Taking Care, Bringing Life: A Poststructuralist Feminist Analysis of Maternal Discourses of Mothers and *Dai*s in India

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Abstract

My poststructuralist feminist reading of the antenatal and birthing practices of women (*N*=25) living in a *basti* in India makes visible how the meanings of maternal experiences constituted as *our ways* open discursive spaces for the mothers and *dai*s as procreators to: challenge (i.e., question the authority of), co-opt (i.e., conditionally adopt), and judge (i.e., employ sanctioned criteria to regulate) competing knowledge production forms. In critiquing maternal knowledge as feminist discourse, the women's strategies contribute theoretically to an integrative construction of care by reclaiming displaced knowledge discourses and diversity in meaning production. Pragmatically, consciousness-raising collectives comprising the mothers and *dai*s can co-create narratives of *our ways* of maternal experiences articulated in public discourse to sustain equitability of knowledge traditions in migrant urban Third World contexts.

Keywords: maternal health, knowledge discourses, poststructuralist feminist theory, South Asian feminisms, *dai*, migrant communities, untrained birth attendant, midwifery, integrative practices

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Women constitute two-thirds of India's urban migrants yet remain amongst its most marginalized populations (UNESCO, 2013[1]). In urban centers, they live in temporary settlements (*basti*'s) with their in-laws, often working as housemaids or fruit sellers to meet household expenses (Bhattacharjee, 2012). Migrant women are among the least likely to access reproductive health services; relying instead upon home births utilizing high-risk practices (Devasenapathy, George, Ghosh, Singh, Negandhi, Alagh et. al.,2014). Even as India accounts for a quarter of global maternal deaths, four out of five deaths occur during an unsafe practice by an inexperienced *dai* (i.e., the traditional untrained birth attendant; Vora, Mavalankar, Ramani, Upadhyaya, Sharma, Iyengar et al., 2009). In the *basti*, the *dai* embodies orally transmitted knowledge of women's health and traditional medicine, thus her position provides a vantage point to critique how maternal choices are imbued with meaning in a community (Kraft, Wilkins, Morales, Widyono, & Middlestadt, 2014; Weedon, 1996). In this reading, I examine how the maternal health discourses of the mothers and *dai*s articulate the struggles constituting the knowledge and power relations circulating in a Third World *basti* site as they constrain and enable the mothers' choices.

I take a gendered approach to health communication to understand how maternal care can be made more inclusive through understanding the dilemmas faced by women in making maternal and reproductive choices (Guo, Munshi, Cockburn-Wootten, & Simpson, 2014). I draw upon the intersectionality of South Asian feminisms (Spivak, 1999) with poststructuralist feminist theorizing (Weedon, 1996) to identify how the mothers and *dai*s exert ownership of particular maternal knowledge forms within the geographical and social relations constituting the

basti. By embodying *our ways* as procreators, the women evoke a reconstituted set of power relations to (a) challenge, or question the authority of knowledge production; (b) co-opt, or conditionally adopt knowledge discourses; (c) judge, or employ sanctioned criteria to regulate maternal practices. In doing so, I provide a glimpse into the challenges and potential for achieving transformative understandings of maternal health knowledge for marginalized women.

Next, I present the ethics underlying antenatal pregnancy and birthing norms within the obstetric and midwifery models of care as constituting the "body of common-sense knowledge" discourses in maternal health (Weedon, 1996, p. 79). Discourses are words, values, and symbols that function to organize meaning through social practices and knowledge systems (Lupton, 2003). I then present the poststructuralist feminist standpoint (Butler, 1990; Weedon, 1996) overlaid at the intersection of Foucault (1972) and transnational South Asian feminisms (Loomba, 2005; Mohanty, 2003; Spivak, 1999) to reveal how the competing discourses defining the maternal experiences of the women are (re)produced, contested, and resolved.

The Midwifery and Obstetric Model of Care in Maternal Health Policy

In order to lay out the maternal discourses circulating in the *basti*, I start with a review of institutional discourses underlying the clinical practice guidelines (CPGs) for obstetric nurses for healthy women. The obstetric position categorizes practices by stage of labor (Appendix 1) suggesting, for example, an empathetic relationship during labor; interventions like epidural anesthesia during the first stage; spontaneous or directed pushing during the second stage; and active management of delivery during the third stage with non-pharmacological (e.g., hot water immersion) and pharmacological (e.g., nitrous oxide) methods for pain management. The CPGs conceptualize a rational and autonomous maternal subject—an assumption Lupton has critiqued as "imposed by the impetus toward evaluation from public policy," privileging a "consumerist

approach to health care" (1997, p. 374). For example, given the diminishing experience of obstetrician-gynecologists in vaginal breech delivery techniques, Cesarean deliveries are the recommended mode (The American Congress of Obstetricians and Gynecologists, ACOG, 2006). Maternal care is defined as including antepartum, intrapartum, and postpartum care, with the goal of ensuring that "appropriate personnel, physical space, equipment, and technology are available to achieve optimal outcomes" (ACOG, 2015a). However, unlike the *dai*'s intuitive grasp, expert knowledges do not recognize how difference (e.g., gender, class) influences everyday choices, and the ambivalences and contradictions underlying decision-making (Ellingson & Buzzanell, 1999). Further, a review of India's institutional discourses (e.g., the Safe Motherhood Initiative) reveals how public health campaigns construct reproductive health via CPGs. The Division of Maternal and Child Health (DMCH) recommends emergency obstetric care by Accredited Health Care Activists (ACHA) mandated to "detect and manage" maternal mortality (DMCH, 2005).[2] With a focus on lowering postpartum maternal morbidity through integrating ACHAs and the *Panchayat* (village committees) to promote breastfeeding, delayed bathing, and cord care practices, these initiatives have seen a significant reduction in neonatal mortality in the first 24 hours of life (WHO, 2016).

