Chapter III

Experiencing Pregnancy: Multiple Knowledges, Resources and Support Systems

This chapter explores different ways in which women mobilise knowledge, resources and support systems in negotiating patriarchal control of their pregnancies through different structures of authority – specifically the family and the state-financed biomedical institutions. The forms of control, support and negotiations are explored with respect to pregnant women’s diet, mobility, physical work and medications. Continuities and changes in women’s experiences are explored not only across women’s multiple pregnancies but also between older and younger women’s pregnancies.

Within the family, there is a shift in the role of mother-in-law from being the dominant authoritative figure during older women’s first pregnancy to a weakened position during the younger women’s first pregnancy. This is due to the availability and accessibility of biomedicine as an alternative knowledge system for the younger women. The chapter argues that mothers-in-law negotiate to reclaim their legitimising and controlling position in daughter-in-law’s pregnancy. In this process, they attempt to accommodate the demands of the biomedical system and do not hesitate to follow rituals of other communities. The chapter also analyses various social support systems (family, community and biomedicine) that women invoke during their pregnancy, which is dependent on their household composition, geographical proximity with their natal family, accessibility of NMCH intervention services, in order to have a better experience during pregnancy.

The experiences of older and younger women depict that their pregnancies were controlled by the power structures of traditional authority and that of the institutionalised biomedicine. Women’s responses to these power structures have been varied and strategic as they collaborate, resist and negotiate with the overlapping and different layers of control and authority. Women’s negotiations with different structures and relations of power during pregnancy are analysed specifically with reference to first and subsequent conceptions, food intake, physical mobility, working outside the household, performing household chores and medication. In negotiating
with the intra-household control, women mobilise external resources such as biomedical institutions and knowledge. Women also mobilise family and community support system in dealing with biomedical power. Negotiations varied with household compositions, proximity to natal house, level of awareness and working status of women.

**Confirming Pregnancies**

The mothers-in-law played an important role in the pregnancies of the older women. Their marriage at a young age and the general lack of awareness regarding pregnancy made them rely on their mothers-in-law for both, support and knowledge. Often it was the mother-in-law who educated her about menstruation and who confirmed her first pregnancy. The experiences of younger women differed due to their relatively mature age at marriage, access to biomedical services, exposure to media and even the availability of home pregnancy tests in the medical shops. However, the first pregnancy of both, older and younger women was the focus of control and support as they were seen as inexperienced, and was invested with high expectations to prove fertility and produce a male heir. The direct control of familial structures eased out for subsequent pregnancies since women were expected to use their experience as a source of knowledge.

**Older women’s experiences.** To elaborate on the dominant role of mother-in-law as the source of knowledge for older women during their first conception, given here are experiences of older Baniya and Dalit women. Madhavi, an older Baniya woman from a village in Uttar Pradesh, who had got married at the age of twelve, stayed with her conjugal family. She had started to vomit and informed her mother-in-law about it. It was her mother-in-law who had told her about menstruation, since she attained her puberty after marriage. Being the only daughter-in-law in the house, Madhavi did not have any other option but to speak to her mother-in-law about all the fears and anxieties related to her first pregnancy, regarding eating a particular food item, doing a particular work, and even about wearing new dresses. However, Madhavi mentioned that for her second pregnancy, there weren’t too many dos and don’ts. It was believed that Madhavi would have learnt from her first experience of pregnancy which she would apply in her subsequent pregnancies, causing less anxiety.
Madhavi was expected to manage subsequent pregnancies herself and not make demands on her mother-in-law. It was believed that after experiencing pregnancy once, women would be able to manage future pregnancies themselves. Thus, women’s personal experience was a valid source of knowledge and also relied upon in the management of pregnancy. Cultural knowledge of pregnancy was validated and reproduced in this manner.

A similarity is seen among the older Baniya women and older Dalit women, who shared their experiences of conceiving for the first time. Pushpa, an older Dalit woman, was just ten years old when she got married. It was her mother-in-law to whom she went to when she got her menses:

*I got married so early that I did not even know anything about menses. My mother-in-law had told me that this happens to every girl... Since my menses had stopped for a couple of months, I was more than happy! Then once my mother-in-law caught me eating pickle, which I otherwise did not eat, she was surprised and asked me since when did I start liking pickle? She asked me about my menses and I happily told her that I have been missing it for two to three months. She then took me to another room and told me the meaning of missing menses. I must have been thirteen then, clueless about what was happening.*

While comparing experiences of older Baniya and Dalit older women, it was seen that mothers-in-law played an important role in daughter-in-law’s conception. This is due to residing in extended conjugal households and early marriage that made mother-in-law to have a stronghold over their daughters-in-law’s conception. Getting married at an early age was very closely related to women’s sexuality which was linked to the family honour (Jeffery et al. 1989; Dube 2001b; Chakravarti 2003; Geetha 2007). Their young age, confinement to home, lack of exposure to any other knowledge system and their low levels of education led women to adhere to instructions given to them by their mothers-in-law regarding managing their pregnancy. Consequently, there was almost no scope for any negotiation as the avenues of being aware about pregnancy were very less. Thus, it was seen that the dominance of mother-in-law as a patriarchal figure was strongest in older women’s lives during their first pregnancy. While describing her second and subsequent pregnancies, Pushpa mentioned that her mother-in-law’s role in monitoring pregnancy had reduced since her first child was a boy. The sex of the child also influenced mother-in-law’s role in her daughter-in-law’s subsequent pregnancies. The cultural knowledge around managing pregnancy was reproduced as long as the structure of the household composition did not change,
across communities and regions. With a change in the household composition, mother-in-law’s hold on the lives of daughters-in-law decreased (Kandiyoti 1988). Tulsi Patel (2006), discussing on similar lines, the dominant role of mother-in-law in the lives of daughters-in-law, refers to the former as ‘agents of patriarchy’, who takes decisions regarding women’s social as well as sexual life.

Younger women’s experiences. Getting married at a later age, living in a city, media exposure, having access to biomedical services and changes in household composition led to differences in the way young women experienced their first conception. This section explores the influence of availability of an alternative to cultural knowledge. Biomedical services led to a decline in mother-in-law’s role even in the first pregnancy.

Sumana, a young Dalit woman, stayed in a nuclear set up with her husband, one son, and had her parents-in-law, three sisters-in-law, one brother-in-law staying downstairs. Her mother-in-law came up to her kitchen once a day for breakfast, and rest of the meals were cooked separately. Sumana was well acquainted with Poorvinagar, since she was born and brought up in another block of the resettlement area. Sumana argued that mother-in-law could not have helped her much during the pregnancy since she belonged to a different era, when they did not have an access to biomedical services during pregnancies. Sumana’s natal household was close by and she was very close to her brother’s wife, bhabhi, who had delivered two sons in a government hospital:

*I had gone to my mother’s place which is in the vicinity. I had told bhabhi that I had missed my menses that month. She took me to a clinic nearby to get my urine test done and then the doctor told me that I was expecting. Since bhabhi was with me, she was the first one who got to know. I did not want my mother-in-law to tell me what all I need to do during my pregnancy. I do not doubt that she has raised more children than me, but their zamana [time] was different and they did not have an access to biomedical facilities during pregnancies, the quality of food was better.*

Sumana delivered a male child. For her second pregnancy, she drew from her experience of managing first pregnancy which had a ‘successful outcome’, a son. She asked her bhabhi’s brother, who worked in a hospital to get her three-four home pregnancy test kits. Thus, she used biomedicine to confirm her hunch regarding her second pregnancy. She subsequently used the NMCH services. Sumana also had the
support of her natal family, especially her bhabhi, brother’s wife, who supported her emotionally throughout her pregnancy.

Another young woman, Sheela, from the Baniya community, who had finished schooling and had got herself enrolled in a college, resided with her parents-in-law, husband and a daughter. While talking about her first pregnancy, she revealed that when she had missed her ‘periods’, without confiding in anyone, she went to the chemist to ask for a home pregnancy test kit. She had learnt about home pregnancy tests through television advertisements. The authority of mother-in-law over daughter-in-law’s pregnancy is concerned with the help of biomedical knowledge. However, Sheela had to abide by the mother-in-law’s decision to deliver in a public hospital despite her desire to go to a private hospital. On the one hand, her awareness and media exposure made her less dependent on the mother-in-law and to confirm her pregnancy on her own accord. On the other hand, her educational level could not enable her to surpass her mother-in-law’s decision of making her deliver at a public hospital.

There were women across Baniya and Dalit families who discussed the dominant role of mother-in-law due to their household structure of residing in or close to conjugal family members. Prema, a young Dalit woman from Kumao, Uttarakhand, who stayed with her husband and three children narrated that she was in her conjugal village when she conceived for the first time. Prema was around eighteen, when she got married. The next day after their wedding, her husband left for Delhi. She stayed back with her conjugal family members, younger unmarried sisters-in-law, brother in-law along with her parents-in-law. She narrated her first pregnancy experience:

* I had got pregnant on the day of the wedding. That night itself. I had missed my next month cycle and had started vomiting. I had a feeling that I was pregnant... That time I was in my conjugal village in Kumaon. I stayed there with my in-laws since my husband left me the next day alone with his family and came to Delhi... that is why I know that I got pregnant on the day of the wedding. It was very embarrassing! I did not want a child that early... may be after a year. What would have people thought! That I got pregnant on the night of my wedding! People want any reason to batein banana [gossip]! And they would only talk bad about me, not about him! They might think that I was pregnant beforehand and my family duped my husband’s family.

