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From Dias to Doctors: The Medicalisation of Childbirth in Colonial India

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If she have sent her servants in our pain,
If she have fought with Death and dulled his sword,
If she have given back our sick again,
And to our breasts the weakling lips restored,
Is it a little thing that she hath wrought?
Then Birth and Death and Motherhood be nought.

-- Rudyard Kipling [1]

Kipling was paying tribute to the Vicereine who established the Fund associated with her name. This was an organisation which employed medical women (or 'lady doctors') to run a chain of hospitals and dispensaries all over India and Burma. Established in 1885, the avowed aims of the Dufferin Fund were to provide medical tuition to Indian women, medical relief to Indian women, and trained female nurses and midwives for women and children in hospitals and private homes.

Because the Fund was the first large endeavour in the area of women's health in colonial India, and because it enjoyed the patronage of the successive Vicereines and was associated with a great degree of official interest, it assumes more importance to historians than it perhaps deserves. It is said that no less august a personality than Queen Victoria herself was the moving force behind the establishment of the Fund. The medical missionary, Elizabeth Bielby, is said to have carried back to the Queen-Empress a message from the Maharani of Panna, imploring her to 'do something' for her 'daughters in India' who suffered so terribly in childbirth. When Lord Dufferin was sent out as Viceroy in 1883, the Queen asked his wife to interest herself in maternal health.

This story may be apocryphal but it is not without significance. It reflects the belief, widely-held, that the women of India were 'too backward' to help themselves, and improvement in the conditions of childbirth would have to be given to them by English women. It demonstrates the relatively newfound faith of the upper and middle classes of Britain in the medical management of midwifery. Queen Victoria had herself been delivered by a male surgeon, and

had made 'twilight sleep' respectable by using chloroform in labour. And the supplication had come from the Maharani of Panna, a member of the very class of purdahnashin women that the Dufferin Fund intended to reach.

Elizabeth Bielby, a 'zenana missionary' who spent most of her life in north India, represents the attempts to 'medicalise' childbirth in India that pre-dated and paved the way for the work of the Dufferin Fund. She had engaged in some amount of kachcha or untrained medical work in the zenanas for several years, teaching herself basic skills from manuals. When medical schools in England were opened to women, Bielby, like some other missionaries, returned on furlough and acquired a formal medical education in order to continue her work in India.

This was the origin of the Fund, which played a critical role in making Western medical knowledge acceptable and even desirable among 'respectable' Indian women.

As with many official histories, the foregoing account does not tell the whole story. In 1885, when the Fund was inaugurated, strenuous efforts had already been made, albeit by individuals and small organisations chiefly from the missionary fold, to provide an alternative system of care during delivery. They had played a part in convincing a small but influential section of the middle class that present methods and attendance were unsatisfactory and that it was, indeed, possible to provide a safer alternative. Therefore, medical care in childbirth was not a `gift' that arrived unsolicited from Britain to India. Pauline Branca has pointed out (1977: 89-107) the role of middle-class patients as innovators who demanded better health care in Victorian Britain, their threshold of pain decreasing faster than that of working class patients. The idea that pain was related to class was very strongly argued by most of the commentators on childbirth in India, and this was central to the special efforts, to draw the purdahnashin women to hospital. But we cannot always assess pain by the expression it is given for, in some cultures, screaming in labour may be a matter of shame. [2]

The role of medical missionaries is important in more ways than one. It was they who made a small but influential group of Indians desire medical attendance in childbirth, thus creating the climate for later more widespread work. It was this climate that made wealthy benefactors donate to the Dufferin Fund and other bodies.

And it was the missionary women who first drew attention to what seemed to them to have been appalling customs and beliefs surrounding the occasion of birth. It has been pointed out by a missionary author, who was not herself a

doctor but who described the practices of Bengali village midwives in the mid-nineteenth century, that 'unscientific' and 'unchristian' customs seem to have been indistinguishable. [3] For although the women who sought to reform childbirth in India themselves carried with their medical knowledge a vast quantity of cultural baggage, they were both baffled and shocked to find how much of the traditions that surrounded the occasion of birth were part of a wider cosmology of 'heathen' beliefs and rituals.

