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CULTURAL INFLUENCES ON HEALTH BEHAVIOUR AND PRACTICES RELATED TO MOTHER AND CHILD HEALTH

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ABSTRACT

The 1000 day window is critical to the health of not only the child but also the mother, as almost all maternal and infant morbidity and mortality, arises from this period. The strong intersection of the biological and the social, along with other factors, during this period, translates into health outcomes for the mother and her child. Among the social aspects, the influence of culture on the health of the mother and child remains a very critical determinant of the MCH health outcomes. This paper attempts to review systematically, the prominent cultural practices around mother and child health, around the world, which translates into positive or negative health outcomes. The paper also highlights the limited availability of such literature in India..

1. Introduction

Maternal health is important to any society due to its profound effects on the health of women, survival of the newborn, well-being of children, that of families and ultimately of any nation. A number of studies have pointed out that health is inseparable from cultural perceptions of wellbeing and illness. Perceptions on health are often shaped by cultural beliefs and practices of a society. The significance to health information is interpreted in cultural systems of values, thereby impacting the care processes. Social and cultural influences not only shape health behaviour, but also construct the major perceptions of health. While culture is an influential and vigorous concept, it may not be overtly expressed, but their effects are pervasive. However, the influence of cultural systems of values on health outcomes is significant, across the length and breadth of various cultures (Napier, et al, 2014).

The Lancet commission recommends the following definition of culture: 'The shared, overt and covert understandings that constitute conventions and practices, and the ideas, symbols, and concrete artefacts that sustain conventions and practices, and make them meaningful'. Culture can be understood as a set of ideas, customs and behaviours shared by a group of people or community. It differs across nations. These customs and behaviours are particular to the members of that community or society and distinguish them from other groups. There are several possible factors influencing any culture, thereby resulting in great diversity across nations. In the context of maternal health, the culture is shaped by ethnicity, language, religion and spiritual beliefs, socio-economic class, age, sexual orientation, geographic origin, group history, education and so on.

Culture is often learned and passed on through generations, thereby passing on the cultural practices related to maternal and child health through different generations which becomes integral to the life of people following and believing in that 'culture'. Culture influences health practices particularly maternal and child health in every community. Both the pregnant mother and care provider's beliefs and practices are influenced by historically dominant cultures. Health-related preferences and perceptions are based on cultural practices which may or may not adhere to mainstream health practices often prescribed by health professionals.

The cultural influences on the health of the mother and the child, is an emerging body of knowledge, which relates the normative and cultural practices to the health and wellbeing of the mother and the child. In this paper, the one thousand days (from pregnancy till the child is two years of age), corresponds to the term mother and child health. This paper attempts to synthesize the various practices and behaviours, which are influenced by cultural realm and which affect the health of the mother and child.

2. Methodology

The paper is based on review of literature focussing on cultural or traditional practices and beliefs influencing mother and child health. We systematically searched the following electronic databases from 1990 to 2016: Proquest, Google Scholar, Science Direct, and Web of Science. The abstracts were reviewed in the preliminary round, discarding studies which did not fit the inclusion criteria. The second round of screening involved assessing the quality of the study, after which 23 articles were selected. The subsequent sections would unfold the themes relating to cultural practices and its influence on health behaviour.

3. Birth Preparedness/Ante-Natal Care/ Child-Birth

Various studies were reviewed on the theme of preparedness for birthing, ante-natal care and on childbirth which delineated how cultural practices across geographies determined safe or unsafe health practices. A qualitative study conducted by Nigenda et al (2003), carried out in four developing countries - Cuba, Thailand, Saudi Arabia and Argentina, attempted to explore the thematic cultural based interpretations of illness, health care supply and ANC experiences etc. Concepts about pregnancy varied across countries and in certain cases, positive association between these concepts and the cultural framework could be identified, as in the case of Saudi Arabia or Thailand, but not in case of Argentina and Cuba, where the concepts had a more live-in experiential interpretation. In the instance of Saudi Arabia, the distinct effect of how religious values define the concepts and practices related to pregnancy, delivery and child birth was predominately visible. In the case of Cuba, the amalgamation of catholic and African religious values yielded a cultural framework which emphasized on the technical knowledge imparted by the caregivers. Regardless of the framework of cultural values underlying women's thinking in each society, the view that younger ages are better for pregnancy is present across countries. Differences may be explained by the different social roles assigned to women at different ages.

