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Subaltern Midwives and the Caste Question: *Dais*, Cleanliness, and the Medicalization of Childbirth in Colonial Bengal

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Abstract:*This article examines the transformation of childbirth practices in colonial Bengal through the lens of caste, focusing on the marginalization of traditional birth attendants known as Dais. It argues that the medicalization of childbirth was not merely a scientific or humanitarian intervention but a socially embedded process shaped by caste hierarchies and middle-class identity formation. By analyzing colonial discourse, reformist writings, and the emergence of professional midwifery, the study demonstrates how the language of sanitation and modernity was mobilized to delegitimize lower-caste knowledge systems while consolidating control over women's bodies within institutional and upper-caste frameworks. The article highlights both the persistence and the reconfiguration of Dais' roles, revealing the complex interplay between caste, gender, and colonial power.*
Keywords:*Caste,Colonial Bengal, medicalization, midwifery, subaltern studies etc.*

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Introduction

The transformation of childbirth practices in colonial Bengal marked a significant shift in the relationship between knowledge, power, and social hierarchy. Traditionally, childbirth was a domestic and community-centred process in Bengal predominantly managed by experienced women, particularly *Dais*, whose knowledge was rooted in oral traditions and embodied practices. They were described as 'experienced and courageous women of advanced age and with clean clothes before whom she. However,[the birthing mother] may not feel shy, who have cut their nails and who cheer her with friendly words.[1] But with the advent of colonial rule and the introduction of Western obstetrics, childbirth increasingly became a site of medical intervention and administrative concern.

This transition, often described as the medicalization of childbirth, has been widely interpreted as part of a broader project of modernization. Yet such interpretations risk overlooking the deeply social nature of this transformation. The marginalization of *Dais* was not simply the result of scientific progress but was closely linked to caste hierarchies and the emergence of a new middle-class identity. By framing indigenous practices as unhygienic and dangerous, colonial and reformist discourses reinforced existing notions of purity and pollution, thereby legitimizing the exclusion of lower-caste practitioners.

This article explores how caste shaped the discourse and practice of childbirth in colonial Bengal. It argues that the medicalization of childbirth functioned as a mechanism for reordering social relations, using the language of sanitation and modernity to consolidate upper-caste and middle-class authority over reproductive practices.

I

The position of *Dais* within Bengali society was deeply embedded in the caste structure. Predominantly drawn from lower-caste communities like Dom, Hadi, etc., and poor-class Muslims like Polia, Badiya, Nashyashekh, etc. In the Jangal Mahal region, particularly within the districts of Bankura and Purulia, an intriguing ethnographic observation emerges: the Sahis caste is exclusively dedicated to the practice of traditional birthing. This distinctive cultural role is noteworthy not only within Bengal but also in the broader Indian context, underscoring its uniqueness in the subcontinent's socio-cultural landscape. *Dais* were associated with occupations involving bodily fluids and reproductive processes—activities that were considered polluting within the Brahmanical framework. As a result, their work, though indispensable, was socially stigmatized. Treatment to them is evident from the account of Nagendidi an assistant of Kadambini Ganguly, the first practicing female doctor of Bengal as well as of India. Actually, in earlier days, the lady doctors were treated like *Dais*, and they were summoned only in cases of complicated obstetric crises. During the birth of the first child of a wealthy household, when the midwife had abandoned hope of saving both mother and child, Kadambini was called in, and through her intervention, both lives were preserved. However, upon completion of their work, Kadambini and Nagendidi discovered that their meal had been arranged not in the inner quarters but on the veranda adjacent to the courtyard, the place typically reserved for household servants as the mistress of the house had no idea about trained doctors and thought them as *Dais*. After they had eaten, the mistress of

the house instructed that they must remove their banana-leaf plates and ritually cleanse the space, lest it remain polluted and unfit for further use. [2]

