Chapter I

Introduction

As sites of patriarchal control and reproduction of gendered ideologies, women’s bodies are subjected to multiple, often overlapping, forms of socio-cultural and medical interventions. However, women experience a more intensified form of control during their pregnancies and childbirths. Cultural norms, beliefs and practices circumscribe women’s experiences and their caste, class and other locations influence the course as well as the outcome of their pregnancies. Further, the pregnancies of women belonging to socio-economically marginalised groups are placed under specific surveillance of biomedical and state intervention programmes. Placed within these constraints and controls, women, however, resist and negotiate patriarchal power using different strategies. The present study explores the different ways in which women from poorer urban communities mobilise knowledge, resources and support systems in negotiating patriarchal control of their pregnant and birthing bodies. It analyses the way women use plural and often contradictory discourses of cultural and biomedical knowledge simultaneously to deal with the various societal demands over their pregnancies and childbirths. It addresses questions such as how do women manoeuvre traditional and institutional exercise of power and strategise their experiences? Their strategies of compliance and resistance are explored to gain insights into the everyday experience of gender-power relations and women’s continuous efforts to counter their subordination.

Studies have shown that women’s experiences of pregnancy and childbirth vary across cultures and over historical periods (Jordan 1993; Lazarus 1994; Jolly 1998; Chawla 2002; Jeffery et al. 2002; Rozario 2002; Samuel 2002; Unnithan-Kumar 2002; Donner 2003). In the Indian context, studies by Jeffery et al. (1989), Kalpana Ram (1992, 1998), Jeffery and Jeffery (1993), Maya Unnithan-Kumar (2002), Van Hollen (2003), Tulsi Patel (2006, 2012), and others have extensively explored the socio-cultural context of pregnancy and childbirth in rural and semi-urban location. In recent times, modernity has had an overwhelming influence on women’s experiences of pregnancy and childbirth through the introduction of biomedical practices. In India, the influence of modernity can be traced to colonialism, especially to the colonial
policies and programmes that targeted the reform of indigenous birthing practices and the replacement of traditional dais with trained midwives. These reforms were part of the larger political agenda of the colonial mission of ‘civilising’ the ‘uncivilised natives’ (Jolly 1998). The colonial civilising mission propagated and reinforced not only the difference between the binary opposites, it also implicitly legitimised a hierarchy between them—between modernity and tradition, science and religion, and rational and superstition (Ram 2001). Thus, between indigenous practices and modern medicine, the colonial discourse privileged the latter. These binaries continue to be employed by the state and biomedical institutions in the policies and programmes aimed at improving women’s maternal health.

The present study is an extension of feminist theory in arguing that women are active agents in managing pregnancy and childbirth rather than being viewed as passive recipients to societal control and institutional interventions. The studies of Barbara Ehrenreich and Deirdre English (1973), Datha Clapper Brack (1975) and Ann Oakley (1976) discuss how historically, pregnancy and childbirth have been regarded as women’s domain where women healers attended births, provided advise and enjoyed a high social status. This venerated status was accorded to them not only because of their experiential knowledge and skills in the management of pregnancy and childbirth but also because of their wider knowledge and skills in treating a host of ailments and conditions. As these studies show, historically, women’s experiential and empirical knowledges were usurped, devalued and discredited with the enlightenment, and subsequently with establishment of biomedical authority over women’s pregnancy and birthing.

**Historical and Cross-Cultural Contexts**

In pre-industrial Europe, women healers were the main providers of medical support and services for a wider section of the society. These women healers were not only the knowledge bearers of pregnancy and childbirth, but also had an expertise on anatomy of bodies (Ehrenreich and English 1973; Brack 1975; Oakley 1976). Women healers laid out prescriptions and proscriptions of pregnancy and provided emotional support during the process of childbirth. They also advised women on contraception, abortion and child-caring. The role of healers gave them high status in the society. They were referred to as ‘wise women’ by the peasant population for whom they
provided medical assistance in poverty stricken areas characterised by a lack of medical facilities (Ehrenreich and English 1973).

The position and status of the women healers were challenged with the emerging power of the Church in the medieval period. The Church was not against medical care for the upper class that had male physicians, but was against female healing who was believed to use ‘magic’ as against medicine to cure women. The reason behind this was a fearful apprehension on the part of the Church that if the power and acceptance of wise women grew in society, people would be more dependent on wise women, thereby undermining the authority of God and the Church. It was also believed by the Church that women healers could use their powers against the Church and thus constituted a threat to the very institution of control. Thus, it was necessary to construct women healers as a negative force (Ehrenreich and English 1973). Hence, these women were seen as ‘witches’ with alleged links with the Devil, which was in turn considered to be closely related to the ‘feminine temperament’, deriving power from intercourse with devils (Oakley 1976). Consequently, women healers were also charged with reproductive and sexual crimes and executed in large numbers. Ehrenreich and English (1973) refer to these women healers as constituting a ‘triple threat’ – of firstly, being a woman, secondly, belonging to a network of peasants, and thirdly, believing and practicing empiricism due to their reliance on senses.

In this process of labelling and subsequent criminalising, there existed a close nexus between the Church, the state and the biomedical profession which targeted both ‘witchcraft’ and women healers respectively. Further, women healers were labelled as ‘malevolent’ and ‘superstitious’. This conscious and deliberate demonic construction and devaluation of both, the knowledge and the knower, facilitated the rise of the establishment of biomedicine as a profession and consequently suppression of women healers by not allowing them to be a part of the formal institutional system of university training and curricula. The massive witch-hunt of the women healers led to the replacement of women healers by male doctors (Ehrenreich and English 1973). Thus, there was a playing out of both gender politics and the politics of modernity.

The emergence of male midwives trained in modern medicine and the establishment of obstetrics as a field of medical profession could be read as men’s encroachment into what was traditionally seen as an exclusive ‘women’s domain’. With the professionalisation and the masculinisation of biomedicine, the midwifery-tradition underwent major transformations in the post-Enlightenment period.
(Ehrenreich and English 1973). This period saw how women’s bodies started to be controlled together by patriarchal authorities of the Church, state and medical profession which reproduced patriarchal power relations in complex ways. The biomedicalisation of pregnancy and childbirth became the trend in the West, which replaced the centuries old midwifery tradition of women healers.

In the context of India, the embedded caste structure and purdah system shaped discourses of pregnancy and childbirth in India differently from the trajectory of the West (Forbes 2005). One of the striking differences between the European and Indian tradition of birthing practices was that in India, in the pre-colonial situation, midwifery was not a part of the Sanskritic medical practice, dominated by the upper caste brahmins. These male practitioners were not involved in providing services to women during the actual birth as it was considered not only inappropriate for men to be present during delivery but was considered ritually highly polluting. Since teachings were in sacred languages, women’s access to indigenous knowledge systems were restricted (Forbes 2005). Birthing was thus handled mainly by older, experienced women and dais who belonged to lower ranked castes. Dai status was relegated due to the rigid caste system that adhered to the principle of purity and pollution. Dais, unlike their western counterparts, by the virtue of their class and caste location, were not recognised as bearers of traditional wisdom on pregnancy and birthing.

The major changes in birthing practices occurred under colonialism. The strategy of the colonial state was to target the high maternal and child mortality, and morbidity rates and blamed dais (midwives) for their ‘unhygienic’ and ‘dirty’ ways of conducting delivery. For the colonial powers, high mortality and morbidity among the ‘natives’ posed hindrance in having a healthy workforce. Since the Indian population served as cheap labour, it was profitable for the colonial state to invest in having a healthy workforce (Van Hollen 2003; Forbes 2005). It was against this colonial, economic and political backdrop that the institutions and services of modern medicine were introduced in India in the second half of the nineteenth century.

The ‘progressive’ and ‘modern’ colonial state considered women’s status in society to be an indicator of society’s advancement. The colonial discourse targeted birthing for they believed that society could not advance as long as women were confined to zenanas. Thus, the cultural practices of the purdah and the zenana were seen to be social barriers for women from transcending the ‘given’ domestic sphere.
Women were barred from seeking health care (in the public sphere) as they felt uncomfortable visiting male practitioners during pregnancy or delivery due to cultural restrictions (Forbes 2005). The colonial state attributed this aspect of lack of women’s mobility in the public sphere to the high incidences of female mortality and morbidity due to dais’ ‘unhygienic’ ways of conducting deliveries (Engels 1996; Jolly 1998; Forbes 2005; Hodges 2006). Therefore, the colonial state focused on birthing in ‘hygienic’ conditions at the institutional site of the hospital. To improve the infant and maternal mortality rates, the Dufferin Fund was created in 1885, which marked the beginning of the western medical care for Indian women. The Fund’s work gradually encouraged the upper class Indian women to accept biomedical hospital birthing which was increasingly seen as being ‘hygienic’ and ‘modern’ (Forbes 2005).

