Few people would dispute that midwifery is the keystone to a nation's progress.

- Sir A.L. Mudaliyar at the Tenth All India Medical Conference, 1934.

If midwifery is the measure of a nation's civilisation, there is no doubt that the zenith was reached in ancient India centuries ago.

- article in Bangalakshmi, 1928.

In his evidence before the Fever Hospital Committee in 1837, Pandit Madhusudan Gupta had suggested the training of a class of Hindu midwives who could attend on Hindu women in their own homes. If a lying-in ward was established at the proposed hospital in Calcutta, he said, 'women of the inferior castes' would be happy to avail of it. This, together with an associated class under a European professor, would help train a category of superior midwives. He was convinced, in fact, that their services would be readily availed of by women of 'all castes and ranks'. Just as the Brahmin inoculators against smallpox were hardly ever seen since the introduction of native vaccinators, he said, the class of ignorant
midwives who currently practised the profession would be eliminated altogether.¹ Since the distinguished doctor had practised as a Kaviraj in Calcutta for twelve years, and said his practice had been among 'the respectable, the middle and the poorer classes of natives', he was believed to have an intimate knowledge of Bengali customs. The Committee resolved to adopt these suggestions and establish a Lying-in Hospital.²

A century later, a medical woman who worked in Bengal was less sanguine:

The bulk of the midwifery is done and will be done by her [the dhai] for many years to come.³

In a later article, the same author explained that though 'the replacement of the indigenous dhai by a more educated and better class of worker' was 'the avowed objective of the health authorities in most of the provinces in India', this task was rendered difficult for a variety of reasons. She referred to the long-standing debate about the respective merits of attempting to...

¹Report of the Committee Appointed by the Right Hon'ble the Governor of Bengal for the establishment of a Fever Hospital, and for Inquiring into Local Management and Taxation in Calcutta, Calcutta, 1839 (Fever Hospital Committee Report), Evidence of Madhusudan Gupta, p.63.

²The Lying-in Hospital, containing a hundred beds, was constructed in the Medical College compound in 1840. The funds were raised by public subscription. See Calcutta Medical College, Centenary Volume, 1835-1934, Calcutta, 1934, p.23.

³Jean M. Orkney, Director of the Maternity and Child Welfare Section of the All India Institute of Hygiene and Public Health, Calcutta, 'The Bengal Nurses' Act, 1934' in The Journal of the Association of Medical Women in India (JAMWI henceforth), XXIII:3, August 1935, pp.39-46.
long-standing debate about the respective merits of attempting to oust the dhai altogether or to train her to be a auxiliary para-medical worker. The doctor was not optimistic about the facility with which the latter end could be achieved. 'Many of the dais,' she pointed out:

realize that training is a first, and to many of them an unwelcome step towards control of their practice; others realize that after training their status in the eyes of the law and of the public is not enhanced, nor are their prospects of employment any better,...'.

These, for several years, were the two main questions regarding the dhai. Was she to be 'improved' through training and supervision, or was this an impossible task? The status of the dhai was central to the issue.

The status of the dhai

While it is not hard to understand why dhais would resist attempts to replace and control them, the status of the dhai lay at the crux of the problem of midwifery in India. The cosmology of beliefs relating to ritual purity, of which the caste system was a part, were inextricably linked with beliefs about birth and death. Madhusudan Gupta, who described indigenous birthing customs before the Fever Hospital Committee, had said they were universal, but added that they were not founded on any religious principles and would therefore be easy to eliminate.' The vexed question of what

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'Ibid., p.109.'
constituted 'religious' practice, which was believed to be immutable, dogged many of the reformers who sought to alter the culture of childbirth. 'After 1858 in particular, there was official hesitation to interfere in what were feared to be doctrinal matters.' Both Hindu and Muslim medical reformers disclaimed the scriptural sanction of actual practices.' This made it all the more difficult to determine why particular customs were clung to with tenacity, and the part played by professional midwives, who were drawn from a few 'unclean' castes was much remarked upon. The figure of the dhai came to represent the dangers that Indian women faced in parturition and the elimination of the dhai became the initial goal of those who worked for a medical system of childbirth. The role of caste within Hinduism was itself a baffling phenomenon, and colonial bureaucracy was not unaffected by some of the ideas that characterised the system.'

'Lady Dufferin, for instance, emphasised that she hoped to initiate a movement in which all classes of individual, irrespective of creed or nationality, might usefully join...'. Dufferin Fund, Annual Report, 1890, p.8.

'See, for example, the unsigned article 'Dhatrividyar itihas' in Bangalakshmi, Magh 1334 (January 1928), p.180, which emphasises the advanced state of obstetrics and gynaecology in ancient India. Also see Hassan Suhrawardy, Prasuti o sisumangal, Liluah, 1925, pp.3-4 on the 'un-Islamic' nature of the birth customs among contemporary Bengali Muslims.

The dhai castes

It was commonly observed that women were assisted in childbirth by a class of indigenous midwives called dhais in Bengal. However, a medical man observed in 1840 that there were very few villages in Dacca district which had midwives - the offices being performed for women by neighbours. There were no Hindu midwives in Dacca town, only Muslim women worked professionally as midwives, he said.9

The Chief Medical Officer of Bankura, Dr Conolly, said in 1874 that every village and town in the district had its Hari or Bauri dhai, who afforded assistance to women in her 'beat or locality'.10 According to Risley's ethnographic glossary, dhais were drawn from the castes of Chamar, Bhuinmali, Chandal and Ghulamkayasth (which was synonymous with Sudra).11 The other castes he names as 'permitting their women to work as midwives' are Hari, 'Dai-Dom (an inferior sub-caste among the Doms) and Daikurar (a group of Muchis).12 Crawford reported that in Hooghly dhais were mainly Haris or Muchis.13 Risley's account of the work of dhais is based almost entirely on Wise's detailed description, after a reference


12Ibid.,p.316 and p.212.

13D.G.Crawford, Hooghly Medical Gazetteer, Calcutta, 1902, p.393. I am grateful to Geraldine Forbes for sharing her notes from this book with me.
to Wise's 'special opportunities for learning the truth on the subject' while working as Civil Surgeon in Dacca. In 1910, Kedarnath Majumdar described the 'dais' as a Muslim caste of Bengal.14

The dhais who attended on the women of wealthy families in Dacca, according to Wise, were generally Muslims, though some were Chamains.15 The Chamars were a migrant community from Hindispeaking districts and were mainly an urban caste in Bengal. In the villages of the interior, reported Wise, where Chamains did not live, the women of the Bhuinmali, Chandal, and Ghulamkayasth acted as midwives.16 Wise listed the 'outcast tribes' of Bengal on the basis of the roll of pilgrims excluded from the Jagannath temple at Puri: these included Chamar, Namasudra, Dom, Dhoba, Bhuinmali, Hari - all of whose women were sometimes practising dhais, indicating the lowly status of the profession.17 The male relatives of these women are usually tailors or musicians; while in the villages they often work as weavers. There is generally great jealousy between them and the barbers and professional musicians, as, though equally degraded, each claims a superiority over the other. The degraded status of the dhais had led to the pejorative term, narkata, or

14Kedarnath Majumdar, Dhakar Vivaran, Calcutta, 1910, p.208. While the Bengali word is dhai, the Hindustani word is dai.
16 Ibid., p.256.
17 Ibid., p.194.
'cord-cutter' being applied to women of this profession.¹⁸ There was said to be a proverbial saying among Hindus that a household became unclean if a Chamar woman had not attended the birth of any child belonging to it.¹⁹ The dhai thus had an important ritual role to play, as she carried the pollution away on her person, just as the napit (barber) and the dhopa (washerman) helped to restore the mother to a state of purity by paring her nails and washing the puerperal garments respectively.²⁰ Among the lower occupational groups of East Bengal who converted to Islam relatively late and experienced very little change in their manners and customs up to the early twentieth century was the group who used the family name 'dai'. The work they did was regarded as so unclean that they, along with hajjams (Muslim barbers) and some others were treated with much contempt by the Muslim agriculturists.²¹

James Wise reported that the dhais who practiced in Dacca were generally Chamains, though the most skilful midwife in the town was 'a Kurmi from Hindustan'. Mohammedan dhais were numerous but they invariably declined to cut the cord.²² The dhai janai who attended

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¹⁹Wise, p.256; Risley, p.181.
²⁰Wise, Races, Castes and Trades, p.349 and p.261.
²²This is borne out by the account given by Professor T.W.Wilson in Norman Chevers, A Manual of Medical Jurisprudence for Bengal and the North-Western Provinces, Calcutta, 1856, p.526n.
women in confinement rarely divided the navel cord. For this operation a special class of women called narkattas were retained. They belonged to the lower castes, such as the mehtaranee and hari. The dhai generally left after wiping the child and giving it to the mother, but was expected to make daily visits during the lying-in period.23

The term dhai or dhatri was also used for a wet-nurse or nursemaid. Wise distinguished between the word, dai, by which he meant a midwife and dhai, which he said was the Sanskrit word for a wet nurse but was used in East Bengal for a midwife, a 'dudh-pilai' being, according to him, a wet nurse.24 In her memoirs, Shobha Ghosh describes the common practice of a child-bride in the early years of this century being accompanied by her 'dhai-ma' to her in-laws' home.25 Bamandas Mukherjee, in a diatribe against the hiring


24Wise,p.50. In her study of Traditional Birth Attendants in rural Bangladesh in the 1970s, Shamima Islam distinguishes between dai, which she describes as a word with 'an urban flavour', dhatri, which is used to describe a more prosperous midwife with some education, usually found in sub-divisional or thana headquarters, and dhoruni, which is used to describe a woman who functions mainly at the level of the para and for a specific class in the village. Dhorunis and the function which they call khalash kara or delivery are, according to Islam, 'women's words, often expressed along with a gesture in a group discussion'. Shamima Islam, 'The Socio-Cultural Context of Childbirth in Rural Bangladesh' in Maithreyi Krishna Raj and Karuna Chanana eds., Gender and the Household Domain: Social and Cultural Dimensions, New Delhi, 1989,pp.235-236.

of 'low-caste' women as midwives claimed that in 'ancient India', midwives were of high castes and enjoyed an exalted status. As evidence, he quoted a Sanskrit sloka about the 'seven mothers' of man: these included the 'original mother, the guru's wife, [any] brahmani, the king's wife, the 'dhatri' and Mother Earth. He added that as the famous midwives from Indian history, Panna of Mewar and Shanta of Jaipur, lived in royal palaces, they could not have been of the lowly castes, such as, 'Hari, muchi, dom'. Dhai may have also been used in the more general sense of 'maid servant', though such a serving-woman may have been called upon to help in the labours of a woman of the household. The last meaning is suggested by two proverbs: 'Age hatni, pan batni, pradip berani, baur dhai, Ei sakal karmmer jash nai' ('walking in front, preparing paan, preparing the lamps, serving as the wife's dhai - these jobs won't earn you fame' - said to be prevalent in the Vikrampur area of Dacca District) and 'Apni thakte nai thai, baur lage sattar dhai' ('Can't make both ends meet, but the wife needs seventy dhais')."

It is not difficult to understand the low status of midwifery as a profession, given the nature of the taboos that surround parturition. What is more interesting to consider is the nature of the inversion of social relations that was temporarily made

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possible by the same beliefs that relegated these 'polluting' functions to normally untouchable women. Not only was the dhai permitted intimate access to the female body, there seems to have been a belief that making a woman who was suffering a prolonged or difficult labour touch or wash the feet of the dhai would speed the delivery. A prosperous household would engage a dhai to come and reside with the mother and infant for a period of time, while some families appear to have had the services of a 'family dhai' or a dhai in permanent residence, though there seems to be no indication that they belonged to any but the lowest castes. Wise reported that:

A midwife forms and important part of a household, and no family of note is without one. Like the Purohit and barber, the Dai is a privileged person and has freedom of access to the female apartments at any hour. ... a woman being satisfied if she is attended by the family Dai, or by the pupil of the Dai, who aided her mother, or sister, under similar circumstances."

This implies a relationship between patron family and dhai that was not terminated with the 'coming out' of the mother and child from

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28 Therese Blanchet cites a study of rural Bangladesh where it was reported that the woman in labour washed the feet of the dhai on entering the anturghar. Therese Blanchet, Women, Pollution and Marginality: Meanings and Rituals of Birth in Rural Bangladesh, Dhaka, 1984, p.87. Gourkishore Ghosh refers to a similar belief in Jal pare pata nare, when Giribala is told to drink water with which the feet of the tanti-bou, who has had several easy deliveries, have been washed. Ghosh, Gaur Kishore, Jal Pare Pata Nare, Calcutta, 1978, p.12.