Prema was embarrassed by the circumstances of her first pregnancy, and was afraid that the society might think that she was pregnant beforehand and would question her virginity. On the one hand, where the societal pressure of proving a
newly married daughter-in-law’s fertility was important, the virginity of daughters-in-law was equally important on the other hand. She also mentioned that she knew what was it to get pregnant, seeing her sister-in-law at her natal house along with friends and other relatives but had not expected to conceive on the night of the marriage. Her ability to draw a link between missing her menses and conceiving was a part of exposure to media, especially television, age at marriage, and her close interactions with married relatives and friends.

For Prema’s second pregnancy there was a lot of pressure on her to deliver a boy since the first child was a girl. Her mother-in-law used to feed her well, thinking and hoping that the next child will be a boy. This was different from other older women’s experience, where they had to manage the second pregnancy themselves. She said,

There wasn’t any difference between the first and the second pregnancy. My mother-in-law wanted me to deliver a son and she did everything to make sure that it is a son. She took extra care of me, probably more than as compared to the first pregnancy by making me drink milk, making food for me. She was very upset after I delivered a daughter again and she threatened me saying that if I delivered another daughter, then she would not see my face ever again. I did not know what to do. So, I decided, the next time my husband comes, I would convince him to take me with him.

Prema’s mother-in-law’s behaviour during her second pregnancy was influenced by a strong desire to have a male child once Prema’s fertility successfully proved. Prema’s mother-in-law’s complete control over her was evident in the way she threatened her and closely monitored her second pregnancy.

Prema’s husband visited them, six months after her second daughter was born. Her mother-in-law expressed that he had become very lean, probably because he had to do so much work throughout the day and then cook for himself as well. Prema said, ‘I grabbed the opportunity and tried my best to convince my husband to take me with him to take care of him’. Her husband expressed this to his mother, who readily agreed since she was concerned about her son’s health. Prema went with her husband and two daughters to Delhi and conceived for the third time in Poorvinagar. Prema asserted her identity as a dutiful wife to overcome her ‘unsuccessful’ role of a daughter-in-law, unable to give birth to a boy child. Thus, some women assert their patriarchal role of a dutiful wife to escape other patriarchal structures and ideologies such as the mother-in-law’s taunts to give birth to a son.
While comparing younger women’s experiences with that of the older women, it was seen that younger women were more aware and more informed about conception. They also had more resources to access biomedical services, as compared to the older women. Along with age, they also got an exposure to the latest technology in the field of reproductive health on television through various advertisements and awareness building programmes of NMCH. This awareness decreased the dependency of the young women on their mothers-in-law as they now had multiple sources and methods to confirm their pregnancies. Absence of such sources made older women to adhere to the prescriptions of mother-in-law, since she was the only source of knowledge.

**Food Intake**

This section on food intake attempts to explore the cultural prescriptions regarding diet of a pregnant woman, the ideological underpinnings of dietary practices and women’s responses to them. It was seen that the cultural prescriptions related to diet was not only to produce a healthy child but had patriarchal undercurrents to have a male child and to have a fair complexioned child.

It is well established that gender norms and practices govern intra-household distribution of food both in terms of quality and quantity. These norms, in general, disfavour women. Although these norms are relaxed in the case of pregnant women, their food intake is closely monitored for cultural reasons. The socio-cultural context of pregnancy made older women monitor younger women’s pregnancy through various rituals, beliefs and practices (Lingam 1998). Diet was one of the most important components of experiencing pregnancy (Das 1998). Indira Mahadevan (1998) referred to diet during pregnancy as ‘a social product of collective shared experiences and ideas of the community’. Expecting women were mostly seen to be dependent on the cultural knowledge held by older women; be it mothers or mothers-in-law, regarding diet during pregnancy. As argued by Lakshmi Lingam (1998), there are some beliefs regarding diet that are held by people in general, cutting across caste, regions and other structural arrangements. One of the common beliefs held across age, regions and community was to eat less during pregnancy as compared to women’s usual diet in order to deliver with ease. Moni Nag (1994) and Das (1998) argued that these beliefs influenced the state of pregnant women’s nutritional status in India.
In the present study, one of the common beliefs included avoiding food items producing heat in the body, as it was believed that consuming such food would increase the possibility of miscarriage. There was a lot of stress on eating white coloured food items in order to have a fair complexioned child, yellow food item in women’s diet to conceive a male child. It was seen that the essence of white and yellow remained the same across regions but only the food items changed according to its availability. There were some food items that were associated with the caste and class status of the community to which the women belonged.

Pregnant women are also expected to show cravings for special food which are expressions of foetal desires. Food cravings are also culturally associated with pregnancy outcomes such as weight, sex and skin colour of the baby. The biomedical prescriptions were aimed mainly at preventing mother’s anaemia and improving weight of the new born children.

**Diet to have a healthy child.** The first pregnancy was perceived as a matter of proving women’s ability to reproduce. The older women, in this study, focused on consumption of *ghee* to have a healthy child and also to have a smooth delivery. They also recommended the same to the younger women. Older Baniya women focused on consuming a lot of *ghee* during pregnancy, since they believed that it was a remedy for all ailments in pregnancy and made delivery comfortable. *Ghee* was considered to be an expensive food item. Despite rising expenses, there was no compromise made as far as diet was concerned. Mothers-in-law were concerned that daughters-in-law ate well and most importantly ate right to produce a healthy heir of the family. There was a lot of stress on dry fruits among the Baniyas. Krishna, an older Baniya woman, criticised young women for running to the hospital for everything:

*Our mother-in-law used to tell us to have ghee as it was the best medicine for everything. We used to make ghee at home. Now-a-days if you tell daughters-in-law about ghee, they would start making excuses to not make it at home because they feel it stinks, forget about eating it. That is why these women are so weak! I think ghee is the best medicine for everything.*

Krishna was of the opinion that because young women did not have *ghee*, they kept rushing to the doctors to get tests done and ensure that the foetus is healthy and safe.
In the poorer socio-economic contexts, eating ghee was not stressed on during pregnancy. Shivati, an older Dalit woman, mentioned that her mother had told her the secret of having a healthy baby:

_One should have a lot of tomatoes and carrots to have a healthy and beautiful baby with red cheeks. My mother used to also tell me to have curd everyday. This would strengthen baby’s teeth and also kill worms, if at all, in the stomach. A lot of black pepper is also made to eat so that the pregnant woman does not catch a cold, as it would affect the baby as well._

On the other hand, Sumana, a young Dalit woman mentioned that she adhered to doctors’ prescriptions. She also stated that abiding by her mother-in-law’s ways of managing pregnancy did not ‘guarantee’ that she would have a safe delivery and a healthy child. _‘My mother-in-law would also ultimately take me to a doctor if something goes wrong, so it is better to go there myself and ensure safe delivery’, _claimed Sumana.

The younger women were, however, concerned about the consequences of weight gain from the highly valued items such as ghee. Such a diet defeated their efforts to achieve the idealised image of a ‘lean body as beautiful’ that the media portrayed. In order to accomplish that, young women of Poorvinagar were very cautious of the enhanced food intake during pregnancy and devised ways to circumvent older women’s pressures. For instance, Sumana’s mother-in-law used to make ‘ghee ke laddoo’ and insisted that she consumed them. _‘I used to eat very little and give the rest to my younger sisters-in-law because I did not want to put on weight after pregnancy’, _she claimed. Sumana opted for the biomedical prescription, offered by Poornima, the public health nurse. According to Poornima,

Five grams of ghee had nine kilocalories which was essential for women to absorb vitamin A, D, E and K. The cultural belief that women should be made to eat extra ghee is not required, it will only add up to their weight, which is unnecessary. It is important for women to stay fit and have everything in the required quantity.

While following the biomedical recommendations, Sumana also tried to negotiate the intra-household power dynamics around eating ghee. Consumption of ghee was considered as a culturally valued dietary practice and is symbolic of class and social status. While Baniya women used more ghee, there were instances when Dalit households too tried to follow these practices to gain status in the neighbourhood. Economic resources are mobilised, and intra-household allocation of valuable
resources are directed towards daughter-in-law to realise the patriarchally desired pregnancy outcome—a male child.

**Diet to have a male child.** There is socio-cultural pressure exerted on women to produce a male child. It was seen to be stronger among the Baniyas, but was also observed among Dalits. There are strong cultural beliefs that the sex of the foetus can be known and also manipulated through diet. Sushma, an older Baniya woman, also mentioned that expecting women were made to have certain vegetables,

*It is said, if you dream of gheeeya [green gourd] or cauliflower, then you will have a girl. If one dreams of apple, coconut, mango, yellow colour and gold then the chances are that it will be a boy so it is best to make the expecting woman consume what she should dream of.*

One such belief was that if a pregnant woman craved for sour food, it was an indication of a male child. Anju, a young Dalit woman, who stayed in a nuclear household, near her marital household, was the only daughter-in-law. She remembered how her mother-in-law played an important role in monitoring her first pregnancy to ensure that she delivered a male child. Her mother-in-law made her eat more of sweet food items in anticipation that she would then crave for sour food, consuming which could then increase the possibility of a male child. This also saw the way mother-in-law had an instrumentalist approach towards daughter-in-law’s pregnancy to ensure a male child. On the other hand, doctors had told Anju to avoid sweets because her blood sugar levels were already high. Anju stated,

*I used to vomit out sweet and rich food. It did not suit me, but still when my mother-in-law used to ask me to have it; I used to have a little bit out of respect. She used to scold me whenever I used to refuse to eat it... saying that this would help me deliver [a male child]...but I had to see my body also! If the doctor had told me to avoid sweets, how could I eat more sweets if it is harmful for my baby?*

Anju mentioned that the next time her mother-in-law accompanied her to the NMCH van she made her interact with the NMCH counsellor. He told them that she had diabetes and should avoid sweets or else it will be harmful for the foetus. Anju succeeded in using biomedical knowledge and authority to resist the strong hold of mother-in-law on her pregnancy. But at the same time, Anju also ate a little portion to
adhere to the cultural prescription of eating sweet and *ghee* to ensure that in her first pregnancy she met the cultural expectations.