Reforming Birthing through Modernisation. In the colonial era, with state supported expansion of biomedicine, there was an emphasis on ‘development’ within modernisation. Development was implemented through social reforms. Sarah Hodges (2006) argues that within the history of reproduction, between 1850–1950, there were ‘three overlapping problematics of reforms’– one, the medicalisation of childbirth, which involved the complex relationships between women’s reproductive health practices, biomedical institutions and medical professions. Second, the social practices of reproduction, which were historically and culturally embedded. They dealt with different reproductive health practices of diverse groups, leading to difficulties in understanding of reforms of reproductive practices for socio-political changes. The third problematic was national efficiency. In the late colonial period, national planning was influenced by politics of reproduction. Therefore, maternal and child welfare, population control and development of the nation were regarded synonymous.

Social reforms were seen as integral to ‘progress’, to be undertaken at various sites, like marriage, family and education, where the focus was on controlling women’s bodies. With colonialism, brahmins, the privileged caste group in the Indian caste hierarchy, used the benefits of western education and hence got official positions. This reinforced their dominance within Hindu society and they became advocates of social reforms and orthodoxy (Kosambi 1996). There was a shift in the focus of social reforms since development was being defined in medical terms, emphasising on hygiene, aiming to reduce infant mortality and morbidity rates.
Despite the shift in the focus of development, gender and class divisions reinforced the notion of the ‘ideal woman’—‘self-sacrificing, chaste, loyal mother’ (Whitehead 1996: 207). This reflected female respectability through controlled sexuality and chastity which had undercurrents of class elements which was maintained by social reformers. ‘Women’s body as nation’ was used as a metaphor by reformers to regulate bodies, minds and population. This metaphor was highlighted in the biomedical discourse and Indian historiography to control female sexuality in the name of development and progress of the nation.

The concern of the state, deeply embedded within the modernisation project was two-fold—first, to educate women to access institutional care; and second, to reform dais by eliminating the ‘unhygienic’ practices. Whitehead (1996) argues that early twentieth century social reformers targeted middle-class women to get educated. They tried to achieve this by advocating social reforms in a way that built a nexus between motherhood and biomedicine. Consequently, biomedicine became a medium in defining women’s role, by constructing the narrative of women as homemakers. Thus, the urban middle-class linked scientific modern progress with confinement to the private sphere of the household and focussing on child-rearing. This was also in line with the image of the ‘ideal’ woman as projected by social reformers—the educated mother who had knowledge about being a homemaker and understood the importance of hygiene, thus, making her accept the image of a ‘modern’ mother.

Social reformers advocated public health models of motherhood emphasising on improving hygiene standards within their houses (Whitehead 1996). With emerging emphasis on public health and inclusion of women’s health and hygiene, many dispensaries were opened in cities and towns in the late nineteenth century. The health status of women was used for measuring progress of the nation. The hygiene model of public health focussed on improving housing and sanitation. The public health projects of early twentieth century also reinforced the notion of the nuclear family and the gender division of labour with mothers as homemakers and fathers as providers. The health of a nation was related to women’s domestic labour being carried out more scientifically.

Other social reform movements like the Arya Samaj also reiterated this relationship between ‘vitality of Indian women and strength of the nation’ (Whitehead 1996:198). Dayanand Saraswati, argued that mothers ought to be educated and proposed the learning of the basics of sanitation to prevent diseases and maintain
family. The Arya Samaj also critiqued early marriages on the grounds that it could result in the reproduction of unfit and weak children, ideas that reinforced the colonial ideology of improving motherhood to have a healthy population.

Mary E. John and Janaki Nair (1998) argue that in the nineteenth century, sexual practices were the focus of reform by colonial administrators and missionaries. Social reforms targeting women’s sexuality is also analysed in J. Devika’s work (2008), *Individual householders, Citizens: Malayalis and Family Planning 1930-1970*, which is contextualised in Kerala. She explores the transformations in rural Kerala in favour of small families by controlling birth as a way to claim social mobility. She argues that the state and the reformers invoked the notion of respectability by popularising the prevalence of nuclear family through family planning methods. Devika further discusses how women themselves availed family planning methods through social reforms under the ‘Kerala Model’ which shaped ‘modernity’ as an extension of ‘rational’ nationalist development. There were efforts to link development with reproduction in order to have disciplined individuals. The success story of Kerala’s development is highlighted through its achievements of family planning and 100% institutional delivery (NFHS III, International Institute of Population Sciences 2006).

Devika (2008) further discusses that the reformist discourses of colonialism focused on progress and elimination of ‘primitive’ features of society. As a part of social reform, child rearing was targeted and was adopted as a means for upward mobility. This led to ‘domestication’ of Malayalis— a process due to which people concentrate on their homes. Malayalis had aspirations to become more modern, and this was to be realised through the site of the domestic sphere. It targeted children along with controlling women’s reproductive functions through measures of population control. A modern, ideal woman was constructed to be one who handled private and public affairs equally well. Public affairs were seen through actively participating in the state reforms of family planning in a non-coercive way. Devika argued that this was related to increasing domestication of Kerala society and the role of ‘modern’ mother as homemaker. In order to achieve social upward mobility, women themselves opted for family planning, which also enabled women to negotiate with one type of patriarchal institution by ‘choosing’ another one. This was perceived to be ‘liberating’ from traditional structures and at the same time also a marker of ‘modern’ patriarchy.
Kalpana Ram (1998), in the context of Tamil Nadu, discusses how reforms were remoulded and seen through a blend of Tamil clergy, Christian values along with scientificity which reinforced patriarchal role of mothers and wives. Ram discusses a pamphlet by a reformist priest, Father Alphonse, known to provide sexual counselling for married people that aims to rationalise false beliefs and myths with respect to sexual urges. These ‘rationalities’ were seen in terms of biomedicine. Thus, one can argue for bodily knowledge being equated with biomedical knowledge of the body. Through social reforms, it was emphasised that social control is replaced by inner control through new definitions of self and different parameters of normative conduct.

The colonial state, with their modernisation projects, targeted women’s fertility apart from hygiene and other public health issues. Jolly (1998) discusses the way indigenous knowledges regarding mothering was targeted in the colonial and post-colonial period with undercurrents of promotion of the supremacy of modernity and science in Asian communities. She also argues that women had not passively internalised these practices which were introduced as a modern package of patriarchal control on women and their sexualities under the ‘modern mothering’ and ‘maternal improvement’. Jolly asserted that women did not succumb to these projects, but ‘embraced’ them selectively. Such choices were influenced by women’s class, caste and ethnic backgrounds.

Discussing the context of Malaya, Maila Stivens (1998) argues that similar processes of the imposition of ‘modernity’ were replete with women’s negotiations and resistances. The colonial state blamed mothers for low progress levels and focussed on women’s roles as wives and mothers. Similarly, in the context of Bangladesh, Lenore Manderson (1998) discusses how the natural process of mothering was questioned and mothering came to be medicalised and hence under the purview of state intervention. Manderson also argued that women actively selected and adopted state interventions through reforms.

**Reforming through the state programmes and policies.** The post-colonial ideology of the state is seen as an extension of the colonial ideology which focuses on reformation through controlling women’s sexuality and women’s bodies. Maya Unnithan-Kumar (2005) defines the state, borrowing from Hansen and Steppuhatat, where they argue that the state is ‘both, an illusory as well as a set of concrete institutions, as both distant and impersonal ideas as well as localised and personified
institutions; as both violent and destructive as well as benevolent and productive’ (Unnithan-Kumar 2005: 5). Further, she points that the state is influenced by the global discourses on reproductive health that brought international population programmes and state programmes together. Unnithan-Kumar (2005) argues that population management and medical technology exercise control over women’s bodies. This makes women key targets of development signifying ‘economic and social progress’ of a country.

In the post-colonial period, population growth became a global concern and the agenda of controlling women’s fertility was taken over by the state through various programmes and policies. The Family Planning Programme in the mid 1960s was one of such major initiatives which focused on method-specific family planning targets (Visaria et al. 1999). With a tremendous increase in the population of developing countries, the First World proposed breaking the link between poverty and population by controlling high fertility of the poor and minorities (Jeffery et al. 1989; Chayanika et al. 1999; Patel 2006). This notion of development, with its underlying Neo-Malthusian ideologies, was publicised by the global funding agencies. This ideology was consequently integrated in the Indian developmental policy as India witnessed various programmes and plans to control population growth in order to achieve ‘economic growth’. Rao (2004) has discussed extensively the strategies and programmes to control population that were formulated. Thus, the independent Indian state came to play an over-arching role in the lives of the urban poor by targeting them in most of the policies and programmes and through its population control policies became an important stakeholder in taking decisions on behalf of urban poor women (Chayanika et al. 1999).