This episode illustrates the entrenched prejudices against even women physicians and modern-trained midwives, who were perceived as transgressing caste and gender boundaries. Such disdain was not isolated. Contemporary autobiographical accounts, such as those of Gurucharan Mahalanbis, record similar incidents in Dhaka during the 1870s, where women travelling independently or engaging in professional work were subjected to ridicule and suspicion.[3] Even in the case of receiving medical care, caste barriers exerted a significant influence. Upper-caste women were often reluctant to conform to practices such as the "first-come, first-served" system in dispensaries and hospitals. In certain instances, they even refused to consume prescribed liquid medicines on the grounds that the water used in their preparation had been drawn by Muslim women from the well.[4]

This marginal status was marked by a fundamental contradiction. On the one hand, *Dais* were essential for the *antahpur* treatment and maternal care, be it prenatal or post-natal, and on the other hand, their presence was circumscribed by notions of impurity, limiting their social mobility and reinforcing their exclusion from upper-caste spaces. Obstetric practice had two distinct dimensions. The first concerned matters of pregnancy and childbirth, which were closely tied to the conditions of the maternity rooms of the time, the dietary regimen prescribed for expectant mothers, and the skills of the *Dais*—in short, the system of obstetric care managed primarily by *Dais*. The second dimension involved the treatment of obstetric illnesses. Particularly in this latter case, when confronted with severe complications, male physicians were occasionally summoned out of necessity. Yet this gave rise to a dilemma: on the one hand, the restrictions imposed upon women due to seclusion, and on the other, the perceived impropriety of allowing men into the inner quarters. As a result, male doctors rarely gained easy access to the domestic sphere for the treatment of women.[5]

The association of *Dais* with impurity was not merely symbolic but had material consequences. It shaped the conditions under which they worked, the recognition they received, and how their knowledge was valued—or dismissed. Their economic condition also played a very important role in this case.

II

The introduction of Western medical ideas in the nineteenth century brought new attention to childbirth practices, particularly in relation to hygiene and mortality. Colonial officials and Christian missionaries frequently attributed high rates of maternal and infant mortality to the practices of *Dais*, portraying them as ignorant, untrained, and unhygienic. William Ward, a missionary from Serampore, drew attention to 'traditional customs of childbirth' which seemingly contributed to high maternal and infant mortality. Another missionary author termed the practice of Bengali village midwives as 'unscientific' and 'unchristian'.[6] Actually, to the missionaries, India was an area of darkness where they hoped to bring the light of Christianity.[7] The birthing environment itself was described as filthy, reinforcing the perception that indigenous practices were inherently dangerous. But it is to be noted that the *antahpur* of the colonial and precolonial era was itself an unhealthy portion of the house with no abundant air and light. This caused high mortality among women.[8] The oft-repeated colonial rhetoric of the "dirty dai" was largely a Western construction, rather than a reflection of indigenous practice. In reality, *Dais* had little or no role in determining the architecture or furnishing of the anturghar (lying-in chamber). The responsibility for preparing the space fell squarely upon the household itself. The coarse mats, worn rugs, and old cloths—later to be burnt after the confinement period of one month (or eight days in some traditions)—were provided by the family, irrespective of wealth or social standing. This ritualized austerity was not a mark of poverty alone but a normative practice across classes.

It would be misleading to assume that *Dais* lacked any conception of hygiene. In fact, ethnographic accounts reveal that they employed specific practices aimed at maintaining cleanliness and preventing infection. For instance, the *anturghar* (lying-in room, where women stayed during childbirth and postpartum recovery) was regularly disinfected using cow dung mixed with water.[9] While such methods may appear unconventional from a Western biomedical perspective, they were rooted in indigenous understandings of purification and sanitation. Cow dung, in particular, carried ritual significance in Hindu households, symbolizing both purity and protection, and its use in domestic spaces was believed to ward off harmful influences. Thus, these practices demonstrate that local communities possessed their own culturally embedded notions of hygiene and disease prevention, challenging colonial and missionary claims that Indian women were ignorant of sanitary principles. Rather than being devoid of medical rationality, these traditions reflected

a different epistemology of health—one that combined ritual, environment, and embodied experience.

