CHAPTER 2

Concepts, Related Studies and Conceptual Framework

The concepts, related studies and conceptual framework are thoroughly reviewed in this chapter. In order to understand the pregnancy care practices of the displaced, pregnant Karen women, in terms of "how they take care [during] their pregnancy and how family relations is connected and/or reconnected" in the new location, I use three concepts to explore this social phenomenon, these being: (1) displacement (2) family relations, and (3) pregnancy caring practices.

2.1 Displacement

To understand displacement and "uprootedness", it is necessary to understand the commonsense ideas that exist regarding countries and roots, nations and national identities. Malkki (1992) discusses the metaphorical concept of having roots, meaning the linkages between people and place, with territorialization, clearly expressed in the conceptual, visual device of a map, also being evidence of this. However, the assumptions of linking people to place, nation to territory are not simply territorialization but deeply metaphysical. People are usually thinking themselves as being rooted in place and as deriving their identity from that rootedness. Motherland and Fatherland suggest that each nation is a grand genealogical tree, rooted in the soil that nourishes it. The concept of sedentarism is deeply metaphysical and deeply moral that shows sinking "peoples" and "cultures" into "national soils," and the "family of nations" into Mother Earth. Therefore, uprootedness or territorial displacement is presumed to be a pathological circumstance, and as a result, refugees or displaced people may be considered to have lost their moral bearings, because of their loss of bodily connection to their national homelands.

Turner (2005) carried out a study of Lukole refugee camp in north-western Tanzania, finding that the Tanzanian state has decided the refugees are a threat to nation-state security and so has placed them into an exceptional space – a space is governed differently to the rest of the national space, because its population is isolated

from the normal citizenry. The Tanzanian authorities and the UNHCR presume that the refugees, as helpless and passive victims in a humanitarian discourse, have no past and have lost all their cultural and moral codes during the process of being 'uprooted' from where they once belonged.

Following this, Grundy-Warr and Yin (2002) describe refugees and displaced persons as people who have been forced to flee from their homes as individuals or in groups, and have usually been torn from their established environment and their economic resources. As a result, they have lost their livelihoods and the means to generate an independent income and, as a result, have to depend on aid from agencies such as the UN. When refugees and displaced persons live in camps or organized settlements, condition can be damaging to their physical, psychological and social health and well-being, and living in such condition for a long time can also prevent people from maintaining links with family members and may lead to an erosion of cultural practices, those that to the socialization of children and help create a sense of identity.

However, Malkki (1992) argues that a new awareness of global social behaviors has recently emerged because people are constantly mobile, routinely displaced and so create homes and homelands in the absence of territorial and national bases. The author explores how the lived experience of exiles shapes the construction of national identity and historicity among two groups of Hutu refugees inhabiting two very different settings – an isolated refugee camp and the more fluid setting of Kigoma Township on Lake Tanganyika in Tanzania. The study shows that the refugees in the camp continually engage in an emotional construction and reconstruction of their history as a nation in exile; whereas, in contrast, the township refugees have tended to seek ways to assimilate, and have manipulate identities to adjust to their lives in the host society. The author argues that the camp refugees celebrate having a categorical "purity", in contrast to the township refugees' cosmopolitan "impurity", but that both kinds of identity are rhizomatic.

Gupta and Ferguson (2001) describe that the representations of space in social science are significantly dependent on images of break, rupture and disjunction. Most world maps describes the collection of "countries", inherently fragmented space, divided by different colors and shows each country has its own distinctive culture and

society. So, the classic "ethnographic maps" clearly display the spatial distribution of peoples, tribes, and cultures. The author argues that this expected isomorphism of space, place, and culture have been resulted in some significant problems. First, there is the issue of those who inhabit the border and those who cross borders more or less permanently such as immigrants, refugees, exiles and expatriates which shows the disjuncture of place and culture clearly. Second, there is the issue of culture differences within a locality, "multiculturalism", that challenge the mainstream idea. Third, there is the important question of postcoloniality which further problematizes the relationship between space and culture. Lastly, challenging the ruptured landscape of independent nations and autonomous cultures raises the question of understanding social change and cultural transformation as situated within interconnected spaces. In this case can also be explained the following situation by the approach of Appadurai, "the dynamics of global cultural systems as driven by the relationships among flow of persons, technologies, finance, information, and ideology" (Appadurai, 1996:47), lead to cultural change, what we may refer to as modernization, as all of these flows are modern phenomena.

