

*OCCASIONAL PAPER*

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November 2011



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# Women, Medicine and Politics of Gender: Institution of Traditional Midwives in Twentieth Century Bengal

Krishna Soman\*

## Abstract

*Women's role in biological reproduction is recognized in the Indian society over and above their contributions to social reproduction. For ages, Dais – the traditional midwives - have played important roles in birthing care in India, yet they are subjected to a great deal of social and economic marginalization. Contemporary queries into lives of these women reveal their precarious condition. In contrast, they continue to represent a rich heritage of health care and serve probably as the only resort for those who are yet to benefit from planned and induced development. This current picture has roots in the social history of the institution. The institution has undergone transformation in time. At the beginning of the twentieth century, it was shaped largely by the colonial forces of medicalization of childbirth and later joined by the politics of nationalism. With time, the global forces in control and applications of health-related modern knowledge and technology established power and posed conditions on this institution as part of the larger discourses on medical reforms. Politics of gender in global and national spheres has influenced observations, interpretations and discourses on childbirth in India and images of the dais in its health culture. While historical writings are indicative of their position within and beyond the health care system, their life experiences are thinly documented. Further, available literature reflects on images of the dais that are constructed rarely by these women themselves. Drawing upon historical narratives in development, this paper attempts to identify and understand social construction of images of the dais in changing socio-economic, cultural and political contexts of twentieth century Bengal in eastern India. The paper highlights continuities and changes in the institution.*

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Women interact with the health service system as patients, mothers and workers. Feminist discourses on women's health movements have been concerned more about discriminations experienced by the female gynaecologists in health care delivery systems under the influence of patriarchy as compared to those by the indigenous midwives. Traditionally, the institution of indigenous midwives has been a domain of woman workforce with various skills and capacities engaged in birthing care. They are collectively known as 'dai' in many parts of India. They have been socially offered the status equivalent to that of a mother and addressed as 'dai -ma' in Bengali literature of the twentieth century (Sathyamala 2005, Akhter 2002, Mukhopadhyay 2008).

*Dai* - the traditional indigenous institution of midwifery in India – (overwhelmingly comprising women practitioners) has attended childbirths for ages and performed a range of tasks before, during and after delivery. It has undergone transformation particularly since the nineteenth century, when management of childbirth became an agenda of intervention in favour of establishing western medicine by the British in India. This phase continued till 1947 when India achieved freedom but it had to lose part of Bengal province as a consequence of political partition. Transformation in the institution of *dai* that continued through the following period has been in the context of evolution of health services in post-independent India through developmental planning. While the colonial interventions in health care practices were projected as an attempt of 'modernization', approaches in developmental planning have reflected conviction and confidence of the Indian planners in western medicine.

Available literature that has traced the development of modern western medicine and health service systems in pre and post independent India has touched the institution of midwives only marginally. Historical research that has looked into reforms or modernization of childbirth in the region has been engaged in issues of hygienic management, official policies and politics of childbirth in attempts to establish western medicine in India (Harison 2006, Qadeer 1998, Guha 2006, Engels 1993 and others). Malhotra (2003) however referred to the traditional and 'modern' midwives as categories of analysis of women's reproductive health in colonial Punjab.

According to Malhotra (2003), the historical works have begun to explore various compulsions and agendas of the colonial state in their impulse to impose new biomedical regimes (Arnold 1993, Forbes 1994, Lal 1994) and reassertion of indigenous medical systems (Girija 2000) that have thrived along with 'metropolitan' medical science (Arnold 2000). According to her, a few of these 'medicine-oriented' exercises have shown how new medical paradigms interact with the social organization. It is this linkage that she herself examined in the context of colonial Punjab. She explored how the opportunistic adoption of 'seemingly new, that is, hygienic, clean and scientific midwifery practices by the middle class interventions in the management of reproductive health had implications for the social relations. Promotion of 'new' practices went to the disadvantage of those who provided the elite Punjabi with customary services such as the indigenous traditional midwives or *dai*. Such a politics had also divided women into categories of 'lady' doctors, 'certified' and isolated the traditional *dai* from the rest (Malhotra 2003). It is worthwhile mentioning here that promotion of new practices in health knowledge and care not only replaced the *dais* and created a category of 'lady' doctors but also advanced the formation of a new form of class division and new pattern of hierarchy within the secular, social hierarchical network of medicine. It can be compared with the formation of a new class that emerged following introduction of dissection of human body in England in late eighteenth and early nineteenth centuries as Richardson (1988) has argued in her volume *Death, Dissection and the Destitute*. According to Richardson, this new knowledge, in some sense, provided the space in which the 'lady' doctors or alike could claim the status of an epistemologically privileged cultural referee.

In a contemporary context, however, Sadgopal (2009) has analyzed in great detail the marginalization of the '*dai* tradition' in evolution of health services in India. She pointed out that there are still great potentials in this local health tradition, even in the current context of the health services development that has treated *dai* as 'honorary' actor in the management of childbirth. She proposed the idea of 'maternity care governance for the benefit of local communities' and looked at the possibilities of strengthening the existing services with

serious inputs from the *dais*. Simultaneously, she acknowledged that the dimensions of class, caste, gender, power and ideology are likely to be implicated in the acceptance of the '*dai* tradition' within the health care delivery system. Almost simultaneously, in a specific context of Tamil Nadu, Gopal (2010) looked into the practices of the traditional midwives of the *Barber* caste and pointed out that the government training programmes totally ignored their traditional knowledge, experience and skills. However, writing the social history of the constituency of *dais* or indigenous traditional midwives is a task yet to be accomplished.

There are concerns that are collectively engaged in interdisciplinary discourses on writing such history from the point of view of the marginalized or those who are at the bottom of the society. While acknowledging that history of the *dais* is yet to be written, they also state that any inquiry into the lives of *dai*, or indigenous traditional midwives, need to be centrally located in the politics of gender and gendering (Hardiman 2009). This, in turn, indicates that viewing the world through the eyes and perceptions of the women themselves appears to be an important prerequisite to the formulation of a social history of *dais*.

In Bengal, the traditional *dais* who conduct or help in deliveries and maternal and new-born care also constitute the folk communities of traditional healers who have been in close touch with the bio-diverse world and its natural resources. Moreover, many of their practices today are found to be rooted in classical texts. In spite of sharing such a glorious history in social reproduction, their lives are primarily that of women who live in families that are positioned in the stratified and hierarchical society and are influenced by the larger forces of socio-economic transformation including class-caste combine and patriarchy (Soman 1992, 1997). Constructing out of the views expressed by women across three generations cross-checked and validated from available sources, this research reflected on the social dynamics of women's lives in rural West Bengal in eastern India. As a consequence of socio-economic transformation in rural Bengal, the lives and institution of the indigenous traditional midwives or *dais* have undergone transformation in the twentieth century, shaping their productive and reproductive roles within and outside the family. This in turn, influenced their images that were constructed by either

themselves or others in family or society (Soman 1997). Their important role in social reproduction, however, missed the sight of planners in evolution of health services.

