A Sacramental Theory of Childbirth in India

Harish Naraindas

In a country of more than one billion people, with 20 odd principal languages, about 225 dialects, and at least two principal religions, it is difficult to say anything about a phenomenon like childbirth that would hold true for the different regions and peoples of India. But what can be said is that about 65% of the births are at home in opposition to perhaps 3% in the United States. If we break this down into rural and urban, then more than 70% of births in rural India are at home with about 74% of the total population living in rural India. And two thirds of these rural births are attended by family and other forms of local experts, which in the current anthropological and public health literature are called either *dais*, or traditional birth attendants (TBAs). Both are omnibus terms meaning many things depending on the context in which they are used. This has led Sarah Pinto (2006) to argue that the Indian *dai*, cast in the image of the European midwife, as someone who attends to the pregnant woman, delivers the child, the afterbirth and does post partum work may not necessarily exist in one person, or not in one person at all times and in all regions of India. Even the general consensus that in "North India", (including Pakistan, Nepal and Bangladesh), the dai's main task is not catching the baby (any of the many women who attend the birth may do so) but cutting the cord and subsequently removing "the polluted and dangerous" placenta is contradicted by the fact that among the very poor the dai is virtually never called. If called, she does not necessarily cut the cord. Instead the cord is cut by the mother as otherwise the child may turn its affection towards the dai rather than the mother (Blanchet 1984).

The contemporary western equivalent of this so-called Indian dai is either the certified Nurse-midwife in a hospital or the independent lay midwife. Its Third World equivalent in anthropological literature is the midwife who is an independent, sagacious and skilful woman such as the Dona of Bridgette Jordan's work in the Yucatan in Mexico (Jordan 1978). She appears to manage the show from start to finish and catches the baby. In other words, public health literature explicitly, and anthropological literature tacitly, looks for the native version of the obstetrician

H. Naraindas (✉)
Centre for the Study of Social Systems, School of Social Sciences, Jawaharlal Nehru University, New Delhi, India
e-mail: harish-naraindas@uiowa.edu

H. Selin (ed.), *Childbirth Across Cultures*, Science Across Cultures: The History of Non-Western Science 5, DOI 10.1007/978-90-481-2599-9_9,

© Springer Science+Business Media B.V. 2009

who, rather than the woman, delivers the child. Hence, while the South Asian dai certainly exists, her image appears to be a late 19th century colonial creation, in so far as it is an amalgam of roles and functions all of which may not have been carried out by a single figure. There are broadly two opposed views of the dai in anthropological literature. In the first, She is not a particularly skilled menial worker whose main job is to remove the pollution of the birth and afterbirth (Jeffery et al. 1985, 1989; Rozario 1995a,b, 1998). The studies that question this (Chawla 1993, 1994; Ram 2001; Van Hollen 2003) see her as also a repository of skills. Other studies (Pinto 2006; Patel 1994; Blanchet 1984 and Unnithan 2002) de-centre the dai and show that the expertise of birthing is more widespread and diffused through the community. Blanchet's study offers an interesting typology of the dais or *dhatri*, and shows when and by whom they are called, and depending on who the dais are (in terms of caste, position in the life cycle, married status, etc.), what kind of roles they perform and skills they possess. But the dai is a necessary figure and is often depicted from the turn of the 20th century as a semi-barbaric figure with dirty fingernails and often associated with un-sterilised cord cutting. The TBA is a nomenclature created by post-war international agencies, especially the WHO (Pigg 1997; Van Hollen 2003). Both these figures have been the subject of vilification, reform, co-option, or all three, and most recently, as a reaction to a kind of quasi deification, though the last is still very much the fringe (Chawla 2006). These shadowy figures, and the fact that most women in rural India still give birth at home, have been touted as reasons for high infant and maternal mortality. This functioned as a necessary trope for both the colonial and the post-independent state, along with the biomedical fraternity and bilateral and multilateral agencies, to run a concerted campaign to put an end to home births and have women deliver in state-run health centres under the often mistaken assumption that they provide better health care. This campaign is currently underway in the name of "promoting institutional deliveries". One of the mandates of the newly constituted (2005) National Rural Health Mission is to promote institutional deliveries as a safe option for childbirth in India. This aim is consonant with the national socio-demographic goal of the National Population Policy adopted in 2000 according to which 80% of all deliveries should take place in institutions by 2010 (Padmanabhan 2008). Its current justification comes from statements such as these: "A large number of neonatal deaths take place at home" (World Bank 2004: 10, quoted in Haq 2008: 27). Or, a woman in India, as compared to a woman in the industrialized West, is 300 times more likely to die during pregnancy and childbirth (*Hindustan Times* 2009). And the reason for this large number of neonatal deaths at home is due to a "high dependency on the services provided by the untrained traditional dais" (Sandhya 1991: 91, quoted in Haq 2008: 27). Hence, between the causal space of the home (which from the late 19th century was seen as the ill lit, ill ventilated, segregated and sequestered space of veiled women, which not only killed children and women but harboured and fostered diseases like consumption), and the untrained and unclean hand of the dai, children died like flies in the first few days or weeks of pregnancy.

