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POLITICS OF CHILDBIRTH: POSITION OF MIDWIVES IN COLONIAL INDIA

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INTRO

Across several decades, women's bodies have symbolized societal honor and demarcated the boundaries between "us" and the "other." Various familial, societal, and state mechanisms have been employed to manipulate and regulate women's bodies, particularly in the context of their reproductive capabilities. The medical community, wielding significant authority, has played a pivotal role in this phenomenon, particularly evident in its influence over women's bodies and childbirth. This complex interplay becomes apparent when examining the evolving role of "dhai" practitioners in Indian society during the colonial period.

The prevalent reliance on midwives for childbirth in both rural and urban contexts was influenced by factors such as expertise, accessibility, and familiarity with cultural norms. Midwifery, considered a 'hereditary profession,' was predominantly practiced by women from lower castes and social classes. The Colonial and reformist discourses in the nineteenth century often vilified these traditional birth attendants (dhais) and advocated for a rationalized approach to childbirth, perceiving midwifery as emblematic of the degraded status of women in India.This paper aims to explore the transitional dynamics in the status of native midwives, specifically dhais, during the colonial era. Emphasizing the significance of recognizing the perspectives with relation to marginalized dhais, the paper delves into their unique "otherness" as a colonial subject. Drawing on regional analyses of Madras, Bengal, and Punjab, it argues that the shift from traditional dhais to scientific midwives was a gradual process, involving two distinct approaches: the introduction of education to dhais through technical instructions from colonial institutions and the importation of European and American 'lady doctors' to educate young Indian women. The paper critically assesses the success of these endeavors in achieving the professionalization of birth practices in colonial India.

POSITION OF TRADITIONAL BIRTH ATTENDANTS IN INDIAN SOCIETY

Traditionally, Dais have played a central role in managing women's bodies before, during, and after pregnancy, providing cultural competency, consolation, empathy, and psychological support. Recognized as local guardians of women, they possessed the knowledge to administer appropriate treatments for specific infant ailments as well. These traditional birth attendants developed their skills through experiential learning, live demonstrations, instructions and close supervision provided by senior midwives, often their grandmothers. Knowledge transmission prioritized hands-on practices rather than dependence on manuals or textbooks. In rural communities, women drew upon collective wisdom derived from shared historical narratives, personal experiences, and the presence of immediate family, village midwives, and other experienced women. In such settings, these traditional birth attendants actively contributed to providing assistance across physical, emotional, ritual, and spiritual dimensions.

Kalpan Ram highlights the societal disruption caused by midwives' wisdom, challenging established norms by bridging the perceived gap between knowledge and the body.[1] In the intricate social fabric of Indian society, where women historically faced barriers to accessing Sanskritic literary and sacred knowledge (vidya), midwives encountered criticism for challenging the established separation between knowledge and the physical act of childbirth, deemed as polluting.[2] The practical knowledge of midwives, transmitted through oral narratives and hands-on interactions, remained unacknowledged within mainstream perceptions of knowledge. Both Indian and Western elite traditions failed to recognize rural midwifery as a valid and valuable form of knowledge due to its absence from formal literary heritage. Foucault's recognition of “subjugated knowledges” further emphasizes the hierarchical dismissal of certain forms of knowledge, particularly those originating from marginalized or non-elite perspectives, which may be deemed inadequate or insufficient by prevailing societal standards. Dais' unwritten traditional knowledge had little value in a culture that only recognises knowledge that has been documented. Moreover,

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[1] Ram, Kalpana. "Rural midwives in South India: the politics of bodily knowledge." Childbirth Across Cultures. Springer, Dordrecht, 2009, pp.114.

[2] Ibid.

These traditional midwives, did not receive monetary compensation for their services, as they perceived their role as a midwife to be a responsibility rather than a chosen profession. Thus, Dais who once stood at the crossroads of various strata of power, had their knowledge and wisdom of indigenous delivery practices devalued by the patriarchal system and the ever-growing propensity and faith in western medicine and healthcare.

INTERVENTION OF COLONIAL STATE: EDUCATION FOR NATIVE MIDWIVES

> *"The practice of native 'dhais' or midwives in all parts of India is most ignorant, unskillful and cruel. During complicated labor these practitioners resort to useless, hurtful or violent expedients and either inflict injuries which leave behind them permanent disease, or fail to accomplish delivery. The lives of both mother and child are in such cases sacrificed."*[3]

The above excerpt from the Indian Medical Gazette underscores a derogatory view of native 'dhais' or midwives prevalent in India during the period under consideration. It characterizes them as "ignorant, unskilful, and cruel," particularly criticizing their practices during complicated labor. The depiction suggests that native midwives often employ ineffective, harmful, or violent measures, resulting in potential injuries that may lead to permanent diseases or, in worst cases, failure to achieve successful delivery. The statement concludes with a grave assertion that the lives of both the mother and child are jeopardized in such circumstances. Beside this, the abhorrence surrounding the procedures of dai, and the horrific accounts of botched deliveries by Doctors and surgeons who reported at the death of women who had been "sacrificed by ignorant and self-sufficient dhyes"[4] got the state's attention and influenced its action substantially. This negative portrayal highlights the prevailing colonial perception of indigenous midwives as a threat to maternal and infant

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[3] "The Education of "Dhais"." *The Indian medical gazette* vol. 8,4 (1873): 100-101.

