Chapter IV

Striving Towards ‘Safe’ Birthing: Cultural and Biomedical Practices

After exploring women’s cultural and biomedical experiences during the period of pregnancy, the role of family and the NMCH services, the present chapter will focus on women’s experiences of childbirth. The older women gave birth at home either in their natal or in their conjugal homes in the villages. In contrast, the younger women delivered their babies in hospitals. The chapter will discuss this shift in birthing sites and the nature of societal and institutional control and support that govern birthing women’s experiences. It will also examine women’s experiences with dais and biomedical institutions. The chapter analyses the strategies of women in negotiating patriarchal structures and ideologies associated with childbirth to achieve their goal of a safe delivery. It shows that women’s context, comprising of caste, class, household composition, age at marriage and delivery site enabled or constrained their choices and experiences of childbirth.

Decisions regarding Childbirth

As discussed in the previous chapter, for the older group of women, due to their location in the conjugal homes, mothers-in-law took all major decisions on their behalf. From deciding the site of delivery, to deciding the proceedings of cultural practices, all decisions were taken by the mother-in-law. Hence, these women continue to adhere to their mother-in-law’s choices and decisions regarding birthing.

Younger women, due to availability and accessibility of biomedicine opted for hospital birthing. Among the younger Baniya women, residing in extended households had their mothers-in-law taking decisions regarding accessing biomedical services and delivery sites. The younger Baniya women’s mother-in-law adopted the practices of biomedical knowledge systems to ensure that their daughters-in-law delivered at hospitals.
The older women usually got married at an early age of ten to fifteen years. Lolita, a Dalit woman, mentioned that due to the early age at which she got married, she was not aware of how to manage childbirth. She used to blindly follow her mother-in-law’s instructions. Lolita had no exposure to education. Her mother-in-law had decided to send Lolita to her natal house for the first delivery. According to her, ‘we never questioned our dadiya saas (husband’s paternal grandmother) or mother-in-law. We were not like today’s girls, who would argue with elders. Now girls are educated, they know more than us.’

Similarly, an older Baniya woman, Bina also mentioned that she was too young to know anything about getting married or getting pregnant:

*I did what I was told to do. We were not as intelligent as you all, who go to school. Whatever my mother-in-law told me to do, I did that. She had asked my mother to send someone in the seventh month to my conjugal house to take me to the natal house for my first delivery.*

Narratives of Lolita and Bina suggested that they adhered to the instructions of their mother-in-law, who took decisions regarding daughters-in-law’s delivery. Lolita and Bina, although belonging to different communities, Baniya and Dalit, emphasised the importance of *padai-likhai* (education), indicating that education had enabled younger women to express their desires regarding birthing sites unlike older women who blindly abided by their mothers-in-law’s instructions.

Jyoti, a young Dalit woman had completed her education till class eight. She resided in a nuclear household, away from both natal and conjugal households. She had seen her neighbours going through safe deliveries at a government hospital and decided to follow the same process and go to the same hospital for her own delivery. She was supported by her neighbour friends who went with her to the hospital for all her tests and accompanied her for delivery along with her husband. Jyoti was aware of institutional deliveries and staying away from relatives made her follow in the trend at Poorvinagar, where other women also followed ‘safe’ and ‘reliable’ methods and sites for their deliveries.

Sheela, an educated young Baniya woman, stayed in her conjugal extended household, completed schooling and got herself enrolled in a college. Her mother-in-law had delivered in a hospital and considered herself fortunate to have availed the
Army services during her pregnancy and childbirth since her husband was in the Indian Army. Since Sheela was residing in an extended household, her pregnancies were monitored closely by her mother-in-law. Her mother-in-law insisted that since she herself had delivered both her children in a government hospital, she would ensure that even her daughter-in-law does the same. Sheela, who wanted to avail private services at another hospital didn’t negotiate with her mother-in-law and mentioned, ‘since she had taken a decision of making me deliver at a government hospital nearby, I had to do that.’ Thus, Sheela’s educational level did not enable her to counter her mother-in-law’s decision.

Chandini, also a Baniya woman who resided with her mother-in-law expressed that she wanted to deliver at a government hospital. She also mentioned that her mother-in-law did not support Chandini’s elder sister-in-law to deliver at a hospital five years ago. However, her elder sister-in-law still insisted and went to a hospital with a neighbour. This raised questions about Chandini’s mother-in-law’s status in the neighbourhood. Therefore, for Chandini’s pregnancy, her mother-in-law agreed to take her to a hospital, decided which hospital she should go to for delivery and also accompanied Chandini. Thus, the mothers-in-law tried to reclaim the losing authority over daughters-in-law’s pregnancy by an active decision even in her choice of biomedical delivery. This would be further discussed later in the chapter.

The narratives of the older and younger women portrayed that older women and younger Baniya women, who resided in extended conjugal families, were guided by their mothers-in-law. On the other hand, young Dalit women, who mostly stayed in nuclear households, exercised their freedom in taking decisions about delivery.

**Sites of Birthing**

This section would examine women’s birthing experiences at the two sites of home and hospitals. The older women mostly had *dai*-assisted birthing at home and the younger women mostly had institutional delivery. Once again, it was found that the social background of birthing women, their caste, class, household composition, number of children and proximity to natal house influenced their decisions and experiences in the two different sites of delivery.
Home Births

All older women, except one Dalit and one Baniya woman, had all their births at home. Among both Dalit and Baniya women, first childbirth was conducted at natal homes and for second and subsequent childbirths, women stayed back at their conjugal households.

The social background of women influenced their experiences of birthing. *Dais* belonged to the Dalit community, which influenced the way Dalit and Baniya women perceived *dais* during childbirth. The older Baniya women perceived *dais* to be an emotional support during childbirth. This was due to their better status, both traditionally and economically as compared to *dais*. Along with this, the place of delivery was equally important to influence women’s birthing experiences where *dais* replaced the role of mother at conjugal household during second and subsequent birthing. Older Dalit women perceived *dais* to be authoritative and assertive over their birthing bodies since they belonged to the same community.

Krishna, an elderly Baniya woman, mentioned that *dais* behaved with women according to the social standing of the family. If a birthing woman was of a higher class or caste, Baniya in this case, *dais* were meek and supported her through birthing. On the other hand, if birthing women belonged to the same community as *dais*, then *dais* would dominate over birthing women. This was due to their experiential knowledge and authority which would place them at a higher level among the Dalit women.

The place of birthing also contributed to the context that helped women to resist *dais*’ control on her body. It was seen that familiar environment at natal family comforted women at the time of first delivery as compared to women’s experiences of subsequent pregnancy in conjugal house.

*Rituals followed by dais.* Tanuja, an older Baniya woman, mentioned that at the time of birthing, *chuttad khul nahi raha tha* (opening of the vagina was not expanding) the *dai* who was called to conduct Tanuja’ birthing asked *jachca* (Tanuja) to unlock all the locks and knots she had put during her pregnancy, be it unlocking the *attakanastar* (wheat flour drum), unstitching clothes, if she had stitched a torn cloth, knots of her hair, symbolised obstruction. Opening all knots and locks had symbolised smooth process of childbirth. Tanuja was aware of these rituals since she had seen
them being carried out for her older sister during her childbirth. Tanuja had already unlocked all the knots and locks but had knitted a sweater because of which, she believed, her labour pains continued for a long time.

The preparations were associated with cultural knowledge of delivery. Gomati, an older Dalit woman, pointed out that there are certain dos and don’ts during childbirth and a delivering woman must follow them or it could lead to her death. ‘Kabhi bhi saansein uppar nahi leni chahiye’ (it is very important to ensure that one doesn’t take deep breath). She believed that if one inhales deeply, then there are chances that the baby will go up in the stomach and will take time to come out. This could result in baby to move up in the stomach, towards the lungs, making it difficult for the jachcha to breathe, and then resulting in her death. Gomati recalled that it was in a similar way that her daughter-in-law had passed away:

Kajal, my daughter-in-law had told me that she will not go to the hospital because she was scared of tools and instruments that will be inserted in her vagina. She had told me clearly that I will have a home delivery. I arranged for a dai and got prepared for the birthing process, by boiling water, arranging for a thread, and rugs. The dai came and asked her to push hard. She kept trying, but could not give birth. It had been more than a day that she was in labour pain. I got scared, I just told her to keep trying. She tried, but finally, she raised her hands and kept them beside the ears and told me, ‘Ma ji, I will not be able to do this!’ After saying this, she died immediately. Then the dai hurried up and helped in delivering the baby.