The Family Planning Programme later became Family Welfare Programme that looked into Family Planning and Maternal and Child Health services through primary and community health centres and district hospitals. In the 1970s, the state focused on sterilisation by ignoring the choice of the client (Visaria et al. 1999). In order to bring down the maternal mortality rate, the state, in the year 1992 introduced Child Survival and Safe Motherhood Programme with a little improvement in the quality or availability of reproductive health services for women. Although, the state abolished the target approach, to introduce Reproductive and Child Health programme in the year 1997, little was done on the implementation front. Visaria et al. (1999) further argue that under the reproductive health services, providers extended referral services,
counselling services, along with monitoring and evaluating performances including ANC, delivery and PNC. Recording and monitoring also saw the way women’s pregnancy and birthing bodies were controlled through state programmes. An extension of colonial ideology of promoting institutional deliveries through state-funded programmes and the colonial construct of perceiving dais as ‘unhygienic’ and ‘dirty’ has been seen through schemes and programmes even in the late twentieth and early twenty-first century through National Maternity Benefit Scheme in the year 1995 to Janani Suraksha Yojna in the year 2005. The state also provides monetary incentives to attract women and encourage them to opt for hospital deliveries.

Thus, the state play a crucial role in controlling pregnancy and childbirth, but also pregnant women’s bodies by recording examinations in antenatal care and institutionalised deliveries which rendered women ‘powerless’ owing to the institutionalisation of biomedical care. The state is also responsible for imparting knowledge, attitudes, practices and, in turn, influencing the behaviour of people, especially the urban poor. Through its intervention programmes, the state aimed at ‘improving’ their ‘target’ of reducing health statistics like infant mortality rate and maternal mortality rate.

Studies have also shown that in addition to the authority of state, upper class and upper caste men also considerably appropriated women’s knowledge, skills and bodies, which became strong sites of domination (Ubero 1996; Whitehead 1996; Ram 1998; Forbes 2005). Kalpana Ram (1998) discusses the influence of modernity on pregnancy and childbirth by arguing that caste and class privileges impose notions of what constitutes rationality and what does not. She elaborates on this through an illustration of how the lower caste Mukkuvar women, who traditionally belong to the fishing community, are subjected to violence with respect to institutionalised deliveries. The dominance of factors like caste and class over women’s bodies is manifested through scolding and lecturing imparted by impatient nurses and doctors who abuse and demonstrate a condescending attitude to these women (ibid.). Ram (1998) also discusses how women themselves have internalised this ‘rationality’ as normative, imposed on them by the upper caste, upper class women and men respectively, to such an extent that they begin viewing their bodies through an upper caste, upper class lens.
Medicalisation of childbirth. Women’s bodies have been under patriarchal control to reinforce power asymmetries (Oakley 1984; Ram 1992, 1998; Van Hollen 2003; Ghosh 2010). Medicalisation of childbirth is one such arena which is understood by feminist scholars not merely as a medical advancement of technology, but coercive medical intervention which could lead to women losing control of their bodies during childbirth. ‘Medicalisation’ is seen as a process by which medical experts become an all pervasive stakeholder in taking everyday life decisions about pregnancy and childbirth (Oakley 1976, 1984; Graham and Oakley 1981; Van Hollen 2003). It involves widely used technological apparatuses, surgical interventions during the time of delivery which Jeffery et al. (1989) and Kolenda (2003) maintain are often unnecessary and harmful. This reflects how women’s reproductive bodies become the objects of the ‘medical gaze’. This medical gaze constructs and reinforces hierarchy between the medical expert, ‘the looker’, and the so-called passive ‘victim or patient’, who is almost invariably ‘the looked at’ (Danaher et al. 2000).

Ann Oakley (1984) discusses two phases of medicalisation of pregnancy. The first phase starts by enveloping pregnancy within the purview of medical discourse as a ‘natural’ state in the seventeen and eighteenth century. The second phase discusses the redefinition of pregnancy as a medical phenomenon in terms of pathology. Graham and Oakely (1981) are of the opinion that there is a tendency in bio-medicine to treat pregnancy as an illness, since it requires various tests and procedures for examination for assurance of safe delivery and better maternal care.

Feminists have argued that pregnancy and childbirth are natural, physiological capabilities of the female body which is associated with ‘wellness’ as opposed to ‘illness’. Positioning pregnant women as ‘patients’ means that their bodies become objects of legitimate interest on which health professionals perform experiments and procedures (Johnson et al. 2004). This power that the biomedical ‘experts’ wield over the ‘patient’ is derived from the hegemony of the biomedical discourse which objectifies the ‘patient’ and renders her helpless due to her lack of knowledge about medicine and medical technology. The biomedical discourse, thus, perpetuates exploitation, oppression and violence by one class of ‘experts’ upon another class- the so-called ‘passive patients’. Rosemary Tong (1989) is of the opinion that placing women in a passive position can result in her experiencing pregnancy as an alienating experience.
Feminists, while critiquing the medicalisation of birth, suggest that ‘modernity is patriarchal in nature’ as it brought men to encroach upon and control the sphere of pregnancy and childbirth, which was traditionally considered as a ‘women’s domain’ (Perkins 1996 as cited in Ram 2001). This ‘sidelined’ women as midwives since modern male doctors began to ‘overtake’ it by practising more ‘scientific’ and ‘rational’ ways of dealing with pregnancy and childbirth. Feminists believe that this has reduced women’s bodies to a ‘mechanistic and physiological process’ (Martin 1987 as cited in Ram 2001). Even with reference to women’s bodies, the biomedical discourse assumes a patriarchal position that often implicitly violates women’s bodies. In fact, the presence of male doctors examining women makes the latter uncomfortable and vulnerable to sexual abuse. However, this is ‘naturalised’ by not only the dominant discourse of the medicalisation of pregnancy but also by women themselves, when they justify such violence and violation of their bodily integrity in the name of professionalisation of biomedicine (Van Hollen 2003). This process led to disregarding women’s knowledge of midwifery and traditional healing and monopolisation of healthcare by male medical professionals by the nineteenth-twentieth century (Ehrenreich and English 1973; Oakley 1976).

The feminist discourse on medicalisation of pregnancy and childbirth challenges the dominance of the biomedical discourse and posits women as active agents of their bodies. Feminists argue that women should have a right to take decisions with respect to their bodies rather than to merely accept the ‘advice’ given by the medical practitioners. Maya Unnithan-Kumar (2005) asserts that while on one hand, medical intervention is perceived as controlling women’s bodies and agencies, on the other hand, it is also seen as empowering. In this context, empowerment of women is equated with reproductive consciousness. Lock and Kaufert argue that women have a ‘complex response’ towards medicalisation. They refer to women’s response to medicalisation as ‘pragmatic’. This is seen through how women are not victims of medicalisation but as active agents who act in their own interests. Maya Unnithan-Kumar (2005) argues that feminists believe that women’s reproductive functions should be in the control of women, but which, as a result of the medicalisation process, has been shifted to the domains of the state and biomedicine.

Ann Oakley (1984) discusses how antenatal care (ANC) controlled women in the process of medicalisation of pregnancy. She argues that ANC had a close nexus with population control which was in the interest of the state. She further asserts that ANC
before the nineteenth century focused on lifestyle and a few therapies. It was after the nineteenth century that technology was used to overpower mother’s experiences of pregnancy and thereby controlling pregnancy.

In the context of the West, Ingrid Zechmeister (2001) discusses that ultrasound restricts women’s reproductive freedom by forming new power-relations that reinforce women’s subordination. In the context of Canada, studies discuss how medicalisation of childbirth leads to curtailment of freedom of choice in institutional delivery. Women are aware of medicalisation of childbirth and they resist it in favour of midwifery. They make choices to resist going for hospital delivery and instead opt for midwifery. By making this choice, women gain internal strength and confidence that they can give birth without any biomedical intervention. This is closely related to empowerment, as a process and as an outcome of women’s resistances to medicalisation (Parry 2008; Shaw 2013). The loss of self-confidence regarding birthing, leads women to feel disempowered. Shaw (2013) further clarifies that medicalisation of delivery does not mean advancement of technology but unnecessary usage of medical technology. These two aspects are closely related, thus, recognising the linkages between disempowerment and overuse of technology calls for demedicalisation of childbirth.

In the context of India, medicalisation of childbirth is seen through usage of medicines to induce pain and caesarean deliveries (Ram 1998; Van Hollen 2003; Hodges 2006). In her study in Tamil Nadu, Van Hollen (2003) also discusses medicalisation where women opted for oxytocin drugs to increase pain. This was in sync with the cultural belief of linking pain with regenerative powers that made women opt for oxytocin drugs. Women used biomedical technology to influence their regenerative power either to increase or decrease *sakti*, which is required to give birth. The social construction of ‘pain’, that is, how pain is considered ‘normal’ and ‘natural’ for women during childbirth is also discussed by Rosemary Tong, who argues that ‘men have even dictated to women how to feel during the process of childbirth- when to feel pain and when to feel pleasure’ (Tong 1989: 80). Further, Tulsi Patel in her study in a rural setting in Rajasthan (2006) asserts that normalisation of pain is culturally bound and is internalised by women.

