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Waren and Dais: Women's Healing, Birth Rituals, and Indigenous Midwifery in Kashmir

By

Hilal Ahmad Tantray

Ph.D. Research Scholar, Department of History and Culture, Jamia Millia Islamia (JMI), New Delhi

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Abstract

Midwifery is an ancient profession that continues to be practiced almost exclusively by women. This study contends that the history of midwifery in Kashmir cannot be comprehended just through bio-medical narratives but must be reconstructed through the oral, embodied, and material archives that underpin women's healing practices. The occupations of *waren* in Kashmir and *dais* in Jammu illustrate two divergent yet interrelated histories of reproductive care influenced by caste, purity, and gendered labour. Although *waren* maintained a measure of local authority through apprenticeship, ritual practice, and sensory knowledge, dais were socially marginalized and consistently regarded as unskilled, a view further perpetuated by colonial medical discourse that pathologized indigenous midwives to rationalize missionary and state intervention. The study challenges

preconceived notions about authorship and professionalism in medical history and shows how midwifery expertise circulated outside of textual archives by highlighting oral traditions, tactile skill, birthing spaces like the *hammam*, and the material culture of herbs and tools. It also contends that, despite systemic exclusion, childbirth operated as a contested sphere in which women wielded authority. Thus, reexamining *waren* and *dais* reveals the political, social, and ecological entanglements that influence women's health in Kashmir and shows how reproductive care evolved into a site of negotiation between bio-medical modernity and indigenous epistemologies.

Keywords

(*Waren, Indigenous Midwifery, Health, Oral Traditions, Kashmir, Dogra*)

Introduction

Birth is more than just a biological phenomenon; it is profoundly political, socially located, and historically textured. (Squire 2009, 1–33) In Kashmir's contested territory, marked by protracted conflict, shifting sovereignties, and persistent inequalities, the experience of childbirth is molded not only by medical infrastructures, but also by broader socio-political disparities. This study investigates how childbirth and midwifery are integrated in Kashmir's marginality politics, reflecting power struggles, identity issues, and access to care. It focuses on the lived experiences of women, traditional birth attendants, and medical practitioners to investigate how birth practices

and politics reflect greater issues about state authority, community norms, and structural exclusion.

Midwives are health professionals who are known all over the world for their specialization in caring for women who are in labor. They play an important part in the health of both mothers and babies. Midwives are trained to help women who are in labor and are very important in ensuring that women have healthy vaginal births. They also care for pregnant women, support them and their families, give them advice, and help low-risk pregnant women have healthy births and stay healthy during their pregnancy. No matter what, although midwifery is a separate career, it can be hard to get recognized in some countries as a part of its official duties. Not clear policies and a lack of regulatory frameworks make the job of the midwife unclear in many countries. This makes it hard for the public to understand what the midwife does. (El-Ardat et al. 2025)

In Kashmir, reproductive health and midwifery reflect broader fault lines of gender, class, religion, and colonial and postcolonial governance legacies. Traditional midwives, who typically work outside of formal biomedical systems, have played vital roles in community health, particularly in rural regions; yet, their knowledge systems have been delegitimized by contemporary medicine's professionalizing logic. (Lawrence, 1928, 233-242) The subsequent debates about authority in childbirth underscore the politics of expertise: whose knowledge is valued, whose bodies are prioritized, and how institutions control or marginalize women's reproductive autonomy. Furthermore, increased militarization and surveillance in

the region have exacerbated existing imbalances by limiting mobility, weakening healthcare infrastructures, and heightening vulnerabilities related to pregnancy and delivery.

Within these overlapping spheres of power and opposition, our research places midwifery practices. It poses the following question: How do healthcare practices and governmental regulations in Kashmir regulate the birthing process? In the face of competing healthcare systems, how do women find their way? In a politically unstable area, what does midwifery teach us about belonging and not belonging? The research reveals how marginalization, belongingness, and the right to health are reflected in the everyday politics of birth in Kashmir by following these interconnections.

