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CHILD-BIRTH IN INDIA.

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The barbarities practised in Indian homes even amongst the well-to-do at the time of delivery would horrify civilised people if made public. None but those who have witnessed a case conducted by ignorant dais (midwives) can realize the unnecessary suffering and the risk to the women and children. Many women who are childless and permanently disabled are so from mal-treatment received during delivery. Many men are without male issues, and in consequence many homes are unhappy because the child has been killed by ignorance, or lack of proper care during and after birth, or because their wives were so mangled during child-birth that they are incapable of further child-bearing.

These words are not the views of a Western specialist or practitioner, but are taken from a paper by an Indian lady doctor, Miss Jerbanoo Mistry, read at the All-India Social Workers' Conference held at Bombay so recently as last November.

There is no country in the world where the desire for children is stronger than in India. In the home of a newly married couple it reaches a pitch of passionate longing to which those of the West are mostly strangers. To the husband it is not merely the parental instinct strengthened by the wish for an heir to his name and property, it has with a large bulk of the population a strong religious basis, founded on the duty of the son to pay the last sacred rites to the bodies of his parents. To the wife even stronger than her desire for motherhood is the knowledge that if she fails to bear a son her chances of a happy married life are small indeed. Even if her husband's affection survives the disappointment, she will incur the scorn and derision of his family and have to face the possibility of a rival. Pregnancy is a source of intense gratification to any Indian woman and she looks forward to the culmination of her hope with joyful expectancy, but unfortunately custom has placed her at the moment of the realization of her hopes under desperate disadvantages as compared with her more fortunate sister in the West. The "barbarities" referred to by Dr. Mistry have a three-fold basis, viz. (1) the religious prejudice that the lying-in woman is ceremonially unclean, (2) the belief that fresh air is dangerous to mother and child and (3) the ignorance and superstition of an hereditary caste to whom for centuries custom has consigned the care of all parturient women.

The notion that a woman at the supreme hour of her existence is a source of defilement to others, determines the whole entourage of the confinement.

The scene of labour is some apartment not used by the other members of the household. Usually it is a small dark room, almost devoid of all means of entrance for light and air. The low, narrow door covered with matting and sacking. The window, if there is one at all, is closed with wooden shutters and any chinks are stopped up with paper and rags. The walls and floor are

usually plastered with the mixture of cowdung and mud so popular in India. The woman lies on old clothes filthy from age, either on the floor or on an old string "charpoy" in one corner of the room, and is screened from every breath of air by means of dirty old quilts or blankets.

The attendant or *dai* inherits her office and her skill (or lack of it) from a relation who has been a *dai* before her, and her work is considered unclean and is naturally of the lowest class.

In some cases the *dais* have attendants whose sole duty is to cut the cord as this is supposed to be the most unclean part of a labour case. This operation is carried out with either an old knife encrusted with the rust and dirt of years or by means of a split bamboo. The cord is tied with a dirty piece of string, usually the mother's hair tie. At times the *dais* do not tie the ends of the cord properly and the infant dies of hæmorrhage: at others they tug at the maternal end with the result that a portion of the placenta is retained, or the uterus is inverted.

In the third stage the patient's abdomen is massaged often with the unfortunate woman against the wall until the placenta comes away. Where massage is not resorted to, the instant the infant is born the *dai* pulls on the cord to extract the placenta. If this is not sufficient she puts her dirty hand into the uterus and pulls it out whole or in pieces, generally the latter. The general belief is that if the placenta is not delivered at once it will get on the liver and cause the death of the patient, hence the relations insist on the *dai* doing everything she knows to extract it. When delivered the after-birth is covered with salt and burned, or buried in a corner of the room! A very light roll of cloth is wound round the woman's waist in such a way that it has no effect either in supporting the abdominal muscles or aiding contraction. The *dai* then inserts a vaginal tampon consisting of either salt, crude sugar (with or without a copper coin) or cotton wool (which has probably been taken from an old pillow or quilt) soaked in native spirits or oil taken from the *chiraz*!

