CHAPTER VI
WOMEN AND PUBLIC HEALTH

Indigenous systems of medicine and health care practices came under severe
strain due to the introduction of Western medicine. The indigenous practices like
Ayurveda, Unani, and Siddha were relegated to an inferior status by the Colonial
government and Western medicine and practices were accorded the official status.
Therefore, the British established administrative and institutional infrastructure that
was necessary for the practice of Western medicine. Hospitals, dispensaries and
medical colleges sprang up and slowly Western medicine established its supremacy
over all other systems. However, the sheer magnitude and cost of providing medical
facilities covering the growing population was impossible and indigenous systems
continued to provide their services particularly in rural areas. This was true of the
sphere of maternal health also. The essential service to women during actual delivery
did not form a part of the physician’s duty but was generally performed by midwives.1

The increasing death of mothers during childbirth became a major concern
to the government in the late nineteenth and early twentieth centuries. The
government depicted this pitiable condition of women as preventable and blamed the
indigenous midwives or dhais as responsible for this sorry state of affairs. The
problem was approached in two ways. On the one hand, emphasis was laid on
delivery at a western maternity institution and on the other hand, the British medical
administration advocated training of the barber midwives in Western methods of

1 The indigenous system had its own well defined theories of reproduction and birth. The indigenous
medical texts of Charaka and Susruta discuss the subject of obstetrics and gynecology at some length
particularly in the Sarirasthana and Chikitsasthana. Charaka concerns himself mainly with the medical
aspects of gynecology and with normal pregnancy and delivery. Sushruta deals in addition with the
surgical aspects of obstetrics. P. Kutumbiah, Ancient Indian Medicine (Chennai: Orient Longman,
1999), 177.
midwifery. In Colonial South India, the training of midwives was undertaken by the colonial state, missionaries, non official organisations and public spirited individuals. The chapter examines the impact of training women on modern methods of midwifery.

**Mortality of Women and its Reasons**

The statistics of maternal mortality as recorded by the public health authorities despite its inaccuracy indicated that in the early 1920s at least 25,000 mothers were dying annually due to childbirth in the districts of Colonial South India alone. The high maternal death rate was attributed to different problems, the first and foremost being the social evil of child marriage. The lesser the age of the mother, the greater was the mortality rate. The maximum deaths were noticed when the mother’s age was under 15. The Madras Hospital for women and children reported that for the years 1922-24 given the ages of 2,312 primiparae of whom the average age was 19.4 years. 13 was the youngest age, seven mothers being 13 and twenty two mothers 14 years of age. The report on the “investigations into the causes of maternal mortality in the City of Madras” by Dr. A.L. Mudaliar indicated that 71.1 percent of the maternal deaths belonged to the age group of 15–29. It pointed out that due to the strain caused by premature pregnancy and its serious after effects, a large proportion of such mothers became chronic invalids or physical wrecks.

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2 G.O. No. 1369, P.H., dated 29. 9.1924.
4 The average age of Indian girls, when they co-habited with their husbands was about 14 and at an average age of 16, they gave birth to the first child. Further, each mother gave birth on an average, to about 6 children before the age of 30. It was noticed that the majority of deaths were during the first confinements. A.Lakshmanaswamy Mudaliar, *Report on the Investigation into the causes of Maternal Mortality in the City of Madras* (Madras: Government of Madras, 1933).
The existence of certain diseases or conditions connected with pregnancy, such as anemia, osteomalacia, eclampsia, accidents or complications, venereal disease and outbreak of epidemics like smallpox, malaria and tuberculosis debilitated the mother. Further, the ignorance of the traditional birth attendants on sanitation and unhealthy habits had increased the suffering. Nearly, ten lakh labour cases per year were managed by barber midwives. In 1917, Srinivasamurthy, a notable advocate of indigenous medicine in his book entitled “The Slaughter of Innocents” was candid in his statements. In this regard, he observed as follows: “Our own apathy and callousness are responsible for this grievous situation.

And yet another reason was the poverty of the people which prevented them from calling in the assistance of qualified medical practitioners. The Third All India Sanitary conference highlighted that the unskilled midwifery at the time of attendance of labour and the malpractices of quack midwives without proper knowledge of mother crafts had played a lot of havoc in causing maternal and infantile mortality. The barber midwives were denounced for their crude and dangerous techniques. The medical authorities arguing on their ignorance said that the duties of the physician, midwife and scavenger were performed by them whose “ignorance of cleanliness was stupendous.” Russell, the Director of public health remarked: “their methods, the instruments used by them and the medicaments given to mother and child were “so revolting that no language sufficiently strong can be used to condemn them.” Hence the indigenous midwifery was severely condemned by the Colonial authorities.

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6 For a detailed account of the impact of these diseases related to pregnancy, see Maternal Mortality in Childbirth, 1–19.
7 Madras Medical Journal, September 1918, 301.
8 The Proceedings of the First All India Sanitary Conference, 2: 59.
9 Along with conducting deliveries, they also carried out abortions when asked to. The most common method was using some irritant chemical substance, or twigs of certain irritant plants. These were
In minor details, birth customs were diverse in different parts. The journalist Mary Francis Billington speaking about the late nineteenth century says: “The newly-confined woman was made to stand against the wall, while the *dhai* with her head or bent knees exerts her whole force against the lower part of the stomach, to bring about the contraction of the uterus, an embrocation made from the leaves of Artemisia vulgaris, and to lessen superabundant flow of milk, a plaster made of pea-flour and the dried bark of Cucurbita was employed. Altogether certain ideas opposed to sanitation were common; the birth fire kindled with charcoal, which East and South, West and North, with Tamil and Punjabi, with Brahmin and Mussulman women alike, smolders beneath the bed, on which the mother lies. After a premature or still birth, it was a very usual practice on the part of the *dhais* to administer a decoction of bamboo leaves, in which a copper coin has been soaked, the underlying idea of this seemingly risky practice”.

