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Maternity advances in nineteenth and twentieth century Europe and its impacts on colonial North India.

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Abstract**:** *The coming of western medicine and science has brought many changes in the sphere of childbirth practices in India. The development of science in the west had its own history and this paper attempts to explore the same. Maternity related knowledge in the west evolved with the advancement of western medicine. The paper explores the perceptions and advancement of western medical childbirth practices in the west and its impacts on the childbirth related developments in India. It studies the similarities and differences in perceptions about childbirth practices and traditional midwives, also called the Dais.*

Key words**:** *Western medicine, maternity, childbirth, midwives, Dais, North India.*

1. INTRODUCTION :

Maternity practices and beliefs have had as shift with the coming of British rule in India. The developments in England related to women's body and health impacted the way childbirth was seen traditionally, i.e., from a divine act to scientific act. The shift came with the advancements in medical field. Women's body was studied and gestation, pre-natal and post-natal care developed with time. These changes were transported in India with the coming of British rule. The paper will look in the medical advancements made in the field of maternity and childbirth in England and their impacts on maternity practices in India. It will study the similarities in trends of maternal practices, response of the people in the late nineteenth and early twentieth century.

2. Statement of Purpose :

The paper aims to study the medical developments related to childbirth in the west and its impacts on Indian childbirth practices. It studies the perceptions towards traditional childbirth practices in both the countries and the similarities in seeing childbirth in both north India and west.

3. Methods :

For studying the medical developments in both India and west primary and secondary sources have been used. The descriptive and analytical approach is used in the work. The primary source includes the newspapers and manuscripts published in those times. An extensive secondary literature on the theme in also studied.

4. Maternity developments beyond borders :

The practice of seeing science and technology as a purely objective knowledge that developed independent of any cultural biases and impacts has been questioned by several authors. In a book on technology and labour, David Noble discusses the assumption that technology evolved according to autonomous processes of evolution and hence, was independent of coercive forces of culture. He says,

> "Our culture objectifies technology and sets it apart and above human affairs. Here technology has come to be viewed as an autonomous process, having a life of its own which proceeds automatically, and almost naturally, along a singular path. Supposedly, self-defining and independent of social power and purpose, technology appears to be an external force impinging upon society, as it were, from outside, determining events to which people must forever adjust."[1]

[1] David F. Noble, *Forces of Production: a social history of industrial automation*, New York, Knopf, 1984.

In Indian medicine. the body is seen as synchronising with the environment and surroundings. The changes in the one affect and reflect in the other and both are dependent on each other. The case is opposite in western medicine. The body is seen to function independent of the surroundings, or the impact of the environment on the body is less emphasised. Aspects of the environment such as light, heat, sound and movement from one place to another affect the length of labour in humans and animals.[2] Surprisingly, this knowledge is not brought to bear on obstetric treatment of women. For instance, in the medical practice, if a woman's labour slows down as her contractions are not sufficiently strong (hypotonic uterine dysfunction), most obstetrics texts imply these causes: the pelvis is too small; the improper positioning of fetus; the distending of uterus. Nowhere was the women's general state of mind, fear, anxiety or stress were emphasised to have resulted in disruption of labour.[3]

In the period before 1900 pregnancy was not treated as a medical problem. It was a natural process where women gave birth. The assistance in childbirth were midwives who were not necessary the women. The males also acted as midwives. For instance, Dr. John Grigg's in his manual Advice to the Female Sex in General, particularly those in a state of Pregnancy and Lying-in, published in 1789, mentioned himself as a 'practitioner of midwifery as well as a Surgeon to the Pauper-Charity in Bath and late of his Majesty's Navy'. In the end of nineteenth century in Britain, there was a plethora of medical advisory literature produced for pregnant women. Such books included Thomas Bull's 'Hints to Mother for the management of Health During the Period of pregnancy and in the Lying-in-Room' and P.H. Chavasse's 'Advice to a wife in the Management of her own Health' published in 1837 and 1832 respectively. Chavasse wrote of childbirth "Nature is perfectly competent to bring without the assistance of man, a child into the world… Assist Nature! Can anything be more absurd? As though God in his wisdom… required the assistance of a man."[4] The assertive statement of Chavasse gives a link into the opinion about pregnancy as a purely natural act requiring no intervention of humans in it. The intention was telling women what kind of state pregnancy was, and thus inform them of the appropriate conduct they ought to carry when nature decree itself.

