Giving Birth: The Voices of Women in Tamil Nadu, India

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Abstract

Purpose: The purpose of this qualitative descriptive study is to describe the perceptions of childbearing women living in Tamil Nadu, India. This study can increase cultural understanding and foster cultural competence in nurses caring for Indian women.

Study Design and Methods: Women were invited to share their childbearing experiences. Following institutional review board approval, interviews were held with 22 women who had given birth in the previous 18 months to a viable infant. The women were grateful for the opportunity to share their perspectives with an interested nurse investigator. Data collection proceeded concurrently with data analysis. Themes were generated collaboratively by the research team.

Results: This research provides insights into the perspectives of mothers living in Tamil Nadu, India. Themes included anticipating becoming a mother, following the advice of mothers-in-law and other “wise” women, fear of childbirth related to lack of knowledge, and valuing support during labor and birth. Others included having the greater blessing of giving birth to a son, making the transition to motherhood, following postpartum rituals/ceremonies, and having a desire to give their child the best that life circumstances allow.

Clinical Implications: Nurses should be sensitive to the social determinants of health, which frame giving birth. Listening to the voices of women is helpful in guiding clinical practice. Understanding of childbirth practices in culturally diverse women is essential. Potentially harmful practices can be changed through appropriate educational offerings.

Key words: Cultural competency; India; Parturition; Women.
With a growing influx of immigrants coming to the United States, the urgency increases for culturally competent nursing care. Because childbearing women cope with the stresses of pregnancy and birth, as well as making the psychosocial and physical adaptations to motherhood, culturally diverse women particularly need expert, culturally sensitive nursing care. Developing cultural competence is of importance to nurses caring for childbearing women (Callister, 2011).

The purpose of this qualitative descriptive study was to describe the childbearing experiences of women in rural Tamil Nadu, India. These study findings can increase cultural understanding and foster cultural competence in nurses caring for Indian women. The research question is: what is the meaning of giving birth to childbearing women living in the Indian state of Tamil Nadu?

**Background and Significance**

India has a population of 1.15 billion people, making it the second most populous nation second only to China with 17% of the earth’s population. India has an annual population growth of 1.40%, with 21.72 births per 1,000 people. India has one of the highest infant mortality rates globally with a rate of 50.78 deaths per 1,000 live births. The World Health Organization (WHO) indicates the maternal mortality rate (MMR) is 230 per 100,000, with the majority of women (61%) in India giving birth at home. The fertility rate is 2.65 children born per woman of childbearing age. Seventy-five percent of pregnant women make at least one prenatal care visit. Nearly 60% of Indian women have mild to moderate anemia related to malnutrition. The female literacy rate is low at 47.8% (WHO, 2012).

In comparison, the most southern Indian state of Tamil Nadu is known for initiatives to improve maternal health services in order to reduce MMR. In Tamil Nadu, there are 16 births per 1,000 people, a fertility rate of 1.7 children born per woman of childbearing age, and a female literacy rate of 64.4%. The infant mortality rate is 37, and the MMR is 134 per 100,000 births. The sex ratio (that is, the number of females per 1,000 males) is 987 (Vora et al., 2009). The rate of births in healthcare institutions is 90.7% (Padmanaban, Raman, & Mavalankar, 2009).

These statistics are related to the Janani Suraksha Yojana program, which financially incentivizes women to give birth in a health facility rather than at home, and incentivizing having a tubal ligation after giving birth to 1 to 2 children. The need has been identified to improve targeting the most socially disadvantaged women and increasing the quality of care in healthcare facilities, which is generally viewed as being substandard (Human Rights Watch, 2009; Lim, Dandona, Hoisington, James, Hogan, & Gakidou, 2010). Paul and associates (2011) noted that “increases in the numbers of births in institutions have not been matched by improvements in the quality of intrapartum and neonatal care” (p. 132). The MMR is still 25 times higher than in developed countries (Women Deliver, 2010).