The cultural preference for a male child among the upper castes is associated with inheritance of wealth and transference of property. Traditionally, only upper caste could own property and thus in order to keep the property within the family, to perform death rituals and as old age security it was considered necessary to have a son (Dube 2001a). On the contrary, daughters were not considered owners of immovable property and were considered as financial burden since dowry in terms of cash and movable property was given to their conjugal family members (Chakravarti 2003; Geetha 2007). The upper caste notions of preserving the property and the caste lineage made them to prefer sons over daughters. Thus, giving birth to a son enhances a woman’s social and economic status. It was seen that this upper caste value for preference of a male child had percolated even among the Baniya and Dalit families and could be perceived as one of the ways of sankritisation.

**Diet to have a fair complexioned child.** Women’s narratives also showed a strong desire for a ‘fair child’ and its realisation through diet management in pregnancy. There was a lot of emphasis on eating white-coloured food items among both Baniya and Dalit communities due to the patriarchal reinforcement on fairness. Among the older women, it was seen that they followed the culturally prescribed diet during their pregnancy, and this was maintained by the younger women as well as with the media emphasising skin fairness through creams and bleach for men and women. All these products were easily available in grocery stores in Poorvinagar. Younger women, who had internalised the cultural value of being fair-skinned, were particularly susceptible to the literal and traditional association of colour of the food with that of the skin. Older Dalit and Baniya women emphasised consuming milk, egg white, cottage cheese and curd during pregnancies in order to produce a fair child. Shakuntala, an older Dalit woman from Himachal Pradesh, also said that to have a fair baby it is good to have milk with saffron everyday. It improves the colour of the skin of the baby in the womb. The ideology of eating white food for fair child remained the same across states but the food items that symbolised and promoted the belief varied with region.

Bina, an older Baniya woman, who belonged to Rajasthan added that drinking milk regularly, two glasses a day, helps in making the complexion of the baby better,
while Madhavi, an older woman, added that in Uttar Pradesh, there is a belief that gola (brown coconut) with mishri (sugar) and badam (almonds) makes the baby fair. She further believed that if a pregnant woman is made to eat thin long slices of coconut, then her baby will have thin lips, which was considered a sign of beauty among the Baniya community.

Among the younger women, a similar experience was shared by Tanu, a Baniya woman belonging to Bihar, who used to get a stench from milk since childhood. After getting pregnant, she had started to get bouts of vomiting seeing milk, but her mother-in-law used to forcefully make her have haldi (turmeric) milk in anticipation that she would have a fair grandson. The belief that a combination of turmeric (yellow colour) and milk (white colour) would make a pregnant woman deliver a fair son was common. Tanu expressed that since she used to stay with her mother-in-law in an extended household, it became difficult for her to always refuse it. She maintained, ‘I could not say no to her for making me drink milk because I was deep down convinced that it if I had milk then my baby will be fair’.

Among young women, who did not have their families nearby, had neighbourhood women imparting cultural knowledge regarding having a fair-skinned child. Asha, a Dalit woman, who stayed in a nuclear household away from both her conjugal and natal households, mentioned that after shifting to Poorvinagar with her husband, it was her neighbour who prescribed the diet to have a fair child:

When I came to Poorvinagar from the village, I did not know anyone here. Thankfully, I had made friends with our neighbour who was elder to me and she treated me like her younger sister. She told me the importance of consuming white coloured food items. She also used to make some of them for me. White chole [chickpeas] was one of the things she used to make for me, apart from milk with turmeric and egg white. And really, my children are way fairer than me!

There were hardly any signs of resistance by older or younger, Baniya or Dalit women on account of this. Not only the traditional cultural systems and the modern consumer industry propelled these beliefs, but also the biomedical staff reinforced the cultural beliefs in order to obtain women’s compliance in following their instructions. The NMCH doctors gave justifications to such cultural beliefs that increased pregnant women’s intake of protein. Some of the medical staff too shared women’s cultural beliefs. ‘Protein is required to make muscles and nervous system of the foetus. Probably this cultural belief rested on some reasoning’, claimed Tina, a medical staff of NMCH.
**Food Cravings.** The urban character of the city influenced younger women’s cravings for specific foods. Women used pregnancy-induced ‘food cravings’ to legitimately satisfy their desire for ‘junk’ food. The protective mother-in-law of younger women, especially Baniya women who resided with them, believed that it was necessary to monitor what her pregnant daughter-in-law ate since they believed that junk food did not have much nutritious value.

Amma, an older Dalit woman, spoke about her daughter-in-law, and recollected that she herself used to crave for chaat pakodi and her mother-in-law allowed her to eat it once in a while, that too if pakodi is made of moong daal and not urad daal, because the latter was considered to be quite heavy to digest. She further opined that eating this once in a while is still ok, but not on an everyday basis. She complained, ‘chowmein, burger and golgappe comprised of junk food which had no nutritional value’. Craving for junk food was seen to be common during pregnancies of young women across communities and regions. Kamala, an older Baniya woman, believed,

*Now-a-days daughters-in-law don’t listen to us [mothers-in-law]. They listen to everyone else except us, be it a doctor, or her friends. Now even her friends would be of her age only, what would they know! I have delivered three children, but only if she listens to me and does what I tell her to do! They like to eat golgappe and burger. I keep telling my daughter-in-law to have homemade food, but Maggi is her latest craving.*

This reflected mother-in-law’s helplessness and sense of loss of control over her daughter-in-law’s pregnancy. Since women’s cravings were associated with foetal cravings, women used the double opportunities, that is, the easy availability of junk food items in the vicinity and the norm of satisfying food cravings of pregnant women, to satisfy their desire for ‘outside’ food. Gomati, an older Dalit woman mentioned, ‘*everyone feeds her [pregnant woman] well with assorted things so the child does not salivate. It should not seem like we did not give enough variety to the daughter-in-law*’. This provided a cultural as well as an economic concession for pregnant women to eat junk food. Satisfying women’s cravings were also related to maintaining a status in the neighbourhood that pregnant daughter-in-law was fed well by the mother-in-law.

During the second and subsequent pregnancies, women could assert themselves more since there were relaxations of norms and cultural prescriptions governing their
pregnancy. Women who meet the cultural expectation of proving fertility and producing a male heir through their first pregnancy enjoy higher status and power within families. Some of them use their cultural and social status to assert themselves. For instance, Sumana had given birth to a boy in her first pregnancy. During her second pregnancy, her mother-in-law, once scolded her for eating three eggs. Sumana argued, ‘I will eat what I like, irrespective of what the doctors tell me or what my mother-in-law tells me. I ate eggs because I liked it. Even if the doctor would have said to avoid it, I don’t think I would have’. In asserting her views and wishes, she was trying to challenge both cultural and biomedical recommendations.

Young Baniya and Dalit women were seen to make the most of the opportunity of biomedical prescriptions regarding ‘eating everything’. This was done by reinforcing her status of a pregnant woman, who is the carrier of the family’s heir. Her cravings, therefore, received attention and were satisfied by family members. This was because of a cultural belief that, if a child is seen to salivate, then the family members especially the mother-in-law, were taunted for not fulfilling their duty to satisfy expecting daughter-in-law’s cravings. This also involved mother-in-law’s status in the society and, therefore, she ensured that daughter-in-law’s cravings were satisfied. Young Baniya and Dalit women tried to subvert some of the patriarchal ideologies to express and satisfy their desires, and to experience pregnancy their way.

Physical Mobility

*Mobility restrictions*. Pregnancy is seen as a stage which is particularly susceptible to the influence of supernatural forces which placed several restrictions on women’s physical mobility. During this period, women could not make themselves look attractive or be seen in public places. Bina, an older Baniya woman mentioned that some pregnant Baniya women were made to wear iron rings to protect them from evil eye. Garima, a young Baniya woman mentioned, older women believed that pregnant women should not wear any make-up, including lipstick, perfume, and powder as the scent could attract spirits which could be harmful for the foetus. Kusum, an older Baniya woman, asserted that pregnant woman should avoid wearing any new clothes. If at all she has to wear them, then she should dye a corner of the cloth yellow and then wear it. Yellow colour was considered to be an auspicious colour. It is believed that it will ward off evil spirits. To add to this, Prema, a young Dalit woman recalled
that no new bangle is worn during pregnancy, if the circumstances are inevitable, then another married woman with a child is made to wear it before making a pregnant woman wear.

There were cultural beliefs proscribing a pregnant woman from crossing a river; it was feared that evil forces might harm the baby in her womb. With a shift to an urban area, there were modifications in these cultural beliefs. Older Baniya and Dalit women maintained that pregnant women should not cross any drainage or any sewer in the vicinity. It was believed that evil spirits resided there and could harm either the pregnant woman or her foetus. Thus, the mothers-in-law reinvented cultural restrictions on women’s mobility in the urban context.

