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Dealing with Impurities of Childbirth: Contemporary Reconfiguration of Disgust in India

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Abstract

For a long time in India, childbirth belonged to the exclusive domain of traditional midwives, the so called *dāī*. Because notions of impurity (*aśuddh*) and shame (*śaram*) are intrinsically connected to delivery in the Hindu system, childbirth used to fall upon 'specialists of impure tasks' (Dumont, 1966: 70). Even though some of these women are called upon for their skills, they today still remain requested to handle in particular physically the impure substances of delivery (blood, umbilical cord, placenta among others) as well as the mother and the new-born baby in the impure state in which they are.

The article analyses how concerns with physical proximity are reshaped in the current context of the increasing institutionalisation of motherhood. Drawing on ethnographic fieldwork conducted in the obstetrics service of a government hospital in Jaipur (Rajasthan), the author demonstrates that the minimisation of contact is driven less by the notion of ritual impurity (traditionally inherent in delivery) or by some hygienic prescriptions (aimed at preventing contamination) than by the feeling of socio-moral disgust experienced by members of the hospital staff while in contact with illiterate and underprivileged low caste/class patients.

While many investigators have underlined the evolution of conscientiousness concerns in hospitals, the article instead shows how staff are increasingly hiding or keeping quiet any feeling of disgust and also focuses on the reasons why both trainee doctors and nurses openly show their disgust in front of some of the patients. The article demonstrates that, while expressing socio-moral disgust contributes to maintaining social boundaries, its main objective is 'performative' (Austin, 1962), i.e. to correct effectively 'non cooperative patients' as well as 'bad citizens'.¹

Keywords: impurity, socio-moral disgust, India, hospital, childbirth.

¹ This article is based on a paper presented by the author at *Disgust*, the eighth *Skepsi* conference held at the University of Kent, 29–30 May 2015.



Disgust has been the focus of in-depth and often well-known studies in the many fields: in History, we find Corbin's *Le miasme et la jonquille. L'odorat et l'imaginaire social XVIII^e-XIX^e siècle* (2008) and Vigarello's *Le propre et le sale. L'hygiène du corps depuis le Moyen-âge* (2013); Philosophy has given us discussions on the topic from Rosenkranz's *Ästhetik des Häßlichen (Aesthetics of Ugliness)* (2015), first published in the mid-nineteenth century, and, more recently, from Sartre (*La nausée* (1972)) and Nussbaum (*Hiding from Humanity* (2004)); in Psychology, we have Freud's *Das Unbehagen in der Kultur (Civilisation and its Discontents)* (2001) and Kolnai's *Der Ekel (On Disgust)* (1998), both dating from the late 1920s, and, at the turn of this century, Rozin, Haidt & McCauley's 'Disgust' (2000); Bourdieu's *La distinction. Critique sociale du jugement* (1979) and Elias's *La Civilisation des mœurs* (1973) have considered the topic in Sociology. Anthropology, however, seems to have approached disgust in a more scattered way, through broad structuralist and symbolic theories of categorisation (Douglas 1992), as well as through more personal and anecdotal experiences of disgust felt during fieldwork and reported with little theoretical ambition. As the American anthropologist Deborah Durham (2011: 135) recently underlined, the heuristic uses of disgust remain, in the field of anthropology, relatively under-theorised, and disgust should become 'something to prompt us to ask us questions, not an object in and of itself'. In the last decade, there has appeared a growing number of studies, the aim of which is to analyse the strategies to deal with disgust put in place by professionals and institutions (Memmi, Raveneau, & Taïeb 2011). In line with these studies, the focus of this article is to consider the social functions and implications of disgust by analysing how the impure aspects of childbirth have been and are now dealt with in India by the people, mainly women, whose expertise traditionally enabled them to assist in the process of childbirth and by contemporary institutions.