This represents the conduct of an ordinary case, but when labour is delayed it is complicated by frequent examinations and efforts to extract the child by the dirt-grimed hands of the *dai*. Hot water is not thought of: towels are unknown: and the cleansing process prior to intra-vaginal and intra-uterine operations is to wipe the hand on the mud-plastered floor!

After delivery, for a period of five to thirteen days, the young mother—she may be only twelve or less—lies unwashed in an atmosphere of incredible foulness, undergoing a dietetic régime of the utmost severity. Milk and every kind of nourishing food is forbidden during most of the first week. Water is regarded as likely to cause chill and is given sparingly: indeed, sometimes it is entirely withheld during the first twenty-four hours. Bitter drugs and condiments are given freely, and if the child dies it is the practice in Rajputana to give the mother a decoction of copper coins and bamboo during the first three days. Generally speaking, the gruel of old Sarah Gamp finds its counterpart in rice and pepper water as the favourite diet for the most trying and exhausting days of a woman's life.

What of the child whilst the mother is receiving this medieval treatment? Its cord is dressed with charcoal or red earth. In the North no dressing is applied but the string with which it is tied is fastened round the child's neck, generally tightly pulling the cord out and causing hernia. It is not put to the breast for three or four days, and is fed on milk, often on a rag leading from a brass cup. A loathsome practice in the Central Provinces is to give the unfortunate infant sugar mixed with its own urine.

When the *dai* is sent for to a case she usually changes even her working clothes for filthy rags, and the delay is a fortunate thing, as if she reaches the woman during the first stage of labour, so much the worse for the patient. She makes her run about the room, lift heavy weights, or squat on the mud floor: and if these efforts fail to produce sufficient progress, she places heavy weights on the abdomen or inserts a vaginal tampon of dirty rags. The results of these manoeuvres are often precipitate delivery, with injury to the child, hæmorrhage, and of course rupture of the perineum.

What I have outlined may be news to most people in this hall, but it is an old story, for as far back as 1885, the unhappy conditions of child-birth among the Indian women were already known to a few in this country, and Queen Victoria asked the wife of the then Viceroy to endeavour to arrange for a supply of women doctors for the zenanas of India.

Lady Dufferin started a fund to provide women doctors: zenana hospitals sprang up all over the Empire, and the training of nurses and midwives was begun.

Increased knowledge of actual events only served to bring into relief the terrible suffering and unnecessary loss of life amongst mothers and babies. It became evident that while natural labour was not more difficult, if so difficult as in Western countries, yet an appalling amount of puerperal sepsis followed. The disease of osteomalachia was found to be prevalent in many parts of India, causing pelvic contraction, so that delivery without skilled help was impossible. It also became established that in addition to the altruistic attitude of the charitably minded there was also the *dai's* point of view. As we have said, the *dai* has inherited a despised calling, and is always wretchedly poor. She has all the valour of ignorance, and is out to earn a living according to her lights: moreover, she is very badly paid. She may be given for a fee anything from two annas for a girl and four annas for a boy in a poor neighbourhood, up to Rs. 15 in the houses of the rich: and be it remembered that the conditions of maternity nursing I have outlined do not apply to houses of peasants and labourers, but are to be found in the inner recesses of pretentious Indian homes, even in houses of the wealthy, where outwardly such evidences of Western progress are present as electric light, the telephone, the gramophone, or even the wireless. The *dai's* fee includes attendance not only during labour but also for about ten days afterwards, at the end of which period it is customary for the woman to have her ceremonial bath. In Hindustan the bath is always taken on the fifth day, and when the patient is poor and has to work on the

second or third day, after the bath the *dai* does not touch the patient, she is not even allowed into her room. The *dai* is expected to heap with cowdung the defiled accouchement chamber and to wash all the soiled linen of patient and baby which the *dhobi* will not touch.

It was felt that something must be done for the women and as the result of the efforts of Lady Curzon the Victoria Memorial Scholarship Fund came into being in 1903 expressly for the purpose of training the hereditary *dai* class as opposed to midwives, taken from other classes, whose training was left to hospitals and municipalities, which had already started work in this direction.

