Understanding Food and Diet Pattern During Pregnancy Among the Chamar Women in Rural Uttar Pradesh: Perceptions and Practices

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Abstract: Food and diet pattern determine nutrition and health status of individual and community as well. Food and diet pattern are much significant for women and girls of reproductive age owing to their nutritional vulnerability during their reproductive careers. Reproductive careers being bio-cultural phenomena subjected to many prohibitions and prescriptions regarding food and diet pattern. Considering these points, present paper aims to investigate the perceptions and practices regarding food and diet intake during pregnancy with special reference to the Chamar women in a village of Uttar Pradesh. The study observed that among the women ‘eating down’; a contributory factor in low intake of nutrient is practiced during pregnancy. Fear for obstructed labour and lack of toilet facility have been reported as justifications for practice of ‘eating down’. The field data analysis reveals that perceptions and practices regarding food and diet intake during pregnancy is embedded into class and culture matrix. Methodology of the study comprises of empirical data taken from an ethnographic field work during a period from June 2011 to June 2012.

Keywords: pregnancy, food and diet pattern, eating down, myths, Chamar, women.

INTRODUCTION

Food, being a material object, culture identity marker, health determinant, and one of the sources of communicating supernatural power, is concerned for a matter of prohibition, prescription and purity. Thus food entails biocultural dimensions. While it performs a core function providing energy and nutrition in the body, it also represents a culture specific trait. People develop a specific food habit and diet pattern on the basis of availability and accessibility to food items and edible material. However, food habit and dietary pattern determine the nature and extent of nutrition, very true is set distinctively for man and woman within households and communities. It is reflected in practices of prohibitions and prescriptions regarding food items and diet intake during pregnancy.

During my study on women’s health and their lives in a rural setting of Uttar Pradesh, I analyzed that reproductive stages; especially the state of

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pregnancy is treated as an arena of practicing rituals and ceremonies that do have motive of welfare of foetus and pregnant woman in Indian Hindu societies. In this regard, practices of prohibitions and prescriptions on food items and diet intake during reproductive age in general and during pregnancy in particular overlook the maternal nutritional issues to a large extent. These practices have significant impacts on women’s reproductive health and pregnancy outcome. Concerning these points, in this paper I tried to explore the analytics of food and diet patterns and also tried to document prohibited and prescribed food items, local knowledge, perceptions related to nutrition, food items and diet intake during pregnancy by Chamar women of an Ambedkar village in Uttar Pradesh. This study observed noticeable prevalence of anaemia, greater infant mortality, lower birth weight, and prevailing night blindness among majority of the pregnant women. These health problems occurred due to consistent practice of ‘eating down’ (deliberately restricting diet intake) as per prohibitions and preference for food and diet intake during pregnancy. Prohibitions on food items and practice of ‘eating down’ resulted into maternal malnutrition and subsequent reproductive health problems. These problems include complications of pregnancy such as lower weight gain, protein and vitamins deficiency, weakness, low weight baby, preterm birth, and complicated obstetric etc.

Malnutrition, in a wider context emanates from eating too much or eating too little, or eating an unbalanced diet that lacks necessary nutrients. The last two are major nutritional problems in India, and become much critical for rural areas where about 81 per cent of the population do not consume the balance diet or recommended level of calories. Eating too little or eating an unbalanced diet leads to under nutrition, which is defined as the failure to consume adequate energy, protein, and micronutrients to meet the basic requirements for body maintenance, growth, and development (Planning Commission, 2011). This in turn leads to nutrition related problems characterized by low height for age (stunting), and/or low weight for height (wasting), and/or low weight for age (underweight). In scientific term, malnutrition reflects an imbalance of both macro- and micro-nutrients (Iron, Iodine, Zink, and vitamins) that may be due to inappropriate intake and/or inefficient biological utilization due to the internal and external environment.