[4] "The Education of *Dhyes* or Native Midwives." *The Indian medical gazette* vol. 1,12 (1866): 370-371.

well-being. The use of strong language and the emphasis on potential harm positions the native midwives as a target for reform and replacement, reinforcing the colonial discourse advocating for the introduction of European medical practices and professionals to address perceived deficiencies in traditional childbirth practices. Contrary to optimistic British expectations, the establishment of a new maternity facility did not herald the disappearance of the dai from the societal framework.

The predicament confronted by British medical professionals emanated from the profound cultural attachment of Indians to the role of the dai.[5] The pivotal decision confronting medical practitioners was whether to assimilate the dai into a European-style maternity strategy, equipped with fundamental European midwifery skills and sanitation training, or to endeavor her eradication from the obstetric process in anticipation that her role would gradually diminish.[6] These institutions endeavored to enable the integration of traditional dhais, deeply ingrained in societal norms, into the realms of hospital and dispensary. The aim was to impart extensive education in the physiology of childbirth and associated complexities,[7] emphasizing a departure from the conventional educational trajectories followed by female doctors or midwives.[8]

Midwifery in Europe and America, although not requiring extensive education, commanded respect within communities. In England, midwives were not part of the medical society but played a crucial social and religious role. They needed licenses from the Church and faced penalties for illicit practices.[9] Colonial midwives in North America were similarly unregulated. At this point, It becomes important to note that the Enlightenment era marked a significant transition in midwifery practice in the west. Here the states' intervention which led to the introduction of technical instruction and surgical

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[5] Lang, Sean. "Drop the demon dai: Maternal mortality and the state in colonial Madras, 1840–1875." *Social history of medicine* 18.3 (2005), pp.368.

[6] Ibid.

[7] "The Education of "Dhais"." *The Indian medical gazette* vol. 8,4 (1873): 100-101.

[8] "Vernacular Education in Midwifery." *The Indian medical gazette* vol. 3,3 (1868): 64.

[9] Ibid, pp.3.

procedures in the practice of childbirth resulted in displacement of traditional midwives by male physicians.[10] A prevailing sentiment among the majority of Americans expressed admiration for male doctors, attributing credit to them for introducing scientific principles into the birthing process and ostensibly reducing the previously high mortality rates of mothers during childbirth.[11] The case of India was different in this scenario because of the cultural and social restraints like the seclusion of women or the *purdah* system which limited the presence of male professionals in midwifery and thus explained the centrality of female doctors in medicalizing childbirth in India.[12]Therefore, the replacement of dhais with western trained midwives could be best understood by the realignment of professional relationships between female and male medical midwives, with the former dominating the realm of actual practise (i.e. attending women during childbirth) and the latter contributing to the more theoretical domain of midwifery education and research on obstetrics as illustrated by Ambalika Guha in her work
'*Colonial Modernities.*[13]

Sean Lang's meticulous analysis of government records from the Madras Presidency illuminates the colonial state's keen interest in reforming midwifery practices in India, a concern that emerged prominently in the 1840s and persisted thereafter. This consisted of managing and funding a large lying-in hospital in Madras, as well as smaller lying-in wards at provincial dispensaries, with the goal of training midwives to work across the Presidency.[14] At Madras, the plan was to replace her with a group of Indian-trained midwives who would work in the community.[15] The initial training efforts for Indian women at the hospital were limited, with only five trained by 1871. Notably, four of them were trained before the official opening of the school, underscoring a certain level of pre-existing interest or demand for such training. Recognizing the need for reform, the

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[10] Guha, Ambalika. *Colonial Modernities: Midwifery in Bengal, c. 1860–1947*. Routledge India, 2017, pp.64.
[11] McMahon, Devon E. "From Midwives to Obstetricians: The Fixed Maternal Mortality Rate in America from 1750 to 1930." (2010), pp.1.
[12] Guha, Ambalika. *Colonial Modernities: Midwifery in Bengal, c. 1860–1947*. Routledge India, 2017, pp.64.
[13] Ibid.
[14] Lang, Sean. "Drop the demon dai: Maternal mortality and the state in colonial Madras, 1840–1875." *Social history of medicine* 18.3 (2005), pp.360.
[15] Ibid, pp.361.