Augustus Granville, an Italian physician's manual 'A Report of the Practice of Midwifery at the Westminster General Dispensary During 1818' was a detailed account of dispensary practice. It extended assistance for worried women. In another work of Surgeon Douglas Fox 'The Signs, Disorders and Management of Pregnancy' was both a reference book and a source of information of expectant mothers. According to Fox, in order to increase their emotional comfort, women must have a work that contains the knowledge they need. And in order to achieve this, he took satisfaction in creating a work 'free from all technical phrases.'[5] A few pregnancy manuals from this time did not make a distinction between the pre- and post-pregnancy period. During this period pregnancy, childbirth and motherhood were not the separate entities requiring the supervision of separate medical specialties. Childbearing and childrearing were not divided responsibilities of separate spheres. Instead, both were integrated and viewed as one unit.

The authors of the above-mentioned texts did not view pregnancy simply as a normal psychological function. That would have defeated their goal of disseminating information. What they achieved was considerably more complicated; in essence, they created a pregnancy structure that organised what was believed to be the common experience of pregnant women. This experience became systematised and was later portrayed as technical medical knowledge.[6] Montgomery remarked that it was not my purpose to portray pregnancy as a disease, but rather as a period during which a significant temporal change occurs in the status of a specific function. Pregnant women suffered a variety of bothersome symptoms as a result of these changes. The demand for medical care was nonetheless driven by the bothersome nature of these symptoms to their owners rather than any underlying medical concern.[7]

By the second half of the nineteenth century, the opinion was formulated that resorting to traditional midwifery services while childbirth indicated lower social status while delivery by the doctor was the indictment of the class and

[2] Emily Martin, *Women in the body: A Cultural Analysis of reproduction*, United States, Beacon Press, 2001, p. 62.
[3] Jack A. Pritchard, Paul C Macdonald and Norman F. Gant, *Williams Obstetrics 17t Edition*, Norwalk, 1985, p. 643.
[4] Ann Oakley, *The Captured Womb: A History of the Medical care of Pregnant women*, Oxford, Basil Blackwell Publisher, 1984, pp. 13-14.
[5] Ibid., pp. 13-14.
[6] Ibid.,
[7] W.F. Montgomery, *An Exposition of the Signs and Symptoms of Pregnancy the period of human gestation and signs of delivery*, London, 1856, p. 41.

status symbol. The Survey by London Obstetric Society in 1869 gave the above report.[8] In that era the imagery of a traditional midwife derived very much from the Charles Dickens' Sarah Gamp as a sloppy unsanitary and ignorant old woman. In pre-war period the narrative was developed to associate motherhood with nation. The glorification of mother started in this period. The Journal of Royal Sanitary Institute wrote in 1908 of the reform measures like better housing, better milk supply, education and economic condition of mothers were given attention. It also mentioned that the growth of feeble-minded population would lead to racial degeneracy. Hence, to maintain and gain superior race citizens, it was essential to train, educated and facilitate motherhood. Most reforms related to mother and childcare in nineteenth century were informed and concerned with racial degeneracy.[9]

In nineteenth century, Britain many theories of pregnancy gained currency. William Flux, the father of British Midwifery had an opinion that women were most likely to conceive just before or after the menstrual flow.[10] J.W. Ballantyne, also called the founding father of antenatal care believed that conception occurs just after menstrual flux.[11] Contrary to Ballantyne, Hirst believed that ovule is discharged at the height of menstrual congestion.[12] Apart from these theories an opinion also existed that questioned the surety of these claims. For instance, R.W. Johnstone wrote about the uncertainty of occurrence of ovulation and the exact time of fertilization. He maintains that coitus just before and after ovulation is most fertile.[13]

Regarding the pregnancy and its confirmation evaluations were also made about menstrual blood. Though pregnancy and labour pain were considered to be divine act and commanded by God upon the women. Montgomery assumed the general period of gestation to be 280 days and cited some cases to prove his claim. For instance, a woman whose husband left the nation on 5 April informed her doctor that she would need his help on 10 January, and she duly made the necessary arrangements. When her husband returned home, he convinced the doctor that the same regularity had also marked her last pregnancy and labour. Other doctors working on confirming the gestation period gave the explanation of Avicenna, a tenth century Persian physician that 'at the appointed time, labour comes by the command of God'.[14] The explanation depicts that even till the early nineteenth century no firm medical explanations were derived for pregnancy and it was considered more as a divine act rather than a medical condition. A lot of contentious knowledge floated in the market about childbirth and the processes related to it. Newer claims were made every now and then. The field was developing rapidly and the medical professionals were desperately working on it. The race to claim ones knowledge superior, reliable and trusted and backed by science pushed the women's rights over their bodies at the backfoot. The medical intervention was limited as the physicians were unsuccessful in proving it on medical lines hence, limiting interventions to it.