It was not only Kipling who suspected that, before the coming of Lady Dufferin, birth and death and motherhood were nought in India. The callousness and complete uninvolvement of men in the matter of maternity is a recurring theme in the medical literature of the early twentieth century. Several midwifery and household manuals are specifically addressed to men, asking them to be more concerned with the sufferings of their mothers, daughters and sisters (and, sometimes, their wives). A member of the elite Indian Medical Service delivered a public lecture in Delhi in 1920 on the responsibilities of men in matters relating to maternity, in which he compared the disinterest of Indian men with the complete involvement and care demonstrated by Englishmen. [4] This was central to the book Mother India written by the American 'feminist' journalist, Katherine Mayo, in 1927, which argued that a nation incapable of treating its women better was unfit for self-government. It is important to recall that Mother India was not an insignificant book. It went into many editions and was very widely read and quoted. The number of books written to counter it, apart from all the articles and reviews it generated, tell us something of the notice it did receive. [5]

Thus we see that the issue of women's health became an emotive issue that was used freely in the rhetoric for and against Indian nationalism. This had been central to the dispute that had revolved around the Age of Consent Bill of 1891, and again in 1929 when the Sarda Act was being debated. Whether early marriage and early motherhood debilitated Indian girls and made them produce weak, degenerate offspring led to a display of emotional and eugenicist arguments, often with racist overtones. Yet, we must not forget how crucial to the debate the marshalling of medical evidence was. The Committee set up to enquire into the matter in 1891 used the testimony of medical women. The passing of the Contagious Diseases Act and various amendments to it in the 1860s had also brought doctors to the forefront, for medical examination was necessary to establish whether a prostitute was indeed diseased, and the period needed to ensure that she was no longer infectious was also prescribed by doctors. Meanwhile, medical jurisprudence had developed as a specialised science, and doctors were being called in to give evidence in a number of legal cases, both criminal and civil. For example, property and inheritance disputes often hinged on matters like whether a widow was pregnant and the length of

the gestation; and criminal law reports are replete with instances of abortion and infanticide where a doctor's word for whether a child had-been born alive, or been viable at all, or whether there were signs of injury caused to the uterus could turn the course of the trial. Thus, in a number of ways the nineteenth and early twentieth centuries saw the growing importance of the medical profession. It is hardly surprising that doctors began to operate as an important political lobby as well as an influential social group that worked to further its own professional interests. [6]

Although the colonial state had not excessively concerned itself with matters of women's health, particularly in the early colonial period, by the 1870s it was sufficiently interested to consider the issue of training midwives at government expense, and the Dufferin Fund received official patronage. [7] When mid-wifery was included in the teaching course in medical colleges, there was the practical problem of finding enough clinical material. In order to provide enough maternity cases for medical students to handle, the Lying-in Hospital, set up at the Medical College in 1840, initially had to offer incentives in the form of small gifts to the women who came there for delivery. It seems only the poorest and most desperate women would go there, and this was the state of affairs for a fairly long time. In 1885, when the Fund was established, there were very few hospitals in India that catered only to women. In Calcutta, European women went to the Presidency General Hospital and some to the Medical College Hospital, while what was set up as the Municipal Pauper Hospital (and later renamed the Campbell Medical School Hospital) drew the poorer Indian women. In the early 1880s, midwifery had become important enough for the Medical Hospital to set up a separate hospital for women and children (interestingly, the two always went together) called the Eden Hospital. Neither medical students nor medical missionaries required `a particular class of women'. In fact, much of the mission work was in rural areas. Missionaries did not themselves always enjoy smooth relations with official authorities as they sometimes championed awkward causes.

In the second half of the nineteenth century, there appears to have been a general effort to co-opt the Indian elite groups through education and by avoiding interference in many issues that were seen as sensitive. Some members of this class of propertied, upper-caste gentry were themselves eager to adopt western medicine and medicalised childbirth for the women of their households. If we look at the list of patrons of the Dufferin Fund and the other Funds floated by subsequent Vicereines, we will find that a very large number of rajas, maharajas, nawabs and urban professional gentlemen were donors. The Fund was aimed directly at this class of person, as it reiterated repeatedly. To this end, purdah hospitals were set up, and such strict vigil maintained on the keeping of rules of seclusion that the Fund was accused by some of encouraging the custom. There

were attempts to keep out Indian Christians and Eurasians from the Dufferin Hospitals, arguing that they had no special reason for coming to purdah hospitals and their presence might discourage 'caste' Hindu women.

