Chapter VI

Conclusion

The present study was carried out in an urban resettlement area in Delhi, Poorvinagar, against the background of biomedical intervention by a state-funded hospital (NMCH), to explore women’s negotiations with patriarchal control over their pregnancy and childbirth. Biomedical and cultural discourses around pregnancy and childbirth were analysed, to understand the way these discourses shaped women’s pregnancies and childbirth experiences. The study explored women’s perceptions and negotiations with the power dynamics of the various bio-medical and cultural discourses in a socio-cultural context dominated by patriarchal ideologies. The key participants of the study were women from Baniya and Dalit communities, the two predominant groups in Poorvinagar. Among them, women who had experienced pregnancy and childbirth before the commencement of NMCH intervention programme and women who availed NMCH services during pregnancy and childbirth were interviewed. Apart from women, NMCH staff and doctors, dais and some of the relatives, including husband, mother, and mother-in-law were also interviewed.

The analysis of women’s experiences is carried out in the context of the two state interventions, firstly, state intervention to create Poorvinagar, a resettlement colony. Poorvinagar was created by forcibly relocating people residing in slums. The families of this artificially created colony therefore belonged to the lower socio-economic strata of urban society. They belong to the Dalit and Baniya communities but from different parts of the countries such as, Bihar, Haryana, Himachal Pradesh, Madhya Pradesh, Rajasthan, Uttarakhand, Uttar Pradesh, West Bengal. The artificial and mixed nature of the colony led to the weakening of some of the traditional social control based on caste, regional background and familial structures over the residents which they would have experienced had they been living in their own community.

The second intervention was the state-funded biomedical services introduced in the year 2002. These services mainly targeted women and children with an aim to control maternal and infant mortality rates, and women’s fertility. Young women not only used these services to safeguard their pregnancies but also to negotiate with their mother-in-law’s authority over their pregnant and birthing bodies. While the state
interventions have eroded the power and influence of traditional structures, they have not been able to erase or discard the caste, cultural and regional differences. As the experiences of women show, while biomedicine has been able to make inroads into their lives, they are deeply engaged in the complex processes of reproduction of cultural knowledge and patriarchal ideologies in varied forms.

The interventions and erasures are evident in the way women negotiate and comply with patriarchal ideologies and structures. In this process, women also strategise and assert their patriarchal identities to manage pregnancy and childbirth their way.

**Role of Knowledge in Controlling and Negotiating Pregnancies**

The study shows that women’s bodies, especially during pregnancy and childbirth, are subjected to intensive surveillance and control by multiple and overlapping structures of power. Women’s experiences revealed that their pregnancies were controlled by both traditional authority structures of family and community as well as by the structures and practices of institutionalised biomedicine. Women’s responses to these power structures have been varied and strategic as they collaborate, resist and negotiate the overlapping and different layers of control and authority. The study shows the role and significance of knowledge in the aspect of control as well as in women’s agential acts.

It was seen that women’s first pregnancy was the focus of control and also of support as women were seen as inexperienced. The first pregnancy was invested with much expectations to prove fertility and to produce a male heir. These findings were similar to the findings of studies such as Carla Risseeuw and Rajni Palriwala (1996) on support system where they discuss how marriage, family and kinship entail elements of security, support and care as well as control. First pregnancy was also the occasion to socialise and discipline the young daughter-in-law to the household gender dynamics and behavioural norms. Over the number of pregnancies, direct control of familial structures eased out since women were expected to learn from their previous pregnancy experiences. This also meant reduced support from both her marital and natal families during the second and the subsequent pregnancies. A successful pregnancy not only enhanced a young woman’s social status within the family and the community, but also elevated her from an ‘ignorant’ one to ‘an
experienced and knowledgeable’ one. The traditional family explicitly and the biomedical institution tacitly endorsed women’s experiential knowledge.

There were marked differences in the experiences of older and younger women. Having delivered at home in the villages, older women had little or no experience of the biomedical discourse or its institutions. In contrast, the more educated young women, living in the city, were confronted by plural knowledge and traditions, control and support systems. Knowledge, especially for young women, was not a complete understanding of the body from any one perspective, cultural or biomedical; it was in the form of pieces of information provided by biomedical staff or family members as advice and prescriptions. To closely monitor women’s pregnant bodies, the state, medical institutions and family drew upon contrasting discourses of knowledge to legitimise their control.