Theoretical Framework

This study is anchored in an interdisciplinary theoretical framework that draws primarily on Foucauldian theories of power, knowledge, discipline, and biopolitics, while also engaging feminist scholarship on care work, subaltern studies, and medical anthropology. Together, these approaches enable a critical examination of midwifery in Kashmir as a historically contingent practice shaped by colonial intervention, postcolonial governance, gendered labor hierarchies, and local epistemologies.

At its core, the study employs Michel Foucault's concept of power/knowledge to understand how medical authority is produced, legitimized, and enforced. Colonial and later postcolonial medical

regimes in Kashmir did not merely introduce new forms of healthcare but actively constructed regimes of truth that defined what counted as legitimate medical knowledge. Indigenous midwifery, grounded in oral transmission, embodied expertise, ritual practice, and ecological familiarity, was rendered inferior through biomedical discourse. In Foucauldian terms, the knowledge of warens and dais constitutes subjugated knowledge, forms of expertise that were widely practiced and socially embedded but systematically disqualified by institutional medicine and colonial science.

The concept of disciplinary power further illuminates how traditional midwives were pathologized within colonial medical narratives. By framing dais and warens as ignorant, unhygienic, and dangerous, colonial authorities justified interventions into women's reproductive lives through surveillance, regulation, and institutionalization. The birthing body became a site of governance, where norms of cleanliness, professionalism, and medical rationality were imposed. This disciplinary gaze separated childbirth from its social and cultural contexts, reconstituting it as a clinical event subject to state oversight.

The study also draws on the notion of biopolitics to analyze how childbirth emerged as a crucial site for managing populations. Through maternity hospitals, missionary medicine, and later welfare programs, both colonial and postcolonial states sought to regulate reproduction, maternal health, and infant survival. In Kashmir's conflict-affected context, biopolitical control intersected with militarization, mobility restrictions, and infrastructural fragility, intensifying women's vulnerability during pregnancy and childbirth. Midwifery thus

becomes a lens through which the uneven reach of the state and the limits of biomedical governance are revealed.

Feminist theories of care and gendered labor further inform the analysis by situating midwifery within broader structures of social reproduction. Midwifery in Kashmir was predominantly performed by women from marginalized social backgrounds and was often hereditary rather than formally certified. Although indispensable to community survival, this labor remained undervalued and stigmatized due to its association with bodily fluids, impurity, and pain. Feminist scholarship helps expose how reproductive labor is rendered invisible even as it sustains social life, and how women's authority in childbirth coexists with their social marginalization.

Medical anthropology and subaltern studies contribute to understanding childbirth as a culturally embedded practice rather than a purely biological event. By foregrounding oral histories, sensory knowledge, ritual practices, birthing spaces such as the hammam, and the material culture of herbs and tools, the study challenges archive-centered historiography. It treats embodied practices and community memory as legitimate historical sources, thereby expanding the epistemological boundaries of medical history.

Finally, the framework recognizes agency not only in overt resistance but also in everyday negotiation. Women's continued reliance on traditional midwives alongside biomedical services reflects pragmatic choices shaped by trust, accessibility, cultural comfort, and political constraints. This form of negotiated agency complicates binary

narratives of domination and resistance and highlights how care practices persist within, rather than outside, structures of power.

Analysis of the Chapter

Women's Work for Women: Medical Missionaries and Gendered Care

The history of women medical missionaries in Kashmir cannot be understood in isolation from broader transformations in gender relations, medical authority, and colonial governance in the nineteenth and twentieth centuries. Women's participation in missionary medicine marked a significant departure from earlier evangelical models that confined women to domestic or auxiliary roles. Over time, missionary women emerged as autonomous medical actors, reshaping both the internal dynamics of missionary households and the external landscape of colonial healthcare. In Kashmir, this transformation intersected with existing indigenous systems of reproductive care, producing complex encounters between missionary medicine, traditional midwifery, and state power. From the early phases of Christian medical missions, women accompanied male missionaries primarily as wives, assisting informally in clinical work, education, and evangelism. Their labor, though indispensable, was rarely recognized as independent or professional. As Dana Robert has demonstrated in her seminal work on American women missionaries, until the mid-nineteenth century women were largely accepted in mission fields only if they entered as spouses. Gradually, however, this arrangement began to shift. By the last quarter of the nineteenth

century, women increasingly entered mission fields as single, trained professionals—particularly as doctors and nurses. This change was encapsulated in the ideology of "women's work for women," which argued that only women could effectively access, treat, and evangelize other women, especially in societies structured by purdah and gender segregation. (Robert 1996, 13–40)

