CHAPTER-6

DISCIPLINING THE DAIS: COLONIAL ‘DE’CONSTRUCTION OF INDIGENOUS BIRTH METHODS

During the early phase of western medicine in colonial Punjab the indigenous system of midwifery was under strain. Exposed by western travellers and women missionaries a critical overview of the cultural and social practices emerged. Their agenda was based on rejection and reform of what they saw of the obstetrics methods. The central figure that was identified with the Indian practice of childbirth was the dai. Attempts were made to replace her with professional nurses and ‘certified’ dais. The issue of midwifery was not only undertaken by the women missionaries as an activity for social reform but was also intervened by the State in the complex process of cultural imperialism. While confronting the indigenous methods, the British government was placing the indigenous medical systems as its subordinates.

While studying western medicine, scholars share conceptualised relation between the indigenous medical system, gender and nation. Acceptance towards reform of Indian obstetrics was not a one-sided affair but had indigenous supporters. On this view David Arnold asserts that just as in Bengal, Punjab too saw the physical management in childbirth change as a result of increasing influence of western medicalisation and so, too, were wider perceptions of women and
reproduction.\textsuperscript{1} There is an assumption on part of some scholars that western intervention in childbirth method divided society into class and redefined religious boundaries. Anshu Malhotra states the issue of reproduction was bound with the perception of the new middle class of Punjabi who alienated those who provided them with customary services including the \textit{dai}.\textsuperscript{2}

Certainly, the colonial state played an important role to professionalize reproductive methods. As pointed by Sujata Mukherjee population reproduction and disease are central to economic processes and are therefore subject to political control.\textsuperscript{3}

In the light of the general observations made above, this chapter shall examine the initiatives undertaken by the State and missionaries to control and train the indigenous \textit{dais}. Focusing on how reality was perceived, it seeks to explore on the hegemony of western medicine in the Indian society. Within this process there was confrontation and acceptance of colonial medicine. This movement hence had multiple voices within it. The urge to reform indigenous traditional childbirth methods reflected a struggle between the colonised society and the coloniser. Consequently, the process redefined the status of both.

\begin{thebibliography}{9}
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**Confronting Birth Practices**

To assess the significance of western medical intervention in childbirth in India, it is important to study the nature of traditional medical practices of birth in Punjab. After all, birth is a natural event proceeding in a cultural setting. And as such this part of the chapter would identify the cultural backdrop encompassing the various traditions and customs of birth represented in each community.

At the beginning of the colonial rule a variety of indigenous practices such as Ayurveda, Unani and folk were meeting the medical needs of the Indian women. Both the Hindus and the Muslims had cordial understanding in the field of medicine. Although the seclusion of women from direct medical treatment contributed even after the coming of western medicine in India, yet it does appear that Ayurvedic physicians did examine Muslim women. This has been so observed by John Marshall.

The Hindoo physicians being not permitted to see any of the moores women, so that when they are sick and desire their assistance, they cause them to take a handkerchief and rub all over the body so that it be well wet or moistened with the body or dirtied.
therewith. The handkerchief then the physician puts, into a basin of fair water and steeps it, and by the smell of water knows the distemper.......4

Along with Ayurveda predominant popularity of Unani medicine has so been observed. It was practiced by Muslims, Sikhs and Hindus of Punjab. 'Ayurveda, so little known and practiced in Punjab when the unani system seems to have supplanted it altogether'.5 Women's health treatment was more so exposed with aspect to child birth methods. Medical literature on colonial times talk about the seclusion of indigenous women from direct treatment. Such discourses laid a backdrop for imperial medicine to move. Clearly targeting the indigenous women as passive victims, anecdotes about their lack of medical access seemed to direct towards the 'other' culture in a disparate society. It all came down to the belief that Indian women were 'too backward' to help themselves and any improvement in childbirth would be delivered by the English women. And it was the women missionaries who first drew attention to what seemed to them as appalling customs and beliefs surrounding childbirth.

The gynecological needs were met by the local dai or midwife. Clearly targeted on her credibility, the dai was an integral part of childbirth. Back in England, similar pictures of their women midwifery were drawn. A 'non-professional' midwife

5 The Tribune, Lahore, Nov. 10, 1833, p.7.
dominated the scene, she learnt her work by becoming apprenticed to an older experienced midwife.\(^6\) Professionalisation finally entered into medical field with the coming of male counterparts in the mid-18\(^{th}\) century. Yet, it was seen that the unprofessional women midwives were far more numerous than men midwives in Britain.\(^7\) Dominance of the indigenous practices in India by untrained *dais*, hence should not have come as a shocking revelation to the advocates of colonial medical facilities yet it was reinterpreted to make space for the dissemination of ‘scientific’ health methods.

Our knowledge of the practice of the midwife is pulled from the obstetrical cases mentioned in various histories. They were mentioned in close context with quackery. Since birth was seen as an unclean event, no high caste vaid or hakim was likely to interfere in the event. Instead, childbirth together with most gynecological ailments, seemed to have belonged to the domain of superstitious remedy. A number of instances on the situation were highlighted. It was a part of the colonial quest to construct the knowledge of the subjected. Attention was given to every aspect of the indigenous obstetrics systems that gave a clear distinction between Indian and colonial perspectives. The former considered childbirth an impure process and the demotic healing traditions of India also believed that the women after childbirth became impure. Any other who came to see her must wash her hands in cow’s urine to purify them before doing any household


Since the scene of delivery was considered a lowly task, the *dai* herself was seldom from a high caste. The Indian *dai* in the Punjab was a Muhammadan widow, usually and her trade was hereditary. There are references of Hindu *dai* who too belonged to the low caste. Among the Bagri jats, the midwife was usually a Thori, Chuhra or Dhanak woman.

Before studying the role of the *dai* as an indigenous practitioner, it is of significance to study the historical setting where she worked. Different cultural practices were observed in the ‘native’ society. Along with customs and religion, the domain of childbirth worked with the notions of ‘dirt’. The association of the low caste *dai* with filth promoted the training of high caste women in midwifery. In this context, Anshu Malhotra quotes the work of Mahindra Kaur, having not belonging to the traditional class of *dais*, argued her ‘high caste status helped to keep the woman free of germs’.