29 Wise, p.50.
The case of Bengal: greater resistance?

While it is not difficult to guess why established dhais would have been suspicious and hostile to attempts to replace or control them, it is evident that they resisted such attempts with greater success in Bengal than they did in provinces such as Sind and Punjab, where the training of indigenous dais (as they are called in North India) enjoyed noteworthy success. In Madras Presidency, the early development of a body of educated nurse/midwives made it possible to consider the complete elimination of the indigenous midwives (generally of the barber caste) as a feasible goal.31

Balfour and Young suggest that the difference in achievements between Eastern and North India lay in the greater part played by medical women, especially missionaries, in the training and supervision of indigenous dhais. The pioneer was Miss Hewlett of

30Blanchet reported that the Hindu dhais of Jamalpur district in Bangladesh in 1979-81 told her they were the 'dhorom-ma' or 'mothers in religion' of the children they delivered. See Therese Blanchet, op.cit., p.94.

31Thus, it was the avowed goal of medical missionaries like Dr Ida Scudder of Vellore. Mary Pauline Jeffery, Ida S.Scudder of Vellore: An Appreciation of Forty Years of Service in India, Mysore, 1939, pp.24-25. See also, Dr.S.Muthulakshmi Reddy, Autobiography, Madras, 1964, p.132. By 1927, A.L. Mudaliyar could declare that dhais 'should be ended, not mended. Dr A.L.Mudaliyar's scepticism regarding the training of dhais is reported in the Report on the Seventh Congress of the Far Eastern Association of Tropical Medicine held in Calcutta in December 1927, p.88. This was reflected in the post-Independence health policy document produced by the Mudaliyar Committee.
Amritsar who was active in this field since about 1886, while in Sind, Miss Piggott was said to have established a rapport with all the women who flocked to join her Sind Dais Improvement Scheme. From time to time, efforts to train the dhai were made but most of them were not very successful because medical men could only impart theoretical instruction and often had very little obstetric experience themselves. Not surprisingly, the usual conclusion was that it was an impossible task. Bengal was a province where the medical establishment was well entrenched and there was, comparatively, not much medical missionary activity here, particularly by women. Another possible reason for the failure of dhai training schemes could relate to the relative position of dhais in Bengal and in Punjab/Sind. The very low caste status and the highly segmented nature of social life in the Presidency could

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32See Margaret I. Balfour and Ruth Young, The Work of Medical Women in India, Bombay, 1929, p.128-136. Also see Miss Hewlett's account of her work in the Punjab: Daughters of the King, London, 1886. Miss Piggott's own reports from Hyderabad, Sind, described her efforts in the Annual Reports of the Victoria Memorial Scholarships Fund. See for instance, Victoria Memorial Scholarships Fund (VMSF henceforth)Annual Report, 1925, p.66; and 1926, p.69. In 1931, when the Fund was taken over by the Indian Red Cross Society, a promise to continue the work of Miss Piggott was made. Indian Red Cross Society (IRCS) Annual Report, 1931, p.29.

33Balfour and Young,p.128.

34There was only one fully qualified woman medical missionary in Bengal in 1895. This was Dr Lucy Nichols at Jiaganj. She was employed by the Church Missionary Society. (Richard Lovett, The History of the London Missionary Society 1795-1895, London, 1899, p.256.) SOAS Missionary Archives/Box 8:Christian Medical Association of India, Report to India Committee from the Committee on medical Missions Policy in India, London Missionary Society, dt.10.3.1930, 'A Survey of Medical Missions in India'.
in fact have worked to make the indigenous midwife sufficiently certain of her monopoly to ignore attempts to co-opt her into the new structures of health care as a subordinate para-medical worker. For instance, Dr Dagmar Curjel reported on Miss Piggott’s class in Hyderabad, Sind in 1920:

A recent triumph was the coming to the class of the grandest dai in the town, a good class Mahomedan Sindhi, who attended the rich families. I am told she is the seventeenth generation hereditary dai in her family.\textsuperscript{35}

In this context, it is interesting to consider the implications of a curious practice called the Mohalla System that existed up to at least the end of the nineteenth century in East Bengal. In fact, it may have been a more widespread phenomenon and may have lingered for a longer period. What the system seems to have done was assure a dhai or a family of dhais of a monopoly over a particular locality or quarter, which was respected by all members of the community of indigenous midwives and by their clientele. This would have made it difficult to replace entrenched midwives, while also minimising their interest in upgrading or altering the nature of their skills or qualifications.

The Mohalla System

Dr James Taylor reported in 1840 that the persons who followed the profession of dhai or midwife in the town of Dacca were divided into classes under the orders of the mahaldarnis or mohalladarnis who settled their disputes, and were entitled to a portion of the

\textsuperscript{35}Victoria Memorial Scholarships Fund, Annual Report, 1920, p.2.
fees they earned. This municipal regulation was made in the time of Jahangir and appeared to have originally been a part of police jurisdiction. The mohalladarnis were required to report cases of premature labour and infanticide to the authorities and were employed to enter and search female apartments and to assist in taking the evidence of women who were prohibited by their rank from appearing in an open court, that is, of purdanashin women. Their services were, at the time of the doctor's report, still held in requisition by the Magistrate of the city. Dr Norman Chevers, whose professional experience had been mainly in Bengal, said in 1856 that indigenous midwives were occasionally called upon to testify in criminal cases, regarding the evidence of recent delivery (such as the lochial discharge and lactation) and to give their professional opinions with the utmost confidence. This may have been a legacy of the older system.

In his report to the Government of Bengal as Civil Surgeon of Dacca, Wise said that poorer women of Dacca city engaged the mohalla or ward dhai, who was not allowed 'by etiquette' to practise beyond the limits of their ward. Wise found that the midwives he trained at the Mitford Hospital were unable to obtain practice owing to the influence of the mohalladarnis. Mohalladars

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36Taylor. p.245.
38IOL/Bengal Medical Proceedings July 1871, no.22, p.92.
or amladars and mohalladarnis were appointed under Regulation XXII passed by the Governor-General-in-Council in 1793 for the better protection of certain towns. They were intended to report on the 'thieves and other bad characters' in the perwanna or ward awarded to them. The mohalladarnis did not apparently have any special duties, nor were they by profession dhais. The Magistrate was also empowered to issue sanads to certain respectable residents in each ward to act as mohalladars and mohalladarnis. This was done regularly until the 1840s, when the practice fell into disuse. The Act was repealed in 1868, but the mohalladars continued to levy a tax on all dhais, who paid a small tax to be recommended. The people of Dacca still persisted in observing the old rule and employed only such midwives as were sanctioned by the mohalladars.39

Wise enquired into the veracity of the claim that the custom was old and went back to Mughal times and found no corroboration.40 In October 1871, as a result of Wise's investigations, the mohalladars were summoned and only two or three sanads were forthcoming. Only in one instance had the holder personally received it from Government. Sons and distant relatives made use of these documents and enjoyed all the advantages they conferred.


40IOL/Bengal Medical Proceedings November 1871, No.32.
What was more, any person, male or female, who proclaimed himself a mohalladar was recognised as entitled to all the rights of that official. Many of the fictitious mohalladarnis were found to be dhais in practice. The chief privilege of these 'officials' was the levying of a tax on all dhais practising midwifery. The tax occasionally rose to half the fees earned. Unless it was paid, no dhai was allowed to attend women in confinement. 'This custom,' said Wise, 'although illegal, is hallowed by its antiquity.' It was obeyed by the populace and maintained by the mohalladars, but as it was beyond the reach of the law, said the Civil Surgeon, it had to be tolerated. Wise said that since it had proved impossible to introduce educated midwives into the system, the only solution left was to instruct the practising dhais free of charge.41

In other urban areas, the local dhais themselves resisted the introduction of alien midwives. This they could do through social networks which tied them to particular families. It was perhaps a remnant of the old mohalla system that functioned in different towns of the erstwhile Bengal Presidency that made it so difficult to replace the practising dhais. The Civil Surgeon of Bhagalpur reported in 1872 that there was a midwife attached to each mohalla or district of the town, and the rule that they should not encroach on each other's district was said to be strictly observed.42

41Ibid.

42IOL/Bengal Medical Proceedings, February 1873, no.32, from Dr N. B. Bailie, Civil Surgeon of Bhaugulpore to the Magistrate of Bhaugulpore.
Reeves, a Maternity Supervisor from Patna reported at a Conference on the training of indigenous *dhais* in 1929:

There is in Patna an ancient custom which is far as I know, peculiar to that place. The Indigenous Dai possesses what is known as the "brit-Jajmanka" of her Elaka, i.e., the "Hereditary right of Service" of her Elaka. This no one can take from her, she inherits this right from her Mother, or Mother-in-law, and has stamped documents to prove her right. Any cause of complaint from one Dai about another, is heard at a Panchait, and fines are levied, and orders issued that are her's by right, and often by might, it is a matter of indifference to her that the people of the house may not want her services. I have seen a Dai conducting a case, and when it was almost completed, another Dai walked in and simply said "move" and the Dai got up quietly, and walked away, and not a word was said by the house people, another time I saw a stand up fight between two Dais over a case. If a householder does not want the Elaka Dai, he has to pay her in full to stop away, rich and poor are treated alike. The Dai herself may mortgage or even sell outright this right of service, but no one else can interfere with her, however great the neglect of the Dai or harmful her attendance may prove to be.43

Ranks among indigenous midwives

Can we assume, then, that a homogenous class of professional midwives existed in Bengal before the European attempts at training? There seems to have existed a clear division in terms of skills, expectations and status within the ranks of the women who performed the tasks of midwives for remuneration, if we use payment as the criterion for distinguishing between 'midwives' and 'handy-women/gossips', or between 'dhais' and 'dhorunis'.44 Richard and Dorothy Wertz have described what they call 'social childbirth' in

43Report on the Lucknow Conference organised in December 1929 at Lucknow by the Victoria Memorial Scholarships Fund, p.83.

44"It is probable that the latter category of 'unprofessional' helpers would also receive gifts in kind, such as clothes."
pre-industrial America. The system included the gathering of women who were not members of the family but were not paid attendants either. They continued to throng even after the presence of doctors had become common. This was part of a system of reciprocity that permitted the woman to have more rest after delivery than she would otherwise have had.

The laboring woman must have gained confidence from being surrounded by women who had themselves suffered and survived, often to old age."

It seems likely that only 'narkatta dhais' or the women at the lowest rung in the hierarchy of midwives were engaged by the majority of poor women, and their role was more ritual than obstetric. In fact, Crawford reported that in Hooghly, dhais were seldom required to take part in conducting actual labour because there was a superstition that the presence of a dhai prolonged labour."

As Roger Jeffery suggests, women healers in a stratified society are likely to be diverse, with wealthier women receiving more sophisticated support."

In a hierarchical society, there was an inevitable gulf between the possibilities available to women located at different positions. We have more information about childbirth among the relatively prosperous classes, because of the greater attention they received


"Hooghly Medical Gazetteer, p.394.

"Roger Jeffery, The Politics of Health in India, Berkeley, 1988, p.50."
from the medical establishment and their consequent domination of the records. (See Chapter Three of this dissertation.) It is much more a matter of conjecture how the majority of women, who could not afford to have resident midwives, gave birth in Bengal. It is not unlikely that a system like the one that prevailed among peasant women in early modern Europe operated here.48 Friends, relatives and neighbours helped each other in their labours, and some of these 'handy-women' may have acquired reputations as skilled or 'lucky' and they may have been called in more than others.

There was also the occasional instance of the woman who gave birth alone, unattended. This was not only in the case of illegitimate pregnancies, but also among women who were isolated for some other reason. In the following case reported by a Lady Health Visitor of the Calcutta Corporation the severance of social links may have been related to extreme poverty in an urban context:

... Living, 155, Raja Nobo Kissen Street. - Delivery case, normal social conditions exceedingly bad. Attended only by her son 8 years old. On the fifth night after delivery, husband came and took away son and all else from the hut.