Separate kitchens and cooking arrangements were provided in these hospitals, which also had a number of isolated cottage wards where patients could bring their own servants and arrange for their own food to be cooked. It is interesting that there should be so much emphasis on class. It is true that the women of this class would never enter the general hospitals or allow medical men to attend to them. [8] In addition, colonial authorities were made painfully aware of the high rate of child mortality among them because of the amount of litigation they were caught up in as a result of the disputes over succession that frequently arose in the case of a landlord dying without a legitimate heir. It was important to be able to pin down descent, preferably biological descent, since the laws of adoption also led to disputes. Certainly, infant mortality seems to have worried more people in India than maternal mortality did. Perhaps one of the factors that drew the attention of the colonial authorities to the high rate of mortality in birth was the large number of zamindari estates that seemed incapable of passing down in simple lines of patrilineal descent. The question of lineal descent was a vexing one-whereas Indian custom seemed to permit adoption and other forms of indirect inheritance (as when estates passed from uncles to nephews), the British courts seem to have been anxious to establish the supremacy of biological descent which was dogged by the problem of low rates of child survival especially, it appears, among boys. The colonial authorities could not but note the high rates of infant mortality among the propertied classes. This led to frequent disputes over the succession to landed estates. It may be too simplistic to attribute the concern over conditions of childbirth to the motive of ensuring the survival of male infants who could provide a clear lineage of revenue-payers. However, it was towards the class of landed proprietors, both Hindu and Muslim, at whom most of the efforts to reform midwifery seem to have been directed.

The argument was that women of the purdah class would rather die than see medical men, so it was necessary to provide them with 'female medical aid'. Newspapers in Britain carried colourful stories about the plight of women in seclusion, and this was to aid the cause of medical women in England who had fought a long battle to gain admittance to medical schools till as late as 1867. The prospects for medical women in India compared very favourably with those at home in Britain and, at the turn of the century, as many as a third of the graduates of the Royal Free Hospital of London wanted to work in India. [9]

The advantages of medical work in India were many. Women doctors in Britain were kept out of the more prestigious specialisations like surgery, while in India

operations on Indian women were performed by medical women. At a relatively young age, a medical woman could find herself in charge of a hospital or dispensary, and the social prestige they found was quite extraordinary. Two doctors described the affection medical women could enjoy among the families of patients and how rewarding medical work could be. On the other hand, a sore point was the relative privilege bestowed upon the male service, the Indian Medical Service. Pay and prospects were far better but more aggravating still, the civil surgeon of the district where the Dufferin doctor was stationed still retained the right to 'supervise' her work. By the early twentieth century medical women were a sizeable and important interest group. The issue of pronatalism and the health of the nation became very important in inter-war Europe, and this found reflection in India. Here the language was of nationalism.

In Britain, medicine had gained by leaps and bounds over the last two centuries, with the gradual ousting of midwives, who traditionally handled birth, by 'men-midwives' or professional accoucheurs. Queen Victoria herself had set an example by availing of the services of a medical man during her numerous confinements, and had made the use of chloroform, to induce 'twilight sleep' during labour, come out of the controversies in which it had been embroiled (Poovey, 1986). At this time, all the women belonging to poor and marginal groups within the western world still did not have medical attention in childbirth. As late as the 1830s, women in parts of the American South, poor whites as well as blacks, had become a stock figure in English literature. By the 1880s, only the poorest o women would have to take recourse to handy-women, and, therefore, it appeared to the English reading public, who were regaled by gruesome descriptions of Indian women dying in small, smelly lying-in rooms at the hands of dirty, untrained crones, both tragic and absurd that Indian women refused the aid of medical men. It seemed important then, to provide an army of medical women to go out to India, and this was to be done under the auspices of the Dufferin Fund.

A large number of the women who graduated from British medical schools did so with the express intention of coming out to India. India provided medical women with opportunities they did not have in their own country-certainly professional and possibly emotional. Although the conditions of service offered to women who came out to work for the Dufferin Fund did not compare with those available to men of equal qualifications who joined the prestigious Indian Medical Service, work in India allowed young women to assume wide responsibilities, often giving them charge of small hospitals and dispensaries at a relatively young age. They could also exercise their skills in branches like surgery, which were jealously guarded by medical men as the prerogative of very qualified and senior doctors. It was not just that career prospects were encouraging: women doctors wrote of the satisfaction to be gained in the sense of

doing very 'useful' and valuable work and of winning gratitude and loyalty from patients and their families. [10]

To assess the significance of medical intervention in childbirth in India, no matter how limited its impact, we must try to recapture the natures of traditional management of birth. After all, birth is never a purely natural event in an animal sense, but proceeds in a cultural setting (McCormack, 1982, preface). It does appear that the higher medical science of Ayurveda did not concern itself excessively with childbirth. Although the texts contain chapters on the subject, they deal mainly with prescriptions for the design and preparation of the lying-in room. Since birth was seen as an unclean event, no high-caste vaid or hakim was likely to interfere in the event were he to be invited to do so. Instead, childbirth, together with most gynaecological ailments, seems to have belonged to the domain of the demotic remedy, which was a mixture of herbal cures, ritual and magical treatment. It seems to have been the business of women, and women were not part of the Sanskritic traditions of Ayurveda.