Though during the nineteenth century, many medical experiments and changes took place which later increased the medical intervention in the realm of childbirth. The "plethora" theory was the dominant theory about the physiology of pregnancy during early nineteenth century. The classical Hippocratean and later Galenic philosophy of sickness, which held that health reflected a condition of balance between the four "humours"—black bile, yellow bile, blood, and phlegm—was the foundation for the notion of plethora. The disease was modelled as being induced by disruptions in bodily fluids using a fundamentally chemical approach. The term "plethora" was used to describe a wide variety of illnesses and referred to the body's surplus blood, which could cause symptoms like a flushed face and a rapid heartbeat. Plethora was the main chemical disequilibrium of pregnancy and was thought to be caused by the retention of menstrual blood and was thought to be the root of a wide range of pregnancy disorders, including miscarriage, premature labour, convulsions, bowel problems, fever, and maternal depression.[15]

Apart from the plethora theory, another theory which was adhered to prior to the coming of modern obstetrics was that of 'maternal impressions. According to the hypothesis, the mother's mental and emotional state had a significant

[8] Tania McIntosh, *A social history of Maternity and Childbirth: Key themes in Maternity Care*, United States, Taylor & Francis, 2013, p. 30.
[9] Ibid., p. 34.
[10] H. Thoms, *Classical contribution to Obstetrics and Gynecology*, Springfield, C.C. Thomas, 1935, p. 9.
[11] J.W. Ballantyne, *Essentials of Obstetrics*, Edinburgh, William Green and Sons, 1904.
[12] B.C. Hirst, *A Textbook of Obstetrics*, London, W.B. Saunders, 1900, p. 63.
[13] R.W. Johnson, *A Textbook of Midwifery*, London, Adam and Charles Black, 1913, p. 98.
[14] W. Tyler Smith, *A Manual of Obstetrics*, London, John Churchill, 1858, p. 218.
[15] Ann Oakley, *The Captured Womb*, pp. 21-22.

impact on the condition and viability of the foetus. This idea, of course, was in line with the widely held belief that only a perfectly balanced lifestyle, synchronised with natural dictates could ensure a successful pregnancy. According to Dr. James Blondel's definition from 1727, the propensity of the foetus does depend on the welfare of the mother, and anything harmful to her is either directly or indirectly harmful to the other. This is established as a general rule, and it is true that the child may experience some harm through the mother. Despite the fact that Blondell himself had noted that maternal emotions could not be as harmful to the foetus as is frequently reported, or else the race of men would insensibly degenerate into a generation of monsters, the maternal impression theory's influence on the beliefs of many medical professionals persisted unabatedly. For instance, Dr. James Blundell noted the case in his 1834 book *The Principles and Practice of Obstetrics* under the heading 'Cause of Monstrosity', where a woman gave birth to a baby whose head resembled a large bunch of grapes. On being closely questioned by the accoucheur, she stated that in the early period of her pregnancy, she saw a boy eating a bunch of grapes quite greedily. The conclusion derived was the glance of the boy eating grapes had affected the foetus to an intensity that the child had developed grape like head. This conclusion was extended to all the deformed pregnancies and infants born with some disorder. It was the result of a mother seeing or experiencing something during pregnancy.[16]

With the increasing research on pregnancy, women's bodies, menstruation and gestation, the belief that pregnancy was a sin and child being the consequence of that sin, came to be challenged. Women were also eager to relieve themselves from this painful experience, which often took a toll on their lives. The development of caesarean method and use of chloroform to relieve the pain were appreciated within the female community. Queen Victoria herself in her exchange with her daughter wrote of the deathful experience of pregnancy and how she dreaded it. She delivered her eighth child using chloroform which gave it wider recognition and legitimacy. Before that the use of chloroform was staunchly opposed by the Church saying that the pain brought by labour was the command of God and hence, to reduce the pain using outside intervention would be to go against the will of the almighty. But, the Queen's chapter, made these criticisms less viable and gave currency to the idea of using external substances to assuage the labour pain. She wrote on the experience with chloroform during childbirth: "The effect was soothing, quieting and delightful beyond measure." [17]