Next morning patient weeping on the roadside with the baby." It was to treat this class of destitute person that the Municipal Pauper Hospital had been established at Sealdah.50 There are references to the ease with which poor Bengali women gave birth, the classic example often given being of the peasant woman returning from a day's labour in the fields with a newborn infant in her arms.51 A doctor described in 1923 how he had been called in to attend on a 35-year-old peasant woman who had had nine children already and claimed that her previous deliveries had been so easy that she had had no need for a dhai.52 Wise reported that the poorer women of East Bengal attended on each other, and only in cases of difficulty was the European doctor or the 'professional accoucheuse' called in. 'Parturition,' he said 'is in most cases easy, and the poor have seldom any need of skilled attendance...'.53

We cannot, however, assume poor women did not need professional help simply because they did not receive it, although if the level of skill of dhais was as low as the reports of doctors suggest,

50WBSA:GOB:Municipal:Medical, Progs.B89-94 of April 1873.'Extra Coolies and Dhyes for the Municipal Pauper Hospital'.
51William Ward, op. cit., p.116n. Also see Norman Chevers, op. cit., p.508.
52Dr D. Bharadwaj, 'Adherent Placenta and Hour Glass Contraction of the Uterus' in The Antiseptic,XX:10, 1923, pp.519-520.
53Ibid.,p.50.
they may have been fortunate to go without it. Since they are mainly written by doctors and midwives to describe their own miraculous interventions, the accounts we have of the actual techniques of dhais dwell on their more dangerous practices.54

...Of the mechanism of parturition, of the dangers to be avoided and provided against, midwives are profoundly ignorant,...55

The other point of view was that reflected in the Purnachandrodaya of 23 December 1872. A leading article described an incident in which a newly-fledged Sub-Assistant Surgeon was sent for, to assist at the confinement of the wife of a 'respectable native gentleman'. The sub-assistant surgeon gave it as his opinion that the child had died in the womb, and proceeded to extract it by cutting it in pieces. After considerable effort, however, he failed to bring away the child, and signified to the husband that he had not the necessary instruments, which were to be had only in Calcutta. The infant was ultimately drawn out, piece by piece, with the assistance of an experienced midwife who was present and who had protested against the doctor's belief that a child was dead. The Editor gave neither names nor places.56

54For example, Dr H. Das Gupta in The Antiseptic of 1923 gives no less than twelve instances where he had personally saved the lives of women who had been 'mercilessly handled' by dhais. See his 'Reduction of Infant Mortality by Training Village "Dais" 'in The Antiseptic,XX:6, June 1923, pp.291-293.

55James Wise, Races, Castes and Trades, p.50.

56WBSA/Reports on Native Newspapers of Bengal, 4 January 1873.
We can conjecture as to the 'motive' behind such reports in the vernacular press, but it seems likely that such reports indicate hostility to colonial innovation rather than the professional respect received by dhais.\(^5\)

The allusion to the doctor's dependence on instruments reflects a popular prejudice, based at least partly on the respectability of kaviraji and yunani methods of diagnosis based on reading the pulse of the patient, whereas 'English medicine is never dissociated in the mind of the Bengali female from the syringe and the knife'.\(^5\)

One medical man reported that he had personally found and also been informed by others that 'native women more obstinately oppose such measures as [hiring trained midwives], as also vaccination and medical and surgical treatment, than men...'.\(^5\)

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\(^{5}\)In a similar case in Madras Presidency in 1931, an unregistered medical practitioner cut off the arms of foetus in a case of breech presentation but was unable to deliver the child. Both mother and child died, but the 'doctor' was acquitted because there was only the testimony of two indigenous dhais against his claim that the child was already dead. See 'Medico-Legal Item: Alleged Mishandling of Delivery Case' in the Journal of the Indian Medical Association, 1:5, pp.206-207. In her autobiography, Dr Muthulakshmi Reddy describes the birth of her first child in 1915, when a minor domestic accident held up the craniotomy the attendant doctor was planning to perform on her living child. See Autobiography, n.d., pp.20-22.

\(^{5}\)IOL/GOB Medical Proceedings, July 1871, no.22. From J. Wise, Civil Surgeon of Dacca to H. B. Buckle, DIG of Hospitals, Dacca Circle. The general scepticism about Western medicine is reflected in the saying: 'Jal, jalap, jochori - ei tin niye daktari' (Water, purgatives, and charlatanry - these make up doctoring). Sushil Kumar De, p.23.

\(^{5}\)IOL/Bengal Medical Proceedings, no.32, Dr N. B. Bailie, Civil Surgeon of Bhaugulpore to Magistrate, Bhaugulpore.
Supervisor said at the Lucknow conference of the Victoria Memorial Scholarships Fund in 1929:

To the Mass of the People, to whom she is a well-known well-respected figure to whom her methods are known and trusted, she is all-sufficing, all-sufficient. ...It is seldom the men will not listen [to new ideas], it is the older women, the Mothers-in-law, and the Grandmothers, who fight against new methods as being unlucky.60

Remuneration for services

The elite group of dhais may have enjoyed a reasonable level of prosperity, but the trade was not a highly remunerative one for the less privileged dhais. It appears that many of the women who worked as dhais in rural Bengal combined their work with other occupations, such as agriculture.61 Dr Baman Das Mukarji said midwives in Bengal normally worked as 'coolies' and 'mazdoors' to make ends meet.63 Their ranks were traditionally closed to outsiders by the stigma associated with the work.63 According to Wise's report to the Government of Bengal, the dhai's post was a hereditary one, descending from mother to daughter. If the woman was childless, some one specially recommended by her was

60Paper read by Miss Reeves at Lucknow in Report on Four Conferences on the Victoria Memorial Scholarships Fund, 1929-30, p.82.
62See Bamandas Mukherjee, op.cit.,p.i.
appointed." Since such skills as they possessed were handed down over generations, many doctors suggested that the training of the daughters of dhais was a useful pre-emptive step. Dr P C Sen of the Dacca Maternity Trust made the same point in Lucknow 1929.

Wealthy families in Calcutta in the late nineteenth century paid such generous amounts (up to Rs50 at the birth of a son) to daids that some women of the Dom and Bagdi castes were reported to have acquired considerable fortunes." In Dacca around 1840, dhais expected at least 4 annas and, if they came for the whole period of confinement, they received tobacco and betel-nut, bringing the whole expense to about a rupee. The 'handy-women' of the villages were given a piece of cloth or some similar gift." Forty years

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"IOL/Bengal Medical Proceedings, July 1871, progs.no.22, p.91. Many of the dhais who practiced in rural Bangladesh in the 1970s said they had learnt their skills by watching their mothers, grandmothers or other elder women. See Shamima Islam. 'Childbirth in Bangladesh', op.cit., p.238, 248, 244.

"The Surgeon-General of the Indian Medical Department made the suggestion to the Government of Bengal in 1873, saying it would 'disarm the hereditary system'. (See GOB General:Medical, December 1873,Proceedings no.7.) Dr Agnes Henderson, a Scottish missionary, had combined her dhai training scheme with a montessori school for their children, with much the same intention. (See Balfour and Young, p.137.) The story of one of her pupils writing to her on a postcard many years later, when she was married and practising as a dhai appears in the VMSF, Annual Report, 1920, p.5. The eighteenth Annual Report of the VMSF, 1919, carries as its frontispiece a photograph of three generations of women. The caption reads 'The Dai of the Future'. See Report on Four Conferences of the VMSF, p.29.


"Dr James Taylor, A Sketch of the Topography and Statistics of Dacca, Calcutta, 1840, p.263."
later, in the same district, the fees paid were said to have varied with the means of the husband - the narkatta dhai usually received a present of old clothes and rations for five days. Occasionally, money was also given. The poorer classes gave the dhai janai about 4 annas in cash and some rice and oil. Among the 'baboc' class, Rs 5 was a usual fee at the birth of a son.

The duties of a dhai

The dhai was responsible for burying the placenta. This was an important ritual duty because the umbilicus was symbolic of attachment to home and the family. The duties of a dhai, according to women workers of the jute industry in 1921-22, included giving the mother and infant a daily massage for two or three weeks after delivery and, sometimes, washing clothes. Although Chamar women delivered their own relatives free of charge, they expected to be paid between Re.1 and Rs.5 by others. The usual fee, it was reported was Rs.2 /as.8 at the birth of a girl and Rs.3 at the birth of a son. These rates, which were quoted as prevalent in the industrial suburbs of Calcutta, were said to be high. The women would have paid only 2 to 4 as. for the same services in their villages. Around the same time, coolie women in

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68IOL/Bengal Medical Proceedings, July 1871, J. Wise to H.B.Buckle.

69 Victoria Memorial Scholarships Fund, Improvement of the Conditions of Childbirth in India, Calcutta, 1918, pp.85-86.

70 'Narir tan' or the 'tug of the umbilicus' is used to describe the affection of a son for his mother. R.B.Inden and R.W. Nicholas, Kinship in Bengali Culture, Chicago, 1977,p.21.
the tea gardens, who were mainly from the Santhal Parganas and Chhota Nagpur, with some Nepalis and a few tribals from the Dooars and the Terai, generally received some ante-natal and post-natal care at the dispensary but their actual deliveries were conducted by dais who charged at least Re.1. In many cases, the payment was the same for the birth of a son or a daughter. The hill women, according to Nepali custom, were helped during childbirth by their husbands and women neighbours or relatives. The women who worked in the Raniganj coalfields said they went home for their deliveries. In their villages, the dhaais were paid in rice or foodstuff. They generally belonged to the same tribe or caste.71

The author of a household manual on midwifery and health care reminded his readers that the 'modern dhai' (that is, the trained dhai of 1904) could not be given a mere Re.1 as.4 as payment, like the indigenous dhai. The equipment she had to carry (nailbrush, new soap, 'Higgins syringe', tin douche, catheter, enema, clean thread and scissors) necessitated better payment.72 Payment was made both in kind and in cash, with the word 'sidhe' (which is also used for the gifts given to a priest) used for the former. Inevitably, bargaining had an important part in the negotiations before the dhai was finally dismissed. 'extorting money in proportion to the anxieties of their patients'. In Sarat Kumari Chaudhurani's story,

71Dagmar F.Curjel, Women's Labour in Bengal Industries, Calcutta, 1923.

72Debendranath Ray, Garhasthya svasthyaraksha o sachitra dhaatrishiksha, Calcutta, 1904, p.144.
the mother-in-law refuses to pay the dhai because the child born is a girl, while in another novel, written for children, there is a description of the dhai's efforts to make a case for enhanced payment by playing up her own role in saving the newborn son.73 The ceremony of holding up the child at the door to be looked upon by those outside the anturghar, which Lal Behari De describes in Bengal Peasant Life, was related to the practice of rewarding the woman who first displayed the infant.74 In prosperous households, this could involve large amounts of money.75

Levels of skill
It is plain that when we speak of the indigenous midwives as a class, there were differential levels of 'skill' involved. The better-paid dhais may have played more active and, quite probably, more dangerous roles in childbirth, while the narkatta dhai may have done little in terms of manipulation and intervention during labour. Dhaís frequently played an active role in massaging the perineal passages of women in labour and in pressing points in the

75Professor Sheila Lahiri Chaudhuri informed me that when her husband’s uncle was born at the turn of the century in Mymensingh, the dhai was so eager to show the baby to the male elders of the family and to claim her reward that she neglected the mother, who died of post-partum haemorrhage. Sheila Lahiri Chaudhuri, Oral Interview, Calcutta, February 1994.
abdomen to speed labour. This was said to be the cause of the high incidence of uterine prolapse to be found among Indian women especially those who had borne several children.76

Discussing the development of the idea of 'natural childbirth' in America, Wertz and Wertz point out:

The degree of trust in nature varies; it is greatest when one is shielded from nature's mistakes, when one has learned to outwit its pain.78

By the eighteenth century, the notion of 'nature' being allowed to take its course had come to dominate European obstetrics, under the influence of Enlightenment ideas.79 Consequently, along with the development of technology to alleviate complications of labour, there was a simultaneous move towards less intervention in normal deliveries. It was not till the 1920s that substantial intervention began to be recommended once again, for 'the protection of the foetus', as a consequence of the child welfare movement that developed after World War I.80 The caesarian section

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76Bengal Law Reports: Cases tried at the Sudder Nizamat Adawlut, Volume III, Part II, p.703, evidence of Dr Bose, the Civil Surgeon of Sarun, in the trial of Mmt.Parbuttea and Mmt. Luggun, in 1853.


78Wertz and Wertz,p.25.


80Ibid.,p.383.
was not a safe or practicable operation until the 1880s even in the best equipped European hospitals.81 Thus, the bulk of the criticism levelled at the dhais' practices dwells not so much on their inability to assist in a crisis of labour as on their 'meddlesome' and violent methods.

... one often sees normal labour cases, which would have apparently proceeded uneventfully, but where the dai has interfered too early, with usually disastrous results. For instance, the dai may have been summoned only for false pains - but she is expected to do something to earn her fee. She may sit all night kneading the patients' abdomen - in the morning nothing has happened...the dai to save her reputation does something quite unnecessary, such as rupturing the membranes when the mouth of the uterus is only a little dilated, and it is only later, when with delayed labour the patient is utterly exhausted that she is brought to us in hospital, with the child forced into a malposition.82

A manual written for 'women and dhais' speaks of how dhais made women walk to speed the labour and decrees that this was a dangerous custom as it is unsafe for women to be upright after the plug comes out and the second stage of labour begins. 'Many dhais,' it warns, 'press down on the woman's chest to prevent the placenta from climbing up into the chest.'83 The manual refers also to the practice of putting the parturient woman's hair into

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82Improvement of the Conditions of Childbirth, p.69.