In India, malnutrition costs at least US $ 10 billion annually in terms of loss of productivity, illness, and death (World Bank, 2000). Nutritional issues, therefore, is a major threat to social and economic development and is a silent emergency. In an alarming situation of nutritional issues,
socially marginalized groups amongst the whole population are found to be at stake in respect to adult female malnutrition. Among women, malnutrition is higher than the national average of 36 per cent for both the SCs (41 per cent) and STs (47 per cent). SCs and STs are diverging from the national average in terms of female malnutrition. These groups have a higher percentage of women with BMI (Body Mass Index)* <18.5. The ‘Others’, that is, the general category women, had the lowest incidence of women with BMI<18.5 (29 per cent). More than one-fourth (26.9 per cent) of the women are classified as underweight, conforming grade severe 4.8 per cent, moderate 6.7 per cent, and mild 15.4 per cent under nutrition (Ravishankar, 2012). Low BMI and IDA (Iron Deficiency Anaemia) are significant variables and indicators of malnutrition.

Reportedly, in India IDA is rampant among women in the reproductive age group, children, and low socio-economic strata of the population. It is evident in NFHS 2 (1998–9) and NFHS 3 (2005–6) data as 55% women are suffering from at least one type of anaemia. The adolescent girls are more vulnerable group. As per the District Level Household Survey (DLHS 2002–4), the prevalence of anaemia in adolescent girls is very high (72.6 per cent), the prevalence of severe anaemia among them is much higher (21.1 per cent) in comparison to pre-school children (2.1 per cent). It is resulted by various factors; an important one is being the lack of balanced diet intake during initial stage of reproductive career. Iron deficiency anaemia is much perilous for pregnant women as it evokes to adverse pregnancy outcomes such as high maternal and neonatal mortality, lower birth weight, increased risk of obstetric complications, increased morbidity, and seriously impairs the physical and mental development of the child. It remains one of the major indirect causes of maternal mortality in India.

Malnutrition being a bio-physiological phenomenon has their roots in socio-cultural background since it is attributed by food behaviour. In this context, here in forthcoming description I will discuss the matters of prohibitions and prescriptions on food items and diet pattern during pregnancy, its cause and consequences. The whole matter have been discussed and analyzed in light of narrative accounts of complications of pregnancy and behaviours regarding food and diet consumption during pregnancy.

**Brief Account of the Study Community**

The study community is an Ambedkar village in district Ambedkar Nagar of Uttar Pradesh located about 26 km. from district head quarter. The field area consists of 181 household and population is scattered in small kin-
related neighborhood. About 80% of the total population is of dalit, primarily Chamar. The Settlement is dispersed in form of groups of extended and nuclear families, and merely divided in two distinctive Tolas; one is Chamraoti Tola and second one is Bharaoti Tola. Majority of the inhabitants in the community are subsistence farmers, but they work as farm labourers. Almost all women in the community work in agricultural farms either in their own or in other's farms as daily wage labourers. Almost all young men have been migrated to cities for work, and rest are engaged in house construction work (Rajgiri) in the village.

The village is well equipped with drinking water facility and on every ten households minimum one functioning hand pump has been set up by the government. But toilet facility is very poor. Each household has been provided with toilet infra-structure but they are not in functioning condition so not in use. The village has two unqualified health care practitioners to whom villagers approach first and then they look for other private clinics, medical and health care facility located in town area Jalalpur 6 km. far from the village. The primary health centre is 5 km. away from the village. The village has access to special paramedical staff consist of an ANM (Auxiliary Nurse Midwife) and ASHA (Accredited Social Health Activist).

**The Study Material and Method**

This is primary data based study. The study material is taken from data gathered in a large proportion through an ethnographic field work that has been conducted from June 2011 to June 2012 at an Ambedkar village in Ambedkar Nagar district of Uttar Pradesh. Techniques of data collection comprise participant observations, case studies, individual in-depth interviews, and focus group discussions. The later one was conducted initially to establish rapport with the community to understand local, social and cultural beliefs and behaviors relating to rural lives, food habit, gender relation, and health matters particularly women’s reproductive health. The key informant interviews were conducted additionally with ANM, ASHA, and Dai (Traditional Birth Attendant). Pseudonyms have been used for respondents to ensure their privacy.

**NUTRITION AND PREGNANCY OUTCOME: NEED AND IMPACT**

At specific stages in life cycle such as pregnancy, a woman needs good nutritional status for a healthy outcome. Women who have a poor nutritional status or malnutrition at conception are at higher risk of disease and death; their health depends greatly on the availability of food, and
they are, therefore unlikely to be able to cope with their increased nutrient need during pregnancy (WHO, 2011).