Similarly, R.J. Blackman, in his guide to Indian Home Nursing published in 1913, stated “When the *dhai* is sent for to a case, she usually changes even her ordinary working clothes for filthy rags, and the delay was a fortunate thing, as, if she reaches the women in the first stage of labour, so much the worse for the patient. She makes her run about the room, lift heavy weights, or squat on the mud floor; and if these efforts fail to produce sufficient progress, she places heavy weights on the abdomen, or inserts a vaginal plug of dirty rags. The results of these manoeuvres are often to precipitate delivery, with injury to the child, haemorrhage, and of course, rupture to the perineum”.

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In certain areas of South India, women during the confinement were considered unclean and hence relegated to a separate place. “In North Malabar, where a proportion of the population is Karavas, the woman is taken to a shed at some distance from the house, and is left absolutely unaided for twenty-eight days. Even her medicines are thrown to her, and beyond placing a jar of warm water near her about the expected hours of delivery nothing whatever is done for her. Ideas as to pollution were very strongly held all along the Western shores of India, and, in fact, worse uncleanness was supposed to be conveyed by it than from the touch of death itself. To trace the customs of isolation of the mother, and the still more curious one which also obtains of regarding the father as also impure for fourteen days, only to be freed at the end of that time from his defilement by holy water supplied by Brahmans from temples or consecrated tanks.” Moreover, the infant mortality was also very high owing to the appalling ignorance of the dhais whose methods of treatment were simply barbarous. “The child was maltreated even worse than the mother. The cord was cut with anything handy and the most common thing to use for ligature was the hair-string from the mother's head, a greasy cord which she had worn for months. The usual tongue-tie operation was then performed. The most amazing thing was that the child was allowed no nourishment for three days, but was kept quiet with opium. As may be imagined, this lead to marasmus in the child and great discomfort to the nursing mother”. In order to alleviate women from suffering during childbirth, the British government provided Western methods of medical care to the women as early as 1844.

Institutions providing Maternal Care

Madras claims the honour for having the oldest maternity institution in British India since the first Women and Children’s hospital was opened on 26 July 1844.\(^{13}\) It was originally named as the Lying-in hospital as women were encouraged to give birth not in their homes but in the lying-in hospital. Though it opened its doors to all, it was mainly used by Europeans, Anglo-Indian, and Indian low caste people. High caste Hindu and purdah Muslim women generally avoided it due to social and cultural prejudices. The unique feature of the hospital worthwhile considering is that here, any case of puerperal sepsis\(^{14}\) or any ‘possible’ or ‘suspect’ case of sepsis, before or after delivery, was segregated to a separate pavilion in the hospital in charge of a separate medical and nursing staff, so that there was very little possibility of a communication between the two.\(^{15}\)

A school of midwifery, consisting of a limited number of European and East India female pupils for instruction was formally opened in 1854 in this institution. They were granted a certificate of qualification only if found competent after examination. The certificate granted was a diploma in Midwifery training. The pupils were resident in hospital and allowed to remain under instruction for a period not exceeding twelve months. Practical instructions were also provided once in a week supplemented by lectures in anatomy from the superintendent and the Hospital

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\(^{13}\) Madras Almanac, 1854 (Madras: Asylum Press, 1855), 691.

\(^{14}\) Puerperal sepsis, as the name implies, is an infected condition of a lying-in patient, incident to the delivery of a child. Introduction of the sepsis from the without must come from improper sterilization of the hands or instruments of the accoucher or attendant, along with improper preparation and sterilization of the parts involved. It should be regarded as negligent on the part of the attendants to have the development of sepsis in any given case of parturition. The infection may be introduced by the use of unsterile napkins, gowns or bed clothing or not infrequently has it been brought about by the use of an unsterile syringe nozzle in giving cleansing douche.

Apothecary.Interestingly, certain basic qualification was required for undertaking training at the institution. A woman who was trained up to the fifth form or above and possessing a good knowledge of vernaculars was alone considered. It is a fact that this insistence on qualifications gave no chance for all classes to undergo the training. Only the Indian Christian women, caste Indian women came in large numbers. Very rarely the Dravida women were also included. During the period of training, they received a pay at the rate of fifteen rupees per mensem, and at the end of six months, if qualified, received a Nurse Certificate. In case of failure of a candidate to obtain the Diploma in Midwifery, a certificate in Sick Nursing was granted. However, it was considered much below the required standard.

A Scheme for more efficient training was drawn up in 1871 and submitted to the Government for approval by the Inspector-General, Indian Medical Department. The Madras Government sanctioned the scheme for training of six nurses in the Government General Hospital and the Government of India sanctioned the recruitment of a Lady Superintendent and four trained Nurses from England for starting the School of Nursing. The school was started on 1 July 1871. However for those who were desirous of being instructed both as nurses and midwives should furnish, with a written application for admissions as a pupil, testimonials of character, and state her age, condition, residence, previous experience in nursing and finally whether European or Indian. It was expected that the sum of rupees two will be sent with all applications for assistance obtaining Nurses to cover the coolie cost and carriage hire.