The knowledge that was provided to pregnant women by both biomedical staff as well as family members was partial and restricted. The biomedical and cultural knowledge, in the form of prescriptions and proscriptions, monitored every aspect of women’s life—their diet, physical and social interactions, work, medication etc. and carried moral judgements about women’s behaviour. Both the biomedical and cultural discourses construct women as ignorant and inexperienced and therefore in need of advice, surveillance and interventions to achieve the goal of safe pregnancy and delivery. However, the presence of plural discourses led women to draw upon the knowledge of one in order to negotiate the demands of the other, in their attempt to safeguard and also enjoy their pregnancy.

Further, women’s household composition (nuclear or extended), age at marriage and number of children, being a mother of a son and proximity to natal family members enhanced their overall negotiability. Factors influencing women’s negotiations were in tandem with the findings of Keera Allendorf (2012) where she establishes a relationship between quality of family relationships and women’s agency. The study also confirms Joy Deshmukh-Ranadive’s (2005) analysis of household and family dynamics where she argues that women’s space within household (physical, economic, socio-cultural and political) influences her capacity to act within and outside the household. However, these and other studies do not consider knowledge as an important variable that circumscribe or enable women’s agential responses.
Weakening and Reclaiming the Authoritative Status of Mother-in-law

Among the older women, role of mother-in-law was authoritative and she held an important position in her daughter-in-law’s reproductive life, especially if they resided together in an extended household. However, there was a shift in the role of mother-in-law from being the sole authoritative figure during older women’s first pregnancy to a weakened position during younger women’s first pregnancy. This was due to the availability and accessibility of biomedicine as an alternative knowledge system, for the younger women, their relatively mature age at marriage, change in household composition from extended to nuclear, and exposure to media and the urban environment that supplemented biomedical knowledge. The authority of mothers-in-law over their daughters-in-law’s pregnancies was reduced and gradually was replaced by biomedicine.

Young women’s mothers-in-law, especially those who resided in extended Baniya households, tried to reclaim their losing power over their daughters-in-law’s pregnancy by adapting to the demands of the urban aspect of the city. They tried to adapt themselves to biomedical services, and tried to adopt some of the diverse cultural practices of the mixed community neighbourhood that also included Dalit households.

This was seen in the way the cultural practice of going to natal home for the first delivery was modified. Going to natal home for pregnancy when conjugal family members resided in the same household, or close by, was perceived in a negative way. It was associated with financial and emotional crisis at the conjugal household. The family’s class status and urban character was increasingly related to the manner in which daughters-in-law’s pregnancies were managed and urban character was increasingly related to the manner in which daughters-in-law’s pregnancies were managed. Thus, mothers-in-law moulded themselves to maintain the status of the family in the urban neighbourhood. Although many of the rituals and practices around pregnancy and childbirth were followed even in urban context by upholding patriarchal norms, the place of residence in an artificially created urban resettlement community led to the relaxation of caste and community control over its members. With consumerism pressing for more rituals and practices, it was seen that notions of class and status were entangled, even more, in celebrating pregnancy. By observing
newer rituals and practices and also celebrating pregnancy, mothers-in-law were seen to reclaim the lost ground vis-a-vis their daughters-in-law’s pregnancies.

As contrary to a common assumption that modernity leads to decrease in religiosity, it was found that in the contemporary context, it led to the reinforcement of birthing rituals as economic investment in these rituals enhanced families’ social status (Appadurai 1996; Van Hollen 2003). In spite of the modified practice of not going to the natal family during the first pregnancy, the ideological core of the practice was kept alive with natal family bearing the economic burden of the pregnancy related rituals and celebrations organised by the conjugal family. With increase in consumerism, there was greater emphasis on the exchange of gifts and clothes between the natal and the conjugal families to the extent that the new rituals became an additional financial constraint on the natal family.

There was a new culture of celebrating godbharai among younger Baniya women. This may be seen as a form of acculturation in an urban resettlement colony of mixed castes and communities. It could also be the result of commodification of certain rituals becoming a pan Indian phenomenon. It nevertheless indicates the spirit of an urban resettlement life which transformed rituals by engaging with each other’s cultures.