Van Hollen (2003) discusses how medicalisation gave different meanings in diverse cultural contexts. She further argues that the cultural and political contexts of India influenced the intensity of biomedicalisation of birthing. She explores how
medicalisation of birth, seen as a manifestation of modernity, influenced the experiences of childbirth through women’s power and cultural conceptions of maternity. She discusses the notion of vali, which meant both pain as well as power. It is culturally believed that women’s reproductive ability is related to suffering, which in turn is necessary for childbirth. Thus, women were forthcoming in the adoption of biomedicine that fitted the cultural ideology of women’s suffering and pain. Despite being conscious about the hostile and painful experiences, women subscribed to these practices as they believed that this would enhance their respect. Kalpana Ram (1998) discusses how poorer women preferred home births with a help of a midwife since women wanted to avoid medical staff, who encouraged caesareans which was not aligned with the cultural value of enduring pain. Women expressed that biomedicalisation of birth hindered their ‘religiously informed expression of femininity’ (Ram 1998:136).

The class aspect is seen through the way medical drugs were used to reduce labour pain for middle and upper class women. They, it was believed, could not withhold pain and therefore required anaesthesia. This practice was largely prevalent in private hospitals in urban areas. Van Hollen (2003) argues that socio-economic status influences medicalisation. Henrike Donner (2003), in her study on delivery experiences of middle-class Bengali women in Calcutta, argues that women could choose and negotiate aspects of ANC and PNC within medicalisation of pregnancy and childbirth. This makes women empowered in certain ways. Donner argues that the residential patterns and involvement with household chores influence women’s decisions to opt for caesarean section. This provided women respite from the household by giving them a ‘sense of privilege’ (Donner 2003: 333). In another study by Ghosh and James (2010) explore the linkages between increasing technological intervention during childbirth and factors that led to increasing caesarean-section. They discuss both medical and non-medical reasons for undergoing caesarean. It was argued that caesarean-section rates are higher in urban areas as compared to rural areas in India. Ghosh and James (2010) associate higher levels of women’s choice and decision making in favour of caesarean-section with access to and achievements of education, place of residence, socio-economic status and factors like the widespread prevalence of private sector healthcare.

In the post-natal phase, studies have also discussed how forcefully, without women’s knowledge, contraceptives were inserted in the pregnant women’s bodies
(Graham and Oakley 1981; Treichler 1990; Lazarus 1994; Ram (n.d.) as cited in Ram 2001; Van Hollen 2003). This experience of women’s encounters with forcible insertion of contraceptives reflects the naturalisation of violence in institutionalised settings of healthcare.

**Studies on Pregnancy and Childbirth**

The present section will map the studies on pregnancy and childbirth through the following perspectives—public health perspective, political economy perspective, and feminist and cultural perspectives. Studies with public health perspective focuses on reforming the existing biomedical services like improving the availability and accessibility of biomedical services related to ANC, institutional deliveries and PNC. Another strand within the public health perspective also focuses on getting women to overcome cultural barriers through the modernisation and biomedical framework. Studies also focus on the aspect of service delivery that is, providing quality services to women belonging to the poor sections in order to reduce the maternal mortality rate.

Studies with the political economy framework focus on how socio-economic factors act as barriers to accessing biomedical services. Another strand of studies within this perspective has focused on the ways in which women are viewed in population and reproduction policies and programmes, in the sole capacity and role of reproducers and mothers.

Feminist and cultural perspectives critique the above perspectives by arguing that accessibility and availability of biomedical services are not the only reasons for women to not avail biomedical services during ANC, delivery and PNC. Feminist theories argue that there is a need to understand the underlying deep structures, ideologies and institutions that reinforce patriarchy and influence women’s experiences. Moreover, feminist theories state that women’s experiences need to be understood in their context rather than through rational generalisations. Studies from feminist perspectives also critique the other two perspectives that view biomedicine as the only valid medical knowledge system through a strategic sidelining of other cultural knowledges on pregnancy and childbirth.
The Public Health Perspective

The Public health in the context of pregnancy and childbirth focuses on controlling population. In the post-independent era, it was introduced as ‘family planning’ and later became ‘family welfare’. It was in the 1990s that the concept of reproductive health was brought in to replace ‘family welfare’ (Kulkarni 2011). Reproductive health, opposed the then focus on overpopulation and the perception of women as reproducing machines. This resulted in a ‘paradigm shift’ where the focus shifted to women gaining knowledge about her sexuality, regulation of her fertility through access to information, right to freedom from reproductive morbidity and mortality, an ability to bear and rear healthy children and to include birthing in the sphere of individual right to sexual and reproductive health (Qadeer 1998b; Pachauri 1998).

A report by the Population Council praises the global family planning programme as ‘the most successful development intervention of the past fifty years…governments are able to reduce fertility and produce large scale improvements in health, wealth, human rights and education’ (Bongaarts et al. 2012: ix). It further argues that the aim of public health is to reduce inequalities in access and use of biomedical health services– access, quality, and cost of biomedical services.

In the context of India, public health studies have broadly focused on a) indicators of maternal health (namely maternal mortality, ANC check ups, institutional deliveries, PNC visits, immunisation), b) utilisation of maternal health services by women, and c) an analysis of maternal health and child health programmes. Women’s autonomy is an important aspect of maternal health that reduces maternal morbidity and mortality. Autonomy is dependent on socio-economic and demographic status of women– cost of care, maternal age, women’s earning status, educational level, to name a few (Dyson and Moore 1983; Leslie and Gupta 1989; Bloom et al. 2001; Mahapatro 2012). The indicators of women’s autonomy include women’s mobility, decision making powers, status of women, age hierarchies, levels of male employment, coping strategies with instances of male alcoholism and domestic violence (Ramasubban and Rishyasringa 2001; Matthews 2005). The link between financial empowerment and autonomy is discussed by Rammu (1988 as cited in Mahapatro 2012) when he discusses that employed women have greater autonomy as compared to those restricted to household chores. Apart from these, women’s autonomy is linked to the cultural context of kinship relations and property rights. In
the context of traditional societies in India, the issue of physical mobility is particularly significant (Bloom et al. 2001). Thus, studies show that women who have greater autonomy utilise maternal health services more.

Women in southern India utilised health services better as compared to women in northern India (Dyson and Moore 1983). Within southern part of India, Navaneetham and Dharmalingam (2000) discuss Tamil Nadu, Andhra Pradesh and Karnataka and argue that the determinants of maternal health care services differ across the three states. They attribute this to the difference in accessibility and availability of maternal health services. They also point out that women in rural area received more ANC check up as compared to urban women, who have more access to maternal health services. They acknowledged the role of Auxiliary Nurse Midwife (ANMs) and MPHWs (Multipurpose Health Workers) in giving rural population information by visiting their homes since it reduced cost incurred on utilisation of maternal health services.

In a study by Ramakrishna et al. (2008) conducted in rural Karnataka and argue that women preferred to deliver at home. This led to a need to improve quality of ANC, delivery and PNC. Thus, public health approach focussed on these issues to tackle one of its major obstacles to good health, which is, decrease in maternal mortality rate and reducing unwanted pregnancies through promoting contraceptives, its benefits and side effects through behaviour change communication, counselling and media and encouraging discussions among couples towards its usage to regulate fertility rate.

The third aspect of public health studies focuses on various programmes and policies on maternal health. The state funded programmes aimed at remoulding programmes and policies that focussed on women-based services by contextualising women within their socio-cultural surroundings. Radhika Ramasubban and Shireen J. Jejeebhoy (2000) discuss that reproductive health issues have socio-cultural ramifications that are influenced by power-laden gender relations. They recognise gender power imbalance as an obstacle to women’s reproductive health. The public health approach attempts to address the consequences of unequal gender relations in reproductive health by ‘bargaining’ for quality biomedical services for women during pregnancy and childbirth.

In the context of Asia, studies have shown that women have decision making power as far as accessing biomedicine is concerned. This is dependent on various
factors like educational level, earning status, number of children and women’s position within the household. In the context of Indonesia, Frankenberg and Thomas (2001) examine bargaining power within couples and the use of ANC and delivery care. They argue that economic and social dimensions of distribution of power between spouses influence women’s use of ANC and delivery care. Meurs and Giddings (2012) study in the context of Tajikistan assert that women’s spouse and eldest women in the household take decisions regarding accessing maternal health services. Also, women are less likely to access maternal health services if they have previously had children. Furuta and Salway (2006), in the context of Nepal, explore the way socio-cultural factors influenced the use of healthcare focussing on women’s position within the household influencing use of healthcare. They argue that education, spousal communication, women’s status within the household also determine women’s access of maternal health services.