As both ethnographic and sociological studies of institutions have often underlined, the term 'dirty work' generally refers to stigmatised tasks delegated to specialists belonging to subordinated groups; accounts of childbirth in India confirm this general rule. The Sanskrit word *sūtaka* refers specifically to the impurity linked to childbirth,² and French anthropologist

² While many authors (Banerji 1971; Dumont 1966; Sinclair Stevenson 1982) consider *sūtaka* to be the impurity caused among parents by a childbirth, some authors have nuanced the term, showing that, in a Hindu British community (Firth 1997) as well as in the region of Malnad in Karnataka (Harper 1964), the term is also used to mean the impurity of death and even includes the impurity of menstruation (Bean 1981). Indeed, as the eminent Indologist Pandurang Kane emphasises, *sūtaka* is used in three senses: the impurity of birth, the impurity of death or the impurity of both birth and death (1975: 648).

Louis Dumont has noted that, for Hindus, childbirth is so impure that the process is conceptually linked to the lowest castes of the untouchables.³ Indeed, in India childbirth is so tightly linked to impurity (*asuddh*), shame (*śaram*), and dirty work (*gandā kām*) that by tradition only ‘specialists of the impure tasks’ (Dumont, 1966: 70), the so called *dāī* used to, and still, handle delivery. These traditional attendants are women, generally of low caste, who acquire their knowledge from their mothers or mothers-in-law by experience. As a category of person, Hindu society views these women with ambivalence. On the one hand, they enjoy social recognition. On the other hand, their expertise is often undervalued; some are called only to deal with impure tasks, such as cutting the umbilical cord, dealing with the placenta, or bathing the new-born baby and mother, rather than for their actual skills (Jeffery, Jeffery, & Lyon 2002: 92).

These ‘specialists of the impure tasks’ have been subjected to growing social discredit since the beginning of colonisation, as is evidenced by the sharp criticism manifest in the accounts of colonisers and medical missionaries, criticism which has been reinforced in recent decades by the Indian government.⁴ In this context, it is important to recall that, since Independence in 1947, maternal and child healthcare have not truly been on the Indian government’s health agenda. Following the Millennium Development Goals announced in 2000, which included the reduction of maternal and infant mortality rates, the central government has, however, undertaken two crucial programmes during the last decade: *Jananī Surakṣā Yojnā* (Programme for Maternal Protection) in 2005 and *Jananī Śiśu Surakṣā Kāryakram* (Programme for Maternal and Infantile Protection) in 2011. First, maternal healthcare, namely, antenatal check-ups, medicines, deliveries (including C-section), and hospitalisation, is provided for free in all government hospitals. Secondly, patients receive a small financial compensation of 1000 or 1400 INR (£12–18/15–21€) after an institutionalised delivery, as an incentive to stop women from delivering at home with traditional birth attendants (*dāī*).⁵

Since these schemes were launched, traditional birth attendants have been less and less called upon, while doctors, who are mainly high class/caste, supervise an increasing number of deliveries in government hospitals. In June 2011, Ghulam Nabi Azad, the Minister of Health

³ This comparison has been criticised by many authorities (Bean 1981; Das 1976; Harper 1964; Parry 1991) since the first impurity is temporary, while the second is permanent.

⁴ The lack of hygiene was particularly criticised: ‘Cleanliness is a thing unknown to her. Soap and water are her great enemies. Often she is so dirty she stinks, and her hands and nails are covered with dirt’ (Misty 1924; quoted by Forbes (2005:79)). Because of their ‘ignorance and superstitions’, *dāīs* were also held responsible for ‘hundred[s] of lives’ sacrificed (Beilby 1882: 342; quoted by Burton (2006: 383)).

⁵ These are the sums given in the so called ‘Low Performing States’ (LPS) to which Rajasthan belongs. In the ‘High Performing States’ (HPS), sums are slightly less (600 or 700 INR). For those in the poorest social stratum, whose daily wage averages 150 INR, 1400 INR thus represents approximately ten days’ work.

and Family Welfare, proudly announced at the Plenary of the High Level Meeting on HIV/Aids during the 65th Session of the United Nations General Assembly that 700,000 women in India had had an institutional delivery in 2005–06 but more than ten million in 2010–11 (Azad 2011: 2).

