INTRODUCTION

Childbirth and Modernity in Tamil Nadu

Modern Birth and the Transformation of Gender

Whereas earlier anthropological approaches to reproduction tended to focus on how reproductive practices and beliefs *reflected* social and cultural systems,[1] scholars now argue that anthropology can benefit from viewing reproduction itself as a key site for understanding the ways in which people *re*-conceptualize and *re*-organize the world in which they live.[2] This book also takes this *processual* view of culture-in-the-making.

What then is reconceptualized and reconfigured in the process of the modernization of birth for poor women in Tamil Nadu? This book does not make one, overarching point about the transformation of ideas and practices relating to childbirth in Tamil Nadu at the end of the millennium. It does not provide the reader with some neatly packaged before-and-after scenario of modernity as the grand makeover. Instead, like the intricate patterns of *kōlams* which adorn the thresholds of houses in Tamil Nadu, this book loops and swirls around several key points of reference, each of which is given equal valence. Each point in the *kōlam* maintains its independence, suspended in space in the interstices of the looping lines which pull the individual points together into one web of interlocking boomerangs flying in different directions. Unlike the elaborate *kōlams* drawn for the festivals of Pongal or Dipavali, with hundreds of individual points, mine is a very humble *kōlam*. I do not begin to touch on *all* the ways in which childbirth and reproduction are being

transformed. I have tried to highlight those aspects of change which seemed to be of greatest concern to the women whom I met and which had the greatest impact on their decisions about where to go for prenatal, delivery, and postnatal care. Also, out of my interest in underlining unique aspects of modernized birth in Tamil Nadu, I have highlighted those transformations which are different from those noted in similar studies of the biomedicalization of birth in Europe and the United States.

My *kōlam* twists around five primary processes of change, five aspects of the modernizing process which impact childbirth in Tamil Nadu: 1) the professionalization and institutionalization of obstetrics, 2) transformations in the relationship between consumption patterns and reproductive rituals, 3) the emergence of new technologies for managing the pain of birth, 4) the international mandate to reduce population in India, and, 5) development agencies' agenda to spread biomedical conceptions of reproductive health for mothers and children. These processes, taken together, have transformed cultural constructions of reproduction and social relations of reproduction in myriad ways.

In the process, constructions of *gender* are reconfigured. First, women's reproductive bodies have become irrevocably linked to colonial and postcolonial state interests as well as to the interests of transnational development projects. This is particularly evident in the context of international fears of India's "population explosion." Women in India have thus come to be viewed as the bearers of bodies to be counted. The state of Tamil Nadu prides itself on being a "success" in the area of modern population control. For women in Tamil Nadu, being sterilized or having an IUD is a sign of being "modern." But women have mixed feelings about this embodied modernity.

Second, new forms of ritual and patterns of consumption and exchange, along with new drugs for pain, have radically altered the cultural construction of women's power, or *sakti,* such that in some respects women are said to have more *sakti* than in the past, while in other respects they are said to have less. But to culturally ascribe women with more or less *sakti* can have unexpected effects on women's social power.

And, finally, new concepts of nutrition and disease are transforming understandings of the mother's body, the baby's body, and the relationship between the two. Some of these new concepts have the potential to save lives. But when this transformation is occurring in the context of a developmentalist discourse, which reinforces *social* differences by equating poverty and non-biomedical practices with "underdevelopment," new concepts of the body are unevenly conveyed and may be resisted be-

cause of the condescending way in which they are imparted. Whereas non-biomedical understandings in Tamil Nadu tend to view the mother-child body as one, this entity is coming to be viewed as two distinct bodies, in the context of not only biomedical praxis but also policy, where the emphasis has shifted from maternal-child health care to a focus on the child as a separate entity. In Tamil Nadu, where female infanticide is reported to be on the rise in *some* poor communities, poor mothers in general are increasingly viewed as potential criminals, and non-biomedical practices are sometimes associated with this criminality. Clearly, then, new constructions of gender, and particularly of motherhood, are class-specific. That is, they are reconstructions of *lower-class* mothers.

My *kōlam* then turns around a sixth point. I try to assess how the five processes of modernity mentioned above, in relation to other factors, influence the "choices" poor women and their families make about the kind of care to seek for childbirth-related needs. "Choice" here is in quotation marks simply to remind us that the decision-making process is never a matter of the free will of rational, value-maximizing individuals, but, rather, it is always enacted in political-economic contexts and shaped by socio-cultural factors such as gender, class, caste, and age. As Linda Garro points out, however, an awareness of the contextualized nature of "choice" does *not* negate the relevance of applying a decision-making perspective.[3]

In her work on decisions regarding obstetrical care among the Bariba of Benin, Carolyn Sargent suggests that we anthropologists should differentiate between aspects of the decision-making process in which an individual "believes herself/himself to be engaged," on the one hand, and the macro-social forces which may be more evident to an external analyst, on the other hand. Thus, she argues, women have a definite *sense* of making rational choices.[4] In my own research in Tamil Nadu, I found women to be not only aware of but extremely articulate about what we might call the "macro" factors impinging on their reproductive decisions. In fact, I do not feel that it is useful to make a distinction between the "macro" and the "local" in discussions of decision making. As the reflexive turn in anthropology reminds us, even the "macro" of the analyst is always locally constructed.[5]

Like most complex societies within which medical anthropologists work today, India contains a plurality of medical systems of knowledge and practice, including multiple forms of biomedicine; "indigenous" systems of medicine such as Ayurveda, Unani, and Siddha; homeopathy; and a wide variety of medical knowledge tied to religious practice and

astrology.[6] These all become part of the decision-making process for women during childbirth.

In India biomedicine is most commonly referred to as "allopathy." The other term most frequently used by informants is "English medicine." In the medical anthropological literature terms such as "Western medicine," "modern medicine," and "cosmopolitan medicine" are often used interchangeably with "biomedicine." In this book, when referring specifically to the Indian context I use the term "allopathy" or "allopathic medicine," since my aim is to stay within the specific ethnographic field of my research and to underscore my point that biomedicine always takes on a unique form at the local level. When referring to the global context, I use the term "biomedicine."

There has been very little anthropological or sociological attention given to the use of allopathic services for childbirth in the context of India's medical pluralism in the postcolonial period; although Kalpana Ram's work on the management of birth among the Mukkuvar fishing community in southern Tamil Nadu is an important exception.[7] Most of the studies dealing with these questions were carried out by colonial historians (as I discuss in Chapter One). Most anthropological and sociological research on childbirth in India in the postcolonial era has focused on rural areas and has tended to depict childbirth practices as relatively untouched by allopathic institutions.[8] Yet allopathy has had a major impact on childbirth in urban and semirural areas throughout India, though the impact has been uneven. By focusing on the major metropolitan city of Madras and a semirural town on the outskirts of Madras, my study looks at the central role which allopathy plays in women's decisions regarding childbirth and considers how women choose from among different allopathic options as well as non-allopathic practices.

According to Linda Garro, anthropologists interested in decision-making processes can be loosely grouped into two camps: those who are primarily concerned with policymaking issues and those who are interested in the cultural underpinnings of the cognitive processes that go into decision making. While still others, she writes, "see cognition and policy as intertwined, but they discernibly foreground the policy implications."[9] As far as my work addresses questions of decision making, I would place myself in this third group. Although I am interested in the wide range of social and cultural processes which go into decisions about where to go for prenatal care, whom to see during a delivery, and whose advice to seek in the postpartum period, I must make my own "choices" about which of these processes to foreground. In my own se-

lection process, I try to attend to the voices of the women whom I met, to hear what they considered to matter most to them, and to convey as forcefully as possible their concerns, their criticisms, and the problems they faced in pursuit of reproductive health care during their childbearing years.

