

Chapter 6

FIRST-TIME PARENTHOOD AMONG MIGRANT PAKISTANIS GENDER AND GENERATION IN THE POSTPARTUM PERIOD

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This chapter examines postpartum convalescence as it was practised among a small group of young Pakistani women who were migrants or sojourners in London at the juncture of becoming mothers for the first time. Pakistanis are currently the third largest group of immigrants to the U.K., and London is their primary destination (Rienzo and Vargas-Silva 2013). Given the momentum of ongoing immigration from Pakistan, new generations of Pakistani migrant women in the U.K. are continually building their families away from their own natal kin, and often from their husband's too (Harriss and Shaw 2009). Anthropologists have noted that rural-urban and international migration tends to alter the structure of Pakistani families, with women building more matrilateral forms of kinship when separated from their in-laws and living close to their families in urban neighbourhoods (Qureshi 2015; Charsley 2013; Shaw 2004; Werbner 1988; cf. Vatuk 1972). In this chapter I consider how migration and such tensions in women's relations with their natal and affinal kin play out in the postpartum period. This is a time when women are temporarily entitled to return to their natal kin for delivery and convalescence: an important entitlement

and conduit for ongoing sociality and interaction with their families following virilocal marriages (Gideon 1962). The chapter explores what women do when their natal kin are not physically near, and how they and their families improvise, using technologies of travel and communication, within the constraints of 'frontiering' transnational kinship (Bryceson and Vuorela 2002: 12–13).

In Pakistani Punjab, as more widely across the Islamicate world, postpartum convalescence is normatively practised for a period of forty days (Chesney 2007). An older literature identified postpartum seclusion or confinement with an ethnophysiology of pollution and impurity, reflected in restrictions from praying, cooking and sexual intercourse (Thompson 1985). However it can also be understood as a culturally-sanctioned rest period when women are the focus of attention, released from their domestic obligations and ritually restored to health. Authors have suggested that forty days of postpartum convalescence is rarely observed today, if indeed it ever was. In rural North India, Jeffery, Jeffery and Lyon (1989) show that women have to negotiate postpartum rest with their mother- or sisters-in-law, who would take over their duties at their marital home, and identify that forty days of inactivity is an unaffordable luxury in most families. In middle-class urban families, Donner (2003) argues that the culture of conjugal domesticity has changed and curtailed this practice as women no longer expect to return to their natal homes. In spite of this conditionality of postpartum convalescence on material and domestic circumstances and on the conjugal relationship, the young women in my study expressed a sense of entitlement to *challis din* (forty days) or *sawa maheena* (a month and a quarter) of help from their kin. Whether or not they were able to avail it, it remained a powerful referent.

In my ethnographic work with first-time mothers, I have found the postpartum period a very illuminating window onto family practices and intergenerational transmission. A literature on sibling caretaking has identified that in places like Pakistan and North India, where large families are common, children – particularly girls – are given caretaking responsibilities from an early age. Such studies argue that young girls learn appropriate models of motherhood long before they become parents themselves, by observing and copying their older family members and providing first-hand care to younger siblings, cousins, nieces and nephews (Seymour 2004; cf. Weisner and Gallimore 1977). Against this assumption about motherhood being transmitted in childhood, however, I emphasize here that there is a realm of embodied maternal practice

and subjectivity that is only encountered during the moment of transition, when women are faced with being the primary caretaker for their newborn. The postpartum period is a time when women learn very intensely how to mother an infant. Moreover, while work on transmission in childhood implies that girls are moulded seemingly insensibly into motherhood, I found women reflecting openly on their embodied knowledge and working to develop particular nurturing capacities. This calls for an interpretation of learning that sees people as sentient and not merely directed by their habitual formation.

The chapter also explores the gender dynamics of transmission. Recent studies have described white British and American men as sharing the tasks of care with new mothers and learning together with their partners, at least during the brief period of their statutory paternity leave (Miller 2011; Tomori 2009). But in the families with whom I worked, the presence and wisdom of the women's kin in the postpartum period could often be overwhelming. I consider how relationships across generations of women's natal kin may affect fathers' involvement in sharing tasks of care, as well as how fathers learn particular techniques.

Finally, the chapter takes issue with studies that examine migrant women's practices and orientations in relation to ideas of 'acculturation' (for example Homans 1982; Katbamna 2000; Maharaj 2012; Woolett and Dosanjh-Matwala 1990). In taking non-migrants in the countries of origin as the platform against which change occurs, such an approach fossilizes culture in the sending countries. By contrast, I take inspiration from feminist work that has argued for the inherent dynamism of the reproductive sphere in the places of origin as in the diaspora (Gedalof 2003, 2009). Here, my interest is in examining how migrant mothers and their families manage the postpartum period as well as how class and migrant cultures impact on the transmission of caring capacities.