The testimony of Kailasbasini Devi, wife of Kishorichand Mitra (1822–1873), a renowned social reformer and senior British official, offers striking evidence. Despite belonging to an elite household, she described the anturghar as a "jail," lamenting that even as the daughter and wife of a wealthy family, she was subjected to extreme discomfort. Her account underscores the paradox: while considerable sums were expended on ancillary figures such as barbers and *Dais*, the mother herself was denied even a proper bed, since bedding was destined to be destroyed after the confinement.[10] This reveals that the deprivation was systemic, embedded in ritual logic rather than economic necessity, and it also reveals that *Dais* had very limited control over preparing or selecting the location of *anturghar.* Such narratives complicate colonial medical discourse, which often portrayed indigenous childbirth practices as unhygienic or careless. Instead, they highlight a culturally sanctioned austerity, where the suffering of the mother was normalized and ritualized, regardless of class. The "dirty dai" trope thus functioned as a rhetorical device to justify colonial intervention, obscuring the fact that the material conditions of childbirth were shaped by household custom and ritual economy rather than by the agency of the dai herself.

So the Colonial administrators and Western observers criticized the traditional birthing systems of Bengal and India, largely to reinforce the supposed superiority of 'advanced' Western civilization. But it is interesting to find that in 1901, the editors of the Census Commissioned a special inquiry into the methods of indigenous midwives and found that some of the birthing practices followed in India and Europe were similar in many respects.[11] Before 1900, midwives in Europe interfered with the process of giving birth to a greater extent. It was, according to one authority, a common practice to reach into the vagina and the uterus with unclean hands to speed up labour, a practice which was unheard of in Bengal. Moreover, the isolation of mothers in uncomfortable surroundings was, in 19th-century Europe, as widespread as in Bengal.[12]

However, this discourse of cleanliness cannot be understood in isolation from the caste system, which profoundly shaped perceptions of purity and pollution in colonial Bengal. The characterization of *Dais* as "dirty" was not simply a medical observation but drew upon long-standing associations between lower-caste occupations and impurity. By framing these social prejudices in the language of science and sanitation, colonial discourse

effectively transformed cultural hierarchies into medical critique. The emphasis on uncleanliness—whether in relation to the *anturghar* (maternity rooms), the use of soiled cloths, or the physical appearance of the midwives—served to reinforce caste-based stigmas under the guise of modern hygienic standards. In this way, colonial medicine did not merely challenge indigenous practices on technical grounds; it rearticulated entrenched social biases in biomedical terms, thereby legitimizing exclusionary attitudes while simultaneously undermining the authority of traditional practitioners. This intersection of caste ideology and medical discourse reveals how colonial interventions in obstetrics were as much about social control as they were about health, embedding caste prejudice within the emerging framework of "scientific" obstetric care. This pattern was not unique to Bengal. In Africa, colonial health systems were deliberately designed to protect European settlers while segregating indigenous populations, often portraying African healers as unclean or dangerous to justify exclusion and control.[13] Similarly, in Southeast Asia, colonial interventions in obstetrics and public health frequently recast indigenous practices as unsanitary, using hygiene rhetoric to delegitimize local traditions while privileging Western-trained personnel. It enabled colonial authorities and indigenous reformers to present themselves as agents of progress, committed to improving public health. At the same time, it justified intervening in the domestic sphere, which had previously been governed by women and traditional practitioners.

III

The nineteenth century witnessed the emergence of a self-conscious middle class in Bengal, often referred to as the *bhadralok*, which played a key role in shaping the discourse on reproductive reform. This group sought to construct a modern identity that was both distinct from colonial rulers and superior to lower-caste populations. Childbirth became a crucial site for this project. Quite early in the nineteenth century, Madhusudan Gupta, an indigenous medical practitioner and teacher of medicine in Bengal, emphasized the urgent need to reform reproductive health. In his evidence before the Fever Hospital Committee in 1837, he argued that training Indian women in midwifery was essential. Gupta highlighted that if a sufficient number of qualified Hindu midwives were available at moderate charges, they could provide valuable advice and care to patients.[14]