My object in this article is to understand how the increasing institutionalisation of maternal healthcare reshapes conceptions of disgust inherent (or not) to childbirth. To do so, I will rely on the anthropological fieldwork I conducted in Jaipur (Rajasthan) over 18 months in 2011–2012 as part of my doctoral research on the politics of health reproduction. More precisely, I will focus on a three-month study I carried out in one of Jaipur's main government-run obstetrics hospitals (Hospital H)⁶. Through ethnographic vignettes, I will demonstrate that the disgust felt by caregivers stems from their socio-religious background rather than from bodily substances thought to be impure. To this end, I will underline the ways in which the stigma of patients' bodies relies on socio-moral disgust. This will lead me to question the reasons why some hospital staff hide this objectionable socio-moral disgust by overplaying physical disgust reactions. Finally, I will explore the impact of these reactions on patients.

1. The prejudices against the body of the poor

Knowing the importance of childbirth-related impurity in the Hindu system, I expected to find during my fieldwork that hospital staff would be particularly cautious in the way of dealing with it. On the contrary, the disapproval that I detected never concerned either the ritual impurity of childbirth or the substances (such as blood, stools, urine) associated with the process of delivery; disgust was rarely expressed as a result of physical contact with these substances. In fact, it transpired that the expressions of physical disgust were but a cover for deep-seated feelings of social contempt.

A case in point is that of Sohan, a woman of twenty-five occupying one of the six beds in the labour ward. All the while she was moaning during strong and painful contractions, the nurses were rudely ordering her to keep quiet. When telling her to 'shut up', not only did they tap Sohan's mouth with a finger, they also employed the disrespectful form *tū*.⁷ At one point, Sohan turned onto her side to vomit; immediately, one of the nurses rushed forward and spread out Sohan's scarf (*dupattā*) to prevent her from soiling the bed.

⁶ In order to guarantee the anonymity of both the hospital and its staff, all the names used in this article have been changed.

⁷ Hindi distinguishes between three second person pronouns: '*āp*', the most polite and common form is used when addressing adults, '*tūm*' when more familiarity is permissible or when addressing people who are 'lower' in the social order, and '*tū*' in intimate relationships, in addressing God, with children or, as in this case, as an offensive and disrespectful form.

A few minutes later, Vasudha, also twenty-five, who was in her first year as a trainee doctor, entered the labour ward and shouted with a laugh, 'Oh, my God!' while pointing to Sohan's forearm. Tattooed on her arm in capital letters were her husband's name followed by the words 'my wife' and 'Sohan'. Although Sohan was both in pain and embarrassed to see us staring at her, the trainee doctor continued to make fun of her tattoo, making faces of contempt and, very visibly, wanting me to join in her laughter.

These tattoos are quite common among low class/caste in both rural and tribal areas. While vomit or other substances involved in delivery are never commented upon, social marks on the bodies of patients (e.g. callused feet, dirt, or tattoos) are, in contrast, openly discussed and stigmatised. Indeed, at Hospital H, which is both a government and a referral hospital, many of the patients were illiterate women, both Hindus and Muslims, coming from rural villages or peri-urban slums located a few kilometres away.⁸ Constantly, these women were referred to by the staff as 'uneducated', 'unhygienic' or 'country bumpkins' (*gānvar*). In the delivery room or operating theatre, doctors used to complain about women who were overweight, while trainee doctors used to snigger and make comments amongst themselves about the extent of a woman's pubic hair, even calling to each other to come and look at her as she was lying on her back exposed to view. When some trainee doctors or nurses disapprove of such features as overweight or an excess of pubic hair, they offer neither medical nor hygienic reasons to justify their attitude. Their disgust mainly stems from the degree of social difference between them and people belonging to underprivileged groups. In other words, the stigma of the body appears to be based on socio-moral disgust.