The rise of women's missionary societies in Britain and the United States played a crucial role in enabling this transformation. These organizations raised funds, advocated women's medical education, and created institutional pathways for women to work overseas. The establishment of the London School of Medicine for Women in 1874 marked a turning point in Britain, while similar developments in the United States ensured that American women were among the earliest female medical missionaries in India. Dr. Clara Swain's arrival in India in 1869 as the first female medical missionary exemplified these shifts. By the late nineteenth century, women doctors were no longer peripheral figures but central to missionary strategies, particularly in the domain of women's healthcare. (Hardiman 2008, 138–40)

Within this broader context, the entry of women medical missionaries into Kashmir assumed particular significance. Kashmir presented unique challenges: geographic isolation, political sensitivity under Dogra rule, conservative gender norms, and deeply entrenched indigenous healing practices. Early male missionaries such as Dr. William Elmslie had long emphasized the need for women doctors to reach Kashmiri women, whom male practitioners could not attend due to norms of modesty and seclusion. It was only decades after Elmslie's

death that this aspiration materialized with the arrival of Dr. Fanny Butler in 1888. Dr. Butler's career illustrates both the opportunities and constraints faced by women medical missionaries in Kashmir. Trained at the London School of Medicine for Women and sponsored by the CMS Zenana Missionary Society, she arrived in Srinagar after years of dispensary work in central India. Her appointment reflected the growing recognition within missionary circles that women's medical labor was not merely supportive but essential. Establishing a dispensary and later a hospital in Srinagar, Butler catered primarily to women patients—wives of artisans, laborers, boatmen, and villagers—who had previously lacked access to biomedical care. (Gracey, 1898, 137-40)

Language and cultural barriers posed significant challenges. Unlike some missionaries who relied on interpreters, Butler insisted on mastering Kashmiri before fully commencing her work, recognizing that medical intimacy required linguistic and cultural competence. Her practice extended beyond clinical treatment to encompass health education and religious instruction, reflecting the inseparability of medicine and evangelism in missionary ideology. Yet, her work was constrained by chronic staff shortages, limited resources, and resistance from the Dogra administration, which imposed restrictions on missionary mobility and public preaching. Over time, persistent negotiation and support from British officials enabled the establishment of more permanent medical facilities in central Srinagar. (Tonge 1939, 38)

Women's medical missions in Kashmir also relied on transnational networks of patronage and philanthropy. Isabella Bird's support for the establishment of the John Bishop Memorial Hospital illustrates how missionary medicine was sustained through imperial circuits of funding and moral legitimacy. Hospitals and dispensaries became not only sites of healing but also spaces of religious instruction, moral reform, and surveillance. Missionary women doctors, nurses, and evangelists used these spaces to disseminate Christian ideas, often reading scripture to patients during treatment sessions. (Tonge 1939, 43)

At the same time, missionary women produced powerful narratives about Kashmiri society that framed their medical work as a civilizing mission. Figures such as Irene Petrie, who arrived in Kashmir in the 1890s, described the region in starkly contrasting terms: picturesque landscapes juxtaposed against what they perceived as insanitary living conditions and moral stagnation. Kashmiri women, in particular, were depicted as oppressed, apathetic, and resigned to patriarchal control. (Stock 1899, 84) Such representations echoed broader colonial discourses that equated hygiene with civilization and framed Indian women's bodies as sites requiring rescue through Western medicine and Christian morality.