institution underwent changes in 1872 with the explicit objective of enrolling more Indian students.[16] As a consequence of this reform, by the 1870s, midwives trained in Madras became more widespread, extending their presence not only across India but also reaching regions beyond, such as Burma and Singapore.[17] This evolution suggests a growing recognition of the importance of midwifery education and an increased willingness among Indian women to pursue such training, thereby contributing to the dissemination of medical knowledge and practices in the broader Southeast Asian context.

year	Cases attended
1872	9 (in-ward cases) and 18 outdoor cases
1873	22 (in-cases) and 23(outdoor cases)
1874 (1st quarter)	5 woman admitted to lying-in hospital
1874-75	24 woman admitted to lying-in hospital

Source: Annual report on civil hospitals and dispensaries in Madras, year 1874-75, pp.62 http://books.google.com/books?id=prQIAAAAQAAJ&oe=UTF-8

The data extracted from the Annual Report on Civil Hospitals and Dispensaries in Madras for the years 1872 to 1874-75 presents a nuanced perspective on the evolving landscape of maternal healthcare during that period. In 1872, the attendance records reveal a modest beginning, with 9 in-ward and 18 outdoor cases. However, the subsequent year, 1873, witnesses a significant surge, indicating 22 in-ward and 23 outdoor cases. This notable increase may suggest a heightened awareness of maternal health issues or an expansion in healthcare services, leading to an upswing in patient numbers. The first quarter of 1874 shows a specific focus on maternal care, as evidenced by the admission of 5 women to the lying-in hospital. This suggests a dedicated facility catering to childbirth and maternity-related services. The culmination of the data in the year 1874-75

[16] Lang, Sean. "Drop the demon dai: Maternal mortality and the state in colonial Madras, 1840–1875." *Social history of medicine* 18.3 (2005),pp.361. [17] Ibid, pp.362.

underscores a continued trend, with a total of 24 women admitted to the lying-in hospital. This sustained demand for such specialized services over the years may reflect an increasing recognition of the importance of maternal healthcare within the community.

The Annual report on civil hospitals and dispensaries in Madras of the year 1869 indicates a deliberate decision to enlist the services of an experienced midwife from the Pariah caste for the lying-in hospital.[17] However, the motivation behind this choice reveals a societal bias and a strategic consideration aimed at broadening the hospital's appeal. There is a clear perception that utilizing midwives from lower castes, such as the Pariah caste, was viewed negatively, possibly because it was associated with the poorer sections of society. This perception led to the belief that the use of such midwives might limit the hospital's acceptance primarily to individuals from lower economic strata. The decision to procure services from European or Eurasian midwives reflects a conscious effort to attract a more affluent segment of the native population, specifically the higher class.[18] This approach is indicative of a discriminatory mindset, suggesting that the European or Eurasian midwives were perceived as more acceptable or desirable in the eyes of the higher class. The underlying assumption here is that individuals from the higher class may be hesitant to avail themselves of services provided by midwives from lower castes, thereby necessitating a preference for midwives from backgrounds considered more socially acceptable during that time. Thus, reflecting the intersection of social biases, caste dynamics, and strategic considerations in the provision of maternity services during the late 19th century. The preferences for midwives were not solely based on their expertise but were influenced by societal perceptions and efforts to cater to specific socio-economic strata.

ethnicity	No. on the roll	Percent of total	Completed successfully (no.)	% of ethnic group completed successfully	Failed to complete (no.)	% of ethnic group filing to complete

[17] Annual report on civil hospitals and dispensaries in Madras, year 1874-75, pp. 6. http://books.google.com/books?id=prQIAAAAQAAJ&oe=UTF-8
[18] Ibid, pp.62-63.

European	6	14	5	83	1	17
East Indian	21	49	21	100	0	0
Indian	13	30	5	38	8	61
Unspecified	3	7	0	0	3	100
Total	43		31		12	

- Madras Lying-in Hospital Midwifery Class, 1872–4: ethnic profile

  Source: Madras: Report on Civil Hospitals and Dispensaries, 1872 and 1873–4. (Cited from Lang, Sean. "*Drop the demon dai: Maternal mortality and the state in colonial Madras*, 1840–1875. pp.362.)