‘The secrets to delivery seemed to have its roots in superstition’, claimed Babulal, an MPHW of NMCH. He explained that breathing is very important and once you raise your hands, blood goes in the upward direction. But that doesn’t mean that the baby in the womb will reach the lungs and the delivering woman will die.

Shakuntala, an older Dalit woman, described her experience of giving birth at her natal home for her first delivery:

Earlier women never told anyone that they were getting pains, when they got pains, then they used to take strands of lock of the left side of the head and used to take it in her mouth, in between her teeth. They used to do this for ten to fifteen minutes and easily the baby used to come out. In case this didn’t help, then a dai was called. For my first childbirth, all this didn’t work, so a dai was called. My mother took out some money and maa ke naam pe chadaye [moved around Shakuntala three times]. Then my mother took a sieve full of rice and asked me to divide it into two halves. This is called kooda karvana. Once my child was born, then a tawa was kept under the charpai [bed] and, some mustard seeds were sprinkled around it. This was kept for the next five days and only on the sixth day was the tawa removed. Jwala maa, the goddess of fire, is believed to be the first goddess, only goddess where jyot amar
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rehti hai [the fire never dies]. I knew what all the dais were doing since these rituals
during my elder sister’s delivery. Seeing all these rituals, I knew what to expect!

Shakuntala’s narrative expresses the symbolic meaning of rituals carried out at
the time of birthing. Taking strand of hair from the left side of the hair symbolises that
an impure work is going to be done, since the left side is associated with pollution.
The rationale behind this ritual is drawn from Ayurveda, which is described in a
Matrika report (2010). By tickling the throat with hair would make a woman vomit
and this action helps in contractions and in no time a child is born. There was a close
similarity between the dai-tradition and Ayurveda knowledge (Radhika and
Balasubrismanium 1990; Singh 2006; Matrika 2010). According to the Matrika report
(2010), there is an imbalance of vayu that can cause problems in labour. To avoid this,
jachcha’s body is oiled and massaged. Along with this, she is also given warm drinks.
Chawla (1994) and Radhika and Balasubramanium (1990) also mention that dais gave
hot liquids to drink in order to induce labour pain.

Shakuntala’s mother held some money in her hand and moved it around
Shakuntala’s body three times. This is seen as a way to ward off evil spirits that are
hindering the process of childbirth. The ritual of separating rice also symbolised the
separation of mother and her child. This rice is usually thrown away or given to the
dai, probably that is why it is called kooda karva lena. Keeping a tawa under jachcha
signified that just after childbirth, jachcha is considered to be very vulnerable to
spirits. Black iron vessel, tawa was seen to symbolise a nazarbattu (an evil eye to
keep the spirits at bay). Mustard seeds were sprinkled around tawa so that even if
spirits come to haunt her, they slip on the mustard seeds and are not able to reach
jachcha or bachcha. Chawla (1994) also discussed the significance of sprinkling
mustard seeds. Shakuntala spoke of Jwaala Ma, others spoke of Bemata, who was
invoked to help the woman deliver. Jwaala ma was considered to be an incarnation of
Durga, thus, symbolised sakti, regenerative power that a woman derived at the time of
giving birth. Another symbolic meaning of invoking Jwaala Ma could also be the fact
that her temple hosted an unending fire. This fire goddess could symbolise unending
hope that the birthing process will be smooth and that the outcome with be healthy.

From the narratives, the cultural knowledge was contextualised in the agrarian
context, especially among Dalit women. Amma, an elderly Dalit woman from Uttar
Pradesh, mentioned one of the rituals of birthing, placing a sickle under jachcha’s
bed. This was done by dai herself. There could be two interpretations of this ritual,
one could be that sickle, a sharp iron tool, is kept under the bed to ward off evil spirits so that the jachcha and bachcha do not get possessed by them. Another interpretation could be seen in the agricultural context. Uttar Pradesh, a state which produces wheat and rice, sickle is seen as an important medium at the time of harvesting. In this scenario, crop symbolises the unborn child; land, the womb of a pregnant woman; harvesting symbolises child birthing and sickle, the role of dai. Thus, the dais’ knowledge and the birthing rituals are contextualised in an agrarian economy and Hindu cosmology.

**Dais as emotional support: Baniya women’s experiences.** As mentioned before, the caste location of birthing women shaped their interactions with dais. Birthing women’s ritual hierarchy of caste influenced dais behaviour towards them. This could have been probably because of the ritual and socio-economically higher status which could fetch dais more neg. Madhavi, an older Baniya woman, recalled her first experience of birthing at her natal house:

*I had gone home for my first delivery... when I started to get pain, only my mother was home that afternoon. I told her, and she went and called a dai, who stayed on the outskirts of the village. Meanwhile, a neighbour [another Baniya woman] came and started preparing for my delivery. Dai came and after massaging my stomach with hot mustard oil sat down next to my legs. She kept massaging and talking to neighbours and my mother. I could not take the pain, so I was screaming with my mouth closed. She used to stroke her fingers through my hair when pain came and used to ask me to push hard. She had even shared her own experience of delivering that how painful it was for her to give birth to her children. This helped me to gain confidence that other women also find it difficult to give birth and I was not the only one.

I had given birth to a boy, my mother gave her some money, one new sari, blouse and sweets for her family. She told my mother that a boy has been born and she should not be miser! My mother must have given her one more sari and only then she agreed to come for the next six days to give massage to me and my child.

From the narrative of Madhavi, it was seen that dai was an emotional support for her since she comforted Madhavi during her delivery. Dais asked for more goods from Baniya families, especially after giving birth to a boy. They bargained and manoeuvred their ways to get more neg by reproducing simultaneously, the caste and the patriarchal ideology of birthing as polluting, and the value of birthing a son. Neg was considered to be a cultural token for not only helping out a birthing woman but also taking away ritual pollution from the family (Chawla 1994).
Madhavi recalled her second delivery experience, when she was at her conjugal house. She mentioned that after trying to deliver for hours, the *dai* asked her mother-in-law to dip her big toe in hot *ghee* which Madhavi was made to drink. She was hesitant to drink it. The *dai* sat down next to her and told her to sip it gradually and that she should not worry, the *dai* was there to help her out. Within a couple of hours, she gave birth to a baby boy. It was believed that the ritual of dipping the big toe in hot *ghee* was seen as a way of transferring the experience of mother-in-law’s delivery to daughter-in-law. Janet Chawla (2006) also discusses this and argues that the big toe had a nerve which was considered to be a carrier of knowledge and experience which joins both big toes to the brain. It was a way to show respect and learn from the experience of an elder woman. This would be influenced by the experience and knowledge of the mother-in-law symbolising that Madhavi, like her mother-in-law, would also have a healthy boy. It was probably lack of exposure, inexperience and young age at which Madhavi had got married that she didn’t resist drinking *ghee*. She recalled, ‘thoda sa tel bhi khane ko mana karte hain, peena to door ki baat!’ (*nowadays nobody would have had ghee since doctors are against consuming too much oil, let alone drinking ghee!*).

*Dai*’s supportive behaviour was also seen in the narratives of Kusum, another older Baniya woman, who narrated her birthing experience. Following the cultural practice of going to the natal home for delivery, she had come to her mother’s house. She said that it was always better to deliver at one’s natal house because of the pampering and mother’s love which comforted childbearing women during delivery. Kusum had her parents along with her elder brother, his wife, and their daughter residing in the natal house. She was pampered and treated to all kinds of food items that her mother and her sister-in-law had prepared at home to satisfy her cravings. When she started getting pain, she tried to withstand it and didn’t inform anyone. She said that she didn’t want her mother to get worried when she got her labour pain, and finally told her mother, when the pain became unbearable, who had sent her sister-in-law to call a *dai*. She recalled the way her mother sat down next to her, comforting her till the *dai* came:

*I didn’t want to show that it was such an unbearable pain because it was believed that if it pains a lot and woman screams out of pain, then the woman is thought to be a kapati aurat [bad character]...the *dai* helped me to deliver, told me to be*
patient and push hard. I gave birth to a girl. My mother gave some money which was usually given when a girl is born.

For one of her subsequent pregnancies, Kusum was at her conjugal house where she delivered in the presence of her jethani, mother-in-law and mother-in-law’s sister, who had come to visit them for a few days. She said that for the second delivery, it pained her much more, almost to the extent that she could not help but scream aloud. Both her mother-in-law and her sister started scolding her for it. Kusum said, ‘in spite of trying to push a millionth time, the baby was not coming out. Then my mother-in-law started scolding me for not putting enough pressure. This had not happened at my natal family.’ She recalled that when the dai came, she sat down next to her and with affection referred to her as beti:

I was really missing my mother, and it was the dai from who I got this support and delivered a boy. My mother-in-law was thrilled and gave the dai a good amount of money, sweets, and two new saris. I remember this because my mother-in-law used to keep reminding me that she had given a lot of neg to the dai once I delivered a son.