83Debendranath Ray, pp.150-151.
her mouth to make her gag (probably in order to speed the third stage of labour.)

A missionary doctor has described how cases of eclampsia were invariably interpreted as demon possession, so that the woman was made to endure the tortures of exorcism through beatings at the hands of an ojha or witch-doctor. This was with the complicity of the family and the dhai had no special role to play here.

A doctor of the VMSF said normal cases were comparatively safe from the intervention of the dhai, as they were often over before her arrival. It was in cases of delayed labour that interference resulted in foetal arms pulled off, rupture of the uterus, lacerated cervix and perinuem, and applications which resulted in partial or complete atresia of the vagina afterwards. In almost all cases where delivery was not rapid, the dhai was called on to make several vaginal examinations beforehand with the object of foretelling when the child would be born. This she did with unwashed hands 'anointed with some unaseptic lubricant, usually either castor or sweet oil.' Once delivery was over, if the placenta did not come away within five minutes, she would 'plunge her hands into the uterus and remove it.'

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8Ibid. See also T.A.Wise, The Hindu System of Medicine, 1845, p.417.
86Improvement in the Conditions of Childbirth, p.86. C.L.Houlton, in her study of 57 septic cases, found that the incidence of sepsis was markedly worse if there was interference or lacerations of the vagina or cervix, with the introduction of
By the early twentieth century, one of the greatest advances made by European medical science in India was the acceptance of the germ theory. In the late nineteenth century, the texts used in the vernacular medical schools criticise the dhais' practices on a number of grounds, but none of them refer to sepsis as an infection transmitted by the dhais. For instance, Jadunath Mukherjee, whose celebrated text went into several editions and was prescribed for the vernacular medical course, declared tetanus (dhanushtankar) was caused by the native custom of not bathing the infant with soap and water immediately after birth but anointing it with oil instead. Meer Ashraf Ali, whose book was also recommended by the Medical Department as a text for basic instruction in midwifery, attributed the disease to lack of ventilation in the anturghar. In other words, the dhai was criticised for being the repository of superstition and harmful traditions (kusamskara), while the practices relating to lying-in and the anturghar were regarded as the cause of disease. With the shift away from the miasmatic theory of disease, the accounts of the dangerous customs of dhais focused more sharply on the puerperal sepsis and neonatal tetanus.


"Jadunath Mukherjee, Dhatri-shiksha evam prasutishiksha arthat kathopakathanchhale dhai evam prasutidiger prati upadesh, Chinsura,(first published 1867), 3rd edition, 1875,p.9.

"Meer Ushruff Ally, Dhattrividya, Calcutta,(first published 1869),1874, p.33, p.35."
The third stage of labour was speeded by the dhais massaging the patient's abdomen, sometimes after making her stand up against the wall for the purpose, till the placenta came away. A very tight roll of cloth was then wound round and round the mother's waist with the object of keeping the uterus in the lower abdomen. Dhais were said to have frequently attempted to remove the placenta manually.89

Dhais in Bengal were reported, by Professor T.W. Wilson, to have cut the navel-cord near its insertion to the umbilicus, using a piece of bamboo, sharpened into the form of a knife. This bamboo knife was called a chyanchali and is referred to as a source of tetanus infections.90 Sometimes the well-to-do used a special silver knife. Only one ligature, of strong thread was used. It was applied to the placental end of the cord, while the foetal end was left hanging without any dressing. Dr Wilson also found that dhais divided the cord before the placenta came away. Although he quotes William Ward as having said various religious ceremonies lasting for about two hours were performed before the cord was cut, Dr Wilson thought this was true only of wealthy families.91

89Jadunath Mukherjee, p.69.
90Improvement, p.85.
91Chevers, p.526n.
Poor families in Bengal were said to sever the cord with the broken edge of an earthen pot. It was also reported as being cut with a piece of conchshell or with a length of yarn. A medical woman reported to the Victoria Memorial Scholarships Fund that she had variously noted the use of a 'rusty nail, an unspeakably dirty and blunt household knife which had just before been used to peel vegetables, also a piece of a kerosene oil tin.' The women who worked in the Raniganj coalfields in 1921-22 and went to their rural homes for childbirth said they were delivered by dhais who used household knives or sickles to cut the cord. D.N.Ray refers to 'old-fashioned' dhais using shears and 'modern' dhais (presumably trained ones) using scissors. The infant's cord was dressed with either haldi, charcoal, red-earth, or ashes. In Hooghly, a new cotton thread was reported to be tied around the cord, about four fingers' breadth from the umbilicus, with a few blades of dub grass placed parallel with it. (Both thread and grass were first washed in a solution of turmeric.) The cord was separated on the placenta side of the knot with a thin bamboo splinter ('the chyanchali'). Since the cord was not tied on the

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92Ibid.
93Census of 1911, Vol.5, p.269; Jadunath Mukherjee, pp.63-64.
94Improvement in the Conditions of Childbirth, p.71.
95Curjel Report.
96D.N.Ray, p.155.
97Improvement, p.86; Census 1911, p.269.
placenta end, if there was much bleeding it was covered with the ashes of burnt cowdung.98

The custom of leaving the cord untied is referred to by Annada Charan Khastagir, who refuted the 'common claim' that tying the navel string was redundant, saying the human cord was 'different from those of animals'.99 In her memoirs, Nistarini Devi describes her brother's navel cord being cut with a chopper, passed into the anturghar by a jubilant uncle. It had just been used to sacrifice a goat to celebrate his birth and the goat's blood was fresh on it.100 This occurred in a kulin household in Hooghly District in 1847.

Dhais advised the mother to sit up soon after birth. Dr Jadunath Mukherjee listed this among their dangerous practices, along with the 'heating' customs of jhal to the mother and tap or hot compresses to both mother and child. He said the latter was completely unnecessary, if not dangerous. If there was really water in a newborn infant's body, no English child would survive, he said, as it received no such heat treatment. However, he

9Hooghly Medical Gazetteer, op.cit., p.394.


10Nistarini Devi, Sekele Katha, in Jana et al.ed. Atmakatha, Volume , , p.17. Nistarini Devi was born c.1832-33 in Hooghly District, died in Benaras in 1916. Sekele Katha was first published in serial form in Bharatvarsha from Ashadh 1320 (June 1913). The memoirs were dictated to her nephew.
recommended a milder form of heat application, senk, using a warm cloth to help dry the navel stump.\textsuperscript{101}

The relative security ensured by the 'elaka' system and the assurance that the work they did was rendered a monopoly by the strict taboos that surrounded it made it possible for dhais, despite their degraded social position to develop something akin to professional pride. Thus, the impression of arrogance they seem to have conveyed:

\begin{quote}
In Dacca, the midwives are invariably ignorant and generally consequential, while, being few in number, they are very independent, extorting money in proportion to the anxieties of their patients.\textsuperscript{102}
\end{quote}

The Head Dhai at the Imambara Hospital, Hooghly, was a hereditary dhai called Champa. At the hospital, she was taught reading and writing and given oral lessons in midwifery. She was reported to be practically competent in cases of both natural and difficult labour, but was unable to learn reading and writing. It was said that people had confidence in her as an old and experienced dhai, and she was frequently sent for in the houses of respectable Hindoos, Mahomedans, native converts, and Christians, both at Hooghly and Chinsurah, and sometimes [was] sent for at a distance

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\textsuperscript{101}Jadunath Mukherjee, p.72, p.75. However, in her paper on 'Puerperal Sepsis', op.cit., C.L.Houlton emphasised the importance of making the patient sit up to allow the lochia to drain freely.(p.440.)
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\textsuperscript{102}Races, Castes and Trades, p.50.
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of two or three days' journey to attend cases of difficult labor'. In a book of memoirs about a childhood in District Tangail in the 1930s, there is a description of a dhai from a 'high gharana', Tahmina Dhai. (Her grandmother was a dhai in the Nawab of Dhaka's household.) The author describes her as firm and capable, and very laconic, with her conversation mainly in the form of scoldings. He speaks of her great self-confidence and the pride she took in her work. He says she was famous in 'a hundred villages', where she had delivered innumerable babies, and every one called her 'Dadi'. If, in some wealthy household, a medical man was also called in, Tahmina would not allow him to enter the anturghar, saying it was not men's work. She would make him wait outside until she handed him the infant.

II
Training the dhai: Government efforts

When the Government of Bengal first circulated a proposal that indigenous dhais be trained, not so much to create a class of


104 Tarapada Ray, Charabari Porabari, Calcutta, 1990, pp.83-84. A curious incident was reported from Benaras in 1921. Dr Margaret Balfour and a Midwife Supervisor were on a tour to inspect the dhai training centres set up under the auspices of the Victoria Memorial Scholarships Fund and they spoke to the dhais on principles of hygiene and, later, distribute sweets. After they left, the dhais refused to attend further classes, saying they had been insulted by references to their personal hygiene and they had 'lost caste' by accepting sweets from the European women. Above all, they suspected an attempt to oust them from practice. (VMSF, Annual Report, 1921, pp.28-29).
accomplished midwives as 'to teach the midwife the danger of following her own malpractices', Dr Norman Chevers, then the Principal of the Calcutta Medical College was cynical about this limited objective. He said:

Here and everywhere else the midwife is one of the most obstinate, prejudicial and unteachable of human beings. I should altogether despair of being able to teach an "experienced" native dhye to abandon any of her mischievous practices.  

Balfour and Young suggest that it was partly this spirit of scepticism among medical men that condemned most experiments in the training of dhais to failure from the outset. We cannot, however, discount the possibility that the difference in structures of caste and the operation of the mohalladari system in Bengal Presidency posed a more serious barrier to the upward mobility of traditional birth attendants through the respectability afforded by training them than any that existed, for instance, in the showcase provinces of Sind and Punjab. Dr Edith Brown of the Punjab Medical School for Women reported from Ludhiana in 1919 that trained dais were masquerading as doctors and charging high fees. One was found to be carrying a little black box, giving medicines and calling herself 'kala Doctor Brown'.

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105GOB Medical, progs.no.44,from G.Saunders,Deputy Inspector-General of Hospitals, Presidency Circle to the Inspector-General of Hospitals, Indian Medical Department (dt.9 Sep.1869) and from Norman Chevers, Principal, Medical College to G.Saunders,Deputy Inspector-General of Hospitals, Presidency Circle (no.445 dt.3 Sep.1869).

106Balfour and Young, p.128.

complained in 1929 that some dais called themselves HMD (presumably standing for Her Majesty's Dai) and set up practice as Lady Doctors.  

In Bengal, it was reported that people refused to pay the higher fees charged by trained dhais.  

Although the elimination of the indigenous birth attendant or dhai and her replacement by a 'superior class of midwife' remained the ideal of the medical profession since Madhusudan Gupta, it was generally acknowledged that it would not be possible to provide fully qualified medical attendance for the majority of Indian women, but the more sanguine commentators hoped to do so.  

In 1869, the Lieutenant-Governor of Bengal resolved to adopt a scheme for the instruction of 'professional midwives' (in other words, dhais) in the art of 'rational midwifery.' A suggestion had was made for the training of dhais at the Calcutta Medical College. Such an experiment had already met with considerable in Amritsar in the Punjab and in Bareilly in the North-Western Provinces and the Indian Medical Department was eager to see the extension of such efforts. According to this scheme, the dhais were to be instructed by the surgeon or the Sub-Assistant Surgeons, with the use of models and with clinical practice in the obstetric wards. They were later to practice in the city and call in the Surgeon or 

108Report on the Five Conferences of the VMSF, p. 56.  
110GOB Medical: August 1870 progs. no. 12.
Sub-Assistant Surgeon in cases of difficulty. The Inspector-General of Hospitals added a caveat:

This will require great tact on the part of the Professor of Midwifery, as these native physe have a high opinion of their own skill in the management of childbirth, and the people have strong prejudices in favour of ancient customs, and against male interference on this occasion.\[11\]

After a year of the experiment, the Inspector General of Civil Hospitals reported to the Government of Bengal that the main obstacles in training native women as midwives in mofussil hospitals arose from, first, the difficulty of obtaining eligible pupils, second, the reluctance of women to come to hospital for confinements, and, third, the want of accommodation for lying-in cases.

