number of societies, especially those in South Asia, where individuals such as midwife who must handle the blood as part of their work are of inferior status (Jefferey and Jefferey 1989). The notion that blood from birth is polluting echoes the numerous reports of proscriptions related to menstrual blood in the ethnographic literature. As Buckley and Gottlieb (1988) have shown, ambiguous meanings may be attached to menstrual blood, which may be seen as polluting and at the same time, as powerful or even sacred. A study (Obermeyer 2000) in Morocco, this is also true of the blood from the birth, which is believed to be potentially poisonous, if it remains inside the body, although its principal valence is magic power rather than pollution.

In Chinese philosophy, women's body is unclean and polluting---women are believed to be able to disrupt the cosmic order (Lhamo 2003). In death, men and women are equally polluting, but women, as life-giving agencies, are in many ways believed to be more polluting than men. Their uterine blood is endowed with the potential to disrupt the interaction between the divine and human realm (Seaman 1981). He also narrates the potency of menstrual blood, and it is the most potential ingredient in magic charms that give power over people and Chinese medical theory holds (Furth 1986) that uterine blood is efficacious in curing diseases related to sexuality and fertility.

The use of oxytocin and similar substances, by women and families in Tamil Nadu is a cultural practice for relieving the difficulties in pregnancies. It also helps in bringing down the birth pains gradually. The concern is that it is easily available to the use of midwives, and there is complete absence of monitoring by the health officials about how and when such injection needs to be induced (Hollen 2003). Jeffer (1989) also reports the usage of synthetic oxytocin during the time of delivery. Government may not bother or are not aware about the wrong usage of substances or the diversified usage of hormonal substances among the poor people. Good (1980) has noted the use of the contraceptive pills in Iran to induce abortion. She found that it was not uncommon for Iranian women to take a month's supply in one day to ensure menstruation when they suspect an undesired pregnancy.

A number of studies published in last decades seem to have come a long way in redefining the characteristic of the African traditional healer. The World Health Organisation (WHO 1978) has

---

15 Midwife
16 Oxytocin is a hormone; it is released in large amount after distension of the cervix and uterus during labour, facilitating birth. Artificial Oxytocin is available for inducing birth
not only declared the importance of traditional healers in Africa but it also has encouraged research on their healing techniques and remedies (Akerele 1987; WHO 1978). The national Governments are apparently successful in establishing research institutes and initiate programmes to integrate traditional healers into the public health sector (Green et. al 1995). In an evaluation study of witch doctors in relation to the modern psychiatrist, Torrey (1983) claims that the evidence regarding the efficiency of therapists in other cultures is instructive. It was almost unanimous while suggesting that, witch doctors get about the same therapeutic results as psychiatrists do.

Many Taiwanese men and women alike still adhere, by and large, to misogynist attitudes towards female bodies and sexuality. They consider their bodies as unhygienic and circumscribe them with taboos. Indeed, taboos relating to the female body and discourse of women's unhygienic are ubiquitous in contemporary Taiwan; yet, they are neither uniquely Taiwanese, Chinese, or a Buddhist phenomenon. Still, many Taiwanese Buddhists discriminate women on account of their embodiment (Kloppenburg 1995). This discrimination goes back to the fundamental paradox of underlying Buddhist philosophy: at the heart of Buddhism stands the conviction that life is suffering - the first noble truth states that the greatest sufferings are birth, old age, sickness and death. Thus, birth is explicitly stated as suffering. Moreover, it is said that the Buddha specified five additional sufferings of women: menstruation, pregnancy, childbirth, having to wait upon a man and being subjected to in-laws.

Taiwanese folk wisdom connects the most polluting bodily substances with birth and death (Ahern 1975). Hence, menstruating and pregnant women are banned from participating in folk and religious rituals and are advised not to go in the premises of temples. Their presence is believed to disrupt the rituals to the extent that mediums may not be possessed and even could be harmed. “Childbirth is deemed even more polluting than menstruation: taboos restricting women who have given birth are more complex than those relating to menstruation” (Ahern 1975: 198). Srinivas (1952: 87) says “They treat the body as if it were a beleaguered town, every ingress and exit guarded for spies and traitors. Anything issued from the body is never to be re-admitted, but strictly avoided”. Further he reveals that the ritual life of the Coorgs gives the impression of people obsessed by the fear of dangerous impurities entering their system.

Superiority or inferiority relationship serves to reproduce gender hierarchies and legitimize everyday practices that instantiate hierarchy. Semen and menses are the Greek biological differentiation of male and female on conception. Lloyd (1966) argues that the belief of semen
and menses are the end products of the process of concoction and menses is an impure residue, which is created by men.