Improper nutrition or malnutrition often begins in utero and extends to adolescent and adult life. Since, an undernourished mother produces a weak and low weight child. Underweight mothers giving birth to underweight children have low capacity to exclusively breastfeed for the first six months, which is critical for the survival of the child and for the development of the brain. Further, the caring capacity of the mother is the proximate determinant of a child’s health and nutritional status. This caring capacity of the mother in turn depends upon her own health and her physical capacity to breastfeed for an extended period. Maternal malnutrition and iron deficiency anaemia increase the risk of the mother’s life during delivery and impacts significantly on aspects such as intra-uterine growth retardation and child nutrition. In such way, a mother’s health status is intricately linked to the health status of the child and the society at large. However, maternal deficiencies in micronutrient may lower infant birth weight and jeopardize development and survival. Hence, maternal nutrition is key determinant of both pregnant woman’s health and child’s survival and health as well.

A pregnant and lactating woman needs more protein and extra nutrition. According to a chief district medical officer (CDMO) the general recommendation, as far as caloric intake is concerned; women need about 1750 to 2000 calories per day which should include 20 per cent protein and 15 to 20 per cent fat. It is advisable for expectant mother to consume 300 extra calories per day (Lahangir, 2013). Thus during pregnancy the demand for both energy and nutrients is increased. For well-nourished women, only a small amount of additional energy is required because the body adapts to the increased energy demands and becomes more energy efficient by reducing physical activity and lowering the metabolic rate. But for already malnourished and working women a big amount of additional energy is required. It is also very necessary to have a good nutritional status in pre-pregnancy period. Siega-Riz, et al. (1996) found in their study that women who delivered preterm were significantly lower in pre-pregnancy weight and as a result had a lower mean pre-pregnant BMI than women who delivered term. With a poor nutritional status, the probability of delivering preterm is 24% for a teenager who is underweight with a poor rate of weight gain in the third trimester and anaemia after 28 weeks of gestation. An underweight status before pregnancy continues to be a positive predictor of preterm births. The results of their study lend support to the importance of maternal nutritional status before conception and during pregnancy on delivering preterm.
In such ways poor nutrition during pregnancy along with other factors like inadequate health care delivery facilities causes a significant complication of obstructed labour** that is one of the most common preventable causes of maternal and perinatal morbidity and mortality in developing countries. A condition of obstructed labour is evolved due to foeto-maternal disproportion that may be due to Intergenerational cycles of chronic under nutrition, which may include calcium deficiency, in a large proportion of cases. Obstructed labour can also occurs in subsequent pregnancies in which maternal nutrient deprivation may result in a distorted pelvis, and other acquired pelvic deformities. Thus studies suggest there is a critical link between nutrition, health and pregnancy outcome.

Notably, while a large number of rural women suffer from malnutrition in general, it occurs more prominently in their reproductive age (15-49). A woman more likely suffers nutritional deprivation during her pregnancy period rather than pre-pregnancy due to insufficient nutrient supply attributed by pregnancy concerning food behaviour. In pregnancy many prohibitions and prescription on food items consumption are imposed for a pregnant woman. It may results in nutrition deficiency at the time while she needs extra nutrition and care. Why do these practices prevail in rural areas, even when very often these practices put the pregnant women at a state of ill health? It is a matter of empirical and cultural investigation.

**Prohibition and Prescriptions regarding Food Items**

Prohibition and prescription for food are occurred due to belief that body states are particularly sensitive to the ‘hot’ and ‘cold’ quality of foods. And depending on a person’s physiological state, ‘hot’ or ‘cold’ foods are believed to have either a positive or negative effect on the body (Nag, 1994). Owing to health concern and also because of pregnancy is taken as a site of rituals, ceremonies, pollution and purity in Indian Hindu societies, many of considerable code of conducts are applied in it. Among them, prohibitions and prescriptions for food items some of due to cultural point of views and many of due to health concern, are strongly practiced.