To reclaim the weakening position in their daughter-in-law’s pregnancy, mother-in-law of young Baniya women agreed to their demand of delivering in the hospital. The mother-in-law chose which hospital her daughter-in-law will go to for ANC and which hospital would she deliver at. She tried to retain her power over her daughter-in-law’s pregnancy by continuing to be the decision maker for her pregnancy and delivery. Thus, both younger women and their mothers-in-law were engaged in multiple power struggles in a changing structural and cultural context.

**Biomedicine as a Benevolent System during the First Pregnancy**

The relationship between women and biomedicine can be viewed as of being mutually dependent, where both needed each other to achieve their common goal— safe delivery and a healthy child. The underlying concerns were however different for women and biomedical institutions. While women wanted to have a smooth personal experience of pregnancy and childbirth; biomedical institutions aimed at achieving their targets set by the state. Biomedicine was perceived as benevolent during first pregnancy and
delivery since it provided an opportunity for women to negotiate with patriarchal familial structures apart from building their self-confidence for hospital delivery. Thus, women of Poorvinagar sought biomedical services for pregnancy and delivery. This is in contrast with the findings of studies by Van Hollen (2003) and Sagar (2006) where, women preferred home deliveries despite accessible biomedical services.

The NMCH provided younger Baniya and Dalit women of Poorvinagar an alternative to cultural knowledge to manage pregnancy and childbirth by offering services that were considered ‘modern’ and hence more trustworthy. NMCH services helped women to ‘liberate’ themselves from the patriarchal mindset of mother-in-law. Availability of the services in the proximity also led young women to step out alone, without being accompanied by their mother-in-law. Proximity of services also encouraged them to avail NMCH services regularly and helped them achieve their goal of safe delivery.

Women used biomedical services to negotiate and resist societal and familial structures. Women’s approach towards biomedical institution during their first pregnancy was opting as a counter to mother-in-law’s authority. But by their second and subsequent pregnancies, women themselves started viewing hospitals in an instrumentalist way, to achieve their objective of a safe delivery and a healthy newborn. This also indicated change in the role of institution in the lives of women staying in Poorvinagar. The availability of NMCH services helped women to be able to mobilise knowledge, resources and support system in order to negotiate with patriarchal control of familial institutions.

The biomedical institutions functioned in a manner that did not undermine the traditional cultural beliefs and practices. Women biomedical staff elicited pregnant women’s compliance by combining cultural and biomedical knowledge since they themselves were a part of the society having faith in cultural prescriptions. Such efforts not only made women more comfortable with biomedicine but in the processes cultural knowledge was also validated by biomedical explanations.

Once the mutual goal of safe birth is achieved, biomedicine withdraws its support and shifts the focus to child health. In this process, new mother’s health and other needs of care get ignored and take a backseat. NMCH perceived women as targets of fertility control. This made women return to the cultural knowledge system after delivering at biomedical institutions. Women perceived cultural knowledge in post-childbirth to provide them a way to regain bodily strength after delivery along with an
avenue to enjoy the glorified status of motherhood which they would not have been able to enjoy in a biomedical environment. After shifting the site of delivery to hospital, the initial and culturally most important days were mostly spent at the hospital, without the massage, special diet and work restrictions. The post-childbirth cultural practices were reorganised to accommodate this shift in the site of delivery. During the second and subsequent pregnancy, although biomedicine continued to view women as their targets, women did not perceive NMCH or biomedicine as services that would help them to negotiate with the familial control, since they had already achieved that for themselves in the first pregnancy.

Second pregnancy and childbirth is approached with an instrumentalist perspective by women since their main source of knowledge now becomes their first experience of pregnancy and childbirth. Thus, change in the perception of biomedicine from benevolent to an instrumentalist support was seen with a shift from first to subsequent pregnancies. The study showed how biomedical and cultural knowledge shaped women’s experiences of pregnancy and childbirth with a predominance of one knowledge system over other in one phase and the fading away of it to be replaced with another. With subsequent pregnancies women preferred their experiential knowledge over the biomedical and the cultural knowledges.

**Birthing Experiences**

*Older women’s experiences of birthing at home.* Among the older women, their social background influenced their experiences of birthing. Most of them delivered at home and had used the services of a *dai*. Class and caste status of women determined the nature of *dai* services they received. The Dalit women shared their caste and class status with *dais* that led *dais* to assert their power over Dalit women’s birthing bodies. *Dais’* behaviour and perceptions changed while assisting Baniya women during delivery due to their ritually and economically better off status than *dais*. *Dais* were less assertive and more caring and the Baniya households were in need of and appreciated their services. At the conjugal household, Baniya women perceived *dais* as motherly support. Women’s actions aimed to negotiate with *dais* were influenced by their context–site of childbirth, caste, class, first childbirth, mother of a son.