At her natal house, it was the mother who was comforting her during labour pains. As opposed to this, her experience of labour pains at her conjugal household was different. Her mother-in-law scolded her for not putting enough pressure and for screaming out of pain. She was scolded for crossing her ‘feminine’ boundaries as a reflection on women’s socialisation and her character. In the latter case, she got her comfort from the dai, who acted motherly in that situation when her mother-in-law, mother-in-law’s sister were scolding her, the dai sat down next to her and referred to her as ‘beti’.

On delivering a girl, dai didn’t demand for any more neg from her mother, but after giving birth to a boy, dai demanded higher neg and on the occasion of chatti, naming ceremonies and vaar pher (when money is circulated around the new born to ward off evil spirit. That money is given to somebody belonging to a lower caste). Thus, the difference between first and second delivery was seen with a change in the birthing site along with emotional support that women got from dais.

Dais’s caring nature is described by Krishna Soman as ‘social status equivalent to that of a biological mother’ (Soman 2013: 214). This is perhaps the reason why dais are called ‘dai ma’ in West Bengal. In the present study, dais were perceived by Baniya women as an emotional support. This could be for two reasons, firstly, it was
seen that *dais* belonged to the Dalit community and the caste hierarchy demands subordinate behaviours from them. Another reason could be that Baniya community is economically better off than Dalit communities, which gave *dais* hope that on the occasion of birth of a son, *dais* would get more neg. Thus, emotional support added on conduct would add on to the economics of *dai* tradition in form of neg and also post-childbirth massage, *vaar pher* money and other gifts. Apart from these reasons, the *dai* tradition viewed birthing not as ‘work’ but as service in which both the birthing woman and the *dai* had to work together to bring babies into this world.

**Assertive and authoritative *dais*: Dalit women’s experiences.** The Dalit birthing women and *dais*, belonged to traditionally and economically same/similar community. Also, *dais* were more powerful than the mother-in-law of dalit childbirthing women. This was due to their experiential knowledge which allowed them to be more assertive and authoritarian on women’s bodies. Due to the lack of alternative source of knowledge around pregnancy and childbirth for older women, their negotiations were restricted to asserting themselves for a better experience of childbirth.

Mandakini, an older Dalit woman, who had four daughters, discussed her experiences,

_For my first delivery, I had gone to my natal house. It was so painful... I used to scream out of pain when the pain used to come. My mother had asked a *dai* to come, who stayed closeby. I remember, once *dai* had made me open my legs to the extent that it started to hurt me. I started screaming and pushed her away with my leg. She got agitated seeing my behaviour and started to call me names. She started hitting me and pulling my hair. My mother came and controlled the scene by pacifying me. I was in so much pain that I didn’t know what I was doing. This was the last thing I needed at that time._

_For the subsequent deliveries, I was at my sasural. I knew what to expect and how to behave! When I started getting labour pains, I told my mother-in-law about it and she called a *dai*, who stayed nearby. The *dai* tried by making me drink hot oil, which I couldn’t take it in. I wanted water, I asked my mother-in-law for it, but the *dai* told me that I couldn’t have anything cold, it will slow down the process of delivery. I remember how thirsty I was. The *dai* made me gulp down that hot oil, although my mother-in-law was standing there with a glass of water._

Mandakini’s kicking the *dai* away was considered to be a deviant feminine behaviour. One of the reasons for this behaviour could be that she was with her mother at her natal place where she could express her pain more freely.
Leela Dube (2001a), in her article ‘On the Construction of Gender: Socialisation of Hindu girls in Patrilineal India’ also dealt with the same issue of women becoming gendered subjects. She held kinship network and family structure responsible for imparting organising principles which guide the way an individual was placed in a social setting. This was closely related to the discourses of femininity, which women were socialised into since childhood and are constituted of the patriarchal norms and values that govern women’s behaviour in the conjugal household.

In contrast to this, for her second delivery, at the conjugal house, Mandakini was seen to resist dai’s instructions of having hot oil, since she wanted water. Mother-in-law’s supportive behaviour was seen by the way she was carrying water for her daughter-in-law. Mandakini tried to negotiate with dai’s instruction but eventually gave up. The dai didn’t allow Mandakini to have water since it would have slowed down the process of birthing. Among Baniya women, where it was a practice of making women drink ghee, a similar practice was seen among the Dalits, of making a delivering woman drink oil with a belief that it would lubricate the passage of delivery.

Women are more anxious during the first experience of childbirth. This is due to the fear of unknown and uncertainty. The severity of labour pain made them scream to surpass the ‘acceptable’ behaviour. By the subsequent pregnancies, women knew what to anticipate, and sometimes even expressed what they didn’t approve of on their bodies. It was seen that women were more comfortable at their natal place, with their mother, whose presence was comforting, caring, as opposed to mother-in-law, who was seen as an agent of patriarchy by occupying a higher socio-cultural space, as Deshmukh-Ranadive (2005) called it.

Kaveri, an older Dalit woman from Uttar Pradesh, expressed her interaction with a dai at the time of her delivery. She mentioned that her mother-in-law didn’t allow her to go to her mother’s house for her first delivery since her natal house was quite far from her conjugal house. Also, her mother-in-law thought that during monsoons, bumpy ride could be harmful for the baby. Therefore, she gave birth to all her five children at her conjugal house. Kaveri recalled her first childbirth experience,

At the time when I was getting severe pain during my first delivery, I remember, I didn’t know what I wanted that time...the dai had kept two bricks and had asked me to squat... I could not even move. I felt I had no energy and she forcefully picked me up with the help of my mother-in-law and made me sit on the bricks. Despite telling her that I would not be able to sit there, she made me squat. I was on the verge of
becoming unconscious... I wanted to lie down and deliver, but the dai did not allow. I refused to move, even after being screamed at. She hit me... but I had to scream. I delivered my eldest son.

Kaveri’s comfort was not taken into consideration while deciding the birthing position and she was forced to adhere to dai’s authority and experiential knowledge, which was manifested through scolding, hitting, and instructing her to deliver in a position which dai considered suitable. Kaveri although resisted the harsh instructions by initial refusal to move but could not disregard dai’s instructions. Dai’s knowledge was also supported by the mother-in-law and other elderly neighbours. The fact that both, the dai and the delivering woman’s family belonged to the same community, also added to the surveillance of the dai on the delivering woman’s body. Kaveri mentioned that she remembered her first delivery because it was a painful experience, and by her subsequent deliveries, she got accustomed to the pain.

Resistance was seen more in case of Dalit women as compared to that of Baniya women. Dalit women acted against dais’ instructions, which were expressed either vocally or physically. Resistance was also more during the first delivery.

Younger woman’s experience of dai-assisted home birth. Basanti Devi, a young Dalit woman, was the only woman who had had home births. The couple had left their village in Himachal Pradesh to earn some money. In Delhi, she stayed in a slum area, near Poorvinagar before shifting to Poorvinagar. She had three children, two older girls, both in high school and one recently born son. Her husband used to leave early morning for work and returned only by late evening. She recalled her first conception and said,

One day I started vomiting, so I had to tell my husband. The next day he took me to a small private clinic and got to know that I was pregnant. In the fourth month, when my stomach became visible, my husband and I went to my conjugal house, to our village. It was much better there, there were so many people to take care of me. When I started getting labour pains, I arranged for everything, swept the room and lied down. My elder sister-in-law helped me deliver. Then I understood how it was done, I delivered seven children myself without any assistance from anyone. I used to keep hot water, knife, thread and rugs ready before delivering. We didn’t have the culture of calling a dai. She used to be called only under special circumstances, when things went out of control.

Everytime she was pregnant, her husband used to take her to his village for delivery. She pointed out that all her sons that she delivered died one by one, within
two to three days of being born while the girls survived. Her mother-in-law took her to their *kul* deity, where Basanti Devi was told that the deity was angry with her, which is why all the sons were dying. She was made to offer prayers and finally one son survived for thirteen years and then passed away due to some illness. ‘*Everybody told me to conceive again to have at least one son. After eleven years I conceived again, and this time my husband insisted that I deliver in a hospital*’. She mentioned that she was accustomed to delivering herself, without any assistance, by suppressing pain, so she expressed that she didn’t have biomedical staff scolding her during delivery.

Basanti Devi’s experiences of delivery flagged a point that *dais* in some rural areas, were considered as specialist and were called only under complicated situations. Rest of the deliveries were handled by either the women themselves or were assisted by family members. Once a woman understood how to deliver, she gave birth to her children herself.