In nineteenth century, Europe, the accidental discovery of foetal heart in 1821 by Jean Alexandre Lejumeau Vicomte de Kegaradec, a pupil of Laennec (inventor of stethoscope) brought many changes in the field of antenatal care. Earlier the field was limited to advice related to everyday lifestyle and precautions and abdominal palpations. The discovery of X-ray was another important discovery. These new discoveries and inventions were imperative in establishing the rationale behind setting up of modern antenatal care. According to Ann Oakley, two kinds of strategies derived from these new discoveries were, firstly, the medical practitioners claim to know better about the foetus and uterus than the mother herself and other refers to the sphere of controlling the termination of pregnancy i.e., the onset of labour. These inventions and advances were carried out in nineteenth-century Europe and laid the foundation of antenatal care there. The testing of pregnant women's urine, foetal movement, and heartbeat growth gave clues of the healthy progress of pregnant women. It made way for the development of antenatal care as an essential element required for the supervision and follow-up of pregnant women. In England, by the end of the nineteenth century, ante-natal care was considered a vital component of preventive obstetrics, being denoted as 'new midwifery'. A compelling backdrop for appreciating the value of the prospective mother and her unborn child as a national asset was offered by eugenics, sometimes known as the "well-being of the race." In this view, prenatal care was meant to stop infanticide and guarantee a process of rectification of unfitness through antenatal improvement. Thus, ante-natal pathology—which deals with foetal illnesses and embryonic malformations—came under the spotlight.

Lying-in hospitals were formed for the women and it was advised to stay as per the guidelines of the doctors and medical practitioners. The first lying- in hospital for parturient women in England was formed in 1747. In eighteenth century, the sole function of the hospitals was the treatment of the acutely ill. The question arises, why these centres for the sick were though to be an appropriate place for the young women expecting a child.[18] The answer could be, these hospitals catering to the young parturient women would provide larger market to the growing profession of obstetrics. It made it easier to limit competition from female midwives, solidified the doctor's authority over client preferences,

[16] Ibid., pp. 23-25.
[17] Petrina Brown, *Eve: Sex Childbirth and Motherhood through the ages*, United Kingdom, Summersdale, 2004, pp. 159-160.
[18] M. Versluysen, Lying in Hospitals in Eighteenth Century London in H. Roberts (ed.) *Women, Health and Reproduction,* London, Routledge and Kegan Paul, 1981, p. 20.

enabled clinical expertise to be taught to others, and prepared the way for the subsequent portrayal of childbirth as potentially pathological state. For the women to get access to these hospitals, they had to prove their pregnancy, the onset of labour, and poverty. The women also requires to produce a letter of recommendation from the hospital subscriber. The acts of bringing women to the hospital for care also symbolised the loosening of women's authority over her body, increased subversion to the authority of the medical establishment and dictating of her lifestyle after conceiving by the guidelines of the obstetrics. Some hospitals only admitted married women while others laxed rules for unmarried women with first pregnancy. This was done to discourage vice among people, and women in general. These hospitals also became a space to control the sexual conduct of the population. Pregnancy before marriage was labelled as shameful and unacceptable and married women were obligated to produce evidences of rightful conduct and right parish and their poverty.

Apart from the lying-in hospitals, there were also dispensaries that catered mostly to the poor women in labour. The lying-in hospitals were mostly reserved for the well-off sections and women. The management at dispensaries was not rigorous and the women also did not undergo strict supervision. On the contract, the code of conduct in the lying-in hospitals was quite strict and every woman had to undergo a urine examination. Though both hospitals were initially teemed with parturient pauper women, the desirable patient were the upper-class women with means to pay for the emerging obstetric profession. The profession was seeking stability and needed to get a strong base with the moneyed clients with avenues to pay these practitioners.