In contrast, feminist analyses of women's care have legitimized a body-centered mode of identification and inductive reasoning (Hayden, 1997; Willard, 2005). The *dai*'s ethos of nutrition and care draws from the epistemologies of holistic medical approaches (e.g., Ayurveda; Table 1) and seeks to eschew interventions (e.g., a Cesarean delivery). By balancing the three biological energies (*doshas*) through knowledge of one's nature (*prakriti*) and what is beneficial (*hitkara*) in daily (*dincharya*) and seasonal regimens (*rutucharya*; Appendix 1), the *dai* seeks to prevent adverse outcomes by ensuring the women's spiritual, mental, and physical well-being.

The *dai*'s practices privileging body-centered ways of knowing in the *basti* constitute the site of a discursive struggle over privileged knowledge and policy discourses. A close examination of the women's voices can offer spaces for integrative practices within the epistemological foundations of medical discourses legitimizing women's health knowledge.

A Poststructuralist Feminist Standpoint

In this section, I first preview poststructuralist theorizing and attend to its intersections with poststructuralist feminist thought and the South Asian feminist critique of hegemonic (Western) knowledge discourses. I then lay out the arguments presenting how shared languages, meanings, experiences, and community are intertwined with subject positions and discourses of knowledge, power, and social relations, situating these within radical feminist theorists' concerns with power, gender, context, and subjectivity. Finally, I address the gap in existing literature to interrogate how gendered subjectivities sustained by discursive fields (e.g., of medicine) can resist subjugated subject positions through alternative knowledge and power relations.

Poststructuralist theorizing is concerned with how knowledge and power act upon each other to constitute subject positions and produce discourse shaping social and material relations (Foucault, 1972). Poststructuralist feminists critique difference in hegemonistic modes of discourse (e.g., via appropriation of scientific discourse) to theorize transformation through interrogating the taken-for-granted relations of knowledge and power (Lupton & Fenwick, 2001). By theorizing social change through critiquing how language, subjectivity, and patriarchal genealogies construct and perpetuate particular forms of exclusionary and privileged subject positions, poststructuralist feminists offer a way of conceptualizing strategies for resistance and consciousness-raising. South Asian poststructuralist feminists are particularly concerned with

subverting the hegemonic underpinnings constituting the relations between language and subjectivity through reclaiming subjugated knowledges (Spivak, 1999).

Language reflects the relationship of the self, the community, and the world through constituting a vehicle for expressing subjectivity and imbuing experiences with meaning (Weedon, 1996). Subjectivity is continually reconstituted in discourse through discursive systems to give meaning to experience through language. Because communities define themselves via a shared language, the shared assumptions of a community, in turn, give meaning to language (Loomba, 2005). Subjectivities, thus, are continually in relation with discourses (e.g., of institutions, communities) sustaining specific values and forms of social power. Radical poststructuralist feminist theorists further posit that privileging alternative modes of performing subjectivities (e.g., by interrogating gender) opens ways of reconfiguring power relations situated within a specific configuration of socio-material relations (Butler, 1993).

Radical poststructuralist feminists understand gender as performative and continually re-negotiated through iterative (social) practices. In subverting the relations between dominant (patriarchal) and subjugated systems, radical poststructuralists envision transformative identities through (re)organizing the relations between language, institutions, subjectivity, and power. South Asian feminists engage this transformation through the framework of gender, identity, and development to critique how discursive fields (e.g., of medicine) privilege specific ways of assigning meaning to experiences through hegemonic knowledge systems. For example, women living in a Mumbai slum displaced from village relations restructured their history by collective action through storytelling to contest the marginalization of traditions (Sen, 2012). The women enacted resistance to subvert their subject positions by reifying re-envisioned practices through identification. Understanding that social relations have material consequences, I attend to how

discursive knowledge fields (e.g., of medicine) constitute women as subjects and how women's bodies are governed by and can resist forms of power. In doing so, the study contributes to greater understandings of poststructuralist feminist theorizing at the intersection of women's bodies, reproductive choices, and knowledge systems.

My critique of how maternal health discourses contest and/or lay claim to knowledge systems through language is guided by the following research questions: (a) (RQ1) What does a poststructuralist feminist reading of the antenatal and birthing discourses of mothers and *dai*s living in a *basti* reveal about how knowledge production claims constitute specific modes of subjectivity? and (b) (RQ2) In what ways does the mothers' knowledge production discourse of antenatal and birthing practices in the *basti* evoke a reconstituted set of power relations?

Method

Participants

This empirical study is based on 14 days of conversations with mothers and *dai*s (married, with children) residing in a *basti* in South Delhi, India. Following institutional review board approval, informed consent for the semi-structured conversations and video-recorded interviews (N=25) was recorded orally. No identifying information was collected to respect the women's confidentiality. Given my intimate knowledge of Delhi, I found my way to the *basti* removed from conventional access points (e.g., social workers). The *bastis* were known by their location (e.g., adjoining a mud mound), occupation (e.g., trash-pickers, an euphemism for a lower-caste community), or religion (e.g., a Muslim *basti*). Finding acceptance was a complex process. My son and I approached a *basti* surrounding a mound and bordering a chaotic road in South Delhi. I introduced myself to a woman on a *charpoy* with a *hookah* as a non-*desi* (Indian-

born, residing abroad) researcher learning about maternity practices. The woman (Saraswati, pseudonym) was the head *dai,* who related to my experiences and welcomed me to the *basti*.