It was agreed that a scheme to provide thorough training in midwifery to Indian women, however, was bound to fail. It was suggested that the use of texts such as those by Khastagir or Ashraf Ali be combined with practical training at the hospitals. In order to arrange the latter, it was suggested that pregnant women of the indigent classes should be induced to resort to hospital for delivery, by the offer of a subsistence allowance of two annas a during their stay. Success in this direction, added the Inspector General of Civil Hospitals, would be greatly promoted if some of the native gentry at zillah stations would take an active interest in the matter. It was decided, after some

\[11\] GOB, Medical Proceedings nos.41-45, 2 November 1869. See letter no.587 from J. Murray, Inspector General of Hospitals to the Secretary, Government of Bengal, prog. no.43.
deliberation that only Mitford Hospital, Dacca had the resources outside of Calcutta, to support such a scheme and so the finances for the training of three dhais at that institution were sanctioned.

The training of twelve dhais at the General Hospital and the Medical College Hospital in Calcutta had already been sanctioned but the scheme did not take off because it was reported that the General Hospital did not provide a suitable field, having an average of only twelve labour cases in a year, while the Medical College was unable to secure any pupils. Dr Charles attempted to draw women to attend the course through the influence of local zamindars and through publicity in the vernacular press, but with little success. The Bamabodhini Patrika of December 1874-January 1875 carried an item announcing Dr Charles's class for Hindu and Muslim women between the ages of 20 and 30, who were literate in their own tongue and with sufficient education to benefit from the course of instruction.112

Given the lack of enthusiasm of those who were to implement the scheme, it is not surprising that it met with a marked lack of success, though it was not dropped outright. The Civil Surgeon of Dacca reported that the difficulty arose largely from the absence of practical instruction. Three dhais were trained at the hospital and they accompanied the Civil and House Surgeons in all cases of

112Bamabodhini Patrika, Pausha 1281, p.292, item 5.
difficult labour and took care of the mother during convalescence. Nevertheless, they were unable to establish independent practice as midwives. This was attributed to the hostility of the women who were already plying the trade in the city of Dacca.\textsuperscript{113}

The doctor said it was not from the combined opposition of these dhais that he anticipated the failure of the government scheme, but the conservatism and prejudices of the native females themselves. They were wedded, he said, to their ancestral customs and looked with horror on any innovation or reform. However willing the paterfamilias may be to employ educated midwives, his wishes would be overruled by the female portions of the family. The influential native families of Dacca who had often complained to him of the want of skilful dhais, refused to engage any but those who have always been employed by their families.\textsuperscript{114}

The Surgeon-General of the Indian Medical Department later explained that the intention of the Government was to give professed midwives a fair practical knowledge of midwifery, and some of the common diseases of women and children, not to attempt to make them shining lights as practitioners.\textsuperscript{115}

\textsuperscript{113}GOB Medical Proceedings, No. 383, dt. Dacca, the 5th June 1871, from J. Wise, Civil Surgeon of Dacca to H. B. Buckle, Deputy Inspector-General of Hospitals, Dacca Circle. Report on the Charitable Dispensaries under the GOB for 1871. p. 172

\textsuperscript{114}Ibid.

\textsuperscript{115}GOB, General: Medical, December 1873 Proceedings, File 63-7.
The problem, continued the same report was that neither educated women nor hereditary midwives, whose influence in families would interfere with the employment of others, came forward for training. The women who presented themselves for instruction were reported to be 'of low caste and ill-educated'. Speaking of the early efforts made by his 'guru, the late Dr Edmonstone Charles', Dr Sundari Mohan Das later observed that 'only women of the lower class and Indian Christians' attended the Midwives' Class.\textsuperscript{116}

The Government of Bengal seemed eager to abandon the experiment, declaring it unfeasible. By 1874, the Professor of Midwifery was prepared to abandon the scheme to train dhais at the Medical College, giving the lack of pupils as his reason.\textsuperscript{117} He suggested, however, that some women might be found with the cooperation of district officials and influential landowners. The experiment was continued and in December 1874, Dr Charles, Professor of Midwifery, explained to the district officers that their help was needed in procuring literate Hindu and Muslim pupil dhais for the classes he had organised at the medical college. Up to then, all the women who had come forward for training were Christian. Of them, two women, Jane Scott (a Bengali Christian) and Aunro Moonee Dassee

\textsuperscript{116}Dr Sundari Mohan Das, 'The Evolution of the Nurse', The Indian Medical World, 1:1, 1930, p.18.

\textsuperscript{117}GOB, General:Medical, September 1874, File 32-15, from H. B. Buckle to the Secretary GOB, Judicial Department.
were reported to be very able midwives. Both the Principal of the Medical College, Dr Norman Chevers, and the Professor Charles were opposed to the idea of training illiterate dhais. The argument against the scheme was the 'immorality' to which the class was prone.

Pressing his case, Professor Charles said:

...given a Bengalee woman who can read a little, and who has previously acquired the art of profiting from instruction, it is not a difficult matter to teach her the rudiments of midwifery. On the other hand, given a woman who does not start from the same vantage ground, public money may be spent for months and years without producing, as far as I can see, any visible result.

This was the crux of the midwifery debate - the wisdom of giving a rudimentary training to dhais, who were believed to enjoy the confidence of the native gentry, or of giving a more complete course of instruction to educated women. The Government, which was more sensitive to political nuances, was clearly in favour of the former, while Professor Charles, as a medical professional, continued to advocate the latter.)
The Victoria Memorial Scholarships Fund

In 1901, Lady Curzon initiated the Victoria Memorial Scholarships Fund 'with the object of keeping in perpetual remembrance the sympathetic interest taken by the late Queen-Empress in the family life and domestic troubles of the women of India'. To alleviate suffering in childbirth, the Vicereine appealed for funds 'to be utilised in training native midwives to work in zenanas'. A sub-committee was set up to collect information on the possible methods of training women of the dhai class and to frame a definite scheme for applying to the best purpose any available income. The sub-committee included the Surgeon-General of the Indian Medical Department and H.H. Risley, the civil servant and ethnographer, whose study of the tribes and castes of greater Bengal had included detailed accounts of customs relating to birth.

The general objective of 'improving the treatment of childbirth in India' could be approached, it was stated, on two lines which 'could be concurrent and could react on each other'. This was, first, to train midwives of a superior class or, second, to endeavour to impart a certain amount of practical knowledge to the indigenous midwives (dhaís). The policy of training a superior class of midwives was said to be followed in the main by the

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122 Ibid., p.6.

123 Ibid.
Dufferin Fund. The major drawbacks were, one, that it presupposed a certain standard of education among the women who were trained. They had, for example, to be able to read and write, and to be capable of understanding lectures and studying simple textbooks. It was out of the question, said the Fund, that until the number of educated women in India had very greatly increased, that the number of highly trained midwives should be 'anything but infinitesmally small in relation to the demand for their services.' Second, such midwives received relatively large salaries and charged high fees. Most of them, thirdly, belonged 'to classes more or less out of touch with the customs and traditions of the people.'

The establishment of the VMSF in 1903 followed closely upon the passing of the first Midwives Act of England in 1902.\textsuperscript{124} The caution with which indigenous customs and traditions were being handled was characteristic of many of the moves affecting 'family life' since the late nineteenth century. The insistence on the purely secular nature of the medical relief provided by the Dufferin Fund since its establishment in 1885 and the wariness at the time of the passing of the Age of Consent Act of 1891 were part of an increasing respect for native testiness regarding custom.\textsuperscript{125} Lady Curzon was said, therefore, to have decided to adopt the

\textsuperscript{124}Central Advisory Board of Health, Report on Maternity and Child Welfare Work in India by the Special Committee under the Chairmanship of E.W.C. Bradfield, p.2.

second strategy, which she believed (though, quite erroneously), to be 'an entirely new departure'. It proceeded on the principle of 'making the best of existing agencies, and endeavouring gradually to improve them':

The general idea is to get hold of as many as possible of the indigenous hereditary midwives and induce them to attend at Dufferin hospitals, or at the female divisions of ordinary hospitals or dispensaries, for the purpose of acquiring such empirical knowledge as it is possible to impart to them. In comparison with the training of the regular midwife class, the amount of such knowledge will be very small, but the women themselves, or some of them will start with a certain practical acquaintance with the subject and will probably learn quickly. Even if at first only negative results are obtained, and the trained women merely abandon or discourage insanitary practices, the gain will be great.

It was hoped that once this first step had been achieved, the training would become more elaborate.

In time they will learn more, and whatever they learn will spread over a far wider area than can be reached by means of the superior class of midwives. The teaching will at first be oral, and will be conveyed in the colloquial language familiar to pupils. But it is proposed, in course of time, to prepare very short and simple primers of midwifery practice in the various vernaculars for the use of dais.  

The original text for dhais, Daigiri ka Usool, by Dr Edith Brown was in simple Hindustani. The Bengali translation of First Lessons for Country Dais by Dr Margaret Balfour, Bharater deshi dhaider janya dhatrishiksha, was published in 1922. The book is written on a schoolbook model, with lessons in anatomy and exercises for memorisation. There are questions and answers at the

126Brief Resume, p.6.

end of every lesson. There was (not surprisingly) a complaint that dhais tended to repeat lessons 'parrot fashion'.¹²⁸ Up to 1920, there were no rules for examinations and each Centre examined its dhais and given certificates against varying periods of training.

In 1920, it was decided that every dhai who gained the certificate should have conducted at least 20 cases of labour under the supervision of a doctor or qualified midwife in homes or in hospital. She should attend a course conducted by a doctor or qualified midwife for not less than a year, with 90 per cent attendance or at least 75 classes of both a theoretical and practical nature.

Since the endowment fund depended entirely on the enthusiasm of wealthy Indians, a token genuflection was made to indigenous medicine. As long ago as the fourth century A.D., said the authors of the Fund's publication, Indian medicine used the Susruta Samhita.

a treatise on midwifery which a well-known specialist describes as 'a thoroughly rational system of medico-surgical teaching based upon accurate observation of nature.'...The proposals sketched above are, in effect, a revival of the most ancient tradition and practice in India, and as such have received enthusiastic support from all patriotic Indians."¹²⁹

The list of donors to the Fund consists in the main of such anonymous patrons as 'the wife of Bazlul Karim Moulvi', 'the ladies of the Gosain family, Serampore', 'the ladies of the house of Babu

¹²⁸VMSF Report, 1922, p.22.
¹²⁹Brief Resume, p.7.
Mohendra Ch. Mittra, Hughli', 'the wife of Syud Ashruffuddin Ahmed of Imambara', 'sister of Kshetra Nath Banerjee', 'Grandmother of Durga Das Mukherji' and 'Daughter of Babu Jogendra Nath Sen'. This was in keeping with the general report that it was men who were eager to reform practices of childbirth in Bengal.

The Fund was operative only in northern and eastern India; the training centres established under the Fund in Bengal Presidency were at Calcutta, Bhagalpur, Muzzaffarpur and Gaya, only the first of them being in Bengal proper.\(^{130}\) The Fund was not very successful in its efforts, even for the minuscule numbers of dhais it attempted to train. In 1918, in a spirit of self-criticism, the Fund asked medical women to send in special reports on their experience with dhai training. Analysing the reports sent in, Balfour and Young said:

As classes were taught by men who could give only theoretical instruction and not practical demonstrations, and had themselves very little experience in obstetrics, it is not surprising that the teachers were disappointed and felt inclined to say dais were untrainable and no attempts should be made.

Discussing the failure of the early efforts of the V M S F , they admitted that there was no doubt some doctors were 'superior and overbearing'. There was no possibility of making attendance of classes compulsory as there was no registration for dhais. Even the 'hukm' of the District officials was powerless as neither dhais nor patients saw the need for them. The response to the training

\(^{130}\)Ibid., p.8.
was meagre and a very small proportion of dhais were covered, and that too chiefly in towns, leaving villages practically untouched. 131 The special essays published by the Fund in 1918 show that there was much dissatisfaction with the idea of attempting to train dhais but suggested that suitable measures, principally relating to supervision after training, could ensure considerable success. The encouraging reports were mostly from Punjab, while in the U P, Bengal, Bihar and Orissa, training had been tried but in the opinion of the Inspectors-General of Civil Health and the Surgeon-General (who administered the Fund), no good would come of dhai training. Balfour and Young point out that the cleavage of opinion was roughly between men and women. Wherever teaching was successful, they said, it had been in the hands of 'strong capable women' and was, naturally, a failure in the hands of sub-assistant surgeons who were wanting in missionary zeal. The latter had 'no background in the work, no real enthusiasm, no gift for teaching, no imaginative insight into the dhais' mentality.' 132

In the words of the Report:

Unfortunately the new movement, started so suddenly caused considerable alarm among the dai communities who, in nearly every case, believed the purpose to be inimical and somehow intended to deprive them of their livelihood. ... In some

131Balfour and Young, p.128.

132Victoria Memorial Scholarships Fund, 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 Women and Qualified Midwives, Calcutta, 1918.
places the efforts were unsuccessful as no dais were persuaded to attend and operations were never commenced.  