Thus, an exposure to native uncleanliness became the spring board on which western medicine moved ahead. To ‘colonise’ women it was essential to colonise the factors that empowered their bodies, and ‘dirt’ that especially worked in congruence with the *dai*, was one of them. Despite the fact that hygiene was the main subject of colonial childbirth practice, yet it seems that the *dai* was unable to adopt it even long after the introduction of western medicine. The conditions of childbirth in

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9 Ibid., p. 57.
10 Ibid., p. 58.
Punjab were as watched as in other parts of India, wrote Balfour, “It was almost worse in the one or two cases where an outfit and a bag possessed..... .... The articles had no doubt been many times deposited and taken up from the dirty mud floor with unwashed hands, and the idea of sterilization had never entered the owner's head’.12 The role of the dai can be pieced together with the somewhat negative evidence provided in medical literature. What also came in for further criticism was the expertise she displayed in her multi-task performance.

Among others, her work also included cutting the umbilical cord and burying the placenta. Along with it, she performed the traditional ceremonies concerned with pre and post birth care. 'A little before birth some mash and salt are sacrificed over the head of girl by the dhai. The dhai then cuts the maru (navelstring) at a distance of 3 or 4 inches from the navel and is given a rupee for the operation.' 13

The dai combined this with other occupations but her payments were not according to any sort of professional scale. R.J. Blackman states on their deplorable condition ‘.....she has all the valour of ignorance and is out to earn a living according to her lights, moreover, she is very badly paid. The dai fee includes attendance not only during labour but also for ten days afterwards,.........'.14 But a dai would generally receive more for delivering a son than a daughter, fee would then include kind

12 Margaret Balfour and Ruth Young., The Work of Medical Women in India (London : Oxford University Press 1929,p.164)
13 Punjab District Gazetteer Gurdaspur District, 1914, p.38.
and cash. 'After the child is born the midwife and the messengers are rewarded on a customary scale.... There is general rejoicing in a house when a son is born, numbers of congratulations are offered and little presents brought which is the perquisite of the midwife (dai).'

Besides the presence of dai in the scenario of childbirth, it became a matter of concern for the whole community including a large number of friends, and family members to be present. A general feeling of curiosity relating to issues of childbirth always remained. A woman, as observed, goes to her father's house for her first confinement (a ritual seen even today in many parts of Punjab). After confinement the woman is secluded for three days. only. The seclusion included a closed inner room of the house, which was very inadequately ventilated. Some member of the family always remained with the mother until a period of at least thirteen days after delivery had elapsed.

Another source of concern was the superstition relating to pregnancy which was easily dismissed as indigenous belief and custom. The time of childbirth was considered as a time when both mother and daughter were possessed by a devil and as such any disease occurring them was attributed to possession of devils. In the Hindu household, the dai tied a branch of the 'sins' tree and an iron ring over the door to notify the birth and also to keep away evil spirits. Such literature indicated the irrationality that was exercised during childbirth that further

15 Panjab District Gazetteer, Ludhiana District 1904, p. 47.
16 Ibid p. 46.
17 Panjab District Gazetteer Amritsar District 1914, p. 28.
18 Panjab District Gazetteer Ludhiana District, 1904, p. 46.
explained why there was little incentive for professionalism to creep into midwifery and for the dai to upgrade her skills. It was not only the new scientific rhetoric that emphasised on the reform of indigenous medical practices, an echo of it was even found in some indigenous voices. Bhai Mohan Singh Vaid, an ayurveda doctor who worked in Punjab during the late 19th and early years of the 20th century too complained against the dai. About her, he writes, ‘she is given a dirty coverlet and filthy clothes ...... She undertakes to do all her work in these dirty clothes as a result of which the mother-to-be catches germs of various diseases from these clothes and she falls ill...’ 19

Further he throws light on the adversities of purdah on the health of women.

Take another one from the dai! When the dai enters, she removes her clean clothes and wears dirty, torn clothes and comes near the pregnant woman. She performs all her duties wearing those filthy clothes. As a result of this, germs and infection can pass to the mother and the newly born baby, as they are vulnerable at that moment.” Mohan Singh Vaid, Sade Ghar Ate Istrian di Arogta (Amritsari Wazir Hind Press, 1919. pp.10-11.)
On the same lines Bhai Gurdit Singh, too, drew attention for a clean and healthy *dai*.²⁰ Although from the above writings it is not clear whether the vaid wanted to replace the *dai* or not, a suggestion that both the missionaries and the colonial government were willing to take up. But it was apparent that the traditional *dai* was under attack so as to reduce the power she exhibited on the society. Such a step would ensure the colonial state to take over the function of midwifery and exercise its influence on the women of India.

**Cause of Attention: Mortality among Women and Children**

The primary concern of the colonial government in its early years was the health of European women and children in India. The intensity of the tropical climate was held responsible for sickness among them. Not only that, it also hindered the western diffusionism in the indigenous society. As observed by Amy Carmichael, from the CEZMS, “Identification with the people whom we have come to win is the aim of many a missionary, but the difficulty always is the same, climate and customs are dead against it, how can we do it?”²¹ Although recent researchers have pointed out that Indians were far more susceptible to fall prey to their own climatic conditions, as Europeans had better

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²⁰ “She becomes congested with the veil. No fresh air is allowed within the purdah, the woman in it breathes in and out the same air. As a result this can lead to the diseases of the lungs.” Gurdit Singh, *Ghar di dai* (Amritsar n.p. 1918).

constitutional build-up because of better medical treatment provided to them. From late 19th century onwards, the focus shifted on the Indian mortality rate. Official reports carried shocking revelations.

Number of Infants dying out of every 1,000 Live-births.

Table 6.1

<table>
<thead>
<tr>
<th>Province</th>
<th>Dying under 1 year of age, mean of ten years (1891-1900)</th>
<th>Dying under 5 years</th>
<th>Rates in Famine years. Dying under 1 year</th>
<th>Ordinary urban rates Dying under 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Provinces</td>
<td>294.4</td>
<td>273.2</td>
<td>434</td>
<td>366 (1900)</td>
</tr>
<tr>
<td>Berar</td>
<td>257.7</td>
<td>244.2</td>
<td>516</td>
<td>275 (1900)</td>
</tr>
<tr>
<td>Punjab</td>
<td>231.9</td>
<td>245.9</td>
<td>397</td>
<td>268 (1900)</td>
</tr>
<tr>
<td>United Provinces</td>
<td>230.9</td>
<td>228.1</td>
<td>378</td>
<td>272 (1897)</td>
</tr>
<tr>
<td>Lower Burma</td>
<td>210.3</td>
<td>163</td>
<td>297</td>
<td>...</td>
</tr>
<tr>
<td>Assam</td>
<td>206.9</td>
<td>205.4</td>
<td>351</td>
<td>...</td>
</tr>
<tr>
<td>Bengal</td>
<td>201.6</td>
<td>183.3</td>
<td>319</td>
<td>...</td>
</tr>
<tr>
<td>Bombay</td>
<td>199.0</td>
<td>186.4</td>
<td>390</td>
<td>266 (1900)</td>
</tr>
<tr>
<td>Madras</td>
<td>1728</td>
<td>157.1</td>
<td>274</td>
<td>...</td>
</tr>
</tbody>
</table>