The concept of cleanliness became central to the redefinition of identity in colonial and postcolonial Bengal. By aligning themselves with the principles of scientific hygiene,

middle-class reformers were able to assert cultural and social superiority, distinguishing themselves from both lower-caste groups and traditional practitioners. Cleanliness was not merely a matter of health but a marker of modernity, discipline, and respectability, and thus functioned as a powerful tool of social differentiation. Within this framework, the *Dais* were positioned as the antithesis of cleanliness and order, a symbolic figure against which reformist identity was constructed. Their association with unhygienic maternity rooms, soiled cloths, and bodily impurity was repeatedly invoked in reformist discourse to highlight the supposed backwardness of indigenous practices. In this way, the discourse of hygiene became a vehicle for both medical modernization and social stratification, reinforcing caste and class hierarchies while simultaneously reshaping the cultural landscape of childbirth. Such dynamics illustrate how the language of cleanliness operated as a site of negotiation between colonial medicine, indigenous practice, and middle-class reformist aspirations, transforming obstetric care into a battleground for identity and authority.

The medicalization of childbirth was accompanied by the institutionalization of midwifery as a profession. Training programs were established to produce skilled midwives who could operate within the framework of Western medicine. These programs were often targeted at women from more privileged backgrounds, creating a new category of practitioners who were socially and culturally distinct from traditional *Dais*. But no upper caste women, Hindu or Muslim, would come forward for such training, either because of *purdah,* or for fear of losing caste and usually converted orphan girls took the training in earlier days.[15] It should be noted that during the 19th century in India, only domestic helpers and these dai women could earn their own living and choose their profession independently. They even took part in the cultivation shoulder-to-shoulder with their male counterpart. Women from the poorer class and lower caste enormously benefited from the missionaries in the case of training in medicine.[16] In short, they might not have earned cash, but played an important role in meeting their end. On the other hand, the women of the upper caste were usually the inhabitants of *antahpura.* Even many 'Brahmo' did not allow their women to get midwifery training.[17]

In 1871, 10 women started training in midwifery, but the number became 3 in 1874, and only 2 of them finally passed the training. Some trained indigenous midwives became famous at that time, and many of them even gave advertisements in the newspaper about their services.[18]

But as a whole, these training programmes also failed to attract the majority of poor *Dais*. One of the principal reasons was the absence of stipends in most institutions, which made attendance financially unfeasible. Since *Dais* were already poorly paid for their services, the time spent in classrooms would directly affect their livelihood. Moreover, their knowledge was traditionally transmitted through the *guru-shishya* (teacher-disciple) tradition, a system that emphasized experiential learning and apprenticeship rather than formal instruction. This cultural and pedagogical background explains their reluctance to participate in institutional training, which they perceived as both economically burdensome and epistemologically alien. The language barrier was also a very important issue. At the same time, however, certain Western-trained doctors undertook notable efforts to bridge this gap. By writing manuals and books on childbirth and related fields in accessible language, they sought to familiarize *Dais* with Western obstetrics while respecting their role in society. These texts represented an attempt to integrate biomedical knowledge into indigenous practices, highlighting the complex negotiation between colonial medicine and traditional midwifery.[19] The outcome was uneven: while institutional training largely failed to reshape the profession, the circulation of printed materials created new channels of knowledge exchange, underscoring the hybrid character of obstetric practice in late colonial Bengal.

This process of professionalization had significant implications for the organization of reproductive care. By redefining midwifery as a scientific and respectable profession, it effectively displaced lower-caste practitioners and reallocated authority to those who conformed to the new standards. The dai, once central to the childbirth process, was relegated to a marginal position. In the 1871 census, the number of *Dais* was 20,000, but subsequently the number went down over time.[20]

IV

Despite the growing influence of institutional medicine in colonial Bengal, the complete displacement of *Dais* did not occur. Their services remained indispensable, particularly among rural and lower-class populations who lacked access to hospitals, trained practitioners, or the financial means to afford biomedical care. This persistence was not accidental but reflected structural limitations within the colonial medical system. In the nineteenth century, and even into the first quarter of the twentieth century, Bengal had only a handful of midwifery training institutions, most of which were concentrated in urban centres, mainly in

Calcutta and adjacent areas and were inaccessible to the majority of women. The scarcity of such institutions meant that the reach of professionalized obstetrics was inherently limited, leaving traditional midwives to continue their work in villages and small towns of Bengal.