As early as 1994, Alpana Sagar, based on a detailed empirical and ethnographic study of an urban (Delhi) slum and a Kumaon village in the Himalayas, called this into question. Ehsanul Haq calls our attention to this by saying that Sagar quite clearly stated "that there is no evidence of infant mortality being high at home" (Haq 2008: 26). Haq then proceeds to demonstrate, what may appear to be a purely local and thus easily argued away claim by Sagar, that this is indeed the case for the whole country. Through the Government of India's National Family and Health Survey (NFHS) data (1992–1993), he shows that if one compares the home with the public health facility, which is where the poor go, neonatal mortality is exactly 48.4 deaths per thousand in both places in rural India. And in urban India the difference is not much greater with neonatal deaths standing at 34.1 at home and 31.3 in public health facilities (Haq 2008: 27). Despite these figures, produced by its own census department, the Indian State and multilateral global agencies like UNICEF and the World Bank continue to advocate for the extirpation of home births. By now we know the reasons for this advocacy from the large body of literature that has been produced on childbirth: (1) the male incursion (starting in 18th century Germany) into an essentially female domain in the form of the male midwife in the West; (2) the rise of obstetrics as a male profession; and (3) the export of disenfranchised female doctors from Britain to India in the late 19th century with the setting up of the Dufferin Fund, who not only came to India to practice medicine that they were largely unable to at home, but also came to deliver sequestered Indian women from the z*ennana* [the part of the house reserved for women]. If we add to this the post-independent discourse on population policy and the increasing pharmaceuticalisation of medicine, we have the new discourse of reproductive health, where childbirth becomes a significant moment to control poor women's fertility behaviour through contraceptive devices like the IUD, which are routinely inserted immediately after birth and often without women's consent (Van Hollen 2003). The end result is the evisceration of both the birthing woman and birth caregivers, with the former substantially robbed of her agency and literally made supine (lithotomised) and the latter vilified and reduced through the expropriation of their skills. This is not to say that there were not, and still are not, a whole range of other reasons such as urbanization and rural to urban migration resulting in the re-articulation of family, kinship and neighborhood networks and the movement from a village based patron-client network to a cash economy. This resulted in women's entering the workforce and in women seeing the hospital as a necessary substitute for the home. But the exercising of these choices is always enacted in the shadow of colonial/state/institutional campaigns that rearticulate women's reproductive behaviour to suit state interests.

We can see from this that the business of birthing in India and elsewhere is caught between these two poles: the evisceration of the woman and the midwife, which is an unfinished project; and the resistance to this project by birthing women and their caregivers by reaction, compromise and resuscitation, helped by concerned women, feminists, hippies, anthropologists and at times by the medical fraternity. If we compare America and India, we can see that this project is virtually finished in the US with only 3% of births occurring outside a medical institution, and it is still a largely unfinished project in India. But by the same token reaction (lay-midwifery),

compromise (natural childbirth through certified nurse-midwives in a hospital), and resuscitation (by the home-birth advocates) is strongest in America and virtually non-existent in India. If we add to this the people like the Amish and other conservative Christian groups in the United States that continue to practice home births like rural Indian women, and finally illegal agricultural workers in the United States who give birth in the fields by sheer necessity, then we can see that both this chapter and this volume on childbirth worldwide, are part of a larger dialogue on the business of birthing. Against this backdrop of the politics of childbirth and reproductive health, we will now see what birthing may mean in India, especially to those women, both rural and urban, who continue to birth at home, though much of what we will say may well apply to women who choose to have an institutional birth.

