Chapter – III

Review of Literature

This chapter intends to review the scholastic work on reproductive health and reproductive labour and particularly tries to map the literature in this aspect on *adivasi* women. While doing so, it attempts to link those literatures into broader theoretical perspectives and historicise the discourses on reproductive rights. In this regard, four perspectives namely Marxist, feminist, post-colonial feminism and anti-caste feminist perspectives have been discussed. Nevertheless, it has to be noted that these perspectives are not mutually exclusive rather certain approaches converge. Considering this, this chapter is organised into five sections wherein the first section contextualises the issue of reproduction and puts reproduction into historical backdrop in order to highlight how shifts in the birth control discourse took place. The second section discusses the writings on Marxist perspective. The third section covers feminist critique especially radical feminist framework and literature on this direction. Fourth section discerns post-colonial feminists’ deconstruction of indigenous health practitioners and population control programme designed on third world women and fifth section focuses on the scholarship on anti-caste feminist approach.

Part: I

Politics of Reproduction: Historical Landscape

Birth can be thought of as political in its very nature through the force of newness it represents. Gender politics require we continually ask what may be political about spaces deemed at a remove from politics (Pinto 2006). The concern with ‘the female body’ centres on women’s biological ability to give birth linked to a range of social evils (Harcourt 2009). Qadeer (1998) writes that scrutiny and control of women's sexuality and women's reproductive role by the state, are well recognised in the history of societies. Tribal wars over possession of women were rooted in the struggle for survival of the tribe itself. Later, when households became the centre of productive activities, women's skill
and labour began to be valued as much as their ability to give birth. With the advent of the factory system, women also became the key to the upbringing of the labour that they reproduced. The control of women's fertility was thus considered necessary for both economic and social reasons. Studies of the 19th and early 20th century show how the institutions of religion, law and education perfected the instruments of control. In the latter half of the 20th century, largely women-centred family planning programmes (FPP) initiated by the government became the main instrument of this control. The appreciations of the needs of civil society in the regulation of fertility were gradually marginalised by these official programmes. Demography emerged as a discipline [Bose 1988] that appropriated the area of population studies (ibid: 2677).

Writing about the conjugal relations in Southeast Asia, Dube (1994) points out the precisely the mode of control of women’s sexuality. “Since placement in groups is essentially a function of paternity in South Asia, women’s sexuality needs to be rigidly controlled. Virginity at first marriage is a value cherished in both Hinduism and Islam. Concern about it takes a variety of forms: pre-pubertal mock marriage among the Newar in Nepal, child marriage or pre-pubertal marriage with delayed consummation prevalent among Hindus in Rajasthan, Uttar Pradesh and Madhya Pradesh, the widespread practice of marrying off a girl almost immediately after puberty, and ritualizing the onset of puberty as in Nepal and in southern India and less so in eastern and western India. Puberty is a point at which severe control have to be established over a girl, which last until her marriage. The period between pubescence and marriage is looked upon as a liminal one, when girls need protection from their own desires and from the opposite sex. Women in South Asia need to be guarded after marriage as well. Both nikah and Hindu marriage are supposed to establish a man's control over a woman's body and being. Woman's sexuality tends to be equated with her reproductive power. Linked to this is the notion that woman's purity is fragile. The presence of caste as a factor defining status, and the bounded nature of caste along with woman’s role in biological reproduction which, with the processes of gestation and lactation, makes motherhood irrepudiable and thus puts the onus of boundary maintenance of caste on women, make the notion of female purity stronger among Hindus than among Muslims. However, the idea of exclusive ownership of a woman's body and being makes patrilineal Muslims also very
jealous about guarding women’s sexuality. The concept of jutha, 'leftovers' polluted by having been used by another, is prevalent among both Hindus and Muslims (ibid: 8).”

Women's reproductive health and reproductive rights are not only political and cultural; in fact it has been the most debated social issues during the past two decades. In this connection, it is useful to provide a historiography of birth control movement and delineate how it was appropriated for eugenic and racial agenda and simultaneously how different groups/leaders articulated it in variegated manner. The other point is about tracing how it too deprived a certain section of women from their traditional work historically. This latter point is dealt in the fourth and fifth section in detail.

Thomas Malthus, an Anglican priest and English economists, at the turn of eighteenth century, was one of the first to study human population. His principal tenet was that population will always outstrip food supply. So they looked at population growth: too many people as the root cause of all problems (Rao 2016 and Harcourt 2009). In his theory, poor women play a negative role in relation to population growth, as breeders of environmental destruction, poverty and violence. Rao (2016) brilliantly writes that what it did do successfully was to exonerate the various means by which industrial capital in England was pauperising the peasants by taking away their lands and livelihoods, thereby creating a population surplus to capital’s requirements. In the nineteenth century, such economistic population thinking became enmeshed and intertwined with eugenic and racial theories: the population problem was one of too many people of the wrong sorts.

Following Malthus, western birth control advocates such as Margaret Sanger, Marie Stopes, Edith How-Martyn, Mary O’Brien Beadon and others tempered their feminism by deploying racist, eugenicist and class-specific logic in seeking to advance their program to determine and control fertility, of the lower orders in India (Ahluwalia 2008: 57). Blindly following the Malthusian model, they attributed poverty to the effect of overpopulation. They did not question the unequal distribution of power, wealth and class that the British rule created in India. Most importantly, they did not question the practice of racial discrimination by the Europeans in their whole agenda of birth control. All local indigenous medical practices were condemned as backward, barbaric, superstitious and
uncivilised. This was another example of how the western imperialists perceived the cultures of non-western 'other' in racist terms (ibid: 57).

On the other hand, Anandhi (1998) and Ahluwalia (2008) discuss about the different nationalists’ standpoint on this. Anandhi writes how even if Periyar endorsed birth controls initiative of Sanger, however, his support was much more radical than Indian feminists and Sanger. Anandhi (1998) notes that the non-Brahmin Self-Respect Movement is a movement which launched a thoroughgoing critique of Hindu, Brahminic patriarchy in colonial Tamilnadu and emphasised women’s control over their bodies (ibid: 139).

Anandhi (1998) cautions the Brahminical Texts privilege the upper caste Hindu as the ideal and were more than anxious about miscegeny of the inter-mixing of castes. Women’s bodies were thus no more than reproductive bodies with women’s sexuality reduced to reproductive sexuality within the family and caste, thus also rendering illegitimate the existence of other forms of female sexuality. She quotes Uma Chakravari, “the purity of women has a centrality in brahminical patriarchy...because the purity of caste is contingent upon it”. At another level, these normative texts represented reproduction as a desexualised body. Significantly for non-Brahminic activists, this opposition between ‘reproductive sexuality’ (reproductive body) and other forms of sexuality ‘(sexual body’) informed the version of neo-Malthusianism advanced by the Madras neo-Malthusian League (ibid: 143, 144).

Eually she separates Periyar’s position from Women Nationalists of that time who advocated for birth control. Anandhi (1998) writes that the women activists, who spoke in favour of the AIWC (All Indian Women’s Conference) resolutions on birth-control, emphasised the rights of women as ‘mothers’ to have information on reproductive control. But they were careful to qualify their statements by adding that birth-control information should be made available only to ‘married’ women and not to the unmarried, since they considered that the birth-control information might lead to ‘immorality’ among unmarried women. In addition, the defenders of birth-control within the AIWC linked the maternal health of poor women to the need for birth-control. Their emphasis on women as mothers, their anxiety about access to birth-control among unmarried women, and their
concern about the maternal health of the poor women continued to inscribe women’s bodies as reproductive bodies. In other words, though the women of the AIWC spoke in favour of birth-control and critiqued the double standard in middle class sexuality which revolved around the regulation of women’s sexuality while naturalising the male claim to autonomy and sexual pleasures, they primarily linked questions of respectable sexuality to marital relations. Despite early feminist claims for an ‘equal moral standard’ for both men and women, it is obvious in their writing; on marriage reforms and reform of prostitution that they consciously demarcated the reproductive sexuality of the middle class women from the sexuality of devadasis and prostitutes (ibid: 150, 151).

Anandhi (1998) writes that the representation of women as the guardian of procreation within the family was strongly challenged by the Self Respect within the family was strongly challenged by the Self Respect Movement. The demand that contraception should become a means by which women exercise control over their bodies and thus free themselves from male domination was a constant refrain of the Self-Respect Movement (SRM). The movement employed different means to propagate this idea. Periyar E.V. Ramasamy, the founder of the movement and an indefatigable propagandist, constantly wrote in the party press and addressed public meetings in defense of birth-control and contraception as a means for women to end their enslavement by men (ibid: 153).

Anandhi (1998) highlights on the other hand, prominent nationalist leaders such as M.K. Gandhi did not entirely oppose the principle of birth-control. However, unlike the neo-Malthusians and the eugenicists, they advanced a different set of arguments. Gandhi, for instance, argued that until India became a free nation, men and women must ‘cease to procreate’ and channelize their physical and spiritual energies into building a ‘strong and handsome’ nation. Gandhi, was, therefore, strongly opposed to the use of contraceptives and advocated Brahmacharya, abstinence from sex through self-control, as the only legitimate method. According to him, the use of contraceptives would only lead to uncontrolled sexual desires and the breakup of marriages; further, it would result in ‘race suicide’. He argued that, “it is...worse for a person to indulge in animal passions and escape the consequences of his acts” through the use of contraceptives (ibid: 147).
Anandhi (1998) observes that according to Gandhi, the sanctity of marriage could only be retained by self-restraint and control over one’s own sexuality. Gandhi’s arguments in favour of brahmacharya were premised on nationalist patriarchy’s construction of ‘respectable’ female sexuality as reproductive sexuality. He argued that “the [sexual] union is meant not for pleasure but for bringing forth progeny. And [sexual] union is a crime when the desire for progeny is absent”. In marking reproductive sexuality as respectable, Gandhi compared the woman who used contraceptives to a prostitute: “The difference between a prostitute and a woman using contraceptives is only this, that the former sells her body to several men, the latter sells it to one man”. Since he considered sexual pleasures as unnatural (ibid: 148).

Ahluwalia (2008) provides a different rationale of Gandhi’s rejection of Sanger. According to him, Gandhi rejected Sanger and her western notions of birth control. He pointed out that the birth control agenda of Sanger and Stopes was in fact a British imperialist agenda in defence of empire. According to Gandhi, the population of India was not a problem in itself. The problem of India was the British Empire, which had exploited its resources, oppressed its people and created conditions of poverty and backwardness to such an extent that it was unable to take care of its own people. Without the British imperial rule, he argued, India would be capable of supporting twice as many people. According to Gandhi, the solution to poverty and population was not birth control but equal distribution of resources and the end of British rule over India. He argued against the president of the British Indian Medical Board, who claimed that famines in India were the result of high birth rates. Gandhi asserted that this explanation was a way of diverting attention from the real cause of recurring famines in India. A famine, Gandhi said, was not a ‘calamity descended upon us from nature but is a calamity created by the [British] rulers ...’ (p. 80). He notes that the western biomedical community sought to hegemonise the health care sector in colonial India, discrediting and displacing alternative systems of healing. The greatest scorn of the western advocates was reserved for dais or Indian midwives. Western biomedicine sought to colonise the native bodies by castigating and demonising dais. They were universally condemned as superstitious, ignorant and anti-modern (p. 171).
Mohan Rao (2016) writes in critical lens how birth control movement was turned eugenics when it combined with communal agenda in India and termed it as “saffron demography” in 20th Century. He refers about the publication of the book “Hindus: A Dying Race” by U.N. Mukherji, in the wake of the partition of Bengal, which influenced Hindu Mahasabha. Fertility control programme especially among disadvantaged sections were promoted in post-Independence period through contraception and sterilization while key factors to good health like food, water, shelter and employment were undermined. It took an extreme ugly turn during emergency (1970s) when it was imposed on poor and slum dwellers.