The following qualitative studies were found in the literature with Indian women (including Tamil women) as study participants. One study was conducted on childbirth care seeking in women living in the Indian state of Karnataka (Matthews, Ramakrishna, Mahendra, Kilarus, & Ganapathy, 2005). Another study documented childbirth practices in the state of Rajasthan, India through interviews with 18 women who had recently given birth and 39 key informants (Iyengar, Iyengar, Martines, Dashora, & Deohra, 2008).

Hug and associates (2008) identified maternal expectations and experiences in women living in Calcutta, India. Barnes (2007) described the perceptions of childbearing women and their providers living in the Indian state of Jharkhand about obstacles faced when seeking healthcare. Focus groups were held with mothers of infants, health workers, and traditional birth attendants in Vidisha, India exploring sociocultural practices affecting newborn weighing at birth (Bhattacharyya, Dwivedy, Nadeshwar, DeCost, & Diwan, 2008). Van Hollen (2003) has shared insights on disadvantaged childbearing Tamil women, but the research was conducted more than a decade ago prior to maternal/child healthcare reforms being implemented in India.

No studies were found which focused specifically on the perceptions of childbearing women living in Tamil Nadu India except the Van Hollen’s (2003) work, which is dated. Conducting the research in the Indian state with a low MMR is essential. It is important to gain knowledge of women’s perceptions and birthing practices given the initiatives in Tamil Nadu to improve maternal/child health in socially disadvantaged women.

Stenson, Kapungu, Geller, and Miller (2010) assert that reproductive health research in low-resource settings creates unique and complex challenges (p. 2101). These cultural, ethical and logistical challenges to health research teams can be complex and multifaceted (p. 2101). Furthermore, research “in the context of cultures where women may not be empowered to make autonomous decisions” requires careful consideration of “local social, cultural, and ethical standards” (p. 2101). Such research though can “contribute to policy changes, program development, and advocacy” (p. 2106).

Malterud (2006) in *The Lancet* verifies that women’s wisdom represents a significant source of expert knowledge for healthcare providers as we listen to their voices. In addition, the opportunity to share feelings related to a significant life event such as childbirth has been found to be an emotionally satisfying experience to women. This study builds on previous research with culturally diverse childbearing women, including Armenian women (Amoros, Callister, & Sarkisyan, 2010); Australian women (Callister, Holt, & Kuhre, 2010); Chinese women (Callister, Eads, & Diehl, 2011); Dutch women (Johnson, Callister, Beckstrand, & Freeborn, 2007); Ecuadorian women (Callister, Corbett, Reed, Tomao, & Thornton, 2010); Finnish women (Callister, Lauri, & Vehvilainen-Julkunen, 2001); Ghanaian women (Farnes, Beckstrand, Callister, & Carlton, 2011;...
This qualitative descriptive study describes the experiences of 22 childbearing women living in rural Tamil Nadu, India. This study increases cultural understanding and fosters cultural competence in nurses caring for Indian women.

Wilkinson & Callister, 2010; Guatemalan women (Callister & Vega, 1988); Mexican immigrant women (Callister & Birkhead, 2007); Muslim women (Khalaf & Callister, 1997); Orthodox Jewish women (Semenic, Callister, & Feldman, 2004); and Russian women (Callister et al., 2007).

Methods
Data Collection
Following institutional review board approval from the principal investigator’s institution, 22 Tamil women living in a rural area of the southern Indian state of Tamil Nadu who had recently given birth were approached by the principal investigator and an interpreter and invited to participate in the study. With institutional permission, potential study participants were approached in the postpartum unit of a government hospital and in the homes of women in several small villages in the surrounding areas and invited to participate. In addition, snowball sampling was also used, as women participating in the study recommended other women to invite to participate in the study. A teacher at the Peery School for Rising Stars had an infant, and she encouraged women in her village to participate in the study, which helped with recruitment because the women knew and trusted her. Eight study participants were recruited at the government hospital, after receiving verbal consent from the hospital director to conduct interviews. Ten were recruited through snowball sampling in the village, and four at various villages where health clinics were being held.