Research Setting

The chapter draws from a study of migrant first-time mothers who I got to know over a decade of ethnographic fieldwork undertaken in East London, supplemented by shorter periods of fieldwork in Pakistan. Some of the mothers examined here are the daughters and daughters-in-law of women I worked with in 2005–2007 during my doctoral research into chronic illness (Harriss 2008), while others

are drawn from research in 2012–2014 on marital breakdown and divorce (Qureshi 2014). During the latter period of fieldwork I, too, became a mother, which meant that I was continually being offered interesting bits of advice about pregnancy, childbirth and motherhood.

These periods of research gave me the opportunity to observe and participate in the dilemmas of first-time parenthood with eleven women as the events unfolded over time. This method – participant-observation – has been argued to be the defining characteristic of anthropology. Traditionally, it involves year-long isolation from one’s ordinary life and immersion in other people’s. As Wallman (1984) observes, urban settings pose a problem for participant-observation, as it is rarely possible to live round-the-clock with people leading the busy and compartmentalized lives characteristic of urban societies. However, as she argues, ‘the proper criterion of the task is in the perspectives we bring to the analyses we attempt, not in the deceptively simple act of “hanging in”’ (p. 42). Through spending time with the women informally and in the context of their wider families, I was given glimpses into mundane aspects of everyday life and the brief, informal explanations that people offer while in the midst of what they are doing. The kinds of perspectives conveyed by informal conversations are different from the more coherent narratives that people accomplish in interviews. They offer insights into social life in the round, context, and a relational perspective. In studying parenthood, in particular, participant-observation also redirects our approach because it conveys so vividly the open-endedness of social life, which is arguably the very point for those people who are caught up in it (Bourdieu 1977). Although they look back over time, retrospective interviews tend to flatten this temporality. Interviews with mothers generate narratives such as ‘the baby got colic’, ‘I wasn’t producing enough milk’ or ‘the baby was allergic to washing powder’, and tell us about the meanings they attribute to what happens in their lives. But participant-observation makes it possible to see how these meanings are actually generated and negotiated at the time, how people repeatedly reinterpret a baby’s cries, weight or the spots on its chest.

The setting of my research is the docklands borough of Newham, a predominantly working-class borough in the East End of London, between inner-city Tower Hamlets and the more prosperous commuter suburbs of Essex. One of the most ethnically diverse local authorities in Britain, the borough is home to about 30,000 Pakistani

Muslims (Office for National Statistics 2011), mostly of Kashmiri and Potohari heritage but with an increasing number of families from Central Punjab, Karachi and Pakhto-speaking regions. Pakistani settlement in Newham reflects wider British post-war migration histories. Labour migrants settled in large numbers between the 1950s and 1970s, working in the declining dockland industries (Institute of Race Relations 1991). As the factories closed down and labour immigration was tightened, migration streams shifted in the 1970s and 1980s to family reunification (Stratford Community History 1996). Since the 1990s, migration categories have proliferated hugely. Marriage migration represents the largest stream of continuing immigration, but there are also substantial numbers in Newham who are on the student, work, asylum and irregular migration routes (Harriss 2006). At seventy per cent of births, Newham is currently the local authority in the U.K. with the highest percentage of births by migrant women (Rienzo and Vargas-Silva 2013).

The eleven mothers in this study had migrated to the U.K. through marriage, half to husbands who were British nationals and half to husbands who were Pakistani nationals but living in the U.K. on work or student visas. They were recent migrants at the time of fieldwork, and three have subsequently returned to Pakistan. They were aged between sixteen and twenty-six at their first marriage and between nineteen and thirty-two at their first birth, the later first births being to the three divorcees in the study. Six of the women were from cities in Pakistan and five from villages. They had between four and nine siblings, and seven had grown up in extended families compared to only four in nuclear family households. The women's own mothers had built their families in the 1980s and 1990s, a key period of transition in Pakistan's demographic history when a decline in marital fertility and an increase in contraceptive uptake first became discernible (Sathar and Casterline 1998). The majority of the grandmothers gave birth in hospitals and combination-fed their infants with breast and formula milk (see Khan 1991; Pakistan Medical Research Council 1998), reflecting their urban origins and the relatively privileged position of the families who are connected with the U.K. through migration. They are a set of women who in their own time were inclined towards, and had the resources to avail medical intervention in childbirth, and to adopt commercial nutrition.

