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When Mountain Bellies Grow Round: Localized Knowledge and Behaviors Facilitating Pregnancy and Childbirth in Phaphlu, Nepal

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When Mountain Bellies Grow Round: **Localized knowledge and behaviors facilitating pregnancy and childbirth in Phaphlu, Nepal**

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*There were never so many white days
as when I lived in a cloud
with mothers
and tales of blood.*

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Cover page image: A family in front of their house in the community below Baghbani. (photo by author)

Table of Contents:

Acknowledgements.....	2
Abstract	4
Introduction: Authoritative Knowledge and Birth.....	5
Approach	7
The “Phaphlu Area”	11
Local Ecology of Birth Knowledge.....	15
Roles and Responsibilities: the husband as partner.....	20
Wellbeing Through Protective Behavior.....	25
<i>The Hospital and Biomedicine.....</i>	<i>26</i>
<i>Bad Spirits and Big Babies</i>	<i>27</i>
<i>Heat</i>	<i>28</i>
<i>Post-Partum Seclusion.....</i>	<i>29</i>
Conclusion: respecting ethnographic complexity.....	31
Research Assistant Profile: Pema Lama Sherpa.....	32
Appendix I: Limitations.....	33
Appendix II: Interview guides for the Phaphlu area mother and father... 	35
Primary Sources: List of Interviewees.....	38
Secondary Sources: Bibliography.....	38
Suggested Areas for Future Research.....	41

Abstract:

In attempts to gain a level of understanding of a community’s localized experiences, beliefs, practices, and roles around pregnancy and childbirth, ethnographic fieldwork was conducted with the mothers and fathers of Phaphlu in the Solukhumbu district of Nepal. Aimed at the validation of diverse and localized ways of knowing revealed during the fieldwork period, this paper applies anthropologist Bridgette Jordan’s theoretical framework of authoritative knowledge to the emergent themes of subjectively understood childbirth (knowledge acquisition and flow, role of the husband, and protective behavior.)



Orthographic Note:

Non-English words and names in this paper appear in a transcribed version representative of their Nepali, Sherpa, or Tibetan phoenetic pronunciations. The inclusion of a Devanagiri script is not necessary for the reader’s understanding of the content.

Introduction: Authoritative Knowledge and Birth

The ethnographic work of respected anthropologist Bridgette Jordan has made significant contributions in the study and analysis of childbirth in cross-cultural settings. Her theoretical framework of authoritative knowledge allows for the behavioral and social structural investigation of the variety of ways in which individuals in a social setting understand and participate in birth. She explains authoritative knowledge as,

“the knowledge that participants agree counts in a particular situation, that *they* see as consequential, on the basis of which *they* make decisions and provide justifications for courses of action. It is the knowledge that within a community is considered legitimate, consequential, official, worthy of discussion, and appropriate for justifying particular actions by people engaged in accomplishing the task at hand.” (Jordan 1997, 58, emphasis included in original text)

Take this in slowly. Think of knowledge as a substance. This substance is spread throughout a community to constitute a system of knowledge—a way of knowing—that informs members’ understandings of their surroundings and how they actively participate in social activities. Not all members has equal access to the same kind of knowledge, as its substance is unevenly distributed throughout a social setting, perhaps more concentrated and utilized in one area and less so or nonexistent in another. Although their layers may not always overlap, multiple knowledge systems exist in any social setting and members can switch back and forth between ways of knowing according to what will best validate and inform their purposes or domain of activity (ibid.)

Although members may use the available knowledge systems interchangeably as equally legitimate in and of themselves, one system frequently gains ascendancy in a particular setting and is collaboratively achieved as authoritative. Consequentially, other ways of knowing are invariably subverted. A notable example of this is the dominant

logic guided by biomedical training and procedure within a Nepali government hospital in contrast to the dictates of tradition or protective measures against bad spirits in a village homebirth. Labeling a knowledge system as authoritative does not speak to its necessarily being correct, nor does it originate from those who are in positions of authority, but it serves to draw attention to what “makes sense” in that setting.

“Childbirth is everywhere socially marked and shaped.” (Jordan 1993: 1) As a biological process experienced universally by women, birth is mediated by the socio-cultural context within which it takes place. The analytical framework of authoritative knowledge is applicable to the cross-cultural study of birth practices and draws focus to the myriad and subjective ways in which individuals understand and participate in reproductive life events.

The initial objectives of this study was to conduct fieldwork in a community in Nepal to gain a level of understanding of localized experiences, beliefs, practices, and roles around pregnancy and childbirth. Men were included in their roles as husbands and fathers in attempts to move beyond the dominant focus on women as the reproductive bodies. Experience-based narratives gathered during this field study from mothers and fathers revealed a wide array of birth practices and understandings. Aimed at the validation of diverse and localized ways of knowing, this paper applies the theoretical framework of Bridgette Jordan to the emergent themes of childbirth within the Phaphlu area of Solukhumbu, Nepal. First, the flow of birth knowledge acquisition and communication is explored, followed by the husbands’ roles and involvement during pregnancy and birth, and some prevalent concepts of maintaining maternal and infant health through protective behavior.

Approach

The nature of this topic pertains to any community in which birth occurs. Fieldwork took root in the eastern Nepal district of Solukhumbu, surrounding the southern village of Phaphlu. Phaphlu is perched one hour's walk north of the district's capital town of Salleri. The rural, mountainous location and smaller village populations of the area contained the study within helpful physical boundaries. In the Solukhumbu district, healing and culturally marked childbirth practices of the ethnically Tibetan Sherpa populations have received prior scholarly attention in the northern Khumbu region (Adams 1989) and the Khunde Hospital (Heydon 2007.) Although southern Solukhumbu has also been host to a high percentage of Sherpas for centuries, the presence of a greater diversity in castes adds cultural and religious complexity to the area's layered ecology of pregnancy and childbirth.