Turner (2005) points out that refugees are not a blank slate when they enter a camp; they are not simply bare life, but that even though they treat the camp as an exception, they still attempt to inhabit the space and give it social and political meaning. As a result, they bring their politics and history, but in new, constantly contested and negotiated forms. Likewise, Sang Kook (2007) describes a very interesting case of displaced Karen, and how they develop the refugee camp into an "imagined hometown" in the absence of their own territorial space. He mentions the funeral service of the father-in-law of the local school's headmaster, who used to work with the Karen National Union (KNU), which is held in the School. After the ceremony, he wonders whether to bury the dead man in Mae La camp, showing that refugee camps seem to have become the final resting place of the Karen, in the absence of a homeland. So, it can be said that the refugee camp has become an "imagined hometown" in the real world.

In addition, Sang Kook (2001) tries to show how Karen refugees have adapted to camp life and a new situation in terms of the economy, culture and education, and investigates how their identities change in the refugee camp as they face new life

conditions since crossing the border and moving to the refugee camp. He says that the activities carried out by the Karen in order to cope with their new economic conditions are different from those they practiced in the past; they have attempted to create organizations to cope with their current situation and are involved in a wide range of socio-cultural activities.

2.2 Health Care System in Displacement

Berkfield (unknown year) mentions the dependency of the Karen on biomedicine practices in the village camp, showing that their over-reliance on INGOs – which provide emergency food rations, basic necessities like mosquito nets and clothes, and education and health care services – threatens the Karen refugee's cultural identity and their very survival upon repatriation. The author tries to show that the Karen who live in the camps tend to lose their rich herbal traditions, and most of the young also grow-up accustomed to going to the Out Patients Department (OPD) when sick. In contrast, the Karen who have migrated into smaller semi-secret villages in Thailand and the Karen who are struggling to survive in Burma continue to practice a traditional livelihood out of necessity. They possess the best understanding of traditional medicine based on the rich biodiversity of the forests because they have no other options. I argue though that this paper tends to see the Karen refugees as passive victims only, and so ignores how the agencies try to negotiate with and reconstruct their cultural practices in relation to health care – to help them make sense of their roles in the new location.

In contrast, Bodeker and Neumann (2012) focus on the impact of ongoing conflict on the traditional and spiritual health systems of Burma's persecuted ethnic minorities (particularly the Karen and Karenni), and how these populations have adapted their indigenous health systems to meet current, ongoing needs in the face of displacement and protracted conflict. Organizations such as GIFT (Global Initiative for Traditional Systems), the Backpack Health Worker Team, Mae Tao clinic and KDHW (Karen Department of Health and Welfare) have tried to revitalize traditional health services while serving thousands of refugees – to address some vital gaps in the provision of humanitarian care and to support cultural continuity and culturally appropriate care. This survey illustrates that patients have employed a very pluralistic approach towards health care in the camp, and the authors argue that the revitalization

of Karen medicine in the camp by organizations has focused entirely on herbal diagnosis, rather than offering a broader spiritual, philosophical or animistic approach, because of the Christian influence within these organizations. In this sense the authors shows that the revival and contextualization of Karen traditional medicine within a refugee camp setting has to be understood as an adaptive response, because the appropriate levels of scholarship and expertise are not readily available in the refugee context.

The above can be understood in line with what Gupta and Ferguson (2001) call, the "syncretic, adaptive politics and culture" of hybridity – that needed to fit or adjust to a new situation, and raises the questions regarding the imperialist and colonialist notions of purity and nationalism. This case can also be explained using the approach of Appadurai, who says that "the dynamics of global cultural systems as driven by the relationships among flow of persons, technologies, finance, information, and ideology" (Appadurai, 1996:47) lead to cultural change, or what we may refer to as modernization, as all of these flows are modern phenomena.

Similarly, McGinnis (2012) describes how, when people move from one culture to another in terms of the geographical and socio-cultural location, they try to adjust to make sense of their environment. The author specifically looks at how Burmese Karen refugees in the United States have negotiated and made sense of their new roles and expectations, and their traditional beliefs, within the reproductive context of the new country, by exploring their reproductive beliefs, practices and needs.