The childbirth-related developments in Europe questioned the need of traditional midwives and their utility in birthing practices. The coming up of the medical practitioners and the competition faced by both to secure more women under their service has led to defining and controlling the boundaries of the two groups. To widen their influence, the medical professionals created the distinctions between 'normal' and 'abnormal' childbirth, which claimed the midwife as unskilled to deal with the abnormal cases, and hence, legitimising the need of the doctor for the same. In some parts of Europe, many services offered by the midwives were incorporated into the newly developed obstetrics, the preserve of qualified medical practitioners. Oakley and Houd suggested four main reasons for the decline of midwifery and the medicalisation of childbirth in Europe: the need for doctors to recruit new patients as the growing pregnant/parturient women provided potential clients; deliveries came to be seen as a constant monetary source; the medical students of hospitals had to be provided with teaching material related to childbirth and obstetrics; lastly, the redefining of childbirth as a pathological state, hence making it a domain of doctors, not the midwives.[19]

The rules laid by the Midwifery Act 1902 in England made it mandatory for midwives to undergo a training program. Passing the training program with satisfactory results would lead to their certification. The Act also ascribed strict rules to maintain hygiene and sanitation at the time of childbirth. The midwives were also responsible for reporting any new birth, death, baptism at the nearest office for record keeping. Hence, they were also to act as agents of the government in keeping records of new developments. The midwives' certificate could be suspended, cancelled or removed upon giving unsatisfactory performance and could be reissued on improving it. It also emphasised that the midwives ought to have good moral character and her certificated be signed by any two persons in office recognised by the Central Midwives Board. To tighten the administrative regulation, it was mandatory that the signing authorities have known the candidate for at least twelve months. Therefore, the medicalisation of traditional midwifery in England was not only a means to train them in newer technologies of biomedicine, but also discipline them on the lines of morality and norms considered favourable by the medical practitioners and administration.[20]

The trained midwives were also advised by the Board, on being called upon to attend a birth, that they should take use of the chance to visit the patient in her home and offer advice on both specific and general confinement arrangements. Extra attention was paid to keeping everything clean, including her person, her clothes, her appliances, and her home. She needs to maintain short fingernails and avoid any cracks or abrasions in the flesh of her hands. After caring for her patient, she is required to put on a clean, boil-able dress made of washable material, such as linen, cotton, etc., and an additional clean, washable apron or overall. The dress' sleeves ought to be designed so the midwife may tuck them up well over the elbows. Even after a healthy confinement, there will still be remnants of blood, lochia, or liquor amnii on the fingers, especially under the nails, where they will decompose and become hazardous for the

[19] Hilary Marland and Anne Mary Rafferty (ed.), *Midwives Society and childbirth: Debates and controversies in the modern period*, London, Routledge, 1997, pp. 19-20.
[20] Central Midwives Board, London, Wellcome Trust, pp. 7-10.

subsequent patient seen if the cleaning process is not fully carried out. On being called upon to deal with a case in confinement, the midwife must carry with her a bag furnished with removable lining made of washable material which can be disinfected further. An apparatus for administering vaginal injections, a separate apparatus for delivering enemata, a catheter, a pair of scissors, a clinical thermometer, and a nailbrush must all be included in the bag.[21]

The developments related to childbirth and reforming mothers and motherhood practices were taking place all across the globe. American society was not left untouched by it. An appeal was made through the grooming classes and newspapers and magazines of the times to forego maternal instincts and tedious methods of previous generations and turn to the scientific advice given by the physicians and specialists, without which it was claimed that motherhood would be a failure. One such article writes "Add science to love and be a "perfect mother"."[22] It is also to be noted that most of these specialists who tended to train the mothers in scientific motherhood where the males, making this newly evolving sphere a highly male dominated space. These men tend to train and inform young mothers and mothers to be in higher forms of caring and nurturing the child. A collateral change with this was, delegitimising the traditional childbirth and childrearing related knowledge that was passed on to generations through ages. A binary was created with the coming of these new professions between the traditional and the modern forms of mothering and it was instituted that both cannot coexists together as the one was antithesis of the other. Though the specialists tried to create a binary between the two, the mothers were reluctant to follow the advice blindly. There was rethinking involved especially when the expert advice contradicted their own proven knowledge and sensibilities related to mothering.