My son and I would come to the *basti* by auto-rickshaw and play with the children. I participated in the *basti* routine by observing, sharing stories, and conversing. In keeping equity of relations, with Saraswati's permission, I started by asking her advice as *dai*, considering "the informant [as] a kind of teacher and the interviewer a student" (Gubrium & Holstein, 2001, p. 106; see Table 1 for the *dai*'s nutrition recommendations during pregnancy). We brought with us small tokens of appreciation like crayons, coloring books, and building toys for the children.

Procedures

Semi-structured interviewing was chosen to interpret and communicate the women's experiences (Lindlof & Taylor, 2002). I approached each interview as a conversation, using a question guide and moderately-phrased schedule appropriate for an elicitation interview. The domain-specific questions were modified with probes constructed individually to allow for meaningful comparisons. For example, sample interview questions touched upon what the women thought about the traditional (*dai*'s) practices (with probes exploring what was meant by "I thought they were good," or "they are right"), their thoughts on the doctor's advice on television, how they decided which practices to follow, who would they listen to and why, and reasoning for specific practices mentioned by the women. The women's conversational syntax was brief and spare, staying close to facts and observed practices.

I sought to capture the *basti* context in video recordings—the activities of the children, stray dogs, and gatherings as they occurred (Gubrium & Holstein, 2001). The video-recordings were transcribed verbatim by a professional transcription agency, in Hindi, the women's language, upon completion of the study. The transcripts ranged from 3–7 pages each in Hindi

(total=131 double-spaced pages). The researcher, who is bilingual with native proficiency in Hindi and English, translated the interviews into English. Video recordings were chosen to support observations and provide a visual context to the *basti*. The visuals enabled me to derive a rich description of the lived context and interpret responses within the relationships, spaces, and activities of daily life. The audio transcripts were examined to understand the research questions. In immersing myself in the everyday life of the women to experience maternal discourses first-hand (Sharf, 2009), I was sensitive to the temporary context of the *basti* and their experiences as recent migrants, often from far away regions of the country. My experience, although limited in duration, helped me contextualize my observations within the women's chores and informal conversations. I also discussed my interpretations with the women daily for validation.

Data Analysis

I began my reading of the women's discourses guided by holistic approaches to health and health meaning making (Sharf, 2009). As my inquiry was refined further within poststructural feminist sensibilities, I revisited the texts in multiple readings, looking for adaptation to transition in migrant communities (Mohanty, 2003), proceeding line-by-line to examine knowledge claims, ways of expressing self, assumptions, and how experiences were legitimized to privilege certain subject positions and practices (Weedon, 1996). I looked for recurring patterns in the discourses including "commonly used words, phrases, and archetypes, as well as noting common practices" (Lupton & Fenwick, 2001, p. 1013). I noted contradictions, multiplicity of meanings, and changes in positionality between the discourses. I attended to the articulation of choices, description of decisions in contradictory situations, and sense making of outcomes (Baxter, 2003). As a poststructuralist feminist analysis, I sought to make explicit the

gendered nature of knowledge discourses and subject positions as manifest through the women's voices to interrogate the power and social relations shaping their context (Foucault, 1972).

Understanding discourse as a system of ideas and assumptions constituting subjects and practices (Weedon, 1996), my analysis locates how the women's sense of self was implicit in the taken-for-granted assumptions of meaning-making processes. I examine social practices as a situated, stable, enduring form of activity comprising the women and their social relations, values, and discourse (Fairclough, 1989). My positionality as a middle-class, educated mother who experienced childbirth nearby before emigrating imbues the women's perception of my identity and my interpretation of the texts. This reading presents one set of understandings while inviting the reader to approach the discourses from their standpoint (Baxter, 2003). Next, I provide a context to the site derived from my observations and government documents to help situate the observed participant experiences (Lupton & Fenwick, 2001).

Study Context: The *Basti*

The temporary urban slum (*basti*) where the women live comprises mud homes and lanes lined with open drains.[3] The Municipal Corporation of Delhi (MCD) provides slums with sanitation and waste management services (e.g., one tap per 150 people, open drains for wastewater, one bath per 20-50 people, one lavatory seat per 20-25 people). The Directorate of Family Welfare (DFW, 2014; Government of Delhi, n.d.) administers the reproductive, maternal, neonatal, child, and adolescent health program overseeing the safe motherhood intervention in Delhi.[4] Its schemes (e.g., the *Janani Shishu Suraksha Karyakram*) provide marginalized women in Delhi with free services (e.g., C-sections, meals for institutional stays, transportation on discharge; DFW, 2014). Many of these services were only intermittently visible in the *basti*.

During my time at the South Delhi *basti* site, I witnessed several challenges facing rural migrants. Makeshift electrical wires pulled from municipal poles for nearby the neighborhoods brought electricity. A shared hand-pump was used by a cluster of mud-caked hutments for daily tasks. The clean one-room hutments had an attached open-air kitchen with coal-burning mud stoves, shelves, and a temporary wooden slat as the door. Affluent huts had appliances like refrigerators and water coolers. Here, at-home births take place with utensils and boiling water. The women offered me a space to sit here with a glass of cold water, a luxury afforded by those whose husbands also had a livelihood, often as an auto-rickshaw driver or as a driver for families living in nearby neighborhoods where the women worked as housemaids and babysitters.