Hence, Gupta and Ferguson (2001) say that instead of ending with the notion of de-territorialization, we need to theorize how space is being re-territorialized in the contemporary world. Escobar (2001) also suggests that a concern with mobility and de-territorialization has made many researchers lose sight of the continued importance of place-based practices and the mode of consciousness that exist within the production of culture. People continue to construct boundaries around their places, even if permeable, and ground themselves in local socio-natural practices, even though the location is changed and hybridized.

To sum up, I apply the concept of displacement in my study, in order to understand the social phenomenon of the practices of the displaced Karen pregnant women during pregnancy, within the specific refugee camp setting. In humanitarian

discourses, displaced persons may be seen as people who have no past, who have lost all cultural and moral codes, because they have been torn from their established environments, economic resources, culture and families, so could thus be treated as passive victims. However, I go beyond this and agree with the arguments put forward by Escobar (2001), who says "the…focus on deterritorialization ignores the continued importance of [the] place-based practices of agencies, even…practices…changed and hybridized". So, my argument is that the cultural practices of the displaced Karen women in relation to pregnancy care have had to be negotiated or adjusted or modified to fit in their new situation, but have not disappeared entirely due to their displacement.

2.3 Family Relations

When discussing cultural practices, one cannot ignore the role of family relationship. O'Connell (1994) says that family plays a central role in preserving and transmitting cultural values from one generation to the next, while Hoebel and Weaver (1979) describe the basic functions of the family as follows: (1) the institution and channel which establishes legal parents for the children; each partner (spouse) acquires a "monopoly" in the sexuality of the other, (2) the nurturing and enculturation of the young, (3) the organization of a complementary division of labor between spouses, and (4) the linkage of each spouse and offspring within the wider network of kin – universally performed by the family as a social unit.

Kleinman (1980) also states that family members especially grandmother and mother are main providers of health care activities what he calls 'the popular sector' which is the main arena of health care and illness is first defined and health care activities are initiated in it to analyze health care system. He mentions that when people decide to choose folk or professional practitioners, their choices are based in the cognitive and value orientations of the popular culture. He gives the example of that after patients receive treatment, they return to the popular sector to evaluate and decide whether they are satisfied or not, what should they continuous be doing next. In this sense, the functions of popular sector are the main source and most immediate determinant of health care activities.

Concerning with family ideology, Hayami (1998) states that there is no specific word for family or household in the Sgaw Karen language, but that *dau pho mo pho pa* - which laterally means 'child-mother; child-father', and also *pga deu teu xau* – which means 'people living under the same roof', are phrases that can be used to describe the smallest social unit. However, this family structure is a chain-like cluster of relationships with the married couple and their children at its core.

Hayami (1998) describes that it is impossible to discuss the Karen family, a woman's role and any changes therein without entering the realm of rituals, because the form and organization of, as well as the internal relationships and roles within a Karen family are articulated through rituals. In particular, a woman's place and role is clearly defined in rituals as being central to the household and family, and a woman with a large "*au xae*" group in the village is likely to have prestige and be respected as an elder by members of the community. It seems to be that rituals directly related to women's reproductive function – for both pregnancy and childbirth and when nurturing and bringing-up the children – and the socially constructed gender ideology behind them, define women's power and status. As a result, the "*au xae*" rites focus on the biological bond between mother and child, and would seem to help facilitate cultural continuity through maternal ties, and reveal the role of women, both as mothers and nurturers.

Moreover, familial relationships can be clearly seen in this ritual practice. Hinton (1984) describes how family members in the female line reconnect with each other even though they live in different places. The cult leader, normally the oldest female among members of the group, has to manage the ceremonies within her group, but if a cult group became too large – with members scattered across too many villages – a sister or a conveniently located niece of the cult elder will be selected as a new leader, so as to facilitate participation in the rites. The rites were held only after more routine efforts such as herbs or other spiritual cures had failed because the Karen reserved this plea to their most powerful spirit for occasions when it was really needed.

Similarly, Rajah (1984) describes matrilineal spirit cults called "*au ma xae*" (the Sgaw dialect) which are carried out for the purpose of restoring the health and well-being of individuals. This ritual is always held by the parents of the person who is sick, and another significant feature of this ritual is that the parents must call upon their parents to attend the ritual, wherever they live, and even the souls of deceased parents,

to heal and restore their descendants' well-being. This entails a "connecting up" of generations, with all members of the female line required to attend, even if they live in another area. In this sense, familial relations are not only connected with each other across different geographical spaces through this ritual, but also family members can learn cultural practices through their direct participation in the ceremony.

