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Western Intervention in the Childbirth Practices in Colonial India: A Historical Perspective

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ABSTRACT

Childbirth practices in India underwent significant transformations during the colonial period under British rule. Traditional methods, primarily managed by indigenous midwives or Dais, coexisted with the introduction of Western obstetrics and modern medical practices. This paper explores the transition from traditional childbirth practices to the establishment of Western medical institutions, the role of missionary work in providing healthcare, and the initiatives aimed at training indigenous women in medical professions. The Countess of Dufferin Fund and the Victoria Memorial Scholarship Fund are key initiatives addressing maternal health challenges during this period. Despite facing challenges, these efforts improved maternal and child healthcare outcomes and empowered women in colonial India.

Key Words : Childbirth practices, Colonial India, Western medicine, Indigenous midwives, Countess of Dufferin Fund

INTRODUCTION

Before colonial rule, childbirth in India was predominantly managed by traditional birth attendants, often midwives or experienced female family members, within the context of the family and community. However, with the advent of British colonialism, significant transformations occurred in the healthcare landscape, including childbirth practices. During the early stages of British colonial rule in India, Western medicine began to gain traction among the middle class and urban populations. Christian Missionaries and European physicians introduced modern medical practices, including obstetrics, which aimed to replace indigenous healing systems. However, the reach and acceptance of Western medicine were limited, therefore, traditional childbirth practices also persisted to a great extent.

Subsequently, the Nineteenth century witnessed a significant expansion of Western medical institutions in India. British colonial authorities established medical colleges, hospitals, and maternity wards largely in urban locations. This facilitated the training of Indian physicians in Western obstetrics and the dissemination of Western biomedical knowledge about childbirth. The rise of Western obstetrics led to the marginalisation of traditional birth attendants, midwives or Dais in particular, who were often viewed as unhygienic and superstitious by colonial authorities. Efforts were made to replace traditional midwifery with formal medical training for childbirth attendants, although

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these initiatives were also met with resistance.

A few organisations showed interest in the maternal health of native women moved by the civilising mission of the colonial government. Such an interest eventually led to establishing institutions for female medical education and midwifery training. Alongside this, scholarships were allocated to Indian girls to pursue medical education, encouraging them to opt for medical professions. The idea was to make women physicians and gynaecologists available to offer health services to indigenous women. Additionally, small-scale training classes were provided for Indian girls, offering certificates and diplomas to equip them to open their dispensaries and clinics. The difficulties and complexities faced bynative Indian women during labour due to the lack of proper medical help, education and awareness were highlighted by the advocate of Western medical practices. Moreover, some conscientious doctors took it upon themselves to provide medical assistance on a personal level which later evolved into organised efforts to provide proper care to birthing women in India.

Between 1871 and 1900, hundreds of women from Western countries started providing medical assistance in India. These women were missionaries from the United States, Britain, and Canada who established dispensaries, hospitals, and schools for midwives and nurses. Missionary work was among the few opportunities for newly qualified female medical practitioners in Britain and the United States (Harrison, 1994). By the end of the 19th century, missionaries provided more medical care to women across India through qualified medical practitioners than the government. This situation persisted for many decades (Jeffery, 1988).

The Madras Presidency took up the first organised work of teaching women in Western medicine. Dr. T. Balfour, Surgeon General, and Mrs. Scharlieb, an English woman initiated this. Mrs. Scharlieb took a one-year course in midwifery at the Madras Maternity Hospital. One of the finest schemes to train the indigenous midwives of India, which had far-reaching consequences, was started by Miss Hewlett at Amritsar in 1866. Miss Hewlett was a missionary of the Church of England Zenana Missionary Society. She was also a trained nurse and midwife and had considerable medical experience. Her work amongst the women of Amritsar led her to the conclusion that the *Dais* must be trained and their work should be monitored to regulate efficiency (Balfour and Young, 1929). One of the most prominent figures in this field was Dr. Clara Swain, M.D. from the United States of America. She was the first among qualified women in Western medicine to come to India.