As a result, this book may at times seem like a litany of complaints and an unsolicited condemnation of the reproductive health services provided in Tamil Nadu, a state which is usually viewed as a success story in maternal-child health vis-à-vis India as a whole. My intent is not to criticize from afar the work of so many hardworking and dedicated health care providers and policymakers. In fact, I am keenly aware of the historical legacy of the damning depiction of maternal and child health care in India used by colonial discourse to legitimize colonial rule. So I present these criticisms with a certain amount of discomfort about my role in perpetuating this discourse in the postcolonial era, despite the fact that I strive to show how international and globalizing forces are intricately implicated in women's critiques. But as a critical medical anthropologist, my work is first and foremost concerned with issues of social justice. And so, although I hope my ethnography provides what Clifford Geertz has called a "thick description" of the world through the eyes, and indeed through the bodies, of the working-class women whom I met in Tamil Nadu, the "thickness" is not evenly distributed, but, rather, tends to bunch up around those sites where women sense discrimination and desire change.[10]

In his book about aging in India—the stage both farthest from and closest to birthing in the Indian life cycle—Lawrence Cohen continuously pushes us to ask, "What is at stake" in the social, cultural, and medical transformations of the conceptualization of and practices surrounding old age in India?[11] He insists that our conclusions not be simplistically spawned by false dichotomies which force us to take sides, for example, "with medical rationality *or* its holistic or feminist critics, with cultural autonomy and distinctiveness *or* world systems theory and the deserving poor, with medicine as a resource *or* as an ideology."[12] The same question of what is at stake could be asked of my study, substituting "childbirth" for "old age." And, as mentioned above, my response lies in the multiple and complex ways in which gender, as it intersects with class, is being reconstituted.

In my head, I constantly find myself returning to a simpler, perhaps somewhat simplistic response to the question of what is at stake: lives and the potential for suffering. I know from my research and from my

own personal experience that the lives of babies and of mothers can never be guaranteed, regardless of what kind of medical care is given and what kind of material resources are available. And I agree with Ivan Illich when he poignantly argues that we must not lose sight of the art of suffering in the wake of modern medicine's determination "to kill pain, to eliminate sickness, and to abolish the need for an art of suffering and of dying."[13] But when discriminatory practices based on things like class and gender have the potential to deny women easy access to biomedical reproductive health care and thus to precipitate loss of life and suffering, action must be taken. This action, however, must not entail falling into the trap of representing others simply as victims, a pitfall that Chandra Mohanty and Arthur and Joan Kleinman have helped me to see and, hopefully, avoid.[14] This book, then, is my enactment of the action taken by those women who shared part of their lives with me.

THE ANTHROPOLOGY OF REPRODUCTION AND MODERNITY

Because I am interested in emphasizing the specificity of modern birth in this particular ethnographic setting, there is a constant comparative vein which runs through the book. This is, however, an ethnographic tale, not a cross-cultural study. The comparative element hovers in the background as a constant reminder of difference, rather than taking center stage. The scenario with which I contrast my study is the biomedicalization of childbirth in Europe and the United States, not because these are the only valid sites of comparison, but because these are the stories that dominate social and cultural studies of the relationship between reproduction and modernity in medical anthropology, medical sociology, and the history of medicine.

During the first decades of the twentieth century, anthropologists paid very little attention to the study of reproduction in diverse cultural contexts; this is usually attributed to the dearth of female anthropologists at the time and, therefore, to the lack of interest in or access to what was considered an exclusively female domain. It may also be due to the fact that social and cultural anthropologists shied away from studying those aspects of human practice which were so intricately linked to biology.[15] To the extent that anthropologists during this period did concern themselves with the study of reproduction, it was within the context of very broad ethnographic accounts and was given only passing mention which was descriptive rather than analytical.[16]

Anthropologists began to focus explicitly on the study of reproduction within the framework of cross-cultural analyses, around the middle of the twentieth century. These comparative studies sought to discover which aspects of human thought and behavior relating to reproduction are universal and which are culturally specific.[17] These anthropologists paid particular attention to how pregnancy, labor, and the postpartum period are managed both physically and socially and to the degree to which these practices are symbolic or biologically based. In short, they established the central tenet of the anthropology of reproduction: reproduction and the management of reproductive processes are not simply biological; they are also always culturally constructed in unique ways in diverse historical contexts.

The study by Margaret Mead and Niles Newton titled "Cultural Patterning of Perinatal Behavior" was particularly noteworthy for the way it used a cross-cultural approach to critique the social and cultural patterning of birth in American society. Though Mead and Newton did not use the term "medicalization," their analysis of the problems which can arise from defining birth as an illness and from the increasing use of hospitalization and pharmaceuticals during the birth process was a harbinger of later studies which explicitly addressed the issue of the medicalization of birth.[18]

Medicalization is a key theme which permeates much of this book. What, then, do I mean by "medicalization" in the context of this study? The medicalization of everyday life is the process by which medical expertise "becomes the relevant basis of decision making in more and more settings"[19] and has become a key component of the modernizing process throughout the world.[20] The medicalization of childbirth is thus the process whereby the medical establishment, as an institution with standardized professional guidelines, incorporates birth in the category of disease and requires that a medical professional oversee the birth process and determine treatment.

The term "medicalization" is often used to refer to a process of "mystification" of social inequities. As Scheper-Hughes and Lock say, "Medicalization inevitably entails a missed identification between the individual and the social bodies and a tendency to transform the social into biological."[21] Thus, such things as hunger, alcoholism, and attention deficit disorder come to be viewed as purely biological disorders and treated with biomedical interventions on individual bodies rather than with attempts to transform the *social* structure and causes which gave

rise to such problems. Like this process of mystification, the medicalization of childbirth is an extension of the power of professionalized medical institutions.[22] Yet the process of the medicalization of childbirth is different because "non-medicalized" birth is not necessarily a symptom of inequality. Rather, the medicalization of birth entails a pathologizing of the "normal" by placing birth under the domain of the professional doctor. State-regulated institutions have gained a foothold in the domain of birth through this pathologizing process. From a Foucauldian perspective, however, Margaret Lock and Patricia Kaufert point out, "an account limited to the interests of the medical profession and of the state is inadequate because medicalization cannot proceed unless a cooperative population of patients exists on whom techniques can be performed."[23] Yet, to speak of a "cooperative population" does not negate the possibility of resistance. Furthermore, the medicalization of childbirth *can* be viewed as a mystification of social ills when it comes to be touted as the only and most essential means of reducing risks of infant and maternal mortality and morbidity, thereby erasing the critical role that malnutrition and a wide range of other diseases associated with poverty may have on maternal and infant health.[24]

A "non-medicalized" birth does not mean that no medical care or treatment is given if by "medicine" we mean all forms of healing, of promoting and maintaining a healthy, "mindful body."[25] In many communities throughout the world, and certainly in India, there are a wide variety of non-biomedical practices used to attempt to ensure a risk-free delivery and the birth of a healthy baby. And in India, as in many other parts of the world, there are "indigenous" midwives with specialized knowledge regarding childbirth. Therefore, rather than using the term "medicalization," I use the more specific term "biomedicalization" to refer to this process.