After a downturn during the politically conservative 1980s, the third wave feminist movement of the 1990s i.e. Population and Development held in Cairo from 5 to 13 September 1994, focused on issues of women's sexual rights, reproductive health care, and gender equality (Wang and Pillai 2001). Reproductive and sexual health and rights of women became a central element in a universal agreement on population and development. Also the reproductive healthiness and human rights of women got linked to the global struggle to decrease poverty and achieve sustainable development (Mathur 2008, Verma 2004 and Wang and Pillai 2001). Reacting to the earlier prominence on ‘overpopulation’ and projection of women as ‘producers of too many babies’, members of the International Women’s Health Coalition focused on the tendency to neglect the aspects of women’s reproductive health. They argued that a reproductive health approach could strengthen existing family planning and health program as well as accumulate the dignity and basic rights to women. The rhetoric of reproductive health corresponded with the idea of “social development” or “participatory democracy” where it campaigned for women’s empowerment; participation in civic and political sphere was given importance. However, in this new nomenclature, it reinforced new family planning program where women is recognised by the state through motherhood (Qadeer 1998, Kumar and Joshi 2008 and Mathur 2008). Harcourt (2009) writes about Cairo conference that it has had major implications for all those involved in women’s health and rights movements as it gathered together many groups and brought many feminist voices directly into the public
debate regarding body politics. It shifted the population paradigm from numbers to women’s sexual and reproductive rights. The central concept confirmed by Cairo was that of ‘reproductive rights and health’. It broadened earlier demands for rights to safe and legal abortion to encompass women’s rights to control their bodies in all matters of reproduction, including access to contraception and freedom from coercion. In Cairo, women from many countries expanded the concept of reproductive rights to embrace maternal health and mortality, childbearing and child raising (Harcourt 2009: 43). Despite all the promises made in the preamble, it was not women’s overall health but reproductive health that eventually mattered. Mohan Rao (2016) describes that after many years of Cairo, despite a paradigm shift in population policy and despite a liberal democratic framework and gender justice, what we, see is actually is the reinforcement of neo-malthusian thinking through incentives and disincentives.

However, Harcourt (2009) comments Cairo Programme of Action that it was one of the first international documents to deal directly with the fundamental gendered relations of the reproductive body. It translated intimate, very culturally specific behaviours into medical, technical and legal terms within the discourse of rights and development.

Nair (2017) writes on how Indian women’s organisations provided a concerted criticism of family planning programme especially the usage of contraceptives, like injectables and implants, into the FPP. She highlighted that women’s organizations questioned the poor public health facilities of the country and the control of women’s bodies by technology. She writes, “They (Women’s organisations) also questioned the absence of monitoring mechanisms to help women who face side effects and of public health facilities to ensure that all women undergo full body check-ups for contraindications. The groups opposed the medicalisation and control of women’s bodies and the reductionist understanding of reproductive rights post the Cairo Consensus, 1994. Many argued that this “consensus” brought out a change in the semantics of rights in the policy, but the “rights” having been narrowed down to “contraceptive choice” and “women’s empowerment,” became a tool to decrease population. The entry of injectables will most severely affect the poor and marginalised women, who do not have the means to take care of their health in the case of long-term side effects. This debate has to be placed within the context of the socio-
economic backgrounds of the women who are targeted for population control programmes. It is clear that the conditions under which the women’s movement opposed the injectables still remain very relevant today and debates in this regard are necessary. The public health facilities continue to remain in abysmal conditions and the poor budget allocation to the health sector means increased out-of-pocket expenditure. In a country with a strong neo-Malthusian understanding of overpopulation, it will not be erroneous to assume that injectables will be used on a large scale without taking proper precautions or giving mandatory counselling (which seems to be the solution for the side effects that the women will face). Reproductive rights when reduced to “choice of contraceptives,” without considering the overall health and wellbeing of women, results only in control and un-freedom of women. It has to be strongly argued that it is the opposition of “certain women’s groups” that saved a generation of women and by ignoring these voices the government will be failing the women of India (ibid: 19).

**Part: II**

**Marxist/Public Health Perspective**

Marxist perspective in this domain, mainly contributed in two counts. Firstly, they make conceptual distinction between women’s health and reproductive health and then reproductive health and family planning programme. Secondly, they emphasise on the need to develop a strong public health care which would remove the class barrier as well as some of the reproductive concerns. In this realm, feminist and public health specialist converge (Rao 1998, Reddy 2008, Jeffery et al, 1988, Kumar 2002). For instance, Mathur (2008), Ravindran (2000) and Qadeer (1998) urged for improving women’s overall health through provision of basic care rather than reproductive health concerning pregnancy and child care. Likewise, Jeffery et al (1998) while acknowledging the service of *dais* during deliveries in poor localities, pressed for the need to integrate them into public health care system in providing them training on modern medicine. However, they are skeptical about the effectiveness of *dais* in providing emergency care and therefore, they advocated for expertise care.
Thinking through this line, Khanna (1997)'s article discusses about the establishment of a low cost health set up- SARTHI through the involvement of local people i.e. traditional birth attendants as health agents and use of local resources like herbal medicine in Gujarat, Western India as opposed to using advanced medical technologies in tertiary care. She writes, “In 1987, in response to local women's articulated needs, SARTHI started a modest women's health programme with a view to improving delivery care for women, as per their expressed needs. Other components were added on as the programme evolved. By 1992, a women's health programme was on-going in eight villages. Eight women from the local villages, some of them traditional birth attendants, had been trained to function as arogyasakhis (barefoot gynaecologists-cum- counsellors). Their work has included maternal and child health care and treatment of common gynaecological symptoms with validated plant-based medicines. In addition, SARTHI has been carrying out a community health programme in 60 villages with 12 male health workers. The field practice of arogyasakhis has highlighted several unmet health needs among the women, namely, infertility, unsafe induced abortions and sexually transmitted diseases. We therefore decided to focus our efforts on STDs and male involvement in women's health in the next phase of our work. The process through which the various components of the health programme were created was in response to people's articulated needs. It was characterised by the gradual building up of the knowledge and skills of local women and men to respond to local health needs. We relied mainly on local resources, including herbal medicines, and the government health structure for secondary care. Research based on the concerns of the local people, and directed and owned by them (participatory action research) was an integral component of the health programme. Thus, the programme evolved at its own pace, without the demands and time pressures that come with external funding (ibid: 68).”

An important facet of Marxian framework is to critique the privatisation of health care and highlight the structural factors like poverty, early marriage; insufficient income etc. are determinants for receiving health care services as well as cause of disease and morbidity. In this connection, Hodges and Rao (2016) question what do we make of India after liberalization? There is much evidence that the health sector reforms that have been undertaken had dolorous outcomes, that the insurance-led model had indeed contributed
to increasing out of pocket health expenditures, and impoverishment, that it had set out ostensibly to reduce and that it had contributed both to inappropriate medical care while transferring public resources to the corporate sector in medical care. The moral hazard problem of this model of medical care was also highlighted by studies indicating unnecessary surgeries, hysterectomies in particular and unnecessary investigations. For example, 16,765 women in Bihar and 1,800 women in Chhattisgarh had their uteri removed unnecessarily by private doctors in order to claim insurance. That there was a need to strengthen the public health system and move away from this model of health care delivery had been acknowledged by the report of the Planning Commission’s High Level Expert Group (Hodges and Rao 2016: 2, 3).


Rani, Ghosh and Sharan (2007)’s exclusive study on married tribal adolescent girls of Jharkhand is pertinent in terms of underscoring structural factors for high maternal mortality among adolescents. They write that the findings from a number of studies conducted in India indicate that adolescent girls tend to be at a greater risk to adverse maternal and child health outcomes than adult women. Evidences from community- and facility-based studies show, for example, that adolescent girls are significantly more likely to experience maternal death than are older women. Maternal mortality is only the tip of the iceberg. Adolescent girls also experience other adverse outcomes like perinatal and neonatal mortality, which are significantly higher among adolescent mothers than among women in 20s and 30s. Similarly, several facility-based studies report higher levels of pregnancy-related complications like eclampsia, pregnancy induced hypertension, intra-uterine growth retardation and premature delivery among adolescent girls than among older women (ibid: 56).
Rani, Ghosh and Sharan (2007) explain that, the present health system in Jharkhand is characterised by poor infrastructure, low quality of services and lack of personnel. Maternal and child health services from the private sector are more frequently utilised than those available from the public health system. While utilisation of maternal health services is generally low in the state, it is even more limited in the case of the scheduled tribe (ST) population. Data from the NFHS-2 shows that among all castes and groups, the highest percentage of anaemic, who delivered at home, without skilled attendance, tetanus immunisation and iron folic acid supplements during pregnancy, were from the STs (ibid: 57). They further point about the young women’s autonomy her role in household decision-making and access to money and peer and spousal support which influenced maternal health practices and aviling services.

Kumar, Sharma, Sharma and Meghwal (2013)’s study too focuses on weak functioning of welfare programme such as maternal and child health among tribal population of Rajasthan. They write that most of families i.e. 60% preferred to deliver at home with the help of family member or untrained birth attendant, DLHS-3 also found that to be 58.4%. Their study was based in Bakhel, a tribal village which comes under gram panchayat Mandva and block Kotda of Udaipur district, state Rajasthan. It is about 2 kilometers from Mandva PHC and about 24 kilometers from CHC Kotda in remote area. There are about 250 families residing in a very scattered manner in five different hamlets /Phalla’s in the village with a total population around 1200. They work on in particularly tribal women and children of 0 to 6 years age group. They point out that in spite of the presence of Aanganwadi center in the village 49% families reported to be unaware of any MCH services being provided in their area. 59% of families were totally unaware of any family planning method and services and even not heard about condoms. 41% families had the awareness but do not practice because of fear of side effects or not having knowledge about their availability. Most people relate family planning services to female sterilization only (ibid: 319). Second argument is that 62% of families had no knowledge about child immunization. 38% of families were aware about immunization but only 13% children had BCGscar marks but no immunization card made available to them, whereas as per DLHS3 reported 81.6% rural children having received BCG3. Residents are not
aware of any planned immunization session in their area and mobilization by ASHA/ANM of the area found to benegligible (ibid: 319).

Kumar, Sharma, Sharma and Meghwal (2013) write that regarding child rearing practices, weaning started at mean age of around 11 months with roti. This may be responsible for the malnourishment of children. Regarding food practices majority of families reported to use wheat and maize flour. Green vegetables and pulses used mostly once a week, 80% families consume no iodized salt while cooking. Majority of families do not have access to milk and milk products. For the sake of treatment of minor illnesses like fever, respiratory tract infections, diarrhoea, 85% families prefer to visit private practitioners/quacks. Reason for not utilizing health services was the faith these tribal people have in the traditional healers like the bhopas (faith healers) and herbalists (ibid: 319, 320).

Bang and Bang (2010)’s work brings interesting aspect of privatisation of health care very often indigenous healers prevalent in tribal areas against the weak public health services. They write that working with the dais and training illiterate women to become birth attendants has taught them a great deal about non-formal methods of education, such as teaching through games and songs. They decided that the dais knew best and asked them to teach me. It also helped them know the perspectives of people, about trees and medicinal plants. They remark that they had set out to bring about a change in others’ lives, but ended up changing and learning from them! “They taught the authors about communicating with patients, which helps to be a good doctor, and in the process they have also received their overwhelming love (ibid: 10).”