In an enquiry into food and diet pattern, to some extent almost all respondents were agreed on prohibition (avoidance) on some food items during the period of pregnancy. But there were very few who had any idea about prescribed food items. However, of the 112 respondent, most had beliefs regarding why and what food items should be and should not be consumed during pregnancy. (See Table 1)
Table 1
Food Items Allowed and Prohibited For Consumption by a Pregnant Woman by Reasons (N=112 Women) (^Women were confused in their responses)

<table>
<thead>
<tr>
<th>Food Items</th>
<th>Allowed</th>
<th>Not allowed</th>
<th>(^)</th>
<th>Reason for ‘not allowed’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrak (Ginger)</td>
<td>-</td>
<td>32</td>
<td>80</td>
<td>It is hot by nature.</td>
</tr>
<tr>
<td>Doodhi (Milk), Ghee (butter)</td>
<td>27</td>
<td>73</td>
<td>12</td>
<td>Makes baby stick to womb</td>
</tr>
<tr>
<td>Garam khana and garam Chah (hot cooked food and tea)</td>
<td>11</td>
<td>96</td>
<td>5</td>
<td>Heat may cause miscarriage and rotting</td>
</tr>
<tr>
<td>Machhi (Fishes), Anda (eggs)</td>
<td>17</td>
<td>62</td>
<td>33</td>
<td>These are heavy items and hot in nature. Difficult to digest.</td>
</tr>
<tr>
<td>Masaledar (Spicy food), Karha, and Mash</td>
<td>-</td>
<td>77</td>
<td>35</td>
<td>It is hot by nature.</td>
</tr>
<tr>
<td>Bhata (Brinjal), Urad dal</td>
<td>19</td>
<td>51</td>
<td>42</td>
<td>These are heavy items and difficult to digest.</td>
</tr>
<tr>
<td>Papista (Papaya)</td>
<td>18</td>
<td>79</td>
<td>15</td>
<td>These are heavy items and hot by nature.</td>
</tr>
<tr>
<td>Shahtoot (Mullberry)</td>
<td>31</td>
<td>4</td>
<td>77</td>
<td>This is hot by nature.</td>
</tr>
<tr>
<td>Dahi (Curd), Bhat (rice)</td>
<td>28</td>
<td>57</td>
<td>27</td>
<td>These are sour and cold by nature that cause gastric problem and slow labour pains</td>
</tr>
<tr>
<td>Suran (elephant Yam) and Arui or Arvi and Banda (Coco Yam, Taro)</td>
<td>30</td>
<td>54</td>
<td>28</td>
<td>These are heavy items, difficult to digest and cause constipation. Make baby’s skin rough.</td>
</tr>
</tbody>
</table>

(Source: Field data)

Almost all the respondents agreed on prohibition (avoiding) of some food items during the period of pregnancy. But there were only a few who had idea about prescribed food for the same. Respondents seemed well informed on food that had to be avoided. Many respondents opined that cooked hot food, tea, and ‘hot’ food items should be avoided in pregnancy. Many named such food items as adrak (ginger), ghee (butter), goast (meat) and karha (soup of some spices and herbs). Some women also told that they avoid certain types of vegetables such as Suran (Elephant Yam) and Arui or Arvi and Banda (Coco Yam, Taro) during pregnancy as their sas (mother in-law) suggested that these may be bad for the baby’s skins. A myth that baby’s skin may also become rough like these vegetables is carried out by them. Thus, most of the respondents were guided by the associated beliefs and perception regarding consumption of food items during pregnancy.
Empirical understanding of the food and diet pattern reveals while especial attention is given on prohibited food items for pregnant women, there are only few prescribed food items for them. Pregnant women usually take the same food which rest of the family members take. If an expecting woman finds it difficult to digest she consults doctor. Accordingly, they take additional nutrition supplements either in form of medicines or fruits and juice. But in case of inaccessibility and unaffordability of medical help, deprived poor women consume “chawal-ka-marh” with salt (salty soup of rice), “saboodana-ka-kheer” (sago palm pudding/boiled sago palm in water with sugar) and “dal-ka-pani” (watery extract of cooked pulses), because these items are considered light, easy to digest, and nutritious.