Since the 1970s, feminist-inspired anthropological and sociological studies of birth have critically examined the cultural and political underpinnings of modern biomedical approaches to birth in the United States and Europe. This literature is vast, and I do not intend to review the field here.[26] I elaborate more on these various scholars' approaches in the context of specific debates and discussions in the following chapters. In a nutshell, however, most of these studies argue that the roots of modern, biomedical approaches to birth in Europe and the United States lie in Enlightenment thinking. According to these scholars, the modernization of medicine has entailed a shift from viewing reproductive processes, such as childbirth, as tied to natural and cosmological processes,

which could be facilitated through some degree of human intervention but which ultimately lay beyond human control, to viewing childbirth as something which can and should be improved upon through the application of new, scientific practices based on the study of the *laws* of nature.[27] This Enlightenment thinking and the drive to control and harness nature for human, capitalist interests laid the groundwork for the Industrial Revolution. The Industrial Revolution brought with it an increasing reliance on machine-driven production and placed a premium on efficiency for the sake of enhanced capitalist profits. Scholars have pointed out that in the context of the Industrial Revolution, women's reproductive bodies came to be viewed as machines which should operate in uniform and "efficient" ways to facilitate (re)productivity.[28] These studies have focused on the shift from home births attended by female midwives to hospitalized births overseen by a cadre of biomedical professionals with male obstetricians in charge, and have demonstrated how women's reproductive bodies became the object of the "medical gaze."[29] Many have emphasized the ways in which birthing women and female midwives have been disempowered by the rise of the male biomedical establishment. And they demonstrate that this control is legitimized and naturalized by the "authoritative knowledge" of the biomedical establishment, which puts its faith in and derives authority from increasingly complex and costly technological interventions during conception, pregnancy, and delivery.[30] Some scholars, however, have highlighted the ways that women were themselves active agents in shaping the development of obstetrics, and reproductive technologies more generally, and have shown how women have both gained and lost control in this process.[31]

A cadre of feminist activists who have resisted the biomedicalization of childbirth in the United States and Europe have advocated for a return to "natural childbirth" and to "woman-centered" home births attended by female midwives with as little technological intervention as possible, unless intervention is deemed medically necessary.[32] Some anthropologists have become advocates for midwifery and the natural childbirth movement.[33] And ever since the early work of Mead and Newton in 1967, anthropologists have found it useful to study childbirth practices in non-biomedical contexts in other parts of the world in order to learn alternative birthing techniques which can be applied to birthing practices in the West.[34]

Anthropologists have not only been interested in considering how non-Western approaches could be applied in the West; they have also studied the impact of Western obstetrics on childbirth practices and

therapeutic selection in non-Western societies.[35] Such studies often focus on the social, political, and cultural barriers to the acceptance of Western obstetrics in non-Western societies and make recommendations for changes in the manner in which Western obstetrics are delivered in such settings. Conjoining both these approaches in her seminal book, *Birth in Four Cultures* (1978), Brigitte Jordan calls for "mutual accommodation" between non-biomedical, in her case Mayan, and biomedical, in this case American, practices.[36]

One of the important contributions of Jordan's original work was the fact that she not only looked at differences between highly biomedicalized and non-biomedicalized birth practices, but she also revealed variation *among biomedical models of birth* in three different countries: the United States, Sweden, and Holland. Some anthropologists and sociologists have continued to reveal variations in how biomedical models of birth are constructed and acted upon across class, ethnicity, and race within the United States and among different Western nations.[37] And historians have often focused on the history of childbirth in one country or on one continent, thereby pointing to national or regional specificities in the modernization of birth.[38]

In the most recent edition of Jordan's *Birth in Four Cultures,* published in 1993, however, she tends to depict a modern biomedical model of birth as a kind of monolithic structure which she refers to as "cosmopolitical obstetrics" and defines as "a system that enforces a particular distribution of power across cultural and social divisions."[39] Jordan argues that the export of this "cosmopolitical" model to the Third World is a form of "biomedical colonization" and "imperialism."[40] She depicts a scenario in which modernity, and biomedicine in particular, does not emerge locally throughout the globe, but is transplanted around the globe. But biomedicine is *not* a monolithic entity.[41] And the biomedicalization of reproduction is *not* a uniform process either within or across national boundaries.

Somewhat like Jordan, Faye Ginsburg and Rayna Rapp are also concerned with how unequal power relations manifested in the globalization process impact control over reproduction and lead to what they describe as the "stratification of reproduction on a global scale."[42] Yet at the same time, they caution against unidirectional models of the relationship between power and knowledge in the context of globalization. They write, "While our work calls attention to the impact of global processes on everyday reproductive experiences, it does not assume that the power to define reproduction is unidirectional. People everywhere ac-

tively use their local cultural logics and social relations to incorporate, revise, or resist the influence of seemingly distant political and economic forces."[43] In addition to the contributors to Ginsburg and Rapp's (1995) edited volume, other anthropologists have begun to examine the *diverse* and uneven ways that childbirth is being biomedicalized throughout the world.[44]

This perspective can help dispel the misconceptions embedded in those feminist studies that view all the controlling aspects of biomedicalized births as derived from a Western historical legacy of the Enlightenment and Industrial Revolution and that present a romanticized vision of holistic "indigenous" birth, or "ethno-obstetrics," as egalitarian, "woman-centered," and noninterventionist. Janice Boddy's study of childbirth in postcolonial Sudan, for example, shows that due to the practice of infibulation and the need to open and restitch the scars from infibulation during delivery, midwifery there can hardly be viewed as noninterventionist.[45] In this book, I am not engaging in a debate about whether hospital deliveries are fundamentally controlling or liberating. They may of course be both, just as home deliveries may be experienced as repressive, comforting, or both. Rather, my interest is in demonstrating the historical and cultural specificity of the transformations in the experience of childbirth for working-class women of Tamil Nadu in the late twentieth century.

It is important to underscore the fact that just as the nature of modern birth is unique, forms of resistance will, of course, also be distinct. Due to international and local political-economic structures and cultural processes, biomedical births have not become hegemonic in Tamil Nadu, even in urban areas such as Madras, where almost all births take place in the hospital. And obstetrics has never been the domain of medical *men* in India as it is in the United States. Following Jean and John Comaroff's interpretation of Gramsci, I use the term "hegemony" to mean those systems of knowledge, symbols, and practices which are culturally constructed in the context of relations of power and which "come to be taken for granted as the natural and received shape of the world and everything that inhabits it."[46] It is the apparent "natural" quality of hegemony which gives it its profound power. Although allopathy may indeed be the dominant form of maternal and child health care in urban India, it is not taken for granted as the *only* naturally legitimate form of care. Its apparent superiority must still be publicly articulated. It, therefore, cannot be viewed as hegemonic. Unlike the woman-centered, natural, home-birth movement in America, resistance to biomedical birth

in Tamil Nadu is not counterhegemonic; it is based on a critique of the discriminatory ways in which allopathic services are (or are not) provided rather than on a critique of allopathy itself. Resistance to the biomedicalization of birth among the poor of Tamil Nadu, therefore, reflects an effort at bricolage rather than an effort to replace one system of birth with another, wholesale.

Recalling the opening story of Mumtaz, who says she gave birth to her child *right* on the threshold of her home, we can, following James Scott, view her action and inaction as one of those partial, everyday forms of resistance that are the "weapons of the weak."[47] But a far more interesting and significant form of resistance is taking shape in Tamil Nadu today. Some women *want* new technologies offered by allopathy but they want to avoid forms of discrimination which they face in public hospitals. Increasingly, these women are opting to bring allopathy and allopathic practitioners back across the threshold into their homes. In some ways, this appears to be a creative and positive solution to their predicament. But, as we see in the coming chapters, there are also potentially serious health risks involved in partially administering biomedical technologies at home without immediate access to full-fledged biomedical emergency care.