Two weeks of fieldwork centered in Phaphlu consisted of participant-observation techniques and interviews engaging with participants of diverse ethnic, age, socio-economic, and religious backgrounds. Interviews with mothers and fathers¹ were structured to collect data describing demographic information (e.g. age, occupation, socio-economic status, education level, place of origin, place of residence, family structure, etc...) as well as more specific subject-related information (birth histories and experience-based birth stories, how individuals learned what they know about pregnancy and birth, communication between husband and wife regarding such topics, selection of birth setting, childhood healing modalities, traditional gender roles and responsibilities,

¹See Appendix II: Interview guides for the Phaphlu area mother and father.

etc...) Based on the objective of research, interviewees were limited to men and women who already had children of their own².

Interviews were conducted in Nepali with the invaluable assistance of Pema Lama Sherpa, the twenty-year-old interpreter chosen to assist this research. This was Pema's serving as an interpreter and was her introduction to detailed discussion about pregnancy and childbirth³. Interviews averaging around one hour in length were conducted with eleven women and five men (including one couple) who were selected on an opportunistic basis and gave their informed consent. Locations were within a one-and-a-half hour's walking distance from the Phaphlu Hospital. This selection of sites allowed for increased variability in transportation time from an interviewee's place of residence. The following are the village names where interviews took place: Phaphlu, Surke, Chiwong, Bagbani, and Kholagari.

Participants provided informed consent in the audio recording of interviews and gave permission for the disclosure of their names and imparted information. All recorded interviews were reviewed and annotated by hand in a field journal to determine emergent themes amongst narratives. Prior to its commencement the institutional review board of the School of International Training approved this proposed course of fieldwork and research methodology. Healthcare providers involved with pregnancy and childbirth in the community were also approached in an exploration of the existing MCH infrastructure of the area. These encounters were carried out in English and ultimately

² An additional decision was made in the field to not interview pregnant women for research due to my personal feelings that they would be more shy and uncomfortable. I have since learned that the Nepal Health Research Council considers pregnant women as a vulnerable group (Heydon, 11/15/11)

³ Early on in my research, I was advised to collaborate with a female interpreter by a local Sherpa registered nurse currently living in Kathmandu. She emphasized the shyness of local women in speaking even amongst themselves about pregnancy and childbirth and doubted much would be communicated through a man. (Sherpa, S. D. 2011/13/11) This characteristic of women's shyness continued to be a theme throughout the course of subsequent interviews and I am grateful for having received the initial suggestion.

included nurses and nurse-midwives who worked at the Phaphlu maternity center, a district health office official, and instructors employed at the Phaphlu auxiliary nurse midwife (ANM) technical training institute.

The experiences and beliefs of women around the processes of pregnancy, labor, and childbirth in different cultural settings around the world have received a significant array of scholarly attention (Davis-Floyd and Sargent 1997, Jordan 1992). Centering on the relationship between women and their reproductive behavior makes sense in many ways due to the fact they are the bodies who personally experience pregnancy, childbirth, and any related health complications. Yet learning about the contexts within which a mother is situated is also important and can make known the aids and barriers that impact her access to different forms of support and health care during pregnancy and childbirth. Men are a major part of women's social environments whose roles can be of vital influence to the wellbeing of their female relatives and infants through pregnancy, birth, and beyond. However, there is a scarcity of knowledge that relates to men's attitudes, beliefs, behaviors, and roles around pregnancy and childbirth. The little research conducted in Nepal that includes men's involvement is generally situated within the urban setting of Kathmandu, where there exist different barriers to women accessing care than in rural, mountainous communities, such as the Phaphlu area (Mullany 2005, Pandey 2007.) This study includes men in their roles as husbands and fathers to learn of their beliefs and involvement around pregnancy and childbirth.

Fieldwork data was translated with sensitivity to the risk of drawing generalizations that trivialize the broad variety of participants' localized roles, beliefs,

and behaviors. Themes drawn from the ethnographic complexity of narratives are paired with secondary literature.



Figure 1 Maps showing the location of villages included in this study, situated within Nepal and the Solukhumbu district (Wikipedia, Besteyberzone.com 12/6/11)

The “Phaphlu Area”

Her feet navigated the rocky footholds that studded the dirt trail as it steadily progressed uphill in the direction of Phaphlu, still one hour away. The woman’s long, black hair was pulled back from her face and secured by a colorful handkerchief; some stray strands had escaped to cling the beads of sweat on her forehead. With another step up the steep slope, she bent her head forward into the broad sling that securely held the weight of the *kokro* against her back. From within the woven bamboo basket, the soft coo of her infant could be heard, its form shaded from the afternoon sun and cool mountain breezes by a thin, red blanket checkered with squares of black that covered the rectangular frame. The mother walked on alone with her child alongside terraced fields whose ploughed, dark soil anticipated the sowing of the winter wheat crop. “In the village...you have to work anyways.” (Sunuwar, S. 11/22/11)

Phaphlu and its rural cluster of its neighboring mountain communities lie dispersed along the steep, eastern slopes of the Dudh Kund Khola valley in southern Solukhumbu. Single-track dirt paths link these communities to each other, criss-crossing agricultural plots carved out from the thick forests. Villagers rely on pedestrian mobility to navigate these trails and agro-pastoralist livelihoods require bodies be engaged with work whenever they are able. The patriarchal system of social task distribution dominant within Nepal remains true within the context of Phaphlu; women and children often carry out the domestic tasks necessary to sustain a household, such as cooking, and collecting and carrying firewood and water. Men also work to support their families, although they are sometimes required to be away from home for long periods of time. Depending on their line of work, men may be away from home porting basic goods throughout the

region in trade, porting supplies for the thriving tourist industry that exists in Solukhumbu, or employed abroad in order to send remittances.



Figure 2 The peaks of Numbur (left) and Karyolung (right) set north of Phaphlu, in the foreground (photo by author)

Beyond Phaphlu's short, dirt road center lined by singular rows of small buildings, eateries, and lodges, the infrastructure of this village includes one of Solukhumbu's two main airports and the district's central hospital with attached maternity clinic. On clear days when the distant snow-capped peaks of Numbur and Karyolung can be seen, limited flights from Kathmandu arrive and depart from the short strip of packed earth and gravel, providing a consistent flow of people and supplies between rural and urban settings. In the case of medical emergencies beyond the scope of Phaphlu's hospital services, patients can be transported by plane to Kathmandu to receive upgraded treatment (weather permitting).