Official reports carried to introduce professionalisation in a non-professional indigenous medical system. Hence, it was important to expose the areas where intervention was needed the most. The debate on the reasons of poor survival rate of babies went on well into the twentieth century. At this point it came as no surprise when they stated, “The next thing we are up against is the utter ignorance and superstition of our average Indian mother, her lack of knowledge of hygiene coupled with her inherited superstitions in all matters pertaining to childbirth and the rearing of infants.” 24

British critics claimed that in India the ratio of deaths under one week to 1,000 live births is 55, that 1 out of every 18 infants born dies within 7 days of birth. Forty-four percent of infantile deaths occur during the first month and that the mortality rate at this period is 87 per 1,000 live births and was comparatively higher than the total infantile mortality rate in England. 25 Purdah system, marriage at an early age led the list. Prolonged breast-feeding too was set as the cause of the appalling infantile mortality. 26

For the British concern, a high infant mortality rate indicated carelessness and ignorance on the part of those who attended on the mothers at childbirth along with unhealthy conditions in and around homes. Administrators who emphasised poor hygiene admitted that any innovation for

26 The People, July 18, 1929, p.38.
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improving the sanitary conditions was greatly resented especially in a village. The people much prefer to live in their old insanitary surroundings. Diseases too were closely monitored to the problem. Maj. H. S. Lee, Civil Surgeon at Punjab, remarked, “There is however a disease (rare in Europe) which is prevalent in Ferozepore city and cantonment and also in Kasur. It is mollities ossium and affects the women folks of the Buniabs chiefly. It causes childbirth to be extremely difficult and in many cases is probably the cause of death of both mother and child.”

In the Census Report of 1891 it was found that the mortality amongst infants was exceedingly high due to the great prevalence of the autumnal fevers. It was further reported that mortality under the age of six months must largely be ascribed to inherited defects or defective nurture, but the spatial distribution of the districts exhibited a relatively high death rate in children over 6 months and under 1 year of age. This suggested that diseases acquired after birth, and more particularly in many cases, ‘malaria was largely responsible for the relatively high mortality in this age-group especially in the districts of Hoshiarpur and Gurdaspur’. In some official reports the relatively high birth rate attributed to the absence of a widespread epidemic. In the year 1927, a feeling of mild optimism was reflected in the report due to the ‘almost complete absence’ of epidemic malaria. Punjab showed a higher birth rate as compared to the death rate (42.27 as to 27.46 respectively)

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28 Ibid.
29 Punjab Administration Report, 1892-93, Lahore, p. 314.
30 Public Health Administration of the Punjab for the year 1927, p.10.
whilst in no other province was the excess of birth over deaths so large.\textsuperscript{31}

A marked difference was seen in the proportion of abnormal birth cases in different divisions of India. In the north with less than half the total cases, had nearly as many abnormal cases as the other divisions of India. This was only to be expected as north India was above all things conservative as regards women, and the expectant mother seldom entered a maternity hospital unless they feared an abnormal condition.\textsuperscript{32}

Women were reluctant for proper medical assistance in cases of serious illness of their children, preferring own local and hereditary remedies especially in the cases of small pox, torkhi and rakhra. This was evident not only in the rural areas but also in cities like Amritsar.\textsuperscript{33} The dominant tendency of the British administrators was to differentiate and define indigenous diseases relating to childbirth in order to enforce western medicine. The latter’s approach was not static. It moved in separate peripheries of indigenous society. The course that was adopted by the government is discussed in the following sections of the chapter.

There was a clear link between the survival of the infant and its sex. The birth-rate of females was found lower than that of males, a general trend in most districts of Punjab. It was noted that in the period 1892-1902, between the age period of 0-1 years, the female mortality was over 13.5 percent as against

\textsuperscript{31} Ibid., p.5.
\textsuperscript{33} Punjab District Gazetteers, Amritsar District, 1914, p.27.
male mortality rate of 9.7% percent. The result from inquires made in Jullundur, Ludhiana and Ferozepore district prove that among certain classes in those districts female infanticide, using the expression in the wider sense as including also mere deliberate neglect of female infants, still prevailed in lamentable extent. The proportion borne by males to females at birth is shown below:

Table 6.2

<table>
<thead>
<tr>
<th>Province</th>
<th>Males born to 100 females (Mean of 1891-1900)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Punjab</td>
<td>111.6</td>
</tr>
<tr>
<td>United Province</td>
<td>109.0</td>
</tr>
<tr>
<td>Bombay</td>
<td>108.1</td>
</tr>
<tr>
<td>Assam</td>
<td>107.7</td>
</tr>
<tr>
<td>Lower Burma</td>
<td>107.4</td>
</tr>
<tr>
<td>Berar</td>
<td>106.8</td>
</tr>
<tr>
<td>Bengal</td>
<td>106.5</td>
</tr>
<tr>
<td>Central Provinces</td>
<td>106.4</td>
</tr>
<tr>
<td>Madras</td>
<td>104.4</td>
</tr>
<tr>
<td>'Proclaimed Clans' (Infanticide Acts)</td>
<td>106.4</td>
</tr>
</tbody>
</table>

34 Punjab District Gazetteer *Jullundur District and Kapurthala State*, 1904, p. 54.
The range within each area is greatest where registration, always at its worst in regards to events affecting females, is most defective. The highest proportion of males is returned in areas where the male population outnumbers the female, and where the practice of female infanticide formerly prevailed; but in certain parts of two of the Provinces at the top of the list is notoriously defective, viz. in the Western Punjab and in Sind.37

With intense over-exposure of the health condition of the mothers and the infants, improvements in this area became the utmost priority for the state and the medical missionaries, alike. For it was strongly believed that the risks at childbirth were highly dangerous but to a large extent remediable. 38 Unfortunately, the surveillance of colonial medicine remained limited in certain areas and marginalised many indigenous practices. The issue of female infanticide was one of them.

Central to the high rate of mortality among children and mothers among other reasons, was the negligence of dais. Although there are no tabular records that give a detailed and accurate number of deaths caused by the poor and untimely treatment of the dais, yet the dais became a subject of controversy in this matter. From the start, the main factor that drove the mission and the state interest in women’s health was the maternity concern. Articles not only came from the missionary pen but indigenous journals too wrote gruesome

37 Ibid.
accounts of the treatment meted out to mothers by untrained dais. Native methods on childbirth were discredited.\textsuperscript{39}

A lady lived near my camp. I learnt that she was pregnant and she was to give birth to her child shortly. As a demand of human nature we went to her house to help her. Many other women also went there. Although it is a village but being populous, a government hospital has been opened. I advised that an expert nurse being present we should call for her. Some people present differed; some silent, one or two supported my opinion. Anyway a person was sent to bring the Christian nurse from the hospital.