While missionary women often expressed genuine concern for the suffering of Kashmiri women, their interpretations were shaped by racialized and gendered assumptions. Practices of seclusion, joint family living, and ritual observances surrounding childbirth were interpreted as signs of backwardness rather than as culturally

embedded systems of care. Missionary frustration with women's limited autonomy frequently overlooked the structural constraints imposed by patriarchy, poverty, and political authority. As in other colonial contexts, women's conversion to Christianity remained rare unless sanctioned by male family members, underscoring the limits of women's medical missions as instruments of religious change. (Stock 1899, 123-27)

Kinkead's words point to a perceptible shift in the British medical profession's view of midwifery in the late nineteenth century.(Kinkead, 1878, 870–71) Historically, childbirth in Kashmir, as in much of South Asia, was integrated within community-based care systems managed by traditional midwives. Known locally as *warens* in the Kashmir Valley and *dais* in Jammu, these women were essential figures within rural and semi-urban communities. They supervised pregnancies, oversaw labour, delivered postnatal care, and assisted women through the physical and emotional changes associated with delivery. Despite their essential role, however, midwives held a profoundly ambivalent social standing. They were esteemed for their experiential knowledge, yet they faced stigma because of their association with blood, bodily fluids, suffering, and death elements culturally regarded as impure. This contradiction marginalized midwives from social legitimacy while concurrently positioning them at the core of reproductive life.

In colonial India, medicalisation of childbirth has been historically perceived as an attempt to 'sanitise' the zenana (secluded quarters of a respectable household inhabited by women) as the chief site of birthing practices and to replace the *dais* (traditional birth attendants)

with trained midwives and qualified female doctors. (Guh 2018, viii) Most conventional midwives were members of economically disadvantaged and socially marginalized communities. In numerous instances, midwifery was a hereditary vocation, transmitted from mother to daughter or daughter-in-law, rather than a formally obtained profession. Their knowledge was corporeal, experiential, and relational grounded in years of observation, practice, and close engagement with women's bodies. They perceived pregnancy and childbirth not as pathological conditions but as natural life processes that necessitate care, forbearance, and social support. This form of knowledge, although effective within its specific context, remained informal and was not acknowledged by governmental or medical institutions. (Das, 2015, 54-56) In Foucauldian terms, midwifery knowledge represented a form of subjugated knowledge—an indigenous, widely practiced expertise rendered opaque or illegitimate by prevailing regimes of truth.

In Kashmir, these processes occurred within particular historical and cultural contexts. Under Dogra rule, Kashmiri society remained highly conservative, especially concerning women's bodies and sexuality. Gynecological conditions and childbirth were regarded as concerns of female privacy and modesty, deemed unsuitable for male medical practitioners. Consequently, women's health was predominantly administered within female exclusive environments, supervised by elderly women and experienced midwives. The *waren* served as a specialist in childbirth, diagnosing pregnancies, overseeing antenatal care, and assisting with deliveries within the household. Notably, in

contrast to certain Western contexts, neither hakims nor barber-surgeons were involved in obstetric or gynecological care in Kashmir. By the late nineteenth century, numerous *warens* were actively engaged in the Valley, emphasizing their essential role in Kashmiri social life. (Mufti 2013, 21)

Most of the villages in Kashmir are cut off from the rest of the world during the winter because of heavy snowfall, but traditional midwives are still working there. Many of these midwives are old and wise, but their years of experience giving birth have made them lifelines. Older women were just as important as younger guys when it came to carrying on the traditions of traditional healing. Many of these amazing women did important work in health care without getting any credit for it. My grandmother Shamali Begum stood out from the rest of them. She was a well-known and respected '*waren*,' or midwife, who helped women give birth before gynecologists were common in towns. People would get chills just thinking about going to the '*haspatal,*' which means 'hospital.' They thought of going there as a last option. Back then, women gave birth in their own homes with the help of midwives like my grandma. It was a community event. People didn't pay her with money, but they showed their appreciation by giving her a '*Batte Traem,*' which is a plate of traditional Kashmiri Wazwan, during the baby's '*Aqiqah,'* which is a religious event celebrating birth. In her time, maternal deaths were very uncommon, which is very different from today, even though there are more trained doctors and better medical facilities. In those days, normal births were common, and women rarely had current health problems like diabetes, thyroid problems, cirrhosis, cancer, or high cholesterol. People from

nearby towns also went to see older women for a variety of health problems. Hanifa Appa was one of these healers. She was famous for using '*Datur Dohu'* in a very special way to treat tooth infections. She would use a hot knife to burn *Datura Stramonium* seeds mixed with her own ghee, letting the smoke get into the patient's open mouth. It was thought that the process would loosen up dangerous germs, which would then fall into a container of water that was put below. (Hanifa, interview, 12 August 2025)