It was found that there is a prohibition specific to culture on eating certain food in Thailand. Another culturally defined custom referred to by women was that men should stop working in order to be near the women from the final stages of pregnancy until some days after the delivery, but this is not followed by all men. The preference for midwives, among Thai women, was accentuated, primarily because of the evident link with their culture. Whereas, in Saudi Arabia, the preference for female providers was quite strong, this can be traced to the way in which the Saudi society separates men and women. However, receiving care from a male doctor was also acceptable, with the presence of a female nurse, in accordance with the cultural rule. In Cuba, women had no such inhibition with reference to an

examination by a male doctor. In Thailand and Saudi Arabia, the information received by the health personnel is not questioned, but is interpreted according to traditional cultural values.

In mid and far western Nepal, it was found that most of the women chose to deliver at home. In such cases, the women were ashamed to deliver, even at a nearby health facility. A stringent cultural practice of isolating the women and her child, for a few days after delivery, also discouraged them from accessing health care services. Since women who have just delivered are considered impure culturally, there is a prohibition on them to pass if there is a temple on the way to a health centre. Also, many families did not prefer for the women to have a delivery at a health facility, because of a pervasive fear of evil spirits (Onta, Choulagai, Shrestha, Subedi, P. Bhandarai, & Krettek, 2014). Many husbands did not allow their wives to access a health facility, purely on the ground of traditional beliefs. Domian's (2001) ethnographic research in Rio Arriba County in New Mexico identified among other themes relevant to cultural practices, the cultural preservation through anchors of meanings. Beliefs preserve a culture by guiding members to connect via shared lived experiences. Family members expressed overwhelming support and acceptance of pregnancy, even for unplanned and teen pregnancies. Positive birth outcomes were facilitated by a cultural orientation that fostered social support for the pregnant women. In South Sudan, among the Fertit community, conceiving early after marriage is approved culturally, with a pervasive belief among both the sexes that pregnancy is God's will (Kane, Kok, Rial, Matere, Dieleman, & Broerse, 2016).

A qualitative study (Lori, et al,2014) in urban Ghana, which was undertaken to explore the perceptions and understandings of danger signs during pregnancy, birth preparedness and complication readiness, found that one of the most significant obstacle in health service utilization, was the deep embedded cultural belief in alternative medicine. Birth preparedness often meant culturally, the physical acts of preparation, such as cleansing of the body and buying essential things for labour. In cases of sickness of the baby, the mother sought the advice of older family members, which among other remedies, ensued visits to the herbalists as sickness was perceived as a supernatural issue, which ended in delayed lifesaving treatment.

In Eastern Sudan, (Serizawa, et al, 2013), the strong belief among village women that most of the pregnancies could be managed locally, without any expert's help, on account of the years of accumulation of experiences of pregnancy and delivery. This was a significant barrier in accessing health centres for ANC. The omnipresent belief in the susceptibility to witchcraft, the cultural mandate for the mother and newborn to stay at home for 40 days, inhibited access to any post natal care. TBAs remain the first choice for assisting in child births at home, which also helped in subsequent cultural practices like *Ammar.* In Africa, traditional medicines are advised by the TBA to widen the birth canal and speed labour. In Zambia,

traditional herbs are administered to the woman who admits being unfaithful to her husband, in case of prolonged labour (Raman, et al, 2016).