Outside, open drains between the huts were used as bathrooms and for trash. The open spaces were common areas where families tethered pigs and cows. During daytime men, women, and children gathered here to sleep on *charpoy*'s, cut vegetables, or play with grandchildren. Children, carrying the latest electronics (e.g., smartphones) are visited here weekly by a social worker for classes. Later, the common areas fill with men who drink and play cards. Elderly women will tick-off unemployed males who hang around during daytime waiting to drink at night. The residents maintain the lanes but the drains and trash are considered MCD's purview.

Findings

The mothers' and *dai*s' antenatal and birthing discourses reveal knowledge production discourses center subjectivity as procreators through privileging *our ways* (RQ1) that were constituted by the mothers through challenging, or questioning the authority of knowledge production; co-opting, or conditionally adopting knowledge discourses; and judging, or employing sanctioned criteria to regulate practices (RQ2).

Crafting Legitimacy: *Our Ways*

The mothers' and *dai*s' discourses of antenatal and birthing practices were rooted in cultural ownership of knowledge production forms and relationships re-inscribed within the *basti* as *our ways* affirming their subjectivity as procreators in balance with nature. In *our ways*, the women craft legitimacy through their balance with nature, social and geographical relations, subjectivity as procreators, and agency of the body in doing its "own hard work." Gauri, who had four children through *dai*, said: "yes, we listen more to the *dai* because *dai* will ensure a normal (vaginal) delivery, and we don't have to eat foods that are forbidden" (Table 1). Gauri explained: "when we go to the doctor…they put us on a glucose drip, and so in our people's customs, we don't care much for glucose" thus, "with all this, our balance gets spoilt." The mothers and *dai*s center ownership of knowledge production within the *basti* practices and constitute subjectivity as procreators embodying that knowledge of nature using *our ways*.

Maternal discourses intersect social, historical, and material contexts as the women affirm their subjectivity through distancing from or aligning with differences in knowledge production forms (Appendix 1; Table 1). I asked, "if the doctor says something different from what you do, so do you think it is because they don't know or don't understand?" Most mothers articulated resistance through distancing: "in our ways, we don't have cold foods" (Durga); or aligning themselves with difference: "we just say that we eat and do all this at home…[in the hospital] the medicines will do all the work…in our ways, it is the *dal*, *ghee*" (clarified butter; Laksmi); or: "no, no, the doctor also understands us very well…the doctor is very…knowledgeable…but their ways are different, they don't follow forbidden foods" (Gauri). *Our ways* thus spatially defined social and geographical relations (e.g., "in our village, that is what we know to do"), where "our village" ranged from states as far away as Odissa to Bihar.

The women's subjectivity as procreators imbues meaning in maternal practices as using a clay pot and *dai*'s prayers. I asked, "does it have to be a clay pot?" Laksmi said: "it is very important, if it is not available, you should procure it." Kali, a *dai* herself, evoked God for a difficult breech pregnancy: "I know everything, thus I already asked God for blessings." She told worried family members: "I said, no cutting the cord right now, you sit here quietly, let's talk of things you like for a while" as she warmed a cloth over coals to put a hot compress. Then, she "saw the feet of the fetus, then the hands and slowly, slowly," she saved the baby through her worship and skill. The *dai* embodies the collective memory of *our ways* through practices grounded in culturally-owned knowledge systems. Durga, whose three children were home births, said, "we will listen to our mother-father and God"; or "the doctor does not know us as well, that is why they can only tell us medicines and injections, but in our ways, what our elders tell us benefits our well-being" (Parvati); "our elders know everything, the whole world is made through them." Meaning inheres in the performance of knowledge forms (Weedon, 1996), of *our ways* as gendered knowledge: "that is our way, our mother-in-law's ways, she has looked after us, who knows about what has to come…that is why we believe in our ways" (Prakriti).

The women's ownership of oral forms of maternal knowledge as *our ways* is feminist in its appeal to disrupt the workings of historically dominant medical discourses and evoke agency (Loomba, 2005). Thus, *dai* is "also a knowledge worker, she knows everything about us, about all of us, that is why she is able to know" (Sakti). Because the hospital does not "provide care in our ways…every doctor will say their own thing, and you will be sick…that's why we don't go to the doctor" (Sakti). To my question: "so, when we decide what to eat, how do we know what is best for us?" Sakti replied exasperatedly, "surely someone must have told you also!" alluding to knowledge ownership in a community. Occasionally, the women were pulled toward

biomedical options. This discursive struggle privileged *our ways* as displaced by hegemonic knowledge discourses (Spivak, 1999) by exerting agency through "our own hard work":

R: If you have trouble, will you ask (the doctor)?

Uma: Then we will ask.

R: Otherwise, we will do our own?

Uma: We have to follow our own.

R: So what is the benefit of following our own?

Uma: If we follow our own, we do our own hard work, and we will earn our own (family), and then we will also waste our money on the doctor, it is not for free. [Later] At home our food is the best, we make it in front of our eyes, we eat in front of our eyes, we don't know what is mixed in our hospital food, what they do with it.

Savitri, whose eldest was in first grade, said: "we have always listened to our mother and father; when I was two months pregnant, I showed myself to a doctor, then the doctor treated us every month…that is how I had my two children." Later, Savitri added, "both my children are healthy, and because of *dai* I never had to go to hospital for birth, so I believe *dai* is best." As the women were pulled toward knowledge discourses, articulating their subjectivity as procreators gave meaning to maternal practices. By distancing or aligning themselves with knowledge production forms, the women constructed meaning through the agency of the body, its "own hard work," and ambivalence toward patriarchal knowledge. *Our ways* evoked ownership of knowledge production yet shifted through literacy and social relations as the mothers' and *dai*s' maternal discourses intersect with changing historical and material relations in the *basti.*

Contesting Power Relations: Challenging, Co-Opting, and Judging

By challenging, co-opting, and judging, the mothers negotiated knowledge production discourses to evoke a reconstituted set of power relations in the *basti* (Appendix 1; Table 1).