Birthing her own children five times gave her enough opportunity to know and understand her body to suppress pain. Being born and brought up in a village in Himachal Pradesh made Basanti Devi and her husband to prefer going home for childbirth rather than opting for institutional deliveries. For her last delivery, her husband took her to a government hospital as they had shifted to Poorvinagar by then and had availed NMCH services during pregnancy.

**Institutional Deliveries**

With coming to a metropolitan city, Delhi, younger Dalit and Baniya women started to prefer to deliver in hospitals due to the ‘modern’ symbol attached with hospital deliveries. One of the reasons for this was the NMCH intervention programme which had become a way of life for them. All young women gave birth at hospitals except one Dalit woman, who went to her conjugal house in the village, as discussed in the above section. It was the younger women’s exposure to urban context and availability and accessibility of biomedicine that made women to consider biomedicine as an alternative to cultural knowledge system around childbirth. Young women also perceived biomedical institutions and services safer than home birthing since biomedicine was related to being modern and its accessibility gave women respite from mother-in-law’s control over their delivering bodies. NMCH also enabled young
women to achieve their objective of safe delivery and healthy child. Another reason for choosing institutional delivery was to follow the trend in Poorvinagar, where it was a matter of status and prestige to go for institutional deliveries. Many mothers-in-law ensured that they themselves took their daughters-in-law to hospitals for delivery. By doing this they could maintain their hold over daughter-in-law’s birthing bodies and also have a high status in the neighbourhood.

At the hospitals, women were seen as a homogenous category belonging to socio-economically poor section. The young women delivered either at government or private hospitals to achieve their goal of safe, institutional delivery and a healthy child. This coincided with the objective of NMCH and ‘target’ approach of other government agencies to ensure that there is cent-percent institutional delivery. It was seen that the young Dalit women usually stayed in nuclear households, with either their natal or conjugal or both or neither households close by. Along with the change in the household composition, urban elements of consumerism and rising expenditures were associated with notions of class and status. Accordingly, there was a change in the practice of going to natal house for delivery. The presence of NMCH services in the vicinity attracted women to stay back in Poorvinagar in order to experience ‘modern’ biomedical facilities at the time of delivery.

With the state playing an important role in establishment of biomedicine, dai tradition took a backseat since technology started to replace experiential knowledge and cultural discourse came to be associated with being outdated, dirty and unhygienic (Ehrenreich and English 1973; Jolly 1998, Forbes 2005). This attracted women to deliver in hospitals. Van Hollen (2003) discussed the way young women wanted to deliver in hospitals, as it was considered a ‘modern’ symbol. Younger women across communities and regions in Poorvinagar preferred to deliver at hospitals because they wanted to avail biomedical facilities as it was considered to be safe and equipped with latest technology. Women found accessing biomedical services reliable and availing them became reassuring that they were in safe hands. This was contrary to the finding of Singh (2006), which was conducted in an urban slum in Delhi, next to a public hospital. Singh argued that women do not choose to go to the hospital to deliver due to their hostile environment.

The young women’s association with biomedical staff started during pregnancy, much before they were admitted to hospital for delivery, to undergo various tests in order to be ‘eligible’ to deliver at a government hospital. For women staying in
Poorvinagar, usually, delivery preparation started with accessing ANC services and registering oneself for delivering at a government hospital. One of the pre-requisite of delivering in a hospital was registering their names at the hospital latest by the seventh month, or else, ‘...either hospital staff would scold us for not coming on time, or else, they will not admit us at the time of delivery’, claimed Anju, a young Dalit woman, who had experienced delivery at a government hospital twice. This reflected the rules, regulations and procedures that biomedicine had regarding accessing its services.

**Overlapping Structures of Control and Support.** Women experience patriarchal control and support simultaneously within their families and under biomedical care. Women attempt to resist these multiple structures that place demands on their birthing bodies and their personhood. These power structures are experienced most intensively in the first pregnancy. They rely on their previous experiences to assert themselves in the subsequent pregnancies.

This section discusses experiences of women in three circumstances– 1) residing close to natal household 2) residing near or with conjugal households and 3) residing away from both natal and conjugal households.

**Residing close to natal households.** Women who lived close to their natal homes enjoyed the emotional and physical support their mothers. It was the mother who remembered the dates of ANC and also made sure her pregnant daughter delivers at a place where she was comfortable. Since Baniya young women resided in conjugal households and with change in practices of going to natal house for first pregnancy, they were not given opportunities to enjoy mother’s support during childbirth.

Madhuri, a Dalit woman, who stayed with two sons and husband in a nuclear household, close to her natal house, shared her experience of resisting cultural values attached to *sharam* from showing herself to a male doctor by opting to deliver in a private hospital. She mentioned that she was home when she started getting labour pains. Her mother, father and husband took her to a government hospital close by.

> When I reached there, got admitted, my pain decreased and faded away. I stayed there for a night, but since nothing happened, they sent me home. That night I was in a huge room and women were screaming everywhere, lying on beds, on floor delivering while doctors were busy chatting. Doctors or nurses used to come in...
between to check women and tell them not to scream and that there is enough time. Doctors were scolding women, hitting them and also abusing them. Seeing all that I had decided that I can’t stay there for long and had told my husband that I want to go back, but the doctors were not giving me leave. There were both male and female doctors.

I told my mother that I am not coming here again! I wasn’t even comfortable delivering in front of a male doctor. I will go to a private hospital where I know at least that there will be a lady doctor who will help me deliver. I could not see women screaming and crying like that, it was very scary. My mother had also agreed to pay for the private delivery, but I knew that my husband would not have taken money from her.

However, Madhuri’s working status gave her a space to negotiate with the public hospital culture and she chose to deliver in a private hospital where there were only lady doctors. Madhuri overcame the situation by choosing to deliver at a private hospital. Her decision making power is attributed to her earning status and her mother’s economic and emotional support throughout her pregnancy and even at the time of delivery. Staying close to her natal family also enhanced her confidence and made her take a decision against delivering in a public hospital where she was not comfortable, since her mother had always maintained that Madhuri should be comfortable. Thus, she delivered in a private hospital. Her mother’s support and earning status helped her to avoid the humiliating and dehumanising environment of a government hospital.

Archana, a young Dalit woman, who stayed with her husband and two sons in a nuclear household, narrated her experience of availing hospital services. She used to work as domestic help in nearby colonies. In one of the houses where she worked, the employer’s daughter-in-law had delivered a healthy boy in a private hospital. The daughter-in-law kept reinforcing that Archana too must deliver in a private hospital as it is cleaner, safer and good care is assured of the baby. Archana confessed her desire to access private hospital for delivery to her mother and her husband who got her registered at a nearby private hospital:

*I had heard so much about public hospital that the doctors and nurses hit women. I was very scared to deliver there. In private hospital, you pay and get good doctors. There was a lady doctor, who did not hit me. Also, there were curtains between two women giving birth. It was very nice.*

Being able to access private hospital was also related to her earning status that enabled her to make a choice and choose private hospital over public hospital.
Archana’s natal family, especially her mother, who stayed nearby also supported her emotionally and went with her to a private hospital to admit her for delivery.

Sumana expressed that she wanted to avail biomedical services for delivering as she considered it better than dai-tradition, she said, ‘hospital deliveries are safer and included latest technology to handle uncertainties and emergencies’. She drew a comparison of hospital delivery and dais,

They [dais] were good in my mother-in-law or mother’s time, but not anymore...ultimately, I want a healthy child and I will to do anything for that. Dai was good for my mother and mother-in-law generation. But now it is best to deliver at a hospital. Everyone delivers at hospitals! They also show in the TV... all women in serials also deliver in hospitals. Also, my bhabhi has delivered both her children at a public hospital, and so will I.

Sumana’s narrative reflected the mindset of young women in Poorvinagar regarding preferring biomedicine over dai culture. They believed that biomedicine could help them in emergency and uncertain conditions which dais would not be able to deal with.

She narrated her first experience of delivering in a government hospital,

I used to run from the hospital at the time of labour. I could not take the pain and I also used to get scared seeing others in pain, I used to throw glucose bottles in a dustbin, wrap my shawl and run out of the hospital. Then his father [her husband] used to threaten me, scold me and make me understand that I have to undergo this pain to deliver...I used to tell him, please take me away from here. When I was not able to bear the pain then I used to tell the nurse that I want to get an operation done. She used to tell me, “Rani. [dear] go ask your husband. Till the time he doesn’t agree, we can’t do anything”.