We will do this by first situating birth within the larger ambit of pregnancy and post partum work, and then within the further ambit of marriage and puberty. If this is the earthly pole, where birth as a rite of passage is caught up in a social field, we also need to situate this rite as mediating between this world and the nether world. The best way to capture both these poles is by situating birth within a theory of Hindu *samskaras* or sacraments. Rajbali Pandey (1969) has classified them into 5 groups: (1) pre-natal samskaras, (2) samskaras of childhood, (3) educational samskaras, (4) marriage samskara, and (5) funeral ceremonies (Pandey 1969: ix). Of these the prenatal samskaras are *garbhadhana* (conception), *pumsavana* (quickening of a male child), and *simontonnayana* (hair-parting). The childhood samskaras are *jatakarma* (birth ceremonies), *Namakarma* (name giving), *Niskraman* (first outing), *Anna-Prasana* (first feeding), *Chuda karana* (tonsure), and *Karanavedha* (boring the ears).

Another way of approaching this is to make a distinction between *vaidika* (scriptual) rites and *laukika* (wordly) rites. One example of this among the pre-natal rites is the one called *simontonnayana* (hair-parting), which is a vaidika rite and the *Valaikappu* (protective bangle), which is a laukika rite. The latter is performed by all castes from the Brahmins to the Dalits (in Tamil Nadu), while the former is largely performed by the Brahmins. Further, it may well be the case that what appear to be vernacular forms may be no different from the vaidika or other textual sources. With these caveats in mind, I offer a synopsis of some of the crucial moments in the business of birthing with the claim that their meanings may be best understood within a larger theory of Hindu sacramentalism.

While my own case material largely comes from Tamil Nadu in Southern India, I will attempt to make forays into other parts. I will further attempt to situate that narrative, where possible, on a global rather than a purely Indian canvas.

Birth as a Transformative Rite of Passage

In India, if a woman is not returned to her natal household, she may fall prey to being the barren first wife as her husband may marry again to produce an heir and ideally a male heir. It is only with the birth of a child that the woman truly moves

from her natal to her affinal home. If this is a male child, in contrast to the stillborn, missing, or female child, her incorporation calls for celebration.

This remark may not hold in most urban and some rural areas in 2009. What we have instead is assisted reproduction, sex selection, surrogate motherhood, female foeticide and adoption. But even if the husband does not remarry, the stigma of barrenness has consequences. In India, barren women even in educated urban circles, while not abandoned, may face a number of discriminations such as not being invited to prenatal pregnancy rituals.

Hence the birth of a child, and especially a male child, in a household with the means to afford it, may lead in certain parts of India (Rajasthan) to celebratory singing in the form of professional singers marking this transformative rite of passage. The unsaid (the missing, dead or female child), is marked by its opposite: the celebration of the live, present and male child (Rao 2006). In one of the Sohar songs sung by women in Rajasthan, the sister-in-law demands the new mother's gold bracelet, and when she refuses, saying that she brought it from her father's household (natal line), the husband's sister threatens to take away her child, which belongs, she says, to her brother's patrilineage (Rao 2006). The young mother on hearing this wordlessly parts with the bracelet, which may be read both as a bribe, and as a realisation that she has now crossed over from her natal to her affinal household and from one patriline to another patriline. This incorporation by no means marks the end of obligations to her natal household. They continue throughout her life: first by the father and then by the brothers and in some senses mark the fact that the woman continues to occupy a liminal position and is forever in exile from her natal house and in her affinal house, after marriage.