This overarching matri-focality also influences the household structure, because women from other cult groups are not allowed to stay in the same house, and also impacts upon the structure of village, as the houses of matrilineal related women have to be clustered together (Hinton, 1984). This uxorilocal form of residence allows women to interact on a daily basis with parents and sisters, and gives them the opportunity to exercise a solid front and build a strong position in terms of the direction of social affairs. In these circumstances, husbands would seem to be "aliens" in the new setting (Hoebel and Weaver, 1979).

However, this ritual practice has encountered problems due to recent socio-economic trends. The burden of having to consume livestock during the rituals and family dispersal has led to difficulties in terms of continuing the ritual in the required and full form, plus Christian and Buddhist practices have taken the place of such rituals among many Karen people (Hayami, 1998). A study of Karen people living in the forests of the Bago Mountains in central Burma was conducted by Hayami (2012), showing that most of the study villagers are now Catholic or Buddhist, so the "*au xae*" ritual has long been abandoned. However, there are alternative ways in which certain "tradition" can be continued, such as cultivation taboos (certain kinds of grain, fruit or vegetable) and food consumption taboos, as these are handed down from mother to daughter. As a result, the author describes how the house is now the center of continuity and identity in the study village, in spite of the differences that exist and the transient situation.

Moreover, Hayami (2012) describes the pagoda worship folk practices called *duwae*, as carried out by the Pwo Karen in Karen state, Burma. According to her, this practice was brought-in by a Karen monk as a substitute for spirit worship practices such as the "*au xae*" – for the purpose of securing the moral and sexual integrity of couples, and especially the bride, upon marriage. This practice is still handed down from mother to child, and it is believed that if the vows are not followed, disaster will

occur among family members. So, the mothers of *duwae* practitioners do not forget these customs, and still transmit the rules from generation to generation. The author points out; however, that the nature of the vows is changing as a result of the increased use of migratory labor. The element of sexual and moral control require in the vows has been modified, and the emphasis is now placed on cultural practices, those which tie the migrant youths to their parental practices and their homeland. Rather than leading to a discouragement and disintegration of the existing ties and practices, the high levels of risk and pressure brought-about by working as migratory labor have simply led to modification and continuity.

O'Connell (1994) also indicates that traditional family structures are changing due to global phenomenon such as economic development, displacement and urban migration. Likewise, Kwanchewan (2012) examines the changes in familial relations and practices of the Karen, because young people are increasingly migration to urban areas for economic and education reasons. She shows how the most evident changes taking place are one, the increased intermarriage between Karen people and those from different subgroups, and even between Karen people and those from other ethnic groups and two, the couples' choices of residence. Familial practices and relations have changed significantly since most of the Sgaw Karen have abandoned the "*au xae*" and the ancestor spirit cult, and instead adopted Christianity and Buddhism. Kwanchewan shows how the extent to which tradition familial practices are followed by urban Karen may depend on their closeness with family members and their degree of interaction with organizations which reinforce tradition ideas and practices.

Familial relations are changing because people are moving voluntarily or involuntarily, but it does not mean there is a total lack of connectivity. To highlight this, Tsagarousianou (2004) suggests that diasporas should be seen in terms of their connectivity rather than their displacement, or their complex interconnection of linkages that contemporary transnational dynamics make possible and sustain. A study into transnational family ties among Sudanese refugees settling in the United State shows that traditional Sudanese culture and identity have been maintained through contact between the participants and their families in Africa, and that the strong motivating factor for this was to maintain transnational family ties. Similarly, Olwig (2011) describes how family relations still play a central role in immigrants' and refugees'

establishment of new lives in Scandinavian countries such as Denmark, Norway and Sweden, even though the welfare society in these countries takes on many of the social and economic functions of the family. The author shows that the reason why the family is so significant is because it not only gives practical help and comfort, but also constitutes a social environment in which people can attain social recognition and assert their social identity in a foreign society.

In terms of connecting with family members, Leung (2011) illustrates how the phone is the main piece of technology used to maintain vulnerable connections with family numbers during the displacement process, both when in detention an in a technology such as mobile phones and the internet to contact home and family members staying in a third country. This availability, access and affordability of phone services and communications technology has been fundamental to the maintenance of familial relations, helping to avoid the disintegration, discontinuity and dispersal of "families".
To conclude, the concept of "Family Relations" helps me to analyze how family relations is connected and/or reconnected, and plays a key role in relation to pregnancy care in this specific situation of displacement.