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17 G.O. No. 627, P.H., dated 20.3.1925.
18 Madras Almanac, 1854, 691.
19 Madras Almanac, 1854, 692.
During the year 1880, a native gentleman of Madras, Mr. Ramaswamy Moodelly, erected at his own expense a lying-in hospital in connection with the Monegar Choultry of Madras.²⁰ He also contributed a sum of Rs. 15,000 towards the maintenance and endowment of the hospital. It was opened by the Duke of Buckingham in 1880, and so well were caste scruples and customs respected that, although women of high caste would usually have died rather than enter a public institution, as many as a hundred and fifty resorted to her birth and infancy during its first year of existence. Different measures were taken to attract the native women to the hospital. “Very homelike and orderly were the wards, which contained accommodation for thirty-two patients, with their comfortable spring beds, pretty chintz-printed coverlets, and distempered walls, while bouquets of beautiful tropical flowers showed a greater attention to comfort than were usual in an Indian hospital. Ample space and perfect ventilation were secured to each patient, while a salutary rule, considered the malnutrition of many Indian working-class mothers, and the extreme youth of others (one or two girl-wives of only fourteen have been in its wards), enjoined that each woman shall spend a fortnight at the hospital before her confinement was expected.”²¹

By 1887 another ward was added in commemoration of the Queen-Empress's Jubilee and yet another in honour of the visit paid to, and satisfaction expressed at, the hospital by the late Duke of Clarence and Avondale. Repute of the institution spread, people came from great distances to benefit by it. Surgeon-Colonel Branfoot rendered useful encouragement to Eurasians desiring to qualify as nurses. Madras, through the

²⁰ Founded in 1808, the Monegar choultry was an institution which afforded shelter, food and raiment to the native poor, lame and blind of Madras, without reference to caste.
²¹ Billington, Women in India, 10.
generosity of Sir Savalay Ramaswamy, was endowed with one of the best institutions of this class to be found in all of India.22

Along with the Colonial state, the unhappy conditions of child-birth among Indian women became a matter of concern to many others. This was probably foremost in Queen Victoria’s mind when she asked Lady Dufferin to endeavour to arrange for a supply of women doctors for the women of India. The foundation of the Countess of Dufferin Fund in 1885 was the first organised effort to meet the need, although one or two qualified women missionaries were at that time already practicing in India. Lal writes that the Dufferin Fund’s services were mainly confined to upper and middle class women, and that it functioned more as a vehicle for the professional ambitions of English women doctors and an advertisement of the perceived superiority of British gender relations than as an effective measure to improve women’s health.23 Under the Dufferin scheme, a number of midwives were employed in various districts of South India and a large number of maternity cases were attended to by them. The following Table 6.1 shows the number of midwives who practiced in the different districts and the number of cases attended by them in 1888 and 1891. (See Table 6.1)

Under the Dufferin scheme, the number of midwives employed by the District and Taluk Boards and municipalities increased from 157 in 1888 to 208 in 1891. The number of labour cases attended by these women was 11,703 against 6,086 in 1888, or nearly double. These results testify to the good work done under the scheme. The following statement shows the number of midwives. However, when competing with

Table 6.1: Number of midwives in the district and number of labour cases attended under Dufferin Scheme, 1888 and 1891.

<table>
<thead>
<tr>
<th>Districts</th>
<th>1888</th>
<th>1891</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of midwives in the district</td>
<td>Total number of cases attended.</td>
</tr>
<tr>
<td>Anantapur</td>
<td>4</td>
<td>228</td>
</tr>
<tr>
<td>Arcot, North</td>
<td>4</td>
<td>228</td>
</tr>
<tr>
<td>Arcot, South</td>
<td>12</td>
<td>275</td>
</tr>
<tr>
<td>Bellary</td>
<td>8</td>
<td>242</td>
</tr>
<tr>
<td>Canara, South</td>
<td>3</td>
<td>238</td>
</tr>
<tr>
<td>Chinglepet</td>
<td>7</td>
<td>184</td>
</tr>
<tr>
<td>Coimbatore</td>
<td>8</td>
<td>303</td>
</tr>
<tr>
<td>Cuddapah</td>
<td>12</td>
<td>155</td>
</tr>
<tr>
<td>Ganjam</td>
<td>1</td>
<td>87</td>
</tr>
<tr>
<td>Godavari</td>
<td>5</td>
<td>218</td>
</tr>
<tr>
<td>Kistna</td>
<td>15</td>
<td>302</td>
</tr>
<tr>
<td>Kurnool</td>
<td>2</td>
<td>53</td>
</tr>
<tr>
<td>Madura</td>
<td>18</td>
<td>676</td>
</tr>
<tr>
<td>Malabar</td>
<td>4</td>
<td>76</td>
</tr>
<tr>
<td>Nellore</td>
<td>16</td>
<td>1,308</td>
</tr>
<tr>
<td>Nilgiris</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>Salem</td>
<td>8</td>
<td>219</td>
</tr>
<tr>
<td>Tanjore</td>
<td>13</td>
<td>952</td>
</tr>
<tr>
<td>Tinnevelly</td>
<td>9</td>
<td>146</td>
</tr>
<tr>
<td>Trichinopoly</td>
<td>5</td>
<td>51</td>
</tr>
<tr>
<td>Vizagpatam</td>
<td>2</td>
<td>115</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>157</td>
<td>6,086</td>
</tr>
</tbody>
</table>

*Source: Report on Civil Hospitals and Dispensaries for the year 1891, 8.*
the missionary nursing schools, their training programs were of little success.24 The
British Medical Journal pointing out the reasons remarked that the Association was an
organised system, but a loose aggregate of some 140 local bodies, and there
appears to be a defective appreciation of the fact that the success of any medical
charity depends chiefly on its medical staff. Further, in the Annual Report of the
National Association for Supplying Female Medical Aid to Women of India for 1899
one medical woman after another recorded her opinion that the experiment of
refusing to admit low caste women was a failure, yet no attention seems to have
been paid to the opinion of those surely best qualified to judge the practical effect
of such a regulation.25

Another popular institution in the City of Madras was the Royal Victoria Caste
and Gosha Hospital for women, founded by the efforts of Dr. Mary Scharlieb, one of
the first women students of the Madras medical college. The idea to start a hospital
entirely for women who were unwilling to go to hospital run by men germinated in
January 1885. But the meeting held under the presidency of Her Excellency Lady
Grant Dufferin on 6 March 1885 along with eminent persons of yore like Kasturi
Bashyam Iyengar, Diwan Bahadur R.Raghunatha Rao, Rajah of Vizianagaram,
Justice Mithuswamy Iyer, Rajah of Venkatgiri and Rajah Sri Salavay Ramaswamy
Mudaliar resolved to establish a Caste and Gosha hospital.26 A sum of Rs.70,000 was
collected on the spot and with further donations the hospital was declared open on the
7 December 1885 by Her Excellency Lady Grant Dufferin. It was named after Her
Majesty Queen Victoria Hospital by the efforts of Dr. Mary Scharlieb.
Encouragement was given to it by the ready and public-spirited action of some of the

Association of Medical Women in India 32, no.2, 1944, 68–69.
25 “The Dufferin Association in India”, BMJ, 17 August 1901, 424.
26 The Madras Tercentenary Commemoration Volume (New Delhi: Asian Educational Services, 1994),
58.
native princes, including the Prince of Arcot, the Maharajah of Travancore, and the Rajah of Pudakota.\textsuperscript{27} This institution was affiliated to the Countess of Dufferin’s fund from February 1886.