The data from the Madras Lying-in Hospital Midwifery Class for the years 1872-4 provides valuable insights into the ethnic composition and outcomes of midwifery training during the colonial era. Notably, the ethnic profile indicates a diverse enrollment, with Europeans comprising 14%, East Indians representing 49%, Indians constituting 30%, and an unspecified category at 7%. Examining the success rates within each ethnic group reveals intriguing patterns. European trainees demonstrated a high success rate of 83%, suggesting a robust completion of the midwifery program. In contrast, East Indian trainees achieved a perfect success rate of 100%, indicating a notable accomplishment within this ethnic group. However, Indian trainees exhibited a comparatively lower success rate at 38%, suggesting challenges or disparities in the completion of the midwifery training program. The unspecified category showed a 0% success rate, indicating a lack of successful completions within this group. The challenges encountered within the Madras Lying-in Hospital Midwifery Class, particularly evident in the success rates among Indian trainees, warrant closer examination. The observed comparatively lower success rate of 38% among Indian trainees hints at potential hurdles faced during the midwifery training program. These challenges could encompass a range of factors, such as socio-cultural barriers, limited access to educational resources, and potential institutional biases that may have influenced the successful completion of the training.

The parallels with Supriya Guha's analysis of the Dufferin Fund further elucidate these challenges.[19] The reluctance of traditional birth attendants (dhais) to adopt new medical practices, as identified by Guha, is mirrored in the potential hesitancy among Indian trainees in the Madras Lying-in Hospital Midwifery Class. This reluctance might stem from deep-rooted cultural practices, resistance to changes in traditional roles, or skepticism regarding the perceived benefits of adopting modern medical techniques. Moreover, the challenges outlined, including the reluctance to undergo training, financial constraints for patients, and a perceived lack of relevance in lessons, collectively contribute to the complexity of the educational landscape. Financial constraints may have impeded access to training for aspiring midwives, while the perceived lack of relevance in lessons may have been a result of a mismatch between the curriculum and the practical needs of the trainees, leading to disengagement and potential dropouts. Understanding these challenges is crucial for a comprehensive analysis of maternal healthcare education during the colonial era, shedding light on the intricate interplay of cultural, economic, and educational factors that shaped the experiences and success rates of midwifery trainees in colonial Madras.

Bengal, despite being a central hub of British imperial authority in India during the nineteenth century, witnessed a slower pace in the institutionalization of midwifery compared to the region of Madras.[20] This discrepancy is noteworthy, considering Bengal's prominent role within the British colonial framework. In the early twentieth century, the cultural and social significance of 'dai-ma'—traditional practitioners providing maternity and newborn care in Bengal—remained pronounced. These women held elevated social status, a perception deeply entrenched in Bengali society and reflected in literary works such as novels and biographies.[21] However, the esteemed social standing of 'dai-ma' underwent a gradual erosion due to the advent of modern medicine and its subsequent neglect and derecognition. The impact of this transformation was largely mediated by colonial practices. In an effort to modernize healthcare, the Calcutta Medical College, despite initial reservations, established a midwifery ward in 1838, incorporating midwifery

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[19] Guha, Supriya, and Rudyard Kipling. "From Dias to Doctors: The Medicalisation of Childbirth in Colonial India by Supriya Guha. In: Understanding Womens Health Issues: A Reader. Kali. 1998. p. 228., pp. 10-11.

[20] Lang, Sean. "Drop the demon dai: Maternal mortality and the state in colonial Madras, 1840–1875." *Social history of medicine* 18.3 (2005),pp.377.

[21] Soman, Krishna. *Women, medicine and politics of gender: Institution of traditional midwives in twentieth century Bengal*. Institute of Development Studies, 2011, pp.213.

into its curriculum by 1841. A significant stride occurred in 1849 when permanent professorships for anatomy and midwifery were established, marking a crucial milestone in the formalization and institutionalization of midwifery education in Bengal.[22]

Although the addition of midwifery to the academic curriculum, upper-class female isolation continued to block male advancement in the profession. The Empire's economic imperatives and cultural restrictions loomed big in official discourse. In the 1870s and 1880s, it drove the colonial medical system to prioritize the training of female midwives over that of male medical students.[23] This is reiterated in the Volume 3 of The Indian Medical Gazette, where after the introduction of male students into the midwifery programme, it was pessimistically commented that, despite a class of Bengali doctors being trained in midwifery at Medical College in the hopes of spreading the fruits of "excellent midwifery" to the masses, it may provide little assistance to poor women giving birth in their own homes in remote areas, well beyond the reach of dispensaries/hospitals and the doctors and sub-assistant surgeons attached to them, which necessitated the education of “the Native daees themselves".[24] The government, on the other hand, was primarily motivated by financial considerations in prioritizing dhai training above indigenous medical training.[25]

Contrary to the accepted historical narrative that male engagement in midwifery was absent, Ambalika Guha's research on Bengal challenges this notion. Guha demonstrates that the medicalization of childbirth in Bengal was preceded by the formation of a medical discourse on midwifery. This transformation was facilitated by the inclusion of midwifery in the curriculum of Calcutta University in the mid-nineteenth century. Notably, this inclusion was under the guidance of the all-male medical faculty at the Calcutta Medical

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[22] Guha, Ambalika. "Beyond the Apparent: The Male Doctors and the Medicalisation of Childbirth in Bengal, 1840s–1940s." *Indian Historical Review* 44.1 (2017), pp.110.