Inclusion criteria were women who had given birth to a viable infant in the previous 18 months. Exclusion criteria were women who experienced a stillbirth or neonatal death at their last birth. Theoretical sampling took place in an effort to include diverse Indian women, including both primiparous and multiparous women, women with and without education. Prior to being interviewed, each study participant gave informed consent. In cases where the potential participants were illiterate or illiterate, the consent was read aloud and explained to the women. After informed consent (digitally recorded) and completion of the demographic form (with questions asked verbally), digitally recorded interviews were conducted.

A semistructured interview guide was used by the two translators to ensure consistency. This guide has been used for more than two decades of cross-cultural studies of childbearing women. Interviews continued until saturation occurred (Guest, Bunce, & Johnson, 2006). Questions included, “How did you feel when you first found out you were pregnant?” “Tell me the story of your birth.” Interviews were conducted in Tamil with the principal investigator and female native speaking interpreters in the homes of the women or at a government birthing center.

The women who participated in the study were very impoverished. Education levels varied from four women who had never attended school up to two women who had college level educations. Most of the thatch roofed cement homes in the village had no electricity or running water. Interviews were conducted with the interviewers sitting cross legged in the dirt or on a mat or in a birthing center. People in the village gathered around to listen to the interviews, including the paternal and/or maternal grandmothers who added their commentaries. Since this society is very communal, privacy was almost nonexistent and many wanted to contribute their perspectives. While the women were willing to be interviewed, some were not very talkative and did not disclose much information except to directly answer a question, perhaps because others were present. This may affect the trustworthiness of the data; however, interviews that were held in private had similar responses to interview questions. Each study participant was given a modest gift of infant clothing as an expression of appreciation for participating in the study.

Data Analysis
Digitally recorded interviews were transcribed and translated into English. Thick descriptions were kept of the interviews. Data analysis and generation of themes proceeded concurrently with data collection. The principal investigator was the instrument, accessing data from an etic perspective. The researcher was careful not to leave a “research footprint” and focused on reflecting the perspectives of the informants. Preliminary analyses of the transcriptions were performed separately by the two investigators, who then collaborated to identify themes.

Field notes were kept to record observations, impressions, and insights. Content analysis of the interviews and observations made enhanced the quality of the findings. Trustworthiness of the data (which is similar to reliability/validity in quantitative inquiry) was ensured through establishing credibility, transferability, dependability, and confirmability. The two investigators independently performed preliminary analyses, engaging in reflection and highlighting significant data bits. The researchers reflected on the sociocultural context in which these women live and attempted to reflect the perspectives of the study participants. Preliminary results were compared and themes identified. The researchers included an expert perinatal...
nurse who has participated in global nursing initiatives in developing countries, and an experienced qualitative nurse researcher. The question was continuously asked, “What is this mother saying?” (Marshall & Rossman, 2006). Narrative data are used to illustrate the themes, with themes compared with other findings in the literature. It was not feasible to conduct member checks. Demographic data were analyzed using descriptive statistics.

Findings

Demographics

Twenty-two married women who had given birth in the past 18 months participated in this study. Maternal age ranged from 21 to 33 with a mean of 23 years. One woman did not know her age and estimated it to be 22 years. Seven of these women were primiparas and 15 were multiparas. Twenty of the women stated that they had monthly prenatal care beginning at 3 to 5 months gestation. There was a cesarean birth rate of 23% among the sample (n = 5).

Compared to the official rate of cesarean births in this state of 14%, the cesarean birth rate in this sample was relatively high. It is a common misconception that performing cesarean births is associated with better neonatal outcomes, which is supported in a study of childbearing women living in Calcutta, India (Hug et al., 2008). Cesarean births were performed under regional anesthesia. Of those having vaginal births (n = 17) only one woman had pain medication. The others were unmedicated during labor and birth.