The Pre-natal and Post-natal Samskaras or Sacraments

If birth is thus an accomplishment and transformative rite of passage for the woman laterally from one patriline to another, it is also salvific if it is a male child. In the first post-natal samskara called *jatakarma*, the father walks in after the child is born and on seeing it immediately cancels his debts to his ancestors, preceptors and gods. In fact, the etymology of the word *putra* (male child) may be derived from *put* (naraka/hell) and *ra* (as the root of *raksha* meaning to guard, to save). Hence the *putra* is one who will guard or save the father and mother from going to *put* (naraka/hell), by performing their last rites and continuing with the *sraddha* (post funerary rites) that will ensure their movement from being a *pret* (unincorporated soul) to a *pitr* (incorporated soul or ancestor) by helping their soul to successfully cross the river of death.

For some, the first male child is important for the mother's incorporation into the nether world and the last male child for the father. It can be further argued that given the etymology of *putra*, it may simply mean child and is a generic form of address. Given a patrilineal society with patrilineal residence, the funerary rites necessarily devolve on the male child. It is also the case that women on their own may not

perform a sacrifice (*homa*) that involves the sacrificial fire (*agni)*, which for the Hindus and particularly the Brahmins is the fulcrum.

In any case given the fact that the child is a debt cancelling and salvific device, and is almost solely responsible for ensuring his parents' safe passage, it is not surprising that his potential arrival is greeted by a series of prenatal samskaras. They are *garbhadana, pumsavana* and *simanta*. The first is the rite that prepares the couple for conception, the second will determine the sex of the child, and the final one is to ensure that a healthy offspring is born.

While in all these rites the emphasis is on the anticipated offspring and his wellbeing, there is another set of rites where the emphasis is on the woman and her wellbeing. Among my Tamil informants it appears that most castes and classes perform the rites of *poonchuttal* (bedecking the woman's head with flowers) and *valaikappu* (valai/bangle; kappu/protection), which is like a mini wedding where the high point is getting the women to wear protective bangles. Both these rites are almost exclusively women's affairs, while the other three, and especially the *pumsavanam* and the *simantam* are vaidika rites that have textual sanction, involve a *homa* (fire sacrifice) and thus have an officiating Brahmin priest and are done by husband and wife together. While the non-Brahmins may not do the vaidika rites the Brahmins invariably do both. While in both the emphasis is on the wellbeing of the child and woman, the latter are clearly done to make the mother happy. Of these 4 rites, the *pumsavana seemantham* (vaidika or scriptural) and the *valaikappu* (laukika or worldly), are elaborate propositions depending on what every household can afford to do.

The *pumsavanam* is supposed to be done in the second or fourth month, the *poonchuttal* in the fifth or seventh month and the *valaikappu* and *seemanthan* in the eighth or ninth month, with different textual and oral sources for each of these possibilities. But today, especially in large cities and in Chennai in particular, all four rites are performed in the same day. Further, the two vaidika rites of *pumsavanam* and *seematham* to be done in different months are collapsed and the invitation card printed to invite people for the occasion is called *pumsavana seematham*. What often transpires is that the day may begin with a *vallaikappu* around dawn, followed by *pumsavana seematham homa* at about nine, followed by feeding the guests. In the evening there may be the *poonchootal* after which the pregnant woman's mother will take the daughter away to her natal house where she will have the child and stay on for a few months before her return to her husband's home. All these rites are virtually mandatory for the first child and optional for the rest. In fact they are invariably dispensed with for subsequent children.

While Van Hollen (2003) and Petitet (2007) have dealt with the description and meaning of *valaikappu* and *simantam*, I mention the *pumsavanam* to indicate that we need to situate childbirth at the crossroads of marriage and puberty on the one hand and of this world and the nether world, so as to argue that (a) the child allows the double transition of incorporating women from one patriline to another, (b) it ensures the continuity of the husband's patriline into which she is now incorporated, and (c) through this continuity, to potentially make possible the future transmission

