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The Place of Birth: Childbearing and Kinship in Calcutta Middle-Class Families

Henrike Donner

Hospital births were introduced to India during the colonial period but became a popular option during the 1960s. Today they have replaced "traditional" home birth among the urban middle classes, and a significant proportion of hospital births are elective Caesarean sections. In this article I examine this mode of birth in the context of specific marital and residential patterns and cross-generational accounts of birth among middle-class women in Calcutta. By paying close attention to affinal relations and the meaning of kinship for birthing women, I challenge assumptions regarding the positive aspects of previous, less medicalized, modes of birth and explore how the shift towards Caesarean sections does not merely signify an unquestioning acceptance of an alienating allopathic regime. The ethnographic accounts of different experiences of childbirth show that the medicalization of childbirth should be situated within the context of wider kin and class relations that affect women's choice and their sense of agency.

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Key Words: hospital birth; Calcutta; kinship; caesarian section; childbirth

INTRODUCTION

This article deals with changes in childbearing practices and women's views on "medicalized" childbirth in middle-class families in Calcutta and, more specifically, with the meaning of Caesarean sections as the preferred mode of delivery. The place of birth, whether at home or in an institution, has been an important theme in recent debates on the medicalization of childbirth and reproduction. Within mainstream discourses medicalized childbirth has been hailed as a sign of economic and social progress, an indicator of development, and notions of modernity. But advanced technologies, monitored pregnancies, and specialist intervention have also been criticized. In particular, the feminist critique of this process and associated practices has focused on the issue of hospital births and professional interventionist technologies. Thus, how and where women give birth is a highly ideological issue. Even if we assume that the objective of research is the well-being of mother and child, which is arguably not always the case, how the relative well-being of both is construed within the process remains subject to intensive popular and scientific debate.

Anthropologists have contributed to these discussions in two ways: first by demonstrating that a wide range of understandings, techniques, and practices co-exist in non-Western contexts. For more than two decades, pregnancy and birth have been explored from a comparative perspective (Jordan 1993 [1978]; Oakely 1979; MacCormack 1994 [1982]; Davis-Floyd and Sargent 1997). This "anthropology of birth" emerged as a critique of hospital births in the West—and, as such, has been hugely influential in providing middle-class women in Euro-American countries with accounts of alternative practices. The heterodox perspective, which challenges the medicalized understanding of birth prevalent until the 1970s, has helped to contest existing hegemonic discourses.

Second, anthropologists and historians have begun to analyze the discourses surrounding changing ideological and practical patterns of reproduction, especially those relating to colonial rule and processes of globalization (Crouch and Manderson 1993; Ram and Jolly 1998; Guha 1998; Hunt 1999; Ginsburg and Rapp 1995a). The early critique of the "medicalization of childbirth" that brought about the

anthropology of birth as the study of "indigenous" and "traditional" practices has given way to an understanding of reproduction, which is less inclined towards studying static culture-bound traditions. In this context and overlapping with development concerns, hospital births emerge as an increasingly important subject of anthropological study.

This article is part of the growing number of ethnographies concerned with hospital births in the "developing world," and, more specifically, in South Asia, where infant and maternal mortality rates are high and healthcare systems are either inadequate or non-existent. Where the study differs from others, however, is in its focus on a minority that has privileged access to an unusual degree of healthcare services; namely, the Indian middle classes. Unlike much of the existing literature on hospital births, this article explores pregnancy and birth within domestic and kin relationships and as part of class-based identities. Furthermore, what is investigated in this specific context is why, given that "women collaborate ... because of their own needs and motives, which in turn grow out of the class-specific nature of their subordination" (Riessman, cited in Jacobson 2001:222–223), women choose high-tech interventionist deliveries. Specifically, why do younger women prefer Caesarean sections?

The article examines how different modes of birthing are evaluated among Bengali middle-class women in Calcutta. I argue that the recent shift towards elective Caesarean sections does not merely signify a new pattern of consumption and the acceptance of a supposedly modernist allopathic regime; instead, I suggest that an analysis of these patterns must situate different birthing experiences and the medicalization of childbirth within a specific domestic setting that affects women's experiences and ultimately determines their sense of agency.

The role of the contexts within which childbirth is situated is highlighted throughout by an exploration of kin relations and childbearing on three different levels; namely, the shift from birthing in the natal home to spending the pre- and postpartum period in the house of affines, from home birth to hospital birth, and from "normal deliveries" to Caesarean sections.

The maternal histories presented in this article refer to middle-class women, although during some of the interviews working-class women (e.g., maidservants) were present and contributed to the discussion as well. Except for medical surveys, such as the study of

hospital births in Chennai undertaken by Pai, Sundaram, Radhakrishnan, Thomas, and Muliyil (see Pai et al. 1999), such material is rare, and these studies lack the detailed analysis of the context that long-term fieldwork can provide.[1] The focus on the middle classes is relevant because the middle classes serve as a reference group for marginalized communities and "the poor." Perceptions and attitudes of middle-class men and women, who are involved in the promotion of concepts and services as consumers, medical professionals, planners, and social workers, are crucial for the development and implementation of public programs and private enterprise in the health sector—programs and enterprises through which choices are made available to those who are less privileged. Furthermore, there is a trickle-down effect evident in urban areas, where this model is particularly pronounced, and where the expanding middle classes live in close proximity to the urban poor. In Calcutta, as elsewhere, many poor women give birth in hospitals, and anecdotal evidence suggests that the majority are well aware of the possibility of having an elective Caesarean section in a government hospital for a fee.

Most of the women interviewed in the course of the fieldwork are Bengali-speaking Hindus, but a sizeable minority are Bengali-speaking Christians or belong to northern business communities.[2] One neighbourhood is a mixed and densely populated area (Mukherjee 1993:22–48; Nair 1990:13), whereas the second emerged after the partition of India with the settlement of East Bengali Hindu refugees and is therefore more homogenous in terms of ethnic origin and class (Bose 1968:33–34).In this article the term "middle class" is based on the self-definition of those interviewed, who ascribe to common denominators of middle-class status. Although it does not refer to a homogenous group in terms of economic standing, all women interviewed agreed that a common middle-class lifestyle exists among members of the Bengali-speaking community. The term was used in the same manner by Dickey's (2000:465) more affluent informants in Madurai, who referred to a tripartite model consisting of the poor, the middle class, and the upper class. Within the middle class, a household might be perceived as "lower," "middle," or "upper" middle class. These distinctions are dependent on achievement of upward mobility, professional (male) employment, and English-medium education. But, the coherence of the sample derives from shared consumption, marital, occupational, and residential patterns among these Bengali middle-class households.

The related common values overrule variations of caste (Béteille 1996; Donner 1999). Although the middle classes may appear as highly stratified, a specific ideal form of domesticity and gender relations—along with the values, consumption patterns, and the lifecycle expectations that go with it—are significant markers of such middle-class identities (Dickey 2000:466).

The article is based on interviews with women in 37 households during extensive periods of fieldwork between April 1995 and August 2000. The material was collected in two neighbourhoods of Calcutta during the course of semi-structured interviews that, for the most part, took place in the homes of the women being interviewed. All but two women presented their stories in Bengali, and on many occasions more than one woman was present. Consequently discussions included relatives, neighbours, and servants. These interviews were part of a larger project on gender and changing relationships within middle-class households in the course of economic liberalization, and the material I refer to as ''maternal histories'' formed part of wider narratives.

During fieldwork only four births occurred in these households, partly because many women were already mothers of adolescents, and partly because the birth-rate in middle-class households is low (none of the women who gave birth during the past ten years has had more than one child). In two cases I was able to visit the pregnant woman/young mother before and/or after the delivery, and visits in hospital and further informal conversations with friends and medical practitioners provided ample evidence to support the generalizations drawn from the home interviews. The focus of the interviews and the visits was on women's experiences and the context within which they and their relatives placed childbirth rather than on the views of specialists concerned with the pros and cons of specific procedures. This focus might have limited my discussion of the physical effects of reproductive change, but, if we are to analyze the impacts of technology and changing reproductive patterns, then such a ''domestic perspective on birthing'' is at least as relevant as is a ''specialist'' perspective.

Most of the households included members of two or more generations, and this extended, or ''joint,'' setting is the stated ideal for all middle-aged women. Younger, recently married women hope to form a nuclear household at one point, but the patrilocal norm ensures that most women spend a considerable time (if not their whole lives) in their in-laws' houses. Not surprisingly, their

emphasis is clearly on "traditional" family values, and women's orientation towards their roles as mothers and housewives is very pronounced, regardless of whether or not they are employed (Chatterjee 1993:35; Varma 1998:166; Standing 1991).[3] Although some of the younger women were working "outside," the percentage of married middle-class women in employment is very low in Calcutta, and "working women" are expected to leave employment on the birth of their first child.[4] With the birth of a child, preferably a son, mothers devote themselves entirely to the education of their offspring, and employment rarely contributes to this objective.