They argue that, “dealing with dais is rewarding as most of them are genuinely caring, but the over-smart types can be a handful. One day of our trained dais brought three old women to “me”, all of whom “I” found had advanced cancer of the cervix. They said they had gone to a vaidu (traditional healers who not only administer herbal medicine but also claim to practice witchcraft) and taken herbal medicine. When it did not work, they asked to be taken to Bang-bai. “I” was angry with our dais for not having brought them earlier. She replied in all seriousness, ‘I knew they had cancer and it was in an advanced stage. You taught us that nothing could be done in such cases. Why then should “I” waste my
daily wages and your time? So being a vaida myself, I treated them as ‘I’ could.’ (A visit to the doctor in rural areas often takes up most of the day because of the distant location of the health centre, poor roads and transportation. Agricultural labourers survive on a daily wage and cannot afford to spare this time.) Whey then did you bring them here now, “I” shot back at her, frustrated. The dais replied: ‘The women said to me, “We want to meet your Bang-bai before we die.” The three of them pooled in the money and paid for my ticket, so that “I” could bring them to see you.’ The dais was being presumptuous in summarily dismissing the possibility of a cure, but I found it difficult to scold her with a straight face (Bang and Bang 2010:13).”

Bang and Bang (2010) argue that given an overall situation where primary health facilities do not exist and hospitalization is unaffordable for the majority, we should create a cadre of trained village health workers and traditional midwives. NGOs could play an important role in such training programmes. When trained in basic preventive and curative health, local health workers can produce dramatic results, provided they receive regular refresher courses and supervision, along with strong referral support from district primary health centres and the civil hospital. The health system has resisted this approach, although policy-makers are now accepting the importance of this concept. An earlier government experiment in developing community health workers across India failed because of their improper selection, lack of sustained training and support. This approach is now taken up through the government’s National Rural Health Mission and is being implemented nation-wide (ibid: 255). Point to be noted that though Marxist scholars (Bang and Bang 2010) and Jeffery et al (1989) underline dais contribution for underprivileged women simultaneously they are sceptical about their traditional birth skill. Nevertheless, they emphasise on the training into modern health care. This is the point of departure between post-colonial feminists and anti-caste feminists and Marxists.

Several other scholars explain how anemia and malnurition among adivasis affect reproductive health. In this context, these works trace the structural issues like macro-economic policies and laws that exacerbate anemia rather than simply personal attributes. For example, Basu (2007) writes about nutritional anemia is a main problem for women in India and more so in the rural and adivasi belt. Anemia is categorized by a low point of
haemoglobin in the blood. The nutritional status of pregnant women straight influences their reproductive presentation and the birth weight of their children, an issue that is critical to an infant’s probability of endurance and to its following growth and development. Nutrition also affects lactation and breast feeding which are solution fundamentals in the health of infants and young children and a causative thing in birth (ibid: 5).

Khera (2008)’s article too discusses about the malnourishment and subsequently starvation death among the Birhor community-primitive tribal groups - of Jharkhand though it was not exclusively on reproductive health. In this connection, she attributes the problem with the poor functioning of the public programmes like AWC, schools, provision of safe drinking water etc. She writes, “As often happens, the noisiness of the ensuing debate (starvation death among the Birhor community) has obscured the real issue – the vulnerable situation of persons belonging to these groups. Most of the nine deaths in this hamlet have followed a similar pattern: people ate something the night before which caused diarrhoea and vomiting. Soon after – within a few hours in most cases – they were dead. Mansabad Birhor’s wife, he said, died within 10 minutes at around 3 am. Being ill himself, he could do nothing for her. He is now left with two young sons, Budhan and Sudhan (less than a year old). He says he cannot go to work because he needs to be around for them. When asked what can be done to improve the situation, he says there should be some arrangement for his children during the day so that he can go and earn a living. But in a hamlet where there is no road or primary school or hand-pump, the prospect of an anganwadi that might serve this purpose is remote (ibid: 11).”

Khera writes that the Birhors live deep in the forest: their hamlet is 10 kms from Narayanpur (the main village of which it is a part). There is a kachha road through the forest to Narayanpur, but not even that from the village to Hindiyakalan. There is no handpump in the hamlet, and no primary school. In fact, Tulsi Birhor said that when their children try to go to the school in Narayanpur, the teacher shoos them away, saying “bartangandakarenge” (“they will pollute the utensils”) – a stark case of caste discrimination against Birhor children. As a result, these children do not have access to
education, or to the hot cooked meal served at school every day. First, in May 2003, following reports of starvation deaths in Baran district (Rajasthan), the Supreme Court of India in the “right to food case” had ordered that all PTG households (along with other vulnerable groups such as widows and single women) be covered fully by the Antyodaya Scheme. In Hindiyakalan, this Supreme Court order was being violated, more than five years after it was issued: we met members of at least two households who did not have Antyodaya cards (including MansabadBirhor, whose wife died recently). What made this particularly shocking was that a special drive to extend the coverage of Antyodaya to all PTGs had just been completed, in the wake of the storm over starvation deaths in Jharkhand. This reflected poorly on the administration’s resolved to deal with the situation (ibid: 11, 12).

Radhakrishna (2009) comments, in response to and in continuation of Reetika Khera's commentary on "Starvation Deaths and 'Primitive Tribal Groups’”, which discusses the ineffective efforts by the government to provide food to these starving communities through various schemes. She contextualises that this may be the right time to share the research on the primitive tribal groups (PTGs) which was carried out at the research division of the Rational Commission for Denotified, Nomadic and Semi-Nomadic Tribes. Radhakrishna goes into the deeper understanding of the starvation among the PTGs in terms of asking the moot question why these communities came to be termed PTGs and what were their traditional means of livelihood and subsistence (ibid: 13).

Radhakrishna (2009) explains that shifting cultivation has been dwindling over the years, the main reason being the restrictions put on the practice by the state by declaring all kinds of lands associated with primitive tribal groups as “reserved forests”. Further, she asserted that periodic pronouncements about granting property rights to shifting cultivators mostly remained unimplemented.” Hunting was curtailed under the Wildlife (Protection) Act, 1972, but an amendment in 1991 banned it entirely. The minor forest produce gathered by these communities is now severely restricted. Establishment of parks and sanctuaries has meant that communities have been evicted from the places where they stayed for generations, and now have very limited access to hunting, forest produce and fishing within the forest.
Similarly, Qadeer (1998) writes that the problem of under nutrition which is more fundamentally linked to agricultural policy, pricing and the public distribution system. However, any corrective medical intervention without changes in industrial policies can at best be palliative. A clear example is the Bhopal gas disaster, where women's reproductive health was badly affected as they bore the brunt of a callous industrial policy. Expanding the domain of reproductive health on the basis of symptomatology, and not the underlying causes that actually lie outside the domain of reproductive health, creates two kinds of problems. One, it leads to a superficial and medicalised interventive strategy which will never touch the real causes of reproductive ill health. Two, it underplays the importance of industrial and agricultural policy shifts for health and assumes that reproductive health interventions are sufficient in themselves. This false assumption actually becomes the basis for creating a health market where, in the absence of major policy shifts which has a preventive role, perpetual ill-health is ensured and technological solutions can be sold (ibid: 2677).

Besides, underlining the structural factors that causes malnutrition, Marxists too highlight problem associated with the exclusive focus on family planning programme and vertical approach in public health care programmes. For instance Qadeer (1998) asserts that the professed concern about the population problem was refined over time by invoking the feminist principle that every woman has the right to control her own sexuality and reproduction without discrimination: this would ensure the highest possible level of reproductive health care which was fundamental to the exercise of her reproductive rights. The new paradigm referred to a woman's capability to: (1) understand and enjoy her sexuality by gaining full knowledge of it; (2) regulate her fertility through access to services and information; (3) remain free of reproductive morbidity (and death); and (4) bear and raise healthy children. The paradigm based itself on the belief that such a formulation "moves birth control out from under the umbrella of family planning and planned parenthood, with their patriarchal connotations, into the realm of individual rights to sexual and reproductive health". Reproductive health, then, was posed as an ideal. A dream to move towards: it obviously required different strategies specific to the varying social contexts prevailing in different parts of the globe. But this was possible only through recognising the interdependence of reproductive health, general health, and
socio-economic conditions. Yet, despite its potential clarity of scope, the concept of reproductive health failed to clearly articulate its linkages and the strengths in these linkages (ibid: 2677).

**Part: III**

**Feminist Perspective:**

Feminist perspective analyses the role of patriarchy that influences reproductive practices. Questioning reproductive practices started with radical feminist campaign especially the intervention of Firestone (1974) for exposing how women’s biology made women vulnerable and were assigned child rearing work exclusively. Firestone (1974) sees reproduction as central to women’s subordination by men. In her formulation, women throughout the history before the advent of birth control were at the continual mercy of their biology; biological hazards surrounding reproduction, such as pregnancy, menstruation, childbirth, breast feeding and child rearing make women vulnerable and dependent on men. Thus, she advocates the use of scientific technology so that women can get rid of the drudgery of reproductive burden. In this context, she privileges the role of contraception and abortion for the emancipation of women. However, Indian feminists have discussed the way reproductive autonomy or medical technologies were appropriated in Indian context for the patriarchal interest. For instance, feminists Patel (2007) and Visaria (2008) discuss about growing female child deficit and practice of female infanticide and foeticide through modern medical technologies.

Visaria (2008) historicises that, the increasing deficit of women in India's population has been documented ever since the first decennial enumeration of people which was conducted in the British-occupied parts of India in the late 19th century. Over the span of more than 100 years, the deficit of women has progressively increased as evident from the sex ratio of the population; the number of women per 1,000 men more or less steadily declined from 972 in 1901 to 933 in 2001. Quoting Sen, she writes that assuming a female to male sex ratio of 1.022 as a standard that is observed in countries where bias against women is not evident, Amartya Sen estimated that there were nearly 100 million women missing in the world around 2000 and nearly a third of them were missing in
India. She pointed out the main cause has been the persistent survival disadvantage that women experience from early infancy well into their reproductive period. She further stressed that excess female mortality has been due to social practices, such as not providing timely healthcare to girls and women in the event of an illness, including at the time of difficult childbirth or seeking healthcare for them when it is too late. A number of field-based studies carried out since the 1970s have amply shown the presence of cultural practices that undervalue daughters or women in Indian society (Visaria 2008). She pointed out about the misuse of medical technology that “in the past two decades, with the advent of new technologies such as portable sonogram, it has become easy for parents to avoid having daughters by knowing the sex of the foetus in mother's womb, and if found to be a female, resorting to abortion. Thus, parents started re-placing the old practices of neglect of girl child, female infanticide in the provisioning to higher female for pre-birth elimination the help of medical care (ibid: 34).