They were traditional healers who helped everyone, regardless of their social or religious background. They had a real spirit of selflessness and cared for everyone. Their amazing stories of treating people who were thought to be dying and helping them get better are still a testament to their amazing skills and strong faith. Modern medicine has come a long way and helped a lot with health problems, but these healers' work is still an important part of Kashmir's cultural and medical past. They worked hard without expecting anything in return, and their efforts continue to inspire. We should remember them with gratitude. (Fatha, interview, 17 November 2025)

Childbirth practices were distinguished through both spatial and symbolic segregation. Deliveries generally occurred in the most secluded area of the residence, frequently on floors covered with dried grass (*hur*). (Mufti 2013, 21) There exists a traditional postpartum bathing practice known as '*Louse Aab*.' Prepare the *Louse Ghassi*, a blend of herbs, shrubs, leaves, wild fruits, and roots, and is prepared by boiling the mixture in a large vessel filled with water, preferably a copper container, for a period of one to two hours. After boiling, permit

it to cool slightly, commonly referred to as *Sakboul aab*, without the addition of frigid water. During the bathing procedure, delicately cleanse the lady's body with the *Louse Ghassi* and bathe her thoroughly with its water. Furthermore, it is occasionally advised to chew bits of grass to aid in restoring the strength of teeth that may have been compromised by labor contractions. It is a ceremonial wash that women typically undergo within 7 to 40 days following childbirth. The bath is regarded as having therapeutic advantages and aids in the recuperation process following childbirth. *Louse Ghassi* is a complex blend of herbs, shrubs, leaves, wild fruits, and roots, all combined together. (Tantray, 2024, 6) These botanicals are sourced from *Bohru* shops. Once the water reaches the appropriate temperature, a selection of traditional medicinal herbs is introduced. These herbs encompass a variety of botanical species, including Lasora (*Sapistan*), Liquorice roots (*Shanger*), Prunella Vulgaris (*Kalaveuth*), Curima (*Laedri Gandri*), Saussurea iappa (*Kuth*), Adiantum Pedatum (*Gawtheer*), Macrotomia benthami (*Khazaban*), Arnebia Benthami (*Goazaban*), Calendula (*Marigold*), Jujube fruits (*Unab*), Halale, Balale, Sweet Violet (*Banafsha*), Thulbalol, Taraxacum officinale (*Handh*), Kasni (*Kasun Posh*), Rheum emodi (*Pumbachalan*), among others. They are thought to possess restorative properties and support postpartum recovery. (Hanifa, interview, 12 August 2025)

Cultural ideals of isolation and impurity meant that birthing rooms were often dim, windowless, and poorly furnished. Consumption of *hund*, a leafy vegetable thought to help recovery, and the ceremonial bath (*abb shayrun*) on the seventh day were postpartum traditions that encompassed both physical healing and ritual purification.(Mufti

2013, 21) A cultural and moral birth economy was established as a result of these activities, with care, ritual, and social control all interdependent. Midwives were in a strange place in this economy; they were both vital and stigmatized, and people trusted but also avoided them.

A major crack appeared in this structure when Western medicine and missionary involvement reached Kashmir. Traditional midwives were depicted in colonial medical discourse as hazardous, unclean, and uninformed. Colonial authorities and missionary physicians stressed that *dais* and *warens* lacked education in hygiene practices, were uninformed about germ theory, and lacked proper training. Indigenous midwifery techniques were often blamed for high rates of maternal and infant death, but larger systemic issues including poverty, hunger, bad housing, bad weather, and political indifference were mostly disregarded. The Hakim does not participate in midwifery cases; these cases are managed by seventy-four designated women who specialize in such matters. In addition to the professional Hakims, numerous 'wise women' in the villages possess extensive knowledge of the properties of herbs, and it is a noteworthy observation that almost every peasant appears to have some understanding of the medicinal qualities of plants. (Lawrence, 1928, 233) Foucault calls this technique of assigning blame selectively ‘disciplinary power,’ which is the act of designating some groups or individuals as abnormal in order to rationalize government oversight and intervention.