TAMIL NADU: URBAN AND SEMIRURAL FIELD SITES

The state of Tamil Nadu, in the southeast corner of India (see Map 1), is often considered one of India's model states with respect to the provision and use of allopathic maternal-child health (MCH) care. A 1994 government of Tamil Nadu publication showed that 60.6 percent of all reported deliveries in the state were institutionalized; the remainder took place in homes.[48] A separate 1993 government of Tamil Nadu report stated that hospital deliveries accounted for "more than 90 percent" of all deliveries in urban areas and "about 50 percent" of all deliveries in rural areas.[49] In 1993 the World Bank reported that in the capital city of Madras 99 percent of all deliveries were in hospitals.[50] And, by the beginning of 1995, the director of the World Bank–funded India Population Project-V (IPP-V) for Madras reported that 99.9 percent of all deliveries in Madras were conducted in hospitals.[51] Because a number of home deliveries go unreported, these figures reflect a somewhat unrealistically high percentage of hospital deliveries. Nevertheless, they demonstrate that the rates of hospital deliveries in Tamil Nadu are significantly greater than those for India as a whole, for which it was

Map 1. The states of India, 2001.

reported in 1995 that no more than 20 percent of all deliveries took place in hospitals.[52] Yet very little scholarly attention has been given to the cultural and political processes by which MCH care, specifically for childbirth, is being incorporated into allopathic systems of knowledge and institutions in this region or to the quality of that care.[53]

My initial decision to carry out this research in Tamil Nadu, however, had more to do with my own personal history in the state than with a purely scholarly interest in filling a lacuna in academic research. As a child, I spent three and a half impressionable years, from the ages of eight to twelve, living in Sri Lanka, where my father was posted with the Foreign Service. During much of that time, my older brother and sister were attending an international boarding school in what had once been a colonial hill station in Kodaikanal, Tamil Nadu. I remember spending many vacations with my mother visiting my brother and sister on Kodai Lake and sightseeing in the temple towns and wildlife preserves in the plains and jungles of Tamil Nadu. And I, too, attended the same school briefly in 1976 before our family was posted back to Washington, D.C. During that time, I was captivated by the hustle and bustle of even this small bazaar, by the crispy texture of *dosais* and the sweetness of the sesame seed candies, and by the thrill of sneaking off to the mist-covered slope of Coaker's Walk to smoke *beedis* while contemplating the vast spread of the plains, barely visible below.

Ten years later, I found myself returning to the plains of Tamil Nadu in 1986 as a college senior participating in the University of Wisconsin, Madison, Year in India Program in Madurai, one of India's most important centers of Hindu pilgrimage. It was on that program that I first began to struggle with and delight in the innumerable retroflexes and alliterations in the Tamil language. And it was during that year that I began to explore issues of gender in India through visits to a Gandhian women's development project in nearby Gandhigram, through the practice of Bharatanatyam dance, and through a fieldwork project on women's roles in my own neighborhood's nocturnal festival for Mariamman, the goddess of smallpox.

I returned to India and Tamil Nadu again briefly in 1991 and 1993 as an anthropology graduate student trying to formulate a dissertation project which would combine my interest in issues of gender and class and which I felt would have social relevance to people involved in the Indian women's movement.[54] It was during these visits that I was drawn into the field of maternal and child health care and decided to focus on childbirth. And it was this topic which led me to become a medical an-

thropologist. Once again personal experience was influencing my intellectual agenda. In this case, my own stage in the life cycle was a motivating factor, since I was recently married and contemplating having a child myself.

Finally, in January 1995 I returned to Tamil Nadu with my husband and our six-month-old daughter to begin my dissertation fieldwork.[55] We set up home in Besant Nagar, a quiet, newly developed residential neighborhood on the southern edge of Madras. This location enabled me to split my research time between the city of Madras and the semirural community of Kaanathur-Reddikuppam, which lies directly south of Madras, one hour away by bus. Since most of the studies on childbirth in India had been conducted in rural areas, I wanted to look at an urban situation and a semirural community like Kaanathur-Reddikuppam, which was going through a rapid transition in the availability and use of modern MCH services. I spent the year of 1995 in Tamil Nadu, and we all returned to the United States in January of 1996. I then returned to India for a one-month follow-up research trip in May of 1997.[56]

Urban Landscapes: Nochikuppam, Madras

My research in Madras (now officially called Chennai) was greatly facilitated by my affiliation with the Working Women's Forum (WWF), a women's NGO based in Mylapore, Madras, which has branches throughout Tamil Nadu and beyond. It was through the WWF health supervisors and health workers that I was introduced to the residents of Nochikuppam and Bapu Mastan Dargha (BM Dargha), low-income neighborhoods in south and central Madras, respectively. I decided to focus much of my research on the predominantly Hindu neighborhood of Nochikuppam since I felt an immediate rapport with the two WWF health workers who lived and worked there. Therefore the descriptions of Madras field sites which follow will focus on Nochikuppam. My work in BM Dargha was less comprehensive but important for my study since the majority of the residents in this neighborhood were Muslims, and I wanted to be sure to meet women from all three major religious groups in Tamil Nadu, namely Hindu, Muslim, and Christian. Both Nochikuppam and BM Dargha had small populations of Christians as well.

A fishing community, Nochikuppam lies on the southern end of Madras's Marina Beach, the second longest urban beach in the world. Like other beaches around Madras, Marina Beach remained virtually empty all day, scorched by the hot sun. But in the coolness of the evening, it be-

came a fairground. Parents brought their children to play on the slides. Lovers sat together quietly in the secrecy of dusk. And groups of young men met to smoke cigarettes and cool their feet at the water's edge. For the residents of Nochikuppam, Marina Beach was practically an extension of their own beach front, and many set forth in the evening to try to sell snacks to the revelers. The stretch of beach directly in front of Nochikuppam, along its eastern border, was used as a staging ground for all the activities surrounding the arrival and departure of the fishing boats.

The temple of Ellaiamman, a Hindu goddess whose temples reside on the edges of many Tamil villages and towns, lay on the western edge of Nochikuppam.[57] Ellaiamman both defines the spatial parameters of the community and protects those inside the boundary from the dangers which lurk outside of it. She was a special goddess for the fisherpeople of Nochikuppam. Fishermen worshiped Ellaiamman before they set out in their boats; and as their boats pushed out to sea, they sometimes stood to look upon the tower *(kōpuram)* of the temple and pray. Some fisherwomen took pots of milk out to the beach on Fridays and prayed to Ellaiamman from there. They then entered her temple and poured the milk onto the statue of the goddess as a form of worship *(abishekam)*.

As a community grows, it tends to extend beyond the boundary on which Ellaiamman sits. But in Nochikuppam her temple remained the geographic marker of the community since a paved thoroughfare ran along the backside of the temple. The residential and commercial areas which lay on the other side of this main road were connected by paved roads, whereas the government-subsidized high-rise cement buildings and thatched huts of Nochikuppam were connected by footpaths which were dusty in the summer months and muddy and slippery during the monsoon season. Above these narrow footpaths brightly colored saris hung flapping in the sea breeze, drying on poles which connected one high-rise building to another.