This expressed high level of anxiety and fear of the unknown. Sumana knew that her bhabhi was there to support her, who had experienced childbirth at the same setting. Her bhabhi (brother’s wife) encouraged her to go back to the delivering room.

The way Sumana spoke about her experience of delivery and managing her second pregnancy was with asserting her identity of a mother of a male child along with the fact that she had experienced the event of pregnancy and childbirth once. She was pregnant for the second time when she was interviewed. She had availed biomedical services of NMCH van for the second pregnancy as well. She anticipated that it would be a ‘better’ experience the second time as she knew how to manage her pregnancy and delivery, ‘This time I will not run out of the hospital. It is it difficult to bear the pain of delivering’.
Biomedicine provided a platform for women to be able to negotiate the *dai* tradition but were subjected to the humiliating and hostile experience of delivery at government hospitals. Apart from staying near natal family, earning status also added to the negotiability of women, especially in availing private hospital services.

**Residing near or with conjugal households.** In such situations, where women reside in conjugal extended households, mother-in-law asserted their traditional control over daughter-in-law’s bodies through deciding hospital for delivery.

For her first pregnancy, Gita, a young Dalit woman, had gone to an NMCH referred public hospital since her mother-in-law insisted that she went there for ANC. She mentioned,

*I had gone for blood test but they could not find my vein, so kept inserting the syringe at different places on my arm, without realising that it was paining me. If I would have told them that it was paining, they would have screamed at me. My mother-in-law had also come with me, I thought it is best to not scream, but it was horrible.*

Gita said that her mother-in-law’s presence made her withstand the pain and not scream or react to the constant pinging of syringe in her arm. Apart from that, Gita was also scared of being scolded by the biomedical staff.

Rinky, a young Dalit woman, stayed in a nuclear household on the floor above her conjugal family members. As a part of ANC check ups at a government hospital, there were several blood tests like, blood sugar, HIV, haemoglobin, to name a few. Rinky mentioned that in order to conduct these blood tests, the doctors took her blood four to five times. She also stated that the doctors could never find her vein, and thus, had to insert needles many times, which was very painful. This was done in a very inhumane way by scolding her. The experiences of interacting with hospital staff were seen as an extension of the patriarchal practices of scolding women to extract their compliance, a cost that women from a poor socio-economic background had to pay in order to have better chances of safe delivery.

Rinky mentioned that since the hospital was at a distance from the house, her mother-in-law insisted that she should be accompanied to the hospital. Her husband had accompanied her for these tests. Rinky expressed that she used to like going to the hospital for blood test, since in order to accompany her, her husband used to take a day off. Thus, despite the painful experience, which Rinky described as, ‘they take so
much blood and then they say that there is less blood in the body’, she looked forward to going to the hospital. There was a lack of care of women, and biomedical staff did not consider it important to explain the need for the test and proceedings to women. She said, ‘I used to tell my husband to come with me for tests since I felt very weak once my blood was taken. That way, my husband used to take an off and spend time with me the whole day’. This way Rinky mobilised resources to counter authority on her pregnant body and in the process also negotiated for an emotionally satisfying experience. Rinky was able to convince her husband to accompany her for hospital tests since the hospital was at a distance and women were not expected to travel alone. This was also supported by her mother-in-law, which made her decision of asking her husband to accompany her for blood test ‘legitimate’. This way, Rinky was able to use one set of patriarchal ideologies in order to negotiate another set, in improving her experience of availing hospital services.

Another instance of a Dalit woman, Anju, who stayed close to her conjugal family believed prior to her experience of delivery that government hospital staff were very harsh to women. Her mother-in-law and her neighbour, who she was very close to, told her that the doctors at that government hospital were very careless. She spoke about another neighbour who had gone to a government hospital where the beds were placed above a dustbin, where all the ganda khoon (‘dirty’ blood) and ‘dirt’ of childbirth was thrown. The nurse could not handle the pressure with which the woman delivered her child and it directly fell into the dustbin and died. She said, it was a boy and they cried a lot after that. Anju expressed that she had her reservations in delivering at that hospital. Anju narrated another incident of biomedical staff leaving their scissors in a woman’s womb and realised that their scissors were missing after putting the stitches. She also said that she had heard biomedical staff leaving their towels in delivering women’s womb. Her mother-in-law, on the other hand insisted that Anju delivered where most of the Dalit women delivered, which was at a government hospital closeby. Instances of neighbours sharing their experiences increased women’s fear of biomedical institutions and staff.

During Anju’s pregnancy, her mother-in-law took all decisions and made sure that they were followed. Her mother-in-law’s decisions were influenced by NMCH medical staff. She made sure that Anju went to NMCH’s referred government hospital in a nearby locality. Anju expressed that she was scared, but did not have any other option, both financially and because mother-in-law was the decision maker. She also
Yashoda, a Baniya woman from Madhya Pradesh resided in an extended household. She mentioned that she wasn’t comfortable with showing herself to a male doctor but couldn’t escape it. This was due to financial constraints to avail private hospital services for which Yashoda had to compromise with the cultural notion of *sharam* (embarrassment) in front of a male doctor at a public hospital for her first pregnancy, where her mother-in-law had accompanied her:

*I felt very uncomfortable in the presence of a male doctor and especially in government hospitals, doctors could be either a male or a female. Sometimes there was more than one male doctor. Since we couldn’t afford to go to a private hospital, I had to withstand the shame. In private hospitals, you go and pay for all the facilities, a female doctor, a secluded place for you to deliver with curtains on both sides, unlike a government hospital.*

In Yashoda’s narrative, there is a focus on women in *purdah* and seclusion and notions of privacy. For many of these women, whose interactions with men are severely curtailed to encounter a situation of male and medical gaze, increased their sense of vulnerability as a woman, more so as a pregnant woman. Any expression of discomfort or resistance, they fear, may jeopardise their fragile relationship with the service provider and through that the pregnancy outcomes.

The concept of *sharam*, as Lindsay Barnes discussed, how women felt when a male doctor inserted his finger in her ‘private part’ as men’s presence during delivery was considered *sharam ki baat* (Barnes 2007: 65). Van Hollen (2003) and Forbes (2005) also elaborated by pointing out that the concept of *sharam* became one of the key reasons that distinguished medical scenario in India from the West. The cultural context in India required women practitioners to enter the hospitals so that women would feel comfortable and women’s sexuality is not threatened by delivering in the presence of a male doctor (Jeffery and Jeffery 1993; Forbes 2005).

In hospital, poor women’s deliveries are made available to the training of professionals. Medical profession has successfully acquired control including that of male control over women’s deliveries. Ranjan, a doctor of NMCH intervention programme mentioned that in biomedicine, as a teaching discipline, there is no differentiation between male or female student:
there is no gender bias in tertiary care hospitals. If you are a resident posted in the labour room, you have to conduct deliveries irrespective whether you are a male or a female. But most women do feel comfortable with female doctors around, they would not allow male residents to do the examinations... That is why we have a public health nurse who is always present at the NMCH mobile van, to look after ANC patients.

The NMCH had taken the cultural aspect into consideration and made sure that at least two women were present at the ANC clinic so that women do not feel uncomfortable in front of a male doctor. This was seen at Poornimagar’s biomedical intervention programme which gave referral services, but in a government hospital, the cultural aspect of *sharam* was not adhered to and women felt embarrassed in front of male doctors, especially while delivering. The cultural inhibitions are taken into account while drafting women into the ANC programme and once they are registered in the hospital, they are ignored.

Yashoda said that for her second childbirth, her mother-in-law again asked her to go to the same hospital. ‘I knew what will happen there, so, I was prepared. It is always for the first time that one is scared, then subsequently, one gains ‘taakat’ [confidence] to deal with hospital staff.’ She asserted, ‘they always hit, so it is best to do what you feel is right at that time’.

Tanu, another young Baniya woman, resided in extended conjugal household with her husband, one daughter and parents-in-law. Tanu said that she had followed all the dos and don’ts that her mother-in-law had asked her to, including deciding the site of delivery. She shared her first time experience of delivering,

*My mother-in-law had taken me to a government hospital, when I told her that it was paining a lot. She came with me to the hospital and waited for me outside the delivery room. It was paining so much that I wanted to scream but I knew that my mother-in-law was standing right outside the room, what if she gets to know that I had screamed during delivery! I also knew that if I scream, then the doctors would hit me and abuse me. So, the best was to withstand the pain and not scream, so I did not...no, doctors did not hit me. I somehow gathered myself and delivered.*

The cultural ideology of defining women’s ‘appropriate behaviour’ was reproduced at the site of hospital. This showed the way cultural beliefs were prevalent even in the biomedical institutions– its services and practices– where physical abuse was justified on ‘moral’ grounds. Morality stemmed out of cultural ideologies where proper ‘feminine’ behaviour was outlined and reinforced in different ways. She
recalled that a female biomedical staff was pinching her thighs for not being able to push hard. Tanu resisted the hostile behaviour by pushing the female biomedical staff away. In turn, Tanu was hit by the female biomedical staff.