of the souls of those who begat it from this world to the nether world. In other words the child gives birth to the status of mother and father and will in the future transform the *prêt* (which literally means corpse or body, but also means ghost) of mother and father into *pitr* (ancestor). And since a lot depends on the child, namely lineage, salvation and labour, it is not surprising to witness the number of rituals associated with its anticipated arrival. These rituals ensure the safe passage of the *douhrdini* – the woman with two hearts and two desires—by invoking the gods, placating the demons, soliciting blessings and by deflecting the bad influences of jealous and envious onlookers. By the same token, the *douhrdini* is subject to proscriptions and prescriptions around food and mental disposition (*ahara* and *vicara*), or *acharam* and *anushtanam* (etiquette/comportment and its implementation), which will determine the outcome of the pregnancy.

Of Demons, Dispositions, and Desires

Obeysekere (1963) in his article on pregnancy cravings in Sri Lanka tells us that cravings of pregnant women are legion and at times peculiar as it is the craving of the child (or the heart within the heart), and these cravings have to be fulfilled by the kith and kin and by the husband. But these cravings may also be harmful to the mother and the child and she is enjoined to conduct herself with a series of proscriptions in terms of food, conduct and her physical and mental disposition if she is not to lose the child. She is also prescribed all that is good for her so that she and the child are well nourished, in good cheer, and protected from envy, jealously and the attack of *bhut* (demons/goblins).

In the light of this the samskaras or sacraments attempt to ensure a viable, healthy and safe outcome for the child, an eventless pregnancy for the mother and an uncomplicated post partum recovery with no problems with lactation.

What a turn towards the sacraments allows us to do is to show that what appears to be ritual, rather than being divided into the superstitious and the practical, may be seen as efficacious acts that address different orders of reality. This is further compounded by the fact that all Asian civilisations, including the Greek on the periphery of what is now called Asia Minor, had a humoral theory of medicine, where the distinction between mind and body and of matter and spirit was rather differently articulated. What appears to be a superstitious injunction, such as that the pregnant woman should not sleep during the day, may mean something different if it is seen through Indian humoral theory. Sleep, and daytime sleep would lead to an increase of *kapha* (phlegm). This, combined with excessive eating, and a sedentary existence, may result in what is today called gestational diabetes. While this may be admissible as a rational explanation as it deals with possible physiological processes, the claim that similar injunctions if not followed will lead to an attack by the *bhut* and lead to a miscarriage, or the *bhut* sucking the blood of the child, are not scientifically acceptable. But *bhutvidya* (the science of *bhuts*) is one of the eight branches of Ayurveda (Indian medicine) and is now translated as psychiatry rather than as demonology/spirit possession.

I introduce this to suggest that all of the rituals must be seen as addressing (a) the unseen world of *bhut* that comes come from the outside and possess the woman; (b) the general disposition of the woman in terms of both her mental and physical exertions and conduct; and (c) the desires of the pregnant woman, which have to be fulfilled without harming her or the foetus.

In the light of this if we revisit the *pumsavanam*, we see that it is performed when the moon is in a male constellation. The pregnant woman fasts on that day, bathes and puts on new clothes, and the high point of the ritual is the insertion of the juice of the sprouts of the banyan tree into her right nostril. The rationale for this comes from the medical treatise by Susruta, where the juice is said to prevent a miscarriage and to ensure the birth of a male child (Pandey 1969: 61–62). If the father desires that his son should be virile, he should place a pot of water in the lap of the mother and "touching the stomach recite the verse 'suparnosi'" (Pandey 1969: 61), which is at once a prayer, an invocation and a "magical" incantation.

While the *Dharmashastras* and other texts debate on which month this should be done, another famous medical compendium called the *Ashtanga Hridayam* (7th century), talks about the *pumsavanam* as a *kriya* (action) and a medical procedure for ensuring a male child. It says quite clearly that this should be done immediately after conception when the "conception" is still an unformed mass, and lists eight different procedures, including the pounded juice of the banyan tree.[1] This is the one that is still followed, except for the fact that they seem to follow the non-medical texts as they do the *Pumsavanam* much later. While this may not produce a male child it may still contribute to a viable and healthy one.