CHANGING HOSPITAL BIRTHS: TWO CASE STUDIES

The following case studies present the experiences of two women, each belonging to different generations, who gave birth in hospital. They highlight the degree to which hospital deliveries have changed since they first became popular in the 1960s. The first case study is compiled from different interviews and recollects the experiences of women now in their fifties. The second is a detailed account of the circumstances surrounding the birth of Akash, the son of Madhushree and Amrit Chowdhury, who was born on February 25, 2000.

Case Study 1: Ila Chakraborty

At the time of the interview, Ila Chakraborty was in her mid-fifties and lived with her husband and two sons in an affluent South Calcutta suburb. Like most of their neighbours, her family members were refugees from East Bengal. She married at the age of nineteen and spent many years with her in-laws before her husband, who is a contractor, could afford to build the very spacious house they inhabit today. During that period her three children were born, and Ila Chakraborty says that she enjoyed life in her in-laws' house most of the time, her relationship with her mother-in-law and elder sister-in-law being good for many years. She nevertheless appreciated the autonomy she gained once she and her husband separated from the extended family, a move that she asserts resulted from tensions in the in-laws' house caused by her younger sister-in-law.

Looking back at her experience of pregnancy and birth, Ila presented her maternal history in the light of her twenty-eight-year-old

daughter's marriage and the recent birth of her granddaughter, which were very important themes at the time of the interviews. When Ila gave birth, she was the younger of two daughters-in-law in a household consisting of three married couples, their children, and unmarried relatives. Though her mother-in-law rarely allowed her to visit her parents, who lived a short bus ride away, she asserted that her in-laws and her parents got along very well. And she was keen to point out that her own daughter's in-laws make her feel equally welcome. Either she or her husband visited her daughter, who married into the family of a business partner and lives nearby, every day. They arranged the match with a less affluent family because the daughter lacks looks and left school before the final exam. But her mother emphasized that she is a real pearl, an old-fashioned daughter-in-law, and as she now lives with her husband's wider family, she is an asset to the household.

"My daughter does all the cooking, although they have two servants. In my own in-laws' house the in-marrying women were exempted from any hard work but looked after the food and the children—that was enough for us."

The division of work among women in the household was also used as an explanation of the fact that Ila's own in-laws did not send her to her parents' house when she was pregnant with her firstborn; instead, the girl was delivered in a nearby nursing home chosen and paid for by her affines.

When I was pregnant I did not go to my natal home but remained in my in-laws' house, although this is our custom and women should not work for a month after the birth. I gave birth to my daughter in a nursing home nearby and the sons were born in another one. I did my two check-ups during each of the pregnancies but everything was fine, I did not have any problems—not like my daughter who needed months of bedrest. Of course I suffered from nausea, but that did not stop me from working because my mother-in-law did not allow me to work less. So I worked until the end. If I was sick I threw up and got on with it, although when I was pregnant with my daughter I got sick by merely looking at a glass of water and could hardly eat anything: no rice, no fish, only curd.

Reflecting on her deliveries she said:

When the pain came, I told my sister-in-law and when it got worse and worse I was brought to the nursing home by my brother-in-law. At that time husbands, or their parents, would not accompany a woman about to give birth. My mother-in-law was too old anyway, she came the next day to look

at the grandchild. There was a nurse with me, who did all the check-ups, but the doctor delivered the child. I had spent a lot of time worrying what would happen, whether I would be able to cope with the pain, whether the child would be all right ... at that time we didn't know whether the child would be a boy or a girl: we didn't have ultrasonography then. Today doctors can tell, but they won't say. In my daughter's case the doctor could tell, he saw it and said, "Look here is the head, here is a leg." And her husband said to her that he believed it would be a girl. They used to tell you the sex, but then there were these arguments about it and since then they will not tell anymore.[5] Because some people abort girls they stopped telling you. I did not care about the sex of my first child, but with the second one I hoped for a boy and everybody said this will be a boy. After the birth of my second child I realized why people could tell: the birth of a boy is much more easy than the birth of a girl and one can tell in advance because their heads are shaped differently. When I gave birth to my daughter I was already in labor when I arrived at the nursing home, that was around nine o'clock in the evening. They said then after some hours that they would use forceps to get her out, because it took so long. It was terrible and very hard. In the case of my first son the water broke, and I went to the nursing home, but nothing happened so they gave me an injection because I had no contractions for two days after that. They thought they would have to do a "caesar," but that did not happen and after three hours he was born.

Like others, Ila then described the birth of her second son in detail and concluded that she had then had enough: "I thought, I won't do that again—never again." She remained in hospital for two days after each delivery and had a check-up some time later, but since there were no complications this seemed of little significance. When she returned to her in-laws' house she was allowed to "rest" for about two weeks. When the customary period of confinement, which in the case of her sons lasted for 21 days, was officially ended by a *Shasthi puja* on behalf of the newborn, she had already returned to the hearth and resumed her duties.[6]

Case Study 2: Madhushree Chowdhury

Madhushree, who gave birth while I was doing fieldwork in 2000, lived next door to the Chakraborty family in her in-laws' house at the time. She was twenty-eight and had been married for two years. She was three months pregnant in October 1999 when my last period of fieldwork commenced, and I paid regular visits to the household, during which I talked to her and her mother-in-law before and after the birth of her son.

At the time, the Chowdhury household consisted of Madhushree and her husband and his parents as well as a live-in servant. Unlike most of the women interviewed, Madhushree was employed: she worked in the billing department of Nokia telecommunications when she became pregnant, while her husband worked as a representative for another multinational company. Her husband's mother had been the manager of a prestigious nursing home before her children started secondary school and she became a housewife, while his father was a government engineer. They built the three-storey house, which was occupied jointly by both couples, about fifteen years earlier.

When I decided to visit the Chowdhury family on the 25th of February around noon, I anticipated that Mrs. Chowdhury—Madhushree's mother in-law—would be at home alone since Madhushree had been on sick leave for some weeks and had gone to stay with her mother for a couple of days. She was due to give birth by the middle of March but expected an elective Caesarean to take place some time before that date.

When I arrived at the house, I found Mr. Chowdhury fast asleep at home, while Mrs. Chowdhury had just taken her morning bath and attended to the deities. Upon seeing me, she exclaimed that I had chosen a good and auspicious day to come since Madhushree had been delivered of a boy in the morning. We settled down for a cup of tea in the living room, and she began to recount the events of the last twenty-four hours, leading up to the birth of her first grandchild.

Madhushree had called the previous evening and complained about discharge, so Mrs. Chowdhury contacted the doctor, who was an acquaintance of hers. The doctor advised rest but reviewed her recommendation and offered to do a Caesarean section early the following morning since her medical "team," consisting of herself (an obstetrician), an anaesthetist, and two nurses, would be assembled in one of Calcutta's most prestigious nursing homes to perform a series of Caesareans. Working from midnight onwards, they could easily "slot" Madhushree in, and to help them with the decision the doctor had emphasized that it was unlikely that the team would meet closer to the original estimated date of delivery. After many phone calls Madhushree, her mother-in-law, and her father-in-law had agreed, though regrettably Amrit, the father-to-be, was on a training course in Mumbai.[7]

Around 5:30 AM the Chowdhurys had gone to Woodlands Nursing Home, where they met Madhushree, her brother, and her

mother. After assisting her with the formalities, the visitors settled in her room, and shortly afterwards she was wheeled into the operation theatre.

About twenty minutes later the remaining relatives were joined by Amrit's sister, her husband, and his female cousin, and shortly after that the doctor returned and announced the birth of a baby boy. They were also given his weight and the exact time of birth – necessary to compile astrological charts – and then a nurse brought the newborn in. Before he was transferred to the adjacent baby room, she ensured that one of the elder relatives checked the sex of the baby.

Mrs. Chowdhury's account ended here, and she got up to make phone calls to relatives. Thus, I never got the opportunity to ask her about the health of her daughter-in-law, which she had not mentioned at all. When Mr. Chowdhury appeared a little later he reluctantly revealed more details, but he was clearly not comfortable with my questions regarding Madhushree or the baby. I was then invited to accompany them on their afternoon trip to the nursing home, where we were received by a former colleague of Mrs. Chowdhury who was employed in the laboratory and "had kept an eye on mother and child."