Visaria (2008) observes that a clear preference for certain sex composition of children while keeping the family size small is evident. According to her sex ratio is a manifestation of interplay between biological and social and cultural factors. She discusses about the legislation against the practice that the medical termination of pregnancy (MTP) Act of 1971, was amended in 2003 after some health activists filed public interest litigation in the Supreme Court, because the enforcement of the act was very weak. By banning the use of pre-conceptual techniques, the act came to be known as the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PC/PNDT). After the amendment, the enforcement of the act is made even more stringent by regulating and monitoring the sale and use of ultrasound machines (ibid: 35). However, she noted that these laws are circumvented by people. Visaria (2008) argues that, women in the areas where sex ratio is adverse to girls, are well aware about the fact that the test to determine the sex of the foetus before birth is not performed in government-run facilities and that they would have to go to private facilities or practitioners for such service. They are also aware about the exact procedure involved, and the cost to them. While many private facilities offer abortion services, in order to get free abortion, studies have shown that women go to government facilities for abortion and not reveal the information about sex determination test. Although second trimester
abortion in public facilities elicits more questions, there are ways to handle them. In any event, in private facilities there are far fewer restrictions (ibid: 36).

Secondly, she pointed out that the widespread campaign around the PNDT Act, in order to address adverse female to male sex ratio, has also some confusion among both the providers and the clients who have begun to interpret the PNDT Act to mean that all abortions (whether sex selective or not) have become illegal. Some micro studies found that knowledge about the legality of abortion services and the circumstances under which they are available or the medical termination of pregnancy (MTP) Act of 1971 was quite low among people in India. Women did not see or comprehend the distinction between abortion per se as a woman's right and sex determination test and elimination of foetus on the basis of its sex as violations of girl's right to be born and as acts of disempowering women. On the other hand, the limited evidence suggests that some providers used the MTP Act to their advantage and found newer and ingenious ways to provide information on sex of the foetus in coded language and conduct sex- selective abortions. The consequences included reduced access to safe, legal and affordable abortion. Some clinics stopped doing abortions because of the fear of being criminalised or because the elaborate monitoring mechanism and record- keeping prompted them not to offer abortion services altogether. Also, it was alleged that there was no guarantee that the clinics that provided the information to the unsuspecting couples about the sex of the foetus were actually basing the information on actual test (Visaria 2008). Further she wrote, these technologies will be hard to police and regulate. The expansion of medical technologies and tests that can make sex selection easy and possible even at home, would require innovative ways to address the issue of gender equity and challenging the existing social structures and norms that encourage son preference and daughter neglect. The content of the materials has also not been systematically evaluated through gender lens or from women's rights perspective. For example, who is the villain: the mother-in-law or the patriarchal attitudes that women have also internalised? A lot of advocacy material appeals to the emotions rather than the intellect. Also, the premises on which most of the materials and the advocacy and communication strategies are built need to be questioned (ibid: 36).
She suggests that a reversal in the trend that undervalues daughters to those values daughters as equal to sons would require an overall structural change in the role, status and economic value of women. The suggestions that are often made that provision of greater access to education to girls or giving them skill-based training and thereby creating job opportunities for them would enhance their value and status in the family, and therefore, families would not resort to their elimination need to be closely examined empirically. While these are desirable goals in themselves, and also might make a difference in the long run, in the short-run their impact on tackling the issue of sex selection appears quite limited. Women themselves have internalised the patriarchal values to such an extent that even when they say that daughters take better care of parents in old age or are more emotionally attached to the mothers, their statements sound hollow because more sons than daughters are desired (Visaria 2008: 37).

Visaria (2008) writes that their immediate concern that investment in daughters, who upon marriage would become members of someone else's household, is unproductive would have to be addressed through advocacy, through real-life stories of girls and women who have made their parents proud of them. The need is to aim at consciousness raising in both the parents about the value of daughters and understanding the cultural factors that undervalue girls. We have focused too much on implementation of the pc/pndt Act and too little on finding ways to bringing about attitudinal changes such that daughters are valued. At the same time, the policies to counteract sex-selective abortion must go beyond cracking down on health workers, because these practices can easily occur outside the law. Policies must attack the cultural bias against women that is the root of the problem. Changing ingrained attitudes about the value of women is a tough, but a necessary assignment (ibid: 37).

However, Menon (2012) discusses about how there is a discrepancy between Indian state’s rhetoric as working for the empowerment of women and feminist’s agenda through the abortion law. Menon (2012) maintains that MTP Act of 1971 came about not because of feminist concerns but purely a method of population control. From this angle, it does not benefit women who independently wish to terminate pregnancy. Abortion is legal up
to the second trimester, but it is at the absolute discretion of medical opinion. A pregnant woman simply cannot state that it is an unwanted Pregnancy.

Part: IV

Third World/Post-Colonial Feminist Perspective:

Post-colonial feminist perspective made a radical critique of feminism especially its universalisation and imperial approach and tried to highlight how feminists and international development agencies tried to colonise third world women through various development programme especially population control programme. Third world feminist approach was conceptualised by Chandra Talapade Mohanty which brought race, class and gender into critical analysis. Post-colonial or post-structural critiqued transnational/universal rights i.e. reproductive rights. In this context, it is argued that women are not a monolithic category. They live in very different economic, cultural and social circumstances (Sama Team 2004). From this angle, women’s reproductive health should be understood from divergent lens. In this connection, several scholars discuss the faultlines of family planning programme in India even though it was projected as for the emancipation of women. For instance, Ahluwalia writes how birth control programmes were enunciated in India where the primary targets were lower-caste and working class women. From a third world feminist perspective, Harcourt (2009) questioned the reproductive health policies designed for third world women by first world/international donor agencies and remarked that there is gap between the living realities of third world women and policies imposed for them.

For instance, Harcourt writes about the population control programme globally which is systematically planned for poor third world women whereas first world women remain free from these controls. Harcourt (2009) asserts that if reproductive health remains within a ‘population’ context, then it is riddled with contradictions. The assessment is that there are too many poor people and the focus remains on providing contraceptives for them but in circumstances that are far away from notions of individual sexuality and choice of procreation (ibid: 59).
Harcourt (2009) laments that somewhat in contrast to her own contraceptive and reproductive history, this anecdote shows how ‘targeted’ women’s lives and choices in poor ‘over-populated’ countries were reduced to numbers and charts that measure ‘population goals’. Though these women were no doubt benefiting from reproductive health care, its top-down delivery through modern medical interventions with funds for population ‘control’ is in strong contrast with other aspects of their lives. The focus is on delivering the quotas set by the UNFPA programme and approved by the government, rather than on the rights and choices of the women and men involved (ibid: 40, 41).

Harcourt (2009) discusses how feminist actually articulate reproductive right while emphasising the idea of plurality and emancipation. She writes that feminists in the World Social Forum put several key issues of body politics on the political agenda. The first issue is women’s reproductive capacity as the historical mechanism for subjugating women in economic, political, social, cultural and sexual spheres. They argue that reproduction is a right and a pleasure when it is freely decided. It is a source of pain, stigma and intolerance when this freedom is constrained by religious teachings, moral influences, or economic limitations. The feminist struggle aims to liberate reproductive rights from the framework of reproductive health, which is sustained by the traditional role of women in heterosexual relations, leaving aside other sexual diversities such as reproduction among lesbian women. Another key struggle in this framework is to overcome the legal and cultural systems that deny women the right to decide on abortion (ibid: 33).

Ahluwalia (2008) writes that instead of a singular point of origin, this work recognizes the scattered and multiple production sites that simultaneously delivered and sought to possess fecund subaltern bodies during the nineteenth and twentieth century. Numerous proponents of bourgeois nationalism, middle-class feminists, Western birth control enthusiasts, and some biomedical and alternative medical practitioners, along with a few colonial representatives, identified lower-caste and working-class India women as primary targets of contraceptive technologies - both chemical and mechanical. The various historical actors examined in this study emphasized women as primary users/consumers of contraceptive devices and in so doing turned women’s bodies into
embattled sites for control. Birth control enthusiasts sought to contain what they identified and labelled as fecund bodies, whereas those opposed to birth control, such as Mahatma Gandhi, the moral nationalist reformer, sought to wipe out all traces and expressions of non-procreative sexuality from the realms of monogamous heterosexual patriarchal conjugality (ibid: 3, 4). Based on European notion of contraceptive birth control as universal solution, western feminists and the biomedical establishment systematically promoted and imposed a Malthusian agenda on British India. The Indian middle-class elite nationalists and feminists basically adopted the western feminist and biomedical scheme to push birth control on subaltern groups such as the working-classes, lower castes, Muslims, peasants, poor disenfranchised women, etc. The aim and purpose of this elite agenda (referred to henceforth as 'western birth control advocates') was not really for working towards the wellbeing of the subaltern women, but under its guise, to restrain them from exercising control over their own reproductive capacities. He suggested that the birth control debate erased the distinction between the private/interior world and outer and public space by dragging the private domain of contraception and conception into the public domain of open discourse.

Post-colonial feminists also recognised that universal rights do not translate into effective exercise of democratic rights. In this case, clientelism, patriarchy, caste and community subordination define female behaviour that subverts the exercise of rights to citizenship (Verma 2004). From a post-colonial and subaltern perspective the damn depiction of maternal and child health itself is a historical legacy where it is used by colonial discourse to legitimize its colonial rule (Rajan 2003, Hollen 2003, Ram 1998, Pinto 2006). On a similar line, Hodges (2006) lamented that even though institutionalisation of delivery did not improve maternal mortality rate, still colonial government continued with medicalisation of child birth and post-colonial government followed similar legacy.

Another legacy of imperial rule is population control program which the first section substantially focused. While historically traditional practices were attributed by Indian state for poor maternal health among the deprived sections, scholarly work highlight the exclusive focus on fertility control became the reason for avoiding hospital care. Kumar and Joshi (2008) point out that one of the reasons for discontent of adivasis of south
Gujarat is the appropriation into family planning programme while they seek to access reproductive health services from modern health care set up. Likewise, Rajan (2003) and Kumar (2010) argued that the overemphasis of family planning was channelized into sex selective abortion where sex ratios favoured son.

Another criticism against the birth control programme is the unsafe nature of the contraceptives that are used while touting it as providing freedom to women. For instance, Nair (2017) discusses about the harmful side-effects of the introduction of the controversial injectable contraceptive Depot Medroxyprogesterone Acetate (DMPA; brand name DepoProvera) into the family planning programme (FPP) of India. In this connection, she historically traced the introduction of contraceptives such as Net-En and Depo-Provera in family planning programmes in India and the intervention of women’s organization like Saheli and Stree Shakti Sangathan in terms of filing writ petition and raised questions on issues of safety, effectiveness, and the medicalisation of women’s bodies (ibid: 18). She continues to write that the groups also expressed concern over the problems that would arise in the context of India if the contraceptive was introduced into the market. They explained that these injectables could be misused on a population where the government runs an FPP and could be administered to women without their knowledge and consent, especially the poor and illiterate women of the country. They also elaborated that there was a high likelihood that the women will be injected with the contraceptive in the early stages of pregnancy and will not be able to abort in time.

She highlighted that women’s organisations talked about the harmful effects of long-term foetal exposure to Depo-Provera and of heavy bleeding in an anaemic population. They repeatedly stressed on the fact that unless there existed a good public health system to deal with the complications that would arise from the contraceptive, it would be absolutely detrimental to the health of women to introduce the contraceptive into the FPP. They explicitly stated that the dominant neo-malthusian ideology is responsible for the introduction of harmful contraceptives whose only benefit is easy administration. They criticised the Indian government for working on the diktats of the International Monetary Fund and the World Bank and cutting down on health services while “subjecting millions
of Indian women to life threatening hazards from contraceptives developed without an iota of concern for women’s health” (Nair 2017: 18).