[23] Guha, Ambalika. "Beyond the Apparent: The Male Doctors and the Medicalisation of Childbirth in Bengal, 1840s–1940s." *Indian Historical Review* 44.1 (2017), pp.110.

[24] Native Midwifery. (1868). *The Indian medical gazette*, *3*(10), 239.

[25] ibid.

College, comprising both indigenous and British doctors.[26] Thus, revealing a complex interplay of gender dynamics and colonial efforts to advance medical education. Dr. Charles played a pivotal role in attempting to attract women to midwifery training, a task compounded by the challenges highlighted in the government's 1869 inquiry. These challenges included the issue of expenses and the difficulty in finding women willing to undergo instruction training in midwifery.[27] Even amongst the practicing dhais it was found impossible to make them attend these trainings regularly,[28]who expressed unwillingness to attain instructions from teachers of opposite sex and were against any kind of interfernce in their "divine right."[29] The reluctance of women, including practicing dhais, to undergo midwifery instruction due to gender-related prejudices posed a significant obstacle.

In response to these challenges, innovative measures were proposed in Calcutta, such as admitting 20 women to the midwifery ward with stipend of Rs.5 per month for six consecutive months. In addition to this, a scholarship of Rs.15 was provided to the best midwifery student in her fourth year.[30] Furthermore, it was advised by Dr. Chevers to employ six professional midwives between the ages of 30-35 years. This criteria of age was included to keep young girls away from instructional training and by the year 1871, among the ten women received for training only three underwent a satisfactory examination on the subject of natural labor and one promised well, rest were withdrawn from the course because of various reasons.[31] The examination, conducted in the presence of Meer Ashruf Ali, Baboo Kristo Das Sen, and Dr. Charles, underscored the collaborative nature of midwifery education involving both indigenous and British practitioners.[33] The efforts of these male doctors aimed at overcoming gender-based prejudices and cultural barriers were embedded in a broader colonial strategy to enhance the scientific rigor of midwifery practices, reflecting a nuanced intersection of colonial policies, medical

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[26] Guha, Ambalika. "Beyond the Apparent: The Male Doctors and the Medicalisation of Childbirth in Bengal, 1840s–1940s." *Indian Historical Review* 44.1 (2017), pp.110

[27] Report on the Calcutta medical institutions, pp.13. https://digital.nls.uk/indiapapers/browse/archive/74972249

[28] "The Education of "Dhais"." *The Indian medical gazette* vol. 8,4 (1873): 100-101.

[29] "Vernacular Education in Midwifery." *The Indian medical gazette* vol. 3,3 (1868): 64.

[30] Report on the Calcutta medical institutions, pp.13. https://digital.nls.uk/indiapapers/browse/archive/74972249

[31] Ibid, pp.14.

[33] Ibid, pp.14.

education, and cultural dynamics. Therefore, the male midwives and medical practioners primarily focused on fortifying the scientific and theoretical foundations of the profession rather than merely addressing the accessibility concerns of upper-caste purdah women.

Classes of patients	Year : 1871	1870
Indoor patients (medical and surgical)	3,143	3,252
Midwifery ward (indoor)	742	747
Eye infirmary	507	527
Total in-door	4,395	4,526
Out-door patients (medical and surgical)	25,491	23,023
Admission room	763	1,445
Dispensary for women and children	12,049	10,982
Ophthalmic dispensary	3,963	3,496
Dental dispensary	1,184	1,261
Classes of patients	Year : 1871	1870
Total out-door	43,450	40,266
Grand Total	47,450	44,792

- Transactions of the year : Although there was a slight decrease in the number of patients treated indoors, the outdoor attendance increased by 3,104. It shows the significant number of people who utilized the services of indoor midwifery ward and out-door dispensary for women and children

Source: https://digital.nls.uk/indiapapers/browse/archive/74972249 (Report on Calcutta Medical Institutions,p.9)

The data extracted from the "Report on Calcutta Medical Institutions" for the years 1870 and 1871 sheds light on the healthcare dynamics, with a particular emphasis on the utilization patterns among different classes of patients, including upper-caste purdah

women. The categories under consideration include indoor patients, attendance in the midwifery ward, and various outpatient services. In 1871, there was a marginal decrease in the number of indoor patients for medical and surgical cases, dropping from 3,252 to 3,143. However, the attendance in the midwifery ward remained relatively stable at 747 cases. The eye infirmary experienced a slight increase from 527 to 507 cases. The cumulative total of indoor patients saw a slight dip from 4,526 to 4,395 during this period.