On a question about prescribed food, key informants particularly dai, and anganwadi worker responded as following;

‘There is nothing special what a mothering women must eat. Everything should be taken if it is not detrimental for foetus. There is no any prescribed food for pregnant women. In pregnancy, whatever mother wants to eat it is asked for by fetal. So, if she could digest and, is not harmful for fetus she should necessarily take it.’

(Kalpa Devi, 64 years old, dai.)

‘Everything should be taken in balanced quantity but avoiding hot and heavy is better. Pregnant women need more nutrition so she should take a proper diet in time.’

(Sharda Devi, 39 years old, anganwadi worker)

Another young, first time pregnant woman evoked smile when she was asked about her diet and food, and she responded following as-

‘My mother in-law forces me to eat more and to take fruits, juice and milk. But before pregnancy she did not care if I had food or not even when I used to engage in endless domestic works. She argues if I will not take more food how baby will be healthy and grow up in womb. Don’t think about your taste; do care of your baby.’

(Manita, 20 years old, education 10th)

Respondent’s statements reveal that most of the prohibitions on food items are occurred in care of baby in womb negotiating the nutritional need and care of pregnant women. It has been further analyzed by data on practice of ‘eating down’ by expected mother. Prohibition and prescription bearing health consciousness configure food and diet patterns for pregnant women. In this way, some food items are categorized as ‘hot’ and believed to be cause of miscarriage. Thus it is considered to be avoided by pregnant women. Regarding this, being rich source of protein and vitamins, food items like papaya, eggs, fishes, meats, milk, butter, beans and legumes etc. are considered ‘hot’, therefore, strongly avoided in pregnancy. In adding
to this, prohibition on spices and hot cooked food and appreciation to stale food (which is considered ‘cold’) may affect food intake and leading to less energy supply in the body.

**Perceptions and Practices regarding Diet Intake in Pregnancy**

Diet intake during pregnancy along with other variables like women’s status in household, work load, pregnancy status and risk factors, accessibility to health care etc. determines the state of nutrition of pregnant women. And subsequently, influences the harsh event of childbirth. Inadequate and unbalanced diet consumption during pregnancy causes anaemia which may shift a woman towards death during child delivery. Dhurjati (2012) reported that in India 19 per cent maternal deaths are attributed by iron deficiency anaemia.

Furthermore, in rural areas, it can be seen that diet and food intake during pregnancy is partly the outcome of complex cultural belief system and myths. This fact has been previously documented in numerous setting around the world (Brems and Berg, 1988), including a number of studies in different parts of India (Nichter and Nichter, 1983). This fact is still true even on the days when cultural belief systems are in a transitional phase, knowledge and awareness are spreading among the illiterate rural dwellers. Food patterns, along with influencing factors like education, and economic status, are getting change in general but restrictions relating to food and diet intake during pregnancy are still in practice. It is because of its affiliation with culture meaning, myths, and community beliefs. It could be seen apparently in the women’s behaviour regarding food and diet in pregnancy. During women’s interviews, I observed that there is a common contrast belief that the birthing women should take less diet during pregnancy so as to have a baby of manageable size and thus minimize the risk of an obstructed labour. Indeed, a condition of obstructed labour is evolved due to foetomaternal disproportion that may result of intergenerational cycles of chronic under nutrition which may include calcium deficiency, in a large proportion of cases (Konje and Ladipo, 2000). As a matter of fact, nutrient deficiencies such as calcium, vitamin D, folic acid, iron, and zinc deficiencies interact in combination with various biological and bio-social factors to determine the prevalence of obstructed labour (Fraser, 1995).

The field interviews analyzed that the Chamar women perceive as free eating and intake of heavy meals lead to healthy foetus development in womb that consequently makes delivery of the baby difficult. Such perception renders a practice of ‘eating down’ during pregnancy. For example, majority of women who had given birth said that they practiced...
‘eating down’ (i.e. deliberately restricting consumption for fear of obstructed labour) when they were pregnant but they did so generally in the third trimester of pregnancy when their abdomen became protruding. In contrast, some women practiced it since the first trimester when it was their first pregnancy. They justified it as ‘first pregnancy is often associated with narrow and tied vaginal opening making child birth difficult. Therefore, taking ‘eating down’ as a mechanism for coping with the problem, they strongly practice it in pregnancy.