Phaphlu possesses a framework of maternal-child health (MCH) care initiatives expanding from the public hospital and its unique maternity center. The hospital itself was built in 1975 as the second and larger of two hospitals started by Sir Edmund Hillary⁴. In 1980, it was handed over to the Nepalese government and became Solukhumbu's main district hospital (Heydon 2008, 74.) With sixteen patient beds, its position initially served 20,000 people within one-and-a-half-day's walk at the time of its construction, and 60,000 people within three days' walk (Wake 1976, 8.)



Figure 3 The large sign board that directs the way to Phaphlu's health services, which are set back from the main path. (Photo by author)

⁴ The first hospital is the Khunde Hospital located in the Khumbu region of the district.

Founded in 2004, the maternity center's services are augmented and made widely available through funding received from international donor organizations on top of baseline governmental support. It has been designed to help women and their families during pregnancy and delivery overcome barriers of socio-economic ability and facility access in attempts to increase the number of deliveries with skilled attendants. Pre-, neo-, and post-natal care is provided free-of-cost to women who attend the Phaphlu facilities, along with a transportation stipend of 1,500 Nepali rupees. Services also include family planning and immunizations. Nurses employed at the maternity center make their way through villages up to five days walk from Phaphlu to conduct mobile pre-natal health camps where pregnant women receive ultrasounds to determine cases of high-risk delivery⁵. If a woman is "high risk," she is strongly encouraged to travel to the Phaphlu maternity center and stay in the maternity hostel, where she can receive free room and board until delivery.

Despite the hospital and maternity center's presence, homebirth is still a common practice. As of 2006, 14% of deliveries in rural Nepal occur with the presence of a skilled birth attendant (MIDSON). Over the past decade, Nepal has taken on the challenges of the U.N. millennium development goals to reduce child mortality and improve maternal health by implementing maternal-child healthcare initiatives in its more rural areas and has managed to reduce the infant mortality rate from 75 deaths per 1,000 live births in 1999 to the current recorded rate of 44.54 (CIAWF 2011)⁶. Within the context of concern for maternal and infant health and survival during the perinatal period,

⁵ Indicators nurses look for to ascertain whether a woman's pregnancy and impending delivery is high-risk include maternal anemia and a baby in breech position.

⁶ The infant mortality rate in the United States is currently at 6.06 (CIAWF 2011)

what are some of the reasonings behind men and women's choices to remain at home or go to the hospital for delivery?



Figure 4 The buildings of the Phaphlu Maternity center on a quiet day, though the shoes near the door to the right indicate a woman is in labor and attended by nurses in the delivery room. (Photo by author)

Local Ecology of Birth Knowledge

This section is concerned with how interviewees in the Phaphlu area have come to understand pregnancy and childbirth and therefore examines the knowledge content, its sources of dispersion, and its flow between members. The birth settings of hospital and home connect to distinctive systems of authoritative knowledge whose logic is communicated and made salient by the attendants who influence behaviors and beliefs during pregnancy and delivery. The two dominant systems of knowledge pertaining to birth in Phaphlu are that of biomedicine (also known as “modern”, “allopathic”, and “Western” medicine) and folk-wisdom (“tradition”). Biomedical authoritative knowledge is not native to the Phaphlu area and is different from folk-wisdom in that it is

not evenly distributed amongst the participants. Instead, it tends to be concentrated within particular individuals, such as nurses, doctors, and health post workers, whom have undergone specialized training in order to apply the knowledge with certifiable legitimacy. On the other hand, folk-wisdom stems from the community's cultural and religious beliefs and protective practices predating the arrival of biomedicine. This knowledge is more widely spread and accessible to members, although knowledge doesn't always translate into practice. Interviewees would commonly describe the elders or ancestors of their families as the transmitters of such traditional to the younger generations at appropriate times.

Women's knowledge of their reproductive bodies was shown to vary widely when responding to questions of how they first learned they were pregnant. While some mentioned that they became aware of their pregnancies earlier on from being told by female friends to look for the cessation of her monthly menstrual cycles, others related stories of not finding out until the fourth or fifth month of fetal development. The mother-in-law was commonly the older female relative who would confirm the woman's pregnancy after finally being told of her symptoms, such as irregular appetite and stomach pains⁷. An additional way that women came to know they were pregnant was through a hospital visit where they would receive a pregnancy test or ultrasound screen. A twenty-five year old woman in the village of Surke, forty-five minutes uphill from Phaphlu, who had her two-year-old daughter at the Phaphlu hospital expressed how "it's difficult for first time mothers. We do not know what to do and often times we do not

⁷ Many of the women came from villages further away from Phaphlu and only came to live in their current locations after their marriages because it was the husband's family's village. There, the new mother-in-law can exercise control over the household tasks, resources, and activities of her son's wife. Alternatively, as was the case for many interviewees, the mother-in-law was a source of much learning and support during women's pregnancies and deliveries, especially if they were present for homebirths.

learn we are pregnant until we are four or five months pregnant.” (Shrestha, M. 11/17/11) She herself learned she was pregnant at three months when she could no longer drink her usual black tea or “eat well.”