The nursing home, located in one of the best areas of Calcutta, is housed in a purpose-built building, which reflects the tastes of its affluent private clients. From a huge marbled hallway, elevators and a staircase lead to the wards, which are modern, well-maintained, and consist of spacious rooms with up to four beds. When we entered her room, Madhushree was awake and, on seeing her mother-in-law, complained about thirst and pain in her lower abdomen. Mrs. Chowdhury went to find a nurse and to get some painkillers, and afterwards produced a claim form from Madushree's insurance for her daughter-in-law to sign. Later on they discussed whether Amrit, the absent father, should return earlier from Mumbai but both agreed that it would be a waste of money.

In the meantime, Madhushree's mother and her brother had arrived and were led in by Mr. Chowdhury, who had effectively assumed the role of a host, which he performs on festive occasions in his own house. Given the fact that the presence of men and, indeed, a father-in-law at the hospital bed of a woman who has just given birth is a new phenomenon, and may well make the latter feel very uncomfortable, he resigned himself to meeting visitors in the corridor. There were so many of them that one hour later (and ten hours

after the "operation") the room was crowded by relatives, friends, and neighbours who had come to "see the newborn" before they proceeded to greet Madhushree. Most visitors commented on the size and weight of the baby, the skin color and other characteristics, and made some remark relating its more obvious features to his father's looks. In all these conversations his mother's contribution was downplayed because as a son the boy was expected to be like his father.

Three days later I returned to the hospital with my partner and one-year-old son, where we met the Chowdhurys, Madhushree's mother and brother, and some friends who were chatting with Madhushree. She was still in bed propped up against some pillows but had been walking around before and said that she felt much better. Her main complaint was that the nurses did not bring the baby in often enough ("rooming in"—the facility to have a newborn stay in the same room as its mother—is not offered by exclusive hospitals like this) but seemed to enjoy the attention of her guests.[8]

Though she was in good spirit, among the affines the sense of relief, which had united her in-laws and her mother and brother during my first visit, had given way to palpable tension. This related to the question of where Madhushree and (in the eyes of her in-laws, more importantly) the newborn would stay once she was released from hospital. Though the matter was not openly discussed, we witnessed a silent battle and got to know that both camps had stocked up on equipment and extra help to take care of mother and child.

In the end, the Chowdhurys were overruled by their strong-willed daughter-in-law, who took advantage of the custom that allows a young mother to spend some time in her natal home before and after the birth. Her wish to move to her natal home was supported by the ill health of her widowed mother. While her in-laws had helplessly looked on as Madhushree manipulated notions of customary rights and filial duty to her advantage, they also had to accept that Amrit also spent the month-long "confinement" in his wife's mother's house. The resulting tension between the various parties surfaced openly during the *Shasthi puja*, which took place in the Chowdhurys' house a month later. On this occasion, Amrit made clear that he was determined not to accept his parents' attempts to marginalize Madushree and her family's relation to his son, and at one point an argument between him and his father broke out.

The guests, relatives, friends, and neighbours had assembled to greet the young couple and baby Akash, who, in their view, had finally found his way into his paternal patriline (*bangsha*) and arrived at his future home.

THE ANTHROPOLOGY OF BIRTH

Since the publication of Brigitte Jordan's seminal comparative work, "Birth in Four Cultures," the anthropology of childbirth has consisted of a critique of the medicalized, obstetric perspective on childbirth (Jordan 1993:4–6). The numerous cross-cultural studies that followed show the heightened interest in alternative childbearing practices and the concern with changes in traditional ways of birthing. It is within this context that authors like Davis-Floyd and Sargent (1997:5) emphasized the need for anthropological studies of childbirth that "actively seek ways to enhance [this] potential for complementarity."

Following earlier explorations of "other" models of childbirth, scholars have recently focused on the effects the imposition of such a "Western model" has on existing practices and meanings within a wide range of regional settings. Authors such as Jordan came to the conclusion that the medicalization of childbirth has more negative than positive effects, and this critique is perhaps most forcefully articulated by those who study hospital births within various contexts (see Stephens 1986). This recent interest in the exploration of non-traditional, medicalized childbirth (see Szurek 1997; Sesia 1997; Hunt 1999) is fuelled by a focus on the "cultures of globalization" and the diversity of effects the adaptation of Western practices and knowledge may have. It is apparent that a more differentiated view of technologies and the so-called "new reproductive world order" has emerged, and, although a wide range of studies emphasize the negative effects of socio-economic change, authors like Ginsburg and Rapp (1995b:2) argue that

> reproduction also provides a terrain for imagining new cultural futures, and transformations, through personal struggle, generational mobility, social movements, and the contested claims of powerful religious and political ideologies. These imaginings and actions are often the subject of conflict, for they engage the deepest aspirations and the sense of survival of groups divided by differences in generation, ethnicity, race, nationality, class, and, of course, gender.

This more encompassing approach has already provided new insights into "new reproductive technologies" (see Edwards et al. 1993), but it has still to be employed in the study of "normal" birth itself.

As in most studies of hospital births in the West, investigations into non-Western contexts are critical of numerous aspects of medicalized birth, including antenatal services, medical practitioners, the technologies employed, and the authoritative knowledge produced. Jordan's summary, written in 1973, set the tone for the critical work on "cosmopolitan obstetrics":

> In many countries of the Third World, strategies for development include the importation of obstetric technology and of technology-dependent obstetric procedures such as hospital deliveries, pharmacologically managed labours, the use of ultrasound and electronic foetal monitoring, induction of labour, instrumental and surgical delivery, and the care of premature and sick infants in intensive care units. While it is clear that such facilities and their technologies will lower some kinds of mortality and morbidity, their importation often has unforeseen and not really assessed negative effects. Beyond that, the replacement of traditional "low technology" raises fundamental questions about concomitant transformation in the nature of knowledge about the birth process, which in turn affects the distribution of decision-making power and the ability of women to control the reproductive process. (Jordan 1993:199–200)

This critical stance has certainly been employed in the study of childbirth in poor and marginalized communities in South Asia from a development perspective, which followed on from an interest in "traditional" practices and beliefs (see Jacobson 1995; Patel 1998; Rozario 1998). Within this context "medicalized hospital birth" figures as a system imposed on poor women, with mostly negative and often deadly consequences. Decisions on the type of care and delivery are analyzed within an economic framework, the analysis of which may be modified by including cultural values such as ideas regarding purity and pollution. In this region, the high rates of mother and child mortality[9] and detailed studies of reproductive processes based on fieldwork in rural areas do not support a nostalgic view of non-allopathic approaches to childbirth in South Asia (Jeffery, Jeffery, and Lyon 1989; Rozario 1998). But even as more poor women in urban areas have access to antenatal services and hospitals, their well-being may suffer as poor procedures and interventionist reproductive technologies employed to produce children of the desired sex put them at risk (see, for instance, Van Hollen 1998).

The institutionalization of medicalized childbirth on the Indian subcontinent commenced more than 100 years ago, when the first maternity wards were established in Madras and Calcutta during the later half of the 19th century. Among the middle classes today, hospitalized birth has become the norm, and, in line with comparable developments elsewhere, "elective" Caesarean sections have become the delivery of choice. In order to establish why Caesarean sections are common in Bengali middle-class families, a group with routine access to private and state-provided health care, certain older themes that dominate accounts of traditional childbearing need to be explored.

CONTINUITY AND CHANGE

Narratives of pregnancy and birth are here, as elsewhere on the subcontinent, situated in the domestic sphere, that became the subject of intense debate when indigenous practices relating to kinship, marriage, and the raising of children were scrutinized by foreign administrators, missionaries, and social reformers (Chatterjee 1993). The rituals, technologies, and practices involved in childbearing in colonial contexts were typically judged in the light of new discourses of "scientific" knowledge, "hygiene," and "antenatal" and "postpartum" care. In many instances European concepts of pollution, maternal well-being, and household organization were imposed upon women, whose maternal qualities were questioned on the basis of racist stereotypes (Jolly 1998:6). However, although such hegemonic discourses were influential in the Indian context and inform policies of the postcolonial state to date, the diversity of reactions, ranging from direct resistance and indirect protest to partial appropriation and transformation, is well documented throughout the region (see Ram and Jolly 1998).[10]

In the case of urban Bengal, middle-class notions of domesticity and modern concepts of women's duties emerged from the middle of the 19th century onwards, along with the redefined boundaries between the public and private sphere, which where policed by male representatives of different communities. The much contested private domain was defined in terms of tradition and assigned to women as their space—albeit controlled by men, who acted as mediators between the women's quarters (*antahpur*) and the outside world, between specific forms of knowledge and their female

dependents, and between new discourses on medical intervention and the female body (Borthwick 1984; Chatterjee 1992; Walsh 1995). Various forms of disciplining knowledge found their way into women's everyday repertoire via home management manuals and the education of girls. But the "reconceptualisation of Bengali women" (Walsh 1995) did not include the reform of pregnancy and childbirth-related rituals and customary practices. In spite of the efforts of those initiating the foundation of hospitals and funds dedicated to the spread of medical knowledge about childbirth, according to the older women I interviewed, discourses about hygiene and medical intervention did not really affect birthing until the 1960s.[11] Until hospital deliveries became more widespread, pregnancy and birth did not figure as prominently in these discourses as did female education, conjugality, and progressive motherhood, although medical practitioners in Bengal as elsewhere raised the issue of high maternal mortality rates among secluded upper-caste women and the unhygienic conditions under which women gave birth (Guha 1998).