> The practice of native ‘dais’ or midwives in all parts of India is most ignorant, unskillful and cruel. During complicated

> labor these practitioners resort to useless, hurtful or violent expedients and either inflict injuries which leave behind them permanent disease, or fail to accomplish delivery. The lives of both mother and child are in such cases sacrificed. (The Indian medical gazette 1873, 100-01)

Colonial criticisms of midwifery were highly political activities, not just medical opinions. Colonial authorities legitimized their presence as agents of civilization and progress by portraying indigenous midwives as emblems of backwardness. Colonial authority worked to alter reproductive habits through the establishment of women's hospitals, missionary nursing schools, and maternity welfare programs. Standardized medical procedures supplanted relational, community-based care, and these institutions imposed new standards of cleanliness, discipline, and professional hierarchy. According to Foucault, the medical gaze became a part of childbirth. This gaze separates the female body from its social context, breaks it down into its organs and functions, and makes it understandable to those in power.

Kalpan Ram highlights the societal disruption caused by midwives' wisdom, challenging established norms by bridging the perceived gap between knowledge and the body. (Ram,2009,114) Traditional midwifery persisted in spite of these interventions. *Dais* and *warens* persisted as principal caregivers in the hilly and distant areas of Jammu and Kashmir, where hospitals remained inaccessible owing to geography, poverty, and protracted political unrest. They show how biomedical governance has its limits and how the state's influence is

uneven. Trust, accessibility, affordability, and cultural comfort were some of the factors that led women to use a combination of traditional practices and hospital visits. This kind of reasonable compromise exemplifies what could be viewed as the covert forms of agency that exist within the context of bio-political control, as opposed to the more obvious forms of resistance.

In the postcolonial period, the Indian state expanded its involvement in maternal and child health through welfare programs and public health campaigns. While these initiatives improved access to medical care in some areas, they also intensified the marginalization of traditional midwives. Government policies increasingly emphasized institutional deliveries, trained personnel, and standardized protocols. The introduction of Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) marked a further consolidation of biomedical authority. (Ashtekar, 2008, 23-25) These health workers, trained and monitored by the state, replaced community-based midwives as the primary intermediaries between women and the healthcare system.

Consequently, the practice of midwifery in Kashmir sheds light on the dynamics of healthcare system inclusion and exclusion. In addition to physical health, socioeconomic status, location, gender norms, and political vulnerability all have a role in determining who has access to reproductive healthcare. Because of the high costs and long wait times associated with institutional care, women in rural, economically disadvantaged, or war-torn regions must rely on informal networks of support. Also, the state does not acknowledge or assist these informal

caretakers. This seeming contradiction brings to light the politics of belonging, specifically the questions of who gets to receive treatment, whose expertise is respected, and whose work goes unnoticed.

In Kashmir, larger fights for human dignity and citizenship are revealed by the mundane politics of birth. The reproductive lives of women are impacted by uncertainties and vulnerabilities in a territory characterized by militarization, monitoring, and restricted movement. In the midst of curfews, broken infrastructure, and interrupted healthcare services, pregnant women and new mothers give birth. Traditional midwives are vital in these situations because they provide continuity and stability. (Jeffrey and Jeffrey 1999, 278) Despite political and systemic violence, their work highlights how community-based care may persevere.

This study highlights the complex political nature of birthing in Kashmir by analyzing midwifery through the lenses of Foucauldian theories of power/knowledge, discipline, and bio-politics. Care and control meet at the point of birth, together with the production and contestation of marginality and the governing and resisting of bodies. Even though they are still susceptible to rejection, traditional midwives represent alternative care modalities that fight against the supremacy of biological reason.

Midwifery in Kashmir ultimately shows how subaltern wisdom is still relevant and how medical modernity has its limits. In doing so, it demands a reevaluation of reproductive justice that gives equal weight to both institutional care and culturally grounded, relational support.