A qualitative study on Cambodian refugee women in the USA, (A.Frye, 1991), found that in the Cambodian culture, childbearing women were perceived at high risk for death. A culturally defined disease *'toa'*, which resulted in a cold state and collapse of the women after childbirth. This was culturally attributable to the failure in adherence to equilibrium enhancing practices during the childbearing period. Toa could be managed by oppositional treatment like the intake of hot food, and avoidance of emotional stress and sexual intercourse.

In Japan (Miyaji & Lock, 1994), pregnancy and childbirth are seen as family events, with a focus on a number of traditional customs, initiated by the extended family. One such custom is *Omiyamairi*, which involves praying at a Shinto shrine which 'specializes' in safe birth. A pregnancy sash, called *obi*, is wrapped around the abdomen of the pregnant women. The sash is symbolically believed to protect the uterus from cold, keep the foetus stable and prevent it from becoming too big. Motherhood and maternal identity is emphasised in the Japanese culture, and the mother is valued and respected in the society even though the social status of women may be low.

In Bangladesh (Darmstadt et. al, 2006), childbirth is considered a natural event, yet is regarded as a delicate and vulnerable state. A very strong cultural belief is that delivery will be delayed, if more people get to know about it and therefore, there is an overall reluctance in preparing for delivery. Dangers during delivery are perceived as mainly wild spirits who may possess the women if she had ventured outside the home. *Mowlana or fakir*, who is spiritual healers, is brought in to resolve difficulties in childbirth. A number of practices for speeding up deliveries, are followed by the traditional birth attendants which include abdominal massage , standing up on or pushing the mother's abdomen with their knees, kicking the mother's waist (believed to protect the unborn child from evil spirits), putting a number of substances(juices, mustard oil, coconut oil, soap water) in the mother's vagina, placing a Mariam flower in water and the present women to untie their hair, amulets being tied to the thigh of the mother and snails being broken over her forehead. Some other practices to speed up delivery may be asking the mother to reverse and wear their saree, being made to eat molasses juice and hair and rages and sometimes even kerosene so as to induce vomiting, given the water which was used to wash the legs of the father-in-law, eating uncooked fresh duck eggs and squatting during delivery. Many such practices are also adopted for the speedy delivery of the placenta, which is considered to have spiritual value. It is also believed that placenta can grow inside the body and move up to the throat and choke the women to death, if not removed immediately. Forceful massages of the abdomen, is done by the TBA to eject the clotted blood from the uterus. The placenta being considered as the source of the baby's life, is delivered

before the cord is cut. If the baby is lifeless after birth, the placenta is squeezed and massaged to bring a flow of life from the placenta to the baby. The placenta, while attached to the baby, is heated and fried, if the baby is not able to breath. To make the baby cry, the TBA may pour water on the baby's cord; blow into the mouth of the baby as well as striking the baby heavily on the back. Old razor blade, bamboo slices are used to cut the cord, along with the application of some materials (ashes, earth from the oven, lamp soot, dry cow dung), to the baby stumps. The cord is usually tied with dirty threads (from threads used for sewing or jute fibres). The TBAs in most cases do not cut the cord as they will become unholy for the next 41 days and will not be able to pray and in most cases, the mother has to cut the cord. In cases, a young child who has not yet begun to pray will be made to cut the cord. The blood from the cord is put in the baby's mouth and smeared over the chest and back, as culturally this is believed to enhance the bonding between the mother and the baby. Newborn babies are wrapped with dirty clothes/rags and usually bathed on the very first day.

Births in Ethiopia are given in kneeling positions, in secluded areas near their homes, with older women who assist during the birth. The new born and the mother spend the first seven days with a female relative. On the eight day, in case the baby is a boy, he is circumscribed, after which he, along with the mother, moves to a separate hut(hut of birth) for 40 days. In case of a baby girl, the move to the hut of the birth happens after 14 days and remains there for the next 80 days, in seclusion. At the end of this period of seclusion, the mother cleans herself in the river and returns home (Mendlinger & Cwikel, 2006). The studies reiterate the linkage of culture and maternal and child health and how it is impacted by cultural beliefs and practices of different communities.