Social identity of the *dais* or indigenous traditional midwives has constantly been shaped by gender equations prevailing in the society and social systems – the health system in particular. This politics of gender has been discussed in history largely in shared contexts of medicine and nationalism but not so much in the changing interfaces of caste, class and patriarchy. This paper aims at looking into these shared spheres of gendered identity of women as they appeared in the processes of social transformation in twentieth century Bengal. The emphasis is on the twentieth century, which saw contrasts in political, socio-economic and cultural dimensions of both, public and private spheres of women's lives. However, journeys back to the preceding period of colonial history, which could not be avoided, helped in locating the twentieth century in a historical context.

The paper is organized in two distinct parts dealing with subsequent phases in social history. The first part presents various social perceptions of the role and activities of the *dais* in the colonial period, followed by the post-independence decades. The second part, in turn, displays a great deal of own qualitative research and subsequent follow up on the social dynamics of women's existence, health and health culture in transforming villages of Bolpur subdivision in Birbhum district of West Bengal since the 1990s. It is worthwhile mentioning here that the *dais* whose narratives have been presented in this paper are part of this rural womenfolk of Bolpur.

### ***Dais* in Twentieth Century Bengal: A Sketch**

*Dais* of Bengal– the women who have been traditionally providing maternity care around birthing and care of the newborn over ages - were addressed as '*dai*-ma' with high social esteem and importance in early twentieth century Bengal. This social identity of 'mother' was an extension of earlier constructions that surfaced in Bengali novels and biographies till late nineteenth century (Mukhopadhyay 2008). The crucial roles they played in the past earned them the status of mother. This dignified social status of *dais* however began to get neglected, derecognized and replaced by techno-savvy post-modern medicine mediated through policies. Changing social formations also

left their impact on villages making the village environment less conducive for sustenance of the tradition as well. The twentieth century saw few shifts in medicine and medical practices, political equations and social relations in the history of indigenous traditional midwives or *dais* of Bengal.

Periodicals published in early twentieth century largely reflected on the developments that took place in the preceding period. Following the colonial agenda of reforms or modernization of management of childbirth, faults were identified in the practices of the traditional *dais*. They were criticized and held responsible for adverse health implications in the process of birthing and newborn care. These, in turn, became the basis or justification of the then upcoming western midwifery training schools in India including Bengal. A section of the urban elite, convinced by similar arguments in favour of modern medicine over the traditional indigenous knowledge and practices keenly joined the colonial attempts of modernization through training of *dais* into midwifery and public education and motivation towards the colonial initiatives. This situation was sustained only till the political wave of 'nationalism' picked up momentum in British India. The wave of nationalist politics constructed an independent identity for the Indian proponents of western midwifery in the journey of modernization of childbirth in Bengal. In other words, Bengal witnessed the emergence of a split among the so far united 'reformers'. British reformist initiatives failed in the face of the nationalist politics of reforms (Engels, 1993). In this domination of the ruling and elite class over the management of childbirth in early twentieth century colonial Bengal, women followed the model created by the British and Indian medical men (Robertson 1846; Murray 1868 and others).

Managerial reforms of childbirth and traditional practices of the *dais* in particular continued through independence. The reforms, however, led to marginalization of the *dais* in the Indian health care delivery system. At the time of independence, the planners were convinced of only the benefits of modern medicine. Later, obligations of the state to the international agencies influenced the national health and other interconnected sectors in planned development, a great deal (Banerji 2001, Qadeer 2001). West Bengal, at the turn of the century, reiterated similar global links and dependence on the research

initiatives in health (Soman 2005). As a consequence, public health interventions have been marked by contradictions between promotion of institutional delivery on one hand and promotion of local health traditions on the other (Sadgopal 2009). The state of West Bengal, which with great enthusiasm promoted institutional delivery in the past decades, conforms to a similar contradiction. Under such circumstances, Sadgopal (2009) suggested a notion of 'comprehensive maternity services' that would accept the '*dai*-tradition' in health service system. According to her, it demands cognizance of the dimensions of class, caste, gender, power and ideology that prevail in the society.

The *dai* of Bengal has been a constituency, overwhelmingly represented by women. In stratified rural West Bengal, women across generations reveal influences of changing social formations on their position in family and society. Socio-economic transformation touched the lives of women here lightly as compared to that of men. Induced reforms had impacts on the delivery care practices. While a shift from home delivery to institutional delivery has been evident in villages of West Bengal, threat to reproductive function of women in a patrilineal social structure generated greater social concern compared to their ill-health, compromised with nutrition and rest (Soman 1992; 1997). It is within this dichotomy that continuity and change in the lives of *dais* or indigenous traditional midwives needs to be assessed. Moreover, narratives of the living *dais* are stories of the socio-economically marginalized women too. They live under precarious socio-economic conditions. Further analysis of the socio-economic information on a hundred *dais* reported by Mukhopadhyay (2008) reveals that *dais* overwhelmingly represent the marginalized social groups including *dalits*, *adivasis* and muslims. They dwell in landless or marginally landed, wage earning households. This low social status of the *dais* in villages also reflects on their subservient position in the health care delivery system.

In transition through the twentieth century and later, the *dai*-tradition in Bengal has served as a crucial point of dual dependence - for both, the communities and the public health care system as well. As a consequence, the institution has been also a site of conflicts and tensions. *Dais* continue to be valued in sections of the society where fruits of planned development are yet to reach or the public

health care facilities are yet to be made accessible. They continue to serve these communities either free or at nominal fees, without any restriction on their availability or timings (Banerji 1985). Akhter (2002) from Bangladesh has also reported similar conditions of the *dais* there. In contrast, the public health care system has not only always discouraged them from playing their traditional role in social reproduction, but also underestimate their potentials in the health care system as well (Sadgopal 2009, CHSJ 2008).

### ***Dai* and Reforms of Birthing Care in Colonial Bengal**

The Indian tradition of *dai* was at the center of scrutiny and attacks in customs, debates and reforms regarding childbirth that were part of the wider discourses on health in colonial India. Katherine Mayo's essay: 'Mother India' is an illustration of how the colonizers referred to the institution of *dais* as an icon of 'dirty', 'unclean', 'ignorant' breeding womenfolk, who performed 'monstrous' deeds and were 'blameworthy creatures'(Mayo 1937). This attitude towards the *dais* was probably an extension of domination not only in political power but also institution of knowledge related to child birth and its 'management'. Some of this attitude was even carried over in the Malthusian eugenics of the Family Planning Programme in the early decades of post-independence India.

In early nineteenth century, the larger colonial project of establishing the then 'modern' and 'scientific' knowledge of western medicine had set a tone of domination over the age old traditions of indigenous systems of healing and health care. This, in turn, manifested itself as colonial intervention in the management of childbirth in Bengal, implicating local health cultures and *dai* tradition in particular. It was more of a process of consolidation of power under colonial agenda than isolated events that finally led to establishment of the first medical college in the city of Calcutta in 1835. This institutionalization was a landmark in establishment of western medicine in Bengal through medical education and training. The process, however, was marked by socio-political interactions between the defenders of western and indigenous medicine. For instance, the colonial state was earlier apparently tolerant to (if not appreciative of) the indigenous health care practices in India till 1820s. Consequently it had set up the

Native Medical Institute (NMI) and involved Sanskrit College and Calcutta Madrasa to produce 'native doctors' who were trained in both, a traditional system of Ayurveda or Unani and western medicine as well.