In this chapter I provide descriptive accounts of the situations of just two of the mothers as they track over time. I have chosen these three because they illustrate very clearly practices of transmission in

the postpartum period. I attempt to convey a sense of the particularity of the women and their families, and of how they worked things out as they went along. Unless otherwise specified, the translations provided are between Urdu and English.

Guriya

Guriya comes from an urban middle-class family in Central Punjab and is educated to degree level; she is the niece of a woman who I got to know during my doctoral research in Pakistan. At the age of twenty-three Guriya married a cousin, also from Pakistan, and migrated to the U.K. to join him. Four months later she was pregnant. She worked until her twenty-week ultrasound scan and then spent the final months of pregnancy at home purchasing baby equipment and clothing from the internet. She did little by way of reading up about maternity and declined the offer of antenatal classes from the National Health Service, explaining to me, when I enquired why, that she knew everything already.

Three weeks before the due date Guriya's mother arrived from Pakistan, intending to stay until after the delivery. Telling me about her mother's upcoming visit, Guriya expressed an entitlement to support from her mother at this important time in her life, particularly given what she felt were greater difficulties for her in London than if she had been in Pakistan, where she might have had more domestic help. She explained the purpose of her mother's visit as primarily to help with the increasing burden of domestic work. After her mother's arrival, Guriya reported that on the first morning her mother had reprimanded her for cooking *parathe* (fried breads) for her husband's breakfast with her huge stomach (*pait ke saath*). Guriya said she had lectured her mother 'amma, you have no idea how tough life is over here – I've been doing this all the way through my pregnancy!' She reported that life had got much easier with her mother's help. Things appeared difficult for Guriya's husband Ghafar, however, who was visibly uncomfortable to be living with his mother-in-law amid the pressure on space in their small flat. Guriya and her mother were sleeping on the double bed, while Ghafar was on a mattress on the floor, and he was quiet and subdued in his mother-in-law's presence. I overheard one of Ghafar's friends teasing him about how it could not be easy to live with his mother-in-law, at which Ghafar joked, with a conspiratorial look, that he would be relieved when the baby was born.

I heard Guriya's delivery story when I visited them at home ten days after the birth. Although Guriya had planned to go straight to the labour ward, in the event she managed to have a water birth, something that her mother talked about with amusement and a sense of novelty. Meanwhile, Ghafar described his assistance at the birth in heroic terms. He was the first man in his family to attend a birth and he said with awe that 'if my father had seen how much women suffer in childbirth, he would never have had so many children'. There was bad feeling between them over what happened the next night, however. Unusually in my study, Ghafar was offered the chance to stay overnight at the hospital, sleeping on a chair by the bed. Guriya had felt confident about her ability to look after the baby without any help, and had sent him home. But the baby remained awake the whole night; she could not pacify him by putting him on her breast, and she got not a wink of sleep, she said. 'I can only say I was thankful to Allah when they sent me home, and thank goodness that ammi was here, she did everything at home so that I could just concentrate on the baby.' Ghafar was abashed at not having stayed that night.

Guriya looked up to her mother as an authority in caring for her newborn son. After the delivery they had been prevented from washing the newborn by the midwife, who told them it was beneficial for the baby's skin to absorb the vernix. This was an unwelcome dilemma for the family, as Guriya was anxious that Ghafar recite the *azan* (the call to prayer) as soon as possible, a crucial ritual that would make the baby Muslim and bestow upon him full human personhood (see Shaw 2014: 89–91). Yet as Guriya explained, you should not recite the *azan* to a newborn covered in blood because it is *pleet* (ritually impure). Under the watchful eye of the midwife, Guriya's mother instructed Ghafar to recite the *azan* without first washing the baby. Guriya's mother was also imaginative in dealing with another cultural dilemma that arose out of childbirth in London. She had wanted to shave the baby's head as soon as they got back from the hospital, to remove the hair that had grown *in utero* because it, too, was *pleet*. In the absence of a *nai* (barber) accustomed to this delicate task, she instructed Ghafar to shave his son's hair himself using a safety razor. Ghafar reported that approaching his son's head with a razor was one of the scarier things he had done in his life.