The tribe culture in India too has its own life styles, food habits, beliefs, traditions, and social and cultural activities related to pregnancy and the postpartum period. A study (Bharathi 2003) among the Konda Reddis of Andra Pradesh, when the girl first menstruates, she is kept in a small hut built especially for her outside the village mostly on the slope of the hills for seven days. She has to stay in the hut alone for seven days and nights. The mother or mother-in-law takes food for her. No man is allowed to see the girl on these seven days. This process is continued for three consecutive months of menarche. After the third month, the girl comes back home and she puts fire on the hut.

A group of the Indian studies reveals that the health seeking behaviour of the tribal community are not in tune with the existing systems and facilities available to them. In a study conducted by Chaudhari (1986) among the Nocte women of Arunachal Pradesh, it was observed that reproductive health behaviour of the Nocte women is ultimately related to their value system and cultural tradition. Cultural values and practices have a deep influence on health behaviour in general and reproductive health in particular. They do not seem to be very much concerned about the necessity of some special care of the mother’s health. Pregnancy is considered as a natural phenomenon. The Noctes are not motivated to accept medicines during pregnancy. Only a few educated and well to do families go for regular medical checkups in the nearest Primary Health Centre. Thus, there were a number of cases in which spontaneous abortion or miscarriage took place. In the event of any complication during the time of delivery, people generally go to the traditional medicine man, who prescribes some oral herbal medicine for normal delivery. If the child or the mother or both die during the process, people accept it as god’s will. Twins or deformed babies are killed immediately after birth. They are considered to be bad omen and are believed to herald some calamities and misfortunes for the entire community, if allowed to live. Further, the author suggested that it is not possible to raise the health status and quality of life of the people unless such efforts are integrated with the wider effort to bring about an overall transformation of the society as a whole.

The complications during pregnancy, child birth and induced abortions in areas where environmental and health conditions were adverse resulted in large numbers of maternal deaths (Saha 2004). WHO (2000) reports that in developing countries one in 50 women dies due to complications of pregnancy and child birth. In India, the maternal mortality was around 50 times
higher than that of a developed country (UNICEF 1983). Generally malnourishment, poor medical facilities and unfavourable social conditions are the major underlying causes for high maternal mortality in India (Pachauri 1996). Anaemia is a serious problem during pregnancy that affects 50 percent of the women of childbearing age in South East Asia (WHO 2000). Geographical location is an important factor in deciding one's health seeking behaviour, especially for a woman. A study (Varshaney et. al 2012) reveals that climbing steep hills is risky for a woman in labour. Because of difficult terrain, the women in Rudraprayag 30 kilometers away from Srinagar prefer giving birth at home.

The study among the Kutia Khonds observed that the delivery was conducted by the mother herself in half squatting position holding a rope tied down from the roof of the hut. This helped her in applying pressure to deliver the child (Basu et al. 1990). Similar delivery practices were found to exist among other tribal groups like the Kharias, Gonds and Santals. Among the Konda Reddis delivery takes place in the courtyard of her husband’s home. A small hut is built in the courtyard for delivery purpose, Konda women prefer giving birth in squatting position. According to them delivery in sleeping position is difficult as pindam falls aside and it is difficult for it to come out where as in squatting position pindam comes out first making delivery easy (Bharathi 2003). Use of the lithotomy position tends to make pushing the baby out more difficult and injurious than necessary, as this position puts most of the women’s body weight squarely on her tail bone, forcing it forward and thereby narrowing the pelvic outlet, which increases the length of labour and makes delivery more difficult, often leading to episiotomy. It also lowers the oxygen supply to the fetus and the baby’s passage through the birth canal must work against gravity (Davis-Floyd 1990). Floyd argues that cultural behaviour which at first appear to be irrational usually turnout, upon closer investigation, to make excellent sense and to play important and meaningful roles within the context of the overall cultural system. A 'non medicalised' birth does not mean that no medical care or treatment is given by 'medicine'. It means all forms of healing, of promoting and maintaining a healthy, 'mindful body'. In many communities throughout the world, and certainly in India, there are a wide variety of non-biomedical practices that are used to ensure a risk free delivery and the birth of a healthy baby. In India and other parts of the world there are indigenous midwives with

---

17 Head of the infant  
18 In the lithotomy position, the woman lies on her back on a narrow delivery table with her feet up in stirrups and her buttocks at the table’s edge.  
19 An episiotomy is surgical incision of the vagina to widen the birth outlet
specialised knowledge on child birth (Hollen 2003). A number of studies (Shrotri and Bhatlavande 1994) examined the quality of care provided by traditional birth attendants