**Using biomedical services to overcome restrictions.** The NMCH personnel played an important role to increase women’s mobility in public spaces by parking their mobile van in Poorvinagar. This gave women confidence to step out of their houses alone, to ignore mobility restrictions and to avail modern biomedical services. Muniya, a young Baniya woman resided in an extended conjugal household with her parents-in-law, elder sister-in-law, elder brother-in-law and their children along with her husband and a three-year-old daughter. Being the youngest in the household, she was kept busy with the household chores that restricted her mobility, not providing enough opportunities to meet her natal relatives who stayed close by. During her pregnancy, she was initially accompanied by her elder sister-in-law to the NMCH van, but since the van was parked close by, her mother-in-law gradually allowed her to go by herself to avail these services. She used this opportunity to not only step out alone to access biomedical facilities, but also to meet her natal relatives and friends in the vicinity, to eat ‘junk’ food, and also to escape some of the household chores. Women’s availing of the NMCH van services led them to optimise opportunities to negotiate their way through the various structural arrangements of control. Keera Allendorf (2012) explored women’s power of negotiations by terming it ‘agency’, ability to take decision about their mobility with respect to going to local markets, nearby health centres, relatives’ houses. In different ways, young women used their condition of pregnancy and the presence of NMCH biomedical facilities in negotiating with some of the patriarchal arrangements restricting their physical mobility.

As observed in a few instances earlier, older women’s overall control over their daughter-in-law’s pregnancy is weakened due to the presence of a powerful
alternative to cultural knowledge in the form of NMCH which daughters-in-law were choosing to ensure safe delivery and also to counter the unequal power dynamics within households. This did not, however, lead younger women to trust biomedicine fully; they perceived NMCH as a counterforce to the power of mothers-in-law in their pregnancy by considering it as legitimate authority to confirm pregnancy and monitoring of it. In order to regain their losing position, mothers-in-law themselves started to encourage daughters-in-law to access biomedical services. They also accompanied daughters-in-law to NMCH mobile van as younger women had to abide by decisions taken by their mothers-in-law. This was seen more in the case of Baniya women since they stayed in extended conjugal households.

‘Work’ influencing physical mobility. Working outside households increases women’s physical mobility substantially. Also their women’s working status help them mobilise various resources to enhance their experience of pregnancy. Within Baniya household, daughters-in-law did not work outside the house and hence work-related mobility was not available to them. Among Dalit women, only a few younger ones worked outside their household as domestic help in nearby colonies. As work outside introduces women to various options for delivery, shapes their general awareness and brings them closer to market forces. Archana, a young Dalit woman, who stayed close to her natal family in Poorvinagar and had her conjugal household in their native village, used to work in two houses as a domestic help when she was expecting for the first time. In one of the houses, her employer had delivered recently in a private hospital and motivated Archana also to deliver in a private hospital. The employer convinced Archana that private hospitals were cleaner and safer and they take good care of the new born. Archana expressed her desire to deliver her first baby at a private hospital to her husband and she got herself registered at a nearby private hospital. Her husband helped her in the household chores so that she is not overburdened with work. In Dalit households women may be supported by family to work outside the household to earn an income as gender power-relations and division of labour within the household is less strictly defined as compared to the ritually higher castes. Being able to access private hospital was related to her earning status. She also got support from her mother who accompanied her to avail private hospital services. In Dalit families the situation may be different, since the mother-in-law had less influence over daughters-in-law’s pregnant bodies.
Contesting Household ‘Work’ and Rest

Physical work during pregnancy is another site that comes under the surveillance of traditional knowledge system but also of biomedicine. Older women, who abided by the cultural beliefs, kept advising their daughters-in-law to not engage in strenuous work during first three months of her pregnancy. Gayatri, an older Baniya woman stated, ‘we used to abide by whatever our mother-in-law used to ask us to do. She was more experienced than us. Not like today’s girls, who would listen to anyone and anything except their elders’. Further, Krishna, an older Baniya woman believed, 

One should take rest in the initial three months as they are the crucial months as the organs of the baby are being formed. Then in the fourth and fifth month we could start working, sweeping, washing clothes, cooking. I was not allowed to sit in one place in the nine month so that I deliver smoothly, without many hassles.

Tanuja, an older Baniya woman, on the other hand sternly commented on her daughter-in-law’s pregnancy that the latter did not have an option but to listen to what mothers-in-law instructed regarding her pregnancy, ‘there are high chances of miscarriage in the first three months, so it is best to stay away from your husband and take ample rest’, she asserted. It was believed that abstinence during pregnancy was seen as a way to ensure that the foetus is safe in the womb. It was believed that sexual intercourse pushed the foetus upwards towards the stomach increasing chances of foetal death.

Madhuri, a young Dalit woman, had come to stay in Poorvinagar, close to her natal house after being taunted at by her mother-in-law for not being able to conceive within a year of marriage. Adding to the sorrow was the taunts from the conjugal family regarding her husband’s low income, who was a typist in their village. Madhuri utilised the opportunity to shift to Delhi in the garb of family’s questioning her husband’s incapability to earn enough. She convinced her husband and promised him a better life in Delhi where even she would be able to contribute to family income. They shifted to Poorvinagar, stayed near her natal house setting up a nuclear household. Madhuri could draw strength by staying close to her natal family. Madhuri finally conceived after three years and to overcome her anxieties and fear, adhered to what her mother had to say about pregnancy:
I wanted to make sure that my baby is fine. I listened to my mother and also to what the doctors had to say. I tried to work in the initial three months, not only household chores but also working outside as domestic help but ensured that I don’t get tired. The NMCH doctors had asked me to sleep in the afternoon at least for two hours and I used to follow that.

Due to Madhuri’s working status as a domestic help in the nearby colony, her mother had sent her youngest daughter to help Madhuri in the household chores especially when the doctors had advised her to not work too much towards the eighth and the ninth month. Regarding working outside, her financial situation did not allow her to quit her job and sit at home. Thus, she decided to take her younger sister along even at her workplace. It was seen that financial constraints of Madhuri led her to not adhere to either the cultural or biomedical instructions during pregnancy as she went out for work throughout her pregnancy. Thus, her natal family support throughout pregnancy and especially towards the end of pregnancy helped Madhuri to continue with work.

The NMCH doctors prescribed pregnant women to carry out ‘normal’ work throughout pregnancy. This included sweeping, washing clothes and carrying out the usual household chores. This was in contestation with the cultural prescription of increasing or reducing workload at different stages of pregnancy. As evidence for the value of the cultural knowledge of modulating physical labour through pregnancy, Gayatri, an older Baniya woman spoke about her pregnant daughter-in-law, who stayed with her. Gayatri mentioned that her daughter-in-law did not abide by her instructions of resting in the initial period of pregnancy and met with a miscarriage:

*In her first pregnancy I had told her to walk slowly but she wouldn’t listen to me! She told me that doctors have asked her to do everything. Once she was cleaning the bathroom, she slipped and we lost our first grandchild. Did the doctor ask her to clean the washroom?! I am not saying don’t listen to doctors but we are telling you from experience. But she would not listen to me!*

In the subsequent pregnancy, Gayatri ensured that she went to the doctor with the daughter-in-law and spoke to the doctor herself.

As regards doctors’ perceptions on ‘work’ during pregnancy, Tina, one of the biomedical staff at NMCH stated,

*Definitely rest is very important. We advice them that they must have an 8 hours sleep at night and rest for 2 hours in the afternoon and she should avoid any exertions. As far as household work is concerned, sweeping and cleaning the house*
that can be done since that is moderate work. But we will not advice any heavy work like lifting something heavy and running up and down the stairs.

The differences in the cultural and biomedical views were seen in the last two months, eighth and ninth month of pregnancy, where doctors believed that women should rest as the anxiety level increased with approaching delivery date which makes women prone to accidents. On the other hand, older women believed that towards the end of pregnancy, it is important to work to prepare the body for delivering. Shakuntala claimed,

In the last two months, all this [exercise] help a pregnant woman to deliver. Earlier we used to grind a chakki everyday. Our mother-in-law used to give the daughter-in-law grains to grind. Now-a-days they do the opposite! They work in the initial months and take rest in the later months. That’s why there are increasing number of cases of caesarean.

Tina, an NMCH staff had a different opinion on rising number of caesarean operations. According to her the percentage of caesarean deliveries are decreasing due to limited number of beds in a government set up. Ghosh and James (2010), on the contrary, show that in developing countries, including India, rates of caesarean deliveries are increasing. They attribute this to increased access to gynaecological and obstetric services.

The younger women, in general, adhered to doctors’ advice more than family members’ because they considered doctors to have the latest technology which could save the child and expedite the process of delivery, which was the main concern for women. They believed that doctors were more reliable than mothers-in-law since times had changed.

Use of Medications
Biomedicine played an important role in the lives of younger women since they had access to hospitals. Among the older women, the only time ‘medicine’ was consumed was to treat infertility. Older women were not in favour of seeking biomedical services and consuming allopathic medicines during pregnancy. Lakshami, an older Dalit woman from West Bengal, was not able to conceive in five years of marriage, described how she was treated by her parents-in-law back in the village:
I got married at the age of thirteen and I couldn’t conceive for five years. My mother-in-law and other older women used to taunt me and address me as baanjh [infertile]. After a few months of marriage, my saas had started asking me when I will show her, her grandson’s face...I had menstruation problems. I did not use to get it for months. Then my mother took me to a dai mashi who knew about some jadi-booti. After taking jadi-booti for a month, I had got my menses but it was almost black, dark brown in colour and not red. But then I conceived...and stopped medication.

It can be seen from the narrative that the role of dai was beyond just delivering, she also treated infertility. The role of mother, in case of Lakshami, who stayed in a village close by, was seen important as she searched for a dai mashi, and took her daughter there. While the mother-in-law taunted her and also reminded her that she was infertile, her mother made sure that she was treated and able to conceive and prove her fertility.