Guriya's mother saw her primary duty as helping Guriya to convalesce. She prepared a particular set of foods for Guriya which were *taaqatwar* (fortifying), not too *sukht* (tough) or difficult to digest and

had a *garam taseer* (heating effect according to Unani and Ayurvedic humoral medicine, see Shaw 2000: 198–201). These included *yukhni* (lamb's neck or chicken and eggs shredded into a soup), *halwe* (a semolina pudding made with ghee, nuts and dry fruit) and *pinjiri* (a sweetmeat packed with jaggery, nuts, dry fruit and spices like *ajwain*). She told me that these would help strengthen Guriya's body by replenishing the blood lost during childbirth and bring on a strong supply of breastmilk, which would help Guriya's body go back to its original shape. She forbade Guriya to eat cooling foods as these would build up fat around her middle and, she told me, Guriya had already put on too much pregnancy weight. She instructed Guriya to keep her scarf over her head even at home, to cultivate *garmaish* (heat) and have hot showers. On the third day, she also demonstrated to Guriya how to massage her breasts to bring on the milk as quickly as possible.

In the ethos of helping Guriya recover from her ordeal at the hospital, her mother also took charge of the baby. Guriya's mother encouraged her daughter to breastfeed, explaining that breastfeeding was how babies develop *mumta*, a particular kind of love for mothers. However, she also fed the baby formula milk, as she had done with all six of her own children. Guriya's mother felt that formula milk was harmless and also practical in allowing the mother to get some sleep, to feed the baby in public or in front of male family members and visitors. Guriya accepted this advice, and indeed later on, when her son started refusing the bottle, she became frustrated that he was overly fond of the breast.

I noticed that Guriya and her mother passed the baby between them at particular moments. If Guriya's mother was feeding the baby from the bottle and he would still not quiet down, she called Guriya saying *ab tumhara kaam hai*, 'now he wants what only you can give him'. At other times, if the baby was with Guriya and he would not quiet, Guriya passed him to her mother and, in her mother's capable hands, the baby would often calm down. Guriya was grateful and made relieved comments such as *ap ne us ko kaise chupp kara diya*, 'goodness knows how you managed to quiet him down'. In this way Guriya's mother modelled techniques of handling, swaddling, rocking, patting and whispering lullabies and Arabic verses that did pacify him. She had a particular way of holding the baby that struck me as peculiar. She held his head and shoulders in the palm of one hand and his bottom in the other, as if displaying him to the outside world, instead of holding him in her lap or cradling him in her arms. When I tried the technique I found that it put the baby's weight

uncomfortably onto the upper arms, and I never saw anyone else cradling a baby like this. But Guriya held her son in exactly the same way.

As the weeks went by, the baby settled into a routine. When he woke in the morning, Guriya's mother would take charge of him to let Guriya get some more sleep. She massaged the baby for half an hour with olive oil before giving him a bath. The massage was aimed at 'opening up' (*kholna*) the baby. During the long months in his mother's stomach, she told me, his limbs had been folded tightly together, and babies need to be taught how to open themselves up. When Guriya was holding the baby, her mother urged her not to be idle but to keep working on beautifying him or 'making the head' (*sir banaana*). She was emphatic about this because while she had been out and about in London she had seen some babies with heads that were flat on one side from the baby turning its head in its sleep. She warned Guriya that her baby's head would become *dhinga* (Punjabi: uneven) if she did not continually push it into shape by pressing on his forehead with two fingers. She also pinched his nose to try and make it more thin and refined, and pushed at his upper lip in with one finger as she thought his gums stuck out too much. Rather than physical development being hard-wired into the baby, it was the *maan ka kaam* (mother's job) to sculpt and teach its clay-like body.

Guriya's mother had been supposed to return to Pakistan two weeks after the due date. When the time came, however, Guriya decided that she wanted her to stay longer, so Ghafar postponed her return flight so that the customary period of convalescence could be observed. Guriya's mother was anxious to get back to Pakistan, mindful of how difficult it was for Guriya's father to manage at home without her, but Guriya pleaded *challis din to ho jaye pehle*, 'let me have forty days at least'. Thanks to her mother's extended stay, Guriya's case was the most comfortable of the first-time mothers in my study. She got more sleep and had to deal with shorter periods of incessant crying than the other women. It is fruitful to see this as a form of 'kin-work' in the sense used by di Leonardo (1987). The Italian-American women in di Leonardo's study talked about cooking family feasts in a similar way to how Guriya's mother saw staying at her daughter's house. This is work done to respect kinship ties across households, and it is work, in the sense that Guriya's mother recognized that it was taking away from her domestic tasks back in her own home in Pakistan. However, it is also kin-work in that it actually *produces* kinship, in terms of the powerful shared memories, intimacy and interdependencies that derive from face-to-face contact.