Where women did attend, they were not the active practising dhais that the Fund had hoped to draw. Rather, some women may have regarded their monthly stipend as a pension, for it appears many of the women who volunteered to be trained were elderly and some were deaf or blind. The exasperation of the failed trainers is evident:

none had any previous education or had ever exercised their mental faculties: they were very prejudiced and jealous of their reputation and in addition honestly convinced that no one could teach them anything as regards normal labour. They believed that doctors were required in abnormal cases, but they also believed that they themselves were the proper judges as to when a doctor should be called in. This was and is the general opinion of their patients and is the attitude of the people of India at the present day.

Over the years, some of the classes wound up, while in other centres the funds made available were diverted for the training of women not of 'the dhai caste'. Gradually, there was an 'almost total abandonment of the objects of the Fund'.

In 1918, there were dhai training classes in Calcutta, Bankura and Dacca. In the preceding year there had also been a class at Darjeeling, but this was wound up for want of pupils. These classes were for extremely small numbers of women, for instance

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133 Improvement of the Conditions of Childbirth, p.2.
134 Ibid.
135 Ibid., pp.2-3.
136 Ibid., p.3.
five women were being trained at the Dufferin Hospital in Calcutta. Pupils of the indigenous dhai class very seldom came forward for training. In Calcutta, there were no new admissions in 1918, while the Dacca class was self-supporting and did not need to follow the strictures of the Fund. Accordingly, it was reported to be training nine 'non-indigenous' dhais in 1918. A sign of the successful co-option of the dhai cited by some doctors was the referral of difficult cases to medical personnel. In Dacca, nearly 95 per cent of 725 staff cases were taken up at the instance of the dais. Similar reports came in from Delhi, Punjab, Sind and other centres. It was said by some of the early trainers that amongst the dais who attended the classes, 

the subtle 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 medical women in the bad cases.

Another doctor however complained:

The dais is jealous of her reputation and even if a Doctor Miss Sahib is within reach delays summoning her aid till labour has proceeded for two or three days and the patient is in extremis.

The role of rumours
In 1871, after he had trained three women in midwifery at the Mitford Hospital, Dr. Wise insisted on their personally informing the poorer women of the town of their readiness to attend them,

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137VMSF, Annual Report, 1918, p.12.
138Ibid.
139Improvement, p.3.
140Ibid., p.71.
under the Civil Surgeon's supervision, during their confinement. On attempting to carry out his instructions, they were driven away with abuse, 'under the impression of being women come to entice away girls.' The doctor then applied to the Magistrate for his assistance. The police were directed to inform the townspeople that dhais educated at the Hospital were ready to attend any family requiring their services. It immediately became noised abroad that unless every woman confined in Dacca reported the fact, she would either be fined thirty rupees or be sent to jail for three months. Wise was convinced that such reports originated from, and were propagated by the common dhais.\(^{141}\)

In July 1921, exactly half a century later, a training centre of the Dacca Maternity and Child Welfare Trust was set up in July 1921 with a grant from the Victoria Memorial Scholarships Fund. The Chairman reported to the Fund at the end of the first quarter:

As the centre is situated in the most congested part of Dacca, where the population is almost entirely Mahomedan of a low type, there had been much opposition, suspicion and ignorance to subdue before the women trusted our work. The poor people have been so exploited by the agitator class collecting subscriptions for the Khilafat, the Congress, etc., they thought we also wanted money out of them. But gradually by means of the visits round the houses, the distribution of leaflets setting forth our aims and emphasising the fact that there is no charge for the help given, and by speeches in the mosques the people are coming to realise it is to their own advantage to come to us.\(^{142}\)

\(^{141}\)IOL/GOB Medical Proceedings P/172.Letter No.383, dt.Dacca, the 5th June 1871, from J.Wise, Civil Surgeon of Dacca to H. B. Buckle, Deputy Inspector-General of Hospitals, Dacca Circle.

\(^{142}\)VMSF, Annual Report, 1921, p.13
Rumours about the dubious intentions behind dhai training and other such schemes spread rapidly in crowded urban slums. In 1916, the Report of the Health Officer of the Corporation of Calcutta contained an account by Miss Lewis, the Lady Health Visitor. (This was the first year of the new scheme for domiciliary midwifery by trained midwives engaged by the Corporation.) The bustee people, she affirmed, hid pregnant women and refused to give either information or help to Nurse Lewis or her staff of midwives. The rumour was that the British Raj was in need of soldiers and that all the male babies delivered by the Corporation's midwives were to be taken for the Army. Another rumour was to the effect that before the War could end, the King had to offer young children as sacrifices, so the midwives had received orders to let them bleed to death through the navel cord.¹⁴³

¹⁴³Report of the Health Officer of Calcutta, 1916, p.32. this report was quoted in The Pioneer, Thursday, 6 September 1917. A curious incident is also reported in the VMSF Report for 1922. That year, Dr Margaret Balfour of the Women's Medical Service and Mrs Harman, the Midwife Supervisor, undertook a tour of training centres in the U.P. In Dr Balfour's own words:

We stopped a day or two in each centre, examined the dais and showed our models and posters to large audiences of women and girls who all displayed the greatest interest and most of whom evidently were hearing for the first time of the need for care and cleanliness at childbirth.

There was also a small travelling exhibition and questions were answered and instruction given. In addition, sweets were distributed. Yet, later in the same Report we learnt that, after their departure, there occurred in Agra a strike of the indigenous dais, which was supposed to have taken place for the following reasons: first, their caste prejudice was interfered with by giving them sweets; second, they were insulted by being spoken to regarding the wearing of bangles, not washing their hands and general rules of cleanliness; it appeared to them that the scheme was intended to take away their profession. (See pp.3,28-29.)
The counter-propaganda by the Dacca Trust was apparently effective. By 1922, the Trust could already report a 'steady growth in the usefulness and popularity of the Institution'. Of the 3,240 births registered within the Dacca municipal area that year, the Centre's staff had attended about 725 cases or about 20.8 per cent. This compared favourably with the Calcutta Corporation figures of 2,736 cases or 17.8 per cent of the births registered in 1920. Nineteen of the forty-six indigenous dhaïs in the Dacca Municipal Register were undergoing training in the Centre. 244

The limited success

At the Maternity and Child Welfare Conference held in Delhi in 1927, Dr P.C. Sen of the Dacca Trust spoke of the many limitations of dhai training schemes, but said that after about five years of training,

From among a group of dais in the city of Dacca to whom teaching facilities have been available for nearly the last five years, a wholesome dread of needless internal manipulations, a tendency to arrive at a correct diagnosis of the position of the child, and to refer each case with abnormal presentation to the centre doctors, observance of the remembered rules of asepsis, seem to be refreshingly in evidence. 145


His contemporary, Miss K.M. Bose had made similar attempts in the Punjab; her tone was on the whole more sanguine:

The village dai has the confidence of her patients, and can often get them to do what an outsider, however well qualified professionally, fails to effect. The indigenous dai is an essential part of the community which must be considered to be part of an extended family in which every member, however menial, has a share. So it happens that the dai whose family has been an integral part of the village unit, carries the good will of the village, and is trusted to do the best for the patient, as an outsider would not have been. ... This good will and trust we may well use, and they are some of our greatest assets. 

The crucial difference seems to lie in the position of the dhai in the community. Dr Sen spoke of the need to 'change the name of the midwife, and to improve her status in society'.147 Responding to a questionnaire circulated by the Secretary of the Dufferin Fund in 1912, Sir Gurudas Banarji had suggested 'paricharika' or 'susrushu' as more respectable designations for nurses who bore the stigma of being known as dhais in Bengal.) It is pertinent that a large number of the dais in the Punjab were Muslims while, as we have seen, in Bengal they were drawn from the lowest rungs of the caste hierarchy. The equation of power between patient and dai is expressed thus by Sen:

...it seems the deserving dai requires support. How sore must be the temptation for instance, to the woman to avoid the stigma of idiocy, when she is frantically urged to tear out the placenta, when it may be a few minutes late in following the child, while frenzied friends are attempting to stand on

146 Miss K.M. Bose, 'Is the Indigenous Dai Worth Training?' in ibid., p.115.

The need for supervision

When Ruth Young cautioned Health Visitors that great tact was called for in handling dhaís, she was observing what several medical men and women had commented on - the resistance offered by the indigenous midwives at the prospect of their hereditary profession being wrested from them or even of the control they would have submit to. All those who felt dhai training could succeed also agreed that the training and supervision of dhais had to develop pari passu. 'If such supervision is necessary in England with its comparatively educated midwives', said Drs Balfour and Young, it was essential in India.

...the Indian ryot makes a good soldier...but if after six months or a year in barracks he were dismissed to his village to carry on his duties, etc., without officers or indeed without any supervision and at the same time if without allowances he were expected to provide his own uniform and equipment it is likely that after the lapse of a few years little efficiency would remain. But this is the system under which many courses of instruction for indigenous dais have been conducted. They have been trained (three months to two years) and then abandoned to work in cities often among untrained dais without further help or support.

This was the conclusion of the many medical women who reported on their efforts for the Fund. With no supervision, training could

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148op. cit. p112.


150Balfour and Young, p.137.

prove dangerous. This would require a permanent staff even after all the dhais had been trained and registered.

The V M S F Report of 1922 quotes complaints of inability on the part of local bodies to enforce the rules taught to dhais in training classes. Registration was repeatedly advocated as one of the means of ensuring training. For instance, in Dacca in 1922, there were 46 dhais on the Municipal Register, out of whom 19 were undergoing training. In many places in north and north-west India, registers were maintained and it was said this encouraged enrolment. Registration was closely allied to the principle of supervision after training. Supervision then became the raison d'etre of the training schemes. It was suggested that numbers trained be restricted so that all the dais could be adequately supervised. The successes of the V M S F training schemes were related to the inclusion of supervision, it was categorically stated. Since supervision was a problem in a country of the size of India, the training of women as Maternity Supervisors was suggested as the only viable solution. The Fund suggested the immediate empowerment of Local Bodies to introduce rules for the proper conduct of labour cases in their areas. This was deemed

152In 1918 a medical woman reported having seen dais with a rudiment of hospital training giving large doses of Ergot early in labour, with consequent tetanic uterine contractions and exhaustion of the patient. One dai, it was said, attempted to repair a patient's perineum having seen the operation performed in a hospital. But having used a dirty needle and thread, without any attempt at sterilization, the patient developed septicaemia. Improvement, p.72.
necessary in the light of complaints that some practising dhais evaded or disregarded all precepts and even refused to attend classes. This was said to discourage other dhais from better practice. It was pointed out that in August 1921, a Bill had been passed by the Burmese legislature for training and registration of midwives in Burma. It was suggested that registration should be optional not compulsory.

A plethora of training bodies

There was a scheme in Bengal by which private medical practitioners who trained dhais received a government subsidy. There were training centres in 36 places, but as the Dufferin Fund pointed out, such training was bound to be weak on the practical side as the teacher witnessed few actual deliveries.153 In the meantime, Health Visitors and Maternity Supervisors, similar to the officials who functioned in England since the Maternity and Child Welfare Act of 1918, were appointed by the Lady Chelmsford League for Maternity and Child Welfare.154 Of the three options of training by medical men and women, by Health Visitors and in Hospitals, the second was said by the members of the Fund to be the most practicable and was,

153Dufferin Fund, 1926.

154To note the remarkable parallels between policies for maternity health and child welfare supervision as they evolved in Britain and in colonial India, see Jane Lewis, The Politics of Motherhood, London, 1980. For India, see the Reports of the Lady Chelmsford League for Maternity and Child Welfare, 1920-1930. In 1931, under the impact of the depression, both the League and the Victoria Memorial Scholarships Fund were amalgamated with the Indian Red Cross Society and the Maternity and Child Welfare Bureau was opened, under the directorship of Dr Ruth Young.
in fact, the most promising part of the Health Visitor's work. Training Schools for Health Workers were established in different cities, including the Bengal Health School in Calcutta. The training of dhais was considered the most important part of the Health Visitor's work. All but the Madras Health School included training of dhais in the curriculum.155)

The propaganda work regarded as central to the purpose of the Dufferin Fund was handed over to the Lady Chelmsford League, with the Fund contributing a fixed sum for this purpose. (The Health Visitors passing out of the Health Schools had received special instruction in the training of dhais and the establishment of classes was one of their first activities. The advantages were described as mutual, since getting in touch with the local dhais greatly facilitated the work of the Health Visitor and made it much easier for her to visit homes and be welcomed, under the dhai's influence. She was able to give practical instruction to dhais and to supervise their work. 'If, however, she makes enemies of the dais, her work is hampered in all directions.'156) The bulk of the expenditure of the Lady Chelmsford League was on running Health Schools and on propaganda. They were criticised for being very costly and drawing very few students. The response was that it was

155. The Lady Chelmsford League, Annual Report, 1929, pp.108-112. See also the Report of the Conference of the Lady Chelmsford League for Maternity and Child Welfare, Delhi, 1927, especially two papers by Dr Alice Headwards of Calcutta, 'The Health Visitor and her Work' (pp.79-81) and 'Ante-natal Work' (pp.101-103).