With no public roads running through the neighborhood, Nochikuppam remained somewhat secret and closed off from nonresidents. And many people from Madras, particularly from the middle and upper classes, had never even heard of this neighborhood. Those who had knew it for its reputation as one of the poorest and most crime-ridden sections of the city. It was in part because of this geographic boundedness that residents of Nochikuppam would often say their neighborhood was like a village *(iṅka namma kirāmam mātiri)*. This self-definition also referred to the social boundedness of this community, since most of the people living here belonged to the Pattinavar caste. The Pattinavar caste was di-

vided into two subcastes, the Periya Pattinavars ("Big Pattinavars"), said to be the "higher" of the two groups according to caste hierarchy, and the Chinna Pattinavars ("Small Pattinavars"), said to be the "lower." These subcastes were endogamous and their members often married others from the same subcaste within Nochikuppam or from other fishing communities up and down the coast of Tamil Nadu. In the past, this neighborhood was comprised exclusively of Pattinavars. Now, members of other low, "scheduled caste" (SC), or *harijan,* communities have also taken up residence here.[58] While most members of the Pattinavar caste worked in the fishing industry, members of the other caste communities from Nochikuppam were involved in various types of employment, working as fruit and vegetable sellers, snack vendors, auto-rickshaw drivers, or in factories (particularly leather factories). Residents of Nochikuppam likened their community to a village also because of the existence of a kind of informal *panchayat*—a body of local government (traditionally comprised of five members) which made important decisions for the community.

Nochikuppam got its name from the fact that the land used to be covered by a forest of *nochi* trees. The forest was gradually cleared as members of the fishing community began to build huts right along the beach. It was not until 1973 that the cement, three-story "housing board" complexes were constructed on this land by the Tamil Nadu Slum Clearance Board, while Dr. M. Karunanidhi, of the Dravida Munnetra Kazhagam (DMK) party, was Tamil Nadu's chief minister. After the housing board complexes were constructed, the government assigned flats to families based on a lottery system. Each flat consisted of one all-purpose room (used as living room, bedroom, and dining room), one small kitchen, and a bathroom. Often an extended family of six or more lived in one such flat. Initially each family was required to pay the government Rs. 12 per month per flat. In a later power struggle between the DMK and the AIADMK (All India Anna Dravida Kazhagam) parties, however, promises were made to do away with the rent altogether, and that remained the policy in 1995.

Electricity was installed in all the flats at the time of construction, and it was paid for by the flat owners. The supply of water, however, remained the greatest problem in many people's minds. City water was not provided in the flats. Some residents had their own pumps which drew water from the community well, but that water was salty. Most residents got their water from the large water tanks which dotted the road that ran along the eastern edge of Nochikuppam, separating the houses from

the beach. These water tanks, which brought in water daily, were provided by the Madras city government, which is called the Madras Corporation. Each nuclear family was entitled to three large pots of water per day. Although the water was supposed to be free of charge, the truck drivers demanded bribes for delivering the water, so each family gave a small fee (approximately 50 paise/day) to the *panchayat,* which used some of that money to pay off the truck drivers. As in most parts of India, in Nochikuppam the women were responsible for the daily collection of water. This was strenuous labor and often entailed waiting in lines under the hot sun for the water trucks to come.

For most residents of Nochikuppam, life centered around fishing. Fishing set a daily routine as well as created a daily state of unpredictability. Sometimes a fisherman might earn as much as Rs. 2,000 in one day; at other times he might go for weeks with no daily income at all. On average, the fishermen of Nochikuppam earned Rs. 500 (approximately US $14) per month, which came to approximately Rs. 6,000 (US $167) per year. The amount a fisherman could earn depended in part on a combination of skill and fate, and in part on the equipment he could afford. With a motor it was possible to earn up to Rs. 2,000 per day. Without a motor one could only earn up to Rs. 300 per day. The deep-sea fish brought in better profits, and it was only the boats with motors which could go far enough out to sea to catch such fish. The cost of buying and attaching a motor to a catamaran was, however, exorbitant, somewhere in the order of Rs. 26,000. So, despite the fact that there were government schemes and the local Fisherman's Cooperative Society to help purchase motors, for most this remained an elusive dream.

As in most parts of the world, in Tamil Nadu fishing is a highly gendered occupation; only men go out to sea and women are largely responsible for selling the fish. Men would push the boats out to sea around four o'clock in the afternoon. Those boats which went out for shallow-water fishing would return in the evening around nine o'clock; those which ventured out to deeper waters would not return until the following morning. When the boats came onto shore the women from Nochikuppam were there, ready to collect the catch of the day and take it to the market to sell. Some fish were sold directly to buyers who came to the beach when the boats arrived or were sold on the roadside in front of Nochikuppam. The women from Nochikuppam took most of the fish to government-designated open-air fishing markets throughout Madras. Fish which were ear-marked for export were sold to middlemen who took them to an ice house in Chindaraipet near the Madras harbor. And,

finally, some fish were kept for family consumption. The seafood included in the daily diets of most residents of Nochikuppam was nutritionally beneficial to pregnant women and breastfeeding mothers.

Although before marriage many women in Nochikuppam actively engaged in work which brought in cash, such as fish sales or other work in the informal sector or in factories, they often stopped this work after marriage and during their reproductive years. They would then resume such work once their last child was weaned. During their reproductive years, however, women did continue to do non-cash-earning work, such as cleaning fish and prawns and repairing nets, in addition to their heavy workload looking after the household. And some had no choice but to continue to sell fish in the markets even during their reproductive years.

Semirural Landscape: Kaanathur-Reddikuppam

I was first introduced to the Kaanathur-Reddikuppam area by Dr. Vijaya Srinivasan,[59] who had set up a small outpatient clinic in a new retirement community in Muttukaadu, just south of Kaanathur-Reddikuppam. A couple of the health workers at this clinic also worked for the Voluntary Health Services (VHS) in Kaanathur-Reddikuppam, so they became my first contacts in this small town.

The area referred to as "Kaanathur-Reddikuppam" consisted of a cluster of three communities which were adjacent to one another: Kaanathur, Reddikuppam, and Bilal Nagar. In 1995 a main road separated Kaanathur on the west side of the road from Reddikuppam and Bilal Nagar on the east side. Kaanathur and Reddikuppam were the two original communities in this area. Kaanathur was a community made up primarily of "scheduled caste" Hindus and some Christians, many of whom worked as agricultural laborers in the fields away from the coast or as wage laborers on construction projects. According to the Integrated Child Development Services' (ICDS) *balwadi* workers who kept census-type records for the area, agricultural laborers here earned approximately Rs. 4,000 (US $111) per year, and other wage laborers earned approximately Rs. 3,000 (US $83) per year. Generally, men earned more than women engaged in the same kind of work. For example, female agricultural laborers sometimes earned Rs. 15 per day, whereas male agricultural laborers often earned Rs. 30 or more per day.[60]

Reddikuppam was primarily a Hindu Pattinavar fishing community settled close to the beach. As did their counterparts in Nochikuppam, these fishermen earned an average of approximately Rs. 6,000 (US $167)

per year, but their income varied greatly depending on equipment and the vagaries of nature. Prior to the 1980s all the residents of Reddikuppam were living in thatched huts. Over the years, these huts were repeatedly destroyed in fires and then rebuilt over and over again. Finally, during the 1980s, the Tamil Nadu government began building individual cement-block houses for the residents of Reddikuppam. The government requested payment for these houses, but most residents moved into the houses without paying for them. All the utilities and facilities, such as electricity and the water pumps connected to bore wells, had to be installed and paid for by the residents themselves.

All the land occupied by residents of these two communities was owned by one Telegu landowner whose last name was Reddi. Much of the land that was not cultivated and that was not right on the coast was covered with *casurina* trees, which were sold in Madras as firewood. When Mr. Reddi decided to sell off his land, the people from Kaanathur and Reddikuppam joined together and asked for twenty acres. Ten acres went to Kaanathur and ten acres to Reddikuppam. An adjacent ten acres were sold to a Muslim man named Ahmet Khan. Bilal Nagar was a newer Muslim community which was established in the early 1980s when Ahmet Khan practically gave away plots of land at a very low price (Rs. 25/plot) to poor Muslim families. In 1995 these plots were selling for Rs. 10,000–60,000 and being bought by more wealthy Muslim merchant families who were relocating from but maintaining business connections in Madras.