Though middle-class women gradually entered the public sphere as pupils and students, political activists and professionals, they remained literally hidden from public view as birthing women during the colonial period and beyond (Engels 1996).[12] Anecdotal evidence suggests that, during the 1960s, private nursing homes—as opposed to hospitals run by the state or charities—sprang up and, thus, gave families the opportunity to look for a delivery in a more intimate and less anonymous environment. Gradually, discourses on hygiene took the place of previous notions about the polluting effects of birthing, which shifted towards a semi-scientific view of medical intervention that provided safety through adequate procedures, including ideas about sterilized equipment, hygienic hospital conditions, and the need for postpartum care. However, given the state of most hospitals in Calcutta, discourses on hygiene are peripheral to discussions about hospital births.

Pregnancy and childbirth are complex processes, but individual representations, like the maternal histories upon which this article is based, are dominated by a number of interrelated themes. One of them is the opposition between tradition and modernity, an idiom used by women when describing the changes initiated by the shift from home birth to hospital birth. For them, as for the less well-educated, changing childbirth practices are part of the complex imagery of modernity and are as important as are transformations of

conjugality, the education of girls, and women's political participation (see Borthwick 1984; Chatterjee 1993; Engels 1996). My data suggest that, in the same way as the much studied spread of female education and new conjugal ideals, changes related to birthing represent significant conjunctures transforming the lives of women belonging to different generations. Thus, individual time, chronological time, and notions of progress are often described with reference to reproductive change; and, in many accounts, hospital birth signified intergenerational differences. However, while in hindsight the dichotomy between past and present may appear clear-cut, there are also strong continuities as actual practices were modified within a set of structural constraints—most prominently the norms associated with patrilocality. These link the three different levels of change, with younger women comparing their experience of highly interventionist Caesarean sections with their mother's deliveries in nursing homes and their grandmother's experience of home births.

More often than not, maternal histories of the most senior women and their daughters begin with accounts of the acute sense of shame felt by a young married woman when she realized that she was pregnant. Early pregnancy was characterized by instruction in the appropriate behavioral patterns, food taboos, and restrictions regarding the woman's mobility, and many women still experience this phase in terms of the contest surrounding control of their body.

Living in her husband's house, a pregnant woman relies on her affines, and this often makes the experience of pregnancy an unpleasant one. The majority of elderly women reported that a rigid regimen of food taboos and religious observations was imposed during their first pregnancies. Among secluded upper-caste women, where contact with strangers and male relations was restricted at any time, it became even more minimal. Dangers included attacks by ghosts and the evil eye as well as contaminated food and unhealthy thoughts. Although the last three decades have seen a decrease in such beliefs, the relation between the pregnant woman and food, and how intrahousehold hierarchies determine the well-being of the birthing mother through the provision of specific foods, dominated all accounts of pregnancy.

Numerous food taboos are still observed by pregnant women, although within this group what should have been avoided varied considerably. Thus, 55-year-old Borsa Ganguly asserted that she ate everything during the early stages of her pregnancy but that she

did abstain from eggs and the commonly avoided pineapple. However, she emphasized that her in-laws encouraged her to eat more nutritious foods like butter, bananas, and vitamin-rich vegetables, milk, lentils, and fish. Since pregnant women are supposed to feel comfortable she explained that they should have four full meals a day, just like a sick person. Furthermore, to facilitate the positive development and growth of the child, a pregnant woman should avoid all tension and "consume good words as well as good books." However, pointing out the inherent tensions in common experiences of pregnancy, she went on to say: "But [all that] is rarely possible in the in-laws' house, there you will not get good food or at least you will not eat what you like." Like many others she felt so sick most of the time that she even avoided fish until the fourth month, nausea and vomiting being the most common complaints in early pregnancy. These problems are seen by most women as very serious since it is believed that the body of the child "hardens" fully within the first five months and that deficiencies in the mother's diet can seriously hamper its growth.

Many of these restrictions have become less prominent, but the basic problem—namely, the affinal relations that structure the experience of pregnancy and birth—remains the same. Whereas supernatural concerns are rarely mentioned today, restrictions on the variety of food, movements, and exposure to unrelated persons are still imposed by many a mother-in-law. As a pregnant woman's well-being is the responsibility of her affines, it is up to them to lower her workload, to provide her with healthy food, and to perform rituals promoting the formation and growth of a male foetus and an easy delivery;[13] however, many such rites have disappeared since deliveries have begun taking place in hospital. Today, the typical *shadh* ceremonies, during which the mother-to-be is served "desired food" and worshipped as auspicious and fertile by the women belonging to her husband's and/or her own patriline, are only performed once or twice. In the past, affluent families had organized these rites up to five times during any given pregnancy.

Among the most significant changes in the lives of middle-class women in Calcutta is the effect the shift from giving birth at "home" (in the double sense of natal home and home birth) to giving birth in the in-laws' house or a nearby hospital had on their experience of pregnancy and birthing. Like women in other North Indian communities, Bengali women were traditionally sent back to their parents' house a couple of weeks before the birth of (at least) their first

child and remained there until the period of postpartum confinement was over. As many senior women observed, the right of the affines to refuse their daughter-in-law visits to her parental home was soon legitimized by the demands of continuous professional antenatal care. Thus, Supriya Mukherjee, a widow in her fifties who gave birth to all three of her sons in the late 1960s and early 1970s, asserted that she spent all her pregnancies in her in-laws' house. She went on to explain:

> I was not allowed to go to my parents' house, my father came, but she [my mother-in-law] did not give me permission to go to my parents' house, she also did not give the permission to my sisters-in-law. We had to do what the mother-in-law said. She told my parents that there was no good hospital in their place, "so how can I send my daughter-in-law? How can I be in peace?" She always prohibited these visits [to the parental home], and after the birth she said, "No, the boy is going to feel cold." So I did not go for one and a half years, only long after the first-rice ceremony. At that time we did not think about whether we liked that or not. Today when someone feels that she wants to be taken to the father's house she will just go; but when my mother-in-law said "no" you had to stay. She did not believe in my house, she said that they will not tell me off . . . But it was often hard. When I was sick during the pregnancy the doctor prescribed some medicine, but she said, "No, you cannot eat that because it may harm the child."

In the case of senior women, who often migrated to the city upon marriage, antenatal care and the introduction of hospital deliveries implied the decrease of customary visits to the natal home, facilitated by the gradual emergence of a medicalized birthing model. Today, doctors are involved from the earliest stages of pregnancy onwards, and they are mostly chosen by in-laws. In order to guarantee the much valued continuity of care, a young married woman will remain in their house and will often return there after giving birth in a hospital selected by them.

The issue of daughters-in-law visiting their natal home, and the important role of these ties in the North Indian kinship system, has recently been highlighted by anthropological studies such as Raheja's and Gold's (1994) account of women's perspectives on marriage and kinship in Western India. With reference to childbearing in Bengali middle-class families, this role has been modified to the extent that daughters of the senior generation actually remained in their in-laws' house before and after birth. Thus, a very important positive aspect of women's experience of childbearing—namely, the role played by a daughter's parents, her return to her parental

home to give birth, and the subsequent period of rest surrounded by "one's own people"—has virtually disappeared. There are obvious reasons for this development, among which, in all accounts, the control of the daughter-in-law's labour power was paramount.[14]

The contribution of an in-married woman to the work done in the household figures prominently in the accounts of women belonging to all generations; indeed, as Jeffery, Jeffery, and Lyon (1989) point out, it is the factor that most obviously determines the type of medical care a woman receives during pregnancy and birthing among the less affluent in rural Uttar Pradesh. But the control over the younger woman's labour power is just as pervasive a theme in Bengali middle-class families, where the work undertaken often mainly consists of what Papanek (1989) refers to as status production work. Regarding the relationship between different forms of domestic labour, Sangari (1999:295) observes that,

> though similar in terms of responsibility, the contemporary middle-class woman's assisted labour, often geared to family status production including activities related to high consumption and elaborate maintenance of property, is not comparable to poor rural or urban women's survival-orientated domestic labour, essential to the bare existence of the family. There is, however, a relation between different types and definitions of domestic labour along the joint axes of class differentiation and mobility.