Carsten (1997) writes similarly of the visceral sensing and creation of kinship constituted through coresidence, shared substance and touch. Postpartum convalescence is a particularly productive form of kin-making as it occurs at a moment of generational transition, as in Guriya's case where she was becoming a mother in her own right at the same time as her mother was becoming a grandmother for the first time, and as the newborn was becoming a full person.

Guriya's case also demonstrates practices of passing-on among women with great clarity. Up to the point of the delivery, Guriya showed no signs of apprehension about becoming a mother. She told me that she knew everything about looking after young children and even that she preferred newborns to older children. However, the night she spent alone with her son on the postnatal ward was an ordeal that shook her confidence and made her appreciate all the more her mother's long experience with babies. As Baraitser (2008) has argued, newborns do not always respond to care as they are expected to, and being with and taking the primary responsibility for an unpredictable and implacable baby can be utterly bewildering. Like the other women in my study, this disorientation motivated Guriya to search for authoritative knowledge in particular ways. She looked to her mother as an example. She observed intently the ways in which her mother held, comforted and quieted the baby and imitated these skills. She listened to and largely accepted her mother's advice and its underlying assumptions.

The active nature of this process of habituation is worth considering. Bourdieu's (1977) understanding of habituation as the laying-down of the set of 'durable dispositions', 'structuring and structured', that provide a person's bearing in the world has been extremely influential. However, I suggest that Mauss's (1973 [1935]) inception of the concept may allow us to understand the intergenerational transmission of motherhood rather better. Mauss's choice of the Latin word *habitus* was precisely to capture the 'acquired ability' or what he calls 'the *exis*' of the body (73). Ingold (2000) critiques Mauss's work on the *habitus* for assuming an instrumental approach to the body as being put to work by a controlling mind, preferring Bourdieu for grasping how practical knowledge is actually 'generated within contexts of experience in the course of people's involvement with others in the practical business of life' (162). However Asad (1997) takes the opposite opinion and sees in Bourdieu a failure to put the mind into the body. For Asad, Bourdieu's formulation of the *habitus* does not allow the subject any reflexivity about their bodily learning. Instead, Asad appreciates that Mauss

does not treat the body as passive but rather, as the ‘*self-developable*’ means for achieving a range of human objects – from styles of physical movement ... through modes of emotional being ... to kinds of spiritual experience’ (47–48). Guriya’s keen attention to what her mother was doing and mimetic development of these skills show us the directive, rather than unconscious, character of habituation, and of her using her body as a self-developable means to producing a pliant, healthy and beautiful son.

The following examples of Maryam and Reema show that transmission between generations could be less straightforward and where, in the absence of experienced women, men may take on a greater role in sharing the tasks of care and learning together with their wives. The following examples also illustrate the diversity of what is passed on between generations of women in different class and migrant cultures.

Maryam

When I met her, twenty-eight-year-old Maryam had been married for two years and her husband Mohsin was in London as an I.T. student. After Maryam announced her pregnancy, she confided that they had been trying to conceive since the early days of their marriage but found it difficult because of her *kamzoori* (weakness; a complicated description referring to her thinness as well as physical strength). She was the only woman in the study who talked to me about her apprehensions over becoming a mother. She had witnessed her older sister failing to breastfeed her children because of inverted nipples, which had made it extremely painful, and she had the idea that early motherhood was a demanding business. She wanted her mother’s support, yet her mother was often ill with her diabetes and hypertension and did not want to fly to the U.K. Maryam therefore decided to return to Pakistan a month before the delivery, and for Mohsin to join her there for a fortnight around her due date. This was an option that none of the other women chose because of their concern to stay with their husbands and their worries about the safety and cost of maternity services in Pakistan. Because government hospitals in Pakistan are reputed to be of low quality and only for poor people, it would also be necessary to go to a private clinic, as Maryam did, and pay a considerable fee.

I heard through a friend that Maryam had delivered a healthy baby girl, but the baby had developed ‘colic’, which the friend

described using the English term, and now Maryam was struggling to cope. Gottlieb (1995) identifies 'colic' as a category that interprets incessant crying as a medical condition, and points out that there are other commonsensical approaches to calming a fussy baby out there in the world, as patterned by people's cultural assumptions. However we conceive of the condition of incessant crying, what interests me here is how the urgency of interpreting their newborn's stricken cries sent first-time mothers flying to experienced women for help.

