SOCIAL TRENDS
Journal of the Department of Sociology of North Bengal University
Vol. 6, 31 March 2019; ISSN: 2348-6538
Peer-reviewed National Journal
UGC approved (Sl. No. 42176)

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Childbirth Practices and Midwifery: Exploring Social Changes in Indian Context

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Abstract: *Healthy women represent health standards of any nation, although the maternal health care throughout the world is severely damaged. The paper discusses changes in the social location of Dais and their socio-cultural roles over the decades till the contemporary society. Many scholars have brought to light the way politics of knowledge works, and how the knowledge based on experience, skill, insights and culture is denounced. State has taken several measures in maternal health care but has failed in yielding good results. The paper tires to compare birth practices in different parts of India and tries to evaluate the reasons behind the similarities and differences. Three major areas of the problem have been located in childbirth practices. First, despite of government measures the rural and poor women continue to face discrimination in the maternal health care, particularly those who depend on unskilled birth attendants; second, the over-medicalization of childbirth; and third, the continued practice of homebirth.*

Keywords*:* Dais, midwife, over-medicalization, social change, place of birth, government plans, politics of knowledge.

Introduction

Healthy women are the representation of the health standards of any nation, significantly because of their role in creating healthy infants, but the maternal health care throughout the world is severely undermined. Studies have shown that about half a million deaths occur every year due to childbirth and related complications (Koblinsky and Campbell 2003). In addition, 90% of maternal deaths are in the developing countries (WHO 2005). India has a high rate of maternal mortality rate although various state-sponsored programs are in place (Ved and Dua 2005). Childbirth and associated system of health-care is shaped by various rituals and traditions in all parts of the world. Childbirth continues to be considered primarily as *women's business*.

Since the practice was related to various degrees of purity and pollution, the doctors (mostly from upper caste), who were usually men known as "kaviraj" and "hakims", secluded themselves from birth. Childbirth was clearly the domain of traditional *Dais* that included herbal medicines and supernatural practices (Ghosh 2016).

According to Ghosh (2016) the expectant mother was supported by the experienced women of the family and neighbourhood; and assisted by low caste *Dai*s. *Dais* are addressed differently in different society[1]. Often the term *midwife* is confused with the term "traditional birth attendants". Traditional birth attendants (TBAs) or *Dais* have been the main health care providers for women during childbirth. They play a significant role for women when it is about cultural competence, consolation, empathy and psychological support during pregnancy, labor pain, with benefits to mother and her new born child (Yousuf et al. 2010). Indian *Dai,* according to Sarah Pinto (2006), is someone who attend the pregnant ladies, assist them to deliver the child and help them in the post-partum chores, but this may not necessarily be done by the single person throughout India. The *Dai's* main task is not only catching the baby but also cutting the cord and consequently removing "the polluted and dangerous" placenta. There are also some poor families where the cord is believed to be cut by the mother herself, for the fear that the child may become more familiar with *Dai* than the mother (Pinto 2006). Louis Dumont (1980) in his study among the South Indians referred to the Tamil traditional birth attendants, locally known as "*maruttavacci*" (female doctors), associating it with the lower caste involved in removing impurities of both the menstruation and birth along with the task of cutting the umbilical cord. According to him, they were mainly the wives of washermen and barbers (Dumont 1980).

Childbirth practices and social change

The practice of home birth with the assistance of traditional birth attendants or *Dais* is no more a widely practiced phenomenon. Home birth practice is an age-old tradition in India. It is a phenomenon where childbirth occurs at home (not in a hospital) in the presence or absence of a professional attendant (WHO 1997). There has been a tremendous change in the last few decades regarding the choice of the place of birth. With the advent of formal health care institutions with its co-related modern machines and health care technology some significant changes have taken place in the whole perception and practice of child birth and mother-child care. Some specific and notable changes are in the form of caesarean birth in

complicated situations, ligation, monitors to examine the motion of unborn child, injection to reduce pain during labour, forceps and so on. These new technologies were first invented in the sphere of obstetrics, and then were put to large-scale use in the healthcare system. Although people were hesitant in accepting these technologies because of pressure of tradition and culture over time these practices were adjusted into the culture of the people. These inventions were widely welcomed and induced into the practice of child birth; the modern medical science thus established its dominance over oral knowledge.