\textsuperscript{39} * * *

Tehzeeb-i-Niswan, April\textsuperscript{1936}, p.348. (The journal was found in Aligarh University, while I was visiting the library with a friend of mine for her research work. I was helped in locating the particular information by her father, who helped us in translating records in the library. I was further helped by Jai Gopalji for translation and by Rubina for typing).
who came within half an hour and came happily into the house. She felt fortunate that she had been called where she had never entered before. An old orthodox woman sitting there, became furious seeing the nurse and said "Who has called this Christian woman. What job she has here? Hundreds of children were born in front of our eyes but no nurse was ever called, this child will be born as earlier children were born. We will not tolerate that her dirty hands should touch the mother and child. We won't tolerate such dishonor while alive." The nurse felt a bit taken back on hearing this and her smiling face suddenly darkened and she went back. Thereafter a dai was called. She was wearing dirty clothes and without washing her hands entered the labour room. The child was born half an hour later. The dai was not an expert in her work and made such mistakes that a woman of ordinary wisdom wouldn't commit. Cleanliness was foreign to her. The child was still born. After sometime the mother became senseless. With difficulty she uttered water but before water came she had already died. Seeing this incident, I was perturbed because in my opinion the death of the child had happened due to the ignorant and untrained dai. I had seen all the wrong committed by the dai but what would I do. Who would listen to my opinion? In that noisy atmosphere it was useless to say anything but I was very angry with the dai.

In order to improve the mortality rate, the British Government found it necessary to upgrade the standard of midwifery practice. And since the dai was the only accessible medical authority for the indigenous women, many a steps were made in training these traditional birth attendants and teaching them the basic of hygiene and recognition of dangerous systems.

Training of dai : Missionary Attempt

There will seldom be a medical missionary record that shall not account the methods of indigenous childbirth. It was the universal testimony of the missionaries throughout India that "Hindu women no matter whether rich or poor receive but little attention in childbirth and sickness". The line of reasoning was not an entirely new means of changing the age-old customs of childbirth. The practice of dais was 'a horror to the community'

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and the ignorance about 'the mortality of babies and of mothers is the result of their ignorance'. Through midwifery the 'rationality' and 'skill' of the women medical missionaries was uncovered. India definitely needed a revolution in obstetrics and the medical missionaries took it upon as a challenge to bring forth the reform. ‘........ if the dais learned from us, better results might, in time, give them a name that would increase their income’. 41

Until the mid-decades of the 19th century, initial interest came from the missionaries. There are instances of early enthusiastic reports on the training of the dais. In 1854, training of midwives was undertaken at the Madras lying-in Hospital and the women trained there included Indians as well as Europeans and Anglo-Indian.42 Later in 1882, in Ambala an interesting movement set foot, for the supply of competent female medical attendance in midwifery cases for both the rich and the poor women.

Subscriptions were received and a proposal to start a ‘sadavartha’ subscription not for money, but for flour, ghee & c., had been warmly taken up. The house- to- house contributions in flour ghee & c., resold and the scheme contemplated that the proceeds should be devoted to the purchase of food and

41 North India School of Medicine for Christian Women, Report for the Year Ending Oct. 31st, 1909, pp. 22-23.
42 League of Nations Health Organization in British India, Jan-Feb. 192, np.8 p.88.
medical comforts for indigent women before and after childbirth. The movement spread satisfactorily so far and competent female attendants were brought to Ambala from Amritsar and Delhi, while scholarships were given to local dais who attended lectures and midwifery classes.\footnote{Punjab District Gazetteer Ambala District, 1892-93, p.104.}

The first organised attempt came in 1886, when Dr. Aitchison a civil surgeon, opened a class for the dais at Amritsar.\footnote{Margaret Balfour and Ruth Young, The Work of Medical Women in India, (London: O.U.P., 1929, p. 129).} In the coming years, this became the well-known Amritsar Dais School under Ms. Sarah Hewlett of the C.E.Z.M.S. She persuaded the dais to attend her classes on payment of a small fee. For each attendance, she maintained a register of the cases conducted by the dai. Later, she would visit them and if found satisfactory, she would reward the dai a rupee otherwise she would be fired. Miss Hewlett was of opinion that the more intelligent dais would thoroughly realise the advantage of this plan and would in time crowd out the more prejudiced and less intelligent midwives.\footnote{League of Nations Health Organisation in British India, Jan-Feb., 1928, p. 88} The money for this as well as the stipends were paid by the municipality.\footnote{The Journal of the A.M.W.I, Feb. 1915 p.18.} The dais involved were of a small proportion of the total as the need for a higher standard of trained skill was neither felt by the dais or the patients. Moreover, many of the dais believed there was trap in the scheme and that they would be ousted from their means of

\begin{thebibliography}{99}
\item \footnote{Punjab District Gazetteer Ambala District, 1892-93, p.104.}
\item \footnote{Margaret Balfour and Ruth Young, The Work of Medical Women in India, (London: O.U.P., 1929, p. 129).}
\item \footnote{League of Nations Health Organisation in British India, Jan-Feb., 1928, p. 88}
\item \footnote{The Journal of the A.M.W.I, Feb. 1915 p.18.}
\end{thebibliography}
livelihood. Limitations, however were displayed in the application of the scheme, the work remained undeterred. In 1910, Dr. Jessie Lamb joined St. Catherine, where she too went ahead with the work of the dais. Around that time, the Hospital had grown subsequently. The training centre of dais was attached to St. Catherine known as the Municipal Schools of dais. The Municipality helped in running the classes for certificated and uncertificated dais. In 1914, there were 34 certificated and 15 uncertificated dais practising in the city under the supervision of the Hospital. What bothered the missionaries here was the quality of work produced. If Christian women would be trained the work would get up-graded. It was felt they would not need constant surveillance once trained. The acceptance of the view failed when the missionaries with their own self-doubts on this issue pointed that ‘the life of a dais was not found fit for the Christian women’. Further, they argued that these make good midwives but after, training they expect larger fees than the poor people can afford to give and they are few in number and in demand for other work. This, they found it a pity, as only the Christian women had the entry to houses that no one else would have and could help the people.

