Abstract

Women’s pregnant and birthing bodies are targets of many socio-cultural and medical interventions. Pregnancy and childbirth experiences of women, more specifically of those belonging to socio-economically marginalised groups, are placed under the surveillance of biomedical and state intervention programmes. Placed within these constraints and controls, women, however, resist and negotiate patriarchal power using different strategies. The present study analyses the cultural and biomedical power structures that regulate women’s experiences of pregnancy and childbirth and women’s responses to societal control over their bodies.

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

The present study is located in a resettlement colony in Delhi, Poorvinagar, an artificially created community where traditional control over women, through caste, regional background and familial structures are weakened with no rigid spatial distribution of households along caste lines. 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, and 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. This resettlement, Poorvinagar, is served by a state-funded biomedical institution, the National Medical College and Hospital (NMCH) since the year 2002. The NMCH runs an Urban Health Programme with three components, a mobile clinic, field programme and family health advisory services focusing on maternal child health by encouraging women to
avail ANC, enrol for institutional deliveries in order to decrease the maternal and infant mortality rates.

The study adopts feminist methodology to address the above stated objectives. Feminist research methodology focuses on women’s experiences. It also helps in understanding institutions of power through women’s experiences. For the study, women currently living in Poorvinagar with one or more children were interviewed—those who had availed the NMCH services during pregnancy and childbirth, and women who had their children prior to the establishment of the outreach programme in the year 2002. The women belonged to two different communities, the Baniya and the dalit communities.

Within the feminist literature, Sylvia Walby’s (1989,1990) Dual System Theory is drawn upon to understand the material base of patriarchy along with establishing patriarchal relations of the cultural institutions and the state that form the discourses around pregnancy and childbirth in the study. In order to understand women’s negotiations with structures of power that exercise control over their experiencing pregnancies and childbirths, the study adopts Deniz Kandiyotii (1989) and Bina Agrawal’s (1997) framework of ‘bargaining with patriarchy’ specifically with reference to women’s everyday intra-household and extra-household negotiations. Further, the study draws upon Michel Foucault’s (1980) conceptualisation of power-knowledge relationships where he argues that knowledge cannot be separated from power as knowledge is integral to both, operations of and negotiations with power.

The study showed 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. Over the number of pregnancies, direct control of familial structures eased out since women were expected to learn from their previous pregnancy experiences. 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 knowledges and traditions, control and support systems. To closely monitor women’s pregnant bodies, the state, biomedical institutions and family drew upon contrasting discourses of knowledge to legitimise their control.

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. 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. 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. 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.

The availability and accessibility of biomedicine provided younger Baniya and Dalit women of Poorvinagar an alternative to cultural knowledge to manage pregnancy and childbirth by availing 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. Thus, biomedicine was perceived as benevolent during first pregnancy and delivery since it provided an opportunity for women to negotiate patriarchal familial structures apart from building their self-confidence for hospital delivery.

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. Thus, younger women’s mothers-in-law moulded themselves to maintain the status of the family in the urban neighbourhood. 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. 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, the 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-à-vis their daughters-in-law’s pregnancies.

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 new born since they had already negotiated familial control in their first pregnancy. This also indicated change in the role of institution in the lives of women staying in Poorvinagar. The relationship between women and biomedicine in pregnancy 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 experience of pregnancy and childbirth; biomedical institutions aimed at achieving their targets set by the state.

Further, during birthing, 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 birthing, 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. Resistances were 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.

At government hospitals, younger 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. 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.

Biomedicine’s instrumentalist approach towards women in the post-delivery period is seen once they had 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. However, some women negotiated with the familial structure to access contraceptives. Thus, 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.

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. 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.

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.

Thus, the study saw 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 fading away of it to be replaced with the other. With subsequent pregnancies, women privileged their experiential knowledge over the biomedical and the cultural knowledges. Although biomedicine provided young women a platform to enhance their status 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.

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, traditional authority structures of family and community as well as by the modern structures of the institutionalised biomedicine. Women’s responses to these power structures have been varied and strategic as they collaborate, resist and counter the overlapping and different layers of control and authority. The study shows the role and significance of plural knowledge systems in the aspect of control as well as in women’s agential acts. The study also shows that while bargaining with the intra-household control, women mobilise external resources such as biomedical institutions and their knowledge. Simultaneously, women also mobilise family and community support systems and cultural knowledge in negotiating biomedical power. These micro-resistances provide insights into the everyday bargaining in gender-power relations.