

Introduction

The Cultural Construction of Childbirth

In the past few decades, anthropologists, sociologists, and historians have proposed the notion that categories of illness and disease are culturally constructed: created by human beings in particular social settings and at particular times. The constructionist theme concerning the local production of knowledge about childbirth and its medicalization is introduced here by Roger Jeffery and Patricia M. Jeffery, Patricia A. Kaufert and John O'Neil and Rayna Rapp.

In many ways, the first two chapters form a related, if contrasting, pair. Childbearing practices in Bijnor, India, are examined in the context of women's other work roles, their ownership of property, and a wide array of social and kinship relations. In chapter 1, the Jefferys find no evidence of conflict concerning childbearing knowledge and birthing practice. The work of the midwife is devalued—more so than most of women's work—and she is credited with neither esoteric knowledge nor special skills. The experiences of childbirth and midwifery in Bijnor are thus in keeping with the low status of women as producers, bringers of wealth, and reproducers, three work roles that may be valued differently in Indian society at different historical times. By placing the Bijnor midwife in her specific social and historical context, the Jefferys correct earlier literature on midwifery in medical anthropology that tends to romanticize non-Western birthing practices.

The Inuit of the Canadian Northwest, on the other hand, still respect the work of their own birth practitioners. However, their status is being actively challenged by the Canadian Department of Health, which has implemented a policy of evacuating a pregnant woman prior to confine-

ment so that the birth will occur in a hospital. Moreover, as Kaufert and O'Neil show in chapter 2, the roles of midwives and women's work shift rapidly with changes in the political economy.

By the 1980s the resident English or Australian midwife, with her skills and simple equipment, supported by a few Inuit midwives trained in Canada, was supplanted by complex machinery and hospital staff in distant urban locations. In contrast to Bijnor women who give birth among close kin, Inuit women are now removed from their communities by the institutional demands of high technology and its possessors, but not without protest. Inuit mothers understandably resist the intrusion that hinders their ability to give meaning to their own birthing experiences and to define a sense of community regeneration.

These two cases illustrate the different ways in which health care "medicalizes" social life. In early forms of neocolonial expansion, social life and imagination are infused by health ideologies and practices that do not appear to supplant indigenous views and behaviors, a pattern that also holds true for health care in nineteenth-century South Africa, as Jean Comaroff describes in a later chapter. In subsequent phases, sophisticated technologies provide fewer opportunities for accommodation, and rural people are forcibly placed in urban centers of technology and ideological production. In each case we are privy to what may be a more widespread process of ideological "accommodation": therapeutic knowledge once thought to be situated in the creative margins of "precolonial" societies is later oriented toward a central locus of technical authority. Although state medicine has left a deep imprint in Africa, for example, the outcome remains in dispute in the northwest territories of Canada, where State representatives passionately contest the validity and authority of local knowledge. In rural Bijnor, where the presence of the central government and modern technology are less obtrusive, the knowledge and meaning of childbirth still nest in a metamedical context of the gender and caste hierarchies that give them shape.

The chapter by Kaufert and O'Neil introduces a second constructionist theme developed by several other contributors to this work: the notion that different perceptions of risk stem from different versions of reality. For the Canadian gynecologist, risk is statistically measured, allowing comparison across time and populations. Inuit women, on the other hand, take their measure from the number of successful births remembered in their own communities and from their own reproductive experience, resulting in a risk factor that does not seem to them to be very high, and one that does not outweigh the loneliness of birthing in an alien environment.

Competing languages of risk are explored also in chapter 3, Rayna Rapp's discussion of the cultural meaning of prenatal diagnosis. Follow-

ing amniocentesis, women in a New York clinic evaluate risk information provided by genetic counselors and choose whether or not to continue with a pregnancy. Their decisions are based on a variety of local influences—the proximity and judgment of male partners, kin, and friends, the place of a particular pregnancy in the women's reproductive histories, the weight of religion in their lives, and the blemish of a potential disability in the eyes of their own communities. Local meanings of disability vary greatly, as the parents of disabled children, their advocates, and activists indicate. The cultural meaning of diagnosis emerges as the product of a number of overlapping discourses—genetics, health economics, social work and sociology, bioethics, and feminism, as well as the language of the new workforce of genetic counselors and the women who consult them—a construction forever in the making. The voices of the pregnant women have so far only been faintly heard.