All talks of moulding a Christian dai became an impractical suggestion. The missionaries were entirely dependent on the non

48 Punjab District Gazetteer of Amritsar District 1914, p. 5.
52 Ibid.
Christian native dai. Gradually, Amritsar through its consistency, of training reported in 1916, 40 dais had passed the Lahore examination and were working in the city.\(^{53}\) To make them accessible in every childbirth case the main factor of hindrance were the expense behind the services of a trained dai. In one of the Annual meetings at Aitchison Hospital Committee it was put across to reduce the fees of the native dais. It was further added if the dais treated the patients free of charge and attended purdanashin ladies on payment of carriage hire only, the Lahore public alone would, subscribe an amount sufficient to meet the pay of several dais.\(^{54}\) No efforts to stem the problem of finances could streamline the issue. It was seen that separate bodies controlled the finances in a non uniform way.

However, the childbirth methods kept functioning along the set pattern of Amritsar. Similar steps were taken by Elizabeth Biebly at Lahore. Dr. Bielby observes that the prejudice and superstition which she had encountered in Lucknow were by no means absent in Lahore. This applied more especially to cases of child-birth. When the aid of a doctor was sought it was only after the patient had been labour for days, had been ‘treated’ by one untrained dai after another, by which time all hope of saving the child, and unusually also the mother, had gone. Yet when death supervened it was the doctor who was blamed and not the dai, or the delay of the relatives. Cases of such kinds were not seen in large towns. The results of the dais work in sepsis and lacerations, but to be called to case which had been in labour for many days and was in a hopeless

\(^{53}\) Ibid., p.14.

state, was becoming less frequent. Dr. Bielby herself recognized the great influence hospitals would have in removing ignorance in the indigenous society. For she strongly felt that together with the spread of education and the Child Welfare movement, obstetrics scene would improve.  

Besides taking charge of 'Maternity Hospital', Elizabeth Biebly lectured and took the dais class. About her experience she writes in her reminiscences, “None of the dais could read or write. But after four years steady teaching and doing much practical work, many of those I took over and many more who joined subsequently, obtained the certificates as trained dais.”

Simultaneously, training classes had started in Ludhiana. The first attempt came in 1891 when an irregular class for untrained dais began under the supervision of Dr. Edith Brown in the North India School for Medical Women. She paid them four annas a time to attend classes and for the first time they learnt the need to ‘call the doctor!’ Different skills were applied in the class. In 1903, Edith Brown went down armed with stools, a dummy and pelvis specimens and a supply of annas to keep the class going. The continuity of the class remained bleak. The dais saw no benefit to be derived from learning ‘their’ methods, nor did the authorities in the city wards seem at all eager to press the matter even though an appeal was made by the mission hospital that it was ‘their wives and daughters who

55 The Journal of the A.M.W.I, August 1929, p.47.
would benefit. Eventually, from 1908, the Hospital reported of regular attendance for the midwifery classes. The Punjab Government here supplied the four annas to each dai for the attendance of a class, an initiative taken by the hospital earlier. The class grew to fourteen students, out of which ten passed the examination, given by the civil surgeon on their first three months work and received prizes of rupees three each. After having cleared this level, the course further extended for two years where the dais prepared for the government examination at Lahore. The training programme became, popularly known as the 'Ludhiana system'. Extra practical training in midwifery was provided by Dr. Carelton and Dr. Muller, who allowed students to attend the in-patient and out-patient maternity ward of the women's hospital in Ambala and the St. Stephen's Hospital in Delhi. One of the difficulties most of the missionary doctors met was the lack of normal labour cases in their hospitals. In order to get their cases, dais under training were often sent out with untrained dais, who gave consent to take them for a small money reward. There they saw many dirty and dangerous practices and that was opposed by the under trainee dai. For her 'cleanliness is all very well for doctors but not needed for dais.' To overcome this, a curriculum covered during the course was visiting the houses by the pupils, accompanied by a reliable supervisor. The indigenous dais

59 North India School of Medicine for Christian Women, Report for the Year Ending Oct. 31st, 1908, p.23.
60 Ibid.
received one rupee for each case when they called the staff from the hospital, two rupees paid for any abnormal cases brought into the hospital early enough to save the mother and baby. In addition a bonus of one rupee was given for each ten cases reported during Christmas.\footnote{The Journal of the A. M. W. I. May 1938, p.12.} These remunerations acted as an incentive for the cooperation extended by the \textit{dais} and accounted for the success of their work. A majority of the \textit{dais} when trained returned to their native places, whereas a few were employed in the Mission Hospital itself.\footnote{North India School of Medicine for Christian Women Report for the Year Ending Oct. 31st, 1906, p.22.} Expertise poured from different sides to prepare the \textit{dais} for the exam level. Dr. Balfour recommended an oral examination for the \textit{dais} who could not read or write. She published 'First Lessons in Midwifery for Country \textit{Dais}' to be used by the teacher in the primary level of classes.\footnote{A Survey of Medical Missions in India, 1927, p. 32.} Many of the books on midwifery were translated in the vernacular. 'A Handbook of Midwifery' by Dr. Farrer of Bhiwani was circulated in Urdu, and similarly Dr. Edith Brown published 'Dai Giri Ka Asul' – Rules for Midwives', for the 'Ludhiana classes' in Roman Urdu.\footnote{Ibid p. 32.}

Though the \textit{dais} seemed most of the time reluctant yet the ones who were fully trained took pride in calling themselves 'Miss Sahib's \textit{dais}.' Probably, it worked the other way round. As for the women missionaries the trained \textit{dais} came into the orbit of a successful missionary movement that enlarged the former's image. Furthermore, the evangelizing streak of the missionaries became apparent. Not comprising, the training programme too

\begin{footnotes}
\item[64] The Journal of the A. M. W. I. May 1938, p.12.
\item[65] North India School of Medicine for Christian Women Report for the Year Ending Oct. 31st, 1906, p.22.
\item[66] A Survey of Medical Missions in India, 1927, p. 32.
\item[67] Ibid p. 32.
\end{footnotes}
became a ‘missionary agency.’ After the class, the dais would ‘settle down quietly to listen to a hymn and a few verses of scriptures’, this was proclaimed by the missionaries to be a valuable contribution in the process of evangelization. Once the confidence of the dais having being gained, the missionaries longed to see the ‘Gospel find a new crevice through which it may filter into the hearts of the women of this land, there is so much the more cause for rejoining’. 68

This outlook might have kept the missionary zeal alive for sustaining the missionary work. Although the trained dais were not large in number, the summary of Hospital statistics showed that since 1894 to 1933 only 82 indigenous dais had been trained. 69 Yet observations, put later in the chapter, showed that the work at Ludhiana could not go unnoticed.