Another strand within public health approach argues for strengthening providers at the level of primary care. The public health perspective proposed the inclusion of only trained *dais* as Auxiliary Nurse Midwife (ANMs) in the framework of medicalised birthing. Mavalankar and Vora (2008) argue, ‘in the overall job description of the ANM, the “M”, the role of “Midwife” has been neglected’ (ibid.:4). They assert that in order to achieve the objective of reducing maternal mortality rate, there is a need to focus on comprehensive reproductive health. They cite the reasons for change in the role of ANMs from being a midwife to being a preventive health worker focusing on family planning and immunisation. In discussing the ANMs’ changing role, Mavalankar and Vora (2008) discuss some factors, firstly, changing policy and programme priorities from maternal health to family planning and immunisation of children. Thus, ANMs were no longer required to stay in villages to conduct deliveries. Secondly, poor quality monitoring, evaluation and inattention by international agencies like Unicef, that shifted the focus to child survival. Another factor that the authors elaborate on is, change in training and placements of ANMs. The training of ANMs in the 1950s focused on midwifery within the ambit of Maternal and Child Health. There was a shift in the role of ANM with the formation of Multi Purpose Health Worker Committee in the year 1977 that argued for a shift in the role of ANMs to one of a Multi Purpose Worker (MPW). Lastly, Mavalankar and Vora (2008) discuss training of traditional birth attendants as an alternative to relieve the ANMs from conducting deliveries. They argue that training TBA was carried out
under the Child Survival and Safe Motherhood, and then under the RCH programme. However, they assert that this training could not qualify traditional birth attendants as ‘skilled birth attendants’. NGOs have also ignored ANMs and have instead focused on training TBAs.

Although the public health approach recognises women in their context, credit their experiences, provides space for women’s autonomy and bargaining, but these bargainings are restricted to the availing of maternal health services. Mohan Rao (2004) calls public health a state propaganda that promotes medicalisation of pregnancy and birth by bringing pregnancy and childbirth to hospitals, doctors and obstetricians by linking it up with state family planning programmes. The public health approach popularised and advocated biomedicine as the only valid, scientific, true and empirical medical knowledge system through systematically devaluing other knowledge systems around pregnancy and childbirth, like the dai tradition or other women’s experiential knowledges.

The Political Economy Perspective
As seen in the discussion above, the state along with biomedicine, control women’s bodies and knowledges. Imrana Qadeer (1998a) traces historicity of women’s subjugation and control to transformation from tribal to agricultural settlement where productive and reproductive activities of women have been recognised in agrarian economies. With capitalism, women began to be viewed as reproductive machines which would reproduce potential, cheap and efficient labour force for the capitalist system. This became the basis of state ideology since this was the prevalent ideological perspective of the First World.

Further, Qadeer, argued in a seminar held in Kolkata in the year 2003 on ‘Public health in India: Colonial and Post-colonial Experience’ that in the colonial period, public health interventions had an underlying ideological aspect of control that employed factors like class, caste and local cultures to perpetuate the power and authority of the British state. Qadeer asserts that in the post-colonial era, this ideological core of control was extended by the newly independent nation state (Soman and Subhoranjan 2003).

A set of political economy studies focus on the consistent failure of the various programmes and policies of the state. Unlike the public health perspective that
glorifies family planning programmes and reproductive health programmes and policies, the political economy perspective argues that by the end of 1980s and 1990s, the Family Planning Programme was barely able to survive. Studies have argued that the most significant reason for failure of state-funded programmes was that they were not contextualised in the social lives of women (Jeffery et al. 1989; Karkal and Pandey 1989; Qadeer 1998a; Barnes 2007). As an important stakeholder in deciding and defining women’s fertility, the post-independent Indian state played an overarching role in the lives of the urban poor by targeting them in most of its policies and programmes. These programmes encouraged antenatal and postnatal checkups, hospital deliveries and usage of contraceptives.

The state-funded biomedical intervention played an instrumental role in the life of a woman from the time she conceived, or from the time she started her journey towards becoming a mother (Karkal and Pandey 1989, Karkal 1998; Gupte 1998; Lingam 1998; Qadeer 1998a, 1998b; Kumar 2002; Rao 2004). Throughout the Five Year Plans, the state reinforced its patriarchal ideologies by viewing women only as reproducers and in targeting their bodies as objects. Thus, the burden of fertility regulation was borne by women. Several studies show that state-funded health programmes were ‘women-targeted’ rather than ‘women-oriented’. Manisha Gupte (1998) argues that women’s health has been viewed from the perspective of procreation, and therefore has been limited to married women. She argues for a need to include women’s health services within the purview of health policies. Rachel Kumar (2002) challenges reproductive health programmes and the state’s approach to women. She argues that women are seen as mothers to potential and cheap labour force.

Karkal and Pandey (1989) had earlier argued that demographers did not link the demographic parameters to the social parameters and focused on the quantitative aspects of population control- infant mortality rate, maternal mortality rate, birth rate, death rate. As a result, population policies became synonymous with family planning. Karkal (1998) also points out that though the focus of the programme was on welfare of women and children, it turned out to be a demographic one, targeting reduction of birth rate. Moreover, state policies tend to homogenise women on the basis of providing for their reproductive needs. Thus the state has assumed a utilitarian approach towards its womenfolk, with the ‘usefulness’ of women having been focused upon in various reproductive health policies. To add to the critique of state
policies and state-funded programmes, Mira Sadgopal (2009) argues that while primary healthcare was largely overlooked in these national health programmes, the focus was on promotion and distribution of iron and folic acid tablets, immunisation and oral rehydration for diarrhoea along with family planning for population control. Thus, even at the policy level, the overall health of the expecting women was sidelined.

The state health care programme for women are not only subjected to critical evaluation of their ideological content but also examined in terms of the accessibility and quality of services provided. Leslie and Gupta (1989) argue that economic factors like loss of daily wages during periods of hospital visit, transportation cost and fixed working time of the PHCs contributed to inadequate and insufficient utilisation of health services. Jeffery et al. (1989) opine that there is a cultural gap between the way health workers and rural population understand physiology, disease and treatment which become another obstacle in accessing health care. Karlekar (2000) explores various factors responsible for low accessibility of biomedical services by women. She attributes infrastructural and institutional reasons like unavailability of services due to remoteness, inadequate transportation and condescending attitude of biomedical staff and fear of losing out on daily wages. She, thus, opines that the state should focus on inadequate facilities, non-availing of existing facilities and need to improve indigenous systems of medical healthcare. Further, Radhika Ramasubban and Bhanwar Rishyasringa (2008) discuss three factors that discourage access to biomedical services in a slum in Mumbai— a) women’s perceptions that causes of many health issues are related to diet and are not medical in nature; b) poverty as an obstacle to accessing biomedical services; and c) the absence of support from the family to seek prompt treatment. In a recent study, T K Sundari Ravindran (2011) explores whether public-private partnerships in the area of maternal health have been able to provide quality maternal health services that are affordable and accessible for weaker sections of the population. She argues that public-private partnership has neither improved availability nor accessibility to maternal child health services in rural areas.

While discussing quality of services, Jeffery et al. (1989) argue that women’s medical services are placed lower on priority within the arena of health. Even within these highly popularised and prioritised population control programmes and maternal health in general, health staff do not abide by the national policy of ensuring that
health services reach rural population since they consider obstetrics to be an urban and hospital based speciality. Therefore, ANC in sub-centres are not taken seriously by health staff. They further argue that establishing medical facilities in rural areas would require infrastructure not only for spreading a network of health centres but also to attract doctors from town. Foo and Koenig (2000) discussed quality of care within family planning programmes and argue that the focus should be on more than just reaching out to the beneficiaries. Commenting on the relationship between biomedical staff and rural women, Jeffery et al. (1989), Leslie and Gupta (1989), Ram (1998) and Van Hollen (2003), discuss the insensitive, distant and hostile attitude of hospital staff towards rural women which is enacted through a condescending attitude of the former towards the latter and the rural women are considered dirty and illiterate whereby they are often incapable of comprehending doctors’ instructions, the nature of which is esoteric. Biomedical staff was seen to be indifferent towards them and were only interested in meeting their targets set by the states through various policies and schemes (Rao 2004; Forbes 2005).