Yogendra Singh (2012) has observed that the initiations of modernization of India had emerged during the national movement of freedom struggle in India. He claimed that the colonial rule had created consciousness among the leaders about the improvement in the technological and scientific skills. Similarly, we can also locate the advent of modern health care institutions for maternity care within the modernization process that India had experienced. As a part of its strategy to make its holds strong in India the British introduced modern maternity care service and took measures to improve the status of women. These were welcomed by the new elite, educated and social reformist section in order to formulate their own approach to modernize India. Yogendra Singh (2012) emphasized that science and technology failed to make an impact on the "fundamental values" that society and the individual members cherished. The instrumental power is dominant only till the relation between the means to an end is established. According to Lal Behari Dey (1878), *Dais* were believed to be of great significance in the traditional socio-cultural discourses around the phenomenon of birth. *Dais* had a figure of a mother and believed to have secret connection with God. Thus, Yogendra Singh (2012) is right in asserting his claim that the *Dais* are included in various rituals in Indian society despite of the fact that their social role is declining.

Conceptualizing childbirth: Contemporary critics

Kalpana Ram (2009) in her essay 'Rural Midwifes in South Asia' has criticized the way in which politics of knowledge works. She argues that the criticism of the traditional childbearing methods and practices was one way to criticize the entire indigenous culture. According to Ram (2009), Dumont's *Homo Hierarchicus* (1980) is most problematic for his utmost importance to religion and reduction of entire Indian culture into merely a system of hierarchy through the complex of purity and pollution. The knowledge which the midwives possess is not acknowledged because of

its lack in literary tradition. The medium of transfer of knowledge is from hand to hand (or orally). Ram (2009) has expressed her discontent regarding the attitudes of both the Indian tradition as well as of the western tradition which are least interested in the knowledge that is acquired from body to body. *Dais* representing the lower caste are the women who stood at the intersection of multiple layers of power play. Their knowledge and wisdom of the traditional practice of childbirth has been devalued by the patriarchal order and ever-growing inclination and faith towards western medicine and healthcare. The unwritten traditional knowledge of the *Dais* has no value in the society which only gives legitimacy to the knowledge that is documented. Thus, the knowledge system based upon experience, skill, insight and culture is denounced (Ghosh 2016) and allowed to vanish.

State policies on childbirth in India

There are many State schemes which foster changes in the birth practices. Mira Sadgopal (2009) points to various schemes such as the Janani Suraksha Yojana (JSY), which aims to reduce the maternal and neonatal mortality. The National Rural Health Mission (NRHM) strongly urges expectant mothers to go through "institutional delivery" and avoid home birth. This attempt has led to the marginalization of the *Dais* or traditional birth attendants and their age-old tradition of childcare, thereby excluding them from the category of "skilled birth attendants". The idea of "mainstream" maternity care itself is vague. There arise certain questions like whether proper maternity care means "hospital-centered" childbirth care. If so, then several critics have pointed out that this model is gender-insensitive and highly commercialized. Or, does it imply the parallel practice of indigenous healing and midwifery traditions? Does it mean institutionalized changes only at the primary health care centre to incorporate rural poor? Is there a scope for the referral units, that are mostly allopathic, to become sensitive to the knowledge and skill of the traditional birth attendants and allow them to serve as a backup for home births? An examination of all these questions suggests that the hope of incorporation of the best indigenous knowledge and practice of traditional birth attendants into the modern health care system seems to be on the wane. The need of the hour is a well-linked scheme of women-friendly comprehensive maternity services where maternity services would not only serve as essential referral facilities but also harmonize with the indigenous practices.

The organizations of global health agencies like The World Health Organization (WHO), United Nations Children's Fund (UNICEF), United

Nations Population Fund (UNFPA) and others claim that the reason for the high mortality is within the indigenous practice of communities and that can only be met through technological and managerial solutions. The blame on the *Dais* can be traced since the colonial invasion, which created a tradition-modernity binary, in which the modern was always projected as superior over the traditional. In the last three decades, the official effort to incorporate *Dias* to extend primary health care has been reversed. The trained *Dais* were never incorporated effectively and this has contributed to their marginalization and exclusion from the modern and formal health system. The slower rate of reduction in infant mortality rate and few other factors prompted a reconsideration of the health governance strategy. The overall approach of the Dai-training continued to treat the *Dais* as illiterate, superstitious and unhygienic. However, in the 1990s, because of the lack of any solid evidence that TBAs can reduce maternal mortality rate, the interest in training *Dais* waned. Mira Sadgopal (2009) claims that the training itself has stopped *Dais* from intervening in critical and emergency situations, forced women to non-existent facilities, and taught them unsafe practices for "safe delivery" like the use of rubber sheets.