The role of the dai can be pieced together with the somewhat negative evidence provided by their adversaries in an unequal battle-the doctors who tend to stress their own miraculous interventions and attribute to dais a greater degree of autonomy in their choice of methods than they truly enjoyed.

The dai was always a woman of low caste, generally an untouchable, though in north India and Bengal she could also be a poor Muslim. It seems that Muslim women generally did not perform the task regarded as the uncleanest of all-that of cutting the umbilical cord-leaving it to the lower caste Hindu `midwife'. In Bengal, she could be a hadi or dom, in north India she was generally a chamar or of the sweeper caste and, in the south, as often as not; she was of the barber caste. This indicates the lowly nature of the task she performed, and could explain why there was little incentive for the dai to hone her skills or for midwifery to develop any professional traits as it had in Europe, even before the coming of medical men. Narketa was a term of abuse and, even among castes like the doms, the subcaste that allowed its women to practise as dais was regarded as inferior by those who did not. It had the classic traits of a traditional occupational grouping. Recruitment was ascriptive and never by aspiration, the recruits were from a restricted group and often the calling was handed within a family from mother to daughter.

Whereas medicine was characterised by all the signs of professionalisation, namely entry through merit (and not heredity) and specialised knowledge, dais clearly belonged to a pre-modern order of occupation. Their work was learnt without any formal training, they formed a hereditary caste-based group, and it was undifferentiated in that the duties of the dai could extend from cutting the

umbilical cord, washing the puerperal garments and burying the placenta, to living in the home of the parturient mother and giving her and the infant regular massages and warm fomentations. In fact, many of the dais combined this and other occupations. Nor were payments according to any sort of professional scale. The dai would generally receive more for delivering a son than a daughter, and her fee could also be paid in kind or a combination of kind and cash. A fair amount of haggling was likely to take place, and the dai would take recourse to all sorts of strategies to raise her price. In the homes of the affluent, it could be very profitable to have attended the birth of a son and heir. There were instances of land grants being made to dais. In one tragic instance in Bengal, at the turn of the century a dai who was eager to claim her payment as the first to announce the birth of a son to a zamindari family of East Bengal, neglected the condition of the mother who died, unattended, of haemorrhage.[11]

Early medical literature on the horrors of childbirth in India emphasised the place of birth as being the main cause of the high rates of mortality among both mothers and infants. The miasmatic, theory of disease causation had been replaced by the germ theory, but it was reflected in the literature till well into the twentieth century, and the noxious vapours that permeated the traditional sutikagriha were held to be the main cause of death. This concern with fresh air was influential in the design of hospitals in nineteenth century India, and for some of the more peculiar rituals of fumigation that were observed in their wards. It was suggested, for example, that the greater mortality in the Medical College Hospital as compared to the Presidency General Hospital near the Maidan was the salubrious surroundings of the latter while the miasmas from the slums of Colootola infested the atmosphere of the former.

It is easy to dismiss all the beliefs and customs relating to pregnancy and childbirth as superstition, as most contemporary reformers, be they from India or Europe, did, but it can be more fruitful to try and imagine the rationality that was exercised no matter how alien it may seem to us. Anturghar was the name most commonly used for the site of birth in Bengal. It was usually a small hut built exclusively for this purpose, set off some distance from the main quarters, and constructed of reed or bamboo matting. Sometimes it was destroyed after use. Poorer families who lived in one-room tenements would not be able to afford these luxuries, and the woman would give birth inside the home. Another source for concern was the fact that large numbers of friends, relatives and neighbours crowded around the woman. There was the general curiosity in matters relating to birth and death that seems to compel people, but apart from the spectacle, a certain community feeling was a strategy for survival in an often uncertain world. Women who had themselves had easy deliveries were encouraged to stand by, and mothers of sons of course had important positions. Men were excluded completely but little children watched freely. In households

where inheritance and property were at stake, witnesses to the birth were important. A collection of letters from the late eighteenth century shows how important it was to enumerate the number of women present. [12]