The scheme of NMI was designed primarily to produce a class of doctors to protect the health of the company servants but later the practice was dropped in an organized manner on grounds of poor performance. A committee was set up that, after heated debates, advised abolition of the integrated course and the NMI as well. Instead, it recommended in favour of a new institution for teaching western medicine in English medium. Thus the first Medical College in Calcutta came into existence. It became a major landmark in the establishment of western allopathic medicine in Bengal (Arnold 2000, Harrison 2006). In this shift, Madhusudan Gupta, a Sanskrit scholar and Ayurveda doctor at the NMI, was given admission in the first batch of students in Medical College. He was one of those students, who were the first to dissect a human body and qualify in western medicine in India in 1838. Another Indian advocate of western medicine was the scholar 'Soorjo Coomer Goodeve Chuckerbutty' who first joined the Indian Medical Service with an MD degree from London and later became a distinguished Professor of Medical College— as the Chair of Materia Medica and Clinical Medicine. Thus Medical College became a landmark in institutionalization of western medical education and training in Bengal. This was simultaneously followed by setting up of hospitals not only for health care of the then officials but also for reforms in the prevailing indigenous health care practices (Arnold 2000, Forbes 2009).

As an important part of the colonial project of modernization of health care, hospitals in Calcutta became the immediate hub of training and reforms. Attempts of reforms were not only aggressive but also extended to physical management of child-birth. In 1838, a large female-maternity hospital was started in Medical College. At this time, maternity hospitals were labeled as 'Lying in' hospitals for they promoted the western practice of women giving birth while lying on the back over the traditional Indian practice of giving birth in kneeling or squatting position. This disapproval of traditional practice

was officially recorded in the 1901 Census. Influenced by European medical practice, 'Madhusoodan' Gupta became one among the early native Indian male physicians and advocates of 'western midwifery' – following the European practitioners in India (Robertson 1846). Simultaneously, the missionaries since 1850s and later the Dufferin Fund – a philanthropic initiative that was dependent on state favour - brought in medical women and funds from the West and engaged in hospital centred management of childbirth in the second half of nineteenth century (Arnold 2000). These women were later joined by the women of the Bengali elite. However, the Indians later distanced themselves and consequently resisted their British counterparts during the rise of Nationalism in Bengal. Ongoing reforms in hospitals generated debates in Bengali society and had further implications for the tradition of indigenous midwifery in nineteenth century Bengal. Briefly, this is the way how the western medicine expanded to pose threats to the indigenous health traditions in Bengal, the *dai* in particular.

High maternal and neonatal deaths and precarious hygienic situation and management of childbirth had been an area of major concern of the colonial state that musicalized childbirth. There were instances when the woman graduates in western / allopathic medicine left their country of origin to choose cities in India including Calcutta in Bengal for practising obstetrics and gynecology. They managed to mobilize a section of the urban elite women for active support and promotion of the medical modernization projects of Lady Dufferin Fund and similar others (Qadeer 2005; Jeffery 1988). Though this phenomenon was yet to manifest itself in the villages of Bengal even till the turn of nineteenth century, the tradition of *dai* that dealt with maternal and child care at and around birthing had to face the threat of losing its cultural roots because of alien 'medicalization'.

A number of colonial initiatives that was started in the late nineteenth century had little achievement in reforms of childbirth in Bengal. A major component among these initiatives was setting up of maternity wards or 'lying in' hospitals by the state dependent Dufferin Fund in 1886. Another was the initiation of modern nursing and midwifery course, offered by the British educators and Vicereines at the

Campbell Medical School in 1883. Such initiatives failed to effectively mobilize women to 'lying in' hospitals or retain the acquired practices of the midwives trained by them. These initiatives failed primarily for their disconnectedness with the lives of Bengali women and culture of the Bengali society at large. In early twentieth century, it was the turn of the *dais* to respond, in turn. The Victoria Memorial Scholarship Fund that was organized by Lady Curzon in 1903 to introduce a training scheme for the traditional midwives had failed as the *dais* who had attended the classes for a couple of weeks soon returned to their old habits. For the majority of women, childbirth remained unchanged till 1910 (Engels 1993).

*Dais* were under severe criticism from not only the colonial state but also from the then modern medical women and urban elite of Calcutta. Training in modern midwifery became a prime agenda of this modernization project. Women and men from the elite urban Bengali society who were convinced or already trained in allopathic medicine got engaged in public education in various ways. Some of them took interest in writing related essays in Bengali periodicals. They reiterated the arguments of the western professionals and colonial state, blaming and attacking the traditional *dais* for being 'dangerous', 'ignorant', 'illiterate', 'unscientific' and 'unhygienic', negating the strengths of the indigenous knowledge and tradition of *dai* in the health culture of Bengal. Articles published in Bengali periodicals - *Antohpur* (The Private Space) and *Swastho Samadhan* (Health Solution) published between 1902 and 1912 had echoed these criticisms (Mukhopadhyay 2008: 27-36).

Almost simultaneously, women who argued for 'modern' and 'western' *dai*- reforms reflected diverse views when it came to understanding the social factors associated with high maternal and child deaths. Reports of the 1901, 1911 and 1921 censuses of Bengal revealed such insights. While the British claimed 'early marriage' as one of the major factors associated with infant mortality, the Bengali doctors and health workers on a note of denial, pointed to 'malnutrition of overworked women and economic decline of the province' as the causes of such deaths. They argued that it was not mother's low age at birth which exhausted women but the high frequency of birth

that led to the fatal consequences (Engels 1993). Depending on the political circumstances, the official view, however, had ignored the latter argument raised on the basis of official census data. Eventually the white women doctors became the target of criticism of not only the Bengali press but also competing Indian women doctors who went with the wave of nationalism in Bengal.

In the wake of the First World War, maternal and infant health became matters of worldwide interest. At this time, efforts of Bengali women to reform practices of childbirth got overwhelmingly linked to the nationalist politics opposing the colonial explanations of the adverse maternal and child health and projections on 'improvement'. Their reforms of birthing and child care were welcomed in the vernacular press. In the 1920s, their urban centred initiatives embraced the villages too. In 1926, *Chittaranjan Seva Sadan* – a maternity hospital with a public health section was founded for the special purpose of training midwives for village work. Unlike the earlier colonial attempts, the reforms under *Swadeshi* movement were successful in mobilizing middle class women into midwifery and nursing. Reforms in education and continuing supervision of *dais* for improving their practices were initiated in villages. Though the Indian nationalist women overcame the racial bias of their European predecessors, with their middle class background they could bring limited benefit to mothers and *dais* in rural Bengal (Engels 1993).

This historical account of colonial reforms in health highlights major shifts in the interests and initiatives of the colonial state in Bengal. It tells us that the colonial attempt of modernization of health care in India was part of their imperial agenda. This had influenced the institution of *dais* as part of the indigenous tradition of health care. The traditional indigenous institution was under constant scrutiny by various interest groups – the upholders of western medicine. The Indians followed the Europeans and the women followed their male counterparts. Counter arguments and attacks came as natural consequence of such domination, which had specific intentions of expansion of colonial power on one hand and posing resistance against that power, on the other. The conflict had mounted further when the grim picture of maternal and new-born deaths at and around

delivery emerged as a political concern among the freedom-seeking Indians. At the core of this was the issue of imperialism vis-a-vis nationalism. Bengali women from urban elite families that had earlier collaborated with the colonial project of reforms of childbirth, later caught in the waves of nationalism they adapted the colonial ideas of reforms in local contexts and created their own independent organizations in order to reach out to the villages of Bengal. At least until the 1920s, Bengal was viewed by the British reformers as the heartland of opposition against colonial rule.