4. Postpartum Period

Health-seeking behaviour differs from culture to culture. When we reviewed studies conducted in Kwale, Kenya, we found that after child birth, mothers observe a period of 'pollution', for 40 days that is called *arobani* (40 days in Swahili). This involves segregation from the other family members, especially the males. There is a prohibition on sexual intercourse. The babies though are not included in the state of pollution, yet they remain inaccessible due to their presence with the mother. A very strong reason for the new-borns to be secluded is the perceived vulnerability to evil spirit (Matsuyama, et al, 2013). The importance of postpartum break in Ethiopia is culturally quite significant, in which the new mother is cared for by the other women, which allows her to bond with the newborn and recover from the childbirth (Mendlinger & Cwikel, 2006).

Post-delivery, the mother is expected to remain inside the house at all times to avoid evil spirits and they are strictly forbidden to go out in the dark, in the afternoon, in a storm, after cooking, near a tube well, with their hair

down or with their *saree*, touching the ground, so as not to attract evil spirits. It is a common practice to keep a piece of iron close to the baby and a leather item near the bed, to ward off evil spirits (Darmstadt, et al, 2006).
Unless it gets quite heavy, postpartum bleeding is not seen as a matter of concern. It is understood that the elimination of certain quantity of blood is beneficial to the mother, as the impure and dirty blood from the womb is best to be dispelled. A woman who does not bleed sufficiently recovers slowly and may develop complications. Postpartum haemorrhage is recognised too late to save the life of the mother. It is also believed that excessive bleeding may turn the mother into mad women (Zeitlyn & Rowshan, 1997). Local cultures influence maternal health and can result in adverse health consequences even leading to maternal mortality.

5. Family Planning

The fertility declines have been comparatively low in Tanzania, even in the presence of availability and accessibility to modern contraception. Keele et al (2005), qualitative study in Tanzania, aimed at unearthing the cultural barriers to the adoption of modern contraceptive methods, found deeply embedded religious barriers to modern contraception. The prescriptive contraceptive methods promoted by religious leaders, were coitus interruption and breastfeeding for two years, on account of being natural and ethical. Abstinence which is deeply rooted in Islamic tradition and is culturally approved as a fertility control method is the norm, which promotes the women to live in their maternal homes for up to two years. Contraception related decisions are made by men, in the patriarchal norm and acceptance of polygyny, which further restricts the women from any say in the decisions making on limiting fertility. There are very strong socio-cultural disapprovals against using modern contraception, which makes it '*haram*', and vasectomy is considered unethical in Urban Sudan (Eldahab, 1993).
In Albania (Nielsen, et al, 2012), though it was considered legitimate to have sex once a couple got engaged, however the use of modern contraception was socio-culturally frowned upon. This discouraged young women from adopting any family planning method. The low use of modern contraception in Albania, which has a significant population of married women who rely solely on traditional methods such as withdrawal, which were handed down between generations, as it was the only legal method as modern contraception and abortion were legally banned in Albania, until about 20 years back.
Kane et al (2016), conducted a qualitative study in the state of western Bahr el Ghazal (WBeG) in South Sudan to explore the social norms shaping decisions about family planning among the Fertit community. While pregnancy was considered as god's will, it was desirable to have as many children as possible, which was a women's primary duty. A number of

beliefs on spacing existed, which frowned upon immediate pregnancies, and considered it detrimental to the health of the unborn child and the women. A strong local belief that if a woman conceives again before her previous child has started walking is harmful to the health of the unborn child. This forms an inherent understanding among men and women, about how spacing is traditionally intertwined in their culture. However, normatively men and women both are expected to bear multiple children, or else they incur social disapproval and even ostracism. Abstinence was used as the common method of spacing, among the Fertit women. During this period of abstinence, the husband could establish sexual relations with other women, with cooperation from their wives, as a culturally approved practice. Entrenched patriarchal norms left women, with no role in the decision making around their reproductive lives.