The number of births by the women in this study ranged from 1 to 3. Thirteen of the women had given birth to two children, seven had one child, and two women had given birth to three children. The number of male infants was 12, females 10. Stated birthweights ranged from 1 to 3.5 kg (2.2–7.7 lb) with the mean weight as 2.7 kg (5.9 lb). An attending physician stated that birthweights were low related to increased rates of malnutrition and anemia in the women of this region.

Sociocultural Context

One study participant gave birth at home with her mother in attendance. She said she did not follow the usual birth traditions because her husband was an abusive alcoholic, and she had no money to purchase items such as incense. The fathers would frequently wait outside the hospital with other family members who were not permitted into the labor and birthing area.

The women often returned to their mother’s home near the end of their pregnancy to give birth. It is traditional for families to care for their daughters and to cover any expenses related to the birth. The women and their newborns stayed with their mothers for an extended period of time, often several months before returning to the home of their husband’s family. The women were kept in isolation because of the “impurity and polluting” effects of giving birth.

Themes included anticipating becoming a mother, following the advice of mothers-in-law and other “wise” women, fear of childbirth related to lack of knowledge, valuing support during labor and birth, having the greater blessing of giving birth to a son, making the transition to motherhood, following postpartum rituals and ceremonies, and having a desire to give their children the best that life circumstances allow.

Anticipating Becoming a Mother

Having children is an important sociocultural aspect of Indian life. Many of the participants described being “very happy” upon learning they were pregnant and openly announced the joyous news to family and neighbors. A participant said “after five months of marriage I learned I was pregnant! I was so happy and was telling everyone around ‘I’m pregnant!’” The women said it was important to become pregnant within a year of being married, or the “others” in the village would begin to talk negatively about them and their perceived infertility or unwillingness to bear a child. Most seemed relieved and happy when they learned they were expecting a child, because this proved their fertility. One woman said, “It’s not everyone that gets a baby. To become a mother is like even more happy!” One participant who had been unable to conceive for 7 years prior to the birth of a baby claimed that having a child was “like so much happiness and gives me a complete life.” Another woman described the value of motherhood as “becoming a mother is really special for us, and it’s so nice to be a mother. We feel happiness within us.”

Because of the cultural imperative to bear children, a woman will often take the dried skin from her newborn’s umbilical cord to offer a couple experiencing infertility. It is believed that eating this dried skin will enhance fertility. One participant was very happy that she had given the umbilical cord from her newborn to another couple and said they had recently announced they were expecting a child.

Following the Advice of Mothers-in-Law and Other “Wise” Women

Mothers-in-law have an important role in childbearing and childrearing in Indian culture. They are often the decision makers on all household issues, including pregnancy, birth, and the observance of cultural practices associated with childbearing. Study participants indicated that because they lived in their husband’s home, it was their mother-in-law that told them what rituals to follow during pregnancy. These rituals included certain sleep positions like never sleeping on their back and always sitting up to turn over, or never sitting in the traditional Indian cross-legged position. Other pregnancy related rituals included the avoidance of certain foods that would be “cold” or cause harm to the growing fetus. One woman reported “they say I can’t eat pineapple, mango, or jackfruit during pregnancy because it will get the baby cold inside of me and after it is born it will be cold and get sick.” Another participant claimed, “I was only allowed to eat rice milk and hot water during my pregnancy.” As a result, she was too malnourished and anemic to have a desired postpartum tubal ligation. Some participants accepted these prohibitions willingly and others stated they went against the advice and ate forbidden foods.

Some women were given extra food and rest during the pregnancy. Others were told to work harder and do more chores, in addition to eating less, to prepare their bodies...
for the rigors of childbirth and motherhood. A mother stated "the elders tell you to bend and work and be active so you will have elasticity for a normal birth. Also that you should not always sit, and you should sleep less."

There is a cultural fear of immediate weighing of the neonate because the "evil eye" may be cast on the newborn by onlookers which is supported in the literature (Bhattacharya et al., 2008). Birthweight is not emphasized as it is in other cultures. Women often did not know the birthweight of their neonate shortly after birth nor seem interested in it. When asked an infant's birthweight it always rounded up to 2.5 or 3 kg, making almost all children weigh the same.