Although every household in this sample employed servants to perform certain tasks, virtually all women who had given birth complained about the immense workload they were given by their in-laws, and the availability of servants before and after birth was a crucial issue in these narratives.

Supriya Mukherjee, who lived jointly with her in-laws and her husband's brothers' families at the time of the birth of her three sons, explained the discrepancy between the idealized custom and the reality:

> I was in hospital for seven days when the eldest was born, and with the middle one I said I will not stay long, I left after four days. Again, with the youngest one I stayed for seven days. In the hospital we paid a Bengali woman to help me, she massaged the baby and me and emptied the bedpan and so on. Here in the house we had our own people who did all that. I stayed alone in that room [during the period of confinement], my mother-in-law told me to do that. I talked only to those who came close to the door . . . If the daughter-in-law stays in the house [of her in-laws], we should not let her do any work, that is our custom. For two three months, she should not

carry anything after the birth, et cetera. But I had to do everything, I washed the clothes of the children, I made food, I cleaned the *thakur ghor* [room for the gods] while I was pregnant. I cooked and did all that work; it was only after the birth that I didn't work that much. It was like that: while I was doing *roti* for the children, I felt the "pain" and then had a baby.

Some of the changes addressed in the course of the interviews are related to the management of birth and, more specifically, to the role of the various relatives involved.

In the "old days" (the period before nursing homes became popular) birthing was an all-female affair. At the onset of contractions, referred to as *baetha* (pain), a pregnant woman was ushered by her mother or mother-in-law into a separate room that was equipped with a pile of rugs or, sometimes, an old bedstead. It was up to the birthing woman's senior relatives to decide when to call specialists, but they normally sent for a *dai*, the traditional birthing attendant, although this often happened quite late. Once the *dai* had arrived the birthing mother was left in her care. Unlike the rural women in Rozario's study of home birth in Bangladesh, none of those who gave birth at home were physically supported by a female relative. Confined to the smallest and darkest corner in the house and often seated on a bedstead, the birthing mothers were forced to rely on the *dai*, who played a crucial role in guiding a woman through the various stages of birth. But, because of beliefs concerning pollution, these "traditional birth assistants" were always recruited from low-caste communities. Although some *dais* may have had some obstetric knowledge and were expected to handle complications like a breech birth or excessive blood loss, those who experienced home births agreed that their expertise was minimal.

Given the fact that, in all these families, a *dai* was regarded as a low-caste working-class person called in to deal with a polluting and potentially dangerous event, her effective support of, and autonomy in dealing with, the birthing woman was very limited. Not surprisingly, *dais* are described as "dirty" old women who spent a lot of time shouting and haggling, and, since Rozario (1998) reminds us that even today many traditional birth attendants perform their tasks reluctantly, it can be assumed that *dais* were not necessarily devoted to the task in the past.[15] This reluctance towards performing what was widely seen as a demeaning menial task was also reflected in the disgust middle-class women felt towards these traditional birth attendants. This and the discomfort they experienced in the

room reserved for births led many of the more experienced mothers to postpone the *dai's* arrival for as long as possible and try to "get on with it" by themselves.

These negative feelings and the acute sense of shame described by many were carried over into the early phase of hospital births, when such institutions were mainly chosen within the same locality unless complications were expected and a pregnant woman had to be seen by a specialist in a bigger hospital.[16] Whereas traditionally only women had been involved in birthing, hospital births demanded contact with the outside sphere; consequently, the birthing woman arrived at the nursing home accompanied by senior male affines who were expected to deal with "officials." Many women recall the embarrassment they felt as they travelled with the (normally avoided) husband's elder brother, father, or uncle, who would sit in the corridor during the delivery. Once admitted, the birthing woman was routinely confined to a "stretcher" and attended to by an *ayah*, who was employed by the nursing home until the delivery was imminent. According to many accounts the role of low-caste women, often former *dais*, was even more limited here, and the social distance between her and the birthing woman was reinforced by the institutional hierarchy.[17] As a hospital employee, the *dai* was referred to as an *ayah*, and her duties consisted mainly of cleaning up, inserting catheters, and cutting and disposing of the umbilical cord.[18] However, since doctors only booked a bed in the nursing home and then were only called in when needed, their patients often had only the most basic of medical interventions.

Borsa Ganguly recalled how, in the late 1970s, she delivered her son, who was a breech birth, assisted only by a low-caste attendant. This happened even though she was booked into a nursing home:

> We went to the hospital at night. It was Sunday and it was raining very hard, when he was born around two o'clock. The doctors were not present, only one *ayah* was there when the waters broke around ten. He was born at 1:45 AM, feet first and then the rest, but it still was a normal birth, totally normal. The doctor did not come. There was only the *ayah*, who was not sure what to do, so she went and fetched the nurse. He [the son] then started screaming, and the nurse held him into some warm water and gave him oxygen.

More commonly, a nurse supervised the early period of labour and was responsible for standard procedures such as manual external examinations. The appointed doctor arrived once the actual delivery

was imminent, and in many instances reached the nursing home only after the birth. Nevertheless, all women belonging to this middle-aged generation presented doctors and nurses as powerful, knowledgeable, and proactive. But while one of the positive aspects of hospital birth was the successful management of pollution outside the home, the involvement of lower-class personnel in the care of mother and child was described as less desirable. In fact, it was among the reasons women cited for leaving the nursing home as soon as possible. Returning to their in-laws' house, women were then often put up in a room, and an additional maidservant was employed to look after mother and child.

Although a period of confinement was still observed after women began to give birth in their in-laws' house or a nursing home, this institution now took on a more ambivalent character. The weeks after a delivery were often the only time when an in-married woman could delegate work and withdraw from her duty to concentrate on the new baby. But as an increasing number spent this period in the affine's house, the most enjoyable aspects of confinement—the rest and food a mother would provide for her daughter under the same circumstances—turned into a matter of control. Under the new regime affines decide what is best, and in more than one case they did not provide the expected services at all. Some new mothers demonstrated their dissent and rage over this new pattern by throwing away foods cooked especially for them, others refused to eat "healthy" foods altogether. What in other settings is described as a period of positive adjustment and recovery (see Patel 1998) took on a much more ambivalent meaning under these new circumstances. A majority of those who spent this postpartum period in their in-laws' house experienced it as a rather unpleasant time spent in isolation. And a significant minority alleged that affines routinely neglected them. This new regime provides the context for the following discussion of yet another shift in childbearing practices; namely, the emergence of a preference for elective Caesarean sections.

CAESAREAN SECTIONS

The relatively new pattern of deliveries in nursing homes underwent further dramatic changes brought about by the introduction of new technologies and the recent growth of the private health care sector.

Most prominent among the new trends is the increasing popularity of "elective" Caesarean sections, which today represent the ideal form of delivery in this stratum of Indian society.

Though privatization plays a role here, the women interviewed gave the availability of new "ultra-modern" hospitals in Calcutta—not privatization per se—as a reason for the preference for Caesareans. This mode of delivery was the ideal among all the younger women interviewed, and, although there are many middle-class women who still give birth the "normal" way, those given the choice opted for an elective Caesarean section. The reasons for this preference for a highly interventionist practice are worthy of close examination. Therefore, before we resort to a common-sense view that explains the rise in elective Caesareans as a combination of women's "false consciousness" and the dynamics of the private sector, I would suggest a serious examination of the framework within which women themselves represent this pattern. Here, as elsewhere, Caesarean sections represent a Western and, therefore, contemporary mode of delivery, and women reacted with surprise and disbelief when told that this type of birth is not the norm in the West.

The notion that ideology, not medical necessity, is essentially responsible for the rise in medical intervention in the birthing process has been put forward by scholars who criticize the "production view" of reproduction identified with Western obstetrics. Emily Martin (1987:54), who analyzes the metaphors related to birthing from the 17th century onwards, asserts that "mechanical metaphors" emerged with the modern view of the body as a machine. With the imagery of the body-machine the production view of reproduction spread and produced a whole range of specialist procedures applied at the time of birth. Although such a notion of production seems to be situated firmly within the context of European histories of industrialization, the traditional view of birthing within the given setting lends itself to interventions because of the 'indigenous' mechanistic view of the processes involved. Reproductive technologies are easily adopted in South Asia, partly because the ayurvedic understanding of the body—holistic as it may be—depends on the notion of physical processes being based on a balance of substances, passages, and organs. The mechanistic view of the processes of birthing prevailing among those interviewed borrowed freely from the vocabulary of Western obstetrics but was framed in terms of these "traditional notions," with a strong emphasis on the idea that

most complications during birthing are caused by the baby's failure to ascend through the birthing channel. This notion, which is, per se, mechanistic, is widely used to justify medical intervention and, in particular, Caesarean sections. Madushree, for instance, was convinced that a mother above the age of 25 would face problems during a vaginal delivery solely on the grounds that she would have gained weight after marriage, the additional kilos blocking the birthing channel. Others expressed concerns that overeating during pregnancy would cause the stomach to expand and push on the baby's body so that it would not develop appropriately and so not enter the channel at the right angle. Further related notions involve explaining birth complications in terms of excessive retention of blood during pregnancy: because this blood is not discharged it blocks the baby's way.