Challenging. Challenging referenced the mothers' questioning of the authority of knowledge production forms as articulated through discourses drawing upon literacy, tradition, language, and the routine. Tara, who had six children, questioned *dai*'s work: "it is also a risk to your life, whereas in the hospital…there are all manner of alternatives" in choosing a hospital birth for five of them. Tara also disputed hospital births as begetting impurities (*mala dosha*) because "here at home, we eat with great discipline, with such food our stomachs will not protrude…with the doctor, you can eat anything, because they give you medicine." Ultimately, Tara's experience with what she has "gone through, troubles at home," as a result of which she lost two of her children, prompted her to challenge *dai*'s authority. Tara said: "see, it is based on how each of us evaluates it…and how educated people don't wait for *dai*, but rush to the hospital in the blink of an eye, and start medicines and drip." She used literacy as a basis to challenge existing norms, as educated people "think differently." Tara explained how uneducated people don't know how to assess the situation and believe that the hospital will "do an operation, kill the child." Similarly, balancing convenience and risk, Usha, whose three children were hospital births, reinforced tradition: "we will do…what is in our heart…in olden days, *dai* was good, but nowadays, hospitals are considered good…for an early and painless birth." As Sen's (2012) women used narratives to "rediscover a past," and draw continuities with their present identities (p. 90), literacy and tradition enabled the mothers to question assumptions underlying authority.

Usha challenged *dai*'s position by privileging the routine knowledge of her mother and sisters, distinguishing what she "thought was right": "first, we will listen to our mothers and sisters, if that suits us. If not, we will go to the doctor." Ideologically, challenging knowledge

discourses invoked agency for navigating conflicting meanings (Loomba, 2005): "even [the doctor] is good, what harm is there in listening to both?" Challenging produced a space for the women as mothers to (re)construct the familiar, question assumptions, and articulate *basti* norms. Gayatri did not have her children vaccinated, saying: "my children are all very healthy, they are just right." As Gayatri negotiated knowledge discourses, she felt that, "we understand our own village dialect very well, we understand what we know, but here in Delhi—I don't understand what they say." In challenging, the mothers question the authority of maternal knowledge at the intersection of historical, political, and structural forces of literacy, ways of knowing, and community norms (re)producing social relations within the *basti*. Usha privileged the routine knowledge of her mother and sisters while acknowledging community norms. Gayatri sought a familiar language to (re)create meaning for her experiences, seeking discourses sustaining existing relations, while Tara evoked literacy to question the authority of knowledge discourses.

Co-opting. The mothers and *dai*s co-opted, or conditionally adopted, maternal knowledge forms based on criteria like perceived risk and normality of maternal and fetal condition. Ambe talked about eating what the doctor gave her, but also ate what her mother gave her. No one in Bhavani's village went to the doctor, they "called the *dai* home to give birth"; she did that because: "when the child can be born at home, you don't go to the hospital"; or, "if we need to, we will listen to the doctor, but if we can give birth at home, then we do everything we can" (Parvati). Others reaffirmed norms as part of the domain of "common-sense knowledge upon which individuals draw for their understanding" (Weedon, 1996, p. 79). Bhavani co-opted the different possibilities: "everyone has different practices, in our ways we call *dai*…but others go to the hospital…some have their birth very early there…I hear everyone's experience."

For her son's wife, she said, when she gives birth, everyone will be present, according to tradition. Others said: "nowadays some will go to the doctor and some will call the *dai*, so all are OK" (Brahmacharini), co-opting the different knowledge discourses. Her children were born at home ("but the doctor came and put the vaccines"), but she also believed the doctor was helpful. A new migrant to the city, she carefully scoured the television (TV) where "they tell you how to take care of your children," especially things like "what to do, as what care you don't get in the village you will get at the hospital." Shailputri spoke of her home births: "when I came in 2000 from my village to Delhi, my first daughter was born in 2002, at that time we were in great difficulty, we were helpless." Her husband cleaned cars in the neighborhood and earned fifty to hundred rupees per month (one to two dollars) and "I had to pay three hundred rupees (six dollars) as rent, and the children needed milk, food, everything, then I would have to take my little daughter with me to work (as a maid) and I earned thousand rupees (twenty dollars) and our situation slowly improved." She doesn't want more children so she can educate her two children.

Although ostensibly discrediting hospital births as fraught with risks (Cesarean, babies getting stolen), Adishakti co-opted it, and even preferred it, as for example: "when there is a problem, you pick up everything and run to the hospital. Some will say, hospital is best." Tridevi too, appeared to co-opt and consider both equal for a normal delivery: "they take good care of you, at home also you are well taken care of…both are good…there you will eat everything…here we are more disciplined (about *parhaze*)" but chose the norms of a home-birth. In co-opting conditionally, Adishakti treated both equally: "sometimes it seems they will speak as well as we speak at home, our mothers-in-laws and the *dai,*" but, upon asking if there is a difference, Adishakti "will visit the doctor first." Similarly, Savitri agreed: "both are equal to me. There are some differences, like *dai* will not give medicines…and the doctor does not know what

we eat; but if you need an operation, the doctor can do it, *dai* cannot." Savitri had a normal pregnancy and her two children were home births: "*dai* told me when the child will be born. She gave me a date and following her prediction, my child was born, so *dai* is also like a doctor, she knows everything." Savitri co-opted yet privileged *dai*'s discourses for a normal delivery while ultimately aligning her maternal interests with a successful birth. In co-opting, the women enacted agency in integrating community-owned knowledge discourses with those produced from hegemonic knowledge positions to privilege their goals as mothers to have a successful birth. However, as they employed factors such as literacy, language, and structural barriers (e.g., finances) to give meaning to differences, they were limited in the conscious engagement of the transformative potential of their decision-making to open a deliberative space for integration.