*Girls to Young Mothers: Sexual and Reproductive Health*

Adolescent girls are an important part of reproductive health care. Their perspectives should be included in the development of feminist theory as well as in the practice and policy developments relevant to adolescent girls beyond the discourse of adolescent pregnancy. It is necessary to expand the understanding of the effects and responses to medicalisation among women in marginalized social locations (Sethuraman 2007). The National Nutrition Monitoring Bureau data on Indian women have shown that women below 24 years surveyed in different states had height below 145cms and weight below 38 kg. The percentages were even worse among girls below 15 years. These adolescent girls, if they get pregnant, are at a very high risk of obstetric complications or of delivering low birth weight children (Gopalan 1998). There is a large gap in terms of qualitative studies across different settings and social groups in India that look at what actually happens or document what women have to say about their expectations about quality of care for reproductive and sexual health needs (Ravindran 2002). Tribal sexual behaviour, their awareness and attitude remain poorly explored topics and available findings are not entirely representative. Sexual awareness seems to be largely superficial. Hence, there is a need to get a deeper understanding of the concrete situations of tribal women as seen and interpreted from their point of view.

Adolescence is a period when girls start menstruating, get married and some of them even have their first child especially in the tribal regions. In other words these are the years of maturation, of performing new social roles and responsibilities. It is in these years that a girl transpires herself to womanhood, and therefore a girl needs maximum attention to enable her to be healthy and productive in later life. Unfortunately, in many places, (Kumari 1990) early marriage and child bearing deprive girls of this transitional phase and push them to shoulder responsibilities of adults, for which they are not fully equipped. The growing young girls are not adequately informed about childbirth, childcare, family planning and health care.

Sebald’s (1980) study on adolescence indicates that the various socio economic systems offer different roles to the young. In an agrarian society one may not find typical adolescence but would find youth. In the industrial society, on the other hand, one would find adolescents who are at cross roads to select their own road. However, in the rural context, the girls take up the role of
an adult after reaching puberty. In such instances, one cannot find a typical adolescent stage but instead there is transition from a child to youth (Sebald 1980). In the tribal communities, due to changes in the existing cultural practices and patriarchy, the youngsters especially younger girls are restricted with norms, beliefs and taboos which may lead to traumatic situations in their life. “Suicide is a major killer among young people in India; indeed it is now a leading cause of death among young women, outstripping even maternal death in some regions of the country” (Patel 2010: 120). A study (Aaron et al. 2004) from Tamil Nadu, which utilized a community based ascertainment of the cause of death, has recorded suicide rates as one of the highest causes of death in the world.

Key Events in the Life of Young Women Before Motherhood

Menarche: Generally young women are poorly informed about their own sexuality and physical well being. Whatever knowledge they have, is incomplete and confused. For many girls, the first menstruation is a frightening event about which they have not been informed (Teitelman 2004). She is separated without explanation and kept out from other adults. At the end of four or five days she is given a ritual bath. And subsequently she is treated as a woman eligible for marriage, kept away from her previous play mates and confined to the house (Potts 1979). Low rates of educational attainment, limited sex education and inhibited attitudes towards sex attenuate this ignorance. A brief overview of this lack of awareness suggests that adolescent girls are generally ignorant of menstruation until it occurs. Even then, knowledge is limited to the mechanics of menstruation, and to related behavioural norms like pollution, and not necessarily its links to sexual life and reproduction (Vlassoff 1978). George A (1994: 172) reports, in her study on menstruation perceived by poor women in Mumbai that Menarche evoked feelings of fear and anger because of the avoidance behaviours, disgust towards the body and the messiness of menstruation. Two of the women in the study felt that if they had known about menstruation prior to menarche, they would have been less afraid, whereas, one woman felt that prior knowledge would have made her anxiously await menarche (George 1994). Lack of awareness on menstruation makes girls depressed and anxious on their first menstruation.

The timing of menarche among different populations is probably affected by a variety of environmental, genetic and socio-economic factors. But, most analysts consider nutritional status to be the dominant determinant (Martin 1996). In the developing countries, (Marshall and Tanner 1986) age of menarche is often inversely correlated with socio economic status, showing
significant differences between urban and rural populations and between high and low-income
groups

In India, traditionally, the transition from childhood to adulthood among females has tends to be
sudden. Cardwell (2005) argues on the one hand as a result of the poor nutritional status of the
average Indian adolescent, menarche occurs relatively late; therefore, the biological onset of
adolescence, at least among females, may be later in India than elsewhere. On the other hand,
marrige and the consequent onset of sexual activity and fertility occur far earlier than in many
regions of the world, thrusting adolescent females early into adulthood, frequently soon after
regular menstruation is established and before physical maturity is attained.