Tanu, in her first delivery did not resist pain and tried to avoid the humiliating experience. First pregnancy is one of the instances where cultural domain overlaps with biomedical domain to control pregnant women’s bodies. Women’s experiences show how their reproductive bodies became objects of the medical gaze which constructed and reinforced the hierarchy of the medical expert. However, this is ‘naturalised’ by not only the dominant ideology but also by women themselves, when they suffered such violence and violation of women’s bodies in the name of societal norms. Ram (1992) discussed the dos and don’ts of behaving at the time of delivery along with the notions of ‘rationality’ and ‘hygiene’ that are constructed and imposed by medical persons from the upper class and caste, leading women to begin viewing their bodies through an upper caste, upper class lens. Drawing from Ram, it can be seen that the biomedical practices were reiterating patriarchal ideologies and hence, were seen to be another form of patriarchy, biomedical patriarchy. Through strategies of threats and violence, biomedicine succeeded in extracting women’s compliance.

Thus, among both Baniya as well as Dalit women who resided in or near conjugal households, the role of mother-in-law was seen to be very predominant. They were the decision makers. Also, as seen in the previous chapter, mothers-in-law were also modifying their behaviour according to the societal expectation of institutional delivery where she herself took decisions regarding the place of delivery and preferred institutional delivery over home delivery. NMCH had a major role to play in this, as they were propagating institutional delivery as their objective for more than ten years, which they had achieved with rapport building through domiciliary visits.

**Residing away from natal and conjugal familial support.** This sub-section will discuss some of the Dalit women’s experiences, those who resided away from both conjugal as well as natal households. Since young Baniya women mostly resided in conjugal households, they would not be discussed in the present sub-section. On the one hand, it could be argued that women who stay away from both conjugal and natal household would have more agential power in their experiences of childbirth and on the other hand they would have lesser support systems. Some of these women worked in a nearby colony. Their earning status influenced the site of delivery, as women
wanted to avail private hospital services. The section will also reflect the role of husband in the absence of mother, or mother-in-law.

Jyoti, a Dalit woman, resided in a nuclear household with her husband and two sons. Her husband worked at a mill nearby and was also a part time driver, since that helped them earn extra income. She had her first delivery at a government hospital, and said that she was petrified to go there again. She said, ‘at government hospitals there are long queues for tests, it is quicker in private hospitals, you pay and save time’. Jyoti’s preference for private hospital for her delivery could not be materialised due to financial constraints. While narrating her first experience of delivery in a government hospital, she said,

*There are less number of beds as compared to the number of women admitted. Women even deliver on the floor. Women also share beds, two on each bed, one facing North, and the other facing South. These beds are till the lower back and below that is a dustbin, where all the dirty blood and waste are collected. I saw the woman next to me deliver. It was terrible. There were only 3-4 doctors for so many women. She kept screaming for help. Then one nurse came and helped her out. I saw all that and it is still fresh in my mind. I would never want to go there again! It was so painful that I screamed out of pain. They said now [while delivering] you are screaming! You didn’t scream when you were having fun!! I know that good women don’t scream, but at that time I didn’t care! I was in pain, whether they hit me, or scold me.*

However, for her second delivery at the same hospital, Jyoti claimed that she was less anxious, she knew what to expect from biomedical staff and her last experience gave her courage to resist biomedical practices:

*I knew what to expect. I knew the surrounding of women screaming, cramped up in a big room, I knew not to look at women delivering. This time, unlike last time, I screamed when it started to pain me...Arre! we are humans only, we will also scream in pain. That pain is terrible, then on that if nurses scold and say bad things, how would one feel! I screamed even louder after that.*

The second delivery experience of Jyoti, showed that experiencing delivery once in the hospital reduced her anxiety and fear level to express her discomfort through actions. Knowing that screaming is not acceptable and consequences of screaming would lead biomedical staff to hit her even more, she resisted her way through by screaming even louder while delivering. One of the reasons for asserting herself can also be attributed to the fact that she was a mother of a male child, a patriarchal achievement that gave her space to assert her identity and gave her courage to go against the multiple layers of cultural and biomedical ‘expected’ feminine behaviour.
After delivering the child, a junior doctor started to stitch a tear in vagina. As soon as he was done, Jyoti mentioned that another senior doctor came and started to teach him the correct way of putting stitches on her body. ‘I was dying in pain and kept pleading them to hurry up’. Jyoti’s experience of expressing that the doctors were learning on her body, hinted that poor women’s bodies were treated as sites of developing surgical experiments and expertise.

Mamata, a young Dalit woman, who stayed in a nuclear household along with her husband and two sons, mentioned that for her second delivery, she had started to get labour pains, and was going to enter the delivery room, when her mother-in-law, came to see her at the hospital. The mother-in-law realised that Mamata was not wearing any bangle while entering the delivery room. Being bare-handed or without bangle was associated with being a widow. Her mother-in-law quickly went towards her to tie a handkerchief around her wrist:

*It was paining so much that I pushed my mother-in-law aside when she was trying to hold my arm to make me wear something. I just pushed her aside and was taken inside the delivery room. I realised it later and was scared that my mother-in-law would scold me for my behaviour. I was surprised to see that after delivering my son, her behaviour towards me had changed completely. She was, in fact, very happy with me.*

What she feared as an unacceptable behaviour took a back seat against the background of Mamata giving birth to a second son, placing her at a higher socio-cultural space within Indian patriarchy. Ram (1992) and Van Hollen (2003) maintain that birthing women are considered auspicious due to their regenerative state where she is compared to a goddess. In this context, women’s unacceptable actions are not always taken in a negative sense. Ram (1992) further mentions that women are rather worshipped and are ‘allowed’ to surpass the boundaries of femininity.

Thus, staying away from conjugal and natal family members made young Dalit women more responsible towards their health and thus they tried to follow the trend of the resettlement colony, of delivering at hospitals. Staying away from family members also brought them closer to their neighbours and husbands and thereby, made her more assertive towards managing delivery decisions herself.
Thus, younger women’s residence and proximity to conjugal and natal household enabled or constrained their experiences of delivery. Younger women experienced biomedical institutions’ instrumentalist approach towards poor women by objectifying their bodies and treating them as ‘cases’ for sharpening their skills. Mohan Rao (2004) also mentions that urban poor women had to face the brunt of the state policies and programmes, institutional delivery being one of them. Women, in spite of being aware of the biomedical practices of humiliation and hostile behaviour still chose and opted for government hospitals to achieve their personal goal of safe delivery. Some of the women who were financially more stable, those who worked as domestic help in neighbouring colonies, resisted the exploitative practices of the biomedical institution by choosing to pay money and availing ‘better’ experience at private hospital.

The state promoted biomedical institutions, public hospitals, considered women as a homogenous group belonging to low socio-economic strata. Homogeneity was seen across region, caste and number of deliveries as compared to the way dais viewed women. Some women, although tried to negotiate their way out of the dai-tradition along with mother-in-law’s monitoring at delivery, by choosing biomedical monitoring for their first pregnancy.

Tulsi Patel (2012) compares home births at Mogra, a village in Rajasthan and birth at a city hospital. She argues that at home, women are told to not scream and not make any noises during birthing. On the other hand, at the hospitals, women make noises, and their screamings were common. However, in the present study, the discussion on young women’s experiences of delivering showed that among Dalit women’s first experience of delivering in a government hospital, most of the women expressed fears and anxieties manifested mostly through screaming. Some of these women did not comply with the patriarchal ideologies of ‘femininity’ but could not escape the medical and male gaze of the biomedical staff and the students. By the second and subsequent pregnancies, women knew what to expect and they adhered to their ‘acceptable’ behaviour. Women’s earning status made them to choose private hospital services for better experience. On the other hand, for young Baniya community, women’s first experience of pregnancy at hospital was coloured with the internalised patriarchal behaviour. Younger Baniya women’s socio-cultural context of residing in an extended household along with the conjugal family members made them to abide by the patriarchal practices even at biomedical setting. Only after
experiencing it once did they resist the humiliating and hostile experience in the subsequent deliveries.