Findings (Kane, Kok, Rial, Matere, Dieleman, & Broerse, 2016) clearly show that while both men and women desire to have many children, they have a good knowledge of the importance and benefits of spacing pregnancies and of using modern contraceptives to do so. This knowledge and positive attitudes towards spacing is however failing to translate into decisions to use contraceptives. On one hand, social norms around pregnancy and child bearing and the entrenched patriarchal privileges intersect to concentrate and maintain decision making powers in the domestic, economic and public realms in men's hands and the constraint Fertit women's agency in the reproductive realm. On the other hand, it is also recognised that men's agency in the reproductive realm is perhaps similar constrained by these social norms and by the very hegemonic patriarchy that privileges men.

In Eastern Sudan, the cultural underpinnings positioned having multiple children as beneficial for the family and progress of the community. Fertility was considered natural and controlling it was seen as against God's will. Continued breastfeeding as a natural contraception method was preferred and children up to two years or older were continually breastfed (Serizawa, et al, 2013), to avoid pregnancies. Traditional cultural practices, often patriarchal in nature, influences health seeking behaviour of women.

6. Infant and child Nutrition

Interpretations of breastfeeding vary across cultures, depending largely on the social, economic and perceptual factors. In an ethnographic study of Navajo's traditional beliefs on breastfeeding (Wrigth, et al, 1993), it was found that breastfeeding is an integral component of the traditional Navajo behaviour, where breast milk is considered a sacred fluid, in addition to blood and semen. The Navajo beliefs, see babies to be created from these fluids of the mother and father. Post birth, four days of sacred care of the mother and baby was done, during which the baby was continually fed from the mother's breast. The mother is expected to be responsible to take care of

her diet and to drink broth, eat a lot of food and avoid chillies, so as to provide maximum nourishment and successful life of the baby. There is a strong belief that breastfeeding not only provides nourishment to the baby, but also provides a number of psychological benefits. Firstly, through breastfeeding, a woman marks the child as her own as well as a human and passes the traditional value along with some of her qualities to the baby. Bottle feeding is not considered as the correct way of feeding a child and it is felt that such children are unloved and permanently damaged by neglect, which may lead to aberrant behaviour. Traditionally, breastfed children are seen as more compliant to traditional teachings and well behaved.

Zeitlyn and Rowshan (1997), in their study in Bangladesh, used data gathered in two anthropological studies undertaken between 1987 and 1992, found that colostrums is viewed negatively at times, as it is thick and appears to be similar to pus or thick stagnated blood. The quality of milk is dependent on the mother's diet and behaviour. Cooling foods were to be avoided by the mothers of sick babies. Evil spirits or *batash* (wind), were the most cited reasons for the crying and other sickness among babies, which could strike by spoiling the mother's milk. As a common practice, mothers would either spit on their breast or express a few drops before nursing their babies. The mother's strength and power (*shokti*), is transferred to the baby through the breast milk, thereby enhancing the bond between the mother and her baby. Another belief is that when a woman stops breastfeeding, her milk 'drops to her womb', to form blood for the next child. The belief in kinship developed through breastfeeding is so strong that children fed by the same woman cannot marry, even if they are unrelated. Zou et al (2010) in their study among Chinese mothers in Ireland found that even though the breastfeeding rates in China are quite high, it is not often the case with Chinese immigrants in the western countries. However, around 85% of the respondents did consider that certain types of traditional diets benefit breast milk production, while some diets have a harmful effect. In another study in Bangladesh (Darmstadt, et al, 2006), it was found that breastfeeding is delayed till the mother is cleaned to a 'holy state', and could go upto three days. Colostrums are viewed as dirty milk and is believed to cause harmful and evil, which will make the child sick.