In 1869, Dr. Humphry, a member of the Methodist Episcopal Church, started a class for training women in Nainital. Other Christian missionary women doctors who worked in India included Miss Sara C. Seward, M.D. who arrived in Allahabad in 1871; Miss Rose Greenfield, who arrived in Ludhiana in 1875; Miss Fanny Butler, M.D. who arrived in Jabalpur in 1880 and later worked in Bhagalpur and Kashmir; Edith Pechey, who came to Bombay in 1883; Miss Elizabeth Beilby, who arrived in Lucknow in 1876, went back to England to qualify as a doctor, and returned to Lahore to take charge of a newly established women's hospital set up in 1888; Miss Ida Faye, who arrived in Nellore in 1881; Dr. Jessie Carleton, who outlined in Ambala city in 1887 and established the Philadelphia Hospital for women in 1901; Dr. Alice Ernest, who arrived in Jhansi in 1887; Anna Kugler (1856-1930) who appeared in Guntur in 1883; Edith Brown, who began her medical work in Ludhiana in 1891; and Ida Scudder at Vellore in 1900 (Brown, 1936).

In the early years, qualified physicians who served as gynaecologists, obstetricians, and surgeons ranthe hospitals for Indian women. They started their careers in India by setting up makeshift dispensaries, which eventually grew into hospitals. This led to the first training classes and medical schools for Indian women (Singh, 2005). A lady missionary, Dr. Edith Brown, with the help of two

other missionaries, Miss Greenfield and Miss Hewlett, started a medical school for women in Ludhiana, Punjab. Following the establishment of Ludhiana School, another school was opened in 1918 in Vellore by Dr. Ida Scudder, which grew to become CMC, Vellore and which celebrated the centenary of its founders' work in 2000. Dr. Scudder was an Ameriacn, who began practicing medicine in India in 1900, under Dr. Hilda N. Lazarus, who was the first Indian woman to be appointed Chief of the Women Medical Services (W.M.S.), which later on rose to be one of the foremost institutes of its kind in Asia (Singh, 2005).

In 1911, the Maharaja of Kota gave generous donations for establishing a medical college exclusively for women in Delhi. The foundation stone was laid in 1913 and the college was opened in 1916 by Lord Hardinge. The college was named after Lady Hardinge, as she had done so much for the opening of the college. The college was affiliated with Punjab University for an M.B.B.S. degree. After qualifying, the students became assistants at the Dufferin or other hospitals or started private practice (Jaggi, 2000).

By late Nineteenth century around fifty female missionary doctors were working in India, making up two-thirds of all women doctors in the country. Some of these doctors were motivated by the imperial mission to help their Indian sisters, while others aimed to save souls for the kingdom of Christ. Some were seeking career opportunities away from patriarchal societies where medicine was still male-dominated. Institutionalised maternity services provided Western women professionals with an opportunity to break into a male-dominated profession in their own countries. Many women unable to gain admission to medical schools directly worked in India first and later obtained their degrees to become eminent practitioners. These early women doctors faced many challenges and had to work hard to establish themselves and find their place in Indian society. They often encountered failures and disappointments during the initial phase of their establishment.

In the early days, women doctors had a wide range of skills and treated various ailments, including paediatrics, gynaecological, dental, and surgical matters as well as snakebites and broken bones. However, surgeries were carried out under basic conditions, often requiring surgical needles and instruments to be sterilised immediately for reuse. Their fame spread far and wide if the operation was successful, and English women were known for performing miracles with a knife. However, if the patient died, word often spread in the local community about the evil ways of these strange women, and the number of patients visiting the dispensaries dwindled (Singh, 2005).

In 1907, a group of individuals who ran medical services in India established the Association of Medical Women in India. Dr. Annette Benson of Bombay was chosen as its first President (Qadeer, 1998). Before this, Lady Curzon founded the Victoria Memorial Scholarship Fund in 1903 to train indigenous midwives. By 1912, this Fund had established centers in fourteen provinces and trained 1395 midwives (Mark, 1994). These trained Indian women midwives were in high demand and were quickly employed by civil dispensaries throughout the Presidency. Therefore, in the early twentieth century, several medical funding organisations were created, including Lady Curzon's Victoria Memorial Scholarship Fund (1903), Lady Chelmsford's All India League for Mother and Child Welfare (1920), and Lady Reading's Women of India Fund, which operated a maternity hospital in Shimla.

In the late 1800s, almost a movement emerged in India to make childbirth a medical procedure. The Countess of Dufferin seems to be leading by founding the National Association for Supplying Female Medical Aid to the Women of India in 1885, supported by Queen Victoria. This Association aimed to provide medical relief to women by employing female doctors and building hospitals. The initiative also aimed to provide education to women in the medical field. Though the Fund lost

momentum after 1888, its legacy and infrastructure had a lasting impact on the formalised provision of medical care to women by women in India.