2.4 Pregnancy Caring Practices

Bonnell and Hunt (1999) claim that if someone follows a particular practice, utilizes existing cultural symbols and is capable of understanding semiotic code, then he or she can use it and put it into practice. Here, in terms of cultural practice, the authors suggest that we should not ignore the ability of actors to give multiple meanings to symbols, and so may redefine a situation in line with their beliefs and also to favor their own purposes. Bourdieu (1977) tries to show how people take action in everyday life in his book, *Outline of Theory of Practice*. He mentions "habitus", a mechanism which determines the action of those humans embedded in the human experience under a socialization process. He suggests that practices should be understood as changing process in everyday life, because they are articulated in different social contexts through the learning process.

Pregnancy care practices, in bio-medical terms, are called 'antenatal' or 'prenatal' care, and represent a type of preventive care which allows doctors or midwives to treat and prevent potential problems and to give health education

throughout the course of a pregnancy. Visit to the doctor occurs about once a month during the first six months and the frequency of visits increase to every two or three weeks for the remainder of the pregnancy. During the visits, several tests such as blood tests to check blood type, Rh factor, anemia and hepatitis B, urine tests to check for sugar and protein as sign of diabetes and kidney changes, listening to the fetal heartbeat (typically after 12 weeks) and checking the size and position of the uterus and fetus are performed (www.estronaut.com/a/pre_natal_care.htm). During check-up, women will receive medical information over maternal physiological changes in pregnancy, biological changes, and prenatal nutrition including prenatal vitamins. In this sense, pregnancy is believed to be a state of illness and; thus, women are encouraged to seek out care from health professionals throughout their term and follow the advice of health professionals.

However, many scholars point out that illness for many non-Western people is not private and individual, but public and social, while Kleinman (1980) claims health care as a local cultural system which is composed of three overlapping parts: the popular sector – including several levels such as individual, family, social network or community activities, a professional sector – including the group of healers whose positions are upheld by law, such as doctors and health professionals, and the folk sector – including folk healers who share the basic cultural values and world view of the community in which they live, and carry out sacred and secular healing practices. He says that there are lay, non-professional, non-specialist practitioners in the popular sector, and that it is here that illness is first defined and health care activities initiated. Significantly, this sector activates health care services by deciding when and with whom to consult, whether or not to comply, when to switch between treatment alternatives, whether care is effective, and whether it is satisfied with the quality of the services provided. In this sense, the popular sector functions as the main source and most immediate determinant of health care. Family members, and especially mothers or grandmothers, are the main providers within the popular sector.

Being concerned with pregnancy care activities, different cultures have different beliefs and practices which reflect on food and behavioral precautions, ritual practices and the use of herbs, but all of which have the same purpose; the well-being of the mother and child. Due to the lack of literature available regarding the pregnancy care

practices of the Karen, I have tried to review literature on how pregnant women take care of themselves during pregnancy across cultures, in order to understand the cultural practices related to pregnancy. There are many precautions mentioned with regard to pregnancy, those related to diet, behavior and rituals, all of which are designed to ensure a safe and easy birth.

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Dietary precautions

For many Southeast Asia women "cold" foods such as poultry, fish, many vegetables and fruits are allowed to consume during pregnancy but "hot" foods are believed not to take during this period as they think hot foods can cause spontaneous abortion and premature labors (Bowman et al. 1995). The ultimate goal of dietary precaution is to safeguard the well-being of mother and fetus.

A study of traditional beliefs regarding pregnancy and child birth among women in northern Thailand was conducted by Liamputtong et al. (2005), who describe how women there take precautions during pregnancy and after giving birth. For example, women have to avoid eating spicy food, as it is believed the baby will be born without hair if they continue to eat it. They are also told to consume only half a banana, because eating a whole banana may result in obstruction during the birth. Similarly, it is said that the consumption of eggplants during pregnancy may cause anal pain after giving birth or during the confinement period; however, the consumption of coffee and tea are encouraged, because it is believed the child will be born intelligent. Fadiman (1997) also shows how pregnant Hmong women try to ensure the health of the child by paying close attention to food cravings. If a mother craves ginger and fails to eat it, it is

believed her child will be born with an extra finger or toe. If she craves chicken flesh and does not eat it, the child will have a blemish near its ear, and if she craves eggs and does not eat them, her child will have a lumpy head.