The *seemantham* (hair parting) is to protect the foetus from blood sucking demons by invoking the goddess Sri and bring prosperity to the mother and long life to the child. The idea was to recite sacred hymns that the child would absorb. It was also done to impress upon the woman that she should now take care to prevent any kind of physical or psychic shock to the foetus, symbolised by the parting of the hair as mode of boundary marking (Pandey 1969). The purpose was also to keep the woman in good cheer by showering her with gifts, presenting the choicest of food, dressing her up like a bride, and regaling her and addressing her as if she were a goddess. The *valaikappu* has much the same import in broad terms. In both the expectant mother is dressed in a black sari to ward off the evil eye. Finally, part of the purpose was also to feast the woman in every way, as childbirth was also a wager with death. An un-feasted and unhappy woman, were she to die in childbirth, would be the object of lasting regret to all those she left behind and would haunt them with her memories and might also return to haunt them as a prêt (ghost) (Petitet 2007).

While this is the general rule, the modalities vary by region, sectarian affiliation and caste. And sometimes this ritual may appear with variants not during pregnancy but during marriage, or even during the engagement ceremony. Among the Sindhis it is called *Tel* (oil) where the woman is anointed with oil; it too is done in the eighth month now. In the Punjab it may appear as *godh barai* (to fill the lap with presents).

Birth Ceremony

We will now move from the prenatal samskaras to the *jatakarma*, or birth ceremony proper, which is done prior to the cutting of the cord after the birth. The first part is called the *Medh-Janna*, where the father with his fourth finger and an instrument of gold gives the newborn child honey and ghee (clarified butter). The purpose of this is to ensure the intellectual wellbeing of the child. Given with the uttering of the Gaythri mantra, both the incantation and the substance were meant for stimulating talent and fostering intelligence. At the same time a secret name was given to the child along with the phrase "thou are the veda". The name was only known to the parents in order to prevent enemies from performing black magic on the child (Pandey 1969: 74–75). This was followed by *Ayusia*, done to ensure the long life of the child, followed by another to ensure its hardy and pure life (Pandey 1969: 76), after which the navel cord was severed and then the child was "washed and given the breasts of the mother" (Pandey 1969: 76). This was followed by further ceremonies to ensure the protection of the child and mother during post partum, part of which was to put a pot of water beside the head of the mother and the offering of mustard seeds and rice chaff into a fire that the father had established at the door of the newly built maternity house at the time of her confinement. This offering of seed and chaff was accompanied by a mantra or magical formula, where all the diseases of childhood were invoked and banished. Feasting and alms giving followed this, as "the merits of alms given on the day of a son's birth are eternal" (Pandey 1969: 77).

The *jatakarma* is preceded by the building of a special maternity hut, whose specifications, directions and accoutrements are laid down in some detail. It was anointed to ward off evil, and the expectant woman was confined to it accompanied by experienced women who kept her in good cheer, anointed her with ointments to facilitate the birthing and advised her on proper diet and living. During the time of labour all the knots in the house were loosened, symbolising the loosening of the foetus; and a special rite called *sosyanti-karma* was done to expedite the delivery by the force of an Atharvan verse, "Not as it were stuck in the flesh, not in the fat. . . let the slimy afterbirth come down for the dog to eat" (Pandey 1969: 72).

Of Childbirth and the Sacraments

If we look at the empirical literature on South Asia, we can see that all the themes laid out in the sacramental or samskara literature have full play with their own regional and local variations. The texts themselves are numerous, they debate and disagree, and they too may be seen as instances and practices at par with other living and oral traditions. As Blanchet's (1984) study among the Muslims in Bangladesh shows, both notions of pollution and the belief in *bhut* are fundamental in any understanding of childbirth. In Tamil Nadu the *valaikappu* is performed by Hindus, Muslims and Christians. For example, as one goes down the caste hierarchy, one may not give the child honey and ghee with a gold instrument, but instead give sugar