The chapter highlights the importance of reproductive healthcare in comprehending issues of inclusion, exclusion, and the right to health in Kashmir by bringing attention to the mundane politics of giving birth. This chapter adds to larger discussions on gender, health, and power in areas impacted by conflict.

(OpenAI, 2026)

Implications of the Study

This study has significant implications for the fields of medical history, gender studies, anthropology, and public health, particularly in conflict-affected and postcolonial contexts. By foregrounding the lived experiences and knowledge systems of traditional midwives, warens in the Kashmir Valley and dais in Jammu, it challenges the

dominance of biomedical and colonial frameworks that have long shaped understandings of reproductive care.

First, the study calls for a rethinking of medical historiography. It demonstrates that histories of healthcare cannot be written solely through institutional archives, official reports, or professional medical texts. Instead, oral traditions, embodied practices, ritual knowledge, and material culture constitute vital historical archives. Recognizing these alternative sources destabilizes Eurocentric and colonial notions of authorship, expertise, and professionalism, and broadens the epistemological foundations of medical history to include subaltern and gendered forms of knowledge.

Second, the findings have important theoretical implications for understanding power and knowledge. Drawing on Foucauldian concepts of biopolitics and disciplinary power, the study shows how childbirth became a key site through which colonial and postcolonial states sought to regulate women's bodies. At the same time, it reveals that midwifery functioned as a domain of negotiated authority, where women exercised agency despite systemic marginalization. This complicates binary narratives of domination and resistance by highlighting everyday, covert forms of agency embedded in care practices.

Third, the study contributes to feminist scholarship on labor and care by reframing midwifery as skilled, gendered labor rather than unscientific or residual practice. It exposes how caste, purity, and class hierarchies shaped the social positioning of midwives, rendering their labor both indispensable and stigmatized. In doing so, it underscores

the need to value reproductive labor not only as a health service but as a form of social reproduction central to community survival.

Fourth, the research has policy and public health implications, especially for regions marked by geographic isolation, conflict, and fragile healthcare infrastructures. The continued reliance on traditional midwives in remote and militarized areas of Kashmir demonstrates the limitations of exclusively institutional and hospital-centric models of maternal care. The study suggests that maternal health policies must move beyond the wholesale replacement of traditional practitioners and instead explore integrative frameworks that acknowledge local knowledge, cultural comfort, accessibility, and trust. Such an approach is particularly relevant where state healthcare delivery is uneven or disrupted.

Fifth, the study contributes to debates on reproductive justice and the right to health. It shows that access to safe childbirth in Kashmir is shaped not only by medical availability but also by political vulnerability, mobility restrictions, economic inequality, and gender norms. By situating birth within the everyday realities of militarization and surveillance, the study highlights how reproductive health becomes a marker of citizenship, belonging, and dignity in contested spaces.

Finally, the study underscores the enduring relevance of indigenous epistemologies in contemporary discussions of healthcare. The persistence of practices such as herbal baths, ritual postpartum care, and community-based birthing spaces illustrates that medical modernity has clear limits. Rather than viewing traditional midwifery

as an obstacle to progress, the study positions it as a critical resource for imagining plural, culturally grounded, and context-sensitive models of reproductive care.

In sum, this research not only enriches historical understanding of midwifery in Kashmir but also offers broader insights into how care, power, and knowledge intersect at the site of birth. It advocates for a more inclusive and equitable vision of reproductive healthcare that recognizes subaltern wisdom alongside institutional medicine and affirms women's authority over their reproductive lives.

Conclusion

This study has shown that midwifery in Kashmir has long been shaped by the intersecting forces of colonial medicalization, postcolonial state policy, and entrenched social marginalization. Colonial biomedical and missionary discourses systematically delegitimized indigenous reproductive knowledge by framing warens and dais as unhygienic, unskilled, and dangerous. Through this process, childbirth was removed from its social, cultural, and ritual contexts and reconstituted as a clinical event subject to surveillance, regulation, and institutional control. These regimes of medical truth persisted into the postcolonial period, where state-led maternal health initiatives further marginalized traditional midwives by privileging standardized, hospital-based care.