**Dai-Tradition in an Urban Setting**

The young Baniya and Dalit women preferred institutional deliveries over home deliveries as they found it more safe and reliable and up-to-date with technology as compared to *dai* tradition. This raised a question, what is the status of *dai* in Poorvinagar against an established state-funded biomedical intervention? Did that mean that there were no *dais* in the urban resettlement area? I was initially convinced that there were no *dais*, as everyone, older and younger Baniya and Dalit women kept denying the presence of *dai* in the vicinity. It was only with regularly visiting women that the secret was revealed. The presence of *dai* was seen as a secret in the vicinity but on meeting them, it didn’t seem like they were secretive about it. This section will discuss the presence of *dais* in the vicinity, their status and role in the society. Soman (2013) and Malhotra (2006) discussed that with the setting in of biomedicine, there has been a classification of *dais*, based on their knowledge system, as ‘traditional’ and ‘modern’. This classification has been explored as ‘trained’ and ‘untrained’ *dais*, with the former associated with biomedical training and the latter with indigenous knowledge system. There has been another way of classifying *dais*, hospital and private *dais*, which would be discussed in the following section.

‘*Trained*’ *dai*. Parvati, an MCD employee by profession, an elderly Dalit woman, was around seventy-five to eighty years of age. She had shifted to Poorvinagar ever since the colony was set up in 1978, when Indira Gandhi government had allotted plots by waiving off rent for ninety years. Parvati used to live in a slum close to Poorvinagar when the Government had relocated all the residents there. Parvati was a migrant from Pakistan. Her mother-in-law was a government nurse there and used to take Parvati with her. ‘She always used to say that I have to take this forward’, said Parvati. She, along with her conjugal family, came to Delhi. At that time a government hospital was offering a course on training *dais*, where Parvati’s mother-in-law wanted her to get admission.
It was a one month long course where they were taught to assist in delivering a child. A sum of rupees five hundred were also given for attending the course. Trained dais were told to meet pregnant women during their pregnancy to tell them to eat certain food items like milk, fruits, green vegetables. Trained dais were to visit pregnant women and also encourage them to go to primary health centre and get vaccinated, and register for delivery at a public hospital. Parvati stated,

*Before helping women deliver, it is important to clip nails and then wash hands so that dirt stuck in nails should not enter delivering women’s bodies and vice versa as the chances of infections increase. We were shown films on how to help women deliver and then our teachers had made us assist a delivering woman in front of them, so that they know that we have learnt it.*

For cleaning purposes, there were two small bowls given, one for cleaning the eyes and nose of the new born and another one for cleaning women’s private parts after delivery. Further, she said, ‘*we were told to note down all the marks on the body of a baby*.’ Thus, there was an emphasis on ‘hygiene’ seen through making ‘trained’ dais wear gloves and use a plastic sheet for delivery, which were never replaced by the state. Sadgopal (2009) discusses how the state decides if dai training is ‘effective’ by focusing on the ‘hygiene’ level and decrease in maternal mortality rate. However, Parvati mentioned there were two positions of delivery that she engaged with, one was when she asked the woman to lie down and if the woman was not comfortable due to back pain, then, she made her squat on bricks. She added the biomedical knowledge and practice to her repertoire of traditional knowledge. Thus, the dais did not replace their traditional knowledge with the biomedical, rather used them to enhance choices and comfort for the birthing women.

Parvati, on account of her training, had to deal with this an identity crisis, first, recognition from the state as a ‘qualified’ midwife and then when dais were derecognised in favour of institutional deliveries.

On asking Parvati her opinion about the status of dai in an urban context, she responded,

*This is a personal choice, if somebody believes in me, I go and help them out. But now-a-days women go to hospitals. They think we will not be able to handle it. Now, tell me, so many children who are playing here, inke baap mere haaton ke janamein hain [I had helped their grandmothers deliver their fathers]. If you don’t believe in us, then go to hospitals!*
I had taken this training two three years after partition, since then nobody has thought of replacing the gloves or giving me new gloves or plastic sheet. I ask these NMCH doctors who come here to provide me with it, at least give me some financial assistance, I still have my government certificate of being a trained dai. But they say, that they can not help me! I don’t understand, first government is training us, and then they are not even giving us material to maintain hygiene. My plastic sheet has got torn, what is the point of using it, gloves is something that I had bought later on from my own money, but shouldn’t the government help me out with it?

Parvati’s narrative suggested that the state doesn’t recognise and support skilled dais. Parvati narrated an incident remembering the last time somebody had called her to assist a delivery. One of her Dalit neighbours came running to her one night and requested Parvati to come home to see the condition of her female dog. Parvati went to her house to see that the dog was in labour and was about to deliver puppies. Shilpi, the dog was hauling and Parvati thought it was her duty to help the dog. She mentioned that she patted the dog and then inserted her hand to see if Shilpi was crowning, she then rubbed Shilpi’s stomach with her hand, picked up Shilpi from the back and rubbed her stomach. Then again she inserted her hand and helped Shilpi deliver. She then helped the neighbour clean the room. She stated, ‘I knew that dogs disown their puppies if humans touch them, so I didn’t clean them. Shilpi immediately got up and started licking the puppies’, claimed Parvati.

She mentioned that the government was not encouraging dais to practice, by not financially supporting them. Parvati also mentioned about the ever changing status of dais, first the emphasis was on training them and then it shifted from dai-tradition to institutional deliveries, by marginalising dais. Her helping a female dog deliver portrayed her commitment to the duty of helping a female, irrespective of species to help in delivering. Parvati gave a sarcastic smile and mentioned, ‘and now this is the state of my work, until cats and dogs start preferring to go to hospitals to deliver!’

This indicated what Parvati felt about her status as a dai, as someone who was once in demand due to her ‘skilled’ status which was certified by the government, which had become meaningless in the current context where the same government was disregarding her. She believed that the state-issued certificate for being a ‘trained’ dai had got her a permanent job at the MCD office. She was expected to pick up waste garbage from road side that sweepers had already kept aside. The skilled dai, as an MCD employee is symbolic of the way dais were stripped off their knowledge.
and skills to be only the pollution carrier in the brahminical ideology of pollution and purity.

‘Untrained’ dai. Angoori Devi, another elderly Dalit woman, was a dai. She was residing with her son, daughter-in-law and a grandson. She recalled that her husband passed away in the same year as Jawaharlal Nehru. It was only after his death that they all moved to Poorvinagar. Angoori Devi had two daughters who were married and two more sons. She stayed with her youngest son. On asking her the current status of her work, she said,

Now women prefer hospital delivery. They call me only for massage after delivery, that too very rarely. They think I am too old and will not have any strength in my hands. Little do they know that my diet throughout has been very nutritious, more than theirs. They prefer calling women who are young, thinking that they will have more strength! aajkal ki choriyan takkar nahi de saken mujhe [but they don’t know that these girls can’t compete with me].

Angoori Devi was very young, around thirteen to fourteen years old when she got married. She used to accompany her mother-in-law, who was a dai. She started helping her mother-in-law conduct birthing only when she had her first child, a son, who died within a month from jaundice. She revealed that she used to cry thinking that she will not be able to become a mother again. Her mother-in-law helped her come out of this by asking her to assist in delivering. She said,

I started going for japa [birthing] and also in between to check on pregnant women during their pregnancy. I used to boil water, wash soiled clothes and started to do this very religiously hoping that if I help japa, then God will make me a mother very soon.

She had learnt all her dai expertise from her mother-in-law, who was referred to as, ‘an institution in herself’ while talking about dai training in hospitals. ‘There was no need for me to take any training from a school! These hospitals and colleges are all yesterday’s invention, my mother-in-law’s knowledge was beyond all these institutions’, she said.

From the narratives of Angoori Devi and Parvati, it is understood that dais believed that their knowledge was marginalised by the state as the focus had shifted to institutional delivery. This was also one of the objectives of the intervention programme of NMCH in Poorvinagar. Constant reminders and awareness building
programmes of NMCH along with other media exposure made institutional delivery a norm in Poorvinagar, which probably explained the reason for keeping dai-tradition secretive. Two women, both young Dalit women revealed the name and address of dais in Poorvinagar. It was seen that Baniya women maintained that there was no dai culture prevalent in the urban resettlement area except for women who massaged new mothers and children post delivery.

**Hospital dai and Private dai.** In the context of hospital, dais were a part of the lowest rung of biomedical hierarchy who cleaned dirt after delivery, cleaned babies and declared to the family the sex of the new born. In return, she asked for neg, for breaking the news to them. Sushma mentioned that it was considered essential to give money to hospital dais:

> We have to give neg to dai. Now that deliveries are in the hospitals, hospital dais break the news whether our daughter-in-law has had a daughter or a son. She demands money, sweets and clothes, similar to what a “private dai” demands...if the baby is a girl then they ask for five hundred rupees, but if it is a boy, then thousand rupees along with sweets and sari. She not only asks the mother-in-law of the delivering mother, but all the visitors for neg.