Unfortunately the movement caused considerable alarm amongst the *dai* communities, who in nearly every case believed it was intended to deprive them of their livelihood. As years went on unsatisfactory progress was made, and the Fund came to be applied in the training of women not of the *dai* class and the stipending of nurses in Dufferin Hospitals who received a midwifery training. Since 1916 an effort has been made to get to work on better lines, and the latest Report of the Fund is much more encouraging than its predecessors.

The prospect of success has only appeared since the principle was established that the training of *dai* must be combined with supervision of their work, and efforts are being made in this direction in several places. In support of the work which the V. M. S. F. had been carrying on for over a score of years the Lady Chelmsford All-India Maternity and Child Welfare Association came into being in 1920, and a year or so later the three kindred organisations—the Dufferin Fund, V. M. S. F., and Chelmsford League—whilst still maintaining their identity, were placed under the administration of an able member of the Women's Medical Service for India, Dr. M. I. Balfour. Educational efforts have been made by means of posters, handbills and exhibitions, and Dr. Balfour relates how she has toured various parts of the country, stopping a day or two in each centre examining the *dais* and showing the models and posters of a small Travelling Exhibition to large audiences of women and girls who all displayed the greatest interest, and most of whom evidently were hearing for the first time of the need for cleanliness at child-birth. There is now a Travelling Exhibition, with a trained Health Visitor in charge, which tours in many parts of India and stays a week or so, shewing the exhibits, the Health Visitor gives lectures to women and school children. This exhibition has done an immense amount of good in enlightening the public.

In the municipalities much progress has been made. Calcutta is now divided into four circles, each with a Lady Health Visitor and four midwives, and the latest returns show that upwards of 4,000 cases are attended yearly, and that at least one out of every six babies born in Calcutta is attended by a Corporation midwife. Dr. Crake, the M. O. H., says "Considering the appalling insanitary conditions under which most of the women are confined, it is satisfactory to find only 9 maternal deaths in 3,208 deliveries."

At Delhi two European Lady Health Visitors, two Indian Lady Health Visitors and two trained indigenous *dais* are employed by the Municipality. The Lady Health Visitors supervise the work of the city *dais* and visit new cases as soon as possible after delivery. They attended upwards of 400 cases with the indigenous *dais* last year.

Madras is the only one of the three great Indian Corporations which has a complete welfare scheme. The Report for 1922 shows that the midwifery practice of the scheme grows in popularity. A total of 5,549 cases were attended last year as compared with 681 in 1918, *i.e.*, the work has increased nine-fold in five years. Dr. Chinnappam, the Lady Superintendent of the scheme, says :—

“The practice of the barber woman (or *dai*) is not so great an obstacle as it was in the past, for the value of trained assistance has been brought home to the people, the hospitals have become increasingly popular, and whereas in the early days of the scheme removal to hospital was a great difficulty, now instances are not wanting of patients who of their own accord left for hospital if no nurse was available in time.”

At Bombay there are three Maternity Homes and twenty Municipal nurses are employed. The nurses are all qualified midwives and visit the houses of the poor and advise on health matters, care and feeding of children, and prevention of disease. They endeavour to persuade prospective mothers to avail themselves of the free treatment and nursing provided in the Municipal Maternity Homes, but where this provision is not taken advantage of, the nurses attend the women in their own houses, providing them with bedding for their confinement and with food in the shape of milk and bread during the early days of the puerperal period. Dr. Sandilands says :—

“The visits of the nurses are frequently the means of bringing to the Municipal dispensaries persons who would otherwise either not know of the existence of the facilities provided, or knowing, would through indifference and stupidity neglect to benefit by them. These visits are doing much good and are welcomed and appreciated by those for whose benefit they are paid.”

During the year 1922 the nurses paid 60,000 visits, attended 1,259 confinements and verified nearly 8,000 births by calling on cases attended by indigenous *dais*.

The time available does not permit of reference to the work being done in other municipalities or by the various Social Service Leagues founded and administered entirely by Indians, which are endeavouring to educate the Indian public with reference to the “barbarities” referred to by Dr. Mistry in the paper from which I have quoted an extract. Enough has been said to show that there is a quickening of the public conscience in India to-day and that a definite movement is in progress to combat the social and semi-religious customs which are responsible for the terrible dangers which have hitherto attended “Child-birth in India.”