CHAPTER 7

CONCERN FOR WOMEN’S HEALTH:
STATE INTERVENTION

The medical system in colonial India worked to protect the health of soldiers and administratively important civilians where women played little part. Hospitals and dispensaries worked in a limited way only as centres for vaccination against small pox and malaria. The diseases that affected colonial medicine in the nineteenth century were epidemic diseases. As far as women’s health was concerned it was not seen as a State responsibility. It was left to a host of medical manuals and family health guides to inform and instruct occasionally the health care for mothers and children. As put up by Deepak Kumar, the western medical discourse was an instrument of control which would swing between coercion and persuasion as the exigencies demanded and as a site for interaction and often resistance. The role of the State in relation with women’s health issues befits in the latter context. For the state remained marginalized in its medical discourse for women, a process that was bleak throughout the colonial years.

3 Deepak Kumar, “Unequal Contenders, uneven ground: Medical encounters in British India, 1820-1920”, in Andrew Cunningham and Birdie Andrews (eds), *Western Medicine as Contested Knowledge* (Manchester and New York:Manchester University Press,1997,p.185)
The elusiveness of the indigenous women became a challenge for the hegemonic ambitions of western medicine. Here, the work of the wives of viceroys played a dominant role. Although called as the 'vice regal rhetoric' by many scholars, their activities throw light on a number of issues. As to how 'medicalisation' of women moved in the society, did it create resistance or acceptance? And to a broader area as to whether western medicine adapted hegemonic strategies to expand in the isolated areas of the social structure.

I take this process of government intervention as to study the policies at work to reach the women of the society that probably remained untouched by the mission hospitals. Although the State hospitals could never match the efficiency of zenana mission hospitals with its all-woman staff bound by cultural and social norms of purdah for its indigenous patients, they played an important role in providing 'secular' medicine to the women folk of India. My main aim to focus a chapter on State medicine was to give a broad overview of its involvement in women's treatment, major characteristics of the process was the involvement of the women of the officials that gendered the whole issue. For it was believed bringing the state hospitals in closer contact with the women of State would give a larger acceptance by the indigenous women. If on one hand we see the rhetoric of the missionaries at work, at the same time a strong similarity in the nature of work was seen in the state context, too. Was it no longer western medicine but 'imperial' medicine at play, hegemonising its way through the colonised society? The main objectives behind these moves were to
present western medicine as beneficent of colonialism. The two obvious players in deciding the means of providing medical care for the indigenous women were the colonial government and the Christian missionaries. A number of questions come up at this point. Under what pressure did they both work? Was there an impasse created by both the state and the missionaries when reaching out to women in the different social compartments of the society? Was there something of a state versus missionary medicine at work? Did they negotiate with each other and with the indigenous women to push the cause of the western medicine in the indigenous society? While studying the mission medicine during the nineteenth century, it was but necessary to study the government intervention in providing colonial medicine to the indigenous women, the ‘uncolonised’ strata of the society. It’s important to keep in mind that during this time the Christian missions were already claiming their authority over the womenfolk of India.

Curing the English Man vis-à-vis the Native Women: Discourses on Venereal Diseases

In the nineteenth century, for the British who had to meet their imperial needs with a limited number of soldiers, venereal diseases became a major threat for their mere survival in India. The disease became a metaphor which not only reflected the deeper immoral moorings of the society, its control meant public intervention in otherwise private spaces of individuals and rigid
control over and regulation of their sexual activities. In its attempt to rescue the soldier, the State moved its gaze over female privacy that led to the scrutiny of the profession of prostitution. This could be the beginning of the state's intervention in the field of women's health, that came in the form of the Contagious Disease Act (CD Act) in 1868. The provisions included the compulsory registration of brothels and prostitutes, periodical medical examinations and compulsory treatment of prostitutes found to be infected. In short, this Act spared the soldier and made the Indian prostitutes responsible for the disease. The lock hospitals, which had been set up is 1811 became an important institution of the CD Act and Punjab was no exception. There was a lock hospital of the first class at Jullundhur which was founded in November 1869. Here the women were subjugated to medical examination and if found fit they were certified to carry on prostitution and if found infected they were treated at the hospital. The British soldier remained the criterion in this experiment. Through these measures, the State redefined the nature of the indigenous prostitute and controlled her within certain parameters. The very survival of the lock hospital remained unstable. Besides other factors criticism was faced by officials on the expenditure incurred on the hospitals. One such critic was A.C. De Renzy, Sanitary Commissioner of Punjab, who strongly opposed the "huge