**Schooling:** Soon after the puberty, there are restrictions imposed on the young girls in terms of
social mobility and education. Notions of purity and pollution are introduced strictly in
connection with menstruation (Singh 1996). Pachuari (1996) reveals that by the age of 15 in rural
places of India most of the girls would have left school, have become sexually active and a large
proportion of them get married. The picture is not different in an indigenous community, the
children stop education of girl children after menarche or any other rituals associated with
puberty.

**Marriage:** Marriage broadly defined here to include consensual unions as well as formally
recognized civil or religious unions – marks the beginning of socially sanctioned sexual relations
and exposure to the risk of adolescent childbearing in most societies. Despite the laws stipulating
the legal age at marriage as 18 for females and 21 for males, early marriage continues to be the
norm in India especially among tribes. The median age of marriage is 16 years and as many as
40% of all women aged 15-19 are already married (IIPS 2005). Early marriage is common among
the tribes of Kerala and also among the Muslims of Malappuram district. Among the Muslims of
Malappuram district, 3 percentage of the female are married before the age of 18 (Ajeesh 2007).
Kakkot (2001) explains in her study, the average age at marriage is 15 years among the
Cholanaikkan, a primitive tribe of Kerala and Kurumba tribe in Kerala.

**Women's Autonomy and Reproduction**

In the field of sexual and reproductive health, autonomy means the right of women to choose
whether to have children or not and if so the right to decide the number of children they want and
also includes when and with whom. Further, the freedom to choose the methods for their fertility
regulation and access to good information and methods also comes under this category. And when
it comes to sexuality, autonomy is about self determination on one's body and its reproductive capacities (Archer 2009). Poster-Coster (1987) explains the relation between the individual and social dimensions of reproduction. The choice regarding the number of children depends on the society in which the woman lives. The other factors that are involved in the choice are the availability of contraceptive measures and family welfare programmes. The national population policies, socio-economic status and the state's intervention are also influential towards women's autonomy. Women's pertinent ideologies varies and depends on class, social and her economic position to access resources including knowledge, which also influences the autonomy of women (Archer 2009). Women who commit sex selective abortions are always subjected to direct familial and social pressure; it could be indirect as well. Familial dynamics, such as the process of decision making, authority, and self perception are all important parameters in determining the status of a woman. The state of Haryana is an economically developed state in India with high female literacy, low fertility rates and high age at marriage but ironically child sex ratio is very low. It shows that the so called parameters of empowering women do not support the increase of child sex ratio. Therefore, the autonomy of women is influenced by cultural and sociological pressure. A woman is negotiating her volition between the surrounding web of pressures. Amin and Bentley (2002) point out a need for expanding reproductive and sexual health programmes and policies addressing gender issues as an integral part. Women participate in their own oppression through internalisation of norms since childhood. Hence, they propose reproductive and sexual health should be addressed as part of a larger process of women's empowerment. Ram’s (1994) study among the women of fishing community in Tamil Nadu found out less dependence on hospital services during pregnancy and delivery. The reasons he found out include the need for a prolonged stay in the hospital disrupting their gender based domestic responsibilities, caste difference between the provider and user, harsh treatment by staff and unnecessary medical intervention.

The tribal community is in a stage of transition and is under a conflict situation between their 'traditional practices' and contemporary changes occurring within their culture. They are caught between the lure of 'modernity' and their need for abandoning all that is indigenous which has left these organisations shattered, abandoned or transformed. The term of reference for these institutions is youth dormitory (Roy 2006). A study by Brown and Newcomer (1991), examined the linkage between television viewing and adolescents’ sexual experience. The study found out that the teenagers viewing of sex oriented television programme was positively correlated with
their sexual activities. Furthermore, research conducted in Taiwan found that exposure to pornography on electronic media was the most powerful predictor of adolescent’s sexually permissive behaviour (Lo 1999). Children and adolescents may be shocked or disturbed by premature or an inadvertent encounter with sexually explicit materials (Flood 2009). Pornography exposure can lead to emotional disturbance, sexual knowledge and liberalised attitudes, shifts in sexual behaviour and sexist and objectifying understandings (Flood 2009). These kinds of exposures in tribal community may bring in unexpected consequences, as their custom and system are different from that of a general community.

The review of ample studies in the area of sexual and reproductive health helped in identifying the gap in the existing literature. There were no studies among the tribes of Kerala in the area of sexual and reproductive health. This shows a remarkable gap in the literature of tribal health culture of Kerala. Jeffery’s (1989) and Nitcher’s (1996) studies have highlighted the delivery practices, role of traditional birth, rituals and medicinal practices associated with pregnancy. Bhang’s (1989) studies focus on the area of sexual and reproductive health and especially, the reproductive vulnerabilities among the rural and urban.