The state is critiqued for its target based approach within the reproductive health paradigm, where it was argued that women’s sexual and bodily rights should be upheld, contraceptive responsibility should be shared by men, and women should have full knowledge about the side effects of various contraceptives. In spite of voicing these concerns, they were still not highlighted in the various national health policies (Pachauri 1998) which are based on biomedical knowledge (Lingam 1998). Rao (2004) is of the opinion that women’s needs were equated with contraceptive needs in policies and programmes of the state. Imrana Qadeer referred to this vulnerable situation of women as being ‘bound to become not only targets for selling contraceptives… but also guinea pigs for so-called “research”’ (Qadeer 1997: 86 as cited in Karlekar 2000). The patriarchal attitude is internalised and reflected in their behaviour of utilising biomedical facilities on the part of women, despite being aware of the hostile behaviour during institutional delivery (Karkal and Pandey 1989, Karkal 1998; Kumar 2002). Anandhi (1998) and Ram (1998) discuss that the ideology of the state is maintained not only through class relations but also through caste relations. In this regard, the upper castes teach the lower castes about reproduction by reinforcing not only the values of modernity that include scientificity, progress and hygiene, but also reinforcing patriarchal norms that keeps the caste and gender system intact.
The state’s continuous efforts of targeting and blaming traditional midwives for high maternal mortality and morbidity rates have been critiqued by many scholars. Sarah Pinto (2008) critiques state interventions, which are seen through policies and programmes focussing on women’s health. She argues that forms of interventions have changed but the underlined ideological content of controlling women’s bodies is upheld. The Safe Motherhood programme saw training of TBAs, provision of delivery kits and strengthening of obstetric emergencies. This may be read as an extension of the colonial ‘civilising project’ under which dais were targeted and future efficient ‘labourers’ were protected to work for the erstwhile colonists, (Pinto 2008). In an earlier study, Jeffery et al. (1989) also discuss the state’s initiative to include dai-tradition as an alternative, however through integration within the dominant framework of biomedicine. To this end, dais were provided training and were considered to provide cheap and safe services. In north India, dai programmes failed due to the state’s inefficiency and inability in understanding dais and their birthing practices in relation to structural restrictions of daughters-in-law at their conjugal extended household, where they are not always the decision maker regarding accessing health services. Along with this, the local understanding of childbearing also has notions of shame and pollution attached which the dai training programmes did not acknowledge. In a recent study, Krishna Soman (2013) recalled the focus of Bhore committee and National Planning Committee on integrating the traditional dai into the public healthcare framework. However, this attempt to integrate trained and untrained dais did not meet success. She further argues that government has overlooked dai knowledge system, skill and experience. There appears to be a dearth of literature on the revival of the dai-tradition by the state.

As one of the endeavours to integrate dais knowledge within biomedical discourse, Barnes (2007) mentions home-based skill services. She is also of the opinion that the dai-tradition has certain ‘harmful’ practices, which biomedicine should not incorporate. She further recommends that community based birth attendants can be ‘taught’ the way to conduct deliveries, to address minor health issues and work towards improving accessibility to hospitals. Sadgopal (2009) also proposed ‘maternity care governance for the benefit of local communities’ by taking the inputs of dai-tradition in the health care systems by addressing the aspects of class, gender and power.
The literature reviewed on the political economy perspective, like public health perspective, does not acknowledge any other medical knowledge system other than biomedicine. Nor do they acknowledge women’s subjective, experiential knowledge. While studies from a political economy perspective raise important issues, they seem to have an underlined assumption of validating biomedicine as the dominant medical knowledge system.

**Feminist and Cultural Perspectives**

Feminist scholars like Janet Chawla (1994, 2002, 2006), Kalpana Ram (1992, 1998, 2001), Cecilia Van Hollen (2003), Tulsi Patel (2006, 2012), Sarah Pinto (2006, 2008), have suggested that it is not just a lack of access to biomedical services that constitutes a problem as has been suggested by studies of public health and political economy perspectives, but the nature of the problem is one which involves a linkage of the constructions, processes and practices to women’s lives and their distinctive cultural contexts.

Feminists have challenged the prevalent conception that *dais* were ‘unhygienic’ and were the main contributors to high maternal mortality rates and that biomedicine was the only medical knowledge system that deserved attention of policy makers, medical practitioners and academicians (Chawla 1994; Pinto 2008; Sadgopal 2009, Matrika 2010). Janet Chawla (1992, 2002, 2006) and Chawla and Pinto (2001) discusses *dais* by ascribing to them a cultural repository of knowledge. *Dais*, who belong to the lower, mostly untouchable castes, were called to assist with delivery of women across castes and communities. In a society that was deeply entrenched in the notions of ‘purity’ and ‘pollution’, the *dais* were symbolised as the carriers of pollution who would take birthing pollution with them and receive *neg* in return from the family of the delivering woman. Taking away of pollution meant giving way to purity. This was considered very significant in ritual terms. Another perspective that Chawla and Pinto (2001) and Chawla (2002) discusses is drawn from the *dai’s* historical position in the social ladder, as being in a *jajmani* relationship with their patron, where *dai* didn’t take any cash, but gifts in kind from the delivering women’s family in return for helping a woman give birth. While discussing the role of *dais*, Geoffrey Samuel (2002) mentions that midwives’ work is related to that of dispensing religious services. Unnithan-Kumar (2002) points out in the context of Muslim *dais* in
Rajasthan that the Prophet respected His mother’s midwife and thus, *dais* had a religious connotation attached to them. Razario (2002) shows that in Bangladesh, Muslim midwives believe that delivering one hundred and one children equates to going for a pilgrimage to Mecca.

Feminists argue that there is no one supreme knowledge possessor; instead women share their experiential knowledge in helping younger women with birthing. For feminist theories on birthing, knowledge is not reposed in one source, but is dynamic since it is being constantly created and added through women’s experiences. In the context of India, Sarah Pinto (2006) describes traditional childbirth by drawing from Veena Das’s concept of ‘ecology of care’, referring to social relations around childbirth. Maya Unnithan-Kumar (2002) also discusses this by mentioning that there are two types of midwives in the context of Rajasthan. The first type of midwives are kin midwives who support the pregnant woman emotionally and physically and is usually related by kin bonds. The other is the low caste midwife who is linked by community and assists in delivering the baby by dilation of cervix and progress of the baby in the birth canal. Tulsi Patel (2006) also states that childbirth is managed by some relatives and neighbours along with a *dai* where a *dai* is not considered an expert since the knowledge about childbirth is widely held by women.

The *dai*-tradition includes rites and rituals that *dais* perform to make sure that the birthing woman is able to deliver a child safely, take care of the new born and the new mother for days after delivery by massaging them. Scholars have also discussed various rituals carried out by *dais*, like the *aata* ritual, opening of knots to fasten delivery, calling Bemata (the goddess of childbirth) to help in delivery, keeping an iron sickle under *jachcha*’s bed to ward off evil spirits, facilitating post delivery practices of rubbing the placenta on baby if the baby is blue, throwing or burying placenta, conducting rituals of massaging woman and the child, celebrating *chatti* with the family and taking *neg* after performing all the practices (Gideon 1962; Chawla 1992, 2006; Mehrotra 2006; Pinto 2006).

Anuradha Singh (2006) opines that the *dai* knowledge is parallel to Ayurveda, based on the rationale of cure and care. Singh points out that the folk practices in India, refer to *dai* culture as having commonalities in practices with Ayurveda in the spheres of diet, work and medicines. Singh also mentions that Ayurveda places the mother in a dual position where she is both, the body and the knower of the body. *Dais* also abide by this principle. Apart from this, both *dais* and Ayurveda have
similar understanding on consuming food during pregnancy and childbirth. The similarity is seen in the way both traditions understand bodily processes and knowledge bases, which are embedded in rites, beliefs and rituals.

Another significant aspect of the dai-tradition that has been documented is the sideling or devaluation of dais in favour of biomedical practices where the state supported biomedicine formed its programmes and policies based on modern science and rationality by replacing religion and traditional beliefs and values. Modernity and scientism brought in the concept of hygiene, as opposed to the dirty methods of the dai-tradition; as discussed before, how biomedicine blamed the dai tradition for being responsible for high levels of maternal mortality and infant mortality rates. To introduce and subsequently gain acceptance of biomedical knowledge in India, it was decided to include women. To this end, ‘untrained’ and hence ‘unprofessional’ dais were asked to undergo trainings where the biomedical staff would ‘teach’ them the ‘correct’ ways of assisting deliveries (Lingam 1998; Qadeer 1998a; Van Hollen 2003; Rao 2004; Forbes 2005; Chawla 2006; Mehrotra 2006; Rai 2006; Sagar 2006). Chawla (1994) comments that the dai and her knowledge was demonised, devalued and discredited through a deliberate construction by the colonial and biomedical discourses. Mira Sadgopal (2009) also argues that some of these practices are being revived. Kalpana Ram (1998) and Van Hollen (2003) argue that traditions are being rearticulated and women continue to use them not in the traditional way as Gideon (1962) has described it but through strategic negotiations with patriarchy and all its institutions.