Traditional Birth Attendants in Rural North India

The Social Organization of Childbearing

Roger Jeffery and Patricia M. Jeffery

Anthropological knowledge produced in connection with midwifery and childbirth has often been used for political purposes in both western Europe and North America. On the one hand, negative assessments of indigenous childbearing practices are taken as one indicator of women's low status and used as a stick to beat colonial regimes or colonized peoples. On the other hand, non-Western methods of childbirth are examined in order to compare them with what are taken to be the ill effects of technologically controlled childbirth in formal medical settings. The first approach (called a biomedical perspective by Carol McClain [1982:26]) focuses on the disasters—on rates of maternal and neonatal mortality and on the experiences of doctors in Third World hospitals often faced with the effects of undiagnosed obstructed labors and long delays before hospitalization. The second (which McClain calls a sociocultural perspective) looks for social and psychological evidence of supportive environments, or for beneficial techniques (massage, positions during delivery) which are absent from standard Western practice.¹

Both approaches tend to allow Western medical concerns to propose the agenda. The first sets out to modernize the traditional, but has often been accused of ethnocentrism (see, for example, Jordan 1987). The second calls for the insertion of traditional techniques into technocratic obstetrics, but often relies on a romanticized borrowing from the past of "exotic" cultures (Macintyre 1977). The recent advocacy by the World Health Organization of training programs for traditional birth attendants as a means of improving the conditions of maternal and child

health around the world belongs to this second category (Maglacas and Simons 1986).

We are concerned with two features common to these otherwise contrasting perspectives: first, a tendency to homogenize midwifery by underplaying or ignoring cultural variation; and second, a propensity to detach pregnancy, the birth event, and the postpartum period from their social moorings. In this chapter we wish to argue for strengthening what has been a minority position, one that examines childbirth and midwifery as practices within specific social and economic contexts, especially by locating women in production and reproduction. In other words, we advocate a position that looks for the bases of variation.

One reason for the relatively stereotypical view of midwifery in anthropology is its narrow selection from the many studies undertaken, and particularly its focus on the more detailed, anthropologically oriented accounts that tend to celebrate indigenous midwives or birthing systems. The burgeoning of such studies followed the growth of feminist perspectives in social science, in which the proper task of feminist anthropology was considered to be the recovery of women's knowledge and sources of power and influence. Sheila Cosminsky (1982), Brigitte Jordan (1983), Carol Laderman (1983), Carol MacCormack (1982), and Lois Paul and Benjamin Paul (1975), for example, describe childbirth among Mayan Indians or neighboring tribes in Guatemala, Sierra Leone, and Malaysia. We do not question the value or conclusions of these excellent reports. We do, however, point to the disadvantages of generalizing from such a relatively narrow set of social contexts. McClain's literature review of 1982, for instance, summarizes the earlier reviews by Ford (1945), Montagu (1949), Spencer (1950), Mead and Newton (1967), and Oakley (1977), which draw their material from a wide geographic range, but which deal predominantly with small-scale, relatively isolated communities or tribes, often slash-and-burn agriculture or hunter-gatherer societies.

Although this research potentially grants every separate cultural form its own significance, it has tended to downplay the densely populated, settled agricultural regions where most of the world's women live. Accounts of Han Chinese childbearing, or childbearing in Indo-Gangetic plains India, Pakistan, and Bangladesh are relatively rare. Such regions have been characterized in terms of their dominant agricultural practices as male farming systems (Boserup 1970) illustrating the Eurasian model of plough agriculture (Goody 1976), and have been associated with hierarchical social systems and relatively restricted roles for women. Both of these authors have been criticized for their inability to deal with cultural variation within these broad regions. Nevertheless, they offer a useful vantage point from which to develop an understanding of how childbear-

ing experiences vary, and along which dimensions, in different social settings.

In what follows we will argue that the nature of midwifery in any society must be understood in the context of a wide set of relationships that include the society's range of medical resources (even if childbirth is not usually perceived as a medical event) and people's understandings of anatomy and physiology, as well as the ability of women to enter healing roles, their access to different kinds of healers, and the access of healers to them. Midwifery is also affected by the particular constraints on the organization of delivery and by the roles adopted by those who are permitted to attend a birth. These childbirth events are set in a wider context of the dominant symbolic understandings of the childbirth process and of women's other work roles, their kin relationships, and their access to property. As a result, childbearing women have differing abilities to organize resources on their own behalf, whether these are in the form of social support, cash, or access to scarce knowledge. In this dense context we find differences in the roles of specialized birth attendants, the evaluation of what they do, and their opportunities to develop specialized knowledge. That is, the practice of midwifery in any one place is conditioned by a wide set of social, economic, and symbolic considerations that give it particular shape and meaning.