The seeming lack of core disgust could be discussed through the lens of the 'hedonic explanation' developed by Paul Rozin (2008). As this psychologist has shown, professionals like doctors who are repeatedly in contact with strong elicitors mainly cope with them by developing 'processes of adaptation'. The experiment he conducted indeed reveals a significant decrease of sensitivity to touching cold dead bodies among medical students who have spent two to three months dissecting cadavers. The seeming prominence of socio-moral disgust could be discussed in line with the study of Jane Simpson and her colleagues which shows how 'the disgust response to core items decreased over time whereas the disgust response to socio-moral items intensified over time' (Simpson & others 2006: 39). The analysis relied on experimental tests where participants had to measure their emotions three times after being exposed to

⁸ A referral hospital is a central hospital with more sophisticated facilities and offering a greater range of specialist treatments to which patients with complications are sent from smaller hospitals or subcentres in the region.

photographs (eight represented core disgust elicitors and eight represented socio-moral disgust elicitors). However, this line of analysis would not help in understanding the reasons why the medical staff of Hospital H. so repeatedly and explicitly express disgust. This might partly be linked to the fact that a central element in the following ethnography is taking into consideration the status as well as the social and religious identity of the people, whereas Rozin's psychological studies, while they clearly demonstrate that the variations in the degree of disgust are linked to the criteria of time or the nature of the elicitors involved, are silent as regards the social identity of the people and the social function of disgust.

2. A subterfuge for stronger condemnations

Several social scientists have underlined how health professionals increasingly tend to nuance and deny the disgust they might feel while being in presence of either patients (Marché Paillé 2010; Molinier 2013), the elderly (Schaub & others 2012) or cadavers (Jeanjean, 2011). Drawing on her observations made both during fieldwork in French hospitals and humanitarian experience in medical missions in Africa, the French philosopher Christiane Vollaire (2011) shows how signs of disgust are perceived to be shameful, weakening, and unprofessional, and are consequently emotions suppressed by medical staff. Within the medical community, to feel disgust, let alone to express it, is a major taboo, to the extent that, as Vollaire stresses (2011: 95), not to display disgust becomes a sort of '*mutilation sacrificielle*' (sacrificial mutilation) — a violation of the sense of humanity which conditions medical practice. In the light of this, one might wonder why, on the contrary, the staff in Hospital H so openly express disregard and disgust.

It must be remembered that, since the establishment of the Indian Constitution in 1947, discrimination on grounds of caste or religious differences is punishable (Article 15). However, caste resentment was common at the hospital, due to positive actions that have benefited depressed castes, with important reservation of quotas for Scheduled Tribes (ST), Scheduled Castes (SC) and Other Backward Classes (OBC) as well as negative stereotypes about Muslims.⁹ Several doctors said that they found it necessary to keep their distance from Muslim patients, when having to deal with a crowd of patients in the ante-natal clinic, and complained to me in terms similar to those of Ravindra, a first year trainee doctor: 'We can't say anything to them. And if we do so, they go and complain to their minister, [the health minister of Rajasthan, Aimaduddin Ahmad Khan, a Muslim] and then we get a phone call!'

⁹ Since 1990 (Mandal Commission), 49.5% of government jobs are reserved for the lowest castes (15% for the SC, 7.5% for the ST and 27% for the OBC).

To avoid being blamed, medical staff often resort to subterfuges. For example, between each other, nurses often refer to Muslim patients by the letter M, in order to ‘make better fun of them’ in a more discreet way¹⁰. Comments as well as facial expressions of disgust were often exaggerated in front of the patients. My hypothesis is that the disclosure of their disgust about concrete facts, such as illiteracy or dirt, enabled medical staff to discriminate against patients in a safe and non-political way. To put it another way and as will be developed below, the medical staff stigmatise and demean the patient without exposing themselves to the risk of punishment.