The hospital first began in a rented house offered by Honourable Mir Humayun Jah Bahadur free of cost. Later, new building was constructed with generous donations. Madras government donated a site at Chepauk in the year 1890 and also a sum of Rs.10,000 along with a year’s supply of medicines.\textsuperscript{28} The Rajah of Venkatgiri donated a sum of Rs.1 Lakh towards Superintendent’s quarters; the Rajah of Vizianagaram donated Rs.37,000 towards Nurses’ quarters, the Madras Women’s Memorial for Queen Victoria Fund donated Rs.50,000 towards in patient ward. A delivery ward was opened by Lady Bashyam Iyengar in 1904 and in 1909 a separate ward was built to treat the septic cases. The hospital was unique in a way that it had separate wards for Brahmins, Sudras, and Mohammedans and separate cooks for caste patients. Further, it provided separate accommodation for general diseases as well as facilities for lying-in. The medical superintendence was placed in the hands of a staff of highly qualified lady doctors. Gradually the Gosha women began to appreciate the benefits offered to them, and the number of cases treated annually has shown a satisfactory increase.\textsuperscript{29}

Simultaneously, hospitals were also established by zealous Christian missionaries. The reports of the Christian Medical Association of India remarked that, “the training of Indian girls was one of the most notable features of medical missionary work”.\textsuperscript{30} Women who were trained as doctors in the United Kingdom and the United States had few employment opportunities in their respective countries

\textsuperscript{27} Billington, \textit{Women in India}, 107.
\textsuperscript{28} \textit{Administration Report}, 1885–86, 191.
\textsuperscript{29} Billington, \textit{Women in India}, 107.
\textsuperscript{30} Basavanthappa, \textit{Community Health Nursing} (New Delhi: Jaypee Brothers publishers, 1998), 355.
hence they opted to work in Africa and Asia with the missionaries. They seemed to have been very active on the question of women’s health and entered the Indian subcontinent during the late 18th century mainly in those regions which were directly under British rule. According to Rosemary Fitzgerald, ‘missions developed energetic and often innovative approaches to this subject’, such that by 1916, they ran ninety-three hospitals for women, more than half of the total number of hospitals for women in India.\(^{31}\)

Christian Missionaries started two hospitals in the City of Madras. The former, the Christina Rainy Hospital started in 1894 by the Church of Scotland Mission. Beginning as a Medical Dispensary in Royapuram in 1888, the hospital was named after the educationist and its founder Miss. Christina Rainy. The hospital specialised in methods of painless delivery. It was this feature which attracted women, though it was not recommended for all cases.\(^ {32}\) Of the 65 women who delivered in this hospital during the two months of October and November 1917, 45 were delivered by this method, and among them 41 being Indians mostly high-caste Hindus, and 20 being primiparae.\(^ {33}\) Yet another feature of the hospital that attracted women is the darkened room for painless delivery cases. It gratified women’s instinctive desire to hide herself at such a time. A sum of Rupees five was collected for every delivery if the patient could afford it. Many gave far more and some pay only eight annas, but everyone


\(^{32}\) It was done by giving Infudin or Pituitrin and then putting the patient lightly under chloroform to secure speedy childbirth usually within an hour, and without consciousness on the part of the mother and without added risk to her or to her child. Improvement of the Conditions of Childbirth in India: Including a Special Report on the Work of the Victoria Memorial Scholarships Fund during the past Fifteen Years and Papers written by Medical Woman and Qualified Midwives (Calcutta: Superintendent Government Printing, 1918), 120.

\(^{33}\) Improvement of the Conditions of Childbirth, 120–121.
gave something, a feeling of self respect is thereby engendered, and even well to do caste people thought to have their ladies come to the hospital for delivery.\textsuperscript{34}

Another hospital of repute was the Kalyani hospital of the Methodist Missionary Society at Madras. It owes its origin in 1909, to the altruistic and charitable disposition of a Brahmin convert and philanthropist, the late Diwan Bahadur Narayananayar Subramanian.\textsuperscript{35} He founded a hospital in Mylapore in Madras and named it after his mother Kalyani and later bequeathed the buildings to the Methodist Missionary Society of London to run a hospital for Women and Children which was later taken over by the Church of South India. Opened by Lady White, the Methodist Missionary on 1 March 1909, it served as a small hospital with twenty four beds along with a small group of dedicated staffs.\textsuperscript{36}

The non official organisations also initiated the \textit{dhai} training programme. The necessity for some definite and special effort to meet the condition was felt by Lady Curzon, and in 1903 the Victoria Memorial Fund came into being aimed at improving the condition of childbirth in India. Also called as the ‘National Association for Supplying Female Medical Aid’ to the women of India, its funds were to be allocated to the training of the hereditary \textit{dhai} caste as opposed to the midwives taken from other classes, whose training was left to other agencies (hospitals, municipalities, etc.), already carrying it on. The funds collected were distributed among the different provinces as nearly as possible in the proportion in which the money had been

\textsuperscript{34}The labour ward was painted dark green on the upper part of the wall leaving the white tiled lower portion as before. There was dark green oil cloth (easily disinfected) put on light frames which could be hooked on to the windows and thus darken them. Sufficient air and a subdued light were afforded by ventilators near the roof. When the labour ward was empty it was flooded with a usual blaze of light and no germs could survive. As soon as a patient came in, the room was darkened, a feeling of privacy was thus promoted and she slept peacefully till the event was over. To give light or the necessary manipulations a shaded electric light or lantern was used. Improvement of the Conditions of Childbirth, 122.