There was a general consensus that the most significant change in this area in people's memory was the laying of the main road from Madras. This project began in the mid-1960s, and originally the road only went as far as Uthandhi, a small town about 1 km. north of Kaanathur-Reddikuppam. Residents of Kaanathur-Reddikuppam then had to walk to Uthandhi to catch the bus. This distance was difficult not only for women carrying basketloads of fish to sell in distant markets or bringing back vegetables newly available from Madras, but also for women in labor who wished to deliver their babies in Madras. The road was extended through Kaanathur-Reddikuppam south to Kovalam a few years later. The bridge which crosses the lagoon in Kovalam, south of Kaanathur-Reddikuppam, was finally built in 1987, enabling the road to stretch beyond Kovalam all the way to Mamallapuram,[61] home of the famous seventh-century shore temples from the Tamil Pallava dynasty. Mamallapuram has long been a pilgrimage destination for Hindu worshipers; with the completion of this road it also became a popular tour-

ist destination and a weekend outing spot for Madrasis. Buses passed through Kaanathur-Reddikuppam regularly on their way between Mamallapuram and Madras.

There was a bus stop in the middle of Kaanathur right at the point where the dirt road led down to Reddikuppam and to the sea. In the mid-1960s there was only one tea stall in this zone between Kaanathur and the road leading out to the sea. In 1995, however, passengers getting down from the bus faced a long row of small shops which ran along the side of Kaanathur parallel to the new road, giving Kaanathur the air of a very small town.

The new road not only enabled people from Kaanathur-Reddikuppam to travel farther for such things as trade and medical care but also provided a direct conduit for the flow of people, goods, and ideas from the metropolis into Kaanathur-Reddikuppam and its surroundings. In fact, ever since the road was built to connect Madras with Mamallapuram, the entire stretch of land between these two destinations had been changing rapidly, transforming from a rural agricultural and fishing area into a major resort area. Amusement parks, health spas, an upscale drive-in theater, new homes for the elderly, hotels, and numerous privately owned vacation homes, also known as "farms" (many of which are owned by nonresident Indians), now dotted the landscape on both sides of this road. One major effect which this development had on residents of Kaanathur-Reddikuppam was that landowners were selling off their plots to these new enterprises, so agricultural laborers from Kaanathur were increasingly turning to employment as construction workers and servants for these resorts and vacation homes. And laborers who previously also owned and cultivated small plots of their own land were selling these off as well, leaving them increasingly dependent on wages from the new developments. Some people commented that this loss of ownership had created a sense of helplessness and depression within the community and that alcoholism was on the rise as a result. Some turned from agricultural work to working in an illicit liquor trade.

The emergence of these new resorts did not have the same kind of immediate impact on the work of the fishing community in Reddikuppam. The fishing industry was, however, significantly affected by the increasing use of new technologies, especially new motors. As in Nochikuppam, some residents of Reddikuppam joined the fisherman's cooperative and could purchase motors at discount rates. People in Reddikuppam were somewhat ambivalent about the merits of these new motors. Although a motor could indeed bring in a much more profitable catch, the invest-

ments required to purchase the motor, the diesel, and repairs to the motors were very substantial, so that anyone who made these investments and yet still did not have a good catch could suffer extreme financial losses. Another significant change in Reddikuppam was the recent arrival of private companies that used aquaculture technology to farm prawns. These companies created competition in the prawn trade and perpetuated the loss of land in Reddikuppam by buying land from poor fishing families who resorted to selling it. These companies, however, did not employ Reddikuppam residents in their operations.

The new road not only ushered in the leisure establishments which catered to the whims of middle- and upper-class Madrasis and other outsiders, but it also brought new institutions (such as schools and medical facilities) and new forms of media (particularly via televisions and VCRs) which were used by the local population. In addition, the road linking local residents more directly to institutions and markets in Madras resulted in dramatic changes in the provision of maternal and child health services in the Kaanathur-Reddikuppam area. The changes in childbirth practices which will be discussed in the remainder of this book need to be seen in the context of these more general changes brought in by the construction of the main road. The following story of Murugesan provides an example of the availability and accessibility of MCH services for birth prior to the building of this road.

When I met him, Murugesan was sixty-five years old and the president of the Kaanathur-Reddikuppam *panchayat*. He lived in one of the largest houses in Kaanathur, a light blue, cement house in a walled-in compound at the far end of the main road. Murugesan was born in Kaanathur and had lived there for most of his life. He told me about changes in childbirth practices which he had witnessed during his lifetime.

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When Murugesan himself was born, a maruttuvacci *(midwife) from the nearby village of Navallur assisted with his mother's delivery and continued to come to their house to help his mother for fifteen days following the delivery. Murugesan explained that the* maruttuvaccis *in those days were very knowledgeable about children's diseases like* māntam *(infant indigestion) and* iṛuppu *(fits) and that they prepared their own medicines with herbs* (mūlikaikal) *to treat these diseases.*

Murugesan himself had had nine children, of which only three had survived. His first wife had had two children but only one survived, and

that wife died in childbirth. The second wife, who was his first wife's younger sister, had had seven children and only two of those children survived. All of the children had died before they reached the age of three, and most died within one year. The first child of the first wife was born at home with a maruttuvacci *and died after 28 days. The second baby was also born at home and six days later his wife got* ja<u>nn</u>i *(fits with a fever; in childbirth this often refers to tetanus). The people in the community thought that she was possessed by some spirits and they called the* maruttuvacci *to provide a cure. The* maruttuvacci *gave his wife a* ja<u>nn</u>i *tablet along with* cukku *(dried ginger). But this did not cure his wife and her condition was deteriorating rapidly. It was decided that since the situation was so dire it was necessary to take his wife to Kasthurba Gandhi Hospital in Madras.*

There was no main road to Madras in those days and therefore no buses. The journey was long and arduous so people did not consider going to the Madras hospitals when a woman's labor began. Only if an emergency arose would they make the voyage as they did with Murugesan's wife. It was 9 P.M. *when they strapped her onto a board and transported her by bullock-cart to the canal. It was December and the night was cold. At the canal they boarded a small sailboat and sailed to Thiruvanmiyur. It took seven hours to reach Thiruvanmiyur from Kaanathur. From Thiruvanmiyur they went by horse-cart to Adyar. And from Adyar they could take a bus to Kasthurba Gandhi Hospital. They reached the hospital at 7:30* A.M. *There was a doctor there who attended to them. The baby survived but his wife died in the hospital two days later. That was in 1952. It had taken them ten and a half hours to reach Kasthurba Gandhi Hospital from Kaanathur. In 1995 they could travel that distance within an hour.*

His second wife's first child was born in the Andhra Sabha Hospital near the Adyar bridge in Madras. They had gone to the hospital in advance to avoid the complications which his first wife faced. That baby died from diarrhea after ten days at home where they were treating him with nāḍḍu maruntu *(country medicines).*[62] *The next four babies were all born at home and all died. They were growing concerned, so for the next delivery they went to Kasthurba Gandhi Hospital in advance. That child was healthy until he was nine months old and got severe diarrhea. They took him to the hospital and the doctors said there was no hope to save him. So they brought him home and called the* maruttuvacci, *who gave the child* nāḍḍu maruntu *made out of nutmeg* (jātikkāy), *clarified*

butter (ghee), and honey, and the child was revived within fifteen days. The seventh child was also born in the hospital and never had any serious illnesses.