Within this context, interventions like Caesarean sections are seen as a functional alternative to normal (*emni*) birth, which may not be possible for "today's" women because they lack the strength and physical fitness of the women of the older generation. When I pointed out that I myself had a "normal" delivery at the age of thirty-three, Minakshi, Madushree's mother-in-law, explained:

> But you were physically fit. If a woman here is pregnant at the age of thirty-three she will be afraid, because she is not fit. Look at my daughter-in-law: she knows what she has to do to keep well but she has no tendency to do so, she does whatever she wants to do, she eats everything, she goes out whenever she wants, and goes to see the doctor all the time ... But if there are problems, the system, the doctors are there to fix it. That was different for me at the time, I was living with my in-laws, and I understood a lot, I tried hard, and I can stand pain. If the doctors see that someone has this mentality they will give their best ... Earlier we did not have a choice, they would have just said, you are fit and therefore you will not have a Caesarean, but today the patients have become so focused on their convenience ... They hear that with a Caesarean there is no pain, and this and that. I have seen it myself, when I was working at the hospital, if a woman had contractions for some days, many would say "open it, I can't stand this any longer." What are the doctors supposed to do?

As indicated in her description, the provision of these deliveries is also fuelled by new consumption practices among a growing middle class obsessed with status derived from procuring private-sector services. While a complete review of the way economic liberalization affects the healthcare system in urban India is beyond the scope of this article, some points need to be discussed (see Donner: forthcoming).

The first pertinent changes are related to the wider medicalization of women's fertility and reproductive behavior, including the routine employment of amniocentesis and abortion for sex selection as well as contraceptive measures such as the common use of permanently inserted contraceptives or hysterectomies. Caesarean sections are just the last step in a line of routine interventions, including antenatal care and various other practices related to hospital deliveries. Antenatal care has become big business, and instead of the three checks regularly performed in the past, pregnant women undergo an endless series of tests. This phenomenon is closely related to the emergence of the powerful doctor-laboratory nexus, which is not limited to the private sector but affects the public sector as well. The data collected suggest that tests are as likely to be carried out on behalf of doctors employed in the public sector as those employed in the private sector, and, in practice, the lines between the two sectors are often blurred. Because public opinion of the medical system is very low, urban families entertain close personal ties with specific doctors who are seen as trustworthy and whose skills are rarely criticized.[19] The "privatization" of healthcare shapes the way antenatal care and deliveries are approached and is widely held to be responsible for the rise in Caesarean sections. With liberalization a market for healthcare opened up, and the subsequent restructuring of the Indian economy introduced more competition, with a host of national and multinational corporations operating chains of hospitals and laboratories in urban centers. The privatization of medical care predates these processes, but previously many families would have been happy to send a pregnant woman to be delivered by the doctor of choice in a government hospital. Since new facilities are available in more nursing homes and hospitals, in the private sector all doctors are attached to such institutions and recommend them to their patients.

The prestige attached to a modern, high-tech delivery has rightly been highlighted by researchers investigating the "modern medical hegemony" of hospitalized deliveries (see Georges 1997:94–96). In recent studies the status attached to high-tech medical procedures is held to be responsible for the rising rates of elective Caesareans among middle-class women in Latin America (Belizán et al. 2001), Turkey (Tatar et al. 2000), and India (Pai et al. 1999). A further ready explanation is the interest doctors have in such interventionist and expensive procedures, and recent research has suggested that women in many of these settings are subjected to Caesarean sections

even though they may prefer a vaginal delivery (Potter et al. 2001). There can be no doubt that doctors and those investing in nursing homes and hospitals have a very pronounced interest in a proliferation of reproductive technologies and interventionist procedures, among which amniocentesis, ultrasound, Caesarean sections, and abortions prevail. An elective Caesarean section costs between 5,000 to 15,000 rupees and, depending on the hospital chosen, the resources of the household may be stretched to pay for the delivery.

One reason for the ease with which middle-class families may choose a Caesarean is the increase in the number of jobs that come with health insurance for the family of the employee. However, this is not the case with most government employees, who may still choose a private nursing home but whose expenses for Caesarean sections are not covered. Not surprisingly, it is among this group that one finds women who decide in favour of a vaginal delivery. One of them, Lakshmi Datta, a lower middle-class woman in her mid-twenties, decided for this kind of birth because she lacked any support from her in-laws or parents. She told me before the birth of her son that their savings from her job as an office assistant and her husband's salary as a middle-range government servant did not allow them to spend money on a Caesarean section. The procedure had been suggested by her doctor, who offered to make a special price for her, should she decide to book into the private branch of the charity-run nursing home to which he was attached. Lakshmi herself, whom I had a chance to talk to directly after the birth and many times since, still regrets her decision to have a "normal" delivery. She maintains that the pain was unbearable and insists that, should she ever have a second child, she would go for an elective Caesarean. In her case she had a choice and did not go for the costly interventionist procedure because of the general situation within her household. She did, however, explicitly state that although the doctor was clearly guiding her—a perfectly healthy young woman—towards a procedure the couple could ill afford, this had not influenced her decision.

Generally speaking there has been no evidence of any member of the medical establishment taking a publicly critical stance towards Caesarean sections, although there is a growing concern about the number of such operations carried out in badly maintained hospitals. Among mothers themselves any criticism is directed at the cost of private healthcare and not at such deliveries per se.[20] The shift from vaginal deliveries towards Caesarean sections, does however also reveal how the medicalization of birthing is based on negative

notions of the process itself. Among them are the strong association with shame and the experience of embarrassment, the allegedly extraordinary levels of pain endured, and the possibility of bodily harm, or even maternal death, evidence of which is seen in the high morality rates in rural areas and among urbanites in the past.

Among the many advantages women attribute to Caesarean sections is the successful management of pain, through various forms of anaesthesia and drugs used during and after the operation. The pain experienced during a vaginal delivery is depicted as unbearable and the birth as agonizingly slow as well as at least potentially as dangerous as a Caesarean section.[21] The discourse on pain in general, and pain during childbirth in particular, is medicalized in that pain is seen both as an avoidable side-effect of a particular medical condition and as the most frightening aspect of birthing. Although Mrs. Chowdhury emphasized the strength evident in women who manage a vaginal delivery, a discourse on the positive aspects of *shakti* (female power) manifest in the experience of birthing among Van Hollen's Tamil informants is not prevalent within this setting (Van Hollen 1998:160).

Furthermore, although women are well aware of the interest medical practitioners have in a scheduled and speedy delivery the image of Caesarean sections as less painful and as safe in comparison with the so-called normal birth is of great importance. There are no differences between members of various ethnic communities in this respect, and elective Caesareans are as popular among Bengali Hindus and Christians as they are among Marwari women, who held on to the tradition of home births for much longer than did the former.

In spite of learned debates regarding the safety and pain experienced during and after different types of delivery, in urban Bengal it is widely believed that women suffer more during normal births. In the course of the interviews pain was a much discussed topic, and mothers who had normal births did not hesitate to describe in considerable detail the excruciating pain, length, and problematic nature of birth in general and of the deliveries of their own children in particular.[22]

OF KNOWLEDGE AND INTRAHOUSEHOLD RELATIONS

Within this discourse Caesareans are represented as less dangerous than normal births, mainly by virtue of their shorter duration. Even

doctors described them as safe and less prone to complications, while women belonging to different generations argued that an "operation" is less life-threatening than is a vaginal delivery. Senior womens' narratives of hospital deliveries fuel a negative attitude towards 'normal' births, although some of the older women asserted that they suffered most during the birth of their first child. This is not surprising as there is a belief that birthing becomes easier with practice.