Even in urban areas, the transition to institutional childbirth was gradual and uneven. Though Christian missionaries often condemned what they perceived as an excessive reliance of Indian women on Indigenous practitioners, Elizabeth Beilby provides a more nuanced perspective. She clearly observed that women in Bengal—and India more broadly—were not entirely deprived of healthcare systems. The *Dais*, who primarily attended to women's health, were neither wholly untrained nor inexperienced. Their knowledge was rooted in long-standing traditions, and their expertise was recognized within local communities. Beilby even emphasized that these Indigenous healers were frequently summoned before Western medical doctors were called,[21] underscoring both their accessibility and the trust they commanded. This acknowledgement complicates the missionary narrative of neglect, revealing instead a layered healthcare structure in which Indigenous practitioners played a central role.In her memoir, Kailashbasini Devi recounts that following the birth of her daughter Kumidini, she fell gravely ill. Despite receiving treatment from at least three Western-trained physicians, her condition showed no improvement. Ultimately, it was a *dai* who succeeded in curing her.[22] the working of *Dais* and the trained midwives were different. The midwives visited homes like doctors, delivered babies and left. Cleansing up the afterbirth and nursing the mother during the confinement days were not part of their duties. But *Dais* took care of the mother and the babies during this time.[23]

Far from being static practitioners, *Dais* adapted to changing conditions in various ways. Some incorporated elements of biomedical practice—particularly improved hygiene measures—while continuing to rely on traditional techniques rooted in experiential knowledge. The principal focus of Western medical criticism was not directed at the *Dais*' obstetric expertise per se, but rather at the unhygienic conditions of the *anturghar* (maternity rooms), the use of unwashed cloths, and even the perceived appearance of the *Dais*. Their skill in the traditional birthing system was rarely challenged point by point; instead, critiques emphasized the environment and practices surrounding childbirth rather than the midwives' technical competence. This tension reveals how colonial medical discourse often sought to delegitimize indigenous practices through cultural and hygienic critiques, while simultaneously depending on *Dais*' indispensable role in childbirth. The persistence of *Dais*

highlights the limitations of the medicalization process. It underscores the gap between discourse and practice, revealing that the transformation of childbirth was neither linear nor uniform. Instead, it involved a complex negotiation between different systems of knowledge and authority.

Conclusion

The history of *Dais* in colonial Bengal reveals the deeply intertwined nature of caste, gender, and medical knowledge. The marginalization of traditional birth attendants was not simply a consequence of scientific progress but a socially mediated process shaped by existing hierarchies and emerging identities. By framing indigenous practices as unhygienic and inferior, colonial and reformist discourses reinforced caste-based distinctions while legitimizing new forms of control over women's bodies.

At the same time, the persistence of *Dais* demonstrates the resilience of subaltern knowledge systems and the limits of institutional authority. Their continued presence in the reproductive sphere challenges linear narratives of modernization and highlights the importance of examining everyday practices and lived experiences. Even in post-colonial Bengal, *Dais* continue to hold significant relevance within society, not only as practitioners of childbirth but also as cultural figures embedded in collective memory. Their presence is vividly reflected in Bengali literature, cinema, and folk narratives, where they often appear as trusted caretakers and symbolic guardians of domestic life. In regions such as Jangal Mahal, *Dais* are accorded a particularly warm reception, being invited to participate in major social occasions, including marriages and *annaprashan* (the rice-feeding ceremony), thereby reinforcing their role as integral members of the community. In many places, they are affectionately addressed as *Daima*, a term that conveys both respect and intimacy, underscoring the enduring emotional bond between midwives and the families they serve. This continuity of social esteem highlights how the role of the *dai* transcended its medical function to become a cultural institution, embodying both tradition and trust in the evolving landscape of Bengali society.