The evolution of hospitals in Britain where women worked as caregivers and nurses was a long process which took years to accept them in the role. The women though gradually came to be accepted as nurses as it coincided with their traditional roles as mothers of women being better caregivers, and not as doctors. The doctors, it was believed, needed more specialisation and occasional visits to the hospitals and patients like the father while the mother was present at home and available at a call. The father was associated with the doctor while the mother was with the nurse. The hospitals, in the beginning, were especially for the children of the poor, as the rich were reluctant to send their children to the hospitals. They preferred home services. But even for the children of the poor to attend the hospitals, the latter had to compete with the close-knit cooperation and caregiving practices among the poor neighbourhood where women helped and cared for each other at the time of sickness. The hospitals had to sell their services to the poor mothers and gain their trust. These hospitals were not only places of healing sickness. The children were also trained in middle-class social norms and etiquettes, eating habits, hygiene and cleanliness. Though the hospital catered to the poor children, the ladies from influential families were encouraged to make service and charity for the hospital. The Queen Victoria's visit and gift-giving to the ladies and their families encouraged such a move. It also gave an opportunity to the middle-class families and women to rub soldiers with the elite and the recognised women in turn increasing their social standing. The hospitals also brought in the view that the poor women were naturally reluctant to cleanliness and hygiene. Hence, the nurses were preferred either from countryside or middle-class trainees. It was believed that the poor were 'congenitally deficient' of what the well-off considered good habits and hence, they were considered impossible to reform. The hospital in Britain were the place where the genetic mother of the child and preferably the working-class women had least authority over the child while the child was in hospital. Her mothering, care and upbringing were considered dangerous to the child and hence, the child was nursed and tutored in middle-class mannerism in the hospital. The hospital were not only spaces of treating the sick but also imbibing the middle-class morality in the working-class children. The nurses appointed in these hospitals were also the ones who broke the popular imagery of the Dickensian drunkard slovenly old women stinking and in rags with least social standing. Contrary to that, the new nurses from the middle class had a certain social standing and opportunity to uplift their position by their profession. The training and education in caregiving made them specialised in their tasks and gave them a dignity that the previous nurses were devoid of.[23]

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[21] Ibid.,

[22] Cited in Rima D. Apple, 'Constructing Mothers: Scientific motherhood in the nineteenth and twentieth centuries', *Social History of Medicine*, 1995, 08/02/161-178.

[23] See Andera Tanner, Too many mothers? Female roles in a Metropolitan Victorian Children's Hospital in John Henderson, Peregrine Horden and Alessandro Pastore (eds.), *The Impact of Hospitals 300-2000*, Switzerland, Peter Lang, 2007, pp. 135-166.

5. Transnational developments, national influences in maternity :

The medical developments in Britain and Europe also impacted the childbirth practices in India. The effects could be seen both on modern as well as traditional childbirth practices. Though it is difficult to completely differentiate one from the other as some technologies from modern childbirth knowledge were imported and appropriated while undergoing traditional forms of childbirth in India. Hence, to completely create a binary between traditional forms of childbirth practices and childbirth through modern medical knowledge would be a gross misinterpretation of history. Chloroform, for instance, was one such substance which gained currency in late nineteenth and twentieth century England. Though it had some complications associated with it and only in twentieth century it became safe to use while delivery process. The women centric magazine published from Allahabad, called the *Stree Darpan* had an article titled *Garbhini estriyon ke hit ki baten* Rajkishori Mehrotra from Itawa, talked about the precautions pregnant women ought to take. It compares the lifestyle of such women in England to that of ones in India and advises that women should stay active during the course of their pregnancy. It says that the old women out of their superstitious practices want to cage the pregnant women at home, but the practice can have negative impacts on them. Activity keeps the women healthy, essential for proper blood circulation of body. Ones menstruation cycle is hampered after marriage, it was preferable to consult a doctor, but if situation disallows, some bodily changes can be observed to confirm pregnancy. Like the change of colour of veins near the breasts, bulged and blueish nerves and heaviness of stomach and lethargicness. The writer also advised to not count days as doctor's suggest that women can get pregnant up to fourteen days after consummation. The article explains more about antenatal care and lists precautions to avoid vomit sensation. The writer cites the opinion of famous British Doctor, Mary Stopes about maintaining sexual relations after women conceives. According to Dr. Stropes, if women desire, sex during early days of pregnancy will only give birth to healthy, beautiful child. The mother will also gain strength to carry the foetus. It was recommended to undergo childbirth under doctor's supervision and keep the house and surroundings clean and sanitised as done in hospitals. It was advised to carry childbirth through chloroform, as done in the hospital to relieve the women in labour pains. But regretted that such chemical use in not widespread in India during childbirth. Furthermore, the assistance of lady doctor was advised to avoid any undesirable circumstances. The article gives a detailed list of antenatal care for women. Most of them included lifestyle precautions. It also instructed to reduce dependency on medicines and instead indulge in controlled and balanced lifestyle. The medical developments in Europe impacted the antenatal care and lives of pregnant women in India as well. The antenatal care was devised and became more important part of course of nine months period of pregnancy. The writer writes that for first 40 days, the embryo is lifeless, after one and a half months it gains some form and starts the formation of spine by second month of pregnancy. After third month, embryo becomes three-four inches in size. By fifth month the heartbeat of the foetus can be heard clearly and by seventh month its's almost fully developed with the growth of nails. The women should take great precautions and avoid stress and stay happy and elated. It was also advised for the women to listen to stories reviving women's moods.[24]