Judging. Judging, referencing the ability of the mothers to employ sanctioned criteria to regulate practices, shaped discourses in powerful ways. Durga, a young mother of three children, whose mother was head *dai* and managed her home births, watched TV to see "what can happen when things go bad." Upon probing, "how do you know what you should do and what you should not do?" Durga's response: "that is a matter of each person's own understanding: if you make good choices, you will get good news, if you make bad choices, you will get bad news" referenced the moral undertones regulating the challenges in integrating maternal practices. Watching TV programs advocating hospital births, Durga surmised: "what our elders say, is what we should do…that is exactly what I follow." Judging enabled the construction of "good choices" and interpretation of outcomes. Durga does what "our elders tell us…so that we don't have trouble later…[and] not come to harm." Durga's identification with her subject position ("a good daughter") guided her judgment of outcomes within the moral relations of the *basti* where her mother worked as head *dai* and within which she sought transformation by watching TV.

Parvati, who had home births, had faith in how "elders know everything, the whole world runs on elders," thus "till now, anyone who follows our elders has never come to harm." Highlighting its moral underpinnings, the discourses of judging enabled women to assign multiple meanings to subjectivity (e.g., daughters, being close to God) while judging their outcomes as morally good or bad, and distinguishing them from the successes or tragedies of the birth itself. Markers of breaking away from sanctioned criteria were visible in the women's bodies: "our stomach starts to protrude…all women who go to the hospital have protruding stomachs," [5] or "our breath gets short," which is "not good, that is why" (Gauri). Such bodily markers made visible the women's subject positions as not following sanctioned practices and foregoing balance (between the three energies[7]), thus were judged negatively.

As judging oriented roles and behaviors, it also shaped how loss was interpreted in ways that were averse to integrative practices. Sarama, who lost her child with a home birth, advocated, "following everything the doctor says" because "listening to *dai* one day and the doctor the next, it is not good." Sarama, who had upon her in-laws' advice stayed with *dai* and lost her child when she finally reached the hospital, said: "whoever gives us advice we will follow them." I asked: "if there is a conflict, then?" She said, then, "we need to go to the doctor." When she went to the doctor, her baby "was destroyed…we cried in the hospital for three days." She has no more children and judged herself a good daughter-in-law. However, she blamed *dai* for incompetence without taking into account the risks of a possible vaginal mode of breech delivery. Manasa, who reached the hospital only to have a stillbirth, recounted how her husband persuaded her against visiting the doctor saying doctors will "cut you up." However she would advise everyone to "go straight away to the doctor." A Cesarean would go contrary to the morally sanctioned criteria (balance, alignment with nature). For Manasa such a birth, although

successful, would have been judged impure (in its integrative approach). She interpreted her tragedy as sanctioned by God: "what God wills, will happen." Manasa constructed her identity morally (as a mother, wife, community member) to judge her choices and guide future action.

Usha, whose three children were hospital births, explained how, in olden days, there were the village elders to draw upon. Nowadays, advocating integrative practices, she said, nobody wants to stay home, or have *dai* press their stomach the entire day while in pain, because "if you go to the hospital, in one hour they will let you go free." Otherwise, the child gets lazy in the stomach, the mothers also get tired, and "finally, only death comes for you." While chastising those who sought hospital births, Usha, ultimately, judged its advisability in her conclusion. Bhavani sought *dai*'s care, saying those on TV who said, "give birth in the hospital!" promoted medicines. In her village, "it is all in God's hands," and Cesareans were not how God intended birth to take place. Understanding gender as performative (Butler, 1993), in judging, the women employed sanctioned criteria to enable and constrain practices that produced their subjectivity as good mothers, wives, and daughters and to interpret outcomes as being in "God's hands."

While transformation can be crafted through giving voice to alternative subject positions (Spivak, 1999), judging regulates subjectivities by constructing boundaries producing mothers as wives and daughters in morally sanctioned ways. The mothers' discourses of antenatal and birthing practices in the *basti* evoke a reconstituted set of power relations through challenging, or questioning the authority of knowledge production; co-opting, or conditionally adopting knowledge discourses; and judging, or employing sanctioned criteria to regulate practices.

Discussion

My poststructuralist feminist reading of the antenatal and birthing discourses of mothers and *dai*s living in the *basti* is concerned with how knowledge production claims produce specific

modes of subjectivity and how the mothers' knowledge production discourse evokes a reconstituted set of power relations in the *basti*. In negotiating knowledge discourses, the women constitute their subjectivity as procreators appropriating competing meanings of maternal practices. By evoking cultural ownership to craft legitimacy, *our ways* provide an entry point to critique the interpellation of gender in integrative maternal health discourses within the socio-historical moment of its production. As feminist discourse, they suggest transformative understandings of subjugated knowledge systems of women's health through challenging, or questioning the authority of knowledge production; co-opting, or conditionally adopting knowledge discourses; and judging, or employing sanctioned criteria to regulate practices.