**Fear of Childbirth Related to Lack of Knowledge**
Childbirth is not a topic openly discussed in this region of India. When asked about perinatal education, most women stated that no one talks about what will happen during childbirth other than it will be painful. Many of the participants described feelings of fear and anxiety related to giving birth. One participant said the only thing she was told by her mother was, "you have to be very good and healthy and take care of yourself. Only then can you be a mother." These words were the extent of her perinatal education. Another said she had so much "fear of the unknown and pain, I didn't know what to do." Some of the women stated they were told that the nurses would tell them about childbirth when they arrived at the hospital in active labor.

Fears related to the possibility of a cesarean birth were also present. One participant who reported she was extremely weak and dizzy from anemia during her pregnancy said, "I was so weak and scared. How was I going to have a normal birth and how could I possibly take care of a baby?"

**Valuing Support During Labor and Birth**
Study participants described having repeated (up to 28 reported) vaginal examinations to assess labor progress, being given intramuscular injections of oxytocin during labor, and the application of abdominal fundal pressure to hasten births. These practices, not recommended by the WHO (Iyengar et al., 2008; Iyengar, Iyengar, Suhalka, & Agarwal, 2009), are still in common practice. Women were hospitalized in the healthcare facility for 2 to 3 days following a vaginal birth and a week for a cesarean birth. This time frame varied related to waiting for tubal ligations that were performed only on certain days or complications related to maternal anemia.

Women in this study valued any information and support provided during labor and birth. One mother said that the nurse consoled her during painful contractions and reassured her, saying, "Don't worry, we are near you. We will take care of everything so that everything is fine with the baby and with you." Although not all of the nurses were seen as helpful, gestures of kindness or information on labor progress were always appreciated. Another mother said, "The doctors and nurses said, 'don't be scared. Your baby will come out nice and properly. We are here, and you don't need to be scared.' The nurse was helpful when she held my hand, helped me on the bed, and stayed with me."

A study participant said she was told when she was in labor to, "just keep walking so you get more pain." She noted, "they say the pain only lasts a little while and walking like exercise helps you." A woman who gave birth at home stated she found the warm water massage of her abdomen performed by her mother was helpful during labor. Another mother indicated she would like to see more human touch and consideration for someone in so much pain during labor.

**Having the Greater Blessing of Giving Birth to a Son**
Sons are highly valued to carry on the family name and someday light the funeral pyre of their parents. A daughter is "viewed as a liability and conditioned to believe that she is inferior and subordinate to a son" (Padmanban et al., 2009, p. 203). Although dowries have been outlawed in India, dowries still may be required, creating heavy financial burdens for the parents of daughters. According to Padmanban and associates (2009), sex-selective abortions have been legally banned, but are still being practiced. This contributes to the low male to female sex ratio of children born in India (Jha, Kumar, Vasa, Dhingra, Thiruchelvam, & Moineddin, 2006).

Women frequently stated they were happy with their infant daughters; however, it was observed that if they had given birth to a son they were more overtly joyful and proud, saying they had the double blessing of a son. Women who had a son would be beaming as they made such comments as, "I am soooo...happy that I had a baby boy!" A participant that had recently given birth to her second daughter, when asked how she felt when she saw her newborn for the first time, her indifferent response was, "I don't think anything. Just that 'God gave' and that's all."

Several women expressed disappointment in giving birth to a daughter, making such comments as, "this is my child. What else can I do but accept?" or from a woman after her third daughter was born, "I am disappointed and not happy because I now have three girls and no boys." One study participant related that after having a daughter, she knew in her heart the second would be a son. She signed consent prenatally for a tubal...
ligation, which was performed following the cesarean birth and after she gave birth to the daughter. She later had many regrets and stated she wished she would be able to try again to have a son.