The room itself was sealed, with all apertures blocked off, as though it was a macrocosm of the womb itself, darkened and enclosing. The fire lit in the anturghar is a recurrent theme in the descriptions-one explanation is the need to warm the mother and child, as the humoral theory of Indian medicine believes that an excess of phlegm (kapha) makes them susceptible to chills. The other is the fear of wandering spirits and malefic influences which may be driven away by heat (heat is one of the means of exorcism). The demotic healing traditions of India also believed that upon delivery the body of the mother lost the warmth of the child within, and needed to be comforted through external heat. The belief would have been bolstered by observing the post-puerperal spasm that is common after the expulsion of the placenta, which would seem like a shiver to the women in the room. The mother needed warmth to comfort her body's sense of loss, ease the pain, dry the uterus and help it regain its former condition. Apart from the fire, hot compress is given by the application to her vagina of warm rags, which may contain earth, cowdung and the spices believed to be heating (garam masala). It was (and perhaps is) also used to speed up labour, as in the tragic instance of the woman, described as 'full-time, age 30, primipara, Hindu', who died in hospital where she was admitted in a 'moribund and gangrenous state' after four days of obstructed labour, during which she had been made to sit on hot ashes to expedite delivery. The foetus delivered by craniotomy, was also gas-gangrenous (Thompson, 1930).

Because of the political impact of the alternative midwifery movement in Western countries, there is a tendency to condemn the extension of hospital birth and medical care in childbirth, because it seems that home delivery or non-medical attendance is somehow more 'natural'. We must remember that for women to exercise real choices, they must be in a position of relative power. Recent anthropological surveys suggest that many poor women in rural areas do without the services of dais altogether, especially after the first delivery. Friends, relatives and neighbours help, and some women may even deliver themselves. So when we talk of medicalisation, we have to realize that it can mean the provision of care when none at all was available. To take one example. Domiciliary midwifery was introduced by the Calcutta Corporation in 1916. It had a small staff of qualified midwives but the demand for their services grew so rapidly that, by the early 1930s, they delivered a third of all the infants born in the city. Their record for child and mother survival was remarkable, considering the normal death rate. However, many of the midwives spoke of the difficulties of providing antiseptic conditions in the slums where many of the women lived. The problems were as fundamental as the absence of an accessible source of

water. Thus the maternity homes set up by the Corporation were really to safeguard the mother and newborn infant from the hazards of their everyday surroundings. [13]

Given that antibiotics were not discovered until the 1930s and were not easily available in India for some years after, puerperal sepsis, was a dreaded scourge. It was the single biggest cause of maternal deaths. It was found that weak and malnourished women generally lacked resistance to infection, and were therefore more vulnerable. This made antisepsis very important. This was probably the most important advantage medical attendance had over traditional methods. This becomes more evident when we consider the causes of maternal mortality as categorised by doctors. The first, as we said, was sepsis. The second biggest killer was anaemia in pregnancy. This was hard to detect without detailed antenatal monitoring, which very few women had access to. In fact, the disease itself was not written about till the 1930s. But since sepsis was often the terminal event for a woman with a history of anaemia, asepsis helped. Caesarian sections were very rarely resorted to, and were rarely successful till the end of the nineteenth century. Yet they were the only means of saving a woman who suffered from the dreadful condition of osteomalacia, where a softening of the bones from Vitamin D deficiency deformed the pelvic girdle. Instead, we find many doctors performing craniotomies, when the infant was presumed to be dead. (This could happen, for example, when the mother suffered from a condition called dystocia, when labour suddenly ceases in mid-delivery.) A corkscrew-like instrument was inserted into the head of the baby and the child drawn out. This was done in extreme cases and to save the life of the mother, but could be dangerous in the hands of less than superbly skilled doctors. Dr Muthulakshmi Reddy, herself a distinguished doctor and political activist from Madras, has described her own first delivery in 1915. After delayed labour lasting for a week, the doctor decided to perform a craniotomy. The delivery was taking place in Dr Reddy's home and her husband was asked to bring some boiling water for sterilising the instruments. There was some confusion because Mr. Reddy slipped and fell with the water as he was bringing it in. Meanwhile, their neighbour, Dr A.L. Madaliyar (later to gain great eminence), happened to come in, saw the cervix dilated and delivered Dr Reddy of a normal, living male child (Muthulakshmi Reddy, 1964). [14]