Historical and political factors responsible for the change in birth practices

It has been observed that historical and political conditions also shape the nature and character of birth practices (Ghosh 2016). According to Ghosh (2016), the traditional system of childbirth practice only existed in its pure form until the nineteenth century. In rural India, non-institutional birth is still in practice but several changes have also come due to the interference of modern medical practices. The Western midwifery system was introduced by the missionaries sporadically in the first half of the nineteenth century. Such efforts to medicalize childbirth can be located in the colonial efforts to "civilize the natives", who according to the British were the victims of oppressive social system. A new set of policies was started in the latter half of the 19th century that redefined the experience of women during childbirth.

Ambalika Guha (2017) also argues that medicalization of childbirth in India began in Colonial India as an attempt to 'sanitize' the *zenana* (it refers to the secluded quarters of the respectable households inhabited by women) as prominent site of childbirth practices and replace them with trained midwives and qualified female doctors. According to scholars like Mavalankar, Raman, Vora (2010) the development of midwifery was started

as early as 1797 in Madras with the setting up of a "lying-in-hospital". The first formal training for midwife was started in the same institution in Madras sanctioned by the British government. There were trained midwives from Britain as well traditional birth attendants who were trained by the European midwives in these midwifery schools were allowed to practice childbirth care independently.

Birth practices in Indian Context: A brief overview

Notwithstanding the efforts made historically and even by the present government, traditional birth attendants still continue to play an important role in many parts of India. A study done by a group of scholars in Rajasthan found that unlike many parts of India, where the medicalized child birth have become a norm, people in Rajasthan still strongly favour home birth. Some people avail the facility of institutionalized childbirth only when the expecting mother's health takes a critical turn or in the cases where the pregnant women is very young. (Iyengar, et al. 2008). The Indian government's National Rural Health Mission has invested heavily in promoting mother-child health care facilities from 2006 onwards, and this has led to a marked increase in the number of institutional deliveries across India (ibid).

The situation of Dai in the inner Himalayas was not very different. The study done by Thakur, Sinha and Pathak (2017) in Mashobra district found that though there were the availability of government facilitated maternal services the attitudes of women favouring home delivery remained unaltered because TBAs fed the common cultural and spiritual needs.

A similar study done in Maharashtra by group of scholars among the tribal population found the prevalence of the practice of birth at home by traditional birth attendants to a significant scale. The group found that around 90% of the tribal women preferred delivery conducted by the TBAs mainly because of the strong belief and faith in Dais and the various rituals which they conduct. Poverty is another factor that prevents the tribals from availing the modern health care facilities (Begum, et al. 2017). However, the scholars in the present context blamed "ignorance" of the tribal women due to their poverty and illiteracy as the main reason for not availing modern health care and institutional birth. However, the group failed to record the inadequacies in the modern health system.

The first major issue that has been figured out is the failure on the part of the government to acknowledge the traditional practices and care of the

Dais and this led to the fading out of their indigenous knowledge. In a study done by the Ratika Thakur and others found that only one TBA had passed on her indigenous knowledge to her successor (grand-daughter), however in other cases due the lack of interest of the government health centres the skill was not passed on (Ratika Thakur, et al. 2017). The untrained TBAs, with lack of knowledge, cannot deal with the complicated cases involving risks that might result in the maternal and child mortality. The incorporation of the Dais into the mainstream heath centres is important in reducing the maternal mortality rate especially in the rural areas as some studies shows how the quality of relationship between the birth givers and birthing mothers affects the delivery experiences of the mothers. Unn Dahlberg and IngvildAune (2012) have observed that the quality of relationships and relational continuity between the birth givers and birthing mothers are the key to the positive birth experience. The TBAs are aware of the importance of interpersonal relationships and they take extra care in building a relationship of trust with the expecting mothers. In their own words, 'through relational continuity, psychological trust and predictability may be created. Relational continuity allows the midwife to meet the woman in the context of a holistic perspective. This may promote well-being and a potential for personal growth for the individual woman and her partner, and could in turn promote "empowerment" for the whole family' (Dahlberg and Aune 2012). Ghosh (2016) has elaborated the relevance of the *Dai* in traditional childbirth practices. He notes that the knowledge of the *Dai* should be preserved as there are many traditional practices of *Da*i that have been devalued since ages but there are also many practices which have found its validity in the realm of so-called scientific world. There is widespread prevalence of obstetric violence in Indian hospitals which has been widely reported. While in government hospitals the incidences of abuses like, shaming, verbal abuse, scolding, yelling and also include physical abuse such as slapping and episiotomies are practiced at rampant (Rao 2015). WHO and the other international agencies have significantly put forward the importance of midwifery or skilled birth attendants but the government of India has only promoted the "institutional birth", though it has been funded internally by Reproductive and Child Health Programme and nationally funded by National Rural Health Mission (NRHM) (Mavalankar et al. 2010). Thus, the financially disadvantaged section has to suffer both in opting for home birth and choosing institutional birth.