If societies are placed on a continuum according to the degree of women's subordination, north Indian society would be located toward the "most subordinated" end. As we argue below, this is closely tied to women's childbearing experiences and the status of traditional birth attendants.² Many aspects of childbearing in north India confound the generalizations in the anthropological literature on childbirth and midwifery in non-Western societies. For example, traditional birth attendants are usually described as supportive and sisterly, in contrast to the presumed Western model of professional medical domination. What we describe below, however, is a third model—midwifery as a perfunctory service (Goffman 1968:285). The north Indian traditional birth attendant and the hierarchical biomedical expert are thus located at polar extremes, with the sisterly relationships of Yucatan midwives (Jordan 1983) occupying a middle position. Further, we would predict that conditions similar to those we outline below will obtain in many other areas, and may even be the predominant non-Western pattern in terms of the numbers of women involved.

Our data come from recent research in Bijnor District in the state of Uttar Pradesh in north India. The research was based in two adjacent villages (one Muslim, one Caste Hindu and Harijan) less than five kilometers from the bed of the River Ganges. We also conducted a survey in

eleven other villages in the District, interviewing 301 recently-delivered women.³ In the base villages, maternity histories were collected from all 236 ever-married women. Of those currently pregnant or recently-delivered, forty-one key informant women and their husbands were chosen to provide a wider range of detailed information on their work, aspects of kinship and gift-exchanges, and reproductive behavior. Patricia also attended births in the two villages and accompanied one woman who finally delivered in the local women's hospital. This material is complemented by interviews with twenty-four women identified as birth attendants in the two base villages and the eleven survey villages.

In her critique of Western obstetric techniques, Oakley contrasts "pre-literate societies" and "modern industrial societies," distinguishing five aspects of childbearing: cultural definitions of pregnancy and childbearing; who controls the management of childbirth; the location of labor and delivery; labor and delivery positions; and the degree and kind of intervention in birth and the emotional and social supports for the laboring woman (Oakley 1978:18). Her portrait of childbearing in "preliterate societies" contrasts sharply with the picture of the passive laboring woman in the West, who gives birth in unfamiliar hospital surroundings away from supportive kin and friends, and who is subject to expert medical management of her birthing experience and the intervention of alien medical techniques. Oakley's framework provides the basis for our discussion below. We begin briefly by describing the role of traditional medical systems in childbearing, and the social and economic location of the typical childbearing women in this part of north India.

Women and Medicine in India

India, like China, has one of the most sophisticated medical systems to have survived to the present day. Long traditions of literacy—in Sanskrit and Arabic—and a large, wealthy clientele have supported elite practitioners' schools in *Ayurveda* ("the science of life") and *Unani Tibb* ("Greek medicine"). The classical texts offer only partial insight, however, into the nature of everyday medical practice. Understanding the relationship of these systems of medicine to the medical care given to and by women remains a major problem.

The classical texts and recorded practice mention only male practitioners. Some hints support the idea that *vaid*s and *hakims* (Ayurvedic and Unani healers) were unlikely to play a substantial part in childbirth. Indeed, they might have given a prior claim to Brahman priests to provide amulets or to pray for recovery. But some classical texts discuss gynecological and obstetric issues, and some *hakims* in Bijnor prescribe remedies for infertility or for the inability to bear a son, or to accelerate

labor. Direct consultations on matters of pregnancy or delivery, however, seem to have been very uncommon, both in the distant and recent past. Respectable women were constrained by issues of shame, for poorer women, their poverty was an additional hurdle, and all women had limited time for medical consultations. In the nineteenth century, at least, it seems that in north India women in need might have their symptoms described by another woman or by a related man, but male healers could not touch or examine a pregnant or delivering woman.⁴ The only female folk healers described in the census or in the reports of British medical administrators are *dais*, a term that usually translates as “midwife,” or more recently, traditional birth attendant.⁵ Dais are well represented in contemporary north India: in Uttar Pradesh they are reported to attend over 90 percent of all deliveries, whereas in south India they attend fewer than half.⁶

Women, Property and Kinship

An appreciation of the position of young married women contributes to setting the context of midwifery in Bijnor. This can be done in terms of three key roles: as wealth-bringers, workers, and bearers of children.⁷ Even in landowning families, a woman rarely owns productive property in her own right. Access to any parental land (the main rural resource) is effectively foreclosed when women leave home at marriage. Marriage establishes patterns of gift giving in which a woman acts as a conduit for wealth (usually in nonproductive forms: jewelry, clothing, foodstuffs, and sometimes cash) from her parents or brothers to her husband and his parents. A young married woman rarely controls the distribution of these resources and she cannot reclaim them if the marriage ends. Such gifts, and a woman’s dependence on her brothers to continue to send them if her position with her in-laws is to remain secure, effectively prevent a woman from insisting on her legal right to a share in any productive property when her parents die. Further, marriage migration severs women from supportive relationships with their natal kin and the friends of their youth. Young married women control very few material and social resources.