Conversely, the outpatient services witnessed a significant increase, with the number of patients seeking medical and surgical services rising from 23,023 to 25,491. The attendance in the admission room, however, notably decreased from 1,445 to 763. The outpatient services at the dispensary for women and children, the ophthalmic dispensary, and the dental dispensary collectively observed an upward trend, contributing to the overall increase in outpatient attendance from 40,266 to 43,450. The grand total of patients served during this period increased from 44,792 to 47,450, reflecting an expanding outreach and impact of the Calcutta Medical Institutions.

The significant surge in outdoor attendance by 3,104, despite a slight reduction in indoor patients, underscores the substantial utilization of healthcare services. Particularly noteworthy is the stability in midwifery ward attendance, suggesting a consistent demand for maternal and newborn care services. This finding may indicate a degree of success in addressing the healthcare needs of the targeted population, including upper-caste purdah women. The persistent demand for specialized services, such as those offered by the midwifery ward and the women and children dispensary, highlights their crucial role in catering to the diverse healthcare needs of the community during this period.

On similar lines, in Amritsar a school of midwifery with an attached lying-in hospital was established under the supervision of a lady and was supported by the Municipal Committee of Amritsar that provided it a grant of Rs. 100 per month.[32] Lectures on midwifery were delivered three times a week in vernacular. Here, 52 female patients were

[32] "Vernacular Education in Midwifery." *The Indian medical gazette* vol. 3,3 (1868): 64.

treated since its inauguration in Dec,1867 and also had 7 people studying midwifery among whom two were muslims, four hindus and one christian.[33] Later,the Punjab Medical College was established to modify the practice of midwifery where the emphasis was on imparting education to native dhais, four of whom on qualifying the examination obtained the "certificates of ability to practice midwifery and to treat the disease of women and children."[34]

However, due to its lackluster job prospects, midwifery maintained a minor position in scientific medical education. Nonetheless, the fact that it was given its own professorship demonstrates that it was beginning to be recognised as a medical discipline.[35] In addition to this, the British colonial state did not allow these trained midwives to function autonomously. They were asked to compromise with their demands as it was believed that they were undermining the two main goals for which the government that had trained them in the first place: improving the lives of Indians in poverty and reducing the dominance of the traditional birth attendant, the dai.[36]

Geraldine Forbes has documented the process of Indian women's education and training in Western medicine, encompassing midwifery and medical practice operating in the mid-nineteenth century. In an attempt to determine whether such training aided women in deciding on economic commitments outside the home, she discovered that women were prohibited from using their training to earn a living.[37] As a result, they were forced to act as a middleman and rely on British authorities for training and opportunity. They also

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[33] Ibid.

[34] "The Calcutta Medical Society." *The Indian medical gazette* vol. 17,2 (1882): 50-55.

[35] Guha, Ambalika. "Beyond the Apparent: The Male Doctors and the Medicalisation of Childbirth in Bengal, 1840s–1940s." *Indian Historical Review* 44.1 (2017), pp.110.

[36] Lang, Sean. "Drop the demon dai: Maternal mortality and the state in colonial Madras, 1840–1875." *Social history of medicine* 18.3 (2005),pp.363.

[37] Forbes, Geraldine. "Medical careers and health care for Indian women: Patterns of control." *Women's History Review* 3.4 (1994).

needed acknowledgement of their new responsibilities in families and society, which was difficult to come through.[38]

MEDICALIZATION OF CHILDBIRTH AND ROLE OF EUROPEAN WOMEN DOCTORS

Despite endeavors to promote lying-in hospitals, there remained reluctance among the upper-class women, particularly evident in Madras. The utilization of lower-caste Pariah women's services was perceived as a deterrent, dissuading the upper-caste class from admitting their women to lying-in hospitals. Additionally, proponents of female medical education in India contended that the practice of purdah (seclusion) among respectable Indian women hindered their access to medical treatment from male doctors, underscoring a pivotal rationale for advocating women's medical education.[39] The tradition protected Indian women from both the eyes of outsiders and the effects of the outside world, both literally and metaphorically. This particular practice is significant since it had serious consequences for women's health.[40] On the other hand, the *zenanas*, or women's quarters, were regarded with dread and distrust since women were seen to be living in appallingly ill conditions, with little care for hygiene or even pure air and open spaces.[41] The need of intelligent and skilled medical assistance for the ladies of upper and native middle class which was previously taken for granted was now needed state's intervention. Recognizing the challenges associated with training native midwives, the colonial state sought alternative approaches to exert control over the childbirth process.

One such strategy involved the utilization of trained medical women from Europe as a potential workforce in addressing the complexities and cultural barriers associated with indigenous midwifery training.