Evoking their subjectivity as procreators, the mothers and *dai*s shift between knowledge discourses to interrogate cultural ownership by constituting *our ways* in balance with nature, spatial relations, and agency. *Our ways* reflect the gendered meanings constituting maternal practices (e.g., *dai*'s prayers), to critique how alternative knowledge relations can be envisaged through the maternal body at particular moments (e.g., respectful wife). The shared language of *our ways* constitutes the community of women as producers of knowledge as interconnected with the social relations of the *basti*. By articulating maternal discourses as *our ways*, the women's voices make visible the exclusionary aims of hegemonic knowledge discourses for a meaningful integration of maternal practices. The power relations constituting the taken-for-granted juridical structures at the intersection of Western representation of non-Western cultures (Dutta-Bergman, 2004) through multiple knowledge systems are challenged, co-opted, and judged by the women using *our ways*. Thus, my critique of the mothers' and *dai*s' maternal knowledge forms as feminist discourse offers the language of *our ways* for contesting gendered subject positions in marginalized communities and envisioning integrative maternal health discourses.

The repression of knowledge discourses grounded in alternative ontological and epistemological systems has historically served to close possibilities for self-representation for the Third World woman (Spivak, 1999). Such practices are being acknowledged as exclusionary and inconducive to achieving meaningfully integrative understandings of health (Geist-Martin, Bollinger, Wiechert, Plump, & Sharf, 2016). The mothers and *dai*s resist this by positioning hegemonistic knowledge forms as "speaking a different language" to privilege practices that enact agency through doing one's own hard work in *our ways*. Examining how the gendered subject position is produced in the *basti* underscores the importance of "speaking out as woman," and how "giving meaning as biological females about our experience is a statement of what it is to be a woman" (Weedon, 1996, pp. 81-82). The multiple meanings of maternal experience are inscribed in shifting subject positions (e.g., respectful daughter-in-law) and reified in knowledge production forms and the social practices giving them meaning (e.g., glucose drip).

Epistemologically, the discourses produce women in overlapping subject positions (e.g., as patients or daughters) constituting maternal bodies marked by balance or impurities, or risk or normality. These markers embody the visible and invisible signs of pregnancy (e.g., protruding stomach) that are given meaning through tradition and morality defining an acceptable birth. The women contest the "scientificity" (Spivak, 1999, p. 267) of knowledge discourses through challenging (questioning authority), co-opting (conditionally adopting), or judging (regulating practices) their own and community choices. In challenging, the women critique the discourses of literacy, tradition, language, and routine to co-opt maternal knowledge forms based on discourses of risk and normality of maternal and fetal condition and regulate practices judged in moral or communally sanctioned discourses. Challenging, co-opting, and judging enable the mothers to construct knowledge discourses continually reified by the community. Questioning

the authority of knowledge production, conditionally adopting knowledge discourses, and employing sanctioned criteria to regulate practices challenges the gendered and ethnocentric categorizations of the Third World woman. The multiplicity of social and material relations constitutes the *basti* as the site of the mothers' meaning making, performative, and legitimating claims of knowledge discourses.

Challenging, co-opting, and judging embody the materiality of the women's knowledge production discourses as restrictive or productive as enacted through maternal practices. Their strategies enable the mothers to construct reproductive choices through destabilizing gaps in subject positions and "offer the discursive space" for resisting hegemonic discourses (Weedon, 1996, p. 111). Childbirth and maternity processes evoke multiple discourses of difference and highlight the need for more research into the local moments of resistance and transformation in different contexts to accomplish meaningful integration. Perhaps by constituting mothers as procreators, maternal discourses can be performed through gendered subject positions that challenge, co-opt, or judge in ways that constitute productive forms of power.

Pragmatic Implications

To examine the manipulation of knowledge of "how one knows" (Spivak, 1999, p. 356) as a poststructuralist South Asian feminist project is to foreground subjugated knowledges. Thus pragmatically, the findings can guide initiatives that support the *dai*s' and mothers' subjectivity as procreators in knowledge systems articulating their meanings of maternal experience through consciousness-raising initiatives for culling meaning. A major recommendation is to make the *dai* the focal point for facilitating the creation of maternal support groups to focus the mothers' work of challenging, co-opting, and judging and thus create collective ownership of decision-making. This collective can help enact several pragmatic initiatives. First, it can guide decision-

making, particularly in high-risk births by coordinating with the ACHA to integrate diverse knowledges equitably and honor its principles while discussing how positive outcomes can be achieved in risky situations. Second, it can co-create narratives of *our ways* constituting maternal experiences through co-opting and judging to construct a shared knowledge repository of birthing practices. Weedon's (1996) practice of consciousness-raising involves the coming together of women to share oppressive experiences and articulate ways for (re)shaping meaning of experiences through language. Thus, third, it can open a public space for owning practices as a community through sharing experiences in public without judging to affirm their subjectivities as owners of *our ways* and disallow for isolation and censure of those seen as enduring negative childbirth experiences as a result of their choices. Finally, fourth, it can lead maternal literacy initiatives on TV to create equitable understandings for integrative knowledge production systems by privileging the women's lived spaces with dominant public and institutional domains.

Conclusion

My poststructuralist feminist reading of the mothers' and *dai*s' discourses of antenatal and birthing practices critiques modes of production of knowledge and makes visible how meanings of experiences constituted as *our ways* open discursive spaces for the mothers by challenging, co-opting, or judging by destabilizing essentializing subjectivities. In making sense of a multiplicity of knowledge discourses, the women's strategies of challenging, co-opting, and judging deserve to be integrated in productive ways to bridge the *basti*, village, and institutional domains. Such understandings can inform transformative visions of an integrative construction of care that reclaims knowledge discourses and diversity in meaning production. Theorizing subjectivity around *our ways* as procreators in sites situated at the intersection of multiple discourses can help transform social relations through an integrative approach to knowledge.