Figure 5 Mankumari Shrestha sitting in the kitchen of her tea shop in Surke. (photo by author)

Once women knew themselves to be pregnant, their decisions as to whether and when they would communicate this development to their husbands also varied. Some told their husbands immediately after they found out, while others explained how they left their husbands to find out for themselves through observation, sometimes up to two months later. For Phurba Lama Sherpa in Chiwong, her husband was always working and was away from home during her pregnancies, only learning she had been pregnant after the birth of each of their four children (Sherpa, P. L. 11/18/11) The Sherpa woman’s husband was actually present for the beginning of her interview and began to contribute some of his own childhood background. Just before the questions on pregnancy began, he stood up to leave the smoke-filled kitchen for the outdoors. When

Phurba Lama was asked how she knew when she was pregnant, she said that she couldn't remember. Granted, she was fifty-one and her last child was born over twenty years ago,



Figure 6 Phurba Lama Sherpa and the author sitting in her home near the fire. (photo by author/research assistant)

but her husband was still in the room and on his way out the door. Once he had stepped outside, she quickly resumed with a “now I remember” and details of how she had known she was pregnant for each of her children. It was as though she did not want her husband to hear of such topics or that his non-involvement in her pregnancies was meant to persist even after the experiences had long past.

Variations in communicating pregnancy to the husband, particularly the absence of communication, correlate with Tamang et al's observation of “pregnancy as normality” in rural Nepal (Tamang et al 2002, 150). The normalcy of pregnancy entails a continuation of the mother's regular eating and working habits and is accompanied by shyness. Tamang et al describe these behaviors as mechanisms to avoid the attention of bad spirits that could harm the woman and her child during the perinatal period (ibid.)

Shyness could also serve as a barrier of the woman communicating knowledge of her pregnancy with the husband, although none of the women expressed in their interviews similar beliefs against drawing unwanted attention for purposes of protection.

In Nepal, the government has tried to improve rural access to healthcare services by establishing a meshwork of small-scale health posts in villages lacking relative access to hospital facilities. Solukhumbu's capital town of Salleri facilitates trainings for community health workers every three months in which these individuals are instructed in rudimentary maternal-child health care and to refer pregnant women to hospitals of health posts for pre-natal check-ups and delivery services. In the village of Surke, Mangali Maya V.K. shared that she felt it was her responsibility as the wards' community health worker to identify women who were pregnant and approach them with advice to visit the Phaphlu maternity center. She explained how "women in the village are shy, [they] will keep the pregnancy to [themselves.]" (V.K., M. 11/17/11) Sometimes, she said, she will approach a woman and ask her if she is pregnant, which the woman will deny multiple times as Mangali Maya will persist in her inquiry until the woman finally admits that she is pregnant, "because they are so shy...that's how Nepali's are." (ibid.)

The flow of knowledge that informs women as to what they should do during pregnancy originated in individuals such as Mangali Maya V.K., or the nurses at the Phaphlu maternity center if they attended pre-natal check-ups. In supportive family dynamics, mothers-in-law instructed their daughters-in-law to eat good food, stay warm, and not work too much. Women also followed their own sense of what felt right and made sense to them within the boundaries of permissible behavior, such as acting on

what two women described as the desire to work even more during their pregnancies because they had so much energy.

Over the past three decades, the flow of pregnancy knowledge has changed with the establishment of the Phaphlu Hospital. Women were asked if they had ever given advice to other, younger pregnant women on how to care for their health in preparation for delivery. Fifty-two-year-old Nurmaya Shrestha was one of the most forthcoming women interviewed and explained the progression of how women learn about their pregnancies.

“Before there was the hospital, women only had each other to ask questions to and get advice from them. Now it is no longer women’s responsibilities to give advice because the hospital is there and women can get advice from the nurses... Women start going to the hospital around three or four months of pregnancy and they get a lot of help. Since the women already know from the hospital, [other women] can’t give much advice to them.” (Shrestha, N. 11/21/11)

Her sentiments were echoed by a few other mothers of her generation, indicating a shift in communicative responsibilities; the contemporary view is that the hospital provides sufficient knowledge to expectant mothers that receive their pre-natal services. The change in knowledge sources, and thus its flow, also demonstrates a corresponding change in knowledge systems where pregnant women are receiving increased biomedical knowledge and the older women around them are refraining from imparting the folk-wisdom knowledge to the degree they would have at an earlier time.

Roles and Responsibilities: the husband as partner

The inclusion of men and inquiry into their involvement with pregnancy and delivery is made in attempts to understand how their roles can impact the experiences and

behavior of their wives during this time. In a patriarchal society where women are not as valued, the role of the husband often includes the mediation of resources available during pregnancy and childbirth (Inhorn et al. 2009, 73.) How he decides to partake in the provision of resources directly influences the workload and responsibilities of his other family members, including his pregnant wife. In the United States, the mother's relationship with the father is utilized as a consistent predictor of sufficient prenatal care utilization (Dudgeon and Inhorn 2004, 1387.) Inquiries should explore past marital status to gain a sense for qualitative characteristics found within variable and subjective reproductive relationships⁸. Every interviewee was posed the question, "what should the responsibilities of the husbands be during the pregnancies and deliveries of their wives?" Interviews additionally inquired into the behaviors and participation of husbands to learn from the experience-based realities of individual births. What people described to be the ideals of what a husband should do proved contingent on the material constraints on what they "must" or "can" do.

The time of delivery is one presided over mostly by women, except during situations where there was no suitable female support figure available for a home birth, or male doctors were present in a hospital setting. As the older, Sherpa woman shared, whose husband had been away for her pregnancies and births, "the men shouldn't really be involved; it's women's business." Another said that she wished "the husband stayed close to the mother and not go far away to work." (Shrestha, M. 11/17/11) If the husband was present for the time of birth, his role did not include being with the mother to

⁸ Further research is needed in this study to understand the psycho-relational complexities that influenced the behaviors and wellbeing of both husband and wife during pregnancy and childbirth. Such personal information would have required extended periods of time and cultivated relationships of trust and intimacy with informant, prospects which lay beyond the limitations of the study's inclusion of the husband's role.

physically assist her with her labor or delivery. Instead, the husband was described to provide nourishment. Mothers who had delivered their children at home spoke of being brought cups of hot *chaang*⁹ during labor and that during their recovery period, the husband would cook for them while they rested with their infant. During pregnancy, some husbands told their wives to not work too hard and to eat nutritious food. One mother spoke to her belief that the husband should have the foresight to prepare foods for his wife during her pregnancy so that they were ready at the time of her delivery and early recovery period. “*Chaang* takes two months to make and that is something the husband can do to help the mother because she would have hot *chaang* in labor. The husband should cook for the mother.” (ibid.) Biomedicine discourages women from consuming alcohol during pregnancy due to its contribution to fetal alcohol syndrome and stunting of fetal development. Pema Sherpa, a nurse midwife from Phaphlu who worked at the hospital and maternity center for over 25 years, explained that local folk-wisdom actually encouraged women to have hot *chaang* during their pregnancies and deliveries because it was thought to help the baby become strong and birth easy with less pain.