Some participants stated that because sons are considered an extra blessing, it is traditional not to cut their hair until they are 1 year of age. At that time a special ceremony is held at the Hindu temple, with thanks to the Gods offered for the special blessing of a male child, and then their son receives his first haircut. One participant stated she had prayed for a son, promising to offer up his hair to God if she was blessed with a male child.

Making the Transition to Motherhood

The social status of Indian women changes as they become mothers. Women described a celebratory ceremony held during the last weeks of pregnancy. Friends and family come to this important ceremony for the expectant mother to offer blessings prior to birth. The pregnant woman wears a new sari and her hair is adorned in garlands of jasmine flowers. The women come one by one to place many wrist bangles on her and apply turmeric paint to her face. All come to pray and wish her well. After this ceremony she leaves her husband to return to the home of her mother for the remainder of the pregnancy, birth, and early postpartum.

Study participants described the change in their lives after giving birth as “a different kind of happiness.” One new mother indicated that previously her happiness was “working and was very free to go outside and roam with friends.” Now she no longer enjoys that kind of pleasure but stated, “I feel happy being a good mother. It’s nice taking care of the baby.” This change in life was described by another new mother that when she was young her mother took care of her, but now that she was married and had a newborn, she needed to care for her infant, “It’s a great responsibility for me now, to take care of my child. It’s a nice way of life change, getting mature, and learning responsibility. It’s so nice.” Another woman felt that prior to having a family she was not considered mature but with a family she is mature and is considered truly a woman. The women also described henna being applied following giving birth to reduce sickness, depression, and to promote maternal/newborn attachment.

Following Postpartum Rituals and Ceremonies

Most study participants reported breastfeeding within an hour after birth followed by exclusive breastfeeding for 6 to 7 months. Some Indian women reported not breastfeeding immediately after birth because of the perception that the milk is “not ready.” Colostrum is discarded before putting the newborn to breast because it is “hard to digest.” Most newborns were given a prelacteal feeding immediately after birth, including hot water, honey, mustard oil, tea, or goat/cow milk. This practice is supported in the literature (Bandyopadhyay, 2009).

Mothers in the study frequently said they had their infants’ breath/inhale the smoke from incense to keep them healthy. They said that after bathing a baby and washing its hair, they would burn a particular type of incense on a small plate and then wave their hand and blow the smoke into the baby’s face. The inhaled smoke is meant to help the hair dry out and more importantly kill any germs that might make the baby sick.

Study participants also claimed that providing good infant care included delaying infant bathing. This was frequently delayed for 9 days, but some claimed they would wait until the infant was 3 months old to give it a bath. One new mother stated the reason for this as “before nine days they will get a fever if they have a bath.”

The mothers described applying “bindi” or black dots using carbon based eye makeup or ashes on the faces of their newborns to ward off evil spirits. Threads or small ropes were also ceremoniously tied around the wrist, ankle or neck to protect the newborn from evil spirits. The women buried the placenta near their home, and a ceremony is held on the ninth postpartum day at the site of the placental burial to name the child. According to Hindu tradition, a boy’s name has an even number of syllables and a girl’s name an odd number. Common Hindu names include for a boy “Ravi” meaning “sun” and for a girl “Priya” meaning “loved one.”

The women described the importance of following the “hot/cold” theory. High protein, acidic, and salty foods such as lentils, millet, aubergines, and grapes are considered “hot.” “Cold” foods such as potatoes, milk, and white sugar are often sweet. Women reported consuming foods such as milk, ghee, butter, and fish to increase the quality of breast milk and improve maternal health. Eating quantities of garlic is thought to “dry the womb.” Such practices are also described in the literature (Gatrad, Ray, & Sheikh, 2004). Women participating in this study often indicated they were encouraged to avoid “cold” foods such as mangos and papaya. Hot foods were encouraged for nausea or in the postpartum period.