There was a growing anxiety that the dais mostly from the cities were being motivated leaving the rural areas untouched. However, missionaries reassured of this drawback. At Asrapur a village near Amritsar, where medical work was already in progress under Ms. Bose the training of dais was attempted. She was of the opinion that since the indigenous dais have had extensive practice, ‘when they are taught the theory of normal and abnormal cases intelligently, they are able to relate practice and experience in a way the other trained midwives are unable to do without years of experience’. 70 In contrast to Ms. Boses’

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69 North India School of Medicine for Christian Women Report for the Year Ending Oct. 31st of 1933-34, p. 43.
70 Margaret Balfour and Ruth Young, The Work of Medical Women in India, p. 136.
observation, the village *dai* was unwilling to get trained and even if she did, there was no supervision on her.

Despite these tribulations, Punjab was considered one of the most successful provinces in training the *dais*. Records suggested that in 1914, the number of *dais*, midwives and nurses trained in the past ten years was 289, following second to Madras which had trained 448.

**Colonial Approach: Establishing Schemes and Boards**

Unfortunately, not many *dais* felt it was worth their while to be trained as it meant too much of time. The result of the training methods was viewed with growing skepticism. The government tried to reflect the problem on a wider area of how to produce a uniform system in the country with the help of local bodies of the state and provinces. A new scheme in 1903 was introduced by Lady Curzon called as the Victoria Memorial Scholarship Fund named after Queen Victoria. The scheme focused on maternity and child welfare that dealt only with the practising *dai*. The main object of the fund was to improve the *dais* work until it becomes a perfect system of normal midwifery that would be practical for the whole India. For its execution, committees were formed in each province and in each centre where the work was started a local committee was formed and the money was divided among the states and provinces more or less in proportion. Money collected was utilized on those *dais*.

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72 Proceedings,Home Department, Medical Department, September 1914.
74 Margaret Balfour and Ruth Young. *The Work of Medical Women in India*, p.130.
who were already under training in Dufferin and mission hospitals and of course services were extended to those 'who were willing.' Within a few weeks of its creation reports of the V.M.S.F poured in. With respect to funds, in 1928, the income was of Rs. 40,000 per annum. But somehow the amount failed to provide adequate results. And the Fund failed to establish its ground in the rural areas, it remained constructive in the cities only.

In order to encourage village campaigns the Bureau sub-committee offered stipends to candidates undergoing midwifery, provided they agreed to work in rural areas on completion of their training. Besides this, arrangements were made to bring the rural dai in for short periods where she would take up 10 cases for practical training under the supervision of the Health Visitor. The matter was taken up by the District Board to help the V.M.S.F. but lack of funds seemed a stumbling block. Besides this, the enthusiasm among the dais for rural mobilisation was low and so was the state reluctance on this matter. The latter suggested that training should be encouraged in towns where there is a qualified lady medical practitioner to make arrangements in matter of dais and take support from the local body if willing. All these problems constituted reason enough against rural endeavour. There was, however, new argument when it was felt that since the women outside large towns are purdahashin and are healthy, consequently have little

75 League of Nations Health Organisation in British India, Jan-Feb 1928 p-62.
76 61st Annual Report for the National Association for Supplying Medical Aid in the Women of India, 1945, p-146.
77 Proceedings,Home Department, Medical & Sanitary Department, 1919, p.12.
or no trouble at childbirth and do not require the service of dais, main concentration of work should be on providing dais in towns and cities. Consequently, the village proposal never gained momentum and remained a challenge for western medicine on the whole.

Nevertheless, the development under the V.M.S.F remained visible in the provinces and states. In 1945, 175 centres were conducted for the training of the dais, a total number of 1306 dais received training.78

The work was further intensified between 1917 and 1929 with the advent of the health visitor. In Punjab, a number of centres were opened by the health visitors whose work was limited to train dais and most importantly supervise them. 79

'Supervising and Examining' the dai: Punjab Central Midwives Board

More resolute action was taken in the aspect of examination of the dais. In Punjab, at first the Lahore examination was the goal aimed that offered a two-year course. Seeing the duration of the courses, the V.M.S.F. here offered shorter courses and examination and helped Ludhiana conduct the same. 80 To get uniformity in the syllabus for the whole province, Punjab government framed the Central Midwives Board to provide facilities for the training of midwives from mufassil

78 61st Annual Report of the National Association for Supplying Medical Aid to the Women of India, 1945, p.146.
districts and towns in which no such facilities existed. Although the Lt. Governor had sanctioned the Board's creation with effect from 1st April 1917, yet actual work commenced in 1919. Its first examination was held in November of that year. The Board which consisted of the Inspector General of civil hospitals, certain nominated officials supported the need to hold examinations for midwives and dais and to maintain a register of successful candidates. Significant advances were made to standardise, so far as possible the training of midwives and dais. Regulation concerning the admission had certain conditions. Three distinct qualification were obtainable. The highest being the Diploma in Midwifery for which the standard of knowledge was English, the rest were in vernacular – the certificate for dais and certificate for the indigenous dais. For the qualification, the age of the candidate was kept within 20-40 years. For the indigenous dais, the candidate had to be certified by a Municipal Commission or a Tahsildar or other Government official to show that she was an indigenous dais working in the locality or be acknowledged as belonging in the hereditary dais caste. Besides this category, women who were already in practice as midwives or dais were also eligible for admissions that held the V.M.S.F. certificate.

Question on the character of the dai was under scrutiny, her moral conduct had to be satisfactory. If the dais were found incompetent or guilty of immorality then their names would be

82 Punjab Government Gazetteer notifications, No. 12839 dt. 16 June 1918.
84 A book of rules was framed by the P.C M.B. – Punjab Central Midwives Board Rules, Lahore, 1921,np., pp 3-4.
struck off the roll. Any dai thinking herself aggrieved could appeal to the Punjab Medical Council within three months from the time the notice was given to her.

Another matter brought in the Board was the syllabus. It was finally agreed not to burden the illiterate women with books instead emphasis should be on practical knowledge as cleanliness and hygiene. But for their total 100 lessons, it was essential to have both, theory and practical classes.

In the same direction as the P.C.M.B was the establishment of the Central Training School and classes for dais at Amritsar and other centres. The intention of the latter was to provide facilities for the training of midwives of dais from town and districts. The scheme was in abeyance owing to withdrawal of the medical women to the St. Catherine’s Hospital from the training of the dais in Amritsar. Therefore after taking into consideration the above factor the training of dais would commence in accordance with the regulation of the P.C.M.B.