water (ideally palm sugar) for the first day, and a bit of ass's milk, failing which the child is likely to suffer from weak eyesight and will be open to repeated attacks of hepatitis later in life. And everywhere the cord is never cut until after the placenta is delivered, and often, as Blanchet points out, the placenta is used to revive a stillborn child by warming the placenta in various ways. And while the placenta may not be fed to a dog as in the above Atharvan verse, it is disposed of in special ways, often buried deep in the ground so that dogs actually don't get to it. And in case the child dies in childbirth it is cremated so as to prevent a *mantarvadin* (one who does witchcraft) from accessing body parts, especially the *mulai* (brain), which is cardinal for his craft. And in contemporary times, as Patel and Blanchet point out, the placenta is buried far away with one of its favourite resting places being the University in the belief that the child goes where the placenta has gone.

The post partum "mother roasting" is performed (Manderson 1980), because of the notion that the mother after birth is cold (in terms of the hot cold polarity in humoral medicine) and suffers from a loss of heat, and needs to be kept warm from 10 to 40 days. The husband lights a fire at the door of the maternity house and keeps it alive until the mother rises from her bed post partum. The fire, along with the mustard and chaff that is fed into it, also functions to keep *bhuts* at bay.

Her coldness and vulnerability are also marked by dietary prescriptions that may vary from giving exceedingly rich and heating food made of almonds and pistachios and a host of other ingredients in the Punjab and north India, to giving her nourishing but not so hot food in the warmer regions of South India. And in the north, among the poor, other substitutes to almonds and pistachios exist while the principle remains the same.

Knowledge of birthing is diffuse and widespread, and the role of the dai or midwife may vary by region, religion and social class. But what is important is that birthing seems to be a collaborative exercise by the mother, kinswomen and the midwife, with the dai, dhatri, or marutuvachi handling the afterbirth and immediate post partum work and assuming a more prominent role in the case of a difficult birth. And in Tamil Nadu (and elsewhere) the marutuvachi in rural areas is part of a patron client network, and she may reappear in different moments in a family's sacramental life cycle. As a ritual specialist she is due either a portion of the farm produce and/ or payment at each of these events. As a 76-year-old informant put it, "my grandmother delivered all eight of us, cut the cord and buried the placenta, but she never failed to give the marutuvachi what was her due. That is something you had to do".

It is for this reason that situating birth as part of the samskaras makes sense, irrespective of what community one is studying. Eshanul Haq, in his study of both Hindus and Muslims in Uttar Pradesh found that it is because of sacramental need that rural women prefer the home, quite apart from the fact that most often poor rural women are treated badly in the hospital, are guinea pigs for meeting family planning targets, and as it transpires not necessarily safer in a public health facility than at home. As for high infant and maternal mortality and morbidity, it is moot as to how much of this is iatrogenic, given the fact that episiotomies (for example) in public post-graduate teaching hospitals are 96% and virtually 100% in private hospitals

(Selvaraj et al. 2007: 16). Finally, people may die and fall ill not necessarily due to indigenous birthing practices (though that too is possible) but to sheer want and poverty and the attendant malnourishment and impossible living conditions. Rather than addressing this, a social problem is medicalised and converted into a medical problem and it is presumed that indigenous practices and ill-trained personnel are what need to be extirpated.

Note

1. I thank Dr. Girija, an eminent Ayurvedic doctor in Chennai, for bringing this to my attention.

References

Blanchet, Teresa. *Women, Pollution and Marginality: Meanings and Rituals of Birth in Rural Bangladesh*. Dhaka: University Press, 1984.

Chawla, Janet. *A Woman-Centred Revisioning of the Traditional Indian Midwife: The Dai as Ritual Practitioner*. Research Paper for Masters of Theology Degree. Delhi: Vidyajyoti Institute of Religious Studies, 1993.

—. *Childbearing and Culture: Woman-Centred Revisioning of the Indian Midwife: The Dai as Ritual Practitioner*. New Delhi: Indian Social Institute, 1994.

—."Mapping the Terrain: Birth Voices, Knowledges and Work." *Birth and Birthgivers : The Power Behind the Shame*. Ed. Janet Chawla. New Delhi: Shakti Books, 2006. 11–79.