Due to the lack of alternative source of knowledge or services for older women, their negotiations were restricted to asserting themselves for a better experience of
childbirth. Such assertions were possible only in their natal homes. Resistance was seen more in the case of Dalit women as compared to Baniya women. This was manifested in the way women acted against dais’ instructions, which were expressed either vocally or physically. Dais physical and emotional support for Baniya women increased the possibility of getting more neg, since Baniya community is economically better off. Thus, interplay of caste, status and material resources influenced dai–birthing women relationship.

Younger women’s experiences of institutional deliveries. At government hospitals, women from Poorvinagar were seen as a homogenous category belonging to the socio-economically poor section. They were homogenised into a singular category of ‘poor women’ despite their significant differences in terms of region, caste and number of deliveries as compared to the way dais viewed women. It was observed that young women delivered either at government or private hospitals. This coincided with the objective of the NMCH and the ‘target’ approach of other government agencies to ensure that there is cent-percent institutional delivery.

With the younger women, there was a change in the practice of going to natal house for delivery. It could be attributed to the presence of NMCH services in the vicinity which attracted women to stay back in Poorvinagar in order to experience ‘modern’ biomedical facilities at the time of delivery. In spite of the fact that biomedical institutions subjected women to hostile and humiliating experiences, younger women chose biomedicine over dai assisted, family controlled home births. Kalpana Ram (1998), Cecilia Van Hollen (2003), Sagar (2006) and others have also discussed the hostile experiences of delivering at public hospitals. What may be perceived by the state and biomedical institutions as the success, of their interventions, for younger women, it was the outcome of their negotiations with the traditional structures of control.
Post-childbirth Care and Rituals in the Resettlement Context

The role of biomedicine in post-childbirth period. Biomedicine’s instrumentalist approach towards women in the post-delivery period is seen once they had already met their target of institutional deliveries. Biomedical institutions now focused on another target, that is, family planning, by encouraging women to use contraceptives without informing them about their side effects and precautions to be taken. By doing this, hospitals provided another avenue for patriarchal ideologies to be reinforced.

The role of public hospitals and NMCH intervention programme in the post-childbirth period was limited to providing contraceptives to married women in order to control their fertility. Although, women expressed their needs and desires to use contraceptives, it was the conjugal family members that decided the usage of contraceptives, which was after achieving the desired number of children. However, some women negotiated with the familial structure to access contraceptives. Household composition and sex of the children played an important role in being able to negotiate.

On the one hand, biomedicine provided young women a platform to enhance their resources in order to resist cultural discourses around pregnancy, on the other hand, through its target approach to reach family planning goals, ended up reinforcing women’s subordination in the post-childbirth period.

Dai-services in the urban setting. The status of dais in Poorvinagar suggested that dais were seen as a post-delivery phenomenon, restricted mostly to massaging. Dais felt an identity crisis because of the state’s ambiguous and unclear stand regarding their status and services in the society, since the state itself had initially encouraged ‘untrained’ dais to undergo training to upgrade their skills and then did not recognise their ‘trained’ status. It was also seen that biomedical staff still blamed ‘untrained’ dais for high maternal 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 was seen to the extent that women residing in Poorvinagar did not reveal that there were dais in the resettlement area. A few women revealed it in a very secretive manner, but on the contrary, the few dais who were interviewed were not at all secretive about their ‘profession’.
Dais in Poorvinagar were found to provide services both in the hospitals and in the homes of women who had delivered. Even at the hospitals, there was absorption of cultural phenomenon of dai seen as ‘hospital dai’, who were at the lowest rung of the biomedical hierarchy, with a menial role of cleaning childbirth ‘dirt’ and asking for neg. The biomedical staff considered dai-tradition to be a rural phenomenon and denied and subordinated dai knowledge, experiences and expertise. The other category of dais were the ‘private dais’. They were called for massage post-delivery. They took cash for doing massage on a daily basis and charged higher fees with birth of a boy. They charged for their services and did not claim neg, although some families gave some neg too.