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[38] Ibid.

[39] "Women Doctors for India." *The Indian medical gazette* vol. 17,7 (1882): 184-185.

[40] Ray, Sharmita. "Women's Concern for Women's Health in Colonial India" *Proceedings of the Indian History Congress*. Vol. 76. Indian History Congress, 2015, pp.239.

[41] Ibid.

Regardless of the fact that British colonists imparted Western medical education to Indians in the 1830s, Indian women and their health did not become a subject of concern for British men and women — colonial administrators, philanthropists, and missionaries – and Indian men until 50 years later.[42] The Countess of Dufferin's Fund, often known as the Dufferin Fund, was founded in 1885 and was the first organized attempt by the Raj to provide medical help to Indian women. This Fund brought medical reform to the zenana, which represented everything decadent, regressive, and conservative about India's gender system. Moreover, initiatives by the state like Dufferin Fund also contributed in this process and became a "hallmark initiative by the Government of India, to impose onto India the English model of philanthropy, which colonial rulers claimed reflected a progressive civic ideal."[43] As much as this was one of the grounds for the government's backing for the Association's projects, the Dufferin Fund was also advantageous because of the vast number of jobs it created for British medical women.[44] Later, to help alleviate the problem, the Victoria Memorial Scholarship Fund was also founded in 1901–1902 with the stated goals of 'developing a superior class of midwives' and 'to convey a certain degree of practical knowledge to the indigenous midwives (dais).' The failure of such projects was frequently blamed on the illiteracy of midwives and their resistance to modernisation by colonial officials and missionaries.[45]

In her scholarly analysis of the Dufferin Fund, Supriya Guha discerns a notable trend in the latter half of the nineteenth century wherein a concerted effort was made to assimilate Indian elite groups.[46] This assimilation strategy primarily focused on educational initiatives and the deliberate avoidance of interference in sensitive matters. Within the propertied, upper-caste gentry, there existed a subset keen on embracing Western medicine and

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[42] Prasad, Srirupa. "Imagining the Social Body: Competing Moralities of Care and Contagion." *Cultural Politics of Hygiene in India, 1890–1940*. Palgrave Macmillan, London, 2015, pp.62.

[43] Lal, Maneesha. "The politics of gender and medicine in colonial India: The Countess of Dufferin's Fund, 1885-1888." *Bulletin of the History of Medicine* 68.1 (1994),pp. 29-30.

[44] Ray, Sharmita. "Women's Concern for Women's Health in Colonial India" *Proceedings of the Indian History Congress*. Vol. 76. Indian History Congress, 2015.

[45] Prasad, Srirupa. "Imagining the Social Body: Competing Moralities of Care and Contagion." *Cultural Politics of Hygiene in India, 1890–1940*. Palgrave Macmillan, London, 2015, pp.64.

[46] Guha, Supriya, and Rudyard Kipling. "From Dias to Doctors: The Medicalisation of Childbirth in Colonial India by Supriya Guha. In: Understanding Womens Health Issues: A Reader. Kali. 1998. p. 228., pp.4.

advocating for medicalized childbirth within their households.The Dufferin Fund explicitly targeted this particular demographic, as evident in its recurrent emphasis. In pursuit of this objective, purdah hospitals were established, accompanied by stringent adherence to the rules of seclusion. Nevertheless, it is noteworthy that the Fund faced accusations from certain quarters suggesting its inadvertent promotion of the purdah custom.[47]

Antoinette Burton explores the colonial perspective on scientific midwifery, emphasizing the confinement of Indian women within allegedly "unsanitary Oriental zenana." This belief influenced the institutionalization of women's medicine, leading to the professionalization of women doctors in Victorian Britain, particularly those educated at the London School of Medicine for Women.[48] British women doctors viewed providing medical care to women in zenanas as a national and imperial duty.[49] The introduction of 'lady doctors' was driven by assumptions about the zenana's ready-made clientele, concerns about redundancy among British practitioners, and a woman-to-woman care ethic prevalent in Victorian England.[50]

Towards the close of the nineteenth century, the robust professional opportunities for female medics in colonial India led to the attraction of European women from Britain seeking advanced medical qualifications, often unavailable in the metropole.[51] In India, women doctors enjoyed advantages, performing surgical operations on women, a specialization often denied to them in Britain. The Indian medical landscape allowed young female medical professionals to assume leadership roles in hospitals or dispensaries, garnering social prestige at a relatively early stage in their careers. The presence of women doctors reduced Indian women's reluctance to surgery to some extent may be seen in the increasing number of surgeries conducted by the latter, as evidenced by the Dufferin Fund's

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[47] Ibid, pp.5.

[48] Burton, Antoinette. "Contesting the zenana: The mission to make “lady doctors for India,” 1874–1885." *Journal of British Studies* 35.3 (1996): 369.