Sushma also reflected at the way expenses have increased over a period of time. With increasing consumerism, there has been an increase in the demand of neg, which was once considered as a cultural token. As seen among a young Dalit woman, Gita, who discussed an incident that had happened with her neighbour where woman’s family was duped by a hospital dai at a public hospital:

> They take money from all relatives and more from the in-laws. You know, once, a woman delivered and one of the nurses [hospital dai] told the family that it’s a baby boy. She demanded 1100 rupees, which the family had to give. Later, the family got to know that it was a baby girl. Those people were simple people. If some sayane log (clever people) would have been there, then they would have called the police and taken all the money back. These are their ways of fooling people and making money.

From Sushma’s excerpt it seemed that ‘hospital dai’ was a concept which indicated a blend of cultural and biomedical discourses. This overlap suggested the way both discourses interplayed and maintained their patriarchal practices of focusing on women’s reproductive health. The rationale behind taking neg in cash from the family members was not that dai was taking away ritual pollution, making the
delivering woman pure, but it was a way to exercise power and authority of the most exploited and at the lowest rung of biomedical institution. The only way they could assert their authority was by raising high demands in front of the family members. The concept of hospital *dai*, in reference to the reason for which she was called ‘*dai*’ also reflected the way biomedical institutions too considered a *dai* to be associated with cleaning ‘dirt’ after childbirth, cleaning new mother and bathing new born. This reinforced the ‘scientific’ nature of biomedicine which debunked non-scientific, religious and ritualistic ways and passed on these tasks to the *dais*. Biomedical institutions appropriates *dai* labour and the way it is done, it reinforces the caste ideology, notions of purity and pollution and the patriarchal ideology of birthing as defiling.

The role of hospital *dais* has been portrayed as restricted to post delivery, of ‘cleaning dirt’ of childbirth and bathing new born. By assigning these duties to *dais*, the biomedical institution also constructs a division of labour that trivialises these tasks and also places them outside its responsibility of ‘delivering’.

Private *dais*, are those who were called for massaging post-delivery. I had met women who used to massage *jachcha* and were referred to as ‘private *dais*’. They took cash for doing massage on a daily basis. Kaveri mentioned that private *dais* charged rupees fifty a day. Further, she believed that mothers-in-law usually got their daughters-in-law massaged only if they had given birth to a boy. The role of *dai* in post-childbirth practices are discussed in the following chapter.

**Perceptions of NMCH Staff on Dai**

Biomedical staff maintained and reproduced the colonial ideology of targeting *dais*–as unhygienic, cause for high maternal mortality and morbidity through their ignorance and unhygienic practices (Ukberoi 1996; Whitehead 1996; Jolly 1998; Ram 1998; Van Hollen 2003; Rao 2004). *Dai* was also considered a rural phenomenon. The biomedical staff maintained that there were no *dais* in Poorvinaagar and that it was a ‘rural phenomenon’. Tina, an NMCH staff believed,
Our aim is to reduce maternal mortality and infant mortality rate for which we ask them [pregnant women] to visit an ANC clinic, if not at the NMCH van and to make sure that they deliver in a hospital. We can only tell them and remind them, you can’t ask women to not go to a dai. If their in-laws insist, after all she will listen to them who have been taken dais’ assistance during their delivery. Dais do have experience but they don’t understand the problem that we are now facing like maternal mortality and maternal morbidity, things like post partum haemorrhage, tetanus.

Poornima, an NMCH staff, mentioned that there was a need to train dais in order to enhance their services, ‘which may benefit ANC patients as they would trust the dai more than doctors because she would do according to the wishes and advises of the family’. She agreed with Tina, that dais was a rural phenomenon and some women go back to their villages to deliver, in such cases, meeting women for a brief while once in a couple of weeks would not change their behaviour as they would adhere to what their mothers-in-law asked them to do, especially in extended households. It was seen that the biomedical staff was unaware of the presence of dais in Poorvinagar or at least they did not admit it.

Further, Ranjan, a male doctor, mentioned that it was difficult to promote skilled dais because NMCH didn’t know if they actually maintained hygiene while delivering:

We do not know the skill of trained dais, who the delivering woman was going to, how can we take their guarantee? Where is a dai learning her skills from, one doesn’t know. What are they learning and practicing is not something that NMCH is responsible for! If something unfortunate happens then NMCH should not be held responsible for it.

Biomedical staff believed in the supremacy of hospitals and biomedicine in general by promoting it and favouring it over dai-tradition. On the contrary, Aditya, a male doctor responded to dais’ need for financial assistance for buying materials that helped in delivering. He believed,

...if dais feel that they are not getting material then maybe NMCH should start providing them with basic materials. Because I feel if dais are taken into consideration then it would definitely help mothers as it could reduce maternal morbidity. It could be a useful step. I would say that the urban health programme doesn’t entail such things. We are only to provide ANC services to them.

Although some of the staff talked about supporting dais to help women, the ultimate aim was to replace them. Ranjan added to Aditya’s thoughts that in order to change residents’ cultural practices like dai tradition:
...regular counselling and education are one of the big steps in this area that would be education of the mother and mother-in-law. This education starts from the grass-root level. Small children should be given proper education in the schools, they should be taught about cultural practices, what is good for them and what is not. Gradually over a period of time these changes can be seen.

The status of dais in Poorvinagar suggested that dais were seen as post-delivery phenomenon, restricted mostly to massaging. It was seen that dais felt an identity crisis by expressing the state’s complicated and unclear decision regarding their status in the society. This is further complicated with the state initially asking dais to undergo training and then not recognising their ‘skilled’ status. It was also seen that throughout, ‘unskilled’ dais have not been recognised by the State and were referred to as the reason for high maternal mortality rate and infant mortality rates. With spreading awareness regarding institutional delivery as the only safe method of delivery, young women got attracted to it and favoured hospitals over home delivery. This thought process was to the extent that residents did not reveal the presence of dais in Poorvinagar. Women who mentioned this also spoke about it in a very secretive manner, but on the contrary, the dais were not at all secretive about their ‘profession’. Even at the hospitals, there was absorption of cultural phenomenon of dai seen as ‘hospital dai’, who was at the lowest rung of the biomedical hierarchy, with a menial role of cleaning childbirth ‘dirt’. The biomedical staff considered dai-tradition to be a rural phenomenon and didn’t encourage it in the light of biomedicine.

Conclusion

The chapter reflected on the birthing experiences of women at home and hospitals. Among the older women, there was no alternative knowledge system available other than the dai tradition. It was seen that dais’ behaviour varied with different social background of the delivering women. With the delivering women belonging to the same community as dais, it provided dais a platform to assert their authority while among assisting older Baniya women during their childbirth, dais were seen an emotional support. Their support was also considered more motherly at the conjugal household as a site of birthing, where mother-in-law asserted her identity and authority over her daughters-in-law’s childbirth.
Among the younger women, the control of cultural knowledge regarding childbirth was weakening and was getting replaced by biomedicine. The birthing women and biomedical institutions are engaged in a power relationship where both struggle with the other to attain their respective goals, safe delivery for women and meeting the targets of institutional deliveries for the hospitals. In the previous chapter, NMCH was seen to be of a benevolent nature, where they propagated institutional deliveries, which women themselves wanted to avail in order to have a safe delivery. The delivery experiences at hospital show the other ‘side’ of medical institutions where their birthing bodies become sites of medical gaze, and for developing medical expertise. This reinforced patriarchal ideologies of feminine behavior and the value of subordination. The traditional structural power of mother-in-law based on her social position, experience, skill and knowledge have been eroded and increasingly been replaced by biomedical institutions. In response, mothers-in-law asserted themselves and negotiated with the alternative source of knowledge to reclaim authority over daughter-in-law’s pregnancy by taking decisions regarding delivery– site of delivery, whether government or private, and whether to send daughter-in-law to her natal house for first childbirth.

The chapter also analysed the interplay of cultural and biomedical discourses through the way the concept of hospital dai has come into being, and how the current status of dai is restricted to cleaning, being in a menial job, and declaring the sex of the child. In the urban context and with institutional deliveries, the role of dai was seen to be restricted to post-childbirth practices which would be discussed in the next chapter. The next chapter would discuss the reassertion of the cultural knowledge and practice when biomedicine withdraws its services, after achieving ‘safe delivery’, the mutual goal of women and state-financed biomedical institutions.