Gomati, an older Dalit woman, believed there was no need to go to hospital or take medicine during pregnancy. Morning sickness was the only discomfort for which she prescribed amchur (dried mango powder) and lemon.

A young Baniya woman, Garima, mentioned that her younger sister-in-law, who was expecting her second child, had gone to the family guru ji to ask the sex of the child. The guruji had mentioned that it is going to be a girl and that she should consume ‘goli’ in order to change the sex of the child in the womb. Garima mentioned that the sex of the second child could be determined by looking at the circular direction of hair on the head of the first child (bhaura/bhauri). If the hair is in clockwise direction (bhaura), then it is said that the next child will be a boy, and if the direction is anti-clock wise (bhauri), then it will be a female. Looking at the first child, Garima had mentioned that since there was bhaura on the head, she will beget a son, while the guruji had mentioned that she will have a girl. The sister-in-law went to the guruji for ‘goli’ to change the sex of the child. Garima mentioned that due to the medicine, the sex of the child was changed and she delivered a girl child. While there are cultural restrictions on use of medications during pregnancy, for the ‘ill effects’, women are willing to consume ‘medicines’ to have a male child.

Further, the NMCH referral services were, therefore, accessed by young women in order to be able to register themselves in hospital for delivery. The younger women, who availed biomedical facilities during pregnancy, trusted the doctors for their knowledge and technique to help them achieve their goal of safe pregnancy and a healthy child. Mamata, a young Dalit woman, who was trying to conceive for a
couple of years, stayed with her husband at Poorvinagar, while her conjugal family was back in their village. They had shifted to Poorvinagar due to her husband’s job and arguments with mother-in-law, who would not stop taunting her and did not even allow her to avail biomedical services. Her husband, on the other hand, wanted her to avail biomedical services so that she could conceive after her treatment. He supported Mamata and moved to Poorvinagar:

After coming to Poorvinagar, I got a chance to meet NMCH people who come home. I spoke to the lady doctor who comes home and she referred me to a government hospital. I discussed it with my husband and he accompanied me to a public hospital. I had to take the medicine for about five to six months and today I have two sons!

Such experiences and pregnancy outcome did not always translate into women complying with all the biomedical prescriptions for a safe birthing. There were clear instances where biomedical and cultural knowledges were conflicting. One such instance was taking biomedicine during pregnancy. The cultural belief, however, was that biomedicine should be avoided, especially in the first three months, as heating substances could induce miscarriage. Biomedical staff believed that anaemia was the major reason for high maternal mortality rate and to combat it ‘consumption of iron folic tablets were considered essential for a minimum of first hundred days’, mentioned a medical staff at NMCH. On this delicate issue, the young women had to negotiate with the authorities of both biomedical and cultural knowledge. This was seen through the fear induced by cultural beliefs regarding side-effects of medicine on foetus on the one hand, and biomedical insistence on medications for survival and health of pregnant women and foetus, on the other. Women were seen to be less compliant with respect to intake of medications for various reasons. Chandini, a younger Baniya woman who stayed in an extended conjugal family shared her experience with first-time pregnancy:

Doctors had given me taakat ki goli [iron folic acid capsule] and told me to have it for three months. I used to get constipation. I had told doctors also that I am getting constipated after this medicine. They told me to stop it for two-three days and have isabgol to ease the bowel movement. I did that initially, but eventually stopped taking the tablets without telling the doctors.

Doctors’ disregard for women’s complaints of discomfort is responded through the defiant act of non-compliance. The authoritarian and ritualistic way with which biomedicine treated women’s pregnancies was counter-balanced by their faith in older
women’s beliefs. Studies have shown that urban poor women had to bear the brunt of state’s controlling mechanism, which focuses on controlling population, both quality and quantity, where women were treated as only reproducers (Stephens 1986; Chayanika et al. 1999; Kumar 2002; Rao 2004). During first pregnancy, women tried to comply with cultural and biomedical knowledge systems combining elements from both, while negotiating the underlying controlling and authority structures. However, in their subsequent pregnancies they were expected to and often chose to rely on their previous experiences as valid source of knowledge. For instance, women who had taken medications prescribed by doctors and had on their own discontinued it later during their first pregnancy, chose to ignore such prescriptions in their second and subsequent pregnancies, relying on their past experiences. Among the younger women, the first pregnancy was controlled by cultural as well as biomedical institutions, for the second and subsequent pregnancies, the importance of women’s subjective experiences of first-time pregnancy was taken as a valid source of knowledge.

Rituals and Practices in Celebrating Pregnancy

The present section explores the prevalence of rituals and celebrations in pregnancy among the Dalit and Baniya women. It shows that the rituals and practices around pregnancy were maintained even in urban context among younger women which reasserted patriarchal norms. In an urban resettlement area, there was a blurring of boundaries in terms of exchanging and adopting rituals between Baniya and Dalit communities. With consumerism pressing the economics of rituals and practices, it was seen that the notions of class and status was also involved with celebrating pregnancy. By observing rituals and practices and also celebrating pregnancy, mothers-in-law were seen to try and reclaim the lost ground in daughters-in-law’s pregnancies.
Shift in the Practice of Going to Natal House for the First Delivery

With moving to an urban area, Poorvinagar, there was a shift seen in the practice of going to the natal house for conducting first delivery. Urban context added the influence of class and status on women’s pregnancy. It was seen that managing daughter-in-law’s pregnancy was seen as a matter of maintaining status in the society. Going to the natal household for delivery is increasingly seen as the conjugal families’ reluctance to provide the necessary emotional and financial support for daughter-in-law’s deliveries. Apart from this, the presence of NMCH also influenced daughter-in-law’s site of delivery. Younger women preferred to stay back at Poorvinagar and access biomedical facility, as opposed to going to their natal house. This also gave mothers-in-law a platform to reclaim the weakening status over their daughter-in-law’s pregnancy.

Commenting on her daughter-in-law’s pregnancy, Radhika, an older Baniya woman, who stayed in an extended household with her husband, son and daughter-in-law and one unmarried daughter, raised the issue of being taunted in Poorvinagar for not living upto the resettlement culture of ensuring that daughter-in-law delivered in a hospital. Radhika mentioned that she went out of her way to accompany her daughter-in-law to hospital to ensure that her pregnancy was monitored:

During my daughter-in-law’s first pregnancy, she had met with an accident in the fifth month and we lost the child. So, this time when she got pregnant, I was very careful, not like it was my fault last time! Then if I don’t tell her things, tomorrow society will curse me that I am not taking care of my daughter-in-law...Nothing would have happened to her if I would not have told her, since her mother would have told her everything. It is me, who would have been termed irresponsible and being aloof of my duties.

Radhika also believed that since she was expected to take her daughter-in-law to a hospital, she preferred going to the NMCH van since it was at the doorstep. She had seen MPhWs and NMCH mobile van for years and had built a rapport with them which gained trust in taking their daughter-in-law for ANC check up. Thus, by taking her daughter-in-law to NMCH, she held on to the authority over her daughter-in-law’s pregnancy and also gained high status in the society as a dutiful and responsible mother-in-law.
**Godbharai Celebrations**

It was seen among certain regions and communities that pregnancy was a matter of celebration, especially in the seventh month. A ritual called *godbharai* is celebrated. Shanti Devi, an older Dalit Rajasthani woman narrated the ritual of *Saadh poojna* or *godbharai*.

Saadh pooje ek baar, bhaat pehne baar-baar, meaning saadh, *the ceremony of godbharai, an occasion where the daughter-in-law is pampered with bhaat, [gifts by her natal family]. This is celebrated only for the first pregnancy. In the seventh month, sweets, fruits, dry fruits and savouries are sponsored by the natal family. Daughter is given five different clothes— sari, blouse, petticoat, handkerchief and undergarments.*

**Food.** The seventh month of pregnancy is considered to be special for the daughter-in-law in some regions of Uttar Pradesh and Rajasthan among the Dalit communities where an expecting woman is fed well during her *satavan* or *godbharai*. She is made to eat all those food items that she likes in addition to *chatpati* (sweet and sour) things, both homemade and from the market. This is an occasion where elders give their blessings to have a safe delivery and to ensure that cravings are satisfied.

It was believed that craving was not of women but of the child in the womb to eat a particular food item. The woman herself was just a medium and was therefore fed well to ensure that the child in the womb doesn’t stay unsatisfied. It was also seen that the financial aspect was borne by the natal family.

Tulsi Patel (2006) maintained that giving gifts to pregnant women on godbharai was considered a *‘puniya’ ka kaam* which was a way of paying for their sins. Again, the concept of *punya* was ritually closely associated with upper caste, thus, by following it, it was seen as a way in which sankritisation process was observed.

**Shift from non-celebration to celebration.** Among the older Baniya, pregnancy was seen as a secretive event and hence, no celebrations were carried out. Krishna, an older Baniya woman said,

> We, Baniya, never had these rituals of celebrating the seventh month. Rituals were restricted to post-delivery; we never used to even tell anyone that somebody in the house is pregnant. It is believed that by telling, some of the neighbours also get jealous and especially those who were barren could also do black magic. Our elders used to say that we must not tell anyone, at least for three months as the first three months were supposed to be extremely crucial for the expecting mother and then if neighbours get to know then it is fine... they get to know by the way a
pregnant woman walks and also by third or fourth month it becomes visible. But now-a-days who listens to us! Ab taur tareke alag hain! [They have their different ways of managing pregnancy!] They run to doctors for everything! And tell everyone.