This type of approach was particularly common in the family planning department, located in the basement of the hospital. One of the first comments made to me by the head of family planning, a Sikh Punjabi doctor in her thirties, was that Hospital H was ‘a Muslim hospital’ and that the problematic demographic explosion in India was due to ‘the over-reproductivity’ of Muslim women. The two Hindu nurses who assisted her agreed that ‘nowadays, Muslim patients are in each and every corner of the hospital’.

One morning, two ladies both wearing the *burka* arrived. One of them complained about strong lower abdominal pain. She was doubled up with her hands on her stomach and collapsed onto one of the chairs. This lady had come to the hospital the previous day to have a sonogram done. According to the results everything was in order; however, the lady had been suffering violent pains since five o’clock that morning, which she attributed to the contraceptive device she had had fitted eighteen months earlier. One of the nurses took a few steps back and covered her nose with her hand. The other, who was sitting behind her desk and holding her nose, also made clear her feelings of disgust and disbelief. Without even looking at the patient, she gave her some medicine and dismissed her. By the time the two ladies were at the door, the nurses were already fanning the air with their hands and complaining about ‘the stench of the women’, due to the fact that ‘they change clothes only on Fridays’, while ‘burkas are washed only once a year!’. For my part, I had not noticed any particular smell, and it is worth adding that the nurses’ criticism of the ladies’ lack of hygiene was not accompanied by any advice to them as regards the importance of better hygiene practices on medical grounds.

Clearly, the explicit facial expression of disgust was a subterfuge. Indeed, it is important to note that the nurses waited for the women to be outside the room before making explicitly racist comments, and that, all the while they were in the women’s presence, their behaviour

¹⁰ In fact, and as I underline in my PhD thesis (2016), this code seems less a precautionary measure in order to speak about Muslim patients than a kind of humorous complicity that nurses adopt for professional solidarity.

would hardly have been called objectionable. In the main, the nurses made faces which could be attributable to core disgust, a rejection reaction commonly said to be instinctive and irrepressible, thus unquestionable. As the French philosopher Claire Margat puts it, disgust ‘n'est pas un jugement, ni même un sentiment, c'est une réaction de rejet, une émotion relative à des sensations [*is not a judgement, nor even a feeling, but a reaction of rejection, an emotion related to sensations*]' (2011: 19).¹¹ But, undoubtedly, by either feigning or exaggerating feelings of visceral disgust, their theatrical game was such that outside observers could easily notice that what was at issue here was a deeper and personal contempt of Muslim women. In other words, they do indeed employ small strategies of simulation, but little effort is made not to be discovered. Not only is the Muslim community said to ‘always refuse family planning’ and be held responsible for the main developmental issues in India, but, according to the hospital staff, Muslims are always favoured by government policies and unfairly benefit from government schemes.

In short, these two Hindu nurses, faced with two Muslim patients, were seeking a means whereby to express their sense of having been victimised by a state system that they feel unjustly favours the Muslim population and lower castes.¹² In other words, it was a way to compensate for the broader unfair situation they often commented on. As it will be further discussed in the next section, by showing that the smell of the two Muslim patients was unbearable, the family planning nurses also effectively managed to reduce the length of time the women were present in the clinic.

3. Expecting ‘performativeness’

In the literature on disgust, the justification for it is often discussed in functionalist terms by highlighting two principal and well-founded functions. First, in line with Darwin’s explanations published in *Man and Animal* in 1872, disgust reactions are held to preserve humans from dangers which could imperil their physical and moral integrity; it is, as some American psychologists have emphasised in their brief overview of the cultural expansion of disgust, ‘a mechanism for avoiding harm to the body became a mechanism for avoiding harm to the soul’ through a similar contamination potency (Rozin, et al. 2000: 650). Secondly, in line with the theories of Norbert Elias (1973) and Pierre Bourdieu (Bourdieu 1979), taste as well as disgust elicitors have been discussed through their function of social differentiation. Undoubtedly in

¹¹ Author’s translation.