156. Dufferin Fund, 1925, p.66.
impossible to train large numbers and the poor previous education of candidates made it even more difficult. In Bengal there was a School for Welfare Workers, apart from welfare centres in mills and the two Baby Clinics.

The nationalist position
In 1922, the VMSF declared that the gratifying success it had met should silence those who said the Fund should train only an educated class of midwives.\textsuperscript{157} This was quite clearly addressed to the nationalist medical lobby, which was beginning to gain influence in the Calcutta Corporation and in the District Boards. Sir Nil Ratan Sarkar, the eminent surgeon, observed in 1923 that there were at the time only 3,000 'rational practitioners' in the country, out of a total of about 50,000 practitioners of the healing art, including dhais and Chamains.\textsuperscript{158} He clearly refused to countenance the blurring of the distinction between 'rational' and 'irrational' practitioners, which ruled out the question of training and, thus drawing any of the latter into the medical penumbra.

The nationalist response to the adverse comments by European doctors and other observers about the traditional management of

\textsuperscript{157}VMSF, 1922, p.1.

\textsuperscript{158}Sir Nilratan Sircar, 'Medical education and Research Work in India', Calcutta Medical Journal, XVII:12, June 1923, pp.260-261. He was himself a towering figure in nationalist medical politics and founder of the Indian Medical Association.
childbirth had been twofold: one, to decry the customs as "corruptions" of the original methods, and, second, to embark on projects for training educated midwives. Articles on the skills of ancient Hindu midwives were published in journals like Bangalakshmi, the organ of the Saroj Nalini Dutt Memorial Association, and the Journal of the Indian Medical Association.\textsuperscript{159}

From the 1920s, a number of institutions engaged in the work of training educated midwives drawn from the higher castes. Notable among them were the Chittaranjan Seva Sadan, the Anti-Malarial Cooperative Society and the Saroj Nalini Dutt Memorial Association. The last two also organised the training of dhais, though not necessarily of the 'indigenous' (which was how the low-caste women were referred to). Several of the local boards established under the Montague-Chelmsford reforms supported such schemes, while the Government of Bengal provided subsidies and dhai 'kits'.\textsuperscript{160} The Saroj Nalini Association was proud of having trained Charushila Devi, herself a Brahmin woman, who served as midwife to several low-caste women in her own home.\textsuperscript{161} Dagmar Engels sees the efforts

\textsuperscript{159}Western-style Bengali doctors like Kedarnath Das read ancient texts in Sanskrit to re-discover medical knowledge. Das was the author of A History of the Obstetric Forceps, Calcutta, 1929.


\textsuperscript{161}Gurusaday Dutt, Woman of India: Being the Life of Saroj Nalini (Founder of the Women's Institute Movement in India), London, 1929, p.139.
of the Saroj Nalini Dutt Memorial Association succeeding where the Dufferin Fund had failed because 'the movement was basically democratic and lacked the patronising undertone of colonial baby-shows or the Dufferin Fund.' It is questionable whether an organisation like the S.N.D.M.A. was able to transcend the barriers of caste and class to the extent suggested, but there is no doubt that, with the reform of midwifery included as part of the wider nationalist agenda the training of a superior class of nurses and midwives became a wider endeavour than ever before. On the other hand, the training of the indigenous or 'desi' dhais was more closely associated with state or European effort. The training of dhais shifted during the interwar years from being the responsibility of Health Officers, Sub-Assistant Surgeons and Midwife Supervisors. It was carried out increasingly at the training centres attached to hospitals and maternity homes.

The issue of registration
Midwives trained at the larger hospitals in the Presidency were being employed in increasing numbers by District Boards and Corporations. This became a contentious issue, with European doctors saying less qualified or inadequately trained women were

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being given jobs, thus negating the efforts of years. In 1937, the V M S F reported:

The position is a curious one. Voluntary bodies aided and abetted by Government departments are actively training dais who have neither status nor recognition and who are not brought in any way under the limited supervision and control extended to midwives registered under the Registration Acts of most provinces. (Non-registration of the dai is a serious handicap to any effort to raise the standard of midwifery practice because without registration there can be little supervision and control and no penalties for negligence and malpraxis.)

The Dacca Maternity and Child Welfare Trust reported that 19 out of 46 indigenous dhais on the Municipal Register were undergoing training at the centre and nearly 95 per cent of the 725 staff cases were taken up at the instance of the dais. The Calcutta Corporation had undertaken maternity and child welfare work since 1909. The work received considerable impetus when C.R.Das was the Mayor. How insignificant in terms of numbers all these efforts really were, however, is indicated by the fact that in 1941, Bengal had only 633 trained midwives compared to 2,263 in Punjab and 2,635 in Bombay.

The Corporation scheme

The strategy of attempting to provide trained domiciliary midwives, backed by a chain of subsidised maternity homes, was pursued by the

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165Chittaranjan Seva Sadan, Annual Report, 1925, p.1. Also see Calcutta Corporation, Reports of the Municipal Administration and the Health Officer's Report for various years.

Corporation of Calcutta, since the appointment of the first Lady Health Visitor in 1916. Despite the initial resistance from a wary public and hostility from indigenous dhais, the Corporation seems to have been fairly successful in its efforts. In 1922, the Corporation staff handled 3,917 maternity cases, more than a fifth of the babies born in Calcutta. There were only five maternal deaths. This was, said the Health Officer of Calcutta, a remarkable record for four Lady Health Visitors and sixteen midwives, 'specially in view of the fact that most of the cases were delivered on 'kutcha' floors of bustee huts under the most appalling sanitary conditions'. The growing popularity of the Corporation's services was strongly resented by the practising dhais, as most of the cases cited in the Reports illustrate. There was also a suspicion, however, that high fees would be charged. In 1924, the Lady Health Visitor who attended on the 'wife of Sukhoo, conservancy cart driver, at Budge Budge Road' reported that the women of the house were 'very insulting and abusive to nurse and told the men why did you call the Corporation nurse and memshaheb, as they will only take money from us.'

Both mother and baby were visited daily for ten days after birth and the baby was kept under observation for three months. It was not that the midwives were always welcome. The 'typical cases'

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168 Health Officer's Report, 1924, p.38.
169 Health Officer's Report, 1921.
from Circle IV (with headquarters in Mominpore) all describe miraculous interventions by the trained midwives. For instance:

**Protracted Labour**: A primipara had been in labour for three days. There were two country Dhais in attendance and when the midwife went, they told her that her services were not required. The head was showing and they told her that the patient would be delivered immediately. This was at 4 a.m. The house people also turned the midwife out. Then they called again at 2 p.m. and said the patient had not been delivered yet. Nurse went and found the vulva lacerated and swollen and the child's scalp torn by the "Desi Dai". Patient very weak and exhausted. Advised to remove her to hospital, seeing her in such a conditions, which they refuse. The midwife had to give enema, quinine, etc. and delivered the asphyxiated baby. It took her some time to revive the baby. She had to attend the patient for a fortnight and eventually got her well.\(^{170}\)

Seven maternity centres were established over the 1920s, and they seem to have been full to capacity from their establishment.\(^{171}\)

However, Dr Margaret Neale-Edwards pointed out that the relatively high incidence of post-partum haemorrhage suggested that the Corporation's midwives attempted to hasten the third stage of labour. There was, she said, suggestive evidence that the gross overcrowding in some of the institutions during the 'rush' months of the year and the fact that some of the midwives took a larger number (an average of twenty-five per month) of cases than they

\(^{170}\)Health Officer's report, 1923, p.39.

\(^{171}\)Health Officer's Report, 1928, pp.32-34.
could deal with. By 1937, it was reported that there was a very insistent demand for maternity homes among the middle class.

Training Indian nurses: Corporation politics

Very small numbers of European and Eurasian nurses had been trained at the Hospital Nurses' Institution since 1859, to attend on patients at the Medical College and Presidency General Hospitals. Florence Nightingale was requested, in 1865, by the Sanitary Commission for Bengal to suggest a scheme for organizing nursing by women in Indian Hospitals. She suggested a covenanted service which 'need not exclude recruitment in India, especially for the ranks...such persons as might be very useful from their knowledge of the native languages and of local circumstances.' If the experiment was to be tried in only one hospital, Nightingale suggested it should be in Calcutta, which would 'carry with it public opinion everywhere.' Nightingale identified the two principal functions of nursing as 'nursing the room' and 'assisting

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172 Margaret Neale-Edwards, *Maternal Mortality in Calcutta*, Calcutta, 1938, p.13. In a personal interview on 16 April 1995, Dr Neale-Edwards expressed doubts about the quality of nursing and clinical practice that had been available both at the Chittaranjan Seva Sadan and at the National Medical College during her tenure in Calcutta, but refused to make any overtly political statement in this connection.

173 JIMA, VI:8, p.480.

the doctor'. Nurses, on no account, were to attempt diagnosis or otherwise encroach on medical territory.  

In the Campbell Hospital, coolies and dhais were engaged to attend on male and female patients respectively. In 1912, Lady Carmichael, the wife of the Governor of Bengal, instituted a committee to inquire into 'the question of Indian nurses'. A letter was circulated among 'eminent natives', which specified that the enquiry did not refer to dhais, who were 'drawn from a somewhat low caste of women; and of [whom] there [was] no scarcity.'  

'Unfortunately,' continued the letter,  

the name of nurse has been applied to dhais, so that now when one talks of a nurse, the Indian mind immediately forms that concept of a dhai.  

The nurse, it was spelt out, was a lady trained in looking after sick people. Her Excellency wished to raise the 'status and position' of the nurse to alleviate suffering among the purdah Indian women. The circular included five questions:

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176 IOL/MSS Eur.F 165/155 (Sorabji Collection). Circular letter from Secretary, Dufferin Fund, Bengal Branch.

177 The letter was sent to Dr Sir Guru Das Banarji, Rai Hariram Goenka Bahadur, Hon’ble Babu Hrishikesh Laha, Babu Motilal Ghosh (of the Amrita Bazaar Patrika), Mahamahopadhyaya Satis Chandra Bidyabhusan, Principal of the Sanskrit College, Ray Yatindranath Chaudhuri of Baranagar, Raja Gopendra Krishna Deb, Sovabazar, Mahamahopadhyaya Haraprasad Shastri, Babu Lalit Mohan Singha Ray of Chakdighi, Raja Pyari Mohan Mukharji and Dr Nil Ratan Sircar.
1. Is it true that no nurse, except one of high caste, may give water or food or liquid medicines to a high-caste Hindu lady?

2. Is it not true that the class of orthodox Hindu lady, who used to nurse in the zenanas of the older generation, and who were nurses by instinct, is dying out, and that there is needless waste of life because caste people cannot avail themselves of such trained non-caste nurses as alone exist at present?

3. Is it not true that there is no objection to Hindu caste lady undergoing the necessary training and doing all the work of a nurse (note not dhai), except those duties which now fall to the menials who help the high caste lady of an Hindu household when she nurses her own relatives?

4. Our aim is not to go outside the highest castes in our search for nurses, including none below Baidyas and Kaisths and other castes from whom Brahmins may take food and water. Do you approve of this?

5. If a prejudice, fostered by the low class of women hitherto associated with nursing does exist, what suggestions have you to make so that the status and position of nurses, as exists at present, can be improved to allow of a better class of women taking up the profession?

Sir Nil Ratan Sircar, in his response, deprecated the emphasis on caste. Although Bengali ladies were very particular about respectability, they would not, he felt, reject a lady doctor or nurse because of caste and creed. In Bengal, he said, the 'strict and exclusive orthodoxy of old days' was breaking down, both in ideas and practice. He had very often found attendants of different castes, admitted into orthodox family circles for the purposes of nursing. Further, the rules of orthodoxy were considerably relaxed during illness, and this he said was in accordance with the injunctions of the shastras:
In my humble opinion, therefore the restriction is unnecessary and may prove even mischievous, by setting a premium upon exploded ideas and injurious social institutions. Further the scheme may be impracticable on account of this restriction.