\textsuperscript{35} He served as the Barrister-at-law, and advocate of the High Court of Madras, and later as Administrative General and Official Trustee of Madras. Improvement of the Conditions of Childbirth, 122.

\textsuperscript{36} The Madras Tercentenary Commemoration Volume, 350.
subscribed, after retaining sufficiently being retained to carry on the central expenses and to assist enterprises in the interests of the object of the fund.\textsuperscript{37}

Unfortunately the new movement, started so suddenly, caused considerable alarm among the \textit{dhai} communities nearly every case they believed the purpose to be inimical and somehow intended to deprive them of their livelihood. This was no doubt partly owing to train a superior class of midwives and to the fact that medical women naturally introduced these trained midwives as much as possible into the houses of their patients explaining to the people their superiority over the untrained \textit{dhai}. In some places the efforts were unsuccessful as no \textit{dhai} was persuaded to attend and operations never commenced. In other places a certain number of \textit{dhais} attended for instruction on receiving a daily or monthly stipend. Amongst the \textit{dhais} who attended the classes the sullen spirit of resistance had disappeared. They were willing to come, liked to talk over their cases and more frequently called for the assistance of the women in bad cases.\textsuperscript{38}

Dr. Scudder’s arrival in 1900 further awakened conscience to the plight of women in childbirth. By then, the obstetric practice in the towns was passed into a handful of women doctors, Indian and foreign, and a small band of trained midwives. On arrival, Ida joined a band of elite female obstetricians who had been serving India for many years. It included C. Swain, of the American Methodist Mission to North India, who came in 1869, Susan Brown, an Irish Presbyterian in Surat, who came in 1874, Dr. Lettice Bernard, in Poona, who came in 1887, Dr. Bradley, in Mazgaon, who came in 1890, Rebecca Walker who practiced for many years in Bombay after training herself as a midwife at the J.J. Hospital, who came in 1876, Dr. Phipson succeeded by Dr. Benson from 1883 onwards, Fanny Cama, one of the first women to

\textsuperscript{37} Improvement of the Conditions of Childbirth in India, 1.

\textsuperscript{38} Improvement of the Conditions of Childbirth, 1–2.
graduate in India in medicine in 1892, Dr. Anandhibai Joshi, the first to study medicine overseas, and came down in 1887, Maltida McPhail who opened the hospital in Royapuram and worked there for many years with Margaret McNeil and Gertrude Campbell and others.\textsuperscript{39}

Ida, as a young girl came from USA to meet her missionary parents in South India. One night she was called three times by the local people, to help in the delivery of the young women who were struggling through difficult childbirth. Without any training Ida could do nothing. Neither did the people allow Ida’s father to help the women as they were not allowed to be seen by male doctors. The next morning, Ida was shocked to see that all the three women died. She believed that it was a challenge set before her by God to begin a ministry for health needs, particularly of women in India. And thus Christian medical college and hospital was started at Vellore by Ida in 1902, initially to train women doctors alone so that a cadre of qualified service providers would be prepared for providing health care to women.\textsuperscript{40} In 1907, Scudder opened Vellore’s nurse training school with Miss Houghton as its principal. It was the first to offer urban and rural domiciliary training in midwifery to general nurses.\textsuperscript{41}

Along with the state interest, the role of voluntary organisations in maternal care is worth mentioning. The Madras presidency maternal and child welfare association was started in January 1921. The objectives of this organisation were to run child-welfare centres, give monthly grants to up-country centres to help them to start training health visitors and maternity supervisors, and undertake propaganda work on maternal and child welfare. By 1929, it managed seven centres in the City of

\textsuperscript{39} Tom Barns, “Motherhood or death, \textit{India International Centre Quarterly}”, 1986, 27.
\textsuperscript{40} Basavanthappa, \textit{Community Health Nursing}, 355.
\textsuperscript{41} Barns, 28.
Madras with the help of the corporation grant. It makes a grant sum varying from Rupees to twenty five per mensum to forty six child welfare centres in moffussil. The Indian Red Cross Society also made significant contribution in this work. Later it was affiliated to the Lady Chelmsford All India League. It collected funds for child welfare and established demonstration services on all India basis. In 1931, Indian Red Cross Society started maternity centres in different parts of the country through its “Maternal and Child Welfare Bureau”. Significant efforts were put by the Indian Council of Saint John’s Ambulance Association took much effort in this endeavour of introducing modern methods of maternal care and child welfare.

Training programme

Belonging to the barber community, the profession of the dhais was hereditary. Various herbs, roots, and leaves were used as medicine to promote parturition. Religious charms, mantras, and amulets had an important part in the practice of indigenous midwifery. The dhais skills lay in the fact that she could handle deliveries without the practice of episiotomy which the trained obstetrician performed. This was one which was vehemently opposed in the Western medical circles. Further, the view about the dhai was guided by the fact that she was illiterate, unhygienic, and superstitious and was responsible for high maternal mortality. In the