Likewise, a study of health beliefs and behaviors related to maternal care was carried out among a group of Bamar women by Aye Aye Than (2011), who shows that one variety of eggs is favored because it can induce *leile* (to break wind) and prevent *leih tou* (flatulence). However, pregnant women are not allowed to eat beef and pork because it is believed the fat contained therein will block the birth canal. According to Chit KoKo (2007), rural women in his study area in Myanmar are advised by other women, especially their mothers, mothers-in-law and neighbors, to be careful when taking in foodstuffs during pregnancy and during the post-partum period.

Behavioral precautions

Aye Aye Than (2011) states that in Bamar culture, it is believed that the state of mind and moral behavior of a pregnant woman can affect the unborn baby and the birth process, so; for example, a pregnant woman should not watch a show containing dancing monkeys, because it might cause the child to become restless, and to be born mischievous and ugly. They also believe that sitting on a hammock during pregnancy can affect the fetus, causing a neck injury. According to Daviau (2003), Akha women in his study area in Lao believe the sun and the moon are having intercourse during an eclipse, so are afraid that the blood of the sun (the female according to their mythology) will drop down on them and cause death. Therefore, women must not look at an eclipse of either the sun or the moon during pregnancy, and their heads must be covered by leaves when they go outside at such times.

Behaviors such as lifting heavy objects and indulging in sexual intercourse during pregnancy are seen as harmful and may lead to miscarriage or still-birth (Liamputtong et al., 2005). In the same manner, lifting heavy objects, pumping water, bending over and squatting for a long time – all these activities are restricted during pregnancy, because it is believed such activities will harm unborn babies. Women are also warned not to lean on their abdomen, as this can cause miscarriage (Chit KoKo, 2007).

Some cultural knowledge, such as not attending a funeral during pregnancy is more symbolic (Liamputtong et al., 2005). Chit KoKo (2007) also mentions that rural women in his study area are not allowed to help at funerals, as it is believed that when a woman is pregnant, her fortune level is low and so she can be attacked easily by bad spirits. If a pregnant women wants to go out at night, she has to apply turmeric to her abdomen, as this will prevent evil spirits from coming near (Aye Aye Than, 2011). Similarly, women are asked to put star apple leaves on their abdomen (*awzar* in Burmese), for the synonym of the word *awzar* is the power to influence, counter and attack bad spirits (Chit KoKo, 2007).

Another strong cultural belief is that women should not prepare anything, including nappies and clothes, for their baby during pregnancy, because this advance preparation will result in the death of the unborn baby (Liamputtong et al., 2005). As a result, women accept that some provisional materials for the baby, such as hammocks, bedclothes, nappies and pillows, should not be prepared in advance during the early pregnancy stage, because it is believed the fetus will not survive (Aye Aye Than, 2011).

Rituals during pregnancy

To prepare for an easy birth, women in northern Thailand must undertake magical showers, those blessed with sacred words and known as *nam mon*, during pregnancy. Traditionally, this ritual practice should be carried out from the eighth through to the ninth month, and be performed by a *mor mon* (‘magical healer’) or an older man who has knowledge about magical cures and healing. A ritual practice called the *nam mon sadow kroh* (‘magical water to get rid of bad fate’) is also traditionally used to facilitate an easy and safe birth (Liamputtong et al., 2005). O’Dempsey (1988) describes the traditional beliefs and practices of the Pokot people in Kenya in relation to pregnancy. Here, the women must carry out a purification ceremony known as a *parpara*, a celebration, which is attended by the whole community, to ensure a safe and easy birth.

In Burmese culture, Bamar women used to offer *mel daw ugaba* (‘five royal mother spirits’) with pickled tea in seven piles, to pay their respects and prevent fetal deformity, plus prevent severe labor pain (Aye AyeTha, 2011). Chit Ko Ko (2007) also points out that even though the women in his study area are Buddhist, they still believe

in *nat* (spirits) and follow what the elders do in order to please them. Thus, when a woman becomes pregnant, she is advised to go and worship *anaut me taw* (a supernatural spirit-woman whom villagers believe takes care of pregnant women) in order to be safe and secure throughout the pregnancy. In addition, they sometimes give meat such as beef and chicken to the bad spirits when they do not feel good or feel insecure, especially during pregnancy.