‘A pregnant woman should not take full stomach meal. It is better to eat less so that baby may not gain weight and fat therefore, women can deliver baby easily. After that in post-partum period she should eat more comprising high energy diet so that the lactating mother may produce more milk and ensure good health of the baby.’

(Kalpa Devi, 64 years old, dai)

Majority of women who had given birth said that they did so generally in the third trimester of pregnancy when their abdomen became larger. In contrast, some of women had practiced it in the first trimester when it was their first pregnancy. They justified it as ‘first pregnancy often has trouble because then rout pass for child birth is narrower and tied. Later on, once a child takes birth it become broader and more flexible. So if a baby gains more fat and weight, labour becomes obstructed and risky and woman has to go to hospital for delivery. And if first child is delivered at a medical facility same will happened with later on pregnancies.

Few literate women having some knowledge of nutritional need during pregnancy also practice ‘eating down’ due to fear of obstructed labour.

‘I know a pregnant woman needs extra nutrition because she bears another body that requires nutrition to grow and be healthy. However, first delivery is always difficult. Though, It is my first pregnancy and I am very thin therefore, I avoid heavy diet but I take other things like ‘daal-ka-pani’ (soup), iron-ki-goli (iron-folic acid pills), fruits, juice and milk daily that gives me energy.

(Parmila, 21 years old, graduate woman)

In addition to this a woman from a wealth-off family stated as-

‘I seldom consume fruits and milk in pregnancy. I know it is very necessary for pregnant women and her foetus. But we are poor, could not afford such costly food items. So I eat more and many times than normal meal what I take in pre-pregnancy period.

(Kanchan, 26 years old, a government primary school teacher)

Some interesting statements on issues of nutrition and diet intake in pregnancy came from the women of different age group. One of the statements given by an older woman is following as-
I think it does not matter what and how much a woman eat in pregnancy. No need to be conscious about nutrition in pregnancy same as other animal. God nourish both the mother and the baby in her belly as well

(Sampaty Devi, a 62 years old woman).

In the community, though the food patterns virtually remained unchanged or had changed nominally, yet their dietary pattern changed significantly during pregnancy. ‘Eating down’ is strongly exercised among those pregnant women who already experienced complaints of weakness and poor health. The practice may be attributed to manifold socio-cultural and economic factors but a common reason behind it, as I observed and reported by women in the study community, was a myth as taking full stomach diet cause foetus healthy in the womb. The myth evokes fear of obstructed labour. The same reason, in contrast to a study by Christian et al., 2006 (this study reported no fear of obstructed labour and free eating by pregnant women), had been reported from rural south India by Hutter (2004) in consistence of other similar studies in other parts of world where women in pregnancy deliberately restrict consumption.

Interview data from community women reveal that food and diet pattern especially eating habit can be best understood through a lens of interactions of socio-cultural influences. Poverty, unaffordability, and ignorance about pregnancy need and inadequate health services are the common factors that set women’s perceptions and practices regarding food an diet intake during pregnancy. Restriction on consuming ‘hot’ food item and milk butter occurred only concerning the survival of foetus as respondents gave reason why are the ‘hot’ food items not allowed or prohibited in pregnancy. While practice of ‘eating down’ prevail among them and has been passed on generation to generation concerning on childbirth complication, women’s health and risk of lives, as such the study women have spoken.

In fact, the rural Chamar women are poor, wage labourers and are afraid of going hospital for childbirth because they cannot afford the cost of care. Hence to mitigate the risk of obstructed labour they practice ‘eating down’ in pregnancy irrespective to the work load on women during pregnancy. Same reason plays role behind occurrence of no any prescription on food items. Though, they already cannot consume the proper meal and balanced diet in daily food pattern, the question is how they can approach prescribed one? Along with it, there are ranges of variations in reasons for; why they eat less in pregnancy? The reasons vary as such; one cannot afford expenses on food and health care, while others perform it for comforts and to work easily in field. Some of them told they ate less due to not having toilet
facility in their houses. However, percussion of practice of ‘eating down’ in all ways is same that is under-nutrition among women.