Dufferin Fund was an organisation that employed women, or lady doctors, to manage a network of hospitals and dispensaries all over British India, including Burma. The Fund aimed to provide medical education and health care services to Indian women, as well as to train female nurses and midwives to work in hospitals and private homes. The Fund was the first major initiative in women's health in colonial India, and it enjoyed the support of successive Viceroyalties and a great deal of official interest. Its patrons included the Queen, the Viceroy, the Governor, their spouses, the Nawabs, and others. It is believed that Queen Victoria herself played a pivotal role in its establishment. Medical missionary Elizabeth Bielby is said to have conveyed a message from the Maharani of Panna to the Queen-Empress, urging action to alleviate the suffering of Indian women during childbirth. When Lord Dufferin was appointed Viceroy in 1883, the Queen asked his wife to take an interest in maternal health (Guha, 1998).

The patrons of the Lady Dufferin Fund, made a brilliant effort to provide Western medical services specifically for women. They did this by establishing purdah wards on one side and using purdah customs as an excuse to justify women's hospitals run entirely by professional women on the other side. Additionally, separate zenana wards were designed and built as part of general (non-zenana) women's hospitals, beginning in the 1840s. While these private charity institutions worked hard to provide maternity services to a small proportion of urban upper-class women, the majority of women continued to depend on the traditional Dai system.

Lady Dufferin's Fund established a Central Committee with independent branches in various regions of India including Bengal, Bombay, Madras, Berar, Burma, Central Provinces, Punjab, Mysore and North–West Provinces. Lady Reay led the Bombay Branch in 1880, while Lady Machenjee led the Calcutta Branch in 1896. Lady Northcote took over the Bombay Branch in 1902, and Lady Ampthill led the Madras Branch that same year. Lady Fraser then became President of the Calcutta Branch in 1906-07. These Lady Presidents were passionate about improving women's reproductive health and worked hard to raise funds for the cause. For example, in 1880, Lady Reay made special efforts in Bombay and collected Rs. 3,60,000. Similarly, Lady Mackenjee obtained donations of about two lakhs for Calcutta in 1896, and in 1902 Lady Northcote raised Rs. 1,12,000 from a fancy fete in Bombay. In the same year, Lady Ampthill collected Rs. 91,000 in Madras through her personal influence, and in 1905-06 the Burma branch raised Rs. 67,000 for the Rangoon hospital (GOI, 1908).

In 1903, the Victoria Memorial Scholarship Fund was created as a significant initiative during the colonial period. Lady Curzon established this fund to improve childbirth conditions by training indigenous Dais, who were hereditarily associated with midwifery. The fund was named after Queen Victoria who had recently passed away. The primary objective was to train indigenous midwives, as opposed to midwives from other classes or castes already being trained in the Dufferin and mission hospitals.

The Fund was primarily focused on training midwives who worked in female wards of hospitals and female training schools. The aim was to help them fulfil their hereditary calling while respecting the people's religious beliefs. Additionally, the Fund aimed to help these midwives improve their traditional methods by incorporating modern sanitation and medical knowledge. To attract more Dais to attend instructional classes, the Fund also provided scholarships or fees.

Scholarships for midwives were not consistent and varied depending on the situation and location. Starting classes for midwives was often difficult due to many Dais being hostile and not

wanting to attend classes, fearing it was a trap and they would lose their livelihoods. This created various challenges for the associates of the Fund, who were faced with similar problems to those encountered by missionary women while delivering their services.

Conclusion:

The colonial period in India witnessed a profound transformation in childbirth practices, spurred by the advent of British colonialism and the introduction of Western medical practices. Traditional methods managed by indigenous midwives coexisted with the rise of Western obstetrics and the establishment of medical institutions. While Western medicine gained traction, traditional practices persisted, reflecting the complexity of healthcare provision in colonial India. Initiatives by missionary doctors and organizations like the Countess of Dufferin Fund and the Victoria Memorial Scholarship Fund played crucial roles in changing maternal and child healthcare perspectives. Along with the resistance and challenges, these initiatives left a lasting impact on healthcare delivery in colonial India, shaping the trajectory of maternal and child health for generations to come.

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