The Amritsar school was kept up cojointly by the V.M.S.F, district boards and the local municipal committee. Because of which the cost of the classes here was less (Rs. 113 per head) as compared to the local classes. (Rs. 167 per head). The local training classes at other places were to be approved by the P.C.M.B which at present in 1917 were seven.

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86 Proceedings, Home Department, Medical & Sanitary, Feb. 1917.
87 Proceedings, Home Department, Medical & Sanitary, Sept. 1919.
It became certain that if training had to be carried it was essential to secure financial support of the local bodies. District Boards and Municipal committees agreed to contribute part of the expense on training the dais. Except for Ludhiana where the municipal committee was already spending Rs. 100 per mensem for the purpose was not prepared to undertake further financial responsibility in this direction. 88 Whereas in a large number of other towns, municipal committee after the formation of the PC.M.B., took financial responsibility. A few such cities were Gurdaspur, Sialkot, Lahore, and Gujrawala. 89

One of the problems that had to be tackled was the low turnout of the dais in the class. As shortly reported after the establishment of the P.C.M.B, it was not always the paucity of funds that was an obstacle. Report from Bhiwani pointed in the number of dais willing to undergo the course proposed was the major hindrance. 90 Complaints were followed by suggestions. Just after the making of the P.C.M.B it was considered as a possibility to attract a 'better class' of girls for training as sub-assistant surgeon, nurse and dais. Just as the consideration for Christian girls never took ground in the same manner the above proposal was never applied. The chief reason being that 'respectable' girls considered it degrading to take up the profession of nurse or a dai and it would hence be necessary to educate public opinion on this subject. Indian social reformers would act enact as arbitrators in the matter. They could put forth the view to the employment of respectable widows as dais.

88 Ibid.
89 Ibid.
90 Ibid.
This had been accomplished in Indore, no reason why it wouldn’t work in the rest of British India. The concern further opened the redefinition of the identity of the *dai*. The nature of the indigenous class of *dai* and those entering the profession from other ranks, was a subject often discussed in conferences. Many felt it was better to try to train ‘other’ *dais* whilst some were of the opinion that such candidates differed little from indigenous *dais*. The suggestions led over to considerable agreement over the need to bring out reform in the medical practices irrelevant to the background of the *dai*. Though the work of the V.M.S.F. was supposedly for the indigenous *dais* but in a number of places the money was used to train the non indigenous *dais*, some literate and some illiterate. But the centrality of the midwifery programme was to make a sharp distinction between the indigenous *dai* and a trained indigenous *dai*. It was for this reason that the registration of the midwifery was taken up time and again. For, it was believed that to professionalise the obstetrical and gynecological organisation the reputation of midwifery had to be an integral part of it. Help and efforts from the provincial government to empower the Municipalities to introduce compulsory registration along with training of *dais* was called upon. This was the most suitable solution that emerged as to enlist the *dai* who was certificated by the P.C.M.B. An Act to provide the registration and better training of *dais*, nurses and health visitors was passed that came into force in

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91 Proceedings, Home Department, Medical & Sanitary. July 1912.
92 Report Proceedings and paper submitted to the Conference. 4th Session Servants of India Society, Bombay 1924, pp. 63-64.
September 1928.\textsuperscript{93} It was felt that such a measure would at least facilitate to regularise the strength/attendance of the dais. Unfortunately a large number of indigenous dai remained untouched by this provision. In 1932, the matter was taken up again. The Act did not merely provide for the registration of the different classes of workers specified, but it also provided for powers to prohibit unregistered persons from practicing.\textsuperscript{94} Hence, the local authority could make bye laws to prohibit the practicing of unregistered persons in their local area. In case the local authority failed then the local government may step in. \textsuperscript{95} Under the Act, provision was made for penalty for the unlawful assumption of the title of the registered nurse, dai or trained dai. One interesting fact noticeable about this Act was that the trained indigenous dai did not appear. So it seemed that the old distinction between indigenous dais and other dais (somewhat) disappeared. Women who did not belong to the indigenous dais class were coming forward for training.\textsuperscript{96}

Somehow, the issue became more complex with the appellation of nurse dai. Practical observance showed that civil surgeons in the province were themselves ignorant of the difference between a nurse-dai and a trained nurse with a midwifery certificate. The public, on the other hand, were apt to think that those so qualified were nurses. And as far as the nurse dai was concerned, she was only taken to foster this illusion. To deal with this conundrum it was suggested to have

\textsuperscript{93} The Journal of the A.M.W.I, Feb 1930, p.103.
\textsuperscript{94} The Journal of the A.M.W.I, August 1932, p.24.
\textsuperscript{95} Ibid.
\textsuperscript{96} Ibid.
three classes comprising nurse, *dais* and trained *dais* and further the *dais* be classed as literate and illiterate *dais*. Yet, all attempts in this direction remained contentious. It was clear that at the grassroot level it did not matter as to what the background qualifications of the *dai* was as long as she performed the duties as per the expectation of the patients.

Going through the records the authorities let the figures in totality which still were bleak. During the year 1921, 11 *dais* attended classes in Ambala, 3 indigenous *dais* passed in Ludhiana at the Maternity Hospital along with 10 *dais* where as both at Lahore and Multan the indigenous *dais* refused to attend lectures. A class of *dais* was held at Lahore where 14 attended.

One was apt to misjudge the rate of progress as the records had figures in totality, under broader non-distinctive categories. But it did not require much of probing to see that the indigenous *dais* did not show any flexibility in welcoming western methods. The slow number however indicated slow rate of progress but on the other hand it was also argued that the movement had prevented quality being sacrificed to quantity.

**The Health Visitor: Yet Another Attempt**

The work was intensified between 1917 and 1929 with the advent of the health visitor. In Punjab, a number of centres were opened by the health visitor whose work was limited as maternity supervisors and to train *dais* and most importantly

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supervise them. Most of the provinces and states, however provided some sort of supervision for the pupils whose training they had sponsored. A Local Supervising Committee (L.S.C.) was appointed to maintain a roll of midwives and dais in the district and to submit the same in the Board. The Inspectress under the L.S.C. was to be paid by the local bodies or if failing then by the V.M.S.F. The dais were examined in cleanliness, management of labour and were to report cases of seriousness and abnormality during pregnancy and labour.

But these arrangements were more often inadequate. Hence, it seemed the health visitor would be a more useful worker for this cause. She could even boast of the connectivity established with the trained dai who became instrumental in bringing ante-natal cases to their notice, something that was rarely seen in the attempts made by the fund and the missionaries. So much for the health visitor that a Health Visitor League was formed in the year 1922, the object of the league being to band together the trained health visitors in the country. In 1936, 25, 249 labour cases were reported out of which 8,596 were supervised by the health visitor. Very soon it was regarded that the increasing number of dais under training was due, in fact that health visitors had increased in large numbers.