[49] Ibid, pp.370.

[50] Ibid, pp.373-374.

[51] Allender, Tim. "Learning femininity in colonial India, 1820–1932." pp.178.

yearly reports.[52] This led to the “medicalization of childbirth”, which blurs the line between “the individual and the social bodies, and has a tendency to turn the social into biological."[53] Through the process of medicalisation, the medical establishment, as a standardized professional institution, classifies childbirth as an illness and mandates that a medical expert oversee the birth process and select treatment.[54]Furthermore, The medicalization of birth involves pathologizing the "normal" by bringing it under the control of a professional doctor, which helps state-regulated institutions to gain a strong footing in the realm of birth.[57]

Ambalika Guha's analysis unveils the intricate dynamics surrounding the vilification and estrangement of dhais, illuminating their role in fortifying the professional standing of female physicians.[55] The British female doctors championed a "broader medical outlook" and a "scientific mentality," continually striving to stay at the forefront of contemporary methods and enhance the quality of their practice.[59] This group of British female doctors, propelled by vigorous advocacy, achieved higher recognition in obstetrics and gynecology than their male counterparts. Ambalika Guha terms this phenomenon as the "masculinization of obstetrics," conceptualizing "masculine" not as a biological category but as a cognitive style and epistemological position.[56] This perspective sheds light on how female doctors in colonial India strategically carved out a professional niche for themselves by assimilating the ethos of their male counterparts.

Guha contends against Celia Van Hollen's presumption of the absence of 'masculinisation' in Indian obstetrics, asserting that such claims oversimplify the complex emergence of the obstetrics profession in India.[57] While female doctors played a pivotal

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[52] Guha, Ambalika. "The 'Masculine' Female: The Rise of Women Doctors in Colonial India, c. 1870–1940." *Social Scientist* 44.5/6 (2016), pp.54.

[53] Van Hollen, Cecilia. "*Birth on the Threshold*” University of California Press, 2003,pp.11. Op. quote. Scheper-Hughes and Lock.

[54] Ibid, pp.11.

[57] Ibid, pp.12.

[55] Guha, Ambalika. "The 'Masculine' Female: The Rise of Women Doctors in Colonial India, c. 1870–1940." *Social Scientist* 44.5/6 (2016) , pp.51. [59] Ibid, pp.55..

[56] Ibid, pp.50.

[57] Ibid, pp.53.

role in promoting the medicalization of childbirth, they adopted the professional ethos of the male medical establishment, paying minimal attention to the dhais. Therefore, to reiterate, Guha's argument, in their pursuit of professional excellence, these lady doctors marginalized two crucial cohorts of female caregivers: Indian women doctors and, notably, the dhais.

CONCLUSION

The transformation of midwifery from a traditional, generational practice centered around women to scientific midwifery posed intricate challenges for the British colonial state. The health status of women became an issue related to that of the relative 'backwardness'. Henceforth, interventions during the colonial era were directed toward the 'modernization' of healthcare practices, transitioning childbirth responsibilities from traditional midwives (dais) to formally trained midwives and physicians.The increasing intervention of the colonial state significantly altered childbirth practices, transforming it from a natural occurrence to a process requiring medical intervention. This impact was evident in changes to the place of birth and the gradual disappearance of traditional birth attendants (dhai). Initiatives such as the establishment of 'lying in' hospitals through the Dufferin Fund, the introduction of contemporary nursing and midwifery training programs, and the infusion of rational approaches into healthcare frameworks played pivotal roles. This shift brought the process of childbirth from the domestic sphere to hospitals, allowing the colonial state to exert greater control over its subjects. Simultaneously, factors such as increasing competition among doctors, changing cultural attitudes about the proper place of women, the evolving preferences of middle and upper-class women, and the lack of organized knowledge among midwives, attributed to the disappearance of traditional midwives.

In conclusion, the distinctive characteristic of European medical narratives and intervention lies in the prioritization of the eyewitness account, and statistical data, which collectively contributed to the ascendancy of the emerging biomedical ideology. A noteworthy illustration of this trend is evident in accounts of Indian medical gazetters, the records of Madras Presidency and calcutta medical institutions, wherein the authenticity of the narratives are mainly grounded in the assertion of different colonial officers and doctors appointed under colonial state having personally witnessed the abuses inflicted upon Indian

women by the native midwives. This emphasis on direct observation and empirical evidence underscored the influential role played by the biomedical paradigm in shaping perceptions and discourse during the period under consideration. Therefore,

While the introduction of Western medicine as an administrative exigency justified the paradigm of power and cultural hegemony, the efforts to revitalize Indian systems of medicine were not devoid of internal differences which were intricately entangled with class, and political agendas.

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