In the Phaphlu area, both women and men would speak disapprovingly of the existence of men in their villages who make their wives work hard even late into their pregnancies and not let them rest, else beating them as punishment for not fulfilling their household duties (V.K., M., 11/17/11 Bisu-Karma, K. 11/21/11.) The realities of village life frequently entails farm work, even for pregnant women who cannot always stay at home and not work as is recommended to them by both villagers and maternity center staff (Rana-Magar 11/18/11). Heavy lifting and abundant work during pregnancy can

⁹ An alcoholic drink made from fermented grains.

cause early contractions, increasing the risk of a pre-mature delivery and a lessened likelihood of infant survival due to biological stresses experienced during its development (Sherpa, P.S. 11/19/11)

Kumari Visu-Karma, a forty-three-year old man whose two sons are now twenty and twenty-two, described how he helped his wife as she progressed in her pregnancy by helping her to cook and do the heavier chores around the house. When she went into labor, they lived in Surke where Kumari had to find a stretcher and enough men in the village to help carry his wife to the hospital where she had their son. At the hospital, he waited outside the delivery room because husbands were not permitted to remain with their wives, wishing he could have joined her because he loved her and could have lost her or the baby because birth is a difficult time. He brought with him to the hospital clean clothes for his wife and food for after she had been moved to the recovery room. After they returned home, Kumari shared that he took care to make sure she rested, took a shower from time to time, ate good food, and he helped to do things like preparing warm bath water for the baby. Kumari's descriptions of his involvement as a husband in his children's births was one of the most detailed and focused on his love and care for his wife and he thought other men should do as he did for their wives. However, Kumari acknowledged not all men can be involved to the extent that he was and spoke to some of the barriers.

“It can depend on socio-economic level. Some families are poor; men have to go somewhere else for finding work. The women cannot wait for the men to return to cook for them, so they cook for themselves. Most of the men in the villages are drunk most of the time and they don't know what time to eat, anyways. Some people know what to do, but they don't do it. Some people don't know and that's why they don't do it. Some people know, but they can't do it because of their work.”

He has advised younger men to give their wives additional help during their pregnancies, but confesses that if the man is away for one or two days, “maybe a year or even longer in another country, the men cannot help but be gone. They have to work and earn for the baby and the family.” Kumari shared that he knew how to support his wife because his own mother had told him what was important to do. Other men, if they had participated in the births of their wives, either knew nothing of birth, knew about pregnancy from school, or had listened to the advice of the hospital nurses if the couple had gone together for the initial pre-natal check-up.

The responsibilities of a husband correspond with their roles of resource mediation for the women and support their pregnancies and births from the peripheries of the physiological processes. Yet, two separate interviews with women in Surke revealed that, at times, it is not only the women’s bodies that are affected by their pregnancies. Mangali Maya, the community health worker, shared that, while she felt normal during her pregnancy, her husband’s health changed considerably once he noticed she was pregnant. She explained that what would have otherwise been her pain during her pregnancy “transferred” to her husband; “ he felt burning in his chest, couldn’t eat that much...when the child was born, his problems went away.” (V.K. M 11/17/11) Mankumari Shrestha, a Surke woman who lives down the hill from Mangali Maya in the same village reported a similar occurrence in her husband. While she experienced the common “morning sickness” of nausea or inability to eat well at times that many women will feel in pregnancy, she felt strong and wanted to work more. She told her

husband she was pregnant at four months, after which she said that he developed symptoms of tired hands and legs, he couldn't work and needed to rest and sit down frequently. Again, symptoms dissipated once their child was born.

What both Mankumari and Mangali Maya described in their husbands has received attention from researchers who have termed the phenomena of a husband's biological affinity to the pregnancies and deliveries of their wives as "couvade syndrome." The term comes from the French verb *couver* (to brood or hatch) and a plethora of studies have been conducted over the last century in attempts to identify the symptom origins of what was originally considered to be a psychosomatic disorder (Trethowan and Conlon 1965, 57, Brennan 2007, 173). However, these studies have largely returned with inconsistent theories and findings. In the context of the Phaphlu area, the expression of couvade syndrome stands as another marker for a husbands' involvement, albeit involuntary, in pregnancy and childbirth.

Wellbeing Through Protective Behavior

As has been mentioned above, different socio-cultural settings possess their own systems of facilitating and understanding pregnancy and childbirth. Even within one particular setting, individuals participate in birth in different ways according to their subjective ideas of what will manifest a positive result. Within the Phaphlu area, the actions mothers and fathers performed during pregnancy and birth were consequences of how they understood and navigated the widely known danger of childbirth in a social environment where infants and mothers alike are lost to complications. Keeping this

logic in mind, what the village communities of mothers and fathers actually did during pregnancy and delivery can be seen as a sequence of protection-oriented decisions. Notions of protection frequently arose in interviewees' accounts when asked to explain their reasoning behind certain practices during pre-, neo-, and post-natal times. Prevalent protective practices for achieving forms of health are highlighted here along with their instigative concerns.

The Hospital and Biomedicine

In an environment where multiple settings could be chosen for birth, the basic question for people in the Phaphlu area to decide was whether or not to use the hospital services. Out of the thirteen families represented by the interviews of this study, eight delivered children in a hospital, while the other five delivered at home. Those whom had decided to go to the hospital all received pre-natal healthcare prior to their deliveries, where they were advised on good practices to support the health of both the mother and the fetus. Interviews pursued the reasoning behind men and women's decisions to go to the hospital for delivery and their answers demonstrate the kind of guiding knowledge they possessed at the time and what they valued.