Contrary to the colonial and statist charges on dais are indicators that have revealed that the causes of high maternal mortality and infant mortality rates may also be attributed to poor nutritional levels and inadequate ANC (Karkal and Pandey 1989; International Institute of Population Sciences 2006). But studies have pointed out that most women in India are anaemic and thus consequently are not able to sustain themselves through childbirth (Engels 1996; International Institute of Population Sciences 2006). While there was a drive to incorporate dais within the biomedical framework, this was done at the bottom most rung. Singh (2006) mentions that there was no role of dais in the Mother and Child Health programmes which was among the most prevalent programmes in India and in which dai knowledge came to be regarded as marginal and bordering on quackery.
Studies also focus on the widespread expansion of health care and medical institutions, both public and private, due to state intervention thereby resulting in more women availing institutional deliveries. Soman (2013) has discussed the way *dais* are constructed in the twentieth century in Bengal. She compares the status of the *dai* during the colonial and post-colonial era. She argues that British reforms created two sets of midwives— one set that were trained as per biomedical knowledge and the others who possessed indigenous knowledge. She further mentions that there have been efforts by the state to integrate traditional *dais* into the public sphere, where equal status was proposed to be given to untrained and trained *dais*. However, this was not very successful. Soman (2013) asserts that *dais* have been used by the state agencies as per their convenience— as community mobilisers, link workers between community and public health care system under the National Rural Health Mission (NRHM).

The prevalence of *dais* at the site of birthing is also discussed by Lindsay Barnes (2007) in her study located in Jharkhand. She points out that there are three different medical knowledge practitioners during childbirth. At the site of delivery there were both the traditional *dai* and the RMP (multipurpose health worker). The latter administers oxytocin injections so that women deliver quickly and gives tetanus to mothers and baby post childbirth. Barnes also observed that RMPs do not assist during delivery although they are present at the time of delivery. A third practitioner, the *ojha*, is invoked when both dais and RMP lose hope about the survival of either the mother or the child. However, with spread of biomedicine and science, the influence of the *ojha* is significantly decreasing.

Even in a study by Shamima Islam (1989), in the context of Bangladesh, she mentions that the *dai* is a part of the Family Planning Programme and thus is considered to be an urban phenomenon. The ‘*dai* work’ is carried out by the *dhoruni*, loosely translated as the catcher of the new born, along with others who relieve the women’s womb. They are called the ‘barefoot obstetricians’, who are believed to possess knowledge and skills that are contrary to the maternal health planners.

Further, Mira Sadgopal (2009) asserts that the *dai* still plays an important role in childbirth. She discusses ‘maternity care governance for the benefit of local communities’ by exploring the ways to enhance existing services with inputs from *dais*. She further looks at implications of accepting *dai* tradition in the health care system and various dimensions of class, caste, gender and power. The above section
focused on studies that have made a claim for reclaiming women’s knowledge and strengthening women’s skills. These feminist studies also tried to challenge the construction of pregnancy as a disease associated with risk and pathology. The above discussions indicate a tussle between cultural knowledge of pregnancy and childbirth and biomedical knowledge system (Abraham 2009; Sujatha and Abraham 2012). This is attributed to the differing ontologies, epistemologies and standpoints and approaches between biomedical and cultural knowledge. While biomedicine locates pregnancy within the purview of pathology, cultural knowledge places it within natural and socio-cultural domain. Abraham (2009) refers to the coexistence of more than one medical knowledge system as medical pluralism. In the context of medical pluralism, women tend to draw knowledge from both the discourses. However, as established earlier, both cultural as well as biomedical discourses are patriarchal in nature.

**Women’s bargaining with and negotiating patriarchal structures.** The concepts of resistance, negotiations, strategising, bargaining and agency have been increasingly reflected in feminist studies. Feminists have used these concepts in different contexts and some have used them interchangeably. The present section explores ways in which these concepts are used in studies. Parker (2005) explores the way resistance is conceptualised in the social sciences. She analyses James Scott’s and Michel Foucault’s work on agency, two prominent theoretical perspectives of different epistemological standpoints. She critiques both the approaches for the ‘neglect of the subject of social critique’. She argues that both these theoretical perspectives fall short in focussing on the human subject by not considering the subject in its socio-cultural context. She also expresses that these approaches tend to perceive agential acts as binaries like agent versus victim, domination versus resistance and are unable to reflect subjectivity, knowledge and social relations of the subject. Parker also views ‘resistance’ as an action that actors themselves use in the context of opposition of power and that it should be directed towards the perpetrator of dominance, with a goal other than immediate self-interest. Parker also links the terms ‘agency’ and ‘resistance’ to argue, ‘agency has a potential to transform into resistances, but is perhaps more likely to be deployed towards ends that maybe self-serving and pragmatic’ (Parker 2005). Parker also defines agency as ‘active subaltern, a female with capacity to move and voice to express’. She goes on to discuss that agency does
not exist in its pure form since humans interact with one another and therefore pure agency would be a ‘denial of sociality’.

Kamala Ganesh (1999) places women’s agency in the context of gendered socialisation by questioning and exploring women’s reproduction of their subordination. She argues that women are active agents who ‘attempt to shape their immediate realities’ (1999: 236). Ganesh goes on to argue that women negotiate their position by drawing upon ‘alternative conception of gender available in the larger culture, and by making use of structural lags and ambivalence within patriliny’ (1999: 236). She argues that socialisation of girls not only teach them to adjust to circumstances against their wish, but also makes them learn negotiatory skills. These skills might not always favour women due to women’s subordinate status. Ganesh calls for women to have a subversive counter-culture.

An arena of women’s counter-culture is folk songs. Gloria Golwin Raheja (1988) Anjali Capila (2002), Vidya Rao (2006) discuss the way women articulate themselves against the patriarchy through oral culture of folk songs which are sung on different occasions. This oral tradition is transferred to younger generations through the process of socialisation. One such occasion is childbirth, where some songs, sung in women’s voices are seen as embodiment of motherhood, as well as showing resistance to some cultural practices.

While discussing women’s agency within fertility studies, Tulsi Patel (1999) discusses the way women take decisions against the backdrop of their poor socio-economic and kinship context. She asserts that women are active agents but their compliance to household and society makes the resistance aspect of their agency invisible. Patel mentions that since pregnancy and childbirth are areas considered to be ‘women’s arena’, it is constitutive of both subordination and freedom of women’s acts. Patel believes that women’s acts are influenced by ‘socially situated power equations’ that women perceive themselves to be in (Patel 1999:447). She also discusses complexities in women’s act in her not being considered a ‘free agent’ despite an enhancement of women’s status after proving her fertility in the household. The presence and role of the mother-in-law in women’s pregnancy and childbirth and the consent of the husband in the absence of the mother-in-law become important sites of women’s strategising, negotiating with and resisting patriarchal norms.

Van Hollen (2003) makes a distinction between forms of resistances in the West and in India. She points out that in the West, biomedicine was largely a hegemonic
institution where men had replaced midwives, but were unable to empathise with women and took complete control of women’s delivery in their hands, often making pregnancy an alienated experience for the women. In this scenario, women’s resistances are seen as counter-hegemonic, in aiming to do away with modern technology. In the context of Tamil Nadu, where the Van Hollen’s (2003) study is located, she argues that in India, biomedicine was never perceived as a hegemonic institution due to the culture of dais which was equally prevalent and operational. Indian women had different concerns which were related to reproduction of caste and class discrimination at hospitals. Women, belonging to the lower castes and classes faced the brunt of ayahs, who were at the lowest rung of the biomedical hierarchy, yet forcefully exerted their dominance. Moreover, women had reservations and hesitations in delivering in hospital settings since it was a hostile, lonely environment with coercive hospital rules, norms and practices. Thus, women’s resistance in India was concerned with searching for avenues for access to technological and modern birthing outside the institutional structures. This negotiated preference was seen through the biomedically trained Multi-Purpose Health Workers, who were professionals and used medicines for delivery. This merging or integration of tradition and modernity allowed women to avail modern technology within the familiar environment of the home as well as a surety of safe delivery and maternal care through medicines and better monitoring and tracking of the pregnancy and childbirth process.

In another study, Joy Deshmukh-Ranadive (2005) discusses the concept of ‘spaces’ within and outside the household which defines a person’s capacity to exercise agency. She discusses physical space, economic space, socio-cultural space, political space and mental space which influence women’s agency. Physical space refers to women’s access to, ownership of and control of natal and conjugal houses. This also includes restrictions on women’s bodily movement. The economic space refers to ownership of movable and immovable property that would enhance women’s economic independence. Socio-cultural space refers to hierarchy according to kinship within the household. Apart from the kinship hierarchy, marital status influences a woman’s ability to occupy greater socio-cultural space and assertion in the intra-household dynamics. Apart from this, caste, class, religion and ethnic origins also add to the socio-economic status and possession of socio-cultural space. Political space is seen both at private and public levels. At the private level, political space is
manifested in the responsibilities and authorities that come from possessing socio-cultural space. Public political space, on the other hand, refers to women’s access to and control of public office and participation in the governance of society. Lastly, mental space refers to ‘a feeling of freedom that allows people to think and act’ (2005:113). It involves a process of bringing together women in a new setting as a collective which help them discuss an issue and gain confidence and strength from each other. Another aspect of mental space is evidenced through access to information, which according to Deshmukh-Ranadive (2005: 114) ‘is an important source of power as well as an instrument of empowerment’.