Irrespective of the developments, the tradition of *dai* continued to be a source of dependence and support for the communities in Bengal along with the practices of home delivery. Western and colonial ideas of reforms and training of *dais* were narrow and limited in their approach. It was far from the cultural setting of Bengal within which, the process of birthing was shaped. Taking note of the reality that most of the deliveries were still being conducted at home, the Bhore committee later recommended integration of the traditional *dais* into the health care delivery system (GOI 1946). At the time of independence, this became an important reference point for health care planning in post-independent India, though the conviction of prevailing western ideas of reforms continued to influence the Indian planners and maternity care interventions. By now, the dichotomy of tradition and modernity in the discourses on reforms of child-birth had created two sets of midwives; one – trained in western knowledge and the then ‘modern’ practices and the other – retaining traditional practices and folk wisdom. The attempts of transforming the ‘traditional’ into ‘modern’ continued in the later period through planned interventions.

### ***Dai* in Planned Interventions**

India’s freedom from the British rule in 1947 was accompanied by partition, which divided the Bengal province. Part of the province that remained with India came to be known as the state of West Bengal. West Bengal, as part of the Indian Federal Republic, has been covered by national planning and development. The urgency of dealing with maternal deaths and deaths of new-born came up as concerns at different points of developmental planning. Initiatives in improving maternity services could not keep silent on the huge resources of

*dais* in the prevailing inadequacy of modern midwives in rural health care services of West Bengal.

At the time of independence, there were the recommendations of two committees. Recommendations of the Bhore Committee, which are also known as the National Health and Development Committee (1946), and the Sokhey Committee or the National Planning Committee (1948) both attended to the appalling state of maternal and child health. The recommendations forwarded directives for development of infrastructures and services. In the beginning, Bhore Committee’s notion of integrating traditional *dais* into the public health care services found some importance in planning. This had provided space for four ‘trained *dai*’s along with equal numbers of trained midwives and Public Health Nurses and a woman doctor at every primary health unit that was to serve a population of 20,000 ( GOI 1973). This equal importance of the ‘trained’ *dais* and midwives however did not continue for long (Qadeer 1998). Lopsided priorities in health care planning eventually tilted towards the heavily funded Family planning intervention. In the process, *dais* were converted into a bunch of family planning motivators by the 1960. At the turn of the twentieth century, the picture of health services in West Bengal was not very different in the proposals to empower the *dais* in various ways including their conversion into a bunch of ‘link workers’ to bridge the gap between the people and the public health care system (CHSJ 2008). However, Sadgopal (2009), quite rightly points out that there is an innate contradiction within the discourses on the National Rural Health Mission (NRHM) itself. This contradiction is between its commitment to promotion of ‘institutional delivery’ over home births and simultaneous revitalization of the local health traditions, which the *dais* are part of. This has serious implications for the institution of *dais* that is located in web of class-caste combine, gender, power and ideology prevailing in West Bengal.

The official reports of the health department reveal more. Here is an example. Data cited from the Sample Registration Scheme for the year 1998 revealed that though institutional delivery was higher in West Bengal (36.2 percent as compared to the national average of 25.4 percent), the *dais* played a much more significant role in the



delivery of mothers in West Bengal (49 percent of live birth) as compared to the national figure of 41.8 percent (GoWB 2001). Even after more than a century long 'reforms' of child birth, contribution of indigenous traditional *dais* in West Bengal seemed much more significant compared to that by the modern medical doctors, nurses and trained midwives together (49 percent as against 13.9 percent). Yet, the same official report, while presenting a detailed account of the strength of the government medical doctors, nurses, midwives and others, maintained silence on the strengths of the *dais* who ensured their services in the public health care system of West Bengal. This clearly indicates that the change that has happened so far is more in the institutional structures than in the attitudes of health administrators. In other words, there is a continuity of the core colonial attitude in favour of the western ideas in medicine over the *dai* tradition.

There have been some attempts of *dai*-training and reforms of their practices through planning and interventions, which have been only an extension of the kind of reforms that were evident under the colonial rule. Prevailing western medical thoughts continued to influence the *dai*-training and recommended practices, totally ignoring their folk wisdom and traditional roles in birthing. There is an analysis of around 60 available reports of health related studies conducted in West Bengal at the end of the twentieth century, using qualitative research techniques alone or in combination with quantitative methods. This analysis revealed that given the inadequacy of public health infrastructures, how crucial the roles of the *dais* have been in conducting deliveries at home. Their training, however, has not been effectively translated into desired 'safe' practices at delivery such as use of kit, often due to lack of timely supplies or irregular follow up at the state level (Soman 2003). In short, training failed to release the *dais* from the various charges of the colonial past of damaging the society by being 'ignorant', 'unscientific', 'unhygienic' and raise their status to that of an 'informed', 'scientific' and 'hygienic' lot of midwives. However, there has been a ripple effect of such training on the *dais* that remained beyond the coverage of official training. After training, the *dais* shared with their un-trained colleagues in villages the ideas, knowledge and skills that they had acquired through

training. Moreover, they applied a process of selection of ideas, knowledge and skills that they considered would be viable for improving the outcomes of deliveries in their communities and settings. Some of these selective practices sometimes influenced those who were not formally trained. This ripple effect of *dai*-training went unnoticed in the available documentations. *Dais* of Bengal – irrespective of being trained or otherwise – have constantly combined both, inherited traditional and acquired modern knowledge in their practices to meet the challenges of maternal and newborn care in West Bengal, particularly among the un-served and under-served communities (Soman, 1992; 1997, Mukhopadhyay 2008). This diffusion of traditional health culture and modern western practices in specific social realities of deprivation and marginalization and consequent reformulations of folk practices and knowledge is overlooked in the state level planning exercises.

Globalization since the 1990s witnessed certain developments and shifts in the research and policies of international agencies engaged in health interventions in the developing countries. These agencies through construction and reconstruction of health knowledge tend to influence perceptions and practices prevailing within these countries. This is another face of imperialism. The global agencies not only influence the national government but also impose compulsions implicating its developmental paradigms and domestic policies. This, in turn, has also shaped the course of development in the state of West Bengal. This is how the power and capacities of global agencies induced shifts in the local public health care services. Role played by the World Health Organization (WHO 1994) since 1990s is worth mentioning here.