The setting of labor and delivery tends to determine the attendants. Nurses trained in biomedical procedures catering specifically to the health of the mother and infant presented to families an equipped, facilitated environment they described as safer and better. "Safety" is a concept whose definition can change in relation to the individual who holds it. More research is necessary to determine the particularities of people's ideas of safety and how the hospital was able to meet those needs for those who decided

they wanted to deliver in that setting. In a hospital, as one man noted, his wife had a higher likelihood of surviving, should any complications have developed, because there were nurses who could immediately respond to a problem. Others went to the hospital because an emergency either occurred or was predicted to occur, such as a woman who fell unconscious and remained so for the duration of her labor, and a mother who was advised to go to Kathmandu because the fetus' head diameter was very large. Another prevalent reasoning given for a hospital birth was that the facility was located "nearby," another relative term that could entail a walk between five and forty-five minutes from their homes along steep dirt paths. In the event that a medical emergency occurred, survival of the fetus and even mother could become jeopardized in a home birth setting, thus some individuals protect themselves through their choice of delivering in a hospital.

Bad Spirits and Big Babies

As already explained above, a woman's shyness during pregnancy in Nepal can serve as a mechanism of avoiding the attention of evil spirits at what is a vulnerable time. This can entail the maintenance of what would otherwise be their normal workload, for changes in routine can draw attention from evil spirits as well as other people who may develop ill feelings against the woman and equally cause her or her child harm in the perinatal period (Tamang et al 2002, 150). Continuing to work during pregnancy in this case not only protects against external threats, but corresponds with a folk-wisdom thread where hard work helps with an easier delivery. "If we kept working while we were pregnant, the baby wouldn't grow too big and it would be lighter for us to give birth," shared fifty-two-year-old Nurmaya Shrestha in her small community forty minutes

downhill from Phaphlu towards the Dudh Khund River at the base of the valley. Fears of making the developing fetus too big, thus causing a difficult birth, precipitate the conscious practices of pregnant women who work harder as protection from a long and difficult delivery where she will be most vulnerable to evil spirits.

The negative effects caused by the evil spirits can be mitigated through the ritual role and services of the local *dhami-jhankri*, a traditional healer. Nurmaya Shrestha's father-in-law, who was also a *dhami-jhankri*, attended all of her births. He would be called to the house where Nurmaya was in labor and already receiving physiological support from her mother-in-law. There he would perform a ceremony to pacify the souls occupying the space of birth and she related how her labor immediately felt easier. Mothers also spoke of a *butti* (protective locket) that is made for the infant as a shield against evil spirits and bad thoughts or emotions by saving the umbilical cord and keeping it close to the child prior to or when it becomes sick. Not all mothers or fathers expressed beliefs in evil spirits or the efficacy of a *dhami-jhankri*'s practices, yet these beliefs were some of the many held within the Phaphlu community and shaped protective behaviors.

Heat

“This is a cold place,” said Phurba Lama as she huddled next to the fire in her kitchen, “if women wear thin cloth [when they are pregnant] and the body gets cold, then the baby becomes swollen and it is difficult to deliver.” Having delivered four of her own children in her home, she shook her head knowingly. “I learned from my mother-in-law and the ancestors that even if a woman has labor pains, if the body is kept warm then

the delivery is much easier.” (Sherpa, P.L. 11/21/11) In other interviews, women who had experience with their own home births would repeatedly explain how the use of heat could ease and induce the processes of labor and delivery, holding the palms of their hands up to the warmth of an imaginary fire and then pressing their hands against their own bellies or lower backs in a demonstration. Millet oil was also used to convey warmth to the pregnant belly through being heated and then applied with massage. By consuming hot foods and beverages, particularly *chaang*, the mother’s body could also be warmed from the inside. Heat was therefore considered a protective measure against prolonged, and perhaps painful, labors.

Post-Partum Seclusion

During interviews, the majority of mothers and fathers described the time immediately following delivery as one where the woman, weakened from her exertions, should rest and recover her strength. The recovery period for many families included a four to eleven-day-long post-partum seclusion of the mother and child from the rest of the house in a warm room where non-family members were permitted very little, if any, contact with her and the infant. There, the mother could not touch anything and could not receive touch. She was not permitted to cook or enter the kitchen and food was brought to her. The behavioral and spatial boundaries of post-partum seclusion last until the infant’s naming ceremony (*nwaran*), which occurs earlier for a girl and later for a boy. Presided over by a visiting lama or pundit according to the spiritual faith of the family (Buddhist or Hindu,) the ceremony brought to a close the liminal period where neither infant nor mother were fully integrated or participating in the household roles. After the

naming ceremony, the mother can return to her domestic chores, although some women expressed that they waited another couple weeks before starting to do work for additional recovery. For those who followed the practice of post-partum seclusion but birthed in the hospital, the period of no touching began after returning home and settling the mother and infant to rest. When asked why families partook in the time of seclusion until the naming ceremony, they responded that it was tradition and so implied that it was their responsibility as part of a continuation of their cultural heritage. Mothers who were not separate or allowed to be touched or visited by members of the community expressed that themselves and their husbands did not agree with the tradition of the area, preferring the freedom of individual agency and increased contact and therefore assistance from their families and community with the care of the infant.

Secondary literature speaks to Nepal's cultural practices of the mother's post-partum seclusion using defining terms of pollution and purification (Tamang et al 2002, 151, Winch et al. 2005). Birth is summarized as a polluting situation that marginalizes the mother by reducing her contact with others who would otherwise be contaminated. The naming ceremony is accompanied by purification achieved through the dispersal of holy water throughout the home, alleviating the pollution from the mother and allowing her to move again through her community without negative repercussions (Tamang et al 2002, 151.) Although notions of pollution is mentioned as a defining quality of childbirth and the post-natal recovery period in Nepal and other parts of south Asia, mothers and fathers interviewed in the Phaphlu area about their own experiences of these times did not speak in these terms. The localized role of pollution associated with birth remains to be ascertained through more in-depth research in the future.