¹² For more details on the way government policies interfere on the attitudes of some of the hospital staff towards patients, see Jullien (2015).

the hospital, expressing disgust often contributed to maintaining or reinforcing social boundaries by allowing the staff to display both social and moral superiority in front of patients coming from disadvantaged background. Auxiliaries (*bāī*), who often came from the same social and economic background as the patients, particularly tend to be strongly disapproving of patients.

That function is, however, probably only the tip of the iceberg. At Hospital H., the reaction of disgust was mainly intended to operate for its ‘performativeness’, so that the social expression of the reaction of disgust (whether by facial expression or spoken comments) echoed the claim of the British philosopher John Austin (1962: 6) regarding ‘performative utterances’ in which ‘the issuing of the utterance is the performing of an action’. Similarly, among the hospital staff, disgust was frequently displayed before patients or their family members since, as the following example shows, the action was aimed at correcting their behaviours without the need for explanations.

In the delivery room, it is not uncommon for trainee doctors, who have already ordered a woman to be quiet and push, suddenly to exclaim, ‘This woman wants to kill her baby’, or tell her, ‘If you carry on like that you’ll kill your baby’, then purposely ignoring them and even eventually starting to supervise another woman’s labour. Similarly, both the facial expressions and the comments of disgust and outrage made by a member of staff initiate a process of that person’s ‘empowerment’ over any family member with the woman in labour. Often such a person (usually the woman’s mother-in-law) is called into the delivery room to bring some cloth in which to wrap the new-born baby. A nurse who was given a worn out and dirty piece of cloth by a mother-in-law would simply take the piece with fingertips, showing disgust and asking ‘What is that?!’¹³ Also, in post-natal wards, during visiting hours, staff tried to make sure that visitors sat on the bench. If a family member was seen sitting or lying down on the bed close to the woman and the new-born baby, a member of the hospital would wrinkle his nose and say “How dirty! What are you doing?” A striking example of such an expression of disgust aimed at arousing a sense of shame in the visitor once occurred when, for a second time without permission, a man entered the Septic Labour Room where several women, partly naked, were lying, moaning or crying out in pain.¹⁴ A senior female doctor asked him sarcastically: ‘So in fact you enjoy looking at that, don’t you?!’

¹³ Families frequently justified having brought old pieces of cloth for this purpose, on the grounds that worn-out cloth is softer. Another possible reason for the habit, although one I never heard expressed, is the fact that new-born babies are believed to be impure; the cloth in which a new-born baby is wrapped, as well as what was worn by young mothers during labour, is therefore, so one is often told, thrown away after a ritual of purification.

¹⁴ The Septic Labour Room is dedicated to complicated deliveries (cases of eclampsia, miscarriages, breech, etc).

All in all, by playing with feelings of shame feelings, reactions of disgust operate, as these examples show, as efficient tools for ‘governing the body’, thus saving the staff from wasting time by providing explanations or reasons. However, Austin’s theory of performativeness needs to be complemented, if this tool is to be fully understood. As Pierre Bourdieu (1982: 63) has explained through the case of instituting rites, ‘illocutionary force’ is not only based on the act of speaking. Performative locutions are efficient when they are pronounced by people invested with authority, thus when conditions of social dispositions are fulfilled. Bourdieu’s focus on the symbolic capital of the speaker is all the more important given that, in the ethnographic incidents reported, reactions of disgust from the hospital staff do not act as such but make patients act. Contrary the performative utterance as discussed by Austin, the illocutionary strength of doctors and nurses is rather ensuring that the patients will perform an (appropriate) action than itself performing an action.

To succeed in doing so, the medical staff used to explain, albeit regretfully, that habitual norms of communication were pointless ‘with such patients’. Instead, medical staff pretended to be forced to shout, to repeat the same things over and over, to use mainly imperative sentences with an unfriendly tone, and to adopt the disrespectful *tū* pronoun, in order to have the patients reacting in the expected way. ‘If we don’t shout at them, they don’t listen to us’, a trainee doctor once told me. The hospital staff could thus justify their (overplayed) expressions of disgust in a similar way: a tool they are compelled to use in order to have the patients or the anyone with them quickly adopt required or specific behaviours.