Notes and References

1. Jolly , Dr. Julus, *Indian Medicine*, trans. From German by C.G. Kaushikar (New Delhi: Munshiram Manoharlal, 1994[1951], p.69 cited in Mukherjee, Sujata, *Gender, Medicine and the Society in Colonial India*, OUP, New Delhi, p. 72.
2. Biswas, Soma, *Unabingsha Shotoke Bangladeshe Chikitsabigyancarcha*, K.P. Bagchi and Company, Kolkata, 2015, p. 45
3. Mahalanbis, Gurucharan, *Atmakatha*, Cited in Biswas,Soma, *Unabingsha Shotoke Bangladeshe Chikitsabigyancarcha*, K.P. Bagchi and Company, Kolkata, 2015, p. 46
4. Gourlay, Jharna, *Piety, Profession and Sisterhood- Medical Women and Female Medical Education in Nineteenth Century India*. P P Bagchi & Company, Kolkata, 2017, p. 147-148
5. Biswas, Soma, op. cit. p. 46
6. Mukherjee, Sujata, *Gender, Medicine, and Society in Colonial India- Women's Health Care in Nineteenth and Early Twentieth Century Bengal*, Oxford University Press, New Delhi, 2017, p.73
7. Gourlay, Jharna, op. cit. p. 61
8. Karlekar, Malavika, *Voices from within, Early Personal Narratives of Bengal Women*, Delhi, 1991, p.49.
9. Biswas, Soma, op. cit. p. 51
10. Debi, Kailashbasini, *Janaika grihabadhur dayeri*, ekshan, sharadiya sangkhya, 1388 BN, p.11, Cited in Sur, Nikhil *Dwarakanath Gangopadhyaya O tatkalin brahmo-hindu samajer calchitra*, Bookpost Publication, Kolkata, 2023, p.119
11. Mukherjee, Sujata, op. cit. p.74
12. Shorter, E. , *A History of Women's Bodies*, London, 1983, pp.58-68
13. Latif, L., & Otieno, H. (2025). The Colonial Legacy of Power, Profit, and Prejudice in Global Health Governance. *Modern Africa: Politics, History and Society*, *13*(2), 65–92. https://doi.org/10.26806/modafr.v13i2.259
14. Mukherjee, Sujata, op. cit. p.70
15. Gourlay, Jharna op. cit. p. 154
16. Gourlay, Jharna op. cit. p.161
17. Mahalanbis, Gurucharan, *Atmakatha*, Cited in Biswas, Soma, *Unabingsha Shotoke Bangladeshe Chikitsabigyancarcha*, K.P. Bagchi and Company, Kolkata, 2015, p. 46
18. Biswas, Soma op. cit., p.53
19. Most important among them was '*Dhatri Shiksha'* by Jadunath Mukhopadhyaya. In this work, Mukhopadhyay elaborated extensively on the duties of midwives, the improvement of the *anturghar*, and the incorporation of Western medical techniques into indigenous practices. The book was actively circulated through colonial government channels at the subdivision level, reflecting its institutional endorsement. It also received commendation from eminent literary figures such as Bankim Chandra Chattopadhyaya, whose message of appreciation was included in the volume.
20. Biswas, Soma, op. cit., p.53
21. Lowe, John, *Medical Missions, Their Place and Power*, Edinburgh, 1886, p. 191, Cited in Sur, Nikhil, *Dwarakanath Gangopadhyaya O tatkalin brahmo-hindu samajer calchitra*, Bookpost Publication, Kolkata, 2023, p.122-123
22. Biswas, Soma, op. cit. p.52
23. Bandyopadhyay, Mousumi, *Indigenous Approach to Delivery Deaths in Colonial Bengal,* in Palit Chittabrata and Achintya Dutta (ed.) *History of Medicine in India- The Medical Encounter,* Kalpaz Publications, Delhi, 2016, p.241