The scheme does not appear to have got off the ground. There was a small number of nursing sisters whose services were made available by such organisations as the Lady Minto's Indian Nursing Association, established in 1906. While the majority of patients who engaged their nurses were European, it also served Indians who wished to avail of their services and could afford to, but these were very few in number.\(^{178}\)

The number of nurses grew slowly and there was no public examination until 1923, when the State Medical Faculty began to examine nurses and midwives. Dr Sundari Mohan Das, who was active in nationalist politics and founded the National Medical Institution, became the Chairman of the Public Health Committee of the Calcutta Corporation. His own wife, Hemangini Devi, attended Dr. Charles's class for pupil midwives and later taught and practised midwifery in Sylhet as part of the new political movement to make the science respectable.\(^{179}\) The issue of race was repeated brought up in connection with the training of Indian

\(^{178}\) A Minto nurse received a salary of Rs 110 a month (with an annual increment of Rs10) plus a uniform allowance of Rs 100 per annum and Re 1 for each day actually employed, as well as free board and lodging. See the memoirs of a Minto Association Nurse, Emma Wilson, Gone With the Raj, Norfolk, 1974, p.85.

\(^{179}\) Hemangini Sen'in Bangalakshmi, 1928, p.615-618; Dr.Sundari Mohan Das, 'Amar dhatrividyar prati anurager karan'in Bangalakshmi, 1929, p.636.
nurses. In the Corporation, at the Campbell Hospital and at the Red Cross Society, Anglo-Indian nurse-midwives received higher salaries than Indians.\textsuperscript{180} Questions regarding the terms of these appointments were raised in the new Council established under the Montague-Chelmsford Reforms.\textsuperscript{181} The conduct of nurses was also a matter of controversy, with questions being asked, for example, about the alleged ill-treatment of poor patients.\textsuperscript{182} Dr Das discovered in 1925 that there was no arrangement at the Hospital Nurses' Institution for the training of Indian nurses, as the authorities expressed doubt as to getting 'ladies of the desirable class'.

The Calcutta Hospital Nurses' Institution received an annual subsidy of Rs23,000 from the Calcutta Corporation. Subsequent to the change in its political colour, the Corporation reduced the grant by Rs.5,000 in 1925. The amount was to be used instead for the training of Indian nurses. However, the amount was restored in 1926 under pressure from European corporators. The Corporation attached a condition to their grants to the Hospital Nurses

\textsuperscript{180}Sundari Mohan Das, Presidential Address at the Bengal Provincial Medical Conference, in JIMA, VIII:3, December 1937, pp.168-169.

\textsuperscript{181}WBSA/GOB, Local Self-Government Department: Medical Branch, File Q-7, Proceedings A75-76, April 1921.

\textsuperscript{182}WBSA/GOB, Local Self-Government Department: Medical Branch, File Q-40, Proceedings A32-33, July 1921; also File Q-20, Proceedings A42-43, July 1921.
Institution that a certain number of Indian nurses be trained, allotted some funds for the training of Indian nurses, and subsidised a class for midwives and obstetric nurses at the Buldeodas Maternity Hospital. The latter institution provided suitable opportunity for practical training. The Chittaranjan Seva Sadan and the Carmichael College Hospital both introduced courses in nursing and 'respectable Hindu widows' were said to have joined. Since the Corporation had declared itself on the side of the trained nurse-midwife, it was not interested in supporting schemes to train indigenous dhais. It formulated a scheme for Indian nurses' training, limiting the period of training to two years instead of three as prescribed by the State Medical Faculty of Bengal. The Calcutta Hospital Nurses' Training Institute questioned the efficacy of the scheme and asserted that women of the 'desirable' type would not be available. The JIMA reported triumphantly in 1932 that both apprehensions had been belied: the

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183 Rajat Ray, Urban Roots of Indian Nationalism, New Delhi, 1979, pp.112-113.

184 In 1932, the Maternity Home was reported to have over 1,500 maternity cases a year. Statement by Dr. B.C. Ghosh at the VIII All-India Medical Conference, Calcutta, see Proceedings in JIMA, I:8, 1932, p.347. Also see Editorial in JIMA, III:3, November 1933, p.119.


186 Alice M. Headwards, 'A Plea for the Mothers and Children in the Country', paper communicated to the Scientific Section of the Fifth All-India Medical Conference, Calcutta, 1928, in The Indian Medical World, II:1, 1931, p.21.
seats for the Corporation's course at the Chittaranjan Seva Sadan and at the Buldeodas Maternity Home were full and a large number of 'respectable' candidates were in the waiting-list.\footnote{187}

At a Conference in February 1927, Dr Alice Headwards had complained that the Corporation of Calcutta had lately opened 'Milk Kitchens and Child Welfare Centres' and were employing Indian nurses without any special welfare training. This, said Dr Headwards, was detrimental to the cause of training for welfare workers. She called for all welfare work to be established under one controlling head with certain definite rules of employment. She justified the training being conducted in English only because of the paucity of Bengali candidates.\footnote{188} Another grievance voiced by Dr Headwards was the employment by the Corporation of medical women as Health Officers. She was not in favour of the appointment of anyone without qualifications in welfare work, which she saw as a specialisation in preventive rather than curative medicine.\footnote{189}

\footnotesize{\textsuperscript{187}JIMA, I:5, January 1932, p.203.}

\footnotesize{\textsuperscript{188}Alice Headwards, 'The Health Visitor and Her Work', paper read at the Conference of the Lady Chelmsford All-India League for Maternity and Child Welfare held in Delhi, 4th - 8th February 1927. Report of the Conference, pp.79-81.}

\footnotesize{\textsuperscript{189}See comments by Dr Alice Headwards in Discussion on Organisation of Child Welfare Work in Proceedings of the Seventh Congress of the Far Eastern Association for Tropical Medicine held in Calcutta in December 1927, p.857. Also see paper by Alice Headwards, 'Some Suggestions for the Further Development of Child Welfare Work in Bengal', pp.842-843.}
The Bengal Nurses' and Midwives' Act

This was the time when the agitation for the various registration acts was gathering pace. The Bengal Medical Act had already been passed in 1914, to eliminate sub-standard practitioners. The professional interests of the 'official' nurses and midwives were seen to be increasingly threatened by engaging of 'underqualified' nurse-midwives and this led to the introduction of the Bengal Nurses' Bill of 1933. A Bengal Nursing Council was to be appointed, and this Council was to maintain registers of registered nurses, registered midwives, registered Health Visitors.

The Journal of the Indian Medical Association was edited by Dr B.C. Roy, who was prominent in Corporation politics at the time. In an Editorial, the journal was critical of the bill on several grounds, but mainly on account of doing little to encourage the adoption of nursing as a profession by Indian women. It also criticised the inclusion of Health Visitors under the purview of the Bill, suggesting instead that women medical licentiates could be permitted to practice as Health Visitors. The underlying purpose of the Bill, concluded the JIMA, was as with the Indian Medical Council Bill; which seemed to be to benefit Europeans who came to India rather than to promote the well-being of Indian and Anglo-Indian nurses.

190 Poonam Bala, Imperialism and Medicine in Bengal, Delhi, 1991, pp.85-86.
191 Rajat Ray, op.cit., describes his role, (passim).
At the present time, almost all the nurses in India are European or Anglo-Indian women. Few of them, owing to their environment and education, can bring themselves to understand the mentality of Indian patients. A few may do so, but it requires a great effort on their part; there is not that spontaneity which exists between them and patients of their own kind. Among Indians, nursing has a different tradition and few Indian women of the right type care to take up professional nursing, but that tradition is fast disappearing, more and more Indian women of respectable family and adequate education, through pressure of economic if nothing else, are willing to become professional nurses, but it cannot be said any great encouragement has been given to them.

...Indian patients who are in an overwhelming majority call for nurses of their own manner of life and feeling, and one would have thought the Bill would have sought this end.

Nor again do we cavil at the reciprocity clause, though we cannot see how it is going to benefit more than an infinitesimal number of nurses trained in this province and can only be of material benefit to nurses who come ... from England. ...the constitution of the Council [reveals] how well it is designed to maintain the status quo and relegate any effective encouragement of Indian nurses to a remote date. Out of seventeen members no less than ten are ex-officio including a President appointed by Government, the Director of Public Health and the heads of various Government hospitals. ...Those who are most concerned, namely, the Nurses, Midwives and Health Visitors and the training institutions other than the Government hospitals are relegated to an insignificant minority.\textsuperscript{192}

On the other hand, Dr Jean Orkney of the All India Institute of Hygiene and Public Health, Calcutta, commenting on the Act after it was passed, said the most serious defect in the bill was the omission of any reference to the indigenous \textit{dhái}.\textsuperscript{193} The bulk of

\textsuperscript{192}JIMA. III:3, Nov.1933,pp.119-120.

\textsuperscript{193}Jean Orkney, Director of the Maternity and Child Welfare Section of the All India Institute of Hygiene and Public Health, Calcutta, "The Bengal NUrses' Act, 1934", in The Journal of the Association of the Medical Women in India, XXIII:3, August 1935, p.40.
the midwifery was done and was likely to be done by her for many years to come, simply because the training institutions for nurses were few and the number of candidates for registration strictly limited and totally inadequate to supply the needs of Bengal. Financially, it was not possible for rural areas to employ midwives or for private midwives to make a living wage in private practice in the villages. Since the dhai was so vital a unit in public health, said Dr Orkney, it was surely worthwhile to try to improve her methods, and the first step towards that was registration. She suggested an annual license should be granted to registered dhais.

Dr Orkney pointed out that most of the dhais were shrewd enough to realise that attempts were being made to establish medical control over them. They saw no advantage in being trained. She admitted, nearly a decade later, ruefully that legislation providing for the prohibition of unregistered practice was impossible. The replacement of the indigenous dhai was impossible because of the lack of training facilities for midwives, the scanty economic facilities of local bodies, the scanty economic means of families that hired dhais' services and the difficulties of transport and communications in rural India. Concurrently with the replacement policy, voluntary or official agencies were actively training dhais in most provinces in India. Since the health and life of a large proportion of the women and children in India lay in the hands of the indigenous dhai and would continue to rest there for many years
to come, it was necessary to adopt towards her a more definite and consistent policy.

Persuasion and bribery have failed to bring the dai under control and if progress is to be made some measure of compulsion is desirable. Legislation providing for the prohibition of untrained or unregistered practice after a definite period of time is one method of compulsion by which the objective can be reached. Prohibition of unregistered practice is necessarily impossible until sufficient workers to provide attendance for every mother at confinement are registered. The first step therefore is to register or list the names of all practising dais.\footnote{Jean Orkney, 'Legislation and the indigenous dai' in the JAMWI, XXXI:4, November 1943, pp.114-117.}

Orkney suggested an annual license should be granted to registered dais.

In order to bolster the Act, the Committee for the Revision of Ethical Rules in Force in Bengal recommended in 1935 that 'association with uncertified women practising as midwives' be considered a form of ethical misconduct.\footnote{Recommendations of the Committee of the Revision of Ethical Rules in Force in Bengal, Item no.7, in JIMA, IV:9, pp.412-413.} The suggestion that dhaïs be included under the purview of the Bengal Nurses Act had another aspect. There was nothing to prevent a nurse or midwife who was struck off the register for malpractice from continuing to ply her trade, as long as dhaïs were not governed by the legislation. On the other hand, it was reported that there were a number of midwives in Bengal who had received excellent practical training though their general level of education was insufficient to enable them to pass the State Faculty Examination. Some of them...
were working in government dispensaries and would lose their jobs with the coming into force of the Nurses and Midwives Act in February 1936. It was suggested, by the Secretary of the Eastern Division of the non-governmental Association for the Medical Women in India that they be registered as dhais. \(^\text{196}\)

The Bhore Committee Report of 1946, which was to influence health policy in independent India, also spoke of the need to use trained 'dai' as an interim measure until better attendance could be provided for all women. \(^\text{197}\) It said the 'dai' as hereditary midwife had her recognised place in the Indian home throughout the country - she could prove a valuable agent to spread modern midwifery if trained but her hostility towards health authorities led to a feeling of insecurity and scepticism towards such attempts. Such hostility was known to decline once women of 'dai' families received training as midwives.

The Special Report of the Victoria Memorial Fund had observed in 1918:

> Even where a woman doctor is supposed to be in charge of a case, it is not unusual to find a dai also being consulted, and in the intervals of the doctor's visits, applying her own methods of treatment, the evil effects of which are usually later attributed to the western methods of the unfortunate medical woman! \(^\text{198}\)


\(^{197}\) Bhore Report, p.164.

\(^{198}\) Improvement, p.71.
Ultimately, much depended on the creation of a widespread demand for skilled attendance among the classes that could afford it. For this, it was important that the patients' families did not regard dhais and doctors are cut from the same cloth, in which case the additional expense associated with medical attendance would not seem worthwhile. It was demeaning, felt medical women, to be confused with the very class of birth attendant they hoped to replace.