Haq, Ehsanul. "Place of Childbirth and Infant Mortality in India: A Cultural Interpretation." *Indian Anthropologist* 38.1 (2008): 17–32.

Jeffery, Patricia, Roger Jeffery, and Andrew Lyon. *Contaminating States and Women's Status*. New Delhi: Indian Social Institute, 1985.

—. *Labour Pains and Labour Power: Women and Childbearing in India*. London and Atlantic Highlands, New Jersey: Zed Books, 1989.

Jordan, Brigitte. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. California: Eden Press, 1978.

Obeysekere, G. "Pregnancy Cravings (Dola-Duka) in Relation to Social Structure and Personality in a Singhalese Village." *American Anthropologist* 65 (1963): 323–42.

Padmanabhan, P. *Integrated Service Delivery in Primary Health Care. The Tamil Nadu Experience*. Paper presented at Jawaharlal Nehru University, Sep. 2008.

Pandey, Rajbali. *Hindu Saṁskāras: Socio-Religious Study of the Hindu Sacraments.* Delhi: Motilal Banarsidass, 1969.

Patel, Tulsi. *Fertility Behaviour: Population and Society in a Rajasthan Village*. New Delhi: Oxford University Press, 1994.

Petitet, Pascale Hancart, and Pragathi Vellore. "Ethnographical Views on Valaikappu. A Pregnancy Rite in Tamil Nadu." *Indian Anthropologist* 37.1 (2007): 117–46.

Pigg, Stacey. "Authority in Translation: Finding, Knowing, Naming and Training 'Traditional Birth Attendants' in Nepal." *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives*. Ed. R. Davis-Floyd and C. Sargent. Berkeley: University of California Press, 1997. 233–62.

Pinto, Sarah. "Divisions of Labour: Rethinking the 'Midwife' in Rural Uttar Pradesh." *Birth and Birthgivers: The Power Behind the Shame*. Ed. Janet Chawla. New Delhi: Shakti Books, 2006. 203–38.

Ram, Kalpana, and Margaret Jolly, Eds. *Borders of Being: Citizenship, Fertility, and Sexuality in Asia and the Pacific*. Ann Arbor: University of Michigan Press, 2001.

Rao, Vidya. "Singing the Female Body: An Exploration of Sohar Songs." *Birth and Birthgivers: The Power Behind the Shame*. Ed. Janet Chawla. New Delhi: Shakti Books, 2006. 80–122.

Rozario, Santi. “TBAs (Traditional Birth Attendants) and Birth in Bangladeshi Villages: Cultural and Sociological Factors”. *International Journal of Gynaecology and Obstetrics* 50.2 (1995): 145–52.

—. “Dai and Midwives: The Renegotiation of the Status of Birth Attendants in Contemporary Bangladesh.” *The Female Client and the Health Care Provider*. Ed. J. Hatcher and C. Vlassoff. Ottawa: International Development Research Centre (IDRC), 1995. 91–112.

—. “The Dai and the Doctor: Discourses on Women’s Reproductive Health in Rural Bangladesh.” *Modernities and Maternities: Colonial and Post Colonial in Asia and the Pacific*. Ed. Kalpana Ram and Margaret Jolly. Cambridge: Cambridge University Press, 1998. 144–76.

Sandhya, S. *Socio-Economic and Cultural Correlates of Infant Mortality*. New Delhi: Concept Publishing House, 1991.

Selvaraj, S., et al. *Episiotomy. A Real Need or Ritual?* Poonamalee, Chennai: Institute of Public Health, 2007.

Unnithan-Kumar, Maya. “Midwives Among Others: Knowledges of Healing and the Politics of Emotions in Rajasthan, Northwest India.” *The Daughters of Hariti: Childbirth and Female Healers in South and Southeast Asia*. Ed. Santi Rozario and Geoffrey Samuel. London and New York: Routledge, 2002. 109–29.

Van Hollen, Cecilia. *Birth on the Threshold: Childbirth and Modernity in South India.* New Delhi: Zubaan, 2003.

World Bank. *India: Country Strategy*. New York: Country Management Unit, South Asia Region, World Bank, 2004.