It can be seen that since the mid 1980s, anthropological health research has undergone a shift as it went beyond the conventional framework to understand the linkages between health care system and socio cultural factors, access and utilisation health status of people (Saha 2002). This was an important paradigm shift from understanding people's health services in terms of medical determinants alone to understanding it in terms of social and cultural determinants. There is a large gap in terms of qualitative studies across different settings and social groups that look at what actually happens or document what women and men have to say about their expectations towards the quality of care for reproductive health needs.

Sexual and Reproductive Health can be looked at and studied from the medical and social perspectives which appear to be more relevant in this study. In general, hegemony of medical perspective looks into causative, diagnostic and treatment aspects of health and disease. Infront of health aspects objectivity and subjectivity are important issues. Subjectivity may be defined as a sense of self or self- identity, which is socially constructed through the interactions with others (Lupton 1995). Thus we are not born with subjectivity, but we acquire it through various stages of our life. Subjectivity is fragmented, highly changeable and dependent on the context. Subjectivity is constructed through the articulation of power. Subjectivity varies in reference to people, place and context (ibid). Hence, the medical discourse takes a dominant role over health and related
areas. In the trajectory of the history of reproductive health one can see different perspectives and agenda of the state. From this perspective, the reproductive health programmes were modified and made more target oriented rather than social oriented.

The attempt of the programmes to exert control over women’s bodies is based on social and economic reasons. This attempt to expand the domain of reproductive health on the basis of symptomatology, and not on the underlying causes that actually lie outside the domain of reproductive health becomes problematic. A disparity has occurred in the midway of the family planning programme due to the power and control over women’s bodies exerted from the side of the state (Qudeer 1998). Instead of imagining and visualising health issues from the perspective of women, as women of different regions see it for themselves, the state merge them into universal reproductive health and rights issues. As a consequence of their own priorities and agendas, they have never really examined either the epidemiological basis of reproductive health or the reasons behind women's silence over the reproductive health problems (ibid). The body is conceptualised in different ways in different places and cultures. Osello (1996) argues about different ways of conceptualising the body in different places and he traces the linkage between the physical and social bodies in the context of Kerala. If the body is perceived differently, then the sexual and reproductive health of an individual is also different. In the course of history, health programmes eventually, started viewing things from women's perspectives. Here, one can see the continuities and discontinuities in the discourses and practices of public health from the middle ages until the middle twentieth century. One's sexual and reproductive health is also highly subjective and changeable depending on the context.

Therefore, this study focuses on analyzing the interface of local practices and the external intervention on the Muthuvans of Edamalakudy in the context of social aspects of sexual and reproductive health practices. An attempt has been made to understand how contemporary changes have intervened with the sexual and reproductive health practices and rituals of Muthuvans. The trajectory of conflict between the 'tradition' and its changing trends are addressed in the present study.

**Theoretical Framework**

Theories interconnect and bring out linkages between different concepts emerging from an observation and analysis of phenomenon. It also aims to provide explanations and interrelations between the phenomena and practice.
Each culture has its own reproductive and sexual health practices. They have both traditional and contemporary practices. The adaptability to the technology most often depends on the need and cultural relevance of that particular technology in the particular community. The use of contraceptives as part of a population policy is slowly being accepted by most of the communities but, during the initial period of its introduction, this policy had to face opposition from traditional communities. Furthermore, technological and modern values are more formal whereas indigenous practices are informal and transmitted. Further, the extremist fixation towards romanticizing indigenous knowledge on the grounds of sustainability, abandoning the scientific elements totally is also found to be problematic on various accounts (Sillitoe 1998). One argument put forward with regard to this is that the traditional practices unaltered by external influences can be a mere romantic notion, whereas in reality traditional practices will always remain dynamic and adaptive to external change. Therefore, the external objects may change the traditional practices to an extent. Bebbington (1994) argues that rural people know a lot but, they would like to know a lot more in order to be more powerful in their negotiations with political, economic and social forces.

**Power and Local Construction of Cultural Practices**

Norman Long (2001) emphasises the development, through an actor oriented approach in which social construction and power dynamics play a vital role in carrying the cultural practices. Each community's cultural practices are constructed by its individuals and institutions. The actors of the community are seen to be actively involved in transforming information and generation of the existing practices. They are further seen to be embedded in the web of social, physical and cultural environments and this influences the process of transformation and construction. This approach concentrates on the human agency, which is not seen as a neutral receptacle or transmitter of information but also as one that ascribes meaning to this information and transforms it rather than merely disseminating it. Further, the social relations of power are seen to influence the constructions and their articulations. An actor oriented approach does not see traditional and 'modern' practices running parallel to each other as bounded and make challenges in the community. Interface analysis on the dynamics of culture and its implications on sexual and reproductive health practices are looked at in this way - “Social life is composed of multiple realities, which are, as it were, constructed and confirmed primarily through experience…” (Long 2001:51). The same object in one place/community evokes different meaning in two different communities. The cultural association and importance in daily life varies from culture to culture. This argument gains relevance in the context of the present study. The basic insight from this
perspective is that when actors with diverse values, interest and power come together -
continuities and discontinuities in sexual and reproductive health practices emerge.