This shift from biomedicine to cultural knowledge in the post-childbirth period was not restricted to the urban poor, but was also a part of the upper caste and upper class practice. The post-childbirth period also saw emergence of japa bai, where in there was an attempt to avail the best of both knowledge systems, cultural and biomedical. Young upper caste and class women hired japa bais through agencies or through word of mouth in the post-childbirth period. Japa bais belonged to the Dalit community. Such commercialisation of cultural knowledge in post-childbirth period provided a platform for exchange of the ‘higher’ and ‘lower’ caste-class culture.

**Rituals.** Along with changes in the household composition, emotional support system, city exposure, and availability of biomedical facilities for younger women in an urban area, it was seen that the ideological core of post-childbirth rituals (rasam) and practices were maintained which reinforced patriarchal ideologies and structures. Unlike in the period of pregnancy and childbirth, in post-childbirth period, women’s resistances were seen to be minimal, although the sohar songs and certain rituals provided women a platform to express their feelings of being dominated over.

The rituals in the post-childbirth period were performed mainly when a son was born. There was an influence of urban context on these rituals along with marketisation that led to intensification of the rituals. This was seen through the way the notion of purity and pollution was reinforced leading to reproduction of caste and gender ideologies (Chakravarti 2003). In order to claim higher status within the same caste and also for claiming upward mobility, ‘lower’ castes have also started to follow the newer intensification of post-childbirth rituals. An example is the emergence of shuddhi hawan as a post-childbirth ritual among ‘lower’ caste that marked the end of
pollution period for new mothers. Other practices had become more ‘ritualistic’ in
nature. A manifestation of class status was also evident through the commercialisation
and consumerism of post-childbirth celebrations.

Another ritual of worshipping the well, *Kuan poojna*, was considered to be the
last ritual of the post childbirth practices marking daughter-in-law’s entry into the
public spaces. With shifting to the urban context at Poorvinagar, it was seen that the
ideological content of *kuan poojana* was maintained. The unavailability of well in the
vicinity led women to worship a water tap or any other available source of water.

**New forms of male control.** *Kuan Poojna* ritual also saw another modification; the
‘only women’ ritual had started to see men accompanying women as they went for
worshipping a source of water. This could be a way to ‘protect’ women in the public
sphere, hence a form of male control.

Further, it was seen that with coming to an urban area, some of women’s
traditional role was being replaced by men. Earlier Bemata (the goddess of childbirth)
was considered important in writing the future of the new born child. Hence, the *dais*
played a major role and took decisions about the date of celebrating post-childbirth
rituals. In Poorvinagar, it was seen that male priests had replaced the role of Bemata
and *dai* by becoming the decision makers of carrying out rituals and celebrations
through preparing and predicting child’s future through a *janamkundali*. The pundit
also decided the intensity with which celebrations had to be performed. Increased
male participation also saw marketisation of rituals that led to increase in the
expenditure and also the reinforcement of notions of purity and pollution. These
changes also indicate newer ways of reproduction of brahminical ideology through re-
emphasising the role of astrology, a science practiced by upper caste men in post-
childbirth rituals. This led to reinforcement and reproduction of the notions of upper
castes. It was also seen that the Dalit households also started to abide by this practice
of calling pundit in the post-childbirth in anticipation of upward status mobility.

The study thus shows that women negotiate, collaborate, resist and counter patriarchal
control over their pregnant and birthing bodies. Women bargain within the dominant
patriarchal ideology and in doing so, they tend to reproduce their subordination and
also manoeuvre their ways through, to have a better experience of pregnancy and
childbirth. In bargaining with patriarchy, as argued by Kandiyoti (1989) and Agrawal (1997), women employed intra-household as well as extra-household resources to negotiate control over their pregnant and birthing bodies. However, the bargaining power varied with women’s structural location, like, caste, age, household composition; along with external factors such as availability of biomedical intervention, community resources and market. Further, women use multiple knowledge systems along with their own experiential knowledge as resources in negotiating the patriarchal structures and ideologies.

The study shows how cultural knowledge, biomedical knowledge and experiential knowledge interact and intersect in women’s lives during pregnancy and childbirth. Women play an active role in challenging as well as reproducing patriarchal arrangements. The existence of plural knowledge systems and their practices enable women to resist, bargain and negotiate the multiple and cris-crossing patriarchal structures and ideologies. The study also shows how knowledge forms an important aspect of women’s resistances and negotiations contributing to the reproduction of medical and cultural pluralism.