Consumption of traditional herbal medicines

Yos (2003) describes how indigenous communities grow wild plants in the forest and pass on their knowledge of medicinal plants to new generations based on learning by doing. Effective treatments and remedies are thus transferred from one generation to the next, as a specific and localized collection of healthcare knowledge, beliefs and practices. According to Liamputtong et al. (2005), the consumption of traditional herbal medicine such as *ya tom* is used as a way to prepare for an easy birth and to make the baby strong. Pregnant women are also encouraged to take a shower with herbal water in order to facilitate an easy birth.

Within a Karen community in Minnesota (Oleson, 2009 - cited in McGinnis, 2012) Olsen shows that traditional medicines such as turmeric, ginger, garlic, honey, vegetables and sesame oil, a variety of plants, plus snake and bear gall bladders, hen-fat, white goats' bones, horns and tongue, and prayer, are the first choice among Karen people, prior to the use of American medicines. In the early stages of pregnancy, Thai women in his study area said they drink hot-tasting medicines made of ginger, galangal and pepper, with 28% alcohol (Hanks, 1964).

As I described before, beliefs and practices tend to be reflected in people's food and behavior precautions, their ritual practices and use of herbs, in order to ensure the well-being of the mother and child, with significant family support required also. Liamputtong et al. (2005) show that cultural practices require extensive family support, otherwise pregnant women would not know what to do. Chit Ko Ko (2007) also shows that women who live within an extended family tend to follow cultural practices more

than those that live in a nuclear family – who are away from their kin's close supervision.

Moreover, husbands can also play a vital role during pregnancy, for according to Hanks (1964), the father shares responsibility for taking care of his wife during pregnancy, as it takes both a father and mother to bring forth a child. At this time, quarrels are to be avoided because it is believed a quarrelsome child will be born, so men are tasked with keeping their wives in a good mood. Also, it is believed that a father's industriousness, such as collecting wood for his wife's post-partum fire, will lead to an industrious child. For the child's and their own 'merit', pregnant women and their husbands chant prayers at night together before going to sleep, as it is believed the child will thereafter be 'easy to raise'. Chit Ko Ko (2007) shows that Burman husbands like to help their wives with the household chores, especially when they are pregnant.

When discussing practices, one should not neglect the ability of actors who can give multiple meaning, plus should not neglect the contemporary social context. Liamputtong et al. (2005) state that women only incorporate cultural knowledge when it is practicable and relevant to their daily lives, while Chit Ko Ko (2007) argues that sometimes women's nature in terms of work does not fit with cultural practices - such as not going out late in the evening, and in this case women inevitably break cultural practices during pregnancy. Cultural beliefs and practices concerning food are sometimes also broken when the women have a strong desire to do something forbidden during pregnancy, and this should not be linked to a lack of trust.

To sum up, cultural practices have to be understood as adjustments and modifications made to fit a new situation, because if a given culture cannot be applied to a range of situations, it will gradually disappear. So, Yos (2003) says that local or indigenous knowledge is the knowledge used by local people to make a living in an ever-changing environment, and as a result, knowledge production should be viewed as a process of social negotiation, and must be understood in terms of change, adaptation and dynamism.