Like Ahluwalia, Hodges (2006) too discussed about the birth control initiatives which were imposed on lower class women and repudiation of dais historically. Hodges writes that the medicalization of childbirth in colonial India comprised of two related projects. The first project was that of providing a new setting of childbirth. This project sought to reform or modify the zenana (women’s quarters) on the basis of sanitary principles, as well as to integrate the lying-in hospital into a hierarchy of resort for birthing women. The second project sought to change the attendants for childbirth. In particular, this project sought to marginalise the role of the traditional midwife or dais, and to replace her by the qualified physician or trained midwife. Both of these projects were carried out via a network of colonial officials, medical professionals, missionaries and concerned private individuals who generated official reports, journalistic documentation and initiated quasi-official fund-raising (ibid: 5).

Further she wrote, by the close of the nineteenth century, attempts to medicalise childbirth revolved not simply around providing medical aid to the women of India, but sought to train (ideally Indian) women to minister to their countrywomen. According to Hodges, nineteenth-century came attempts across India to train women in midwifery. These schemes were most often designed to retrain so-called traditional, hereditary or barber women dais and fashion them into modern midwives. For example, Lady Curzon established the relatively high profile Victoria Memorial Scholarship Fund in 1903 to train indigenous midwives. By 1912 this fund had set up centres in fourteen different provinces and trained 1,395 midwives. Earlier, the Government Lying-In Hospital in Madras (established in 1844) had been designed to include instruction for women pupils in a midwifery course. It was not until 1853 however that the Madras Presidency government sanctioned the funds and a midwife training course began at the hospital with 17 students. By the 1860s up to thirty students at a time were waiting up to thirty months to join the course. Yet despite protestations by the medical board to recruit more Indian women for the course and get them through it successfully, between 1854 and 1871 only one Indian woman successfully completed the course. By the early 1880s however,
Indian women passed out of the course regularly. More importantly, these trained Indian women midwives were readily employed by civil dispensaries throughout the presidency. Additional midwife training schemes were started in Bareilly (1875) and in Amritsar (1886), among other places across India (Hodges 2006: 8-9).

Hodges (2006) observes that while many hospitals for women ran training schemes for indigenous midwives, hospital reports regularly lamented that their funds were neither secure nor maintained. More serious were the accusations that indigenous midwives could not serve as suitable candidates for retraining, because they would inevitably revert to their ‘old ways’. Hodges (2006) argues that, the history of the medicalization of childbirth is itself constituted as much by social formations—most notably the discursive figures of the ‘zenana woman’ and the ‘traditional dais’—as it is by the institutional histories of building lying-in hospitals and training practitioners. Nevertheless, because the history of reproduction in India has a life that both precedes and exceeds its articulation as a part of medical history, there is a distinct story to be told of the social history of reproduction. It is not just about how women experienced reproduction, but how reproduction was constituted and reconstituted in political and social reform agendas over the course of the second half of the nineteenth and first half of the twentieth century’s. In other words, the social history of simultaneously a part of colonial administrative or medical practice was intimately bound up with the representational politics of caste, nation, community and family (ibid: 11).

Hodges (2006) juxtaposes the defamation of dais during medical training with a scenario where dais trainings in modern medicine were intertwined with the cultural and community life and argues that the latter brought positive results. For instance, she writes that “at the Congress of the Far Eastern Association for Tropical Medicine held in Calcutta in December 1927, a delegate asked why women preferred to attend the maternity homes run by the Corporation of Calcutta to the more prestigious Eden and Carmichael hospitals. Dr Alice Head Wards, of the WMS, replied that the latter suffered the disadvantage of being teaching institutions, where medical students attended or witnessed many of the cases, a practice to which many of the patients objected. The Corporation of Calcutta in 1916 had introduced a scheme to provide trained domiciliary
midwives, backed by a chain of subsidised maternity homes. Despite some initial resistance from a wary public and hostility from indigenous *dais*, the corporation was fairly successful in its efforts. In 1922, the corporation staff handled 3,917 maternity cases (more than a fifth of the babies born in Calcutta). There were only five maternal deaths. The health officer of Calcutta pointed out that this was a remarkable record for four women health visitors and sixteen midwives, “especially in view of the fact that most of the cases were delivered on ‘kutcha’ floors of bustee huts under the most appalling sanitary conditions (ibid: 162).”

Further she brings how different caste groups maintained their separation through the notion of cleanliness. The newly worked out concept of cleanliness was important for the definition of the middle class as well as the lower caste. The colonial state, entering the competitive world inhabited by a number of medical and semi-medical practitioners, picked on the ‘dirt’ and the ‘filth’ of the lower caste dais and customs related to birthing to assert its hygienic, scientific and moral superiority. The colonial state used the notion of aseptic cleanliness as a weapon to introduce Western medicine, while for the Punjabi upper castes; sanitised cleanliness became an ideology for asserting middle class identity, as it worked in tandem with notions of caste purity and pollution. This did not mean that lower caste labour was not required or indeed utilised, but only that in a number of ways the lower castes were differentiated and put in their place. While the colonial state wished to replace the traditional *dais* with one ‘trained’ in the Western medical system, the emerging Punjabi middle classes initially used the old dais and gradually made place for upper caste women to take over what was seen to be the polluting work of birthing. Even this did not mean doing away with the labour of the lower castes, and it only meant a greater marginalisation of their role and status (Hodges 2006: 201).

Hodges (2006) argues that, the various processes in motion –the defamation of the old *dais*, the breakdown of the jajmani relations between the upper castes and the emerging new professional relationship in its stead, the compulsions which led some upper castes to consider undertaking the job of birthing, the middle class fear of dirt, the lack of hygiene and communal tension with Muslims-appear congealed together in the pamphlet published by Mahindra Kaur in order to explain and advertise the need for upper caste
dais. Between the ignominious disappearance of the old-
dai, and the arrival of new styled
obstetricians and gynaecologists, the history of the trained
dais has been lost. Yet it were
these ‘nurse-dai’ certificated women, though not always belonging to the upper strata of
castes, but certainly professionals, who catered to the needs of women when the dais of
the old became unacceptable (ibid: 219).

She notes that when Kaur wrote her pamphlet ‘Murakh Daian’ in 1930, she had to make
space for herself and upper caste dais as such, for there was still a conservative opinion
which frowned upon women of ‘good’ castes undertaking dirty, polluting work. This
need to explain, defend, justify her choice is what makes Kaur’s pamphlet so important.
Her compelling need to establish her upper caste credentials and explain with scientific
reason why her chores were not dirty plays on the fears of the Hindus and unravels all at
once the multiple agendas of the middle classes that defined the reproductive politics of
the period. Kaur’s arguments worked on many levels at the same time. Her first task was
to justify the need for an upper caste woman undertaking a polluting job. In doing this,
Kaur, in imitation of other ideologues of the period, also tried to recruit upper caste
women from the ambiguous position/status they shared with lower castes into the ranks
of the upper castes and middle class. Thus, on being queried why she was doing ‘dirty’
work associated with sutak (polluting period of childbirth) and not leaving it to the
Chuhrris and Muslims, Kaur replied that the segregation of the jacha (the birthing
woman) had started in the interests of hygiene, to keep the woman free of germs (bimari
de kiram). It was only with the growth of superstitions that the jacha herself came to be
treated as a Chuhrrri, an untouchable. In a similar vein Kaur tried to explain the necessity
for sucham (purity), as essential to keep food free of germs. Kaur followed this up with a
diatribe against Hindus whose concepts of purity had transformed into intransigent
superstition rather than an actual desire for hygiene. Later in the pamphlet Kaur speaks of
the dirty ways of the dais that had no comprehension of cleanliness, lesser still of how
they may be spreading germs through their unhygienic practices. On the suggestion of
bebe (an elderly woman; here the author’s interlocuter), that she may benefit from the
experience of the dais, in addition to her training in midwifery, Kaur is affronted and
gives the stereotypical analogy of the body as a machine in order to dismiss the dais’
experience. An ordinary tailor can work with a sewing machine when it runs smoothly,
Kaur counters, but not when it breaks down. It is by evoking the language of science and scientific hygiene that Kaur is able to dismiss the dirty dais, while underling the seriousness of the own work and accomplishments, and spelling out the differences a lower caste Chuhri and an upper caste woman (Hodges 2006: 219-220).

Like Hodges, Hollen (2003) through post-colonial perspective tries to explain how historically dais were condemned and criminalised first by colonial state and later by post-colonial state in India despite providing a risk free delivery. Point to be noted here is that unlike Marxist scholars who too explain the loss of status of dais and unsuccessful dais training programme, she discusses about how dais continue to provide safe delivery against all these odds. As pointed out earlier, Marxist intellectuals are not positive about the dais training. Hollen (2003) writes that “a “non-medicalized” birth does not mean that no medical care or treatment is given by “medicine” we mean all forms of curative, of promoting and maintaining a healthy, “mindful body.” In many communities all through the world, and surely in India, there are a wide variety of non-biomedical practices used to endeavour to certify a risk-free delivery and the birth of a healthy infant. And in India, as in many other parts of the world, there are “indigenous” midwives with dedicated knowledge regarding childbirth. Therefore, rather than using the term “medicalization,” I use the more specific phrase “biomedicalization” to refer to this practice (ibid: 12).”

She provides the historical trajectories of medicalization and control of women’s body during industrial revolution wherein residence births attended by female midwives were transformed into hospitalized births and dis-empowerment of female midwives. Importantly, Hollen (2003) discusses about the critical connotation of the term “dai” that “deliveries were attended by set behind midwives who were called from outside the family. In South Asia these midwives are often referred to jointly as dais by people writing regarding the area as a total. This term is most broadly used in the northern regions of South Asia and is thought to be of Arabic origin. Some scholars have chosen to use the term “traditional birth attendant,” or “TBA,” which is taken from the international development dialogue, because the term “dais” is deemed superior in the communities they are studying. Definitely, in a lot of the literature on midwifery in India the main role of the dais is deliberation to be the exclusion of custom “pollution” related
with childbirth. In particular, writers talk about that the cutting of the umbilical cord and the dumping of the placenta and blood are the primary household tasks performed by dais and that these everyday jobs are deemed defiling. In common, specialized dais belongs to low-caste Hindu or poor Muslim communities. A lot of daises are members of the “barber” castes, which participated in a general system of patron-client, or jajmani, relationships in the pre-colonial period. The job of the dais is frequently traditional, approved on from mother-in-law to daughter-in-law” (Hollen 2003: 39-40). Unfortunately, debate about the critical connotations of the phrase “dai” have not looked cautiously into the past of the dai’s role in South Asian societies and the scope to which colonial representations of the dais and the very progression of the professionalization of obstetrics in their society (ibid: 40).

Hollen (2003) writes that, South Asia may have considerably misshapen these women’s status. She argues that Patricia Jeffery et al. refer for a short time to the odds of a historically variable status of dais. Here, few historical sources that mark dais and women’s experiences of childbearing are frequently on paper by doctors deliberately partial alongside their competitors. Thus we cannot be certain about how dais’ skills and position capacity have distorted, particularly in the wake of the main worldly changes since themid-60s. Maybe in the expression of what are most likely more limited employment opportunities for women in the poorest classes, proportionately more women are individual pauperized and more women with families lacking habits of dais practice may be resorting to a work that is becoming increasingly de-skilled. Auxiliary, as urban medical facilities have prolonged, any ante-natal, abortion, and poverty work of dais may have declined, and dais may have become more restricted to delivery work (ibid: 39-40). Ahead she writes however, Jeffery et al. do not follow this queue of idea more. Such historical contextualization is significant for a more whole sympathetic of the dais role in India and the role of the so-called TBAs in any society. In order to trace the lower status of dais, she emphasizes colonial representations of dais and of local childbirth practices in the contexts of attempts to professionalize obstetrics in India and of the colonial humanizing progression more commonly (ibid: 40). Therefore, the historical disparagement of midwives in Europe and America has been well recognized. In Europe female healers were accused of witchcraft by the developing selected male
biomedical concern as early on as the thirteenth century, when medicine was becoming a secular science and occupation. By the seventeenth and eighteenth centuries, midwives were singled out as a hazard to society. This clearly had a shock on colonial representations of dais in South Asia, and such harmful representations continue to stigmatize dais in India at the moment. Newly, some scholars have attempted to dig the history of the social and cultural connotation of dais in India, prominence both their power as ritual specialists and their knowledge in many areas of the physical supervision of delivery (ibid: 40).