Keera Allendorf (2012) explores the influence of the familial context on women’s agency in a study conducted in Madhya Pradesh. She takes ‘family relationship quality’ as love, affection and support and argues that women who have stronger quality relationship with husbands and parents-in-law are able to exercise greater agency. She defines women’s agency as the ability to take decisions about mobility and finances. In her study, she also employs control variables like caste, religion, husband’s occupation, husband’s education, age, education, employment, having two sons, payment of dowry etc for determining women’s agency. Allendorf concludes by arguing that a higher level of ‘family relationship quality’ in both nuclear and extended households result in a higher level of women’s agency.

For the present study, the following understanding of bargaining and negotiations would be adopted. Kandiyoti looks at various strategies that women use in order to ensure and maintain their material and social protection. Bargaining takes place within the ‘rules of the game’ or within the contours of dominant normative order. Taking the discussion forward on ‘bargaining’, Bina Agrawal (1997) argues that in order to understand gender relations both within and outside the household, there is a need to question the role of social norms in influencing bargaining power and setting limits to what is bargained. She maintains that social norms influence conduct of household members. Agrawal (1997) also looks at links between extra household (market, community and the state) along with intra-household bargaining power and maintains that the gender ideology that existed within the household was seen to be extended beyond it as well. The framework bargaining and negotiation would be dealt in detail in the chapter on Methodology.
Rationale of the Study

Most of the studies on pregnancy and childbirth in the context of India have been located in rural or semi urban contexts with a focus usually on one community. There are very few studies that are located in a changing urban context. The present study is located in a resettlement colony in Delhi, where owing to state intervention of clearing slums, slum-dwellers were forced to relocate to a resettlement area in Delhi. This led to the establishment of an artificially created colony where traditional systems and structures of control over women in terms of caste, regional background and familial structures were weakened with no rigid spatial distribution of residence along caste lines. This also indicated that there was not a very strong traditional kinship structure to manage women’s pregnancy and childbirth, unlike the social structure in the rural context. Also, most of the studies do not focus on the role of knowledge in women’s strategies of negotiating power. To address these gaps, the present study aims to explore how knowledge is an integral part of both control as well as in negotiating power structures concerning pregnancy and childbirth.

The study raises questions regarding women’s negotiations with knowledge systems in a resettlement colony and seeks to explore whether being settled at a resettlement colony undermines cultural knowledge and practices or not. In order to understand this, women’s ‘choices’ or agential acts of negotiations by mobilising resources, information, and support system need to be explored. Thus, the focus of the thesis is on multiple ways in which women negotiate with various structures associated with pregnancy and childbirth in contexts of biomedical and cultural knowledge systems.

Objectives

Following are the objectives of the study:

- To map the cultural and medical practices associated with pregnancy and childbirth through the experiences of women residing in an urban resettlement colony.
• To study the State medical interventions that target pregnant and childbearing women in the resettlement colony.
• To analyse the power of biomedical and cultural discourses in shaping women’s experiences of pregnancy and childbirth.
• To explore the nature of women’s negotiations with the above discourses in a socio-cultural context dominated by patriarchal ideologies.

Research Questions

Following are the research questions of the study:

• What are the different medical practices associated with pregnancy and childbirth in an urban resettlement colony?
• What are the different cultural practices associated with pregnancy and childbirth in an urban resettlement colony?
• What are the beliefs and values underlying these practices?
• How do women understand the state medical interventions?
• What have been the changes in women’s experiences of pregnancy and childbirth with establishment of state medical interventions?
• What is the interface of cultural practices, beliefs and values with medical interventions?
• What are the available and invoked social support mechanisms at the time of pregnancy and childbirth with change in residence?

Organisation of the Thesis

The thesis is organised into six chapters, where analysis of primary data is further divided into three chapters. The state-supported biomedical services divide pregnancy and childbirth into three phases – pregnancy (antenatal care), childbirth (delivery) and post-childbirth (post-partum or postnatal care). This is different from the cultural understanding of pregnancy and childbirth, where childbirth and post-childbirth are considered as one phase. The reason for adhering to the biomedical division is to
understand the way both cultural and biomedical discourses shape women’s experiences around pregnancy and childbirth in every phase.

Chapter 1
The first chapter, *Introduction*, traces historically, how women’s pregnant and birthing bodies were always controlled. Pregnancy and childbirth were considered as women’s affair. Feminist scholars argue that women healers were perceived as threat to the emerging male profession leading to devaluation and demonisation of women’s knowledge around pregnancy and childbirth which led to attempts to replace women healers by male doctors. The review of literature in this chapter traces studies around pregnancy and childbirth and discusses under the following headings—public health perspective, political economy perspective, feminist perspective and cultural perspective. The feminist and cultural perspective challenged the prevalent conception held by public health and political economy studies that *dais* were unhygienic and main contributors to high maternal mortality rate and that the state-supported biomedicine was the only legitimate medical knowledge system. They also critiqued and argued that *dai* knowledge as ‘dangerous’ was colonial and biomedical constructions that had led to their demonisation, devaluation and discreditation. The chapter further states the rationale of the study, the research objectives and research questions.

Chapter 2
The second chapter titled *Theoretical Framework and Methodology* discusses the feminist theories and methodology that the study adopts in order to achieve its objectives. It further elaborates on the research site, and describes the state-funded biomedical intervention (NMCH outreach programme), and the profile of participants. The chapter also includes researcher’s experiences of doing feminist research, especially her experiences and reflections in the field, and her social location and its influence on the process of data collection.

Chapter 3
The third chapter, *Experiencing Pregnancy: Multiple Knowledges, Resources and Support System* explores different ways in which women mobilise knowledge, resources and support systems in negotiating patriarchal control of their pregnancies
seen through different structures of authorities – family, biomedical institutions and the state. The chapter argues that in bargaining with the intra-household control, women mobilise external resources such as biomedical institutions and knowledge. Women also mobilise family and community support system along with cultural knowledge in negotiating biomedical power. Women’s negotiations with different and overlapping structures and relations of power are analysed specifically with regard to the monitoring of diet, physical mobility, work and use of medication.

The chapter shows that pregnancy rituals and practices are followed even in urban context among younger women by upholding the ideological core and thereby, reasserting patriarchal norms. Lastly, the chapter explores various social support systems (family, community and biomedicine) that women invoke during their pregnancy, which is dependent on their household composition, geographical proximity with their natal family, accessibility of NMCH intervention services, in order to experience a better pregnancy.

Chapter 4
The fourth chapter, *Striving Towards ‘Safe’ Birthing: Cultural and Biomedical Practices* explores women’s association with *dai*-tradition and with hospitals. It argues that among the older Baniya and Dalit women, where *dai*-tradition was prevalent, women’s relationship with *dais* differed with the social background of birthing women, their caste and class. The chapter further explores the relationship between younger women and biomedical staff and services. The chapter shows that it was women’s context, age, caste, class, household composition, age at marriage and site of birthing that enabled women, in some circumstances and also constrained them in other, to experience childbirth their way.

Chapter 5
Chapter 5, *Post-childbirth Celebrations: Resurgence of Cultural Practices* discusses various post-childbirth practices and their prevalence in the urban resettlement context. The chapter describes various familial relationships and dynamics seen in the period of post-childbirth celebrations through cultural rituals and celebrations of a birth of a boy. It also explores the status of *dais* in urban context, including the *japa bai*. Further, the chapter explores the role of biomedicine in the lives of younger women, in the post childbirth period where the focus shifted from women’s health to
child health. This led women to abide by the cultural system since it provided physical support and care, glorified motherhood, and increased social status especially with the birth of a son. Thus, the post childbirth period does not see much of negotiations by women where any alternatives to the cultural system did not exist. The chapter argues that although various rituals were still prevalent in urban context by adhering to the underlying patriarchal current, their manifestations had got modified due to the influence of urban context.

Chapter 6
Chapter 6, Conclusion, recapitulates the study by tracing ways in which women managed their pregnancy and childbirth in an urban resettlement colony where the traditional kinship ties are weakened along with a presence of state-funded biomedical intervention. The chapter draws linkages between the findings and the theoretical framework of the study. The study showed that women, in order to enhance their experience and meet cultural expectations around pregnancy and childbirth, drew upon one set of patriarchal structures and knowledge practices to negotiate another set of patriarchal structures and knowledge practices. In the process, they question some of the prevalent norms. Some of their negotiations reveal that they engage in moments of agential resistances, albeit fleetingly, and experience a sense of agency. Their use and contestations of plural knowledge systems contribute to the reproduction of a culture of plural epistemologies in birthing.