100 Proceedings, Home Department, Medical, Feb. 1917, p. 15.
101 The Hand Book of the Trained Nurse's Association of India. (Published by Trained Association of India Valley View, Conoor, 1939.p.25.)
102 Report of the Public Health Administration of the Punjab during the year 1936, p.27.
Prior to this the influence of the health centres was exercised on every health visitor. Further justification for the work kept pouring in. The work does not carry on honourable status, it is laborious in itself, and its results are not dramatic. This is a matter not only time can right, but also efficient propaganda would undoubtedly hasten matters. Successful child welfare work itself is really the best way of propaganda which makes it very necessary that the standards of work in the health schools should be kept high.¹⁰³ There were 34 centres in 1930 which received no assistance from the fund where the dais had being trained by the health visitor and supervised by the woman principal of the Lahore Health Training School.¹⁰⁴ It was observed that these health schools provided successful results too. In 1931, out of eight pupils examined six were given appointments.¹⁰⁵ By now a health visitor was available in almost every town of Punjab. The follow up of her visit was reported. In Jullundhur, the lady health visitor had attended 95 confinements and in Amritsar 204. The regular visits might have been the proof of the strength of the health visitor but the weakness lay in small proportion of the dais involved in training. During the year 1945, 175 centres conducted classes in provinces and states, and a total of 1306 dais, received training.¹⁰⁶

¹⁰⁶ 61st Annual Report of the National Association for supplying medical Aid to the Women of India, 1945 p.146.
However, despite its usefulness, the quality of the work of the health worker was a ticklish issue in itself. It was found that her attitude was anything but conciliatory. In totality, it was seen that the poorer type of health visitor had insufficient education to teach well and was not experienced enough in midwifery herself. In Punjab this had been guarded against to some extent by making it a rule under the C.M.B that dais were not accepted as candidates for examination unless they had been taught by a worker holding not less than a midwives certificate. Hence, the health visitor was lauded and criticised for the superficial result that was achieved. Perhaps, the solution lay, as Lala Rajpat Rai suggested, not in the appointment of the lady health visitor but in “hospitals staffed by Indians and should be directly under the health Department of the Municipality then only childbirth methods would be controlled by public opinion.”

Moreover, the efforts of the training programme were apparently constructive in the urban areas only. From the village point of view, the benefits delivered from the scheme were nil. Only a rare instance was covered in the reports, the coming of the motor bus is transforming village life in many provinces. The day may be approaching when every village will have its health centre. Nearly all the child welfare centres have tackled the problem of training the indigenous dai. Instead of sending the village dai to the nearby cities, suggestion came to get them trained there itself. A frequent plan adopted for a successful

108 The Tribune, March 7, 1913, 'Health of Labour I'- Lala Rajpat Rai. p.3.
'dais class', encourage the local dais to attend by giving them a small award, equip them with a proper sterilised outfit and then have their cases supervised by a trained midwife. The provincial and state authorities found it difficult to make satisfactory scheme for improving the midwifery services especially in the rural areas. In order to encourage village companies the Bureau sub-committee offered stipends to candidates undergoing training provided they agreed to work in rural areas on completion of their training.

The picture of Ludhiana in 1939 showed the following figures

Ludhiana Maternity and Child Welfare centres maintained by

Government : nil, Local bodies -1 Municipal Bodies – 2

Maintained by other agencies: Rural-nil, Urban- 5

Trained Health Visitors : Rural – 1, Urban 1

Trained Dais : Rural- 75 , Urban – 73.

Ludhiana remained fourth in position, first in Punjab being Ferozepore with rural trained dai numbering 135 and urban 65. The numbers were substantially prominent to be commented upon. During 1929, small conferences of experts to discuss the training and work of indigenous dais were held under the

110 61st Annual Report of the National Association for Supplying Medical aid to the Women of India 1945, p.146.
auspices of V.M.S.F in several centres. 'With a few exceptions,' it was observed, 'in individual places the work is nowhere so widespread or so well organised as in the Punjab, where work along the lines of the V.M.S.F for indigenous dais is longer established than elsewhere.'

Till 1947, great variation in the type of training provided for midwifery personnel was still a feature of schemes aided by the V.M.S.F. But no final conclusion had yet reached regarding the type of worker whose services could bring maximum benefit. On further inquiring the matter, it was found that since the past 45 years some centres had received grants uninterruptedly. However, the period saw that one of the biggest obstacles to expansion of the domiciliary midwifery services was still lack of money, especially from voluntary or official services. British policy-makers had, on the other hand, no doubt about the efficacy in the change of the political scene. They put it as 'an opportunity to revitalise and energise the movement for better midwifery.'

CONCLUSION

The sensitivity portrayed by the colonialists towards women's health, unfortunately, became yet another rhetoric-dominated feature. When training of dais was started, the difficulty of supervision was largely overlooked, partly because the promoters of the first schemes were too much occupied with

113 63rd Annual Report of the National Association for Supplying Medical aid to the Women of India, 1947, p. 166.
the problem of securing the attendance of midwives at classes at all to think what would come afterwards and partly because the efficient supervision of midwives had not been carried out at that time in western countries. The matter came up once they realised no change occurred at the grass root level. What mattered utmost was to loosen the influence of the *dai* on the birth control methods. Her very authority disturbed the hegemonic ambitions of western medicine. Obstetrics reform in India became closely connected with the trained and the untrained *dai*. Western trained *dai* remained primarily an urban affair whereas the indigenous 'untrained' *dai* had monopoly of practice in rural areas, a practice that continues even to the present times.

The mere presence of the indigenous *dai* was perceived as a challenge in the battle of “cultural hegemony”. The working of the dais came across as the strongest cultural practice that came under critical scrutiny. Labeled as traditional the dais was to be transformed and reconstructed through this western knowledge of medicine. She was attuned to a culturally specific concept of health care, that made the effort more strenuous for the missionaries and the government. And to undo the dai, was to directly intervene the indigenous society. Aware of the fact that the social and religious conditions in India made the service of the *dai* favourable, the colonisers intervened in both, the conditions as well as the dais, aspiring to bring a change in either one of them, that would eventually effect the other.

Thus, medicalisation remained incomplete. Family welfare services were included to make women aware of the health
services offered by the missionaries and British Government, a matter that I would like to study in the next chapter. Yet, it seems women who had easy access to trained midwives did not ignore the advantages of the women's hospitals.