Regardless of their class position, young married women work long hours at hard labor, but their work is devalued. Wherever possible, a young married woman is excluded from work in the field, except to labor on the land owned by her marital kin or as part of a kin-based work group. Her contribution to agricultural production (winnowing, threshing, grinding) is done inside the domestic compound, and is usually ignored or described by men as light and unimportant. Most women have specific responsibilities for many other tasks such as cooking, clean-

ing, and rearing young children, as well as the maintenance of courtyards, huts, and grain stores, the collection of fuel, and the conversion of cow-dung into fuel or fertilizer. Men regard this work as demeaning. Women's work is thus trivialized and brings them little credit, yet a woman who wishes to visit her parents may have trouble negotiating leave unless another woman is available to take her place. Women's employment outside the domestic enterprise is rare: young women should not do such work, and men will often deny that it happens. Even when women work outside the home, they rarely gain access to the pay they earn.

As a potential bearer of children, a young woman is carefully chaperoned in her natal village. She has little say in whom she marries. She must observe norms of respect and seclusion during adolescence to achieve a respectable marriage at a proper age—norms designed to ensure a sexual purity not demanded of a young man. Her standing with her in-laws begins at a very low level; she provides sexual services for her husband and offers work and respect to her mother-in-law. Inadequacies or resistance may be met with beatings. Her capacity to bear children is vital for the future well-being of her husband's household since sons, in particular, support their aged parents. The birth of a child begins to raise her status and secure her position, a process that culminates (if she is lucky) in her becoming a mother-in-law herself. The failure to bear a child has serious implications for a young married woman, but the process of childbearing is itself fraught with many problems.

Cultural Definitions of Pregnancy and Childbearing

Three concerns shape women's views of pregnancy and childbearing: shame, pollution, and issues of vulnerability and danger.

Shame

It is important for a married woman to bear children, but matters connected with sexual and gynecological functions are considered *sharm-ki-bat*, matters of shame and embarrassment. As a sexual being, a young married woman must not publicize her sexual relationship with her husband. She should be demure in his presence, and neither of them should hint at their sexual activities, either verbally or through body language. Pregnancy and childbirth, however, provide dramatic and conspicuous evidence of sexual intercourse. During pregnancy, a woman should cover her body even more assiduously. Other people's allusions to her condition should be met with a discreetly bowed head. The act of giving birth is also

profoundly shameful, entailing as it does the exposure and even touching by others of body parts that should always be concealed.

Childbirth Pollution

During pregnancy, the mother nurtures the fetus with her own blood. At the moment of transition to motherhood, she loses some of this blood, which is considered much more polluting than menstrual blood. *Sutak* (the blood of childbirth) or more prosaically *maila* or *gandagi* (dirt, foulness, filth) is the most severe pollution of all, far greater than menstruation, sexual intercourse, or that of death. Only a profuse flow removes the defilement and causes a complete cleansing. Following the birth, the newly delivered woman (*jacha*) remains impure (*a-sudh* among Hindus and *na-pak* among Muslims) or simply dirty and defiled (*gandi*) and can herself be poisoned by this blood. Some defilement (*gandagi*, *maila*) also adheres to the baby: Hindus and Muslims alike consider the baby's first hair to be contaminated by contact with the mother's blood, and the hair is shaved off during the first year. Touching the amniotic sac, placenta, and cord (known collectively as the "lump"), delivering the baby, cutting the umbilical cord, and cleaning up the blood are all the most disgusting of tasks. Considered defiling work (*ganda kam*), these practices are the concerns of the dai.

After the birth, the dai presses the *jacha*'s belly and tells her to bear down to make the placenta deliver quickly. If it is slow to arrive, she may massage the belly. Half the dais said that they simultaneously insert their other hand into the vagina and tug the cord robustly, but the others said that this causes sepsis. The dai cuts the cord only after the placenta has been delivered, since the cut cord could vanish inside the *jacha*'s tubes and spread the poison in the placenta throughout her body.

In some aspects of childbearing, Hindu and Muslim practices differ. For example, Hindus invariably wait for the dai to arrive to cut the cord. One socially isolated woman, totally alone when her baby was born, was found by a neighbor who massaged her until the placenta delivered, and then helped her onto her bed. Neither woman cut the cord, but waited for the dai, who arrived over an hour later. Muslims, on the other hand, do not necessarily leave the cord uncut if the baby is born before the dai arrives. An old Faqir woman in the Muslim village will cut cords for a certain payment. Three other women will also cut cords, but only if no dai is present, and they are not paid or considered to be dais. Nonetheless, many Muslim women say cutting the cord is the dai's right, and this is one of the tasks for which she is paid.

Touching the *jacha* and baby is also defiling-work. Following the birth, the dai gives the *jacha* some old cloth or a lump of dried mud to