Since it was plain that there were not enough doctors or hospitals for all Indian women there was one school of thought that felt that great improvements were possible in the conditions of childbirth simply by training the traditional birth attendants and teaching them the basics of hygiene and the recognition of dangerous symptoms. The training of dais had been carried out with a fair degree of success by some missionaries. The most famous was Miss S.S. Hewlett of the Church of England Zenana Missionary Society. Her dai training school in

Amritsar was set up in the 1870s, and was to inspire many subsequent attempts. In the twentieth century, the Dais' Improvement Scheme run by Miss Piggott in Sind was similarly cited as an example, as was the school in Nagpore run by a Miss Agnes Henderson. Recognising their own inability to provide care in remote areas and to most women, the Dufferin Fund itself introduced a scheme to train dais in 1902. The scheme met with very little success. Not many dais felt it was worth their while to be trained since it meant a loss of time, and not many patients were willing or able to pay more for trained attendance. Besides, most of them found the content of their lessons quite incomprehensible, and some of them seem to have found their teachers patronising and unfamiliar with the realities of their lives and conditions of work. It was also found that, without supervision, the women lapsed back into their old ways. Since independence, many of the old schemes were retained and expanded but without significantly greater success. It has been suggested that the inclusion of family welfare services among their duties has made women wary of them.

Thus, medicalisation necessarily remained incomplete. Those women who had access to doctors or trained midwives (as opposed to dais) did not take long to be persuaded of the advantages of medical attendance in birth. Soon after their establishment, women's hospitals complained of being unable to cope with the rush. To this day, not all women have a choice regarding the conditions in which they give birth, and to speak in terms of autonomy and control would betray an insensitivity to the real needs of the majority of Indian women. Unfortunately, the pressure on medical resources is so great, the problems so acute and mortality in childbirth still so high that to romanticise traditional childbearing in India would be to mock the women who die in childbirth, those who may survive but suffer all their lives from the consequences, and those women who work as attendants because they have no alternative job that will either pay better or offer them more respect. [15]

Notes

1. Quoted in the Annual Report of the National Association for Supplying Female Medical Aid by Women to the Women of India or the Countess of Dufferin's Fund (henceforth referred to as the Dufferin Fund), 1936: p.6.

2. These Blanchet interviewed a woman who had given birth all alone behind her hut out of embarrassment at the presence of her father-in-law.

3. Editors' introduction to excerpts from Hannah Catherine Mullens, 'Phulmani o Karunar Bibaran', in Susie Tharu and K. Lalitha (eds.) Women Writing in India: 600 BC to the Present. (1991: p. 205).

4. Lankester, Lecture on the Responsibility of Men in Matters Relating to Maternity read at the Maternity and Child Welfare Exhibition held at Delhi in February 1920.

5. Judy Whitehead (1992: 47-50) says the book went into 20 editions. She lists some of the books written as rejoinders. Gandhi dismissed the book in the famous words 'a drain-inspector's report'.

6. See Roger Jeffery, (1988) for a description of some of the forces at work within the medical profession. Jeffery, however, does not deal with the question of lobbies within the European medical establishment itself.

7. See David Arnold (1985). The colonial state concerned itself primarily with the health of the European population, civil and military. This meant more attention to contagious and epidemic diseases.

8. As if to prove the futility of generalisations, we find that Maharani Swarnamoyi of Cossimbazaar was delivered in her town house by a Dr Raleigh in 1842. Her descendant, Dr S.C.Nandy, says this was the last infant in the family to be delivered by a male European doctor. See Nandy (1992: 267).

9. I am indebted to Dr Rosemary Fitzgerald for this information.

10. Balfour and Young (1929) give an account of the achievements, failures and frustrations of the movement to provide medical aid to the women of India.

11. This was in the Acharya family of Mymensingh at the turn of the century, I am indebted to Prof. Sheila Lahiri Chaudhuri for sharing this family reminiscence with me.

12. These letters are preserved in the archives of Viswa-Bharati, Santiniketan.

13. See the Health Officer's Report for Calcutta, various years, for annual accounts on the state of maternal and child health in the city.

14. The somewhat baffling conclusion drawn by Dr Reddy from this anecdote is that it is difficult for women to combine marriage with professional lives.

15. A revealing study of childbirth in a village in western Uttar Pradesh can be found in Jeffery, Jeffery and Lyon (1989). The authors point out that the Indian subcontinent, with a fifth of the world's population, sees half of the world's maternal deaths every year.

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