Having a Desire to Give their Children the Best That Life Circumstances Allow

These women reported an increased sense of responsibility as they became mothers. Before giving birth they were often focused on their own needs and desires, after giving birth they focused on the well-being of their newborn. One of the participants that did not know her age and had no formal education indicated her desires for her children were that, “they grow up very good and they go to a good school.” Other comments include, “Now it is my duty to make my children study and to give them the good life.” “I will now need to look after my baby very carefully.” “Before, I was not worried about anything. But now I worry about my child and want to be proud of him.” “Now that I’m a mother I’m wondering what I’m going to do for my child and am thinking about the future.”

Discussion and Clinical Implications

Save the Children (2011) has identified why investments by the United States to improve basic healthcare for women and children are essential, concluding that the health of women and children globally has an impact on
national security, economic growth, and the environment in our own country. Global efforts to provide women with quality care during pregnancy and birth should include increasing women’s access to quality midwifery services (United Nations Population Fund, 2011). Understanding the perspectives of mothers in low resource countries about their health and well-being and that of their children is critical.

This study underscores the importance of understanding the social determinants of health, including reproductive health and quality of life. In a study of Indian women of childbearing age living in Goa, India, findings suggested that variables such as physical, psychosocial, sociocultural, educational, and economic should be assessed because they are important determinants of reproductive health and quality of life (D’Souza, Somayaji, & Nairy, 2011). This is affirmed by Paruzzolo and associates (2010) in a Women Deliver document targeting poverty and gender inequality to improve maternal health.

This is supported in a Countdown to 2015 evaluation of progress toward meeting the Millennium Development Goals in 68 priority countries, including India. Social and environmental factors evaluated include equity in socioeconomic status, gender, and geography (Bhutta et al., 2010). The authors suggest that social determinants are significant barriers, and recommend that “increased education of women, improved sex equality, comprehensive family planning services... and strengthening of women’s empowerment in decision making about seeking care are essential elements of strategies to improve maternal health” (Bhutta, et al., 2010, p. 2043).

A limitation of this study is that it may not reflect the experiences of all women giving birth in this area of Tamil Nadu, India or in other Indian states. Different experiences may be reported by women giving birth at home, private hospitals, or a public hospital in a different region. These women were unaccustomed to being asked about their thoughts and feelings, and some expressed appreciation that the investigator and translator would take the time to listen to their perspectives about bearing and child. The importance of listening to the voices of women was affirmed by study participants.

The clinical environment should reflect respect for the diversity of women served (Maddalena, 2009). Nurses should gain an understanding of and respect for cultural beliefs and practices, including those of southeast Indian women. There are important implications for clinical practice, which are summarized in Table 1. Nurses should seek to develop a relationship of trust, with interactions characterized by openness, understanding, and respect. There are cultural beliefs and practices associated with childbearing in all cultures. It is important for nurses caring for childbearing women from this region of India to be aware of the social norms found among these women. Women value the ability to bear children and anticipate becoming a mother. Although there is little perinatal education, women typically expect an unmedicated birth. Often these young women may experience abuse from their mother-in-law and/or her husband, and should be assessed for such. A new mother will breastfeed, display a gender preference for a male child, and may request to take the placenta home for postpartum rituals. It is important for nurses to understand and support a woman’s dietary preferences and restrictions and the perceived impact on a woman’s health related to intake of hot/cold food items and support those preferences where feasible.

![Table 1: Clinical Implications](image)

- Listen to the voices of women to guide clinical care.
- Recognize the importance placed on cultural rituals surrounding birth in southeast Indian women, and honor those rituals that are helpful or harmless.
- Change harmful cultural practices such as infant smoke inhalation by educating women, making changes in their perceptions and attitudes.
- Follow WHO guidelines for perinatal/neonatal care. Achieving quality care in low resource settings is the key to the attainment of Millennium Development Goals #4 and #5. The quality and safety of healthcare should be monitored.
- Promote initiatives to decrease family violence.
- Support health policy initiatives encouraging female equity, such as banning dowries and female infanticide.
- Recognize the importance of food preferences and restrictions and the perceived impact on a woman’s health related to intake of hot/cold food items and support those preferences where feasible.

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The authors declare no conflicts of interest.