2.5 Conceptual Framework

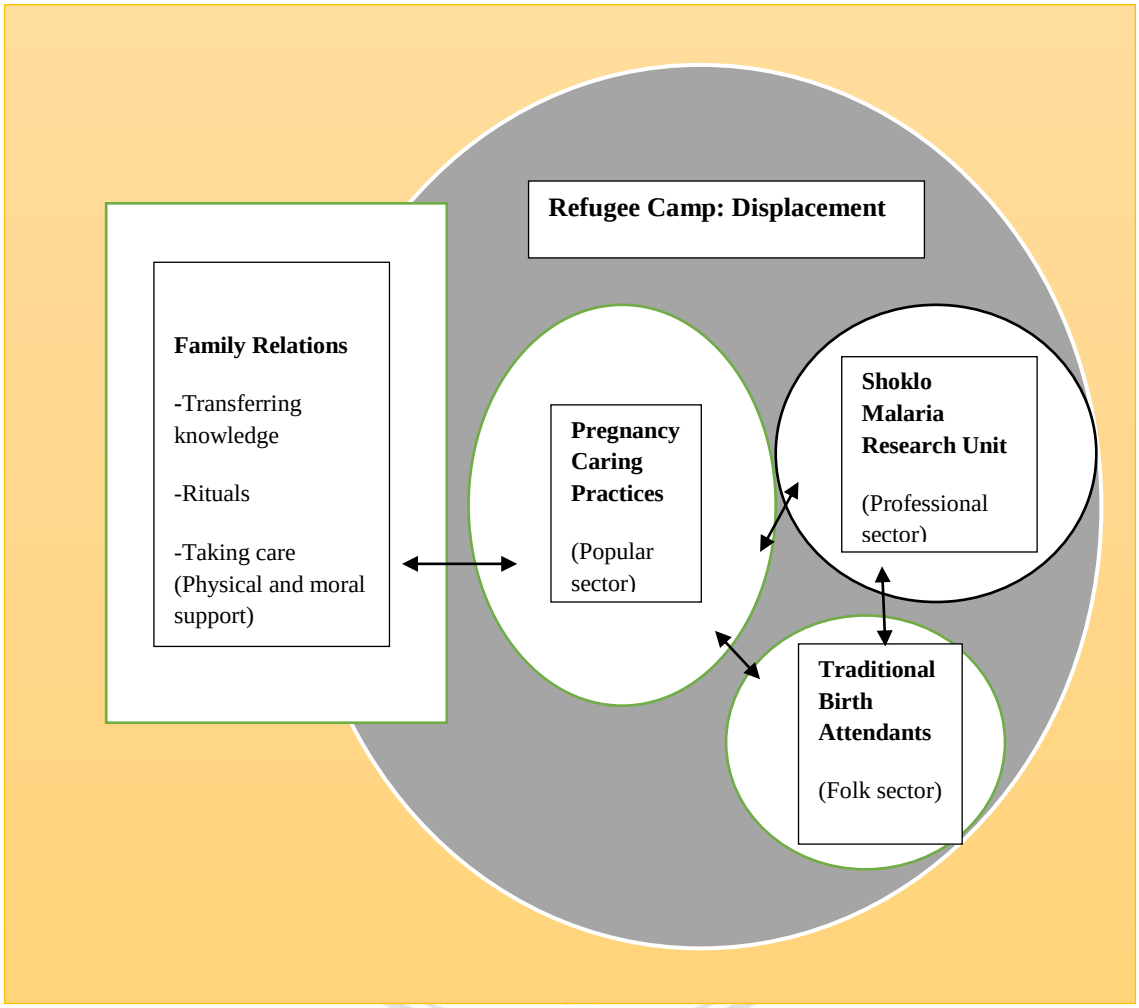

Figure 1.1 Conceptual Framework

I borrow the morphology of health care system by Kleinman (1980), which is the three overlapping and interconnected sectors of health care such as popular sector, folk sector and professional sector, in order to apply in the context of displacement. In the popular sector there are several levels such as individual, family, social network or community activities, a professional sector – including the group of healers whose positions are upheld by law, such as doctors and health professionals, and the folk sector – including folk healers who share the basic cultural values and world view of the community in which they live, and carry out sacred and secular healing practices.

According to his suggestion, the popular sector interacts with other sectors which seems to be isolated from each other. Normally speaking, professionals organize for health care for ordinary people. In contrast, people initiate their health care by deciding when and whom to consult, whether they satisfied the service or not, when to switch between treatment alternatives. In this sense, the popular sector is the main arena of health care and illness is first defined and health care activities are started. Family members, especially grandmother and mother, are main providers in the popular sector. However, their family relations have changed during the process of displacement, but have also been reconnected each other from different directions in terms of transferring the knowledge, organizing rituals, physical and moral support in order to ensure the well-being of both the mother and child to deal with the uncertainty of their situation in the context of displacement. Even though the camp seems to be the isolated and controlled the mobility of people due to the security reasons, people use different networks such as religious network, personal network, family network, friend network, organization network etc. in order to navigate the governance structure to connect each other.

Another factor is that displacement restricts people's access to natural resources-especially medicinal herbs, but also facilitates inter-cultural relationships and expose those displaced to the outside world and to modern healthcare services offered by humanitarian aid organizations and in the case of the Karen, these aspects have influenced their health practices and way of life. In this sense, the displaced Karen women have had to negotiate or make sense of their new roles - in terms of their cultural beliefs and practices – in relation to care during pregnancy and due to the presence of science-based healthcare services in the camp.