

On Pregnancy

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The experience of pregnancy encompasses physiological, psychological, spiritual, and socio-cultural dimensions. Because the future of any given culture depends heavily on women's procreative abilities, these abilities carry strong social significance. Thus, every culture takes upon itself the regulation and management of women's pregnancies. In other words, pregnancy is never an unmarked category; in every society, it is the occasion for special attention and specialized treatment, in forms that vary widely. In Polynesia, for example, the news of a pregnancy is greeted with great joy. Pregnant women move about freely, are nurtured and pampered throughout, their every whim is honored, and the midwife arrives regularly to administer massage. In contrast, the refined ladies of the Victorian upper classes in England and the U.S. were confined to their homes during pregnancy. This society saw sexuality as shameful and pregnancy as blatant evidence of sexual activity, expressing these beliefs in the removal of pregnant women from the social gaze (Leavitt 1986).

The cultural variation in beliefs about pregnancy begins with beliefs about the causes of conception, which can express meanings and values central to the organization and identity of a culture. In the Basque country of France, for example, shepherders understand conception as analogous to cheese-making: the semen of the man causes the woman's blood to curdle to form the baby, just as rennet curdles milk (Ott 1979). Behavior may mirror belief: because the Hua of New Guinea believe that conception is caused by the mixing of menstrual blood and semen, newly pregnant women have sex frequently in order to provide sufficient semen for fetal development (Meigs 1986). The Trobrianders, also of New Guinea, believe that conception results when a spirit child--formerly a Trobriander who died--enters a woman's womb and mixes with her menstrual blood. The elimination of the father's role in conception reflects the matrilineality of Trobriand society (descent is traced from mother to daughter) and the sexual freedom such a belief allows (Weiner 1993).

In many societies, the role of the woman is minimized. The Malays believe that a baby is formed in the father's brain, dropping down to his chest, where it receives human emotions, and then is thrust into the mother's womb, where, implanted, it grows like a seed--a belief which gives active agency to the man (Laderman 1983). This association of men with the creative seed, and women with nurturant soil, is common to all three of the monotheistic and male-dominant religions of the Abrahamic tradition (Judaism, Islam, and Christianity) which have informed folk theories of conception in the West and many parts of the East for millenia (Delaney 1991). Some patrilineal societies take male agency to an extreme: for example, in some Islamic societies a wife's pregnancy is the means by which the husband perpetuates his patrilineage and ensures its purity; thus women's sexuality is tightly controlled through the institution of purdah (veiling and seclusion).

Until the recent appearance of technological innovations such as pregnancy tests, pregnancy could only be confirmed by women themselves, who had privileged access to the sensations of the baby's movement inside their bodies. In many cultures, until such "quickening" was experienced, women might purposefully refrain from interpreting the cessation of menstruation as a sign of pregnancy. In cultures in which health is predicated on the unobstructed flow of bodily fluids, such as Colombia, Jamaica, and rural Greece, late periods are inherently ambiguous, and may be blamed on unhealthy blockages and obstructions, so that women may take a variety of herbs or other substances (such as the cure-all "washout" in Jamaica) to "unblock menstruation" and restore health (Sobo 1993, Newman 1985). Such beliefs and practices provide women with some control over pregnancy, while leaving intact the high value placed on fertility in these cultures.

Many cultures ritually proscribe the consumption of certain foods during pregnancy, and encourage that of others. According to Malay humoral beliefs, a "cool" state is ideal for pregnancy; thus foods with "heating" qualities, such as certain fruits, should be avoided (Laderman 1983: 75-76). Among the Ewe of West Africa, pregnant women consume an edible clay rich in nutrients, which is comparable to the nutritional supplements prescribed in industrialized societies (Farb and Armelagos 1980: 89). In rural Greece, a pregnant woman's food cravings are not to be denied: if she desires olives, for example, she must be given them, or moles shaped like olives will mark the child. Other behaviors may also be pre- or proscribed: Tanala women in Malagasy are enjoined not to touch black-eyed beans, lest their

children be born with black spots; in Europe and the United States, many people believe that a mother's emotions and stress level during pregnancy will affect the psychological health of her child. Across cultures, such prescriptions and proscriptions reflect variations in cultural understandings of the symbiotic relationship between the mother and her baby, as well as the importance of their wellbeing to their society's future. Such cultural rules are far from absolute: women everywhere demonstrate a wide range of choice in their degree of compliance.

In the United States, most pregnancy pre- and proscriptions emerge from the medical domain, which has become in the 20th century the primary source of culturally-recognized "authoritative knowledge" (Jordan 1993; Davis-Floyd and Sargent 1996) on pregnancy and birth. This authority is contested by the midwifery and home birth movements, which resist the technological interventions of the medical management of pregnancy in favor of a more holistic and nurturant approach to prenatal care (Davis-Floyd 1992). Midwives provide prenatal care in most countries. Where such care is physician-controlled, as in the U.S., poor women tend to have inadequate access to it--a partial cause of the higher rates of problem pregnancies in low-income women (Lazarus 1989).

In many cultures, the success of a pregnancy is thought to depend on the observance of ritual behaviors by a woman's husband. Known as the **couvade** (most likely after the old French verb *couver*, meaning "to hatch"), this term refers to both pre- and postnatal behaviors that experientially link the father to the pregnancy. Among the Malays, fathers-to-be should avoid obstructing the entrance to their houses and should not engage in careless destruction of animals. In some parts of rural Greece, men loosened their belts toward the end of their wives' pregnancy to promote an easy birth. In some South American cultures, a man observes the same food taboos as his wife during pregnancy, retires to a private hut attended by male companions when she goes into labor, and mimics her labor pains. European and North American fathers show their identification and involvement with their partner's pregnancy through attending childbirth education classes and accompanying her during labor and birth, and sometimes through developing symptoms such as nausea, vomiting, and abdominal pain which disappear after the birth.

In the West, the male role in reproduction has extended well beyond the couvade into increasing control by technological "experts" of all aspects of the reproductive process, from conception through birth.

The Western belief that pregnancy is caused exclusively by the union of sperm and egg mirrors the Cartesian mechanistic and science-oriented worldview, and has potentiated the development of New Reproductive Technologies (NRTs) such as in-vitro fertilization, artificial insemination of the woman with donor sperm, egg and embryo transplants, and surrogacy. These NRTs, which separate the act of conception from its relational context, make it possible for post-menopausal women to bear children, and for one child to have multiple biological parents. Along with the new diagnostic technologies, such as amniocentesis and ultrasound (which make it possible for genetic defects to be diagnosed before birth), NRTs are necessitating profound re-thinking of notions of kinship, parental rights and relations, women's rights to control of their bodies, and reproductive law in many countries. For example, in India, the use of amniocentesis and selective abortion to ensure that the first child will be a boy is altering the male/female population ratio in some provinces (Miller 1987). Anthropologists have begun to address such issues in depth, as the anthropology of pregnancy and birth (Jordan 1978, 1993) has expanded, over the last decade, into the anthropology of reproduction (Ginsburg and Rapp 1995).

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