Gender and power are integral elements of the construction, transmission, valuation and
marginalisation of cultural practices especially with regard to the concepts of purity and pollution.
Men and women may have specialised roles with regard to their close domains, which may be
mutually exclusive, shared or partially shared. However, power struggles are inherent in gender
relations. It means that these roles will be constructed differently and also valued differently
based on the identities and interests based on gender in each community. Douglas (1973)
theorises that the pollution taboos function to maintain order.

The articulation of pollution is the power play of gender relations as it is of individual agency.
One cannot limit gender in an individual actor but rather critically observe the whole process of
cultural practices and its construction through individual actors and institutions and its further
transmission through a gender lens to understand the embedded power struggles attached with
purity and pollution (Bowie 2000). Unequal division of power is questionable in terms of
controlling one's education and restriction of movement, and then it fails to justify the quest of
social equity. This quest not only questions the unequal access to education and freedom but also
argues for reshaping of norms and practices of community.

Gender approach is not simply 'adding' women, but is a focus on the understanding of being male
and female which is embodied and constructed in the specific area or community. Gender
hierarchies and conflicts of interests between women and men within the household are
demonstrated through various studies (Folbre 1986). These studies reject a unitary static notion of
the household and argue for a further deconstruction of roles on the axis of gender. Gender roles
are not only limited to husband and wife relation but also involve with the relation between
mother and son, daughter in law and mother in law, brother and sister and so on. These relations
are further shaped by and large by the marital status and seniority of the members (Warner 1997).
Due to the taboos and belief system in the indigenous community, women may feel that her body
is attached with evil spirits and she is polluted and feel a marginalised from others. That itself
affects her autonomy adversely.

Lawrence (1982) argues that, the women's behaviour can be explained not by reference to
assumptions of male dominance over women, but to women's conscious choice of modes of
behaviour reflecting on the strategic goals important to their own perceived self interest. Women
are the principal actors in maintaining the menstrual taboo because it allows them to control certain social interactions outside the household and affords them a rationale for taking rest at their homes. In contrast the theories often assume that males are instrumental in limiting the behaviour of menstruating women, presumably because they fear menstrual pollution and have power.

Women's autonomy, as women’s control on her body functions with available technological support and without thinking about its consequences even if it is for the protection of their daily life practices. The situational analysis of cultural practices will help in understanding the gendered identities, roles and multiple livelihood strategies of men and women, which can be linked with sexual and reproductive health aspects. However, women may become the part of this system, but one cannot ignore how various practices have evolved in the community and perhaps the roots of patriarchy are visible in the history of such practices.

**Concept Clarification**

Conceptualisation is a process of constructing and expanding the meanings of various ideas. A concept is understood as an idea that is given meaning within the framework of a theory. Giddens argues (1987) meanings of concepts are derived from the existing body of knowledge (referred to as theories) which emerge out of human adaptation and experience (practice/action). Inherent to this understanding is the dual play of societal structures and human agency in the creation of meanings. Therefore, certain social, cultural and physical norms and structures guide human action, in the process of conceptualisation and conversely human action initiates changes in existing structural experiences and explanations of concepts.

**Rituals**

The study of rituals can indeed provide a key to the understanding and interpretation of culture. It can be used to control, subvert, stabilize and enhance the individuals and groups. Ritual is defined by Tambiah (1979:119), 'a culturally constructed system of symbolic communication'. It constitutes of patterned and ordered sequences of words and acts, often expressed in multiple media, whose content and arrangement are characterized in varying degree by formality (conventionally), condensation (fusion) and redundancy (repetition). Ritual, defined in most general and basic terms, is a performance, planned or improvised that effects transition from everyday life to an alternative context within which the everyday is transformed (Alexander 1997:139). He stresses that all the rituals are grounded in everyday human world. Ortner (1974)
argues that rituals are a way of manipulating and regulating the relationship between natural forces and human life. All the communities possess rituals associated with sexual and reproductive health practices and when it comes to traditional or indigenous groups they count more in number. Rituals carry a prominent role in the life of these people and are attached with different symbols.

**Social Change**

Social transformation or evolution can be explained as a change in the structure and complexity of social formation. It comes about as a result of individuals deliberately and purposively selecting new and improved ways of coping with social conflicts and problems. The acts of individuals are adaptive and reflect changes in habitual ways of thinking and feeling (Febrega 1997). Srinivas (1989) argues that the notion of pollution and purity has weakened and has become less pervasive in the last few decades as a result of external forces. But, one can see its links in most of the communities and it is more pervasive in some tribal communities. Giddens (1984) explains in their very constitution, social life and experience have their own structure to structuration that is continuous, and crossed by contradiction and conflict.