Madhavi, an older Baniya woman, also agreed,

*We are Baniyas and in our community, there are no celebrations before the child is born, but seeing other communities and also Baniya women celebrating their daughters-in-law’s satavan, I thought even I should, now times are changing and so should we!*

Among the older Baniya women, it was seen that Bina, from Rajasthan, while talking about her daughter-in-law’s pregnancy claimed,

*When my eldest daughter-in-law expressed her wish of celebrating her godbharaai and I also saw that the neighbours were celebrating, I could not say no to her. It was also a matter of what people will think about me! A Rajasthani Dalit family that stays in front of our house celebrates satavan of their daughters-in-law. So, after I started celebrating my eldest daughter-in-law’s satavan, both the younger daughters-in-law also expect that I will do the same for them.*

Bina’s narrative suggested that celebrating pregnancy was associated with mother-in-law’s status in the neighbourhood which was closely entangled with the aspect of class.

Older women were conscious of their status in the resettlement area, which could be claimed and maintained through the celebratory spending. Thus, it was seen that Baniya communities that were now celebrating pregnancy rituals earlier did not have them. Van Hollen (2003) also discussed the work of Ruth and Stanley Freed (1980) in a Hindu village in Uttar Pradesh, who in their study showed that about earlier, there was a prevalence of pregnancy ceremonies performed by brahmins. This was also found in Sanskrit texts. It was only after the anti-brahminical Arya Samaj movement in that area that brahmins discontinued to perform them and as a way to gain social mobility, Dalit community started to celebrate pregnancy rituals. Dalit women in Poorvinagar were seen to perform rituals and celebrate pregnancy in the seventh month.

The shift from not celebrating to celebrating pregnancy was part of their urbanisation, assimilation in a melting pot society. In an urban metropolitan area, celebrating pregnancy came to be closely related to maintenance of one’s status in the vicinity. This indicates that caste boundaries in a resettlement area is porous, which
allowed exchange of rituals and practices, and the attempt of the communities was to enhance their class and status in the neighbourhood.

**Mothers-in-law reclaiming their weakened position.** One of the reasons for older Baniya women’s attempt to celebrate daughters-in-law’s pregnancy was also related to reclaiming her weakened position as regards her daughter-in-law’s pregnancy against the background of biomedicine. Mothers-in-law, of Baniya communities, were in favour of celebrating pregnancy since they could be in an authoritative position in rituals related to celebrations. Tanuja recalled her daughter-in-law’s godbharai and said that it was held at the conjugal house, where she had decided when to organise it, who all to call, and what will be cooked for the guests. Women relatives from her daughter-in-law’s natal family and conjugal family were called along with neighbours. As a part of the ritual, they put a tika on her daughter-in-law’s forehead, gave a gift to her which were kept on her lap. They whispered something auspicious in her ears regarding blessing the mother and wishing best for her delivery. After that she was made to eat some savouries or sweets.

**Consumerism intensifying rituals.** Apart from influencing the Baniya community in celebrating pregnancy, urban character influenced the nature of celebrations. Intensification was not restricted to the economic aspect but also included male members in ceremonies. Gifts were not only given to the pregnant woman but also to her husband. The influence of televisions could also be one of the reasons for women to intensify celebrations of pregnancy and include men in the ceremonies.

Van Hollen (2003) discussed this intensification of ceremonies in pregnancy by discussing the way consumerism had influenced it by increasing demands of conjugal family on natal family. In the present study, Gomati, an older Dalit woman commented on the modification in the celebrations of godbharai among the younger women with intensification of rituals along with presence of male members in the ritual:

Godbharai was considered to be a small affair with basic exchange of goods, now there is so much of money involved in buying a variety of sweets, making mutton, chicken, kadhi, chawal, gifting so many saris to the expecting woman.

It was supposed to be an all women affair, where the expecting woman is given gifts and bangles along with different varieties of food but now-a-days even the male members participate in the celebrations. I have heard and also seen on
television that now-a-days even the woman’s husband is made to sit with the expecting wife and gifts are also bought for the husband and conjugal family members.

As contrary to a common assumption of modernity leading to decrease in religiosity, it was seen that it instead led to reinforcement of these rituals manifested in the economic aspect of these rituals. In spite of modifications in the rituals of pregnancy, especially, of not going to the natal family during the first pregnancy, the essence of the ritual was kept alive with natal family bearing the brunt of the celebration. With increase in consumerism, there was an emphasis on the exchange of gifts and clothes amongst the natal and the conjugal families to the extent that rituals also became financial constraint on the natal family. Conjugal family members even demanded for commodities from the natal family members, who were supposed to gift a list of goods to the conjugal family. Kusum reflected on the nature of godbharai and mentioned,

...it has become like dowry, where the natal family is supposed to gift so many things, saris, solah shringaar [sixteen beauty enhancing items], sweets, namkeen, blouse pieces for their daughter, set of clothes for the conjugal family members and additional sweets and namkeen for them. They arrange for a venue and also for a feast.

The splurging on the celebrations of godbharai is in fact to maintain a high social status in the neighbourhood. Van Hollen (2003) discussed that a pregnant woman in the seventh month celebration was considered as an ‘auspicious burden’, ‘auspicious’ since she has the regenerative power and ‘burden’ because she became an economic burden on the natal family.

From the above discussion, it would be inferred that there was a new culture of celebrating godbharai among both Baniya and Dalit families. This modification in the culture was seen as an influence of the urban character of Delhi, which cut across castes and communities residing in Poorvinagar, adopting and adapting elements from their culture. This reproduced certain elements of one community and also transformed rituals by adapting to each-other’s cultures.

In the scenario of mother-in-law’s affirmation to her daughter-in-law’s pregnancy, across communities and regions, celebration could also be looked at as a way of regaining mother-in-law’s lost cultural position, what Deshmukh-Ranadive
Support Systems in Pregnancy

Support system during pregnancy differed with communities, number of pregnancies, proximity to natal and conjugal households and availability of an alternative knowledge system to the dominant cultural discourse around pregnancy. Women mobilise resources and support systems during pregnancy for their physical and emotional wellbeing. This section will explore various support systems that older and younger women draw upon during pregnancy—their mothers-in-law, husbands, natal family, neighbours and NMCH biomedical services.

Mother-in-law

In the previous section, mothers-in-law were seen as traditional authority, where daughters-in-law tried to negotiate with them in order to ensure that their pregnancy was safe. In the present section, mother-in-law will be looked at from the perspective of being a support system for daughters-in-law. For the older women, their mothers-in-law were their repository of knowledge regarding pregnancy. They could fall back on their mother-in-law in terms of experiencing pregnancy and they would provide them knowledge from their own experience of pregnancy and also other experiences that they have seen or heard.

Mother-in-law played a significant role in the lives of women who resided in an extended conjugal household, among older Baniya as well as Dalit women during their pregnancy. On the one hand, she monitored daughter-in-law’s pregnancy closely, on the other hand, she was the one who was physically and emotionally there for her. Age factor, that older women had married off very early, in their pre-puberty age made them consider their mother-in-law as the dominant authority over daughter-in-law’s first pregnancy. It was their mothers-in-law who got them introduced to adolescence and prescribe the dos and don’ts of pregnancy, pampering them with food items and helping their daughters-in-law with household chores along. This had elements of care as well as control. Shakuntala, an older Dalit woman from Himachal Pradesh claimed, ‘My mother-in-law was very supportive probably because I was the eldest daughter-in-law who was conceiving for the first time. She made me eat so
much, and satisfied my cravings! I enjoyed my first pregnancy the most!’ Madhavi, an older Baniya woman from Uttar Pradesh, also mentioned that it was her mother-in-law who had discovered her pregnancy and helped her in cooking and other household chores, *she used to sweep the house and I used to do all the other work.*

Supportive nature of mothers-in-law was also seen through the narrative of younger Baniya woman, Chandini, who stayed in her conjugal household. She said,

*The whole day just the two of us are home, my mother-in-law and me. We cook together, talk, and are there for each other. I understood her value when she had gone to Vaishno Devi for ten days... Even during my pregnancy she took care of me. Asked me to relax and she did all the household chores. But because it doesn’t look nice that one person is doing all the work and the other one is just sitting around, I used to cook and she used to do the rest of the chores- sweeping, mopping, and washing the dishes.*

Rinky, a young Dalit Bengali woman, also mentioned that during her first pregnancy, her mother-in-law was very helpful and supportive throughout pregnancy. She lived nearby and had called Rinky to stay with her:

*Mujhe badboo aati thi chapatti se [I used to get stench from chapattis] to the extent that I used to even vomit sometimes. My mother-in-law was sweet enough to make rice for me everyday and also make chapattis for my father-in-law and husband. She had also made tamarind pickle for me which I used to love.*

Among the younger generation, role of mother-in-law in daughters-in-law’s pregnancies was dependent on the household composition. Women who were staying in extended households were closely monitored by them. It was seen that in anticipation that daughters-in-law beget sons, mothers-in-law made sure that the dos and don’ts of pregnancy were followed. In the process of doing so, sometimes monitoring become both caring and controlling in nature.

**Husband**

A vast literature portrays that the role of husbands is restricted to providing the ‘seeds’ to the ‘field’ (Dube 2001b). From the data, it was seen that there were instances of husband being ‘supportive’ for wife during her pregnancy, which was not influenced by the household composition but caste. It was seen that among the Dalit communities, husbands were more supportive as compared to Baniya community, where husbands clearly followed the demarcations of ‘women’s affair’.
Shakuntala, an older Dalit woman, mentioned that she used to confide in her husband regarding her cravings and ‘...he used to get tikki and extra meethi chutney for me...no one got to know....parents-in-law would have known only if we ever told them!’ Shanti Devi, another older Dalit woman too recalled her days of pregnancy and her experiences of expressing her cravings to her husband:

Sometimes he used to get things for me... like golgappe or chana kulcha. Whenever my mother-in-law got to know that he had got something for me, she used to come and sit right there and ask him, “Shanti got things to eat but what about me?” I used to tell him not to get anything at all to avoid such situations. Then he used to get things for everyone and I used to only get a piece of it.