_I never consume fruits and milk in pregnancy though I know it is very good for pregnant women and her fetus because it contain high energy. But we poor, could not afford such expensive food items. If cannot manage milk for children, how can I consume milk? So I eat more and many times than normal meal what I take in pre-pregnancy period._

(Shakuntala, 36 year old, farm labourer)

_I ate the same food what other members in the family eat. Even, I ate less in pregnancy because I found it difficult to digest. We don’t have toilet facility in house and going to open field for defecation in daylight in general and in night during pregnancy in particular is neither convenient nor safe. Therefore, I preferred to eat less so that I could feel light and comfortable to work in field._

(Kismaty Devi, 31 years old)

Some women were urged to eat more during pregnancy but only to maintain their energy and their ability to work otherwise.

In this ethnographic investigation of food consumption practices and respective taboos, I observed that their practices are grounded primarily into class and culture matrix. All the food items that are costly and unaffordable are generally tabooed during pregnancy. It is so because it is assumed that a pregnant woman should be provided everything that she desires to eat. This is based on the belief that the ‘to be born child’ will always remain unsatisfied for those food items. For the poor, deprived women of the community it imposes a psychological stress. Therefore, they might be found prohibiting the food items as a measure to combat stress.

DISCUSSION AND CONCLUDING REMARKS

In this community based study, it is observed that majority of the women had complaints of weakness, night blindness and swelling in body during the second trimester of pregnancy. 75 per cent women had iron deficiency anaemia and 40 per cent had signs of vitamin A deficiency.

This study as well as those studies cited in this paper provides strong evidence that rural women are experiencing serious nutritional stress which has multiple implications for human development. Women are always at particular risk due to two reason I) increased need during pregnancy and lactation, and II) social issues of women’s status and intra-household food distribution. Practice of prohibition and prescription on food during pregnancy implies the mechanism of structural adjustment in the poor households of the Chamar community. In assistance to this, practices of
‘eating down’ are prevailed and attributed to fear for obstructed labour and lack of toilet facility in the houses.

I observed it empirically that some women were illiterate though aware about importance of nutritional need and proper diet but unable to approach it in assistance of other socio-cultural and economic influences. In contrast to this, even some women were qualified up to graduate level yet they lacked of awareness regarding the necessity of proper meal, extra nutrient and balanced diet in pregnancy. In lack of awareness and knowledge, many myths such as healthy baby’s growth in womb makes labour difficult; consumption of ghee (butter) causes fetus sticky in womb; cooked hot food causes miscarriage etc. are prevailing among the Chamar women which may a common fact about other women of similar rural setting. These myths motivate the theoretical fear for increased obstruction and vice-versa. Briefly, prevailing perceptions and practices of food and diet intake during pregnancy among the Chamar women are rendered due to fear for obstructed labour that has been remained one of the causes of maternal morbidity and mortality in the study community. However, the primary reason for prevailing poor maternal health and pregnancy outcome amongst the Chamar women is improper nutrition status during pregnancy led by inadequate food and diet intake. Cultural beliefs and practices in this context have been observed to being a fundamental ground for women’s health status and pregnancy outcome.

However, community beliefs, myths, perceptions and practices will not be disappeared quickly. Greater awareness about health consequences of traditional and community practices regarding food and diet, negative impacts of inadequate and unbalanced diet on maternal health and pregnancy outcome could facilitate the development of protective strategies. In addition to this, everyone in the community should be informed that ‘eating down’ is dangerous. Proper nutrition is imperative for healthy pregnancy outcome. It would mitigate obstetric complications rather than invoking obstruction in labour.

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NOTE

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BMI (Body Mass Index) is defined as weight in kilograms divided by height in meters squared and reflects the nutritional status of adults. A cut-off point of 18.5 is used to define thinness or under nutrition. The percentage of persons with BMI below 18.5 kg/m² indicates the severity of malnutrition among adults.

Obstructed labour occurs when the passage of the fetus through the pelvis is mechanically obstructed. It is caused due to disproportion between the fetal head and the maternal pelvis (cephalo-pelvic disproportion).

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