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44 Shodhini book (1997), which records research on selected herbal treatments for women’s ailments, briefly discusses dhais and their place in communities. However, both these sources avoid the possible ritual accompaniments of the “practices”. For more details, see Deepti Priya Mehrotra, “Dai Vidya: The Traditional Science of Childbirth” in Shodhini, Touch Me, Touch-me-not: Women, Plants and Healing (New Delhi, Kali, 1997), 369-379.
45 Chawla elucidates in detail the dhais role as ritual practitioner and spiritual guide for women in childbirth. Janet Chawla, Childbearing and Culture: Dai as Ritual Practitioner (New Delhi: Indian Social Institute, 1994).
46 Episiotomy is a surgical incision through the perineum made to enlarge the vagina and assist childbirth. For more details. The Hindu, Online edition, 09 July, 2000.
midst of these views, the problems of training were reduced to that of hygiene. The aim of the training programme according to Van Hollen was nothing but to instill the basics of hygiene for the barber women. The language, content, and institutional arrangements were not only alienating but also disrespected their knowledge and skills. The role of the *dhai* was so deeply rooted in the culture of the people that it was hard to get rid of them. Different writers held various perceptions about the *dhai*. Geraldine Forbes while defending the *dhai* role in traditional childbirth declaims against the views of the nineteenth-century European critics who depicted her as “dangerous” and undermining the legitimacy of the only caregivers of the majority of women in India. Margaret Jolly, Santi Rozario, and Kalpana Ram have argued that sympathy for the *dhai* should not lead us into minimising the sufferings Indian women underwent in labour. In other literature on midwifery in India, their duties were depicted as the cord cutters, disposal of placenta etc. or in other words the removal of childbirth pollution.

The attachment of them to the society was so strong that establishment of any institutions could hardly wean them away. Therefore, there were two important questions before the government. One, whether to seek to incorporate her into a Western style maternity strategy by offering her training in European midwifery or whether to completely exclude her from the birthing process altogether? The opinion

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among European doctors was divided: some thought harnessing the *dhai* the only realistic way to extend at least a medium of European influence into the birthing chamber; others thought the *dhai* so uneducated and entrenched in her ways that attempts to introduce her to Western medicine was a waste of time.51

According to Balfour and Young, the *dhai* training efforts began with the missionary efforts particularly from the women who taught at the *zenana* and witnessed women dying in childbirth.52 The earliest attempt to impart training to indigenous birth attendants or barber midwives in the art of modern midwifery began with the establishment of the church of England *zenana* Missionary society. Started in 1866 by Dr. Aitchison, it was the first effort to train Indian midwives in the Western methods of midwifery.

The impetus for maternal and child health began in 1914 with the origin of the maternity and child welfare movement. During the war, when Western nations mobilised their man-power, almost to the last adult they can lay their hands on, they found to their great surprise that ninety percent of the would-be soldiers were quite unfit for military service, as they were suffering from many congenital diseases which seemed quite unfit for military service, although they were suffering from many congenital diseases which were in most cases preventable. Acting on the adage, that children of a nation are its greatest assets, the entire world began to turn its attention, after the war, to the welfare of the children. As the health and care of the mother during pregnancy, and pre and post delivery are important factors to be counted in any

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51 Sean Lang, “Drop the Demon Dai”, 368.
52 Margaret Ida Balfour and Ruth Young, *The Work of Medical women in India* (London: Oxford University Press, 1929, 13–14; Geraldine Forbes, Women in Colonial India: Essays on Politics, Medicine, and Historiography (Delhi: Chronicle Books, New Delhi, 2005), 85. The earliest attempt to impart training to indigenous birth attendants or barber midwives in the art of modern midwifery began with the establishment of the church of England *zenana* Missionary society. Started in 1866 by Dr. Aitchison, it was the first effort to train Indian midwives in the Western methods of midwifery.52
child welfare scheme, hence maternity and child welfare came to be clubbed together.\textsuperscript{53}

In South India, from the last quarter of the nineteenth century, efforts to employ midwives in the local fund dispensaries were initiated. The government laid down a set of rules for training the individual but the response was not very forthcoming. Therefore the training was imparted largely to the non indigenous women. There were three classes of midwives who were trained in different institutions, which act as training centres in midwifery:-

1. Fully trained nurses who come for a period of six months and get themselves trained with English as their medium of instruction in certain well organised maternity institutions.
2. Midwives who are trained for one year with a preliminary qualification generally up to sixth form, in English, and who have had no previous training in nursing.
3. Midwives who are trained for a period of one year in the vernacular, with a preliminary qualification of reading and writing in the vernacular fluently.\textsuperscript{54}

In 1916, the government as an urgent requirement suggested the local bodies to give some kind of training on cleanliness and hygiene to barber midwives. Accordingly, in 1917, a scheme was formulated to train the country midwives for three months in all headquarter towns where there were no maternity hospitals.\textsuperscript{55} Formulated by Mathias, the Medical and sanitary officer of Salem, it was communicated to all the local bodies for consideration. Though it was thought to make the midwives at least safe, except

\textsuperscript{53} Rama Rau and Krishna Rau, “Maternity and Child Welfare work in Madras”, \textit{Health} 10, no. 3, March 1932, N.P.
\textsuperscript{55} G.O. No. 627, dated 20.3.1925.
for a few places like Salem and the neighboring areas, the scheme proved to be futile. Despite the apparent willingness of the support from the local, the majority of the local boards remained indifferent to the proposal.\textsuperscript{56}

Muthulakshmi Reddy, the first women medical graduate and a popular medical practitioner in the City of Madras criticised the attitude of the government for not having undertaken the work by itself but left it to the initiation of the local bodies that were not able to realise the gravity of this situation.\textsuperscript{57} Comparing the Indian conditions of maternal mortality to England, she projected the neglect on the part of the government. She said: “in England and Wales, maternal mortality is 4.5 per thousand. Even then, a committee was appointed to go into its causes and to consider the means for further research. How much acute is our condition, where, the figure for maternal mortality for our presidency is 20 per thousand.”\textsuperscript{58}

In Salem, the district Medical and Sanitary Officer Dr. Mathias evinced a keen interest in the maternity work. However, he was able to train only twenty eight in modern midwifery over a period of three years from 1916 and 1919.\textsuperscript{59} These trained carried on their profession in Salem town and the outskirts. It is to be noted that these trained were said to be more popular with the people than the regularly trained midwife. Therefore, the Salem municipal council decided to move a step further by persuading the midwives in the town to get trained. Further licensing of the midwives in order to allow them to legally pursue their work was also thought open. But, the government of Madras, while appreciating “the signal success” of training