In case of Bengal, during the late 19th and early 20th century, the medicalization of childbirth was promoted by the social reformist and nationalist discourse especially by the middleclass Bengalis. In twentieth

century, individual tracts on scientific midwifery gained centrality, though the tracts were inherently scientific an attempt was made to write in lucid Bengali terms to attract popular readership. The professionalization of midwifery in 1940s was considered to be the keystone towards nation's building. This was initiated by the new educated Bengalis explicitly to improve the condition of the 'low-status' Bengali women in socio-cultural codes. Developing the discourse of midwifery became one of the ways in which they attempted "modernize" middleclass women as mothers. The political condition in Indian society in the first half of the 20th century was suitable for introducing Western medicine to strengthen its roots in India as the elite reformers or the so called "Bhadroloks" desired their spouses to complement their progressive ideology through adherence to the scientific systems and thereby becoming true "Bhadramahilas'' themselves.

The case of Siliguri

The structure of midwifery and TBAs in town is different from what we generally find in the rural areas. My study in Siliguri on the birth practices has yielded different result on the presence of TBAs and their role in the society (Sharma 2018). Siliguri, a class one city, is located in northern side of state of West Bengal. A total of 30 women, selected by random sampling from various caste and class backgrounds, were interviewed to know about the prevalent birth practices and their social implications. The respondents comprised of mothers (irrespective of the age), health-in-charge of the maternity health centre, a Traditional Birth Attendant (TBA) and a trained midwife. The study found that assistance of TBAs in childbirth is not a common practice among the urban mothers any more. I tried to find out the areas of conflict between the modern and traditional forms of childbirth and the increasing trend towards the medicalization of childbirth. In an interview with Birla Paul, the health-in-charge of a primary health centres in Siliguri, narrated many instances of the contradiction as well as adjustment between the modern prescribed methods by the doctors and the methods of the old traditions.

Birla narrated that:

> the expectant mothers are very conscious and particular about the bio-medicine prescribed to them. However, simultaneously, they follow certain rituals that can be harmful for the maternal health. Few examples of which are the rituals of *Sadh* according to which they can only consume food after the ritual is completed. The health centres has female working members who perform the duty of

surveillance and identify the pregnant women and give them the medical attention they need.

It can be stated that in Siliguri only institutionalised birth takes place. It is primarily the North Bengal Medical College, which was established in 1968, serves as a low-cost provider for the facility of maternity services in the area. It is primarily the mothers of the low-income who avails the maternity services in these government hospitals. It was very difficult to find TBAs as well as new generation mothers who have experienced home births. A few mothers who had experienced home birth are aged. The perception of the mothers regarding TBAs was also sociologically important to note. The TBAs are generally believed to be unskilled with little knowledge and are thought to be accessed by only the people who are superstitious.

The Atur Ghar

In the process of medicalization of childbirth in India the childbirth which was primarily a female oriented ritual has gradually become a medical event (Guha 2015). This resulted in the mixing of medical intervention in the performance of the childbirth rituals. Some of the rituals like making up of Atur Ghar (a makeshift arrangement for childbirth) also has lost its relevance due to the rapid increase of institutional birth. In Atur Ghar in Bengal, several prescribed and at the same time "polluted" acts and rituals were performed, some by the *Dais* and some by the elderly and experienced female members. The design of the 'Atur Ghar' with only one opening through the door replicates the closed, warm condition of the mother's womb (Ghosh 2016). According to Health Family and Welfare Department in West In 2011-12 West Bengal recorded 80% institutional deliveries, which indicates the waning importance of Atur Ghar and the traditional knowledge.

Over-medicalization of Childbirth

The second issue in the current discourse is over-medicalization of childbirth, which refers to a state where the birthing process is severely commercialized specially in the places, such as urban centres like Siliguri, where the unavailability of the maternal health facility is not a problem. The genesis of the problem can be located in the 19th and 20th century studies in physiology about women's body. The terminologies like "engine-object-path" where the engine represents uterus, objects represents foetus and path is the vaginal canal to were used in some classical obstetrics text books to describe the phenomenon. This reductionist approach weakens

the women's agency and thus undermines the biological and sociocultural significance of the birth.