Yet, the lived experiences of warens and dais complicate narratives of decline and disappearance. Despite stigma and exclusion, traditional midwives continued to provide essential reproductive care, particularly in remote, mountainous, and conflict-affected areas where

biomedical infrastructure remained uneven or inaccessible. Their endurance reveals both the limits of biomedical authority and the importance of trust, cultural familiarity, and relational care in shaping women's reproductive choices. Childbirth thus emerges as a critical site where power, knowledge, and women's autonomy are continuously negotiated.

By foregrounding oral traditions, embodied expertise, ritual practices, and material culture, this study challenges archive-centered medical historiography and repositions indigenous midwifery as a form of subaltern yet enduring knowledge. Ultimately, midwifery in Kashmir illuminates broader questions of reproductive justice, belonging, and the right to health in a contested landscape. Reimagining reproductive healthcare in the region requires not the erasure of traditional practices, but their ethical recognition alongside institutional medicine, affirming women's authority over birth and care.

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Endnotes

Kahzaban (گہزبان) in Kashmiri refers to the medicinal herb Arnebia benthamii, commonly known as Himalayan Arnebia or Gaozaban. Native to the alpine regions of the Himalayas, this plant holds significant value in both Ayurvedic and Unani systems of medicine. Traditionally, *Kahzaban* has been used to treat a variety of ailments, particularly those affecting the heart, respiratory tract, and throat. It is known for its cooling and soothing properties and is often employed in remedies for fevers, coughs, and inflammatory conditions. The roots of the plant yield a reddish dye and contain active compounds believed to have therapeutic benefits. In Kashmiri ethnomedicine, *Kahzaban* represents the region's rich botanical heritage and the continued reliance on natural remedies, especially in rural and mountainous areas.

Deliveries took place in the patient's home, usually on the floor supported by dry grass known as *hur*. During the immediate post-delivery period, a unique leafy vegetable called *hund*, a variant species of spinach, was provided to the lady. On the seventh day of the postpartum period, known as *Sundar,* the woman underwent the *abb shayrun* ceremony, involving a warm bath for both her and the newborn baby.

Hund: In Kashmiri, *"Hund"* also pronounced as *"Handh"* refers to a wild leafy green**,** specifically a variety of dandelion**.** This plant is a part of traditional Kashmiri cuisine, especially valued for its nutritional and medicinal properties. The young greens of *hund* are collected from the

wild, thoroughly washed, and cooked as a vegetable, often stir-fried or prepared with spices.

Waren: Midwives possess expert knowledge and skills for providing care to women during pregnancy, childbirth, and the postpartum period. The midwife's role is to provide care that acknowledges the goals and choices of each individual woman and her family. A midwife assists a woman in making decisions about how to cope with labour, explains pain relief options, helps women develop a personalized birth plan that aligns with their needs and desires, discusses realistic expectations about labour and delivery, and suggests position changes and movements that facilitate the birthing process.

Louse Aab: In Kashmiri cultural practice, especially in traditional bathing rituals (such as herbal baths and postpartum care), *Louse Aab* refers to warm herbal water used for cleansing, healing, and relaxation, rather than plain hot water.

Sakboul Aab: Culturally, *sakboul aab* usually refers to water that has been boiled (often for hygiene or medicinal purposes) and then allowed to cool before drinking or use—especially during illness, winter, or for preventive health care in Kashmir.

Author's Bio

Hilal Ahmad Tantray is a doctoral researcher in the Department of History and Culture at Jamia Millia Islamia, New Delhi. His research focuses on the medical, cultural, and socio-religious histories of

Jammu and Kashmir, with particular attention to health, gender, and material culture. He has published extensively in peer-reviewed journals, including *SAGE*, *Cogent Arts & Humanities* (Taylor & Francis), *South Asia Research*, and the *South India Journal of Social Science*. His notable works examine themes such as Dogra-era coinage, food and dress culture, women medical missionaries, and the impact of epidemics in Kashmir. He has also contributed a book chapter on Muslim women's resistance in colonial Bengal. Hilal has presented his research at several national and international forums, including the Indian History Congress and the Public Health World Conference, Singapore. He can be reached at hilalmohiuddin614@gmail.com and his ORCID ID is 0009-0005-2813-6799.