Conclusion: respecting ethnographic complexity

The birth ecology of knowledge acquisition and content specific to the mothers and fathers of the Phaphlu area is complex and accommodates within its flow their varied understandings and practices around pregnancy and childbirth. The framework of authoritative knowledge serves to draw attention to the different ways of knowing that members of any community subscribe to, lending the individual's actions validity by virtue of their moving from a place of socially-constructed belief, regardless of right or wrong. Narratives collected from the men and women of Phaphlu contained unique experiences that were particular to their settings. The roles of the husband during pregnancy and birth are important in determining the behavior and wellbeing of the mother and her infant and deserve further pursuit beyond the scope of this study to include additional perspectives and opinions. Protection from feared threats during pregnancy and birth is achieved through men and women's behaviors that correspond with their subjective understandings of what "safety" means. This study was an endeavor to access several layers of unevenly distributed, localized knowledge systems pertaining to birth through the use of ethnographic fieldwork. The complex variety of behavior and underlying rationale found in the Phaphlu area attest to the fact that pregnancy and childbirth are significant reproductive processes experienced differently by every member of a community.

Research Assistant Profile:



Figure 7 Pema "in the field" on a walk to conduct more interviews in Surke (photo by author)

When I met Pema Lama Sherpa, I was staying at her family's guest lodge on the main road of Phaphlu. At the age of twenty, she was home in the interim of having recently completed a pilot training program in the Philippines and receiving a job placement for a domestic airline. Her holiday of sorts allowed her the free time to collaborate with me as an interpreter in conducting interviews throughout the communities she'd spent time in during her childhood. Her English is excellent with careful word choice and, although she understood the Sherpa language of her family, she did not herself speak Sherpa, but Nepali. She had very limited knowledge of the processes of pregnancy and childbirth and we learned together what existed in the Phaphlu area. I am very grateful for her sense of adventure, compassion, sensitivity, and confidence in navigating the many

approaches of our interviewees, many taking place in their kitchens or tea rooms after we'd followed trails or traversed crop fields in our hunt for those with the willingness to share their stories.

Appendix I: Limitations

Multiple restrictions were present during the process of this study and deserve note for their role in shaping the content to unknown degrees. Little to no scholarly literature exists on this setting-dependent topic for the specific area of the southern Solukhumbu district. Therefore, my understandings of local practices and beliefs around pregnancy and childbirth primarily depend on the interviews with mothers, fathers, and health practitioners of different backgrounds. Because the sample group of interviewed mothers and fathers was relatively small, their individual experiences and rationale stood apart from each other with but some overlap. Due to the time constraints set forth within the allotted independent research period, research conducted in the field was limited to the two weeks in Phaphlu. The fieldwork time period fell within what was for the locals a busy point in the harvest, also corresponding with the sowing of the new wheat crop. Many villagers who perhaps would have otherwise had time to speak about the personal and sometimes sensitive topic of their personal birth experiences were out in the fields working long hours or otherwise engaged with their businesses. Interviewee selection was opportunistic in that we didn't want to keep the individuals from their tasks that needed tending and so we chose people who appeared to be in a period of rest. In addition, pregnancy and childbirth is a topic that is not openly discussed amongst

community members and seemed to be relegated to private conversations. Therefore, my research assistant and I tried to remain attentive to the comfort level of the individual as well as the number and character of others around us and their potentially curtailing impact on what or how the individual was sharing. Our sensitivity to the perceived comfort and needs of the interviewee certainly limited the number of people approached for their participation in the study. Additional time in the field would undoubtedly yield a larger collection of narratives that, once compared with others from the area could begin to demonstrate the existence of more widely-held beliefs and practices.

My own identity, as well as that of my research assistant, needs to be taken into consideration in their effect on the interview process; (among other characteristics) I am a twenty-two-year-old, blonde woman of European descent, Pema is a twenty-year-old Sherpa woman from the Phaphlu community, and neither of us have children. There could certainly have been many underlying relational dynamics that neither of us were aware of, but the fact that we were both young, unmarried, female and asking questions about a little-spoken-about area of personal reproductive behavior no doubt informed what the interviewee decided to share with us in our singular interviews. If the topics of pregnancy or childbirth are broached between community members, it seems to be done with a person of one's own gender. Taking this into consideration, our attempts to seek out men who would be available or willing to participate in interviews were immediately much more difficult than with women and likely experienced qualitative limitations of a different sort in what was shared. The fact that I was a foreigner not familiar with the local social setting and that I do not speak Nepali or Sherpa both limited the forms in which I was able to access and communicate with the people around me. A last

limitation of note in research methodology was the absence of a computer whose services of quick interview annotation and more easeful data coding were left behind in Kathmandu due to security, limited weight load when trekking, and the uncertain availability of electricity.

Appendix II: Interview guides for the Phaphlu area mother and father

For Mothers and Fathers:

Full name:

Age:

Who lives in the house with you? (relationship and age)

Do any other family members live close by? Who?

Where are you from? (if different from current location, when and why did you move?)

How many siblings do you have?

What did you do when you were a child? What were some of your responsibilities/ household chores?

Did you go to school? If so, what is the highest level you completed?

What did your parents do when you were young?

When you were a child, what would be done if someone became sick?

How did you and your spouse meet/get married? How old were you?

What does your spouse do? Do they have an occupation?

Would you be willing to speak about your experiences of pregnancy and childbirth?

For Mothers:

How many times have you been pregnant? Have you ever had a miscarriage?

How many children do you have right now? How old are they?

Before having your own children, what did you know about pregnancy or childbirth?

Who did you learn from?

How and when did you learn that you were pregnant?

What was your reaction?

How and when did your husband learn you were pregnant?

What was his reaction?

Did you share with him anything about the pregnancy as it progressed?