In the 1990s, the WHO shifted its stance from recommendation of integration of trained *dais* into the modern maternity care system to promotion of 'skilled birth attendance for all'. This, while opening up opportunities for the qualified doctors and nurses, reduced the status of trained *dais* to 'link workers' – as mere assistance to the 'skilled birth attendants'. This subservient and declining status of the trained *dais* in the present decade is not very different from what they were offered by the Family Planning programme in the sixties, in the name of 'community-mobilization'. The argument that surfaced in the

beginning of the twenty-first century is that there is no hard evidence to prove that the trained *dai* is an effective lot in reduction of maternal deaths. Simultaneously, relevant literature has drawn attention to the limitations of the components of *dai*-training itself. It has also revealed that as a consequence of training, the *dai*-wisdom had to suffer damage in those spheres of the traditional practices that were safe (Sadgopal 2009).

Debates initiated by the Government of West Bengal and UNICEF on the 'Safe Motherhood Day' in 2004 echoed similar expressions among the modern medical fraternity against the *dais*. This was like blaming one's own creation (which is the trained *dai*) who emerged from modern medical interventions in public health care at the state level. Amongst the physicians, though a larger section echoed the argument of 'lack of hard evidence in favour of *dai*' with reference to studies commissioned by international agencies, a smaller section revealed another view. They expressed that the trained *dais* were needed but only till the process of transition to 'skilled birth attendants' is universal. There were a few physicians and nurses who pointed to the social relevance of the *dai* tradition that works as an appendage to the public health care dominated by bio-medical paradigms. However, such notion of 'skilled birth attendance' propagated by the WHO is not the ultimate in systems of knowledge formation. Sadgopal, informed us that a publication in the WHO Bulletin, based on information collected from a group of countries has already challenged the 'skills' of the existing 'skilled birth attendants' that were projected by the WHO to be superior to the 'incompetent' and 'ineffective' Traditional Birth Attendants (TBA) or *dais* (Harvey et al 2007 cited in Sadgopal 2009). The millennium development goals for reduction of child and maternal mortality imply that the state of maternal and child health continues to pose challenges for the modern medical care. Limitations of the bio-medical paradigm of obstetric practices itself needs to be articulated through systematic investigations in the developing countries.

In brief, the subservient status of the *dais* that surfaced in the colonial discourses on reforms of child-birth in nineteenth century Bengal continued to the post-colonial period. Attempts in reforms of the

traditional *dais* that were initiated in the colonial period got intensified and extensive in the nationalist movement and post-independent developmental agenda. In the process, *dais* lost their traditional autonomy and status in health care system in most of Bengal and were reduced to an appendage of the 'skilled birth attendants' in public health care, comprising physicians, nurses and associate midwives. This marginalization of the *dais* in health care system took place within the larger social and economic transformation. The institution of *dai* underwent transformation too. The tradition, however, has not completely withered away. It still continues to be a source of support and strength in communities where the public health care failed to reach and for the socially deprived who needed it. A narrative of three *dais*, appended to this article, reflects on some aspects of their situation in recent time (End Note-2). Stories of *dais* are narratives of marginalized women too. Hence, it would be meaningful to take a glimpse of the continuities and changes in the lives of these women across generations – with changing social formations in the villages of Bengal.

### ***Dai* in Changing Social Formations: Insights from Villages of Bolpur**

In the preceding section, the focus was on the changing position of *dais* in the dynamics of official health systems in the twentieth century. Here, however, the attempt is to capture some of the social processes that simultaneously touched the lives of the *dais* located in the official category of 'scheduled caste' or *dalit* communities in twentieth century Bengal. *Dais* have traditionally represented these households that have been located at the bottom of the socio-economic hierarchy and plural cultures of Bengal, with some departures later in the process of social and economic transformation. Restraining from an act of wide generalization, here the discussions primarily reflect on a section of the village society that was guided by the laws of the Hindu *Varna* or caste system. This section attempts to find out how the larger socio-economic transformation in villages of Bengal had penetrated these households or families, touching the lives of their women across generations including that of the *dais*. The narrative is located

in the peri-urban villages around the educational institution Visva-Bharati founded by Rabindranath Tagore in the mid-1920s. Both, Visva Bharati and these peri-urban villages are now under the administration of Bolpur block of Birbhum district in West Bengal. Birbhum, which at the beginning of twentieth century was included in the map of 'Burdwan division', later became the backdrop of the social commentaries of the novelist Tarashankar Bandopadhyay (Bandopadhyay 1943).

Establishment of Visva-Bharati, growth of Bolpur town, improved communications with villages and the emerging market economy had a major impact on the stratified villages opening up socio-economic opportunities for the households (End Note-1). Besides, the British Law of scheduled castes in 1935 was enacted to protect the economic interests of the 'scheduled castes' or *dalits*. This had resulted in introduction of welfare opportunities for them that included reservations particularly in education, employment and land allotments. This, in turn, had a noteworthy impact on the households where the *dai* or the medical women were located.

This, almost instantly began to benefit the *Snuri caste* – the traditional dealers of *toddy* ( a local liquor) or the *Saha* households (Amir Ali 1960). Among the 'scheduled castes', the *Saha* households were the first to experience upward occupational mobility. For instance, the primary occupations of the *Saha* households shifted from toddy-making to agriculture, rice-milling and secure jobs in government institutions. Forces of socio-economic transformation in the area, however, did not have any similar beneficial impact on other *dalit* households that had less bargaining power among the 'scheduled castes' per se. In time, though the caste system in villages had loosened to some extent, it was replaced by notions of 'caste-class combine', only redefining the criteria of social discrimination and domination that was earlier associated with the practices of 'purity and pollution'. This, in a way, incorporated the emerging economic criteria in social interpretation of inequalities and differentials in villages. The upcoming *Sahas* were the privileged amongst the 'scheduled castes' in the sense that their women and men had better acceptance

in the upper caste households. They were not subjected to discriminatory cultural practices as intensely as compared to households representing other scheduled castes.

Pictures of socio-economic transition in the villages had constructed the perceptions of their women and men across generations. Not only Visva Bharati alone but also the enactment of social-protection law/s, rupture of the village economy, growth of Bolpur town and development of its communication with the villages acted as harbingers of change in the area. Residents witnessed changes in more specific aspects of their lives in the villages such as family land holdings, seasonal agricultural patterns, growth of welfare opportunities and services including the health services, political and other institutions implicating power structures and social relations in the villages. Women themselves said that their own lives had also changed in spheres of work, rest or leisure. This perceptible transformation in the social and economic lives of the people in villages had a differential impact on the household or family dynamics in different socio-economic strata. The dynamics of the family or household, in turn, touched the lives of the women lightly as compared to that of their men. Women continued to experience a subservient status within and beyond family. They continued to compromise on health care, nutrition and rest (Soman 1992, 1997a, 2007).

The declining social position of women reflected on pointers in development. For instance, time trends in sex ratio of Birbhum district and Bolpur per se reported in the census data indicate that women in Birbhum district had enjoyed a higher social status as compared to their men in the earlier phase of the century. This trend however got weakened in the post 1941 period. At the end of the century, though women worked in agriculture, household industries, government institutions and elsewhere, their social status continued to be secondary to that of men (Soman 1997).