Given this negative image, a newly married woman will not readily agree to attempt a vaginal delivery. Thus, whether or not Caesareans are de facto easier and less painful (or more painful and high-risk, as many of my commentators assert) is not really the issue. However, it became clear in the course of the interviews that, rather than looking at the scientific or medical evidence supporting such assumptions, class and intrahousehold relations provided the framework within which women argued in favour of one or the other type of delivery. A number of women were well aware that the pain experienced in the aftermath of a Caesarean section is intense, but this only led them to conclude that, due to the prolonged periods of recovery, Caesareans represent the mode of birth for "gentlewomen" (*bhadramahila*). They agreed with working-class women who put forward the view that Caesarean sections are for those who can afford prolonged periods of rest. Since Caesareans are also believed to lead to excessive blood loss—which weakens the young mother and makes breastfeeding difficult (breast milk is thought to originate from blood)—this kind of delivery is deemed unsuitable for lower-class women. Furthermore, it is widely believed that a woman who has a Caesarean section will be weak and will have to bottle-feed her baby. All these notions make Caesareans emblematic of middle-class status.

The meaning of this discourse on strength and recovery is reflected in the arrangements after the birth, when "helpers" are employed in even the least affluent middle-class households. Whether or not women get more help after a Caesarean section is difficult to establish; however, since mothers who had a vaginal delivery are expected to recover quickly, they are very likely to return to their duties within a fortnight, whereas those women who had a Caesarean section emphasized that the wound would keep them from active participation in housework for at least fourteen days. This was reflected not so much in the comments of younger women as in those of their mothers and mothers-in-law. For instance

Ila Chakraborti, commented on the fact that she had to take up her duties almost immediately after giving birth in a nursing home whereas her daughter was given some weeks rest in her in-laws' house. The medicalized model of birth helped women living with their affines to gain rest after the deliveries, thereby partly compensating them for the loss of "traditional" support in their parents' house. This post-partum rest is matched by the common practice of spending considerable amounts of time bed-bound during pregnancy.

Extended periods of rest ordered by doctors are the cause of many complaints by mothers-in-law, some of whom pointed out that today a daughter-in-law will get a doctor to prescribe bedrest whenever she feels the slightest discomfort. There is evidence that women do get many more chances to rest within the context of medicalized birth than they do within the context of traditional birth, and older women's experiences confirm this observation.[23]

All women interviewed, including Madhushree, presented their experiences of pregnancy and birth within the context of their role as daughter-in-law living with affines. These young women have multiple responsibilities in their in-laws' households and are expected to leave their employment after the birth of a child. Not surprisingly, they prioritize this role when discussing the pros and cons of different deliveries. This is particularly relevant with regard to the effects of different modes of birth, and it affects their view of Caesarean sections, which is based on the assumption that such a procedure will leave a woman with a serious wound and in need of rest. While working-class women saw interventionist deliveries as a threat to their labour power, middle-class women saw them as a chance to gain extra help, rest, and support. But both groups negotiated hospital births and different modes of delivery within the context of prevailing patterns of residence, intrahousehold hierarchies, and household budgets.

A further argument in favour of Caesarean sections is related to the more traditional notions of pollution. These determine the negative notion of birth and contribute to the view of birthing as pathological. Whereas the contemporary removal of the birthing woman from her home environment has been interpreted as an alienating process, medicalized childbirth in a hospital setting and, more significantly, Caesarean sections are seen as a way of containing the polluting aspects of childbirth by women themselves.

Older women who experienced home births attended by a low-class *dai*, and those who gave birth during the early phase of hospital

birth, agreed that pollution and its related embarrassment were minimized by having Caesarean sections. Birth pollution is minimized because it is related to notions of "bad" and "nasty" body parts—body parts about which one should not speak and which should certainly not be exposed, touched, or examined. The blood lost during birthing is seen as being just as polluting as the blood lost during menstruation, and the discharge of vaginal blood is something that should be avoided. Since medical procedures that involve vaginal examination and intervention can be largely avoided in the course of Caesarean sections, these deliveries appear to be "clean" and help women to manage the shame, pollution, and pain associated with birthing.

CONCLUSION: HOME, KIN RELATIONS AND THE MEANING OF INTERVENTION

My discussions and case studies highlight the importance of the wider network of kin and intrahousehold relations with regard to the analysis of changing childbearing practices. Residential patterns and the class-based involvement with housework, even if it consists "only" of tasks such as supervising maidservants, are as important in determining why women choose a specific mode of delivery as is medical knowledge, the emergence of private hospitals, and the interests of doctors. What became clear early on in the course of the interviews is that perceptions of hospital births are not necessarily determined by questions regarding the kind of medical intervention and the availability of personnel and facilities provided. The decisions taken and the experiences of women are crucially embedded in how their households are organized as well as in the class-based arrangements regarding women's labour power. Pregnancy and birth underwent multiple changes, and here as elsewhere the medicalization of childbirth led to the marginalization of forms of knowledge located within the domestic domain (Ginsburg and Rapp 1991:321–323). However, in the given context this process took a different form from what one might expect. It is apparent from the interviews and the two case studies that young birthing women negotiate their relative well-being—including rest, support, and their ideal delivery—by playing two types of authoritative knowledge against each other. These two types of knowledge are (1) that generated within the domestic sphere (involving strategies for

managing intrahousehold relations) and (2) that situated outside the domestic sphere, broadly speaking medical expertise.[24] The related changes in birthing resulted from the shift from birth in the natal home towards birth in a woman's in-laws house and later in hospital. In the wake of this came the establishment of the supremacy of the medicalized model of birth, with deliveries taking place in private nursing homes. At this point, medical care for the pregnant woman became a matter of affinal prestige.

Early maternal histories are dominated by the shift from birthing as something experienced by daughters in their parents' house towards the birthing woman's gradual subordination to the strict regime of her in-laws. However, the material presented suggests that today a growing number of young women have access to better doctors and hospitals not because their parents or in-laws grant them better treatment but, rather, because their own or their husbands' status as employees entitles them to specific services. Under the new regime, the temporary removal of a birthing woman from the domestic sphere and existing intrahousehold hierarchies provides her with a sense of privilege—at least during and immediately after the actual birth.

How strongly domestic roles and power relations shape women's experiences and decisions is further exemplified through an analysis of the rise in elective Caesarean sections. One of the most criticized interventionist techniques, elective Caesareans are the opposite of the idealized home birth of anthropological literature and parenting manuals, which has been described by MacCormack (1994b:11) as involving a "slow pace, jokes, gossip, and cat naps of village women upholding their neighbour and kinswoman on her heroic journey toward motherhood."

More often than not, critical perspectives on hospital deliveries and "medicalized" childbirth emphasize the fact that women experience an extreme loss of control and alienation during the course of this procedure. Moreover, Caesareans are represented as more painful and damaging to the overall health of the birthing woman than is any other form of delivery. Consequently, the popularity of Caesareans in non-Western countries (Belizán et al. 1999; Pai et al. 1999; Tatar et al. 2000) is explained by reference to the prestige value of high-tech medical procedures, the privatization of medical care, and the decline in woman-centered forms of knowledge associated with pregnancy and birth. While all these tendencies exist within my case studies, I suggest that more sensible insights

into the meaning of hospitalized birth and the emergence of a veritable industry in "planned," or "elective," Caesarean sections among the Indian middle classes can be gained from looking more closely at the reasoning of the women themselves. Their accounts remind us that childbearing experiences are processual and involve a wide range of related factors rather than one single event.

My research shows that women's experiences and preferences may be usefully analyzed in relation to the domestic setting within which they are embedded. It reminds us that home, as in "home" birth, may imply romanticized notions of a safe haven, an assumed sense of belonging, and an imaginary female space. For the women in this sample the meaning of "home" was much more ambivalent; consequently, their evaluation of extra-domestic relationships with doctors and new technologies was surprisingly positive. More specifically, my findings demonstrate the relevance of class-specific intrahousehold relations and the powerful role of affines in the lives of middle-class Indian women. It is for this reason that I resituate the analysis of discourses on medicalized childbirth in South Asia within the framework of an anthropology of kinship, which allows us to deal with the specific power relations that kinship networks entail.[25]

On a different level the transformation of reproductive processes and the understanding of well-being among middle-class women in various settings has been interpreted in the light of a massive consumer-oriented market (Lazarus 1997; Stivens 1998; Jacobson 2001), including childcare and reproductive technologies (Taylor 2000). It appears from the data that middle-class Bengali women identify strongly with the kind of healthcare provided during pregnancy and birth, and the distinctive value of high-tech Caesarean deliveries adds to their popularity (Bourdieu 1984). I would nevertheless argue that, while different modes of childbearing are clearly related to class-based identities, they are not merely a reflection of economic standing or access to specialist services in urban areas. Within my case studies the workings of gender and class subtly determine whether a woman can afford to forego the allegedly faster restoration of physical strength attributed to "normal" birth.