At what point is it okay to talk about your pregnancy to family members/non-family members?

How did you share with your community that you were pregnant?

What did you do during your pregnancy? Any changes to your behavior? How did you prepare for delivery?

Did you ever do any pre-natal visits during your pregnancy? If so, where, how many times, and who went with you?

Did you drink chaang of raksi while pregnant?

What advice did you receive about pregnancy or delivery from other women during your pregnancy or leading up to delivery?
What did your husband do while you were pregnant?
Did you have any problems during your pregnancy? If so, what were they? Did you seek help for the problem?
How did you know that labor started/that it was time for the baby to come?
Where did you deliver your baby? How and when did you get there? Why did you choose that location? Was it a good experience?
Who was with you? What did they do during labor/during delivery?
Who is and who is not allowed to be present during delivery?
Where was your husband and what did he do during the birth of your child?
Were there any medicines/foods that should/should not be taken during delivery?
Did you have any problems during delivery? What were they?
What happened to the umbilical cord? How was it cut?
What happened to the placenta? Who did something with the placenta after delivery?
What did you do after delivery during the recovery period?
(Hospital) how long did you stay before going home? How did you get back?
Are there any people who should not be around the baby or mother after delivery?
How long did you rest?
What did you feed the baby?
Who names the baby? How?
Have you ever given advice to a younger woman regarding what she should do during pregnancy and delivery?
In your opinion, what should the responsibilities of the husbands be during the pregnancies and deliveries of their wives? What should they do? What should they not do?
Anything else you would like to share that could help me to understand what people do in your culture for pregnancy and birth?

For Fathers:

How many times has your wife been pregnant? Has she ever had a miscarriage?
How many children do you have right now? How old are they?
Before you had children, what did you know about pregnancy or childbirth? Who did you learn from?
How and when did you learn that your wife was pregnant?
What was your reaction?
Did you ask your wife any questions about her pregnancy?
Did you talk with other men during your wife's pregnancy about what to do or how to prepare for the delivery? What?
What did you do during your wife's pregnancy? Any changes to your behavior? How did you prepare for delivery?
Did she ever do any pre-natal visits during her pregnancy? If so, where, how many times, and who went with her? Did you go?
Did your wife drink chaang or raksi while pregnant?
Did your wife have any problems during her pregnancy? If so, what were they? Did you seek help for the problem?

Where you present or available for the births of your children?
How did you know that labor started/that it was time for the baby to come?
Where was the baby born? How and when did you get there? Why did you choose that location? Was it a good experience?
Who was with the mother? What did they do during labor/during delivery?
If in a hospital setting, how did you feel about not being permitted to remain with your wife during the delivery of your child? Would you have wanted to be with your wife in the delivery room?
Who is and who is not allowed to be present during delivery>
Where were you and what did you do during the birth of your child?
Where there any medicines/foods that should/should not be taken during delivery?
Did your wife have any problems during delivery? What were they?
What happened to the umbilical cord? How was it cut?
What happened to the placenta? Who did something with the placenta after delivery?
What did you and your wife do after delivery during the recovery period?
(Hospital) how long did you stay before going home? How did your wife get back?
Are there any people who should not be around the baby or mother after delivery?
How long did the mother rest?
What was the baby fed?
Who names the baby? How?
Have you ever given advice to younger men regarding what they should do during pregnancy and delivery of their wives?
In your opinion, what should the responsibilities of the husbands be during the pregnancies and deliveries of their wives? What should they do? What should they not do?
Anything else you would like to share that could help me to understand what people do in your culture for pregnancy and birth?

Primary Sources: List of Interviewees mentioned in text.

Bisu-Karma, Kumari. Nov. 21, 2011 Kumari has two sons and is having a new house built for his family in Surke. He is a business man and has worked abroad.

V.K. Mangali Maya. Nov. 17, 2011. Community Health Worker, lodge owner, and mother of three who lives in Surke.

Rana-Magar, Dankumari. Nov. 18, 2011 Dankumari has two daughters, farms, and lives in the town of Surke.

Sherpa, Pema “Sister”. Nov. 19, 2011 Pema is a nurse and midwife who has worked at the Phaphlu Hospital for over 25 years and is very passionate about maternal-child healthcare in the community. She also serves as an instructor at the local ANM technical training institute.

Sherpa, Phurba Lama. Nov. 21, 2011 A mother to four, Phurba Lama and her husband now run a lodge in Chiwong.

Sherpa, Sonam Dhoka. Nov. 13, 2011 Native to Phaphlu, Sonam is a registered nurse who lives and works in Kathmandu. She is also a mother of one.

Shrestha, Mankumari. Nov. 17, 2011. Mother of one, she and her husband run a small lodge with a tea shop in Surke.

Shrestha, Nurmaya. Nov. 21, 2011 Nurmaya lives between Baghbani and Kholagari, has given birth to 8 children, and runs a small snack shop in front of her house.

Sunowar, Shanti Maya. Nov. 22, 2011 Shanti Maya has two children, runs a small eatery out of her kitchen, and lives in a community between Baghbani and Kholagari.

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Figure 8 The author and Surke mother, Mankumari Shrestha, during an interview (Photo by research assistant)

Suggested topics for future research:

- Social movement in Nepal for improved maternity leave, as well as paternity leave.
- A male student to conduct interviews with fathers to explore their experiences and understandings of childbirth in a way a female researcher could not (or would otherwise do differently.)
- Focus on a more specific topic, specific time of the childbearing year or aspect of motherhood. Examples: breastfeeding/infant feeding practices, localized understandings of conception or “when does pregnancy begin?”, the recovery period immediately following delivery, relationship between pregnant mothers and their healthcare providers at a clinic or hospital.
- Menstruation
- Menopause
- Courtship
- *Dhami-jhankri* traditional healers
- The process of mourning infant deaths
- A woman’s relationship with her biological family and its transformation after marriage if she goes to live in her husband’s village.
- Baby massage and baby protection techniques
- A household survey of a small community to collect quantitative data on reproductive history and behavior.