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Murugesan and others of his generation all told me that before the bus route had been established in the 1960s almost all deliveries in the area took place in the home and were assisted by a *maruttuvacci*. Only in extreme emergencies were women, like Murugesan's first wife, transported to Madras for hospital attention. It was because of the death of his first wife and the deaths of so many of his children born by his second wife that they had taken the trouble to have three of her deliveries in the hospital in Madras. Murugesan came from one of the wealthier families in Reddikuppam and had received more education than others in the community at the time. He said that his wives' visits to the hospitals in Madras were unusual within the community, where most could not afford the time and money required for these trips.

Everyone told me that since the road had been laid and the buses had begun to ply this route, women were all "running to the hospital for deliveries." In fact this was not quite true. What was no doubt true was that there had been a marked increase in the number of women traveling to hospitals for deliveries. But many women I met in 1995 had had their deliveries at home. I decided to gather some statistics on the delivery sites for women in this area during the time of my research.

Based on the records of the Kaanathur Voluntary Health Services mini-health-center and the ICDS *balwadis* in both Kaanathur and Reddikuppam for the period from November 1994 to November 1995, I found that the total number of deliveries during this time period for the whole Kaanathur-Reddikuppam area (including Bilal Nagar) was sixty-one. Of these, twenty-nine were home deliveries, thirty-one were hospital deliveries, and one was unknown. As these records indicate, slightly less than 50 percent of the deliveries took place at home, and slightly more than 50 percent occurred in a hospital. These numbers clearly represent a region going through a transition with regard to maternal health care. In Nochikuppam, Madras, on the other hand, there were no home deliveries at all during 1995.

These two communities—Nochikuppam and Kaanathur-Reddikuppam—are similar and different in ways that are important for understanding women's experiences during childbirth. Both were, for the most part, poor communities which relied heavily on government-subsidized

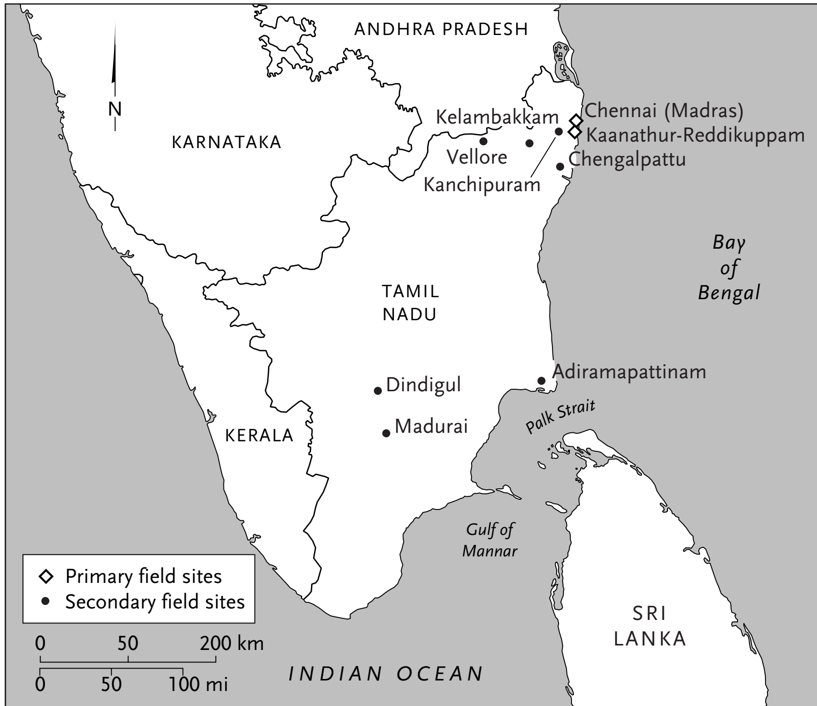
support for many aspects of life, including maternal and child health care. Both also received NGO support for MCH services. Both were comprised primarily of a combination of Hindu Pattinavars engaged in fishing and "scheduled caste" Hindus engaged in wage labor in the informal sector.

The major differences between these two communities as far as this study is concerned was that Nochikuppam was located right in the city of Madras and women had had easy access to government-subsidized MCH care in the city for a few generations. Furthermore, the government had been actively working to prevent home births from occurring in urban centers. For women in Kaanathur-Reddikuppam, however, this access had been greatly restricted until the 1960s, and there had not been such an active effort on the part of the government to prevent home births in the rural regions.

Because of their similar class and caste backgrounds, women from both these communities faced many of the same difficulties and forms of discrimination in government maternity wards during childbirth, which will be discussed. The women from Nochikuppam had few means of circumventing this discrimination, since home birth was no longer considered a viable option. Women in Kaanathur-Reddikuppam, however, sometimes chose to remain home for their deliveries to avoid the discrimination they faced in the government maternity wards. But they were demanding new birth practices in their homes which incorporated those elements of allopathic MCH care which they considered to be beneficial.

FIELDWORK, FRIENDS, AND FAMILY

My research consisted primarily of structured and unstructured interviews with over seventy pregnant and postpartum women and their families in their homes and in public maternity wards. Most of these interviews were tape-recorded, transcribed, and translated with the help of research assistants. Those interviews that were not tape-recorded were recorded with notes on-site. I also interviewed a range of medical practitioners, including doctors, nurses, hospital *ayahs,*[63] both governmental and nongovernmental female multipurpose health workers (MPHWs),[64] and local midwives. And I observed interactions between these workers and their patients in hospitals and homes. (See Appendix I for samples of the questionnaires used for these interviews.) In addition to observing medical procedures in hospitals and discussing childbirth in homes and hospitals, I also had the opportunity to observe, and



Map 2. Field sites in Tamil Nadu, Indian, 1995.

in some cases videotape, pregnancy and postpartum rituals and bathing and dietary practices in a variety of settings.[65] Finally, I interviewed governmental and nongovernmental administrators working on women's health policy issues at the state and national levels.

My research in Kaanathur-Reddikuppam and in Madras was supplemented by brief visits to low-income communities in and around several other cities and towns throughout Tamil Nadu, including Chengalpattu, Madurai, Dindigul, Vellore, Kanchipuram, and Adiramapattinam (Tanjavur District) (see Map 2). The visits to Chengalpattu were facilitated by a local organization called the Rural Women's Social Education Centre (RUWSEC). All other visits were arranged by the Working Women's Forum. In each place I met with the same range of people whom I met in my primary research sites. The purpose of these visits was to see to what extent the information I got in Madras and Kaanathur-Reddikuppam was generalizable for Tamil Nadu as a whole.

I also conducted a brief study in the maternity ward at Apollo Hospital, a prestigious private hospital in Madras catering to a wealthy clientele. Although I do not delve into the details of this research, my findings there serve as a comparative backdrop to my discussion of maternal care for lower-class women. Finally, I gathered government documents and other materials relating to the history of MCH policy in Tamil Nadu from both the Tamil Nadu State Archives and the library attached to the Tamil Nadu Department of Public Health.

Many people have asked me whether it was difficult to get women to speak with me openly about their childbirth experiences. The assumption seems to be that such a topic, which deals with women's reproductive bodies, would be too personal or embarrassing to discuss or would even be taboo in the Indian cultural context. Although it is true that women felt embarrassed to discuss these matters openly with men and that mothers and daughters often did not discuss these things, what I found was that in general this was a topic which women were very quick and even eager to discuss with me and with each other once they had already been through the process of childbirth.[66] (Women who were pregnant with their first child tended to be much more reticent.) In fact, I often found that I would begin a conversation with one woman in her home and within a half hour four or five other women in the neighborhood, who had gotten wind of the conversation, would join us, eager to add their commentary on the subject. This made for lively discussions but made it excruciatingly difficult to tease apart the diverse voices in the process of transcribing taped interviews.