Furthermore, recognizing how ontological and epistemological differences in maternal knowledge are challenged, co-opted, and judged can raise consciousness of how subordinate gendered subject positions are (re)produced in communities. Future research can critique how particular subject positions aid the interpellation of gender in marginalized communities to simultaneously contest and constitute productive forms of subjectivity. Pragmatically, women's collectives in the *basti* can make manifest subjugated knowledge forms and reclaim their subjectivity as procreators to (re)envision meaningfully integrative maternal care practices.

Endnotes

1. WHO defines maternal mortality as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to…pregnancy or its management but not from accidental or incidental causes" (2016). Women in developing countries are 33 times more likely to die from preventable maternal-related causes compared to those in developed countries (WHO, 2017). Ninety-nine percent of maternal deaths occur in developing countries—one-fifth of which occur in India (WHO, 2016). The MMR (maternal mortality rate per 100,000 women) reflects the challenges of bridging the gendered health inequity of access and exclusion.
2. ACHA's mandate involves the detection of conditions (e.g., maternal anemia) and management of high risk pregnancies including direct obstetric causes of maternal mortality (e.g. postpartum hemorrhage, obstructed labor, DMCH, 2005)
3. The Delhi Development Authority identifies unplanned colonies as: urbanized village, *jhuggi jhoppari* (J.J.) clusters, J.J. resettlement, slum rehabilitation, unauthorized, and regularized-unauthorized colonies (Government of Delhi, n.d.).
4. Policy reports identify factors such as threat to female modesty, caste discrimination, and cost as influencing access to healthcare facilities by migrant women and their families. The Sample Registration System which tracks Millennium Development Goals (UN, 2015) on child mortality and maternal health finds that Delhi, with high rural-urban migration, has the highest MMR (> 300; Office of Registrar General, Government of India, 2011).
5. A vitiated *Vata* (one of the three *doshas*) in Ayurvedic medicine is considered to cause maternal morbidity and concerns. To balance *Vata*, herbs and food appropriate to each month of the pregnancy are eaten per specific rules (e.g., not eating pungent food).

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Appendix 1

Nutrition during pregnancy recommended by obstetric/gynecological and Ayurvedic medicine

1. ACOG's (2015b) recommendations are based on the five food groups (grains, fruits, vegetables, protein foods, and dairy) and the amount needed daily during each trimester of pregnancy as based on height, pre-pregnancy weight, due date, and exercise routines. While oils and fats are recommended, these should be plant based and not solid fats (e.g., from animal sources). Daily prenatal vitamin supplements with folic acid are recommended for the extra amount of vitamins and minerals needed during pregnancy. Extra iron rich foods including lean red meat, poultry, dried beans and peas, prune juice is recommended with citrus fruits and tomatoes. Calcium (e.g., from cheese) and vitamin D (e.g., from fortified milk and fatty fish) are also recommended during pregnancy.
2. Ayurvedic system for maternal health: Based on balancing the qualities of *tridosha* (or the three biologic energies): *vata* (of space and air), *pitta* (of fire and water), and *kapha* (of earth) during the bodily state of pregnancy (considered a "hot" state), as guided by the women in the community who are seen as practitioners of women's health. Ayurveda considers three different types of foods: heat-producing foods, cold-producing foods, and gas-producing foods as related to the five elements (space, air, fire, water, earth). Ayurveda seeks a balance, thus hot foods are avoided in pregnancy. Specific combinations of foods are provided that amplify their beneficial effects (e.g., ghee), while others are considered incompatible and dangerous (e.g., mixing milk and fish). Herbs such as nettle leaves, red raspberry leaves, dandelion leaves, *ashwagandha*, *hrahrni* are considered rejuvenating for mother and fetus.

Table 1

Nutrition During Pregnancy Recommended by the *Dai*'s in the *Basti*

Dai	Nutrition Recommended by the *Dai*'s During Pregnancy*
Saraswati	Recommended (during specific weeks of the pregnancy): *Ghee* (clarified butter), dried roasted lentils, a mix of dried fruits, milk, tincture of specific herbs and local plant barks, roti, *laddoo* (dry fruit balls), tea and eggs (morning). Forbidden foods: sugar, rice, glucose, asparagus, *Brahmi* herb
Laksmi	Agrees with Saraswati's recommendations. Recommends (for specific weeks during pregnancy): buy ingredients for all foods from local shops, grind at home with mortar and pestle, mix foods in molasses, bonbons, specific lightly roasted lentils, tempered spices (typically with: cumin, black mustard, fennel, fenugreek, bay leaves, asafetida, cloves, *urad* lentils), vegetables, roti, green gram lentils, rice for evening, warm water, ground *kadha* (a type of tincture) in a clay pot (not steel vessel), licorice, *amla* (Indian gooseberry) For the morning: a *halwa* (dense sweet dish of carrots or lentils) Forbidden foods (in addition to Saraswati): eggs, some lentils, rice
Kali	Agrees with Saraswati. Based on time of delivery due date (give molasses).

*Recommendations include advice on specific utensils (e.g., clay pot, copper), temperature, hot and cold foods, norms (giving mother what she desires), a mix of different composition of the 6 categories of tastes at specific times (sweet, sour, salty, pungent, bitter, astringent).