There is enough evidence in literature that points to a strong connection between the folk wisdom of *dais* and classical texts of *Ayurveda*. Birbhum district had a rich heritage of Ayurvedic healing since 11<sup>th</sup> century AD (Majumdar 1975). This heritage does not manifest itself in the current formal health care systems, though. Villagers do reveal

that use of herbs and plants in cure and prevention of ill-health waned as the natural habitats disappeared following onslaughts of urbanization, commercialization and encroachment of the forest lands, growth of 'hospitals' and dispensaries' offering quick fixes in illnesses, delivery care and other situations. This kind of transition left the onus of folk wisdom with the folk healers who became socially and economically marginalized and powerless in time. Experiences of the *dais* have been similar. In spite of the weakening of the tradition, women across the socio-economic strata expressed that birthing is a natural process and delivery at home, that is, in the hands of village *dai* is the most suitable step for them. In practice however, dependence on the *dais* and practices of delivery at home became more pronounced in the poorer households compared to the better-off. This was a reality in villages within seven kilometers from Bolpur town where women commented: 'after all *dai-ma* is a familiar face and close to us'. This was their opinion as against their experiences in the government health care institutions, particularly Block-PHC in Bolpur (Soman 1997). However, the *dais* influenced by modernization projects advised women to utilize the antenatal services offered by the public health care facilities in order to prevent complications at delivery. These women, nevertheless, appreciated the idea of 'injections' (immunization) and 'fresh iron pills' (preferring the bright red iron-folic acid tablets over those that became discolored in the storage and supply lines).

Modernization of delivery care succeeded in bringing out a shift from home delivery to institutional delivery, particularly in post-independent India. Societal concern for women, irrespective of the position of their families in the socio-economic hierarchy, appeared to be more intense when their biological reproduction was at risk compared to general ill-health resulting from excess of physical labour or lack of nutrition or rest in daily chores. Patterns and quality of health care for women also have been worse than that of their men in families across the socio-economic ladder. In such patriarchal social settings, the households that were at the socio-economic margins either surviving on wage labour or on marginal agricultural land, or both, preferred home delivery over deliveries in primary health centres. This group overwhelmingly represented the *dalits*, or 'scheduled caste'

communities - popularly identified as 'chotolok' in villages – referring to their lower economic and caste status in the village hierarchy as against 'barolok' (the rich) and 'bhadrolok' (the educated wealthy). Deliveries, in these households, even at the end of the twentieth century were conducted largely by the neighbours or relatives who had the skills of traditional *dais* but not necessarily a formal training. The *Sahas* escaped from this process through an upward mobility in their socio-economic position in villages under the collective influences of the harbingers of change. With this, their daughters used 'reservation' and other social opportunities in education and employment that were granted to the 'scheduled castes' and they moved out of the village. This was a departure from the lives and occupations of the *dais* or medical women in the *Saha* households. There are other stories too. Though the women in other 'scheduled caste' households were not able to benefit similarly, their daughters chose to find occupation in the diverse economic opportunities that emerged in Bolpur town and Visva Bharati as well.

In brief, the socio-economic transformation in the villages of Bolpur, by influencing the dynamics of social stratification, penetrated the family dynamics among the *dalit* communities. This had implications for the lives of their women including the traditional *dais*. Women across generations were brought out of their homes to the 'external world' with various reasons and to different extents. As a consequence of the differential impact of the transformation among the *dalits*, experiences of the women in the *Saha* households were different from that of women in *Bauri*, *Bagdi* or similar other households. Nevertheless, what was common for these women is that they were face to face with the world that was beyond the fold of their domesticity. Moreover, this transition drove the tradition of *dais* into three directions. One, *dais* benefitted from the opportunities offered by the state and moved out of villages to take training in modern midwifery and nursing and found employment elsewhere. The second path was that some, limited by the lower socio-economic position of their families, tried to get attached to the public health care system after training. They opted for this as a possible escape from the grinding poverty their families were living in. This was also a way to deal with the fear of losing skills as a consequence of declining

demands in villages due to the shift from home delivery to 'institutional delivery'. In some households of *dais*, despite bearing the brunt of poverty, the daughters opted out of their mother's tradition – as according to them, 'it has neither brought (us) cash nor it relieved us from discriminations of (meted out by) the 'Barolok' or 'Bhadrolok' (collectively the upper caste educated)'. A daughter named *Nando* – picked up a job of domestic help in the town even though she had to walk for half an hour to and from the place of work, through the paddy fields in harsh summers and wet monsoons. The social position of the *dais*, in a way, echoed their status in the health service system. A narrative that highlights some of the aspects of the changing lives of the *dais* is appended for reference (End Note: 3)

These stories of transition are only suggestive of what happened to the tradition of midwives in twentieth century Bengal within the fold of the Hindu caste hierarchy. Larger socio-economic forces of transformation pervaded the households in social class differentially – dividing the *dais* and touching their life processes. This, however, cannot be generalized for others. In other words, the social processes that touched the lives of the *dais* have been not in isolation from either their families or women in families across socio-economic hierarchies. Thus narratives of their social existence or transition are associated with both, the struggles of their families as well as struggles that women themselves experienced under patriarchal influences in their lives in villages of Bolpur in Birbhum district of West Bengal. According to current official data, the 'scheduled castes' represent 23 percent of the total population ([www.anagrasarkalyan.gov.in/htm/state\\_data.html](http://www.anagrasarkalyan.gov.in/htm/state_data.html), accessed on 28 April 2011). Though the average sex ratio at 949 is higher compared to the overall state average of 934, the social status of women is subservient to that of men. Other social pointers reflect on similar pictures. The female work participation rate in West Bengal is 22 percent as against that of 54 percent among men. Similarly, the literacy rate for women is at 47 percent as against that of men at 70 percent (GOI 2001).

Ruptures in the institution of *dai* or medical women in villages around Bolpur town or Visva Bharati in the twentieth century have been

associated with the kind of influences that the larger forces of social transformation in the area had on their families and on the women, in turn. Both, the family dynamics and the dynamics of the public health service system created situations within which their self and social images were shaped. Tagore's idea and experiment of rural reconstruction in these villages in pre-independence period had joined this process of rupturing. This was evident in the attempts of modernization of the practices of child delivery and care through training of traditional village-midwives (Ray et al 2005, *Pathabhavan Praktoni News* 2011). This was in consonance with the larger western health care interventions routed through the village health cooperatives (Rathindranath Tagore 1938). This was also a continuation of the colonial agenda of modernizing indigenous health cultures to make these 'hygienic' and 'scientific'. However, while 'rural reconstruction' was instrumental to rupturing of the *dai* tradition in early twentieth century, it had only begun to influence the status of women in general. For instance, activities of 'village organization' had brought some women out of the boundaries of household and led to the appreciation of their 'feminine' skills such as embroidery, pickle making and others in the extra-domestic sphere (Visva-Bharati 1928, 1933).

### ***Dai*, Medicine and Politics of Gender**

Preceding sections revealed that the *dai* tradition witnessed ruptures in twentieth century Bengal, resulting in discontinuities to a great extent. At the beginning of the century, birthing in villages was a major domain of *dais* who served as an important support to not only biological but also social reproduction. They were offered the status of 'mother'. Their status and dignity, however, came under the threat of imperial projects of modernizing medicine that had subsequently engaged in reforms of the traditional practices of childbirth.