One of the reasons that women seemed comfortable discussing these issues may have to do with the fact that there has been such a longstanding infrastructure of governmental and nongovernmental health workers going into people's homes to collect health data on families and to educate about and advocate in favor of family planning and MCH care. Initially many women assumed that I was in fact some kind of governmental or nongovernmental health worker. At first this was somewhat of an impediment, for I found that many women seemed to be feeding me opinions and stories which would support the family-planning and MCH propaganda they were so used to hearing. At other times, the assumption that I was a government representative had the opposite effect and women saw me as a vehicle for making demands on the government to improve MCH services in their communities. My hope is that my writings on this topic will in fact serve this purpose. The other most common initial misconception about my role was the assumption that I

was a doctor, and women came to me with complaints of a variety of ailments.

When it became clear that I was neither health worker nor doctor, but rather that I was a medical anthropologist who was as interested in learning about the details of religious ritual activities surrounding birth and about the use of local herbs and dietary practices as I was in learning about women's allopathic concerns during childbirth, some women grew frustrated and felt that I was wasting their time. Others became more and more intrigued and welcomed the fact that I took a genuine interest in some of their non-allopathic practices rather than coming to condemn such practices as harmful and superstitious. And those women who were intrigued by the nature and scope of my inquiries were also curious to know about practices and beliefs surrounding childbirth in America and came to view our conversations as cross-cultural dialogues.

The fact that I had a child myself made an enormous difference in the nature of our discussions. When I talked with women about childbirth during my trip in 1993 I did not have a child of my own. And just as women were reluctant to discuss the details of their birth experiences with their daughters or daughters-in-law who had not yet had their first child, they were hesitant to speak freely with me about this subject. In part there was a sense that it was taboo to do so, and in part there was a sense that I simply would not and could not understand. When I began my research in 1995, however, and explained to women that I had a child myself and told them about my own birth experience, they were much more at ease talking with me. The difference did not only lie with their attitude toward me but also with my attitude toward them. Having been through childbirth myself I did feel as though I could understand their experiences more fully, despite the social and cultural factors which made our birth experiences vastly different. Having been through it myself, I felt I had a much better base of phenomenological, social, and biomedical knowledge from which to formulate questions and respond to inquiries.

Many anthropologists have commented that it must have been a great "in" to have had my very young daughter, Lila, with me; that it must have helped me gain acceptance in Indian society, and that this must have benefited my research immensely, especially given the topic of the research. In my more cynical moments, the implication of these comments seemed to be that having a baby must be even better than the traditional anthropological props, like cigarettes and money, for getting "informants" to take you into their homes and divulge their secrets. It

was wonderful to be living in Tamil Nadu with my family and sharing with them a part of the world which has long been a central part of who I am. It was particularly significant to me that Lila was starting out her life with an experience that I hope will influence her lifelong perception of the world. The fact that her first words alternated between English and Tamil was somehow very touching. And of course having a young child did in many ways open doors to friendships as she and many of our neighbors' children played together every day. My research, however, was not focused on my immediate neighborhood but rather required me to commute all around the city, down to Kaanathur-Reddikuppam, and occasionally farther afield to other parts of Tamil Nadu. It did not make sense to drag her along with me wherever I went, into hospitals, homes, government offices, and libraries. In fact, I felt that because of the demands of her age (six months to one and a half years), having her with me during my research would have been disruptive and would have made it very difficult for me to concentrate on what others were saying or doing. Instead, most of the time Lila remained home and part-time in a local day care, and I had to contend with being a somewhat frenzied working mother in India just as in America.

OUTLINE OF THE CHAPTERS

For the most part, each chapter in this book addresses a different aspect of the modernizing process and analyzes the impact that this process is having on poor women's experiences during childbirth in Tamil Nadu. In addition to its thematic organization, the book is also organized loosely according to the chronology of the experience of childbirth itself. Thus, Chapters Three through Six emphasize pregnancy, delivery, family planning, and the postpartum period in consecutive order. Family planning is placed in between delivery and the postpartum period, since certain contraceptive methods are undertaken in hospital maternity wards before mothers return home from their deliveries. I have taken this chronological approach in the hope of conveying some sense of the flow of the experience of childbirth for the women whom I met.

Chapter One addresses the theme of the professionalization of obstetrics as one aspect of the modernizing process. Focusing on the colonial period, this chapter provides a background for understanding the historical context within which the profession of obstetrics emerged in India. As in other colonial contexts, the issues of childbirth and of the professionalization of obstetrics played a critical role in the civilizing

discourse of colonialism in India.[67] Chapter Two shows how the debates and policies regarding the professionalization of obstetrics during the colonial era are reflected in official structures of maternal and child health care in the postcolonial era. This chapter also describes the maternal and child health care services available to women for childbirth in my particular field sites in Tamil Nadu in 1995. Chapter Three looks at the value placed on consumption as a central marker of modernity in the contemporary global order. In India this has become particularly apparent in the context of post-1991 liberalization policies. Increasing consumer orientation has intensified and transformed pregnancy rituals in Tamil Nadu in such a way that these rituals publicized the auspiciousness of women's fertility while simultaneously becoming an important context and conduit for the exchange of consumer goods from a pregnant woman's kin to her in-laws, resulting in the construction of poor pregnant women as, what I call, "auspicious burdens." Chapter Four examines the use of modern technologies which alter the nature of pain during delivery. Most of the women whom I met in Tamil Nadu wanted to have their labors medically induced with oxytocin drugs and were unaware of the possibility of using anesthesia and wary of this notion when presented with it for the first time. The particular use of pain medication among poor women in Tamil Nadu both draws on and transforms cultural constructions of women's reproductive bodies, and of female power, or *sakti,* and is influenced by political-economic constraints of public maternity wards in Tamil Nadu. Chapter Five takes on the theme of population-control programs in the modern era, particularly as these programs have been implemented in the context of postcolonial international development projects. The internationally driven family-planning agenda has long overshadowed all other aspects of maternal and child health care in India, and Tamil Nadu has been touted as a model state in this regard. In this chapter, I show how this impacted poor women's experiences during childbirth. Chapter Six addresses the transnational discourse of "development," in its myriad forms, as a central element in the postcolonial modernizing process. I examine the postpartum period as a key site within which such discourses of development were maneuvered in Tamil Nadu. In particular I discuss the ways in which discourses of development constructed non-allopathic practices and systems of knowledge surrounding the mother's and baby's postpartum diets and baths as "unscientific" and therefore not only dangerous but immoral.

The issue of how poor women in Tamil Nadu made decisions about what kind of care to seek during childbirth is filtered throughout the various chapters of this book. This issue of "choice" is the central theme of the conclusion. By focusing on Kaanathur-Reddikuppam as a community in transition, this chapter examines how new constructions of maternity which emerged in the context of the modernization of childbirth in Tamil Nadu simultaneously compelled women to seek and repelled them from seeking childbirth-related care in allopathic institutions. Although some women were "choosing" to remain home for deliveries, they usually claimed to do so to avoid specific class-based forms of discrimination in hospitals, rather than to rebuke allopathic obstetrics itself. Some women said they were choosing to remain home only *because* new allopathic procedures were being introduced into the home-birth context. This is a specific form of resistance to a specific form of biomedicalization. This response does not necessarily reflect greater reproductive choices for these mothers. In fact, it could, potentially, have negative consequences for their health and the health of their babies.

With improvements in quality and monitoring, however, home-birth care could provide a model for women of all socio-economic classes in rural and urban India. Such a movement should not, however, be pursued at the expense of redressing the serious problems of discrimination within the public maternity hospitals.