The antenatal care which in twentieth century India seemed to be a well-known thing with many advisory literatures produced to inform the new mothers about it had undergone great evolution beforehand. A similarity can be drawn between the emergence of maternity hospitals in Britain and late nineteenth and twentieth-century India. In colonial India as well, most women who volunteered to be treated in these lying-in maternity hospitals were the poor women coming for free treatment and care. But the colonial state from the very beginning targeted the elite women, as they wanted a clientele with ability to provide economic base and stability to the new professionals in colony. The professionals in India were facing stiff competition in Britain, and India could provide them with new opportunities. Hence, to establish themselves, the medical professionals sought after elite women.

The midwifery reforms in India were influenced by the changes taking place in England and other parts of the world. The move to certify midwifery, train them and verify their practice had impacts on Indian midwifery practices as well. In England, the coming of modern medicine and childbirth knowledge led to the marginalisation of the traditional midwives. They were inscribed as filthy, unsanitary and detrimental to the health of the mother and child. The Medicalisation of childbirth in England had its consequences in India as well. Apart from England, New Zealand also undertook midwifery reforms. The New Zealand government decided to give pension to the old Dais who have been involved in the profession for years. The provision was made under the National Provident Fund Act.[25] In a news

[24] Estree Darpan, *Garbhini Estriyon ke hit ki baten*, June 1928, Kanpur, part 40, no. 6, pp. 117-120, Hindi Sahitya Sammelan Library, Prayagraj.
[25] *Daiyon ki pension*, April 1926, Chand, NOV. 1922-April 1925, Chand, Nehru Memorial Museum and Library (hereafter NMML), p. 714

published in Chand, the new laws passed in Australia relating to the Dais were discussed. Under it, the Dais knowledge was to be examined and certified by the doctors, failing to do so they will be charged two hundred shillings. The bill was passed by an Australian female Parliamentarian, named Oolar Rudel. The female law maker on midwifery here symbolises the initiative taken by women themselves in getting rid of the traditional childbirth practices and putting their faith in the new modern doctors. These attempts showed the initiative made by governments across the world to medicalise childbirth and midwifery practices. These reforms became part of the debate around childbirth and maternity services available in India.[26] Though the claims towards institutional childbirth were gaining ground in twentieth-century Europe, they were not very successful in carrying out successful childbirth and post-natal situations. For instance, the rising cases of puerperal fever in childbirth in hospitals led the International Congress of Midwives participant to comment that 'hospital confinements cannot be considered entirely as a form of progress.' [27] By the coming of modern medicine, women's reproductive bodies became the objects of male medical gaze and midwives were marginalised in favour of professionals trained in western medical knowledge.[28] The case was same in Indian context as well. Here, after the coming of western medicine and colonial rule, traditional midwives came to be increasingly attacked and marginalised.[29] The advances made in terms of childbirth technologies were crucial in deciding the course of maternity practices in India.

The concern and intervention of the nationalists. about the reproductive practices, domestic spaces and infant health can be seen as a part of the broader public debate about achieving national greatness and reforming the mothering and reproductive practices for the same. It was also an attempt to show the direct relationship between the health of the child and greatness of the nation.

6. Conclusion :

The development of western medicine and childbirth practices had some similarities in both the settings. Firstly, both pushed the dais to the periphery by terming their practices as unsanitary and detrimental for the child and the mother. Secondly, in India, the health of the women was reduced to her reproductive capacities and they became a barometer to gauge the greatness of a nation. The western childbirth impacted the maternity choices of women in India, and they were presented with wider choices of childbirth and care practices.

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