\textsuperscript{56} G.O. No. 627, dated 20.3.1925.
\textsuperscript{57} Muthulakshmi Reddi Private Papers 1, Part 1, S.Nos. 1-41.
\textsuperscript{58} Muthulakshmi Reddi Private Papers 2, Part 2, S.Nos. 116-154.
\textsuperscript{59} G.O.No. 1027, P.H., dated 26.7.1922.
indigenous, had directed the Salem municipality to employ Western trained midwives under its control.\textsuperscript{60} Contrary to this, at Erode, it was found that they were in no way improved from the training given to them and the scheme hardly succeeded. By early 1920s, the government was convinced that modern methods of midwifery could not be taught to illiterate barber midwives and hence the scheme dropped.\textsuperscript{61}

In 1919, the Government of India had transferred responsibility for health to the provincial governments. Nursing received relatively more attention in Bombay and Madras Presidencies than it did in other states or in any of the princely states. The reorganisation of the public Health department during the 1920s enlightened the elite and government to evince interest in mitigating the sufferings of mothers. It was understood that maternal and infant health was an important aspect of preventive medicine. The Director of Public Health observed: “As the science and art of preventive medicine is concerned with much more ‘drains’, so does infant welfare work comprise more than the examination of sick body and the giving of bottle of medicine, nor can the term be restricted to the provision of skilled midwifery assistance at the time of delivery…the health and welfare of the mother from the moment of conception and of the before and after birth are both fundamental.”\textsuperscript{62}

Though the maternal and child welfare were the responsibility of both the medical and public health departments, lack of infrastructural facilities for providing institutional care and the prevalence of social customs prevented the people from seeking these institutions which in turn forced authorities to leave the aspect of training \textit{dhais} to the public health department. By the passage of time, the barber midwives had realised the importance of their profession and hence tried to maintain

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\textsuperscript{60} G.O.No. 1027, P.H., dated 26.7.1922.
\textsuperscript{61} G.O. 1017 A, P.H., dated 21.7.1924.
\textsuperscript{62} ARDPH, 1927, 36.
\end{flushleft}
separate identity. According to the census of 1921, these women enrolled themselves as midwives and there was an increase of about thirty five percent under of category of medical assistants. The following Table 6.2 suggests the ratio between the available number of midwives, the total number of birth registered in the year 1921 and also the percentage of skilled assistance provided by the authorities to the needy.

Table 6.2: Number and percentage of labour cases attended by midwives, 1921.

<table>
<thead>
<tr>
<th></th>
<th>Number of Midwives employed in 1921</th>
<th>Number of Labour cases attended</th>
<th>Number of Births registered</th>
<th>Percentage attended by midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>District boards</td>
<td>394</td>
<td>29,707</td>
<td>1,03,244</td>
<td>2.8</td>
</tr>
<tr>
<td>Municipalities</td>
<td>183</td>
<td>22,609</td>
<td>94,209</td>
<td>23.9</td>
</tr>
</tbody>
</table>

Source: Census of India, 1911, Vol.XII, Part I, Madras, 1912, 22.

From the above table, it is apparent that by 1921, only 2.8 percent of childbirth was attended by trained midwives in the rural areas of South India and 23.9 percent in the municipalities. In the Madras City alone, there were about 1500 untrained midwives belonging to the “maruthuva” caste. Their services were largely resorted to by the poorer classes of people who could not pay higher charges of trained midwives. These women claimed to possess hereditary skill in maternal and child health activities and carried on their work with usual enthusiasm.

With the introduction of the District Health Scheme in 1923, the public health department got an increased control over the local bodies which were in charge of executing the welfare and relief measures. In 1924, the Director of Public Health sent a memorandum to all local bodies to take steps for maternity and child welfare. They were also asked to form ward panchayat health committees, conduct training programmes for midwives, providing for efficient supervision over their work,

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63 Census of India, 1911, Vol.XII, Part I, Madras, 1912, 22.
64 G.O. 627, P.H., dated 20.3.1925.
65 G.O. 116, P.H., dated 25.4.1924.
offering training to lady health visitors, opening of ante-natal clinics and child welfare centers, provision of hospitals for children with maternity and labour wards, and intensification of propaganda on the benefits of modern motherhood of maternal and child health.66

The response from the local bodies was meagre and was not forthcoming. Only 51 out of 80 municipal councils, 80 out of 126 taluk boards and 10 out of 24 district Boards had sent replies and most of them had expressed their inability to indicate any action due to the lack of funds. Therefore a simple scheme suggested by the Director of Public Health was adopted according to which child welfare centres would be established in all places where the services of qualified midwives could be availed of.67 He also proposed to enlist the cooperation of the “leading members of the locality” with whose help funds could be collected from “philanthropically disposed persons” for establishing child welfare centres.68 The local bodies were also asked to contribute from the local funds towards the expenditure incurred. But due to financial problems and the insufficient qualified staff there, the scheme did not work well. By 1930, there were only 110 for the whole Colonial South, 57 in rural areas and 53 in municipalities.