In this technique centred notion of a pregnant woman is considered as a patient. This leads the pregnant women to lose the agency over her own body. In medicalizing childbirth, it is mandatory that the patient, or the mother, is subjected to regular monitoring by the doctors in the form of overdoses of medicines and electoral foetal monitoring (EFM), induced labour, delivery by caesarean section, episiotomy, epidural anesthesia, and so on (Hausman 2005). Health care has become an industry where the technical side is given more significance than the care aspect. The industrial rationality to develop productivity is applied to the institution of healthcare system. The result of which is the practice of caesarean section as a production line to increase efficiency (Rattner 2009). Gradually it comes in the common understanding that labour is an illness where operation can be required to hit a setback through c-section. Thus, within few years there has been massive rise in caesarean birth. It shows that the private hospitals have conducted 27.7% C-section in 2005-2006 which has increased to about 40.9% in 2015-2016 (Kaul 2007). Thus, we can find a change in culture of birth practice of the people which is extensively motivated by the notion of profit in the health care system.

Making Homebirth a Luxury: Sensing Class in Childbirth

The third issue in the field of contemporary birth practices is making child birth at home a luxury. The urban educated mothers who had a bitter and problem-ridden experience in their initial birth, which might have been a normal birth in hospital, are now ready to experience an alternative child birth practice in case of their later childbirths. In a newspaper article (*Times of India*, 2016, 17 July) Lina Duncan, practicing midwifery in India, explains how the urban women are opting for an alternative birth practice at home. The article narrates different experiences of the women on childbirth in formal birth giving institution and then how they are different from their experiences of child birth assisted by Lina Duncan. While home births are still numerically insignificant the new urban educated women are looking forward to child birth experiences compared to what they experience in busy labour wards in modern hospitals. Lina Duncan started with just one out of hospital delivery in a year, which went up to 14 the following year and in 2015 it went up to 38 women who had midwife assisted childbirth.

The women who are opting for midwife are mostly those women who had disturbing experience at the time of their first child birth. The needs of the would-be mothers are mostly comfort, privacy and the words of ease which they find in these midwives who are available on call 24/7. They are equipped with all medical facilities of birth during prenatal phase, nutritional help and postpartum care.

Aloka Mehta, one of the respondents, remembers how her first baby was pulled out by the doctor three weeks before the due date to suit his holiday plans. She was put under medication to speed up labour. She felt herself to be a mere tick mark in the list of the doctor. For her second birth she turned one of the rooms in her house into a birthing room where she had the favourite music played by her husband and her midwife maid to make the whole process of child birth much less daunting. She explained how she felt much more empowered and dignified. After giving birth and cuddling her new born, she called her dear ones to give them the good news and went back to bedroom to sleep. The former software professional-turned-childbirth practitioner says, "when there's love and no fear, birth happens like a song".

Over-medicalization of the childbirth made these urban educated women to choose an experience where they could feel empowered and have control of the situation. However, the problem arises when a form of birth which is considered ideal by these women becomes a luxurious product which could be availed only by who can afford it. The service of midwifery comes at a cost that are more expensive then the birth at birth giving intuitions. Thus, we can say that the concept of "normal birth" is sold as a product that can be availed by only those who can afford it; empowerment and maximum control over the body come with a cost.

Conclusion

The promotion of institutional birth has put the traditional birth giving knowledge of the Dais and their profession in jeopardy. Despite suggestions from WHO and other health bodies there has been no proper arrangement for training of the *Dais* and incorporate them into the institutional mother and child care practices. This has caused the loss of livelihood of the low-caste impoverished women and their knowledge of birth giving. The over medicalization of birth giving practices has inflicted loss of agency and control over body for the mothers. The near complete take-over of birth giving practices by modern medicine has commodified the concept of

"normal birth". A section of educated urban women who look at institutional birth critically try for alternative birth giving experience at home with the help of professional midwife find the experience gratifying but much more expensive than the institutional birth. For the average women it is thus so difficult to get out of the modern, over medicalized, over commodified mother birth giving practices.

There are several movements going across the world in order to humanize child birth. There is a growing consensus around women's human rights and access to evidence-based care. Though women today are more liberated from the restricted and scheduled private world and have entered into the public sphere, they largely become alienated while losing their agency in her own reproductive labour. She barely has any control over the market-driven forces which exercises dominance through knowledge and power over her body. Maternal mortality rate has become the single most factor for safe motherhood, however the overall goal should be complete maternal health care and rights of the women.

Note

1. In Maharashtra they are referred to as "suin", in Tamil Nadu they are called as "maruttuvachi" and in Bengal and many other North Indian states they are referred directly by their caste occupations like "dom", "chamar", "nain", "bisodin" or "mehrin". *Dai* is a hereditary profession which is passed from one generation to the other like the usual caste occupations. The tradition of *Dai* involved knowledge with community care.

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