Underwood et al (1997), in their study on infant feeding practices among low income African American women in an inner city community in Wisconsin, that cultural influences regarding infant feeding decisions were quite strong, which permeated in their value and beliefs regarding the type of feeding, feeding schedule, amount of feeding as well as the introduction of cereals and solid foods. Most of the respondents described how they had learned these practices from their family as well as other community members. One finding was that when these women encountered a feeding issue and when challenged by associated costs, they tended to rely on their own experiences as well as the wisdom of their cultural groups, even in the case of having sufficient knowledge on the science of infant feeding

practices. Majority of their beliefs and values had been imbibed, either directly or indirectly, from cultural traditions, lay experts, experiential learning etc.

Matsuyama e t al (2013), found that a perception of the mother regarding the insufficiency of her breast milk, was used as a common justification for feeding the baby with uji (maize-based porridge), cow's milk, ugali (staple food made of maize), banana, potato, bean soup or drink including water, tea and orange juice. The opinion of influential people like mother in law was an important contributor in this perceived notion of insufficient breast milk. *Kuria*, a condition of continuous crying, especially during *arobani*, was perceived as an illness caused due to insufficient milk or the evil spirit. Incessant cold and cough among babies was ascribed to be caused due to the heavy loads carried by the mother during pregnancy.

Raman et al (2016) synthesis of literature in LMICs, established that breastfeeding is embedded in most of the cultures, with differences in actual practices. In rural Laos, there was a focus on hygiene of the mother and child before putting the baby to the breast, which included the ritual of massaging fire ash around the breast when wet. In Pakistan, the ideal duration of breastfeeding was seen as up to two years, while in Turkey, the belief was different in which a pregnant woman should not breastfeed her child. Pre lacteals were common in South Asia- Hot water, sugar water, honey etc in India; sugar water, banana in Bangladesh; *ghutti* in northern India and Pakistan; Glucose, water sugar, salt in Uganda. In rural Nigeria, it was believed that the child could get diarrhoea, if the breastfeeding mother slept with her husband. In Ghana, the quality of the breast milk could be assessed by placing an ant in the milk; if the ant died, the milk was considered unfit for the baby. In Turkey, colostrums were believed to be dirty old milk stored in the breast for 9 months, which could kill the child.

A qualitative study among rural households on the Kenyan coast, Muraya et al (2016) attempted to understand the local and cultural understandings and perceptions related to nutrition and under nutrition among children. Three illnesses associated with child under nutrition- *kwashiorkor*, *kirwa and lugwizo,* were culturally perceived to be serious and could adversely impact the children's health. While Kwashiorkor was understood more so in terms of purely bodily aspects and were attributed to insufficient food intake and early weaning, with other indirect reasons as poor spacing among children etc, Kirwa was understood as an illness that resulted due to non-adherence to the cultural prescriptions relating to sexual relations i.e sexual infidelity by either of the parents during the pregnancy of the mother, which took away the strength of the child. Lugwizo was defined as caused by poor child spacing, in which the mother had to immediately stop feeding the child when she got pregnant. Also, in addition to these, evil spirits -*mapepo* was also blamed for the nutritional status of the child. *Kirwa* could be treated traditionally with herbs and other traditional medicines. Older women in the family played a pivotal role while treating Kirwa, before childbirth. The

health of the infant and child nutrition is part of the cultural practices and beliefs and their health outcomes are dependent on social and cultural variables.

7. Maternal Nutrition

Maternal nutrition is yet another theme around which we reviewed the relevant literature and found out that the concept of hot and cold foods are quite widespread over the world, but with unclear parameters of such classification. Nag (1994), in a systematic review found that the concept of hot and cold food is equally prevalent in India, and are mainly graded in context to pregnancy, childbirth and menstruation. Hot food items are perceived to be harmful for pregnant women, while cold food is considered beneficial. There is a focus on maintaining equilibrium between the 'hot state', which pregnancy ensues by taking cold food. There are regional level variations which classify food as hot or cold, however there is an overall uniformity in perception of animal food as being hot. It is believed that hot food makes the babies too large and therefore the practice of 'eating-down', during pregnancy is quite common in India, which negatively impacts the nutritional status of the women. Another quite potent belief is that pregnancy and delivery become difficult in case of increased consumption of food.