This portrayed the way husbands showed care and concern towards their wives but also made sure that they were in their mothers’ good books.

Among younger Dalit women, in nuclear households, husbands tried to step into the mother-in-law’s shoes for monitoring his pregnant wife. Ramu, husband of a young Dalit woman, spoke about his wife’s pregnancy and said that since they were staying in Poorvinagar, before the commencement of NMCH in the year 2002, and his family was back in the village, it was his responsibility to make sure that his wife was fine. This was also seen in the context that Ramu had lost his first wife in Delhi in a hospital right after childbirth. He remarried within a couple of years. Ramu’s literacy level and interest in reading helped him to explore other avenues apart from asking his mother regarding taking care of his pregnant wife:

I used to read books on how to take care of a pregnant woman. All those books were written by doctors and had all information regarding food, and other things to take care of. I used to make sure that my wife eats fruits, dal, roti on time. I used to cook in the morning for my tiffin and used to ask her to wake up late and make food only for dinner. Since she was alone here... I used to go for work. She couldn’t have gone to the doctor all by herself. Bechari [poor thing] did not know anything about how the world functions. I used to go with her.

As he mentioned, it was important to save his second wife as it was to save the child. Husband’s educational status provided an impetus to adopt other methods of helping pregnant wife like acquiring knowledge about pregnancy through reading books.

Gita, another young Dalit woman, stayed with her husband, Anil, and their son in a nuclear household. Anil mentioned that he used to always ask Gita to have
fresh juice, either at a juice centre close by or at a juice vendor. He also accompanied Gita to the NMCH van more than once but he always used to stand at a distance from the van. He said, ‘only women were present there. They might make fun of me that I have come with my wife’. This reflected that there were indications of men caring for their wives, but the society’s surveillance was acting as a barrier, reproducing gender subjectivities.

Though the above described ‘supportive husbands’ (sabse zyaada saath diya) was a phrase used by Dalit women, across generations, it was seen that among the Baniya women, the role of husband was limited to just providing the ‘seed to the womb’. Baniya women predominantly stayed in an extended family with mothers-in-law monitoring their daughters-in-law’s pregnancy. Rajesh, a young Baniya man who stayed in Poorvinagar on rent with two other unmarried boys said, when asked about his wife:

She is back in Agra [U.P.] and is expecting...no she doesn’t stay in Poorvinagar. My entire family stays in Agra, only I have come here. She stays with my mother and helps her in household chores... I go there once in four five months... there is no need for me to be there for her pregnancy, my mother is there to look at her well being and apart from that my sisters-in-law are there. What will I do in... aurton ke kaam mein [women’s affair]?

Among Baniyas, due to their extended household compositions, husbands had internalised their limited role in ‘women’s affair’ and mother-in-law’s role in monitoring pregnancy was of supreme importance. It was seen that among the younger women, ‘supportive’ (saath dena) was equated with ‘caring’ (dhyaan rakhna) which was further associated with ‘protection’. Garima was the only young Baniya woman, in the study, who stayed in a nuclear household with her husband and two children. Her parents-in-law lived in a separate house close by in the same lane. She found the nature of her husband ‘supportive’ and ‘caring’:

My husband did not allow me to go out anywhere alone. If I came home late from visiting my mother or some relatives, then he used to scold me and scream at me. I was not even allowed to go to my neighbours’ house for very long. I had to be back as soon as my work got done.

However, a similarity was also seen among the Baniya and Dalit younger women, where women equated control with support. This was due to the
internalisation of patriarchal norms where a woman is not secure without the presence of her husband.

Sumana, a young Dalit woman, said that she went for walks every evening with her husband and that she did not step out alone. She went out either with younger, unmarried sisters-in-law or with her husband since stepping out alone in the vicinity was not considered safe. She also described an instance where she had gone out in the evening with her sisters-in-law. They reached a shop where four-five men passed luring comments at them. One of the men followed them and caught Sumana by her hand. She screamed and pushed him back. One of her neighbours was there and he came to her rescue. ‘We ran back home, don’t know what happened after that day. It is best to go out with my husband,’ claimed Sumana. Shyam, Sumana’s husband, mentioned that Sumana would telephone him if she wanted him to get anything for her to eat and he would get it. Shyam had also accompanied Sumana to the hospital for the first delivery. He also asserted that he would ensure that she goes out for evening walk with him.

The belief that a woman is safe only with her husband and family, an ideology aimed at controlling women’s sexuality and mobility, was not only popularised and practiced by men, but also internalised by women. This was evident in the way they waited for their husbands to come back from work and accompany them in the public spaces. Husband’s behaviour asserted his power, both, within the public and the private spheres.

Asha, another Dalit woman mentioned, ‘I wait for my husband to come home in the evening to go out with him, I feel more protected when he is around’. It can be seen that women themselves internalise private patriarchy by looking up to their husbands for ‘protection’. Geetha (2007) refers to this as kinship contract, that male members of the society have amongst themselves that they will subordinate female family members, wives, daughters, sisters and mothers not only in private but also in public spaces.

Baniyas, being a ‘higher’ caste as compared to Dalits, had stronger prevalence of patriarchal ideologies of restricting women within the household boundaries. They controlled pregnancy related issues to maintain purity and sexuality of women and norms which sustained their non-Dalit caste status. The Dalit women, on the other hand, were traditionally integrated into labour system and therefore had worked in public spaces. It was seen that after shifting to the urban resettlement area, Baniyas
continued the ideology of not letting women work in the public sphere, and the Dalits have also started to adopt higher caste norms. This was seen through the fact that only a few younger dalit women were working outside as opposed to older Dalit women.

**Natal Family**

Natal family members comprised of mothers, younger unmarried sisters-in-law and other natal relatives played a supportive role in women’s pregnancies. Mother played an important role in daughter’s pregnancy when she came to their natal household for first delivery. Older women went to their natal home usually in the seventh month of pregnancy. Mothers ensured that their daughter’s last few months of pregnancy goes off well and she delivers a healthy child. Mothers were held responsible if something unforeseen happened with the pregnant women or the child. ‘My mother did not even let me hold a spoon. She was extra cautious; she used to be with me all the time. Even at night, she used to sleep next to me to make sure all is well’, claimed Radhika, an older Baniya woman.

Pushpa, an older Dalit woman recalled her experience of going to her natal place for her first delivery. She mentioned that it was in the seventh month of her pregnancy, when she went home and her mother had to organise godbharai. Pushpa claimed,

> I know that she overspent, to maintain our status in front of my mother-in-law. There were so many things to eat in sweets and savouries. Apart from that, I did not have to handle any household chores. She used to make sure that I take enough rest.

Among the younger women, Chandini, a young Baniya woman shared her experience wherein she utilised technology, a telephone booth, to speak to her mother to curb her cravings:

> My natal place was very far from my conjugal house and I was not allowed to go to my natal house for the first delivery. I was staying with my mother-in-law, although my husband had a mobile phone, I used to go down to the juice shop to make a call to my mother, so that no one got to know that I was calling her. I used to ask her to send pickle that I used to crave for. My brother used to come to my conjugal house once in fifteen-twenty days to meet me and to hand over the pickle along with that some food item that I loved.

Thus, it was seen that proximity and communication facilities enhanced Chandini’s experiences of pregnancy by asking her mother to send the food items she
craved for. She said, ‘My mother-in-law could not comment on what my mother used to send for me. That way I used to relish the food while being at my husband’s place’.

It was found that some of the younger Dalit women had set up their nuclear households in the vicinity of their natal homes. Staying in the vicinity also helped women not only in setting up their separate homes but also during their pregnancy. Madhuri, a young Dalit woman mentioned that her mother was the most supportive person during her pregnancy as:

> She accompanied me to the hospital when I was unable to conceive and then when I conceived. She used to keep track of my ANC dates and used to accompany me to the hospital. She also used to make special food for me during pregnancy like laddoos and whatever I craved for. She was a great support.

Jyotsana, a young Dalit woman, also mentioned that staying close to her parents was a great help especially during her pregnancy, ‘when my husband went out to work, it was difficult for me to do all the household chores myself. I used to have lunch at my mother’s place, by this I only had to cook once a day and sometime my mother used to send the food’.

Thus, the young Dalit women, who stayed in nuclear households near their natal house enjoyed greater physical and emotional support from their mothers during pregnancy, than their Baniya counterparts. Their mothers usually accompanied their daughters to doctors, made food for them and also helped them out with household chores. Apart from that, they were also a good companion to expecting daughters as they spent the whole day together. Mothers also accompanied their daughters to hospitals for delivery.

In situations where mothers themselves could not come to help their daughters, they usually sent their younger daughters. Younger sisters were also seen as a good source of support for a pregnant woman. Such responses came from young Dalit women staying in nuclear households or from pregnant women’s younger sisters. Younger, unmarried sisters used to come to stay with their expecting sisters and helped with the household chores like sweeping, mopping, washing utensils and cooking. Pregnant women used to spend time with their sisters enjoying and chatting when husband went out to work. ‘I was very relaxed that at least there was someone in the house, if something would have gone wrong, at least someone would have been there to take care of me since my husband used to go for work in the morning and
used to be back only by the evening’, claimed Jyoti who was staying with her husband and two sons.