“Meaning, values and interpretations are culturally constructed but they are differentially applied and reinterpreted in accordance with the existing behavioural possibilities or changed circumstances, sometimes generating 'new' cultural 'standards'” (Long 2001:51). He clarifies further, “social life is composed of multiple realities, which are, as it were, constructed and confirmed primarily through experience and this interest in culture must be grounded methodologically in the detailed study of everyday life, in which actors seek to grapple cognitively, emotionally and organisationally with the problematic situations they face” (ibid). This concept forms the basis for this research. The same object in one place gives different meaning to two different communities. Its cultural association and importance in daily life varies from culture to culture.

**Culture and Change**

Ralph Linton (quoted in Harlambos 1980) states that, the culture of a society is the way of life of its members; the collection of ideas and habits which they learn, share and transmitted from generation to generation. In Clyde Kluckhohn's (1951) elegant phrase, culture is a 'design for living' held by members of a particular society. Without a shared culture, members of society will
be unable to communicate and cooperate and this will result in confusion and disorder. Culture, therefore, has two important qualities, it is learned and it is shared.

"...a change in any one part of the culture will be accompanied by change in other parts, and that only by relating any planned detail of change on the central values of the culture is it possible to provide for the repercussions which will occur in other aspects of life. This is what we mean by "cultural relativity": that practices and beliefs can and must be evaluated in context in relation to the cultural whole" (Mead 1954:10). The communities undergo changes due to the interaction with the people around and contact with the technology. These changes are in orientation to initiation and response with which contemporary generation meet change. The systematic way of functioning or practicing of culture is affected by technological intervention. This may facilitate sometimes, the convenience and freedom of an individual and at times invites unseen consequences. But, the involvement of new technology depends on how the culture is tightly or flexibly integrated and whether the ethics are internally consistent or contradictory. Sometimes the external objects are diversified in usage which is intended for other purposes. Further she (ibid) clarifies, even when the velocity of change depends on various factors, a single factor like an educated person in a village sometimes may be the deciding factor.

Merton (1968:116) argues that “a distinction between manifest and latent functions subjective categories of motivation and objective categories of function. ...a practice regarded by many laymen as an affront to their intelligence and an offense against common intelligibility”. Functional consequences of action mean the utilisation or consequences of an item which was not expected. Merton (1968) classified it as manifest and latent functions. "This is the rationale for the distinction between manifest function and latent functions; the first referring to those objective consequences for a specified unit (person, sub group, social or cultural system) which contribute to its adjustment or adaptation and were so intended; the second referring to unintended and unrecognised consequences of the same order. Manifest functions are the expected and intended consequences of an intervention whereas latent is unintended consequences by unexpected utilisation of intervention’ (ibid:117). In a traditional community sometimes one can observe these shifts of intended to unintended consequences like that of in the general population. This may be more dangerous in an indigenous community compared to others. Since, for them the convenience is more important than the consequences. That group even, will forget about the hazards on health and stick on to the convenience and importance for daily life activities or day to
day functions. Experts can see change but not in the desirable and expected way, it is manipulated and diverted by the people.

**Autonomy**

Autonomy implies the freedom or ability to make decisions on a given matter, or right to exercise choice. Marriot (1990) has argued that South Asian culture does not encourage individualism and self expression. Growing up in a large community setting, close neighbourhood and sharing of same courtyard with relatives encourages interdependence rather than independence (Jeffery and Jeffery 1996). Further, they add that, for women it may be hard to articulate a desired state of freedom of action: This may make them ambivalent about the possibility of more autonomous and responsible action.

Women’s autonomy regarding the reproductive rights depends on her external assessment and her own views about possibility and desirability. Autonomy of women is related to education and other social, economic and cultural factors. The role of family members is also a prominent factor, which may influence the autonomy of women belonging to that particular family. Mead (1954) emphasises some societies have undergone profound recorded changes in their position in relation to people around them and these changes in orientation, initiative and response have themselves become part of the way in which the contemporary generation meets change.

Power and autonomy is connected. The person aiming for autonomy needs a lot of power. Autonomy means empowerment. The term power is also included within the concept of empowerment (Henifin 1988). It is an extension of the general principal of self determination regarding one's body and to the idea that women must be able to decide about their own bodies and reproductive capacities. Different factors influence the autonomy of women especially in the area of reproductive capacity which includes the policies, availability of reproductive technology and means of fertility regulations and restrictions or social barriers. Women from different ethnic communities deserve attention since women from these sections are strongly affected by these technologies.