Preludes of imperialism that were already set in attempts of establishing the then 'modern' western medicine primarily received attention and support from the urban elite - men and women - who were convinced of the benefits of it. Whatever was traditional in delivery and child care practices was rejected on the grounds of being 'unscientific' or 'dangerous'. *Dais* or the traditional midwives

were blamed for being responsible for high child deaths at birth. They were targeted for reforms through training that they were certainly not comfortable with. They expressed their resistance by escaping from the training sessions that were organized in Calcutta. Later, though the wind of 'nationalism' and 'self-reliance' cornered the moods of alliance of the elite with the imperial constituencies, the image of *dais* as cause of child death continued to stay and so did the needs and attempts for their reforms through training and education. This, however, was seen within the fold of the nationalist project of identity.

In the later period, post-independence planning did not see any change in the attitudes of *dai* training as the Indian planners were overwhelmingly convinced of the superiority of the western medicine as compared to the indigenous systems. Introduction of profit oriented techno-centric modern medicine, supported by international establishments in research and policy formulations first made its entry into Indian planning through the Family Planning Programme and later expanded its territory in the Indian health care delivery system. While expanding its reach it ignored cultural contexts and human experiences. The event of 'birthing' in families was shifted from a cultural setting governed by the *dai* and family to modern health care system. Simultaneously, the aggressive Family Planning Programme reduced the *dais* to a bunch of family planning motivators. Later, the agenda of population control became more aggressive and it encroached the female body by controlling biological reproduction of women in the name of protecting women's health, reproductive health in particular. Techno-centricity of these programmes ignored the fact that technology is invariably linked to social relations and has consequences for women's role in not only biological but also social reproduction. Application of reproductive technologies in public health care programmes silently threatened the respect and relationship that the *dais* had experienced in villages so far. At the turn of the century, internal agencies initiated research and dialogue on policy formulations that not only repeated the act of colonial blaming of *dais* or *TBA*s (traditional birth attendants) but also proposed to replace them by *SBA* or skilled birth attendants. *SBA* is a collective consolidated category of modern midwives, nurses and physicians, who according to the international advocates in health, can only ensure safe delivery

even in emergency obstetric situations. In the process, the disempowered *dais* have been granted the role of honorary link worker or potential activists to perform as mobilizers between the communities and the public health care system. Their marginalization in the public health care system of India impacted on their identity from a dignified social reproducer to one dependent on the state for obligation in exchange of dignity and status.

Changing social formations also had their impact on the tradition. Lives of women changed following that of their men in families or households, across generations. In stratified villages of Bengal, *dais* amongst the Hindus represented the *dalits* or 'scheduled castes'. However, within the community, caste-specific welfare policies had differential impacts. For instance, while the *Sahas*, traditional *toddy-makers* of rural Birbhum, experienced upward socio-economic mobility, others such as *Bagdis* or *Bauris* were far behind. Similarly, the *dai* women in the better-off *Saha* households followed their men. Their daughters moved out of the village with aspirations of becoming modern midwife or nurse. Thus a new category of modern midwives emerged that in turn bestowed women with an economic independence wherein they could bargain in gender relations within and beyond the family. In contrast, the *dais* in the poorer *dalit* households continued to live the lives of those women who were yet to benefit from the welfare policies and got further marginalized compared to their better-off counterparts. They had little power in organizations of work to bargain with the masculine public health care system. In family, they identified themselves with the struggles of their men. The story of Sotika Bauri of Surul sub-centre is one such instance.

Sotika is caught in the contradiction that exists between the inherited tradition of *dai* and her honorary position in the world of modern medicine and midwifery. While admiring the tradition as one of 'socially accountable (*jawabdih*) to own communities', she admitted that she accepted her lower status in her present honorary role of community-motivator for institutional delivery. It was all with the hope of earning a 'salary'. However, there were other *dais* like Vidya Bibi - a Muslim woman of Moldanga or Sundari Hembram - an Adivasi of Balipara,

who silently asserted themselves by remaining independent in their practice and being selective in adaptation of practices that the 'doctors' and 'nurses' had taught them in training, thereby protecting their own independent space and the tradition to the extent possible. According to Vidya Bibi, Sotika had compromised 'autonomy' by joining the (government) health centre.

It is evident that the midwives in Bengal are divided into 'traditional' and 'modern', characterized by differing nature, terms and conditions of work. Similarly, the lives of the traditional *dais* represent a plural identity, bound by differing contexts as reflected in the lives of Sotika, Vidya and Sundari. These divisions in time have destroyed the basis of sharing community resources, principles of social cooperation and balance, the dream of 'self reliance' and 'freedom'.

Simultaneous to the marginalization of the *dai* tradition, a string of continuity can be still observed. The tradition that has been part of folk wisdom sharing strong connections with the classical texts – Ayurveda in particular – is now sustained in smaller sections of those who are un-served or under-served by the social policies and public health interventions, that is, the socio-economically marginalized who are yet to experience the fruits of development. There are other problems that are of etymological importance. For instance, the words 'health' or 'svasthya', often interchangeably used in modern and traditional medicine respectively do not carry the same meaning. For instance, the word 'health', in western notion is primarily interpreted in a negative note of living existence - as absence of disease, whereas the Sanskrit word 'svasthya' used in Ayurveda refers to a positive state of body and mind – as indicated by its grammatical break up into 'sva + stha + ya' meaning being poised in one's own self (Bhattacharya, 2011) or being in tune with one's own self. Given the basic differences ingrained in the notions of 'health' or 'svasthya', implications are far-reaching in the context of current revival of traditional healing or care in modern western contexts. While commercialization of traditional health knowledge and practices provokes rich nations and the rich within nations to access and benefit from such health care, it ensures profits towards further accumulation of capital.

In brief, the changing landscapes in twentieth century Bengal had implications for the *dai* tradition and the woman folk practitioners. Induced development not only undermined the woman-centred folk wisdom, but also reduced the inbuilt autonomy for women. It reduced the status of *dai* from 'social reproducer' to 'birth attendant' and later 'link activist'. However, the institution seems to be still relevant to the underserved and possibly some others too. The picture that emerges in the data provided by the third report of the National Family Health Survey for rural West Bengal (IIPS, 2008) reiterates the contradiction. It reports that more than 60 percent deliveries are conducted at home by *dai*. In addition it shows that while the traditional role of *dai* in post-natal care has withered away in the process of marginalization (2 percent cases only), one fourth of such mothers continue to live with no after-delivery care from the government services either.

Besides, narratives of *dais* are narratives of socio-economically marginalized women too. Social or self, their images emerge in experiences of power relations and struggles in divided public and private spheres. Thus constructs of status and images of *dai* – the medical woman – cannot be separated from the gender relations and struggles of women in society at large.

### **Acknowledgement**

The author acknowledges the valuable comments made by and support received from physician, researcher and author Dr. Jayanta Bhattacharya.