Debates concerned with various types of deliveries often center on the pain and lasting harm caused by each. The women whom I interviewed asserted that normal births were more painful than were Caesarean sections. In the West, it is commonly assumed that the "pain" associated with childbirth today is less severe in cases of

vaginal deliveries than it is in cases of Caesarean sections. Scholars and laypersons with whom I discussed the relative complacency with which women in Calcutta undergo elective Caesarean sections are quick to label them as more subordinated than their (middle-class) Western sisters, who have come to be "critical" of various types of medical intervention. However, I take issue with easy assumptions regarding the reasons why women from very different backgrounds may agree to, or choose, an interventionist procedure. Furthermore, I want to establish that these decisions are not exclusively based on a lack of knowledge about, or access to, a presumed "truth" regarding the relative merits of different types of birth. Whereas there is no popular critical discourse concerning control and choice in these matters, those interviewed did not suggest that Caesarean sections were painless, that they did not cause women to suffer. However, among the various phenomena related to a discussion of pain in this context are the ideology of shame and notions of pollution associated with normal birth. Consequently, a fast, scheduled, and specialized procedure seems desirable, and provides a sense of control, within a setting in which women do not expect birthing to be an enjoyable experience. If we define pain so that it includes psychological suffering, then it is clear why women assert that hospital births allow them to successfully manage pain by relocating the pollution of birth outside the house.

This "sanitizing" of childbearing is supported by earlier upper-caste discourses on pollution, and the spatial separation of childbirth from the home in combination with an "operation" does provide the social space for a celebration of the birthing woman – albeit as a patient. By carefully manipulating the authority attributed to medical procedures and personnel, younger women utilize this development to negotiate individual rights in the in-laws' house and make up for the loss of customary rights associated with birthing such as visits to their natal home and periods of rest before and after the birth.

Today birthing middle-class women feel that they are entitled to certain privileges, including state-of-the-art medical treatment. As patients supported by the legitimizing discourse of medicalized childbirth, they can voice preferences, expect assistance, and negotiate specific aspects of antenatal and postpartum care. This explains why young women experience the new mode of delivery as empowering, though this is limited in its scope and depth by the constraints of a patriarchal family ideology and enhances their

dependency on specialists. However, given that their perspective is determined by the roles played within the household, their relative empowerment provides the space to negotiate notions of individual preference, duty, and responsibility. If empowerment and agency are understood as processual, then we can see how a young woman may create some space for herself within the context of medicalized childbirth. Furthermore, this perspective explains why they are envied by senior women who, in the words of one elderly mother of three, "may have been stronger but suffered more."

NOTES

1. The same holds true for the growing body of comparative literature dedicated to the cross-cultural study of the ways Western models of medicalized childbirth and new technologies are producing new forms of "authoritative knowledge" (Jordan 1993; Davis-Floyd and Sargent 1997; Sargent 1989; Ram and Jolly 1998).
2. Business communities originating from Western India.
3. In colonial discourse the "domestic" became synonymous with the "native" sphere, and the emerging nationalist movement constructed the domestic, local, and feminine as a powerful source of female power (*shakti*) (see Chatterjee 1993).
4. Rates of female employment in Bengal are notoriously low. According to the 1991 Census, Calcutta had the lowest female work participation rate (5.42 percent) among the four main Metropolitan Areas, including Delhi (7.46 percent), Madras (8.46 percent), and Greater Bombay (10.32 percent) (Census of India 1991:13).
5. She is referring to legislation issued to prevent sex-discrimination tests and the selective abortion of female foetuses.
6. The puja customarily celebrated at the end of postpartum confinement after the removal of pollution was devoted to *Shasthi*, who is worshipped as a goddess enhancing fertility and the protector of children. It used to be celebrated after the birth of a son and is today organized upon the return of the newborn and his mother to the in-laws' house. However, these pujas have no relation to the removal of pollution caused by birth and are celebrated to protect the child from illness. The rituals to remove pollution from both mother and child have disappeared, whereas the pujas seem to be directed solely towards the well-being of the child.
7. There has been no incident in which the date of delivery was manipulated so as to match an auspicious day; however, there are reports that this happens elsewhere.
8. Like many middle-class mothers, she did not try to breastfeed.
9. According to the human development report published by the UN, the infant mortality rate in India was 71 per 1,000 live births in 1997; maternal mortality was stated as 570 per 100,000 live births in 1990 (United Nations 1999). These rates compare negatively with countries like Thailand, where the infant mortality rate was 31 per 1,000 live births in 1997 and maternal mortality was 200 per 100,000 live births in 1990. Though the maternal mortality rates decreased marginally in the meantime, maternal deaths in India account for 30 percent of worldwide maternal mortalities (*Times of India*, September 30, 2000).

10. The strategies employed to avoid the control of maternal bodies, fertility, and birthing experiences often included the modification of contraception or abortion (Jolly 1998).
11. Discussing the foundation of the Dufferin Fund, Guha (1998) asserts that the hospitals run by the trust could not cope with the high number of women seeking admission. But to establish reasons for this it would be necessary to provide a break up of the number of hospitals founded and their regional distribution.
12. As under the Madras Presidency, Anglo-Indians and Bengali Christians in Calcutta were the first to accept the services on offer (Van Hollen 1998).
13. Such female rituals cross different regions and have been interpreted as occasions for the positive symbolic integration and affirmation of the fears and insecurity surrounding birth (Jacobson 1995).
14. The term "labor power" is used in the sense of women's contribution to domestic labor, which, as Sangari (1999:279) asserts, is "culturally specific and changing" and "structures and is structured by social institutions, the labour market, and by other institutions that regulate labour and inheritance." In the given setting, arranged marriages, patrilocality, and middle-class domesticity provide the basis for the exploitation of daughters-in-law.
15. As in-married wives, they had few opportunities to get to know the traditional birth attendant. Unlike within other contexts, like the Rajasthani villages studied by Patel, none of the women mentioned special attendants for different castes or a relationship with *a dai* that was not based on a commercial exchange (Patel 1998).
16. Until as late as the 1960s doctors called to pregnant patients diagnosed while the woman in question was represented by a male member of the family or was hidden behind a screen. This kind of "medicalized" antenatal care was seen as an extension of seeking advice from a *kaviraj*, or *fakir*, who was regularly consulted on behalf of pregnant women. This practice continues today.
17. It should be noted that nursing is not a prestigious occupation in this stratum of Indian society.
18. An important issue is the arbitrariness of the decisions taken by the *dais*, which have also been studied by Rozario (1998) in rural Bangladesh.
19. With a heavily unionized public sector, doctors in the private sector are more likely to be liable if procedures are unsuccessful. Assaults on doctors have become increasingly common among employees in both sectors.
20. Data on the Caesarean rates in Calcutta's government or private hospitals are not available. It is, however, common for government hospitals to promote vaginal deliveries, although elective Caesareans are offered as well. I know of only one of the bigger hospitals, run by a charity and therefore relatively well-managed, that does not provide elective Caesareans in order to be able to deal with a larger number of women on the maternity ward. This same charity, which offers various treatments and specialist consultations for a basic fee of 3,000 rupees, has long been the favourite place for deliveries among the lower middle class. Recently, however, its management has introduced elective Caesareans within a separate, more up-market, profit-oriented maternity hospital.
    For a more detailed discussion of the impact new discourses on privatization and healthcare have on hospital birth in this context, see Donner (forthcoming).
21. The multiple meanings of pain cannot be discussed in the course of this article. It is, however, remarkable that women never refer to any strengthening propensity that might be associated with the pain endured during giving birth.

22. Just how powerful is the image of vaginal deliveries as painful was brought home to me when women explained that the expression *baeta*, which is used to refer to contractions, is the general term for pain.
23. There is a widespread assumption in the literature that women who return to their natal home are not expected to participate in the running of the household. This was not necessarily the case; rather, it depended on the composition of the household as well as on its economic standing.
24. GPs working with Bengali women in London often find that these women prefer a non-Bengali doctor as they are allegedly less likely to treat a patient as a "daughter" or "daughter-in-law" (Roseanna Pollen, verbal communication).
25. Data from a sample of 210 deliveries in private hospitals in Chennai suggest a high rate (45 percent) of elective Caesareans (Pai et al. 1999). "Elective" Caesarean sections are popular in many countries, notably the United States and across Latin America, where a correlation between higher national products, a well developed private healthcare sector, and rising rates of Caesarean sections has been established (Belizán et al. 1999; Potter et al. 2001). Caesarean sections in Britain account for one-fifth of all deliveries, out of which 6 percent are classified as "emergency" Caesareans (i.e., due to foetal distress, failure to progress, or other complications).

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