Conclusion: reconfiguration of disgust

This article identifies three categories of disgust. The first one concerns the disgust a childbirth specialist might feel while having to deal with the impurity assigned by Hinduism to childbirth (*sūtaka*). Far from being an updated theory from Brahmanical scriptures, this impurity is still vigorously discussed among the *dāīs* of today, although, in the hospital, nothing was said or done by the staff in this respect. Notwithstanding the difficulty for the British to recruit Indian obstetricians and nurses at the time women’s hospitals were being created, historians have shown that medicine was increasingly seen as a prestigious profession, since it was characterised by ‘entry through merit (and not heredity) and specialised knowledge’ (Guha 1991: 7). The second one, which only appeared in this article by implication, is linked to the standards of hygiene which hospitals are perceived to be obliged to respect and maintain, in

order to prevent contamination and dissemination of diseases.¹⁵ Finally, the third and last one, which has been our main focus of attention, is a socio-moral disgust in which aversion partly results from negative stereotypes of the person.

	Characteristic among <i>dāīs</i>	Expected in hospital	Mainly found at Hospital H
Name	Impurity	Infection	Socio-moral disgust
Type	Ritual	Medical	Interpersonal
Source	All patients	Lack of hygiene (virus, bacteria)	Some categories of patients
Degree of responsibility of the patient	None	Partial	Full
Measure undertaken by the specialist faced with it	Doing rituals	Following some measure of hygiene	Playing with disgust categories

SUMMARY TABLE SHOWING THE THREE FORMS OF DISGUST

As we have seen in this ethnography, the fear of contact is driven less by the notion of ritual impurity (traditionally inherent to delivery) or by some hygienist prescriptions (aimed at preventing contamination) than by a feeling of socio-moral disgust and, more precisely, of interpersonal disgust.¹⁶ Members of the hospital staff feel, or rather express, disgust (playing with the categories of disgust) while being in contact with illiterates and underprivileged low caste patients, both villagers and Muslims;¹⁷ these are accused of being bad patients, bad mothers and bad Indian citizens because of their lack of hygiene, their illiteracy, their superstitions, and/or their fertility.

In this respect, while many Western sociologists and psychologists show that health professionals resort to procedures to minimise, even to deny, the feeling of socio-moral disgust, quite the contrary seems to happen in Hospital H. The social implications of real or feigned disclosure of disgust are threefold. Among the hospital staff, expressions of disgust not only

¹⁵ Length constraints do not allow me to develop this aspect but, as I show in my PhD thesis (2016), the fear of having their physical integrity jeopardized by pathogens was relatively low among the staff.

¹⁶ As Gordon Hodson and Kimberly Costello have shown, this form of disgust 'is not accounted for by fear of infection, but rather is mediated by ideological orientations and dehumanizing group representations'(2007: 691).

¹⁷ It echoes the notion of 'chronical integral disgust' (sense of belonging of the people) developed by Audrey Abitan (2012).

serve social distinctiveness and professional complicity, they also perform as a risk-free way to vent their frustration as well as an efficient tool to heighten the compliance of patients.¹⁸

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¹⁸ This article is partly based on a presentation entitled 'Des parturientes bien embarrassantes: la hiérarchie médicale indienne à l'épreuve' which the author gave at the fifth congress of the Association Française de Sociologie (Nantes, 2013) and which has been published in a collection entitled *Le social à l'épreuve du dégoût* (2016, Presses Universitaires de Rennes) and assembled under the direction of Dominique Memmi, Gilles Raveneau and Emmanuel Taïeb, and the author acknowledges the help she undoubtedly received from their pertinent observations. The author also gratefully thanks the organisers of the *Skepsi* conference, the participants and the reviewers for their thoughtful suggestions, as well as the CEIAS (EHESS/Paris) for financially supporting her participation at the eighth *Skepsi* conference (Kent, 2015).

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