6 Punjab District Gazetter Jallandhar District 1883-84, p 54.
7 Ibid., pp 10-11

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amount spent on the maintenance of lock hospitals and instead pleaded that the money be spent on the improvements of water supply in the cantonments."8 Although such suggestions remained unheeded yet the hospital remained a false structure that failed to check the spread of V.D among British soldiers. And by late 1830’s the experiment faded. To join the same fate was the C D. Act. In 1882, the Act was repealed. In spite of all the ‘extra’ finances applied to implement the Act, the V.D. statistics continued its ascent. And along with it continued the scrutiny of the native prostitutes. There were indigenous protests on the repeal of the CD Act. On its support Akhbar-i-Am observed that enlightened European women should be engaged for the European soldier as they were free from syphilis and the spread of the venereal disease would cease.9 It was strongly felt that the Act should be revived and applied to all “bazaar women”. Impelled by such notion, the colonial inspection of the women’s body stirred moral consciousness among Indians. “So long as they were in force many women are deterred from adopting a life of prostitution from fear of medical examination and now that these examinations have been abolished, venereal diseases are on the increase in the country.”10 In a nutshell, what was felt was that the repeal of the C.D. Act itself was the cause of the spread of the disease among people and hence the indigenous voices urged the

8 Anil Kumar, Medicine and the Raj: British Medical Policy in India 1835-1911 (New Delhi: Sage, pp. 174-175.)
10 Ibid.
government to review the said Acts in the interests of the public health. 11

The disease took a centre stage and preventive discourses began to work on it. There was concern of the disease among the English women, too. The Association for Moral and Social Hygiene in India was founded in England by Mrs. Josephine Butler in 1870. The dominant image of the disease was a moral stigma and the Association became a challenge to check the regular conduct “which not only created a demand for prostitutes, but also results in the spread of venereal disease.” 12

In 1932, of every 10,000 cases attending these institutions in British India nearly 90 suffered from venereal disease. The provinces recording the highest rates were Bombay with 190 per 10,000 cases, Burma with 180, Madras with 140 and Delhi with 130, whilst the Punjab and Assam reported the lowest incidence.13 Reports in connection with measures for suppression of venereal diseases implied that the support from concerned authorities was almost nil. “The Principal of Lahore Medical College informed that none of the female students attending the college are free to enter into any engagement in connection with such work at present ............” A similar response came from the Principal of the Ludhiana School who stated, “No student of this institution will ever, with the permission of the General Committee of the school be available

11 Paisa Akkbar, N.N.P. Vol VIII. No. 48, upto 30th Nov. 1895 p. 706.
12 No.58-18/40h,1940, Third Meeting of the Central Advisory Board of Health. Letter no.5461/PH-40, dt. the 1st of January 1940.
13 India in 1932-33 pp.167-168.
for the work.” 14 The disease was more of a taboo in the society and to ask for indigenous assistance for cure was a far off cry.