Oni and Tukur (2012), study on identifying pregnant women who are likely to keep food taboos, in Saki East Local Government of Oyo state, Nigeria, found that an almost fatalistic belief that the weight of the baby was predestined and could not be influenced by what the mother ate during the pregnancy. Most of the respondents agreed that the practice of adherence to certain food taboos existed in their community and was followed by most of the pregnant women. Eating snails or okro could make the baby drool, bush animals could bring an evil spirit to the pregnant women, which could result in the delivery of a monster and drinking cocoa containing beverages will make the baby very big and result in a difficult labour.

Another widespread belief was about the healing properties of certain food especially in Africa and Asia. In Myanmar, women drank and smeared turmeric to prevent pain. In Kenya, soil eating is practised, as women believe that soil enhances the volume and condition of blood in the body, which affects the *tsango* (guardian of the body's health and fertility) (Raman, et al, 2016). In Bangladesh, various factors, including cultural beliefs determine the nutritional status of pregnant women, especially during her first pregnancy, in which she is completely dependent on her mother in law, for her wellbeing. Since the children and men are given priority for food, there are no special food entitlements for the pregnant women. Culturally, there are opposing view on the diet of the pregnant women- the belief that a pregnant women should keep her stomach full, will ensure that the baby does not grows too big, exists simultaneously, with the

belief that pregnant women should eat less, which will leave the space for the growth of the baby and will also not restrict her movement and growth. A practice of shaming by village elders may happen with pregnant women who may eat adequately. If a pregnant woman feels sick or has problems with digestion, she reduces her movement and observes a strict er*purdah* (seclusion, avoidance of exposure). While rice is perceived as an essential food for pregnant women, other side dishes, even vegetables, are considered relatively unimportant. Pregnant women in rural Bangladesh may consume wheat bread only.

Darmstadt et. al. (2006) found that in Bangladesh, a number of dietary restrictions are imposed during pregnancy and post-partum period, especially during the first 5-9 days. In certain cases, the woman who has just delivered is given no food at all after delivery, for speeding up the healing of the birth passage, while one rice meal a day is commonly practiced. Another practice is of restricting the maternal diet to mashed potatoes and bananas for seven days. Black cumin seed and green bananas are perceived to have a cooling effect on the women's stomach and help in initiation of the production of breast milk. The consumption of black cumin and rice is enforced by the mother-in-law for seven days after childbirth. The mother is encouraged to consume hot spicy food, as it is believed that it helps in the healing of the birth canal. Another predominant belief is that if a lactating mother has no appetite and eats forcefully, she could develop *Sutika*, which is chronic diarrhoea in the post-partum period, which may lead to problems in the next pregnancy, negatively affecting the health or character of the baby. The studies reviewed point out that social and cultural determinants play a pivotal role in maternal nutrition and how it has an impact on overall maternal health.

8. Conclusion

Health is a cultural concept as culture frames and shapes our perceptions and the world view. Our experiences are often based on cultural practices. The review of literature of various research studies discussed in this paper reflects how culture influences maternity, ante-natal care, childbirth, infant and child nutrition, postpartum care, maternal nutrition and family planning across different geographies. Each discussed culture believes in a different approach towards each stage of maternal and child health and may even believe they cannot change the course of events. Instead, they can only accept circumstances as they unfold. Culture is the primary determinant of popular beliefs of what is desirable and healthy. Culture affects diagnosis and acceptance of preventive or health measures.

The normative contexts in which most of these practices and behaviour are exhibited, delineates the pervasiveness of cultural influences on the health of the mother and child. It circumscribes the fact that culture should not be neglected in health care and that the local agency should not be discounted within the popular understandings of wellbeing related to mother and child

health. Also, this synthesis of literature points to the gap which exists in such literature, especially in India. This calls for a systematic research of such cultural influences, from the perspective of the community, the family and the mother.

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