Hollen writes about the impact of introduction on license system on dais. In 1926 the government of Madras Presidency passed the Madras Nurses and Midwives Act requiring certification and registration of all nurses, midwives, health visitors, auxiliary nurse midwives, and dais. Under this act, anyone working without a certificate of registration could be fined, as could anyone issuing false certificates or anyone falsely using such titles as “registered nurse” or “registered dais.” Applicants who wished to be put on the register had to pass standardized exams and had to provide testimonials of both their professional competency from medical personnel and their “good moral character” from persons of “good social standing.” The council deciding who could and could not be on the register included representatives from all the above categories of practitioners except dais. Obviously, the administrative difficulty of officially training all daises and penalizing that entire dais practicing without certification was insurmountable. Additionally, it would be interesting to know, although impossible to ascertain, how councils voted on the “moral” qualifications of dais given the construction of dais as inherently immoral. Clearly this legislation was more symbolic than pragmatic. Many daises then, just as today, of course continued to practice without any government training or licensing. Nevertheless, this act did represent the government’s ongoing efforts to publicly condemn the traditional practices of the dais while simultaneously demonstrating a commitment to officially recognize and sanction the work of that dais that went through dai-training programs (Hollen 2003: 53-54).

During the Victoria finance report, and in the several previous government reports on maternal and child health at the moment, the far above the ground rates of infant and
maternal mortality are credited to the broad lack of knowledge of the Indian population and exclusively to the troubles of the untaught dais in her running of birth. The report does not believe how maternal health throughout pregnancy marks in high rates of infant and maternal mortality as well as miscarriages and stillbirths. A 1928 study of maternal mortality in India reported that 31 percent of “strange” obstetric belongings and 54 percent of maternal deaths were caused by “diseases of pregnancy,” while in Britain just 7 percent of “unusual” obstetric cases and 35 percent of maternal deaths were caused by “diseases of pregnancy.” Unfortunate maternal health for the period of pregnancy is, of course, nonstop connected to poverty and therefore to broader structures of political wealth (Hollen 2003: 53-54).

Kumar (2002)’s study on Muslim women- Nagori– of Rajasthan too discusses the demand of dais for birthing as well as prevention of pregnancies. She notes that while ANMs are trained to be midwives and responsible for promoting contraceptives, but the ANM in the area was not involved in a single Nagori delivery and abortion services. The author observed that Nagori and other rural women in the area differentiated between safai (an induced abortion) and girna (literally ‘to fall’, referring to miscarriage or spontaneous abortion) while some midwives provided medicines to abort the foetus, there was a general feeling that this was a risky procedure. Samina, the Nagori kin-midwife, said it was relatively easy to abort a foetus, as all that was needed was to pierce the sac (bachhadani) with a cloth-tipped stick dipped in a particular solution. Usually the foetus was aborted between half an hour and two hours after this. In some cases it could take up to twelve hours. She said she never performed abortions as they were dangerous and there would be retribution from the community (ibid: 121, 122). In fact, her key respondent called Jetoon said she had never seen an ANM in all her thirty-five years in the village. The Nagori village was barely 12 kilometres from Jaipur city (ibid: 124).

She excavates the reason that, although ‘traditional’ birth specialists are a separate category, and it is acknowledged that not everybody can manage a delivery, the expertise of these specialists is devalued, not only by the biomedical community but more so by the women who have experienced childbirth in their own communities. Simultaneously, Kumar (2002) wrote, while the government overtly promotes contraceptives and the
training of midwives (ANMs as well as selected traditional birth attendants), there is a demand among the villagers for sterilisations at a particular point in the reproductive life-cycle and for experienced, inexpensive yet socially familiar birthing agents. It is unlikely that the more recent, well-intentioned, government schemes to empower midwives in the community will be successful in changing women’s experiences of birthing. This is in part because of the socially diffuse nature of birthing knowledge, on the one hand, and the control which kinsmen and older women can exert over the processes of conception and reproduction, maintained through various cultural beliefs concerning bodily processes, on the other hand.

Kumar (2002) writes that given the particular social, cultural and economic context in which the Nagoris and other rural Rajasthani women in the area live, perhaps one of the ways to assure a drop in maternal morbidity and infant mortality would then be not so much to emphasise midwives as the crucial agents of healthcare delivery in themselves, but to examine their strengths and provide an extension of delivery facilities and antenatal and post-natal care at the level of the primary health centre. She suggested that the gynecologists could work with local kin-and non-kin-midwives to be socially connected with their patients at the same time providing inexpensive, yet expert services. The experience of NGOs (for example, SEARCH in Maharashtra), has proven that such an initiative is possible, practical and effective (ibid: 125-126).

She wrote ahead, moreover, the state’s inability to provide public delivery facilities which are small scale, efficient, inexpensive and convenient to access in terms of distance and opening times reinforces women’s dependence on their own resources (women’s networks and local knowledge’s). Poor women seem to be caught in a bind between the power and hegemony of medicalised institutions which are prone to alienate women from their bodily and social experiences, on the one hand, and the often oppressive nature of kinship institutions and the requirements of the domestic economy which serve to devalue the work and emotions associated with reproduction, on the other hand (ibid: 110).

Kumar (2002) argues that, both Nagori Sunni women and lower-caste Hindu women resort to the services of public and private health personnel for various reproductive
ailments, but in matters of childbirth they routinely consult with local midwives, kinswomen and spiritual healers. While class (occupation, standard of living) and regional culture (including that of healing) make for many similarities in Muslim and Hindu experiences of childbirth, far fewer differences emerge as a result of religious beliefs and practices. She notes that while both kinds of midwives are experienced in delivering children; there is usually a division of labour between them. When both are present, the ‘kin-midwife’ usually provides emotional and physical support to the mother and advises the lower-caste midwife when to check for dilation of the cervix and for progress of the baby in the birth canal. The lower-caste midwife, when present, usually assists the mother in the descent and delivery of the baby. In the delivery this means assisting the baby out of the birth canal, handling the umbilical cord and delivering the placenta. Once the placenta has been expelled, the lower-caste midwife is free to take her small remuneration and leave. Sometimes the whole process is carried out by the kin-midwife herself. The number and combination of insider/outsider midwives present at a birth is not so much a function of the number of children (for example, fewer midwives the more births a woman has had) but more to do with the relative difficulty and danger associated with birthing as estimated by the mother and her kin (ibid: 111).

Kumar (2002) argues that, what is clear from the example of Jetoon’s birthing experience is the complementarity of a range of women perceived to be knowledgeable about birthing (which is referred to as the work of the midwife, dais ka kam). Author remarks that among women who have given birth to children, it is particularly middle-aged women in the community who have the most knowledge and experience of birthing coupled with the ability to influence other women. A woman’s kin-peer group is, however, the most influential when it comes to decisions about whom to consult for reproductive ailments. They influence a range from prescriptions about the nutrition of pregnant women, new mothers and children, including breastfeeding, and specific notions about menstrual blood and its management, to wider concepts of privacy, purity and hygiene, urination and defecation. It is because most of the sharing of information and experiences takes place among kin-peers when they perform their morning ablutions or when they work on menial tasks together. In particular, there is a tendency for close emotional relationships to develop between women and their sisters-in-law (ibid: 116).
She writes that kin-women not only influence birthing practices but also have hold over other aspects like menstruation and proscription on sexual intercourse with the notion of “dirt and heat”. Further she argues that, breast-milk itself is said to be of two main varieties: phunadoosh or milk that makes babies grow, and it’s opposite, katnadoosh, milk that is deficient, making for weak babies. Lactating mothers are also divided accordingly, with the notion that it is thin mothers who produce the best (phulna) milk. In general thin women are regarded as hardworking, whereas fat women are taunted for being lazy. She points out that in rural Rajasthan, where women’s labour is paramount to the success of the domestic economy, we see that such gendered notions permeate the arena of women’s reproductive health (ibid: 120).

Kumar cautions and suggests that that given the uncertain nature of women’s kinship connections, the low use made of the Auxiliary Nurse Midwives or of trained traditional birth attendants, and the insufficient competence of village (kin and non-kin) midwives to deal with reproductive disorders, it becomes imperative to redesign the delivery of reproductive health services in rural Rajasthan. One of the possible ways in which this may be achieved is to have a number of strategic, small-scale, inexpensive, reproductive health units which offer delivery services and antenatal and postnatal care, advice on fertility and sexuality, support for nutrition and hygiene, and which at the same time draw on and mobilise local expertise and support (ibid: 127).

An important part of reproductive labour debate is not only focus on dais but also other faith healers who provide services for infertility. While in post-colonial fashion, Kumar (2011) discusses how faith healers gain legitimacy in low resource setting like Rajasthan village for infertility services where public services failed, she warns its implication on public health. Kumar (2011) writes that a study of the social processes which underlie infertility will, furthermore, contribute to a more situated understanding of fertility itself. Her article contributes an embodied understanding of infertility to health research. She points out that the disruption to procreative ability which results from infertility is often experienced as stigma and a sense of loss of self. According to her, infertility in this part of Rajasthan was feared by most women, including those who had given birth and ‘proven’ their fertility. Locally described as banjhan it is a condition associated solely
with women (referred to as banjhdi with no equivalent term for men). Along with menstrual disorders or maheenkipareshani (the problems of the ‘month’), which ranged from excessive bleeding to an absence of bleeding, infertility was considered to be the main reproductive disorder (ibid: 125). Further she wrote, within Hinduism, infertility is a highly stigmatized and ritually polluting condition. It is the ‘other’ of fertility, which, by contrast, is associated with sacred female power (Shakti). The basis of female power is connected in the Hindu scriptures with the ability to bring forth human life. Given the high value placed on social regeneration, infertility can be regarded as a form of social death. Tremendous power is associated with Shakti, which also renders it dangerous in the sense that it can be ‘all consuming’ (men must guard against this female power) and ‘uncontrolled’ (in the potential for rampant sexual intercourse). Shakti is a positive force only where it can be harnessed for social regeneration in morally appropriate ways. In Rajasthan as well, women who are childless are regarded as incomplete persons and inauspicious. Childbearing women were warned to avoid crossing their path for fear of ‘catching’ this inauspiciousness. Explanations for pregnancy loss, subsequent barrenness, infant mortality (experienced by most women in the fieldwork area) as well as maternal mortality were often put down to the contagion or spells cast through the gaze of jealous, infertile women. To counter the stigma associated with their barrenness, women resort to faith and spiritual healers for a divine or sacred explanation of their condition and to regain their value as women (ibid: 215).

She suggests that reproductive failings are connected in local perceptions to the heavy burden of physical hardship women carry in their daily lives, of which reproductive work is but one aspect.