When Maryam returned to London after forty days at her mother's she was still in the midst of understanding her daughter's unfathomable distress. It was a week after the birth that her daughter began crying uncontrollably. Maryam said that at that time she feared she might have 'postnatal depression', acting out how she would push the baby to her mother and say 'ammi, you look after her, I can't, this is beyond me, too hard for me'. Her mother and other women in the family diagnosed insufficient milk because she was at that point breastfeeding her daughter exclusively, and they worried that she might be too *kamzoor* (weak) to breastfeed. The crying thus came to be defined as a problem of the baby's hunger. Maryam described the women in her immediate family as offering little practical help. Maryam's elder sister, with her inverted nipples, had only breastfed her sons for a few weeks. Her principal role in the events was to sit back, as Maryam acted out to me, and marvel that 'feeding a baby is an incredibly difficult business', *bachhe ko feed karaana bahut mushkil kaam hai, bahut mushkil kaam hai*. I asked after Maryam's mother. She said that even though her mother had many children, all she could say about it was, 'you were all very easy, none of you had any problems'. Maryam said she had tried to probe, 'there were quite a few of us, we can't all have been angels', but her mother could not remember much. The main way in which her mother and sister had helped was by simply by rocking the baby whilst she screamed at her lungs' capacity.

The colic had dominated Maryam's experience of the first two months. 'I was so desperate that I would follow any old *totka* (tips) I was given'. Among the relatives who visited in the weeks after the birth was a number of what she called *tajerbakaar auraten* (experienced women) who gave her alternative diagnoses and *desi totke* (indigenous tips or knowledge) for her daughter's crying. She was advised to avoid foods like cauliflower and chickpeas, which are famous for their 'gassy' effects and might be passed to baby through the breastmilk. She was told to drink hot water infused with *ajwain* or *sonf* in the interest of settling her stomach and through it that of

the baby. They also recommended Woodward's Gripe Water. Maryam said she had followed all these *totke* even though she doubted the logic because she herself had not been experiencing 'gas'. She had also been told that the cause of the feeding problems could be *nazar* (the evil eye). She had been given *desi totke* for counteracting *nazar* involving ritual healings with green chillies, salt and invocations. But Maryam's mother disapproved of these, saying *hamlog to suratien parthe hain*, 'we read Quranic verses over the baby instead'.

This range of diagnoses and remedies offered by the women of Maryam's extended family reflects its socially heterogeneous composition. Maryam's parents had lived their adult lives in Rawalpindi, but came from a large family in which some branches were urban and professional whilst other branches continued to pursue rural agricultural livelihoods. Maryam's mother's objection to ritual remedies based on the personalistic diagnosis of *nazar* was a claim to educated religiosity. The women of her family transmitted diverse techniques of care, but these were ordered along lines of rural-urban and professional status, and the approach favoured by Maryam's mother was oriented to purist Islamic ways of strengthening the baby and towards medical intervention.

Maryam's acceptance of her mother's orientation was apparent in her application of what she had learnt in Pakistan, now that she was back in London. She was trying to adopt a regime of feeding the baby every three hours. She said that in the early days she did not trust herself to be producing enough milk, and she used to offer her daughter the breast every time she cried, thinking she must be hungry. If she did not quiet, Maryam would then offer *topfeed* (formula milk). In Pakistan she had she tried to limit this to just one or two bottles in a day, but since she'd returned to London she found herself giving more: 'I've just stopped counting or trying'. Just before she left Pakistan she had gone with her mother to a paediatrician, who said that the baby was probably not hungry all the time and it could in fact be because of the constant breastfeeding that she had developed colic, because every time the baby fed she would get 'gas'. It was the paediatrician in Pakistan who had instructed Maryam to limit the feeds to every three hours. Maryam was now trying hard to act upon the advice, although she found it impossible to ignore her daughter's terrible cries. In the middle of telling me all this she suddenly looked up and asked me 'What are the signs that a breastfed baby is hungry?' At the time, I did not know what she meant. She explained that her daughter was always sucking on her hand but she did not know whether she was hungry or just sucking

for the sake of it. Another of her London friends had told her that the midwives can tell you signs of when a breastfed baby is actually hungry, and she was wondering about these.

The next time I saw her, Maryam seemed happier and more rested. She had found a health visitor at a baby clinic who had told her about the signs of a breastfed baby:

She explained to me about how you should look to see whether the baby's jaws are moving and then you can tell that they're feeding properly, so now I'm confident that she should be getting enough ... In Pakistan, the midwife only showed me how to do it once, at the hospital when she was born, she put her to my breast and then told me a few points and sent me home. Ammi never breastfed us and my sister never managed it even though she tried, poor thing, so I couldn't get much from them. Here, they explain it so much better!