However, the rising maternal mortality coupled with the infant mortality in the early twentieth century did not stop the government from continuing the policy to train women. Yet another scheme was formulated by T.H. Symons, the Surgeon General in 1924 to meet the precarious situation. Under this scheme, they were to be given systematic training at the district headquarters and municipal headquarters for a

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66 G.O. 116, P.H., dated 25.4.1924.
68 G.O. No. 1017 A, dated P.H., 21.7.1924.
period of six months with a monthly stipend by the concerned local bodies. After undergoing the training, they were to be examined by the respective district Medical officer. Those who cleared this test were certified to practice in the rural areas. For every two years, their fitness to practice were reexamined and continued to practice if fit, otherwise, another months training were to be undergone. However, they were not to handle complicated maternity cases, and if found were to report to a qualified midwife or nurse or to refer to the nearby hospitals.69

The scheme was accepted by the local bodies and came in vogue in 1926. The government also relaxed the restriction laid in the scheme with regard to the field of practice of these trained and certified. Unlike the earlier restriction to practice in the rural areas alone, they were allowed to extend to urban areas as well. Though the training programme was organised to handle maternity cases, ironically, it had stopped them to intervene in difficult labour and forced to refer to hospitals. Hence the training neither acknowledged the indigenous knowledge of midwifery nor provide obstetric care during emergency. Yet, these trained were not considered eligible for government employment, either in local or municipal service. This was the same case as that of Bombay where such training was provided to women but these women could not hold any positions in the government institutions.70 Although the local bodies accepted to offer training and employment to barber midwives, in practice the interest shown was very meagre.

Though a number of schemes were drawn for training to meet the requirements, their numbers were grossly inadequate. On the other hand, the people were reluctant to give up their customs and seek modern midwifery. Hence, in order

69 For each case referred a reward of one rupee was given. See G.O. No. 67, P.H. 9.1.1926.
to discourage the practice of barber midwives in maternal health care, the government thought it fit to propose legislation for permanently seeking the services of trained nurses and midwives. Such a proposal was mooted even in the early 1920s and was recommended by the Third All India conference of the sanitary commissioner held in 1921. It suggested legislation on the subject on the model of an act already passed in the princely state of Baroda. However, the Madras government did not consider it fit to introduce such a scheme unless there was adequate number of trained midwives available. As a temporary measure, in 1923, the Director of Public Health in his memorandum strongly insisted on the employment of trained and qualified midwives, and advocated the gradual extinction of barber midwives and the replacement by midwives trained in modern methods of midwifery. 71 Though the memorandum stressed on trained and qualified midwives, the local bodies expressed satisfaction in the services of barber midwives and continued to employ those who had undergone the necessary training, particularly with the consent from the higher authorities. 72

The proposal to put away the barber midwives through legislation was again put forth in 1923 to the Minister for Public Health. Subsequently, the Madras Nurses and midwives bill was framed on the model of the Nurses Registration Act of 1919 in England. 73 The objectives of the bill stated that it was introduced in the interests of the public who were often exposed to the risk of attendance by nurses and midwives who had neither the skill nor the qualification. 74 In August 1924, the bill was introduced in the legislative council by C.P. Ramaswamy Iyer. It provided for the establishment of the nurses and midwives council and prescribed qualifications to nurses and

71 G.O. No. 67, P.H., dated 9.1.1926.
72 ARDPH, 1923, 23.
73 The bill was finally passed in December 1919 and separate Nurses Registration Acts were passed for England/Wales, Scotland and Ireland (still one country at that time). These acts established the General Nursing Council for England and Wales.
74 G.O. No. 696, P.H., dated 6.5.1924.
midwives. It aimed at safeguarding interests and obligations of those who were already practicing. It also suggested some penalty to erring individuals and insisted that the institutions were maintained and financed out of the provincial funds should employ only qualified and registered nurses and midwives. Madras was the first province to go for such legislation and remained an example to other provinces.75 Though the Minister in charge of public health, Rajah of Panagal was in favour of passing it, the consideration of the bill was postponed for two years due to the apprehension of severe opposition in the legislative council. With some amendments, it was once again introduced after two years particularly with the view that the nurses and midwives council should maintain a register for trained.76

In 1926, the bill was passed as the Madras Nurses and Midwives act, 1926 (Madras Act III of 1926) and came into force on 14 February, 1928.77 This was considered to raise the standards of practice of midwives.78 The syllabus for the training of nurses was revised in 1927 by adopting the syllabus prescribed by the General Nursing Council for England and Wales, London in a modified form. By 1929, nearly two sixty five years after the first hospital was set up in the City, Madras Presidency recognised nine hospitals as training institutions for nurses, four for midwives.

The scheme for training of midwives continued to exist till 1943. The training was initiated on the pretext that the dhais were the sole responsible for the high percentage of maternal death in South India. Though she was skilled in the

75 G.O.602, P.H., 6.4.1926.
77 G.O. 800, P.H., dated 2.4.1928.
78 ARDPH, 1931, 23.
practice of conducting childbirth without mutilating the birth canal, she was opposed from the point of view of her unhygienic practices. Initially when the British could not meet the growing demands of the entire population, the dhais were tolerated though as a necessary evil. With the establishment of supremacy of Western medicine, the Colonial government insisted on promoting modern methods of maternal care whereby the institutional delivery was encouraged. Subsequently, training was initiated primarily for two reasons. First, the dhai practices were deeply rooted in the cultural life of the people that it was impossible to wean her away. The only option was to train her in the Western methods of midwifery. Second, to cope up with the dearth of qualified staff in midwifery, attempts were made to train women in Western skill of maternity.

A critical debate about the training of the dhais was whether it was successful or not and if it created any impact on the indigenous practice of midwifery. From the reports of the Civil hospitals and dispensaries, it is amply clear that the practice of training midwives, and sending them to work in towns under the municipal or local fund boards was increasing and was sensibly adding to the yearly number of women who avail themselves of skilled aid in labour.\(^7^9\) Along with the training, the government also put a check by way of preventing them from attending complicated cases. The prospects of trained were not bright as they were not eligible for public service. Further, due to the inadequate practice and income in the rural areas, not sufficient number of came forward for training.

Even after training, when the mortality still persisted, blame fell on the dhai and her practices were termed ineffective. The government therefore decided to put an

\(^7^9\) Civil Hospitals and Dispensaries Report, 1880, 7.
end to the hereditary institution of *dhai*. Though opposition to this was rather strong, the government did not provide an immediate solution. Nevertheless, the dearth of sufficient trained midwives, these women carried on their activities with usual zeal in many of the rural areas of Colonial South India. The training was urban based and had little impact in rural areas.