**Motherhood**

Judith Brown (1970) concluded that women's work is characterised by the fact that it is compatible with child rearing activities, through which she means, child care responsibilities are a part of not the physiology of women and is thus based on gender and not on sex. Sherry Ortner (1974) argues that women's universal sub-ordination resulted not from the biology per se, but
from cultural constructions which accorded biological reproduction less value than men's cultural accomplishments, further maintaining the negative ideology concerning women centers upon their sexual and reproductive activities.

For an indigenous community, motherhood is the prime important factor in a woman's life. In this study it is apt to take the concept of Moore (1988) and Rosaldo (1980), which brings out the cultural importance and how the society or women look at motherhood. For the traditional society, even when they face gender discrimination they accept it as part of the system and they get along with that. Instead of the feeling dejected they accept the role of men in the biological process of reproduction and the contribution of men in motherhood.

**Sanskritisation**

Srinivas (1989) stated that there are two dimensions of sanskritisation. One is cultural and the other is structural. By cultural, Srinivas refers to introduction of changes in the customs, ritual and ideology and life-style. And the structural dimension leads to a gradual entry into the Hindu fold in the case of outside or marginal groups and to their upward mobility in the local caste hierarchy in the case of groups already within the Hindu fold. Further, he stated that the Brahmanical model holds sway in the south where as Kshatriya model of sanskritisation is dominant in North India. In fact over a period of time just as the culture and lifestyle of the dominant castes spreads among the dependent castes, a few elements of the culture of the latter also get absorbed into that of the dominant castes. When the sanskritisation comes to an indigenous community, the cultural rhythm of their culture is affected. “The desire to control female sexuality, promote female productive powers and culturally encourage the reproduction of sons while discouraging the production of daughters are all built into sanskritisation” (Srinivas 1989:23). This led to the control of female sexuality which insists to take up glorification of virginity and *pativrata dharma*[^20] among the tribal community. Indigenous people who used to practiced polygamy and polyandry is in a phase of transition to monogamy as a result of sanskritisation.

While encountering the so-called modern, progressive cultures and civilizations, traditional communities easily adopt to the ‘taking’ mode than the ‘giving’ one, though these indigenous cultures may have a lot to give especially in the area of comprehensive concept of health that

[^20]: Woman who is devoted to her husband and who dies not indulge in any relation with other men
could contribute significantly to the integral development of the humankind. Over the last two decades, all over the world, the understanding of peoples’ belief systems about health and health related behaviour experienced a sea change (Pelto and Pelto 1997). The new notion that ‘illness domains are inherently complex cultural systems, with variations from household to household, subjected to situation and specific decision making at various points is increasingly replacing the traditional explanation of cultural beliefs as the sole predictor of health behaviour (ibid). People’s ‘explanatory models of ailments’ (Kleinmann 1980) and other factors related to social and economic costs and availability of relevant health services are now considered far more important than cultural beliefs (McElroy et.al 1989).

In other words, the present study looks at what Rosaldo (1980) calls 'people's meaning' and Moore (1988) 'culturally given definitions'. Long (2001) also supports the meaning and culturally constructed values but which are differently interpreted and which sometimes generate 'new' cultural standards. The women's interpretations and meanings attached with their practices and taboos becomes important than giving a general explanation of their culture and action.

**Conclusion**

Understanding the importance of culture in health and health culture are the prominent aspects of health research. The three aspects that are discussed in this chapter include background of the study, literature and the theoretical frame work of the study. The different studies on health and health culture among different groups and in indigenous communities are explored in this section. I have tried to incorporate studies from various areas of sexual and reproductive health as well as from different places which have helped me in giving a direction to the present study. The history of sexual health and the trajectory of changes are traced in this chapter. Literature review has helped in finding out the gaps in the literature.

The theoretical understanding has helped me in positioning the present research. The actor perspective and the feminist theories have helped in bringing out the symbolic understanding of Muthuvans daily life practices. In order to understand the relevant concepts and the way they have emerged and explained, one needs to go through the perspectives that have been developed by scholars, who have been involved in long term academic debates which is brought out in this chapter. The concepts which are discussed are basically on the context of people and their experiences.
Interface analysis on the dynamics of culture and its implications on sexual and reproductive health practices are looked at based on the argument that “social life is composed of multiple realities, which are, as it were, constructed and confirmed primarily through experience” (Long 2001:51). The cultural association and importance in daily life varies from culture to culture. This argument becomes relevant in the context of the present study. The basic insight from this perspective is that when actors with diverse values, interests and power come together then continuities and discontinuities in sexual and reproductive health practices emerge.

The next chapter deals with the research methodology adopted in the present study and it also discusses the process of field work in the Muthuvans kudys of Kerala.