Faith healers are especially considered effective in addressing the stigma related to infertility by lower – and middle - class families in the western Indian state of Rajasthan. They become a significant aspect in the everyday care of the infertile precisely because, over and above its physiological characteristics, infertility represents a disruption in social and moral relations and self-body connections. The role of faith healers as therapeutic agents is, however, dismissed as popular fantasy in national health-planning circles, or treated with ambivalence in more recent international health initiatives. In this
article, she critically evaluates the basis by which such indigenous healers exercise authority (ibid: 123, 124).

Further, by focusing on women and men’s own reproductive desires and agency, she compares and contrasts two different modes in the exercise of bio - power: kin-centred and state - based. Kin - based healing is regarded as more effective by the community as it ‘fits’ more closely with individual and familial desires for social reproduction. State health services, which fail to address infertility in India, reflect the more general tendency, that health programmes embody an inherent contradiction whereby they seek to control fertility at the same time as they seek to be associated with reproductive ‘choice’ and ‘participation’.

Kumar discusses about the gendered burden of infertility in these contexts falls heavier on the woman, for whom childbearing and motherhood remain the key determinants of what it means to be an adult woman. In contexts such as Egypt and India, this is reinforced by local understandings of infertility as an inability to manifest a pregnancy only a few months after marriage, or even as a woman’s inability to give birth to a son. This does not mean that male infertility is not acknowledged, or that it is a condition devoid of humiliation. Indeed the loss of virility which infertility represents is a condition which brings a high social cost in terms of social status for men (Kumar 2011: 128). According to her, part of the reason why men in the former context do not share the ‘discredited’ status associated with their infertility is because, as In horn suggests in her study of male infertility and stigma in Lebanon and Egypt, that their condition is not visible on the physical body. The deeply hidden quality of male infertility also makes it a particularly difficult health and social problem to address. However, with rising levels of medicalization of male infertility and its recognition as a medical pathology, Muslim men in Egypt also may actually experience stigma, though less associated with their inability. Again, we find how medical and technological processes work in favour of men compared to women (ibid: 128).

Kumar (2011) argues that, focusing on the social meanings of infertility and its connection with constructions of identity provides important insights into not only how infertile individuals and couples feel about their condition, but, linked to this, also how
they seek to act in response to their infertility. The conviction that infertility only, or even primarily, requires biomedical intervention is challenged by poor, rural middle - and lower - class couples and individuals in Rajasthan. The healers provide women with opportunities to ritually negotiate the pollution of infertility at the same time as they help them reduce the social and economic vulnerabilities associated with such a condition. They may also delay the quest for biomedical cures or work in tandem with them. Infertile Rajasthani women sought advice from a range of local, informal (non - medical) and low - cost, faith healers as well as expensive, medical, private practitioners in private hospitals and infertility clinics. The inability to conceive was an issue that frequently emerged in gynaecological consultations in public hospitals as well, although there were few technological means available for use by poor patients (ibid: 129).

In addition, informally, infertile women would seek out kinswomen or women of other castes/groups who were considered knowledgeable about procreation and birth. These ‘kin’ midwives would routinely advise a safai or cleansing of the uterus (through medical procedures such as a dilation and curettage) as a way of ensuring a healthy conception in the future. A majority of the 34 healers were kin-based healers and usually elder male in - laws of the woman. The ability to move from healer to healer also depended on what was referred to as the pakad or hold of the healer. The pakad of family healers was considered particularly powerful. Unnithan argues that local people place indigenous methods of redressing infertility above biomedical ones is not because they are ignorant of what the latter offer, but rather the opposite – that indigenous methods are proven to alleviate a disruption in social relations and images of the self (ibid: 130, 131). She suggests in the article that infertility is linked into wider systems of differentiation and stratification such as around notions of pollution, auspiciousness, modernity and healing which both disconnect women’s identity from childbearing, at the same time as reaffirming it (ibid: 132).

There are other scholars who discuss about the intersection of transnational capital and patriarchy that violate the Indian women’s body and at the same time in variegated manner. For instance, Sangari (2015) explains the connection between declining sex ratio and commercial surrogacy which caters to the need of affluent sections of women.
Sangari (2015) writes inequality too is a given, not news, and no longer discloses the hidden conspiracies of capital. Sex selection and commercial surrogacy are practices pursued in the full glare of exposure, demystification and critique. The female-child sex ratio continues to decline while commercial surrogacy has become a fledgling (Trans) national industry. The liberal balancing of commercial surrogacy with the stress of infertility in the media (and some feminist analyses) suspends commercial surrogacy and the medical market in a moral zone of ambivalence (ibid: 1).

Sangari (2015) writes that yet the sense of the already known can normalize and so invisibilize these practices, foreclose even the quasi-political affects of anxiety, dismay or distress. My attempt here then, first, is to unravel the occulted connections, deceptive rationales and imaginaries that underwrite these practices; and second, to seize the formative shifts and conjunctions in the restructuring of familial, state and (Trans) national market patriarchal regimes, and define the confluences, disjunctures and contradictions between them. The argument revolves around the gradual crystallization of a specific (Trans) national reproductive formation grounded in conception and contraception, a systemic patriarchal formation which can be mapped on the relations between the waged domestic-procreative service sector and non-waged domestic-procreative labour that converge in accumulation processes in the transition to a neoliberal economy. It attempts to mark the distance between (UN) controlled and selective procreation, and to see how the latter is catalysed equally by the logics of mobility and accumulation, agrarian distress and immiseration (ibid: 1).

Sangari (2015) writes this form of sex selection has inaugurated a qualitative enlargement of, as well as some discernible shifts in, the domain of marital and natal propertarianism, with several facets and consequences. At one level, ‘women-as-property’ denotes natal family control of daughters’ sexuality and hence their reproductive capacities, that is, a form of propertarianism hooked to ‘conservation’ until the ‘proper’ denouement of marriage, followed by marital family control of the sexuality and reproductive capacities of wives/daughters-in-law. The propertarian imperative could encompass the pregnant mother and the foetus, and it is this enclosure that has tightened as well as amplified with sex selection. The foetus is still connected to a woman’s body and can only be regarded
as property if the pregnant woman, her reproductive organs and capacities, her potential maternal/’natal’ body, are all owned by the marital family and construed as their property. The marital family’s arrogation of the ‘right’ to terminate a pregnancy that bears a female foetus suggests that other social shifts are in the making, since the marital family is also a potential natal family. The prospective daughter is no longer the wealth and property of another (parayadhan) to be handed over by the natal family after due nurture to her husband and marital family – that is, not one’s own to destroy – but seems to have wholly become the property of the natal family. Ironically, ownership, here interpreted as the right to eliminate rather than the obligation to conserve, can only be asserted as “full” ownership if birth is prevented, that is, through extirpation. In other words, some natal families are rejecting the traditional Hindu altruistic responsibility (kanyadan: a unidirectional gift where spiritual merit compensated for the absence of material repayment) of provisioning and looking after daughters (parayadhan) till they marry (ibid: 21).

Part: V

Anti-Caste Feminist Perspective

Anti-caste feminist standpoint emerged out of Dalit women’s movement in 1990s. Brueck (2012) explains aptly that along with the growing presence of a Dalit women’s movement have emerged questions of on the one hand, the compulsion for Dalit women to talk differently, or from the perspective of their own experiential authority and on the other, the need to develop a “Dalit Feminist Standpoint” that can be shared by others and that can interrogate overlapping categories of caste, class, ethnicity and gender. Anupama Rao suggests that political empowerment of Dalit and other lower caste women have posed a strong challenge to Indian Feminism. Dalit bahujanfeminist critique both anti-caste and feminist movements for their particular forms of exclusion. Their alienation both from the anti-caste rhetoric of a Dalit movement that perpetuates oppressive patriarchal structures as well as from Indian Feminist movement that negates caste and class differences in pursuance of a universal “sisterhood” is what constitutes the particularity of Dalit’s women’s perspective (ibid: 225). These points are exactly substantiated by Pinto (2006) through looking at the daily work of dais.
Pinto (2006) describes about the everyday experience of Dalit women that for many, especially those whose work brings them in intimate contact with birth, childbearing is a ‘political activity’ in ways that defy the categorical division intrinsic to much scholarship and public discussion of health and health-care: between women as birth-workers and as birth-givers. In thinking about gender and caste in rural contexts she looks at how Dalit women’s visions of power and subjectivity, their sense of a place in the world, emerge in the domain of reproduction. She views that speaking about dais actually entails the political subjectivity of rural Dalit women (ibid: 1/10). Dai’s birth-work preceded her involvement with the family planning scheme. Both her work and training formed the basis for an adversarial relationship with those representing state power. Like Kumar (2002), she fined that dais relationship with the women and families she served was also often contentious, though her work and skills were valued. Underpaid by some, well remunerated by others, she was teased by some caste-Hindu children and revered by others. Besides being a skilled birth attendant, she was highly regarded for her knowledge of birth songs and often summoned to gatherings to sing old songs that had been all but replaced by songs patterned on film fare.

In the lines of Hollen (2003) and Kumar (2002), she argues that such birth specialists, unless they are also Dalits and designated post-partum workers, do not conduct post-partum tasks. The two-fold reason for this avoidance, as women describe it, exemplifies the ambiguous nature of Dalit women’s work: it is avoided out of respect for the women who ‘own’ it and fear of its dangerous qualities. Some Dalit women may be skilled baby deliverers called to homes to assist in birth, and many conduct deliveries in their own households. But baby-delivering is beyond the domain of jajmani, remunerated ‘out of happiness’ rather than obligation, and is categorically distinct from post-partum labour. There are many ways to think about this system. The delineation of post-partum work involves the social cordonning off of defiling bodily substances, relegating stigmatized labour to Dalits in familiar ways. But it also involves tasks aimed at recuperation and symbolically vital transitions. Ushering mother and baby through a phase of vulnerability and social disarticulation (as one woman told me, ‘a newborn baby has no jati), Dalit women manage the time-space of the sor (space of post-partum ‘confinement’) in which the healing of the body parallels the social reintegration of the person. While all of these
acts can be understood through the idiom of ‘pollution taboo’, to think of Dalit women’s labour solely in those terms is to undermine its symbolic, physical and social value (Pinto 2006: 3/10).

Pinto argues that Dalit women have perspectives on their work that are difficult to pin down in terms of caste subordination. For them, caste is not a stable concept, and their sense of ‘dirt’ and ‘pollution’ is nuanced. Where caste-Hindu women described dais work as polluting, dais themselves referred to it as ‘ours’. Dais in their overt dismissiveness and in the space of labour, they are neither sweeper nor flawed midwives. In fact the most stigmatized elements may also be the most potent: cord-cutting a form of sacrifice, severing a life-source in order to establish a new person, and placenta disposal critical to managing the vulnerable bareness of new life (Pinto 2006: 3/10, 4/10). Further she writes that, in many rural caste-Hindu homes, conflating gandagi with pradushit, dirt with pollution, seemed integral to contemporary concepts of caste in which notions of ‘hygiene’ overlapped with disparaging caste ideologies. Yet it seemed to be the semiotic work of many ‘untouchable’ birth-workers to hold the two concepts apart. Dai’s own relationship to pollution ideology did not involve loud rejection. Indeed, ambiguities were strategically sustained, as the symbolic delineation of post-partum work was her means to an income – to alleviating dependence on male kin. ‘Pollution’ may be an exaggerated trope of anthropological studies of Hindu life. But it remains a critically ambiguous component of ‘modern’ rural identities. Dalit women may reject the notion that their work is polluting while taking advantage of caste-Hindu constructs to demand payment, safeguard work, and preserve the domain in which their skill is valued. Rural Dalit women like dais favoured a ‘practical approach’ to ideology. For women otherwise without independent income, stigma is a delicate equation (ibid: 5/10).