At a tea party at our mutual friend's house, I observed that Maryam's husband Mohsin was helping quite a lot with the baby. He had been faced with the realities of his daughter's almighty colic only after Maryam returned, as he had been back in London by the time the drama began to unfold in Pakistan. Mohsin had invented a way of rocking the baby that seemed to soothe her, which involved holding her in his palms at arm's length and swinging her up and down in long loops. In the section of the living room where the men were sitting, Mohsin's friends were criticizing him for this rocking method and telling him that if he held the baby in his hands the whole time, she would get used to it and become clingy. I believe they were not disapproving of his involvement in this aspect of care, as I saw many men taking pleasure in holding their own and others' young babies, so much as discomfited by the elaborateness of his technique, and they set upon instructing him about the more effective and efficient ways of quieting a baby that they thought they knew. Meanwhile, in the women's section Maryam was also up against dominant gendered models of parenthood. Our friend's sister-in-law asked Maryam the age of the baby and about her experience of motherhood so far. Admitting her lack of confidence in the role but no hint of her earlier ambivalence, Maryam joked that she'd spent the first six weeks in Pakistan where the responsibility was very shared (*zimedari bahut hee shared thi*), 'I've been here on my own for a month, so my real experience of motherhood began only a month ago!'

The third case illustrates a family that was less affluent than Guriya or Maryam, and how first-time parenthood was made harder by their straitened circumstances.

Reema

Thirty-one-year-old Reema was from a village in Potohar. She had migrated to London to marry a distant relative but the marriage had not worked out. Her second husband Rayaana, whom she had sponsored from Pakistan, was doing a low-paid job. When her time came they had neither the money to call Reema's mother from Pakistan, nor the money to send Reema there. Reema was very anxious about childbirth. She was trying to prepare herself for it but little things could set her off. The last time I saw her before the delivery she reported a phonecall with her mother-in-law in Pakistan: "Are you ok *beta* (child)?", "Yes ammi, everything's fine" but then my mother-in-law began to cry, "In these days anything terrible can happen". I told her, "Ammi stop it, I'm scared enough as it is!"

When I visited Reema after the birth she was visibly worn. Only Rayaana had been there at her delivery, and she said he had been even more scared than her. Their son had been born via forceps and an episiotomy. Thinking back to Guriya's dilemmas over the *azan*, I asked Reema whether Rayaana had recited the *azan* and whether the midwives had objected to them washing the baby. Reema said the first thing they did after the delivery had been to phone Reema's mother in Pakistan to give her the good news, and they had asked her advice then on this matter. Reema's mother suggested they wait until the midwife left the room and then wash him as quickly as possible and do the *azan*. After they returned from the hospital an 'auntie' came to stay with them. She was no 'blood relation' but a friend of Reema's mother, who came from the same village and had married in London and was living with grown-up children of her own. The auntie did the cooking, prepared *yukhni* and *halwe* for Reema and helped her manage with the baby. Reema was immensely grateful for her help, but when the auntie's husband complained about her absence she departed, three days after the birth, and Reema was understanding about that too.

Rayaana had asked the auntie to show him how to make the fortifying *yukhni* and *halwe*, and he had tried to cook them a few times. Reema appreciated these little acts of care, but she judged him incapable of managing the routine cooking. So, Reema said, she had resumed the normal domestic load just five days after the birth. She complained:

The way my sisters and my *bhabhian* (sisters-in-law) have people looking after them for the whole forty days ... They're able to

completely rest. My *nand* (husband's sister) didn't even set her feet on the ground for any purpose except to go to the washroom. And still she complained of exhaustion! They have no idea how difficult my life is over here.

I saw bags of unopened *mewa* (dry fruits), almonds and cashew nuts in the kitchen; Reema said her mother-in-law had sent them from Pakistan, but she was too busy to make anything with them. The women of her family had obviously tried to do whatever they could at a distance, advising them and sending things that might be useful, but the techniques of strengthening a mother's body and capacities could only be transmitted through hands-on practice, and this Reema and Rayaan had to manage on their own.

This was tested when, two weeks in, their son, too, developed colic. It began with Reema worrying about his increasingly erratic feeding patterns. She told me:

Yesterday, literally the whole day he was crying. I just don't know whether he's getting enough. Before, he used to feed for forty-five minutes to an hour at a stretch, but now he feeds for only five to ten minutes and then he falls asleep and then an hour, an hour and a half later he wakes up and wants another feed.

This had been going on throughout the day and night, and Reema was utterly exhausted. She had spoken to her mother in Pakistan, who had recommended drinking infusions with *ajwain* and *sonf*, 'You know, these Pakistani *totke*'. She was also worrying over her son's appearance, asking whether I thought that his skin had become darker and whether his head was flattening on one side. He also had little red spots on his chest, and she worried he might have an infection. When I next visited four days later, he was feeding only for five minutes. Reema was agonizing over what this meant. 'I do everything I can to keep him awake but he just comes off the breast and then half an hour later he wants more.'