Younger sisters, in a way, replaced mother’s position in making her sister feel comforted during pregnancy. This could also be seen as a way of preparing, socialising younger women for their future.

Apart from own sisters, elder brother’s wife, bhabhi, was also a great support for some of the women. Sumana believed that she could confide in her bhabhi about being pregnant, who took her to get all the tests done, arranged for home pregnancy kit for Sumana to confirm if she was pregnant. Her bhabhi supported Sumana throughout the pregnancy, gave advice regarding which hospital to go to and also accompanied her to the hospital for delivery.

**Neighbours**

Neighbours played an important role in the lives of women who did not have their family members residing in the vicinity. Apart from being a source of knowledge regarding prescriptions and proscriptions during pregnancy, they also helped with where to go for medical check-ups and also accompanied women to either the NMCH van or to a private hospital. Prema, a Dalit woman, said that when she had come to Poorvinagar, she did not know anyone there. Her husband used to leave for work in the morning and used to come back only late in the evening. The whole day she used to be alone in the house and it was her neighbour who took care of her especially during pregnancy. Prema said, ‘Manasi, also from my jaat [caste], used to be with me always during my pregnancy, she was the one who I could confide in that I was expecting. She told me about the NMCH van and had taken me there with her. Manasi also came with me for all the tests’.

Mamata, a younger Dalit woman, after moving to Poorvinagar, became close to Muniya, a younger Baniya woman, who stayed in a house, above hers. Muniya helped Mamata by informing her about NMCH services for her infertility treatment. She extended help during Mamata’s pregnancy by regularly inviting Mamata over to her house for meals and ensured that she ate healthy food. Thus, the cultural knowledge of pregnancy and women’s shared experiences may transcend the social barriers of caste and community. This may be particularly so in an urban context where women have to build ‘kinship’ like networks in the absence of traditional kinship structures.
Women could have a heart to heart chat and exchange anxieties while interacting with caring neighbours. This was shared by women staying in extended households or close to their conjugal household. How to deal with their mother-in-law was a topic of such exchanges. As one of them stated, ‘I take strength from others’ experience regarding how to deal with mothers-in-law’. This is what Deshmukh-Ranadive (2005) refers to as women’s ‘mental space’, a collective of women outside the traditional setup that help women to learn from each other’s experiences which enhances their mental space as they become more confident, influencing their agential power.

Though Baniya women generally resided in extended households, it was seen that they did not interact much with their neighbours. Their interaction was limited to going to neighbour’s houses in the afternoon once all the household chores were done. Garima, the only Baniya young woman who stayed in a nuclear household mentioned that she had Dalit women neighbours as her friends and she could relate to them in a better way than Baniya women of her age in the vicinity. This was due to the fact that young Baniya women were mostly busy with their household chores and spent time at home with their mothers-in-law. It was found that pregnancy offers younger women in nuclear households in urban context, opportunities to loosen caste norms to establish neighbourhood support systems.

Apart from that, relationships with neighbours also influenced the cultural practices that one followed during pregnancy, especially rituals related to pregnancy. As discussed before, some of the women had tried to imitate or assimilate rituals of their neighbours which their own community did not celebrate. Such imitative practices were not restricted to celebrating pregnancy alone but included observing other rituals as well. One of the rituals, which most of the communities did not have originally but have started to follow after coming to Poorvinagar was godbharai. Godbharai came to be associated with status and prestige of households among Baniya women.

Thus, neighbours were a great support system for women who did not have relatives or elders staying in Poorvinagar. Neighbours grew so close to each other that they became like family members and were referred to in familial terminologies, for instance, didi, chachi, bhabhi. They provided the source of knowledge regarding diet of pregnant women’s emotional support system along with the dos and don’ts of pregnancy in the absence of any relative in the vicinity.
**NMCH Biomedical Intervention**

With ten years of being established in the vicinity of Poorvinagar, NMCH had become very popular among women for availing ANC referral services. NMCH, by offering services that were considered ‘modern’ and hence more trustworthy, was perceived as an alternative to cultural knowledge in managing pregnancy and childbirth, especially by the younger Baniya and Dalit women.

The counselling services were availed by young women in huge numbers ‘to help them overcome myths and wrong beliefs about pregnancy and to make them aware about management of pregnancy’, asserted Poornima, a biomedical staff of NMCH. These services offered women an avenue to equip themselves to negotiate the familial control over their pregnancies. Women also made their mothers-in-law, who used to accompany them to the mobile van, to interact with doctors for making it convenient for them to adhere to biomedical knowledge. Apart from this, the domiciliary visits by MHPWs also helped women gain confidence in them. Their presence in Poorvinagar, on a daily basis, helped women to discuss their health issues freely. The lady MHW spoke to young women regarding contraceptives and also provided condoms to them free of cost. The MHPWs also localised the biomedical knowledge to ensure that women’s iron intake is adequate. They mentioned that an iron kadai (utensil), which was usually a utensil that every household possessed, should be used for cooking to increase iron intake. They also emphasised on eating beetroot and kala chana to ensure that pregnant woman is not anaemic.

NMCH services helped women to ‘liberate’ themselves from the patriarchal mindset of mothers-in-law. This also led young women, who stayed close by to step out alone without being accompanied and also encouraged them to avail NMCH services.

NMCH also became a support system for women who did not have their families residing close by, where doctors advised women regarding pregnancy. Tara, a young Dalit woman, who had three children and had conceived for the fourth time, wanted to go for an abortion. She stayed with her husband, who was a daily wager, and three children. She told the NMCH staff, that the couple could not afford to have so many children due to financial constraints. She was helped by the NMCH staff who advised her regarding managing the number of children:
Only he [my husband] knows, no one else. Neither his parents, nor mine. They would want us to have more children... the more the better, but what will we feed them!?? How will we manage, so best is not to tell them. As it is they stay in the village, how would they even get to know! NMCH doctors have always supported me throughout all my pregnancies, advised me what I should do about it. I did not know who to discuss this with. The lady doctor is very helpful and always hears me out. Also, she knows my history.

Thus, women used biomedical services to limit their fertility and to negotiate and resist societal and familial pressures to have more children. Women’s approach towards biomedical institution during their first pregnancy was tentative, opting for a counter to mother-in-law’s authority. By their second and subsequent pregnancies, women themselves started viewing hospitals in an instrumentalist way, to achieve their objective of a safe delivery and healthy new born. This also indicates the change in the role of medical institution in the lives of women staying in Poorvinagar. It was evident that the availability of NMCH services helped women to be able to mobilise knowledge, resources and support system in order to negotiate with patriarchal control of familial institutions. This made NMCH services a great support for young women residing in Poorvinagar during their pregnancy.

**Conclusion**

The chapter explored older and younger, Dalit and Baniya women’s experiences of pregnancy. The data showed that caste, age, household composition, urban exposure, biomedical facilities in the vicinity, working status and the gender power dynamics in their families influenced women’s experiences of pregnancy. Among the older women, mothers-in-law were considered the sole repository of knowledge and followed all the instructions given to them by their mother-in-law. The exclusive dependence and control of mothers-in-law were crucial to the reproduction of the cultural discourses around pregnancy. This was particularly so in the context where there was lack of an alternative knowledge system to the cultural knowledge. Apart from that, young age at marriage, lack of exposure and low levels of education resulted in their restricted awareness of their bodies and pregnancies.

With the shift to Poorvinagar, young women were exposed to forms of alternative knowledge through the biomedical institutions, along with the cultural knowledge imparted by family and community. An alternative in the form of biomedical system did not result in a complete erasure of cultural practices defining their experiences of
pregnancy. Young women were seen to balance both cultural as well as biomedical practices in order to enhance their experiences of pregnancy to achieve their goal of safe delivery and a healthy new born. In order to reach their personal goal, young women, resisted and sometimes bargained their way through cultural discourses and consciously chose to avail biomedical services undermining the traditional control of their mother-in-law.

Further, the NMCH services provided women a platform to negotiate their patriarchal structures and ideologies, intensified and sustained by their mothers-in-law. Thus, in the narratives of young women, the benevolent nature of NMCH biomedical interventions stood out which enabled them to experience pregnancy in a modern way. During the second and subsequent pregnancies, women adopted an instrumentalist approach towards biomedical institutions. Women used their first pregnancy as a source of knowledge to manage second and subsequent pregnancies.

Women’s household composition of residing in nuclear households, away from the mothers-in-law’s instructions, staying in proximity to their natal family enhanced their negotiability with patriarchal structures. Women’s status of a mother of a son, their earning status, apart from being born and brought up in an urban area enabled some of them to assert themselves and experience pregnancies their way.

Young women’s mothers-in-law, especially of young Baniya women, tried to reclaim their lost power over their daughters-in-law’s pregnancy by drawing upon the urban aspect of the city. Assimilating Dalit community’s cultural practices of celebrating pregnancy, young Baniya women’s mother-in-law tried to reassert their position. Notions of status and prestige associated with elaborate celebrations came to play an important role in these women’s lives. Mothers-in-law recognised and acknowledged changes after moving to Poorvinagar and made efforts to live up to the societal expectations of a ‘good mother-in-law’ within the constraints of class and status in the society.

As the discussion in the chapter showed neighbours, especially in the urban context and in the absence of mother-in-law, provided emotional support, information about the dos and don’ts of pregnancy and also accompanied women to hospitals and NMCH van during pregnancy for all the tests. Thus, for many young women, pregnancy provided an opportunity to build support network within the neighbourhood. At times pregnancy care allowed women to transcend the boundaries of caste, class and regional differences.
The next chapter will discuss women’s experiences of birthing across older and younger groups, castes and sites of birthing.