### **End Note**

1. The words 'family' and 'household' have been used interchangeably.
2. Here is a narrative of three *dais* whom I met in Bolpur block of Birbhum district in the month of August 2010:

#### ***Dais* in the New Millennium: A story of three women**

Sundari Hembram, Vidya Bibi and Sotika Bauri are three middle aged *dais* whom I met in the neighbouring villages of Bolpur town, about a year ago. They almost unanimously echoed that however noble their '*dai*' profession is, they had to depend on additional sources of income for the survival of their respective families. It was then the end of monsoon months. Agricultural wage-labour was still in demand. Sundari and Sotika were busy making use of

this opportunity, while Vidya Bibi sold 'old' (used or second hand) clothes in her community after collecting them from vendors of the city. Sundari, Vidya and Sotika represented the Adivasi, Muslim and Dalit communities respectively. These women represented the socio-economically marginalized sections of Surul census village. Sundari lived in Balipara - at the corner of Tagore's Santiniketan; Vidya is a resident of Moldanga hamlet – a settlement not as old as Balipara. And Sotika lived in Sriniketan where *Surul* subcentre of Bolpur PHC is located. They lived in thatched, cramped mud huts.

As local *dais*, Sundari and Vidya independently serve their own communities, while Sotika is attached to the sub-centre that has a wider coverage. Vidya and Sundari view their work as a 'service' to their communities that require the rare skills they possess. Vidya explained further... 'after all it is about bringing a new life on the earth..... a sacred act'. These women had picked up this occupation when they were at early teenage. Sundari and Sotika learnt it in their families, from mother and a relative respectively. Vidya's experience was different though. In Vidya's family, she was the first to take interest in this occupation. It was her curiosity about how babies were born that brought her in contact with an elderly *dai* of her community who lived in her parental village. Soon they became close and started discussing about the 'dos and don'ts' of conducting deliveries at home. Vidya gradually received hands on training from her. Skills of conducting home delivery that Sundari, Vidya and Sotika had earlier learnt in respective families and communities came under the scrutiny of the modern public health care system, later. This was evident in the *dai*-training that they were motivated to attend at Bolpur PHC. They returned home with some monetary incentives, a 'box and few pictures and papers' and some information and ideas that were new to them.

At least seven years had passed since then; there was little trace of the printed materials or aid that they received at the time of training. Vidya and Sundari, both mentioned that modern instructions on 'chord-cutting technique' and how to deal with 'khichuni' (convulsion) at the time of delivery were useful in their own working situations. They also acknowledged the emerging 'trends' of more and more women visiting the government health centres for 'injection' and 'tonic' to keep both, the 'poati' (mother) and 'bachha' (foetus) healthy. Yet they felt that women in their areas preferred to deliver their babies at home – in a 'familiar' environment. Neither of them remembered 'facing any strange situation' as a result of which, they had to refer any pregnant

mother to the PHC. After the training, they had never visited the government health centre again but did not hesitate to express their pride at their names being included in the register of the health centre.

In contrast to Sundari and Vidya, Sotika seemed to be indifferent to the discussions on the current techniques and practices of the local *dais*, as the honorary placement at the sub-centre had redefined her role in the present public health care system. Her role has been one of 'motivator' and 'mobilizer'. She now feels responsible for 'referring' pregnant women of her community and their families to government sub-centre for antenatal care, delivery and child care. She had to give up her own independent practice and accepted the subordination that the public health care system had offered her in exchange of anticipated social security.

These women live amidst poverty. Their income from the 'sacred' occupation is meagre. Sundari serves her people as a *dai* irrespective of what people offer her in return. She added: '...they are not rich – most of them survive on wages. They cannot pay always....'. Vidya said that her clients do compensate in kind, if not in cash – for instance, a new set of cloth or a 'gamcha' ( a piece of cloth used for wiping body after bath), some rice or vegetables... not so often in cash. In contrast, Sotika gets her remuneration from the PHC in lumpsum, at intervals of few months. Pointing to the small amount and irregular payments, she said: 'this is not a regular income. One cannot depend on this'.

I posed the last question: 'When did you last conduct a delivery?'. Sundari replied, 'at the onset of this monsoon itself' indicating 6-8 weeks before my visit. Vidya smiled and led me to a newborn lying on a mat in the courtyard - enjoying the sun after an oil massage! She said: 'six day old!! They are my neighbors - sharing the same courtyard'. The proud mother, while keeping an eye on her baby, was flipping through the pictures in a vernacular magazine. She looked healthy and hearty.

I left. I left with the images of these women. Will the policy makers ever visit them to learn more to formulate not a bio-medical model but a culture specific model of maternity care services in our country?

3. This is a story of change in the lives of *dais* who also served as medical women in villages of Bengal.

#### ***Dai* – the medical woman in changing villages of Bolpur**

In early twentieth century Bolpur, childbirth was a subject of 'purity and pollution'. Though the senior women in families had some



knowledge about its management, they did not have the skills and experience that the 'dai' women had. The dai who represented the 'scheduled caste' communities extended their services not only to their respective communities but also to the village at large – sometimes in neighbouring villages too. In exchange they earned social respect and remuneration more in kind than cash, from those who could afford it. They ensured their services to those who lived in poverty and could not pay as others.

Shrimati Sarolabala Saha of Aditipur, an elderly dai woman of Saha family (*Snuri* by caste, traditional *toddy* makers by occupation) narrated how time had influenced the lives of her daughters over three decades preceding the 1990s. She remembered that as a dai she was in demand till the sixties (1960s) when she extended maternity services to many of the upper caste and the better-off households in the village. In spite of being from a 'scheduled caste', she was accepted without discrimination based on touch or other criteria as the other members of the 'scheduled castes' had to face. She explained that this was not only for her support but also that 'unlike other lower castes, we have not been engaged in occupations involving bonded or wage labour. We have been engaged in toddy-making, rice-milling, business and similar occupations'. Her practice as a dai, however, slowly withered away as almost the whole village (barring some of the poorer households) turned to 'hospital' for delivery. Village grocery shops stopped selling the herbal ingredients that she required for healing and care of the mother and the new born.

She added: 'our men (belonging to households) shifted to business of rice-mills and some got employment at Visva Bharati. Eventually, the Act of the Scheduled Caste declared by the British Government in 1935 gave another dimension to their emerging social identity and opened up both, social and economic opportunities for the next generation. Inputs of development in post independent India had embraced not only the younger men but also the daughters of the 'Saha' family. Daughters who had appreciated their mothers' skill in delivery took interest in formal training in 'nursing' in the eighties and moved out of the village to join public services later. Briefly, the Sahas of Aditipur experienced an upward social mobility that touched the lives and social position of their women too. In contrast, the village dai continued to represent the scheduled caste households of the 'Bauri', 'Bagdi' and similar other communities that, unlike the Sahas, were deprived of the fruits of development – be it education, employment or anything else in welfare. Women followed their men. With the expansion of public health services in

the villages, such *dais* were left either as an appendage to the government health care system after receiving formal 'training' or remained outside the health care system and continued with their independent practice among the communities or households that represented the socio-economically marginalized who were yet to be reached and served by the public health care services. Gradually, it became difficult for women of these communities to continue to hold on to the tradition of dai. For instance, when a senior dai in Aditipur passed away in late 1980s, her sister who acted as her assistant so long, was ready to take over elder sister's midwifery role in the village. The villagers, however, did not have same confidence as they had in her elder sister. According to some of the villagers, she was 'new' (in the practice). They also preferred to visit the nearby sub-divisional hospital. Simultaneously there were daughters like 'Nando' who opted to work as a domestic cook in the better-off households in the town. For her, this was an escape from the social experience of discrimination and humiliation that she, her family had to experience in the village.

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