By my next visit, Reema had been able to discuss all these worries with the health visitor when she carried out a routine home visit. The health visitor had weighed the baby and reassured Reema that he was doing fine on breast milk, and that there was no need to start supplementary feeding. She said the baby had a little colic and recommended giving him Infacol. She demonstrated techniques of holding him face-down on her lap, to stretch out and soothe his stomach, and said that the spots on his chest were nothing to worry about. The health visitor also inquired 'Don't you have

any family support, any experienced woman you can turn to, who can reassure you about these small things?’ and patted Reema on the hand saying, ‘Don’t worry, these things will come with your own experience’. Reporting the conversation to me, Reema laughed self-deprecatingly at herself, and commented that even though she had plenty of prior experience of looking after children ‘When you become a mother yourself, you see it differently. It’s much harder than it looks!’

Conclusion

The three cases discussed in this chapter demonstrate that the inter-generational transmission of parenthood is a lifelong process beginning with one’s own childhood experience, memories and hands-on exposure to small children. Apart from Maryam, the women in my study expressed confidence that they were good with babies and knew how to look after them. However, in the aftermath of their first birth they found that there was a difference between looking after other people’s children and being the one primarily responsible for an unpredictable newborn. Women cannot learn everything about motherhood before becoming one, and Baraitser (2008) is insightful in insisting that something very powerful happens at the juncture of that transition too.

The immediacy of the challenges posed by new motherhood tested the women’s capacities and made them turn to their mothers and other experienced women for help and for authoritative know-how. Postpartum convalescence was therefore an important entitlement as well as a time where multigenerational networks of women engaged intensely in transmission. Within the constraints of material circumstance and family composition, the women’s families strived to overcome the dispersal resulting from migration and travelled to ensure that a new mother had live-in help from one of her own natal kin. As we saw in the concerns expressed by Guriya’s mother and Reema’s auntie, this was seen by the older women as kin-work in the sense used by di Leonardo (1987). They were labouring outside their own households, and they juggled to provide help as well as manage their routine domestic obligations. But their presence and rallying round over these difficult days generated strong feelings of intimacy.

For the new mothers, postpartum convalescence was an entitlement to being cared-for at the same time as learning how to care

for their newborn. Through acts of nourishment, massaging and demonstrating techniques of care, older female kin strengthened the bodies and maternal capacities of first-time mothers. I have emphasized the keen attention that new mothers pay to the authoritative example provided by their female kin and drawn on Mauss to conceptualize habituation as a deliberate mimetic process of learning, and of the body as the self-developable means for doing so. His interest in the acquisition of bodily techniques, in bodies that 'know what they are up to' (1973 [1935]: 78) is useful to think about the capable and practised hands of experienced women like Guriya's mother.

In contrast with the new mothers, the first-time fathers in my study were less involved in learning techniques of care. They were unlike the white British and American men described in recent studies, who appear to share the tasks of care from the moment of the birth and learn together with their partners, at least until the end of their paternity leave. Marginalized by the overwhelming presence and wisdom of their wife's kin, the men in my study were minor protagonists in the first days and weeks of their babies' lives. However, we also catch glimpses of the men engaged in caring relationships, nurturing their wives, taking turns to provide care, working out how best to placate their colicky babies. The material suggests that international migration, with its strains and absences, may produce situations in which men become more involved in care and where, in the absence of authoritative maternal wisdom, new mothers and fathers learn together in the postpartum period. I also gave instances of men being the recipients of transmission, as when Ghafar took advice from Guriya's mother or when Rayaan learnt how to cook *halwa* and *yukhni* from Reema's auntie, as well as receiving advice from experienced fathers among their peers, as when Mohsin was ticked off by his friends for his elaborate rocking technique.

There is a final thread in this chapter concerning the complexity of what is passed on across generations. Among the women's older kin there were diverse techniques for dealing with the challenges of early motherhood, inflected as we saw by class and migrant cultures. This was illustrated clearly by Maryam, who had two generations of women in her immediate family who had eschewed breastfeeding and relatives from rural and urban areas advocating very different approaches for dealing with the vulnerabilities of newborns. It is therefore vital that we work out new understandings of cultural change that do not caricature the countries of origin as places of

cultural stasis. As Gedalof (2003, 2009) argues, reproduction is inherently a site where replication and innovation are inextricably intertwined.

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