Equally, Pinto carefully charts that Dalit men had a difference with regard to the idea of pollution from Dalit women. She observes “With landholdings, a large brick house, and a sanskritized lifestyle, his position (son of the dais) as a well-regarded schoolmaster has made him exemplary of improvements in the lot of Dalits. When I spoke with him about his mother’s birth-work, he said, in a voice marked by delicacy ‘The old women do this work because they are not educated to know it is wrong. These are old things, things of
the past. But when our people began to become more educated, they learned that such work is dirty and they gave it up.’ As critical as education is to the well-being of women, in liberal ideologies of modernization such as Masterji’s (son of a dais), the root of stigma seems to lie within individuals (and their learning to make the right ‘choices’), rather than in the messiness of social relations. Or perhaps Masterji’s view better represents a form of sanskritization. In case, where ‘dirt’ indicates lack of consciousness (a different kind of stain…), stigma is replaced by ignorance as the source of low status. Similarly, in early 20th century caste-movements, as iconic work was seen as linked to caste status, Dalit women were urged to abandon birth-related work, often to their chagrin. Control of Dalit women’s labour relates to sanskritization on the one hand (as Dalit women take on constraints of pardah and abandon work outside the home) and to modernization on the other, demonstrating an affiliation between the two that makes women’s independence the price of group mobility (Pinto 2006: 4/10, 5/10).”

Pinto writes ahead that, anthropological representations of birth as patently polluting may follow, perhaps too closely, Brahmanical formulae on the one hand and frameworks of intervention on the other. But when we consider post-partum work (a kind of labour not amenable to concepts of progress or valorizations of ‘midwifery’), we see stigmatization in the way dirtiness is conjoined with ignorance and low status. Stigma re-emerges in political narratives that eschew notions of pollution. Though Masterji’s comments bespeak a critical male Dalit consciousness, the ambiguities they employ obscure women as agents and political actors with their own – often strategic – relationships between body, caste and self.

While analysing the state critically, she asserts that in rural UP the word dais evokes a traditional identity acquired through a modern definition. The idea of the traditional midwife is, perhaps, less useful descriptively than in the context of development, as a way of defining not so much what something is as where a person stands in the moral and structural scheme of things. For some women, baby-delivering was dais ka kam; for others, post-partum workers were dais. For others, tellingly, ‘the state makes you a dais’ (a reference to those who had received training). Better educated people used the term for my benefit, as a translation for references I might not have understood. But for the most
part, the term was not used in rural households. Post-partum labour was referred to euphemistically as ‘applying the oil’ (a reference to massage), and specific names or kin terms were used to talk about women who delivered babies (ibid: 6/10).

Like Hollen and Hodges, she writes, colonial renderings are also inconsistent about what a dais is, but all too consistent about how we are to think of this cipher. Portrayals of dais as dirty, ignorant and superstitious enabled one of the functions of the colonial institutionalization of women’s medical care: blaming dais and ‘traditional’ practices for a range of social and physical ills. She asserts that as 19th century colonial writings shifted from representing the dais as ‘the appropriate person to assist in childbirth’ to ‘the symbol of superstition and dogged resistance to change,’ abolition of dais became a goal of women’s organizations and elite society. Low-caste women became the anti-thesis of modernity. During this period the first dai-training were held, beginning a long history in which one of the primary ways Dalit women were linked to the state was through dai-training. Dai-training remain a familiar feature of rural life. Schemes, organizations, and policies come and go in rapid succession. A glance over the five year plans for the state of Uttar Pradesh finds that dai-training has been part of the picture of progress for decades, while the length of proposed training has shrunk from six months to six days, and the role imagined for trainees shifted. In present-day official discourse dais are rendered in stark terms as either hindrance or boon to public health. Hanging on a vision of the ‘traditional midwife’, the two sides of this argument share common ground. Both imagine Dalit women’s work as a flawed version of an imagined standard (midwifery) while making Dalits perpetual trainees, objects (but not subjects) of development. In some public health forums the complex nature of post-partum work is now being acknowledged, but the question of how this pertains to Dalit women’s role as Dalit women in institutional structures remains, for the most part, little examined (Pinto 2006: 5/10, 6/10). Further she argues that, even in trainings whose aim is to incorporate Dalits and transform their social position, the place they are given often formalizes their low social status. They remain at the bottom of institutional hierarchies and on the margins of institutions, ‘trainees’ but seldom paid workers. For some women, the idea that training will transform them into the ideal ‘trained midwife’ is laughable. One woman showed me the shiny, unused delivery kit she had received at her training in the 1960s, and described
the way the new identity as ‘village midwife’ was untenable given the social context of her caste position and the lack of institutional support. Even trainings advancing respect for ‘traditional knowledge’ focus overwhelmingly on cleanliness, reiterating the matter at the core of concepts of ‘untouchability’. While hygiene is a crucial issue for reproductive health and matters such as tetanus no small concern, it is worth noting that the bulk of efforts promoting cleanliness are aimed at Dalit and lower caste and class women. In everyday interactions in villages, such frameworks underscore many caste Hindu women’s stereotypes of Dalits as unclean, providing politically legitimate language for divisive sentiments (ibid: 6/10).

Pinto (2006) argues that, as debates about dai-training focus on ‘traditional knowledge’ and the value of ‘local agents’ rather than on the lived complexities of actual people, Dalit women’s presence as speaking subjects within such programmes remains largely symbolic. When narratives are sought in official settings (trainings in which women are told ‘your voice is important’, conferences in which Dalit women are put in front of an audience to speak about their experiences) their words are often silenced by authority figures speaking to them as, and only as, trainees. Their presence is deployed in the service of legitimizing intervention and demonstrating ‘participatory development’. At the other extreme, well-meaning training manuals that speak praisingly of birth-workers may go too far in avoiding mention of caste status or stigma, placing trainees in an idealized social context.

Pinto wrote that, often neglected in conversations about dais is the fact that Dalit women have stakes in development as women giving birth. She refers Kalpana Ram who points out, a division between women as birth-workers and birth-givers guides most research and writing on the topic of dais, echoing a split in reproductive policy that leaves Dalit women with a divided sense of self (and that impinges on all rural women).

According to her, Dalit women who perform work at once stigmatized and revered, maintain a political subjectivity that is not always loud or even overt. Theirs are perspectives formed in intimate spaces where lines between persons are drawn, contested, and refracted through institutions staking a claim on reproduction, sexuality and fertility. The ambiguity Dalit women show to ‘pollution’ echoes their ambivalence about the state
and NGOs that fail to deliver on promises, or about a vision of progress in which the burden of blame has fallen, over a century, on them. ‘The state makes you a dais,’ one woman tells me. But this is the same state that, another says, ‘wants to get rid of the small people’ – through forced sterilizations or other imagined means that marginalized women associate with medicalized birth. In the rural areas so often reified as ‘backwards’, and for people often considered, by their gender, caste-status, and illiteracy to be lacking in political consciousness, we must continue to ask, rather than take for granted, ‘what is a dais’? And we must go on questioning the stakes of the politics of the body as well as the body politic for Dalit women as birth-workers and as birth-givers (Pinto 2006: 9/10).

Like Pinto, Gopal (2013) too discusses about reproductive labour from anti-caste framework. Gopal (2013) argues that caste hierarchies, as much as gender hierarchies, contribute to the segmentation and depression of hard work labours (ibid: 91). This is attempted by throwing daylight on the strategies adopted by these activists and scholars as independent subjects themselves, and as part of communities. Captivating careful narratives from women of nomadic tribes and Dalit castes, we get to know how they lived experiences of women, in conditions of their intercession as secondary groups; interact with structures of subjugation. She writes that we see linkages here between familial and social patriarchies that continue to exploit women’s labour and continue the segmentations in their labour markets (ibid: 92).

Gopal (2013) argues that various Dalit communities perform the social labour of the traditional midwife or dais as part of the sexual division of labour in villages. As a post-partum worker, the dais has an ambiguous relationship to her work. Other women who require her services avoid this work, even though they might identify how to support in childbirth. This can be seen as the social escaping of defiling physical substances, relegating the stigmatising labour to Dalits, who perform this caste-based occupation. But the midwife herself is able to break out of this perception: forinstance, in childbirth, the most stigmatised essentials are also evoked as the most effective, and cord-cutting is seen as severing a life source in order to found a new person. The Dalit woman is seen to reject the notion that her work is polluting, and maintains her dealings in the empire of
skill exploitation and its assessment, challenging payment and preserving the domain of her work, however not enough the wage may be.

She asserts that it is significant here to pressure the role of the modern healthcare structure, which has relegated the midwife to the bounds in a practical ability. At an earlier moment, when the state intervened to train and improvement skills counting admission to technology for traditional midwives and attempted to reconstitute their work, they only contributed tore in forcing their low status in the social hierarchy and by focusing on concept of hygiene, highlighted their untouchability. Their lower status within the health system was continued through their position as trainees rather than paid workers, and the use made of them to certify family planning targets. Later, when the state laid strain on institutional deliveries and skilled birth presence, traditional midwives were once again left lurking within the existing social relations of the village, where their labours were appropriated to fulfil the state’s intent without any engagement with their caste-base occupations (Gopal 2013: 93). Accordingly, the state as well as social structures contributes to their continuing stigmatisation, although their important part in social imitation.

Resonating with Gopal and Pinto who critiqued the abrupt manner through which dais training programme was stopped; Holland continued the debate on history of dais training programme which was discussed earlier. However, dais’s work in adivasi social setting - in which hierarchy and notion of purity and pollution is not explicit- is relatively unknown which the fifth chapter tries to encapsulate.

**Summary:**

This chapter appraised the significant scholastic work on birthing and reproductive labour and tried to review some of the literature on adivasi women. This chapter was divided into five sections wherein the first section contextualises the issue of reproduction and puts into historical backdrop to highlight how shifts in the birth control discourse took place which blamed and controlled third world, poor and women of colour as responsible for all social problems instead of addressing structural problem. It also documented the different radical articulation of birth control by non-Brahamin social reformers for the
emancipation of women. The second section dealt on the write up on Marxist perspective (Qadeer, Rao, Bang and Bang, Jeffery et al, Radhakrishna) which underscore the structural factors like legislations such Criminal Tribe Act, unemployment, weakening of public health care and promotion of private medical care, etc are responsible for malnutrition among adivasis and affecting reproductive health. Scholars in this paradigm contributed in making conceptual distinction between women’s health and reproductive health and then reproductive health and family planning programme. Third section covered feminist critique especially radical feminist framework through the work of Firestone and discussion on female child deficit through the work of Visaria and Menon. Fourth section discerned post-colonial feminists’ (Sarah Hodge, Maya Unnithan, Cecilia Van Hollen, Wendy Harcourt) deconstruction of the charges against indigenous health practitioners and population control programme which are designed on third world women and fifth section focused on the scholarship on anti-caste feminist approach (Sarah Pinto and Gopal). Nevertheless, it has to be noted that these perspectives are not mutually exclusive rather certain approaches converge. For instance, with regard to reproductive labour post-colonial and anti-caste feminist framework converge in terms of acknowledging the contribution of female healers whereas even though Marxists have discussed the contribution of traditional medical practitioners, simultaneously they are skeptical about its implication for public health.