When previous system of controls failed to check the venereal disease, a likely explanation was that soldiers went to women living outside the cantonment, free from military supervision. Hence, rules were introduced where the boundaries were extended beyond cantonments. Records of such reference are found. An order was carried to control the prostitutes residing in the villages in the vicinity of the Jutogh cantonment. Army professional women who follow the works to the hills and who have been excluded from cantonments on account of disease and those who are known to be diseased from any village within 4 miles of a hill cantonments. Later extended to 5 miles of a hill cantonment could be expelled by written order from the Inspector General State Police, Punjab. 15

Concrete action came much later in 1920, when the government instituted the Central Dermatological Laboratory in Deolali to ‘combat’ the venereal diseases which were unknown in the part. There were provisions of post graduate courses for training lady doctors in the newer methods of the diagnosis and treatment of venereal disease training was held here.16

Under the wide range of concern, women became a subject of colonial gaze. The vital reason for the colonisers to

14 Proceedings, Home Department. Medical & Sanitary, June 1899.
15 Proceedings Home Department. Medical and Sanitary August 1906
16 Proceedings Home Department. Medical & Sanitary, June 1920
deliberately gender the whole situation was to provide protection to the soldiers.

**The State and the Women's Hospitals**

It was not until late 19th century that the colonial government established hospitals and dispensaries for women. This was done consciously to respect “the different customs and prejudices of our high –caste Hindu and Mohammedan patients.”\(^\text{17}\) Initially, the turn-out for the female medical training and aid in Punjab remained relatively low for largely one reason which was the opening of the zenana hospitals by the missionaries where women were treated by women. Whereas the State medical institutions had male staff looking of the needs of the female patients, the inadequate establishment was expressed in the annual reports of the province. 'All women applying for medical aid have been attended by the male staff at the Ripon Hospital, Simla. A female hospital assistant should be appointed to look after the female wards and all women applying for outdoor relief.'\(^\text{18}\) Similar complain came from Ludhiana, there was no special institution for the relief of women and no female medical subordinate attached to the civil hospital.\(^\text{19}\) Lahore being the only city that could boast where treatment for women existed in the Lady Atchison Hospital.\(^\text{20}\)

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18 *Annual Reports of the Dispensaries in the Punjab for 1896*, p. 221.
The end of the nineteenth century saw the starting of medical institutions. There was nothing worth mentioning the way the State hospital era began. A female jubilee Hospital in Kangra (on the 15th June 1898) and the work done at the Charitable Hospital, Ludhiana, both in teaching and affording medical relief were the notable institutions opened.21

By the early decades of the 20th century, as a matter of fact a number of notable hospitals for women were opened. Lady Reading Hospital for women and children at Simla opened in 1924. The same year saw the opening of the Maternity Hospital at Lahore, with the main aim of attracting labour cases.22

In 1927 a fine hospital for women was built by the Municipal Committee of Hazro, grants-in-aid therefore were made by government and a considerable sum was raised by private subscription.23

With the establishments of women hospitals, separate arrangements were made for female staff, female compounders and dais were being increasingly employed. At 7 district hospitals there were fully qualified doctors and female sub-assistant surgeons at 6.24 Logically, the level of acceptance increased when the women’s hospitals were kept in charge of women assistants. By 1930, small ‘backward’ districts too showed such establishments...... Dewan Sarab Dyal Memorial Zenana hospital at Dharmsala had a women assistant surgeon

placed in charge of it ... Another female hospital has opened at Panipat under the change of a women assistant surgeon ... the District Board, Kangra, sanctioned the appointment of 12 nurses and nurse dais and 10 candidates were trained at the Ludhiana school for this district. 25

Comparing the records of the mission and the state hospitals, its not very difficult to point out at the stark contrast between the two. While the mission hospitals kept the sensitivity of the local social customs in dealing with the patients, we seldom see that mentioned in the state hospital reports. The latter neither rejected or accepted indigenous traditional beliefs while dealing with medical institutionalisation. The state hospitals maintained a secular set up, on the other hand the mission hospitals, structured itself on the lines of Christianity. The emphasis from the government to keep a religious free approach was evident, often generating tension between the mission hospital and the State. When it came to the question of medical education, the Government took measures to provide training for the Punjabi women as assistants in hospitals, a similar task as undertaken by the medical missions. The catalyst for change here, initiated by the missionaries and the state officials, was the opening of medical profession for the indigenous women. This would mean that the image of the traditional Indian women would be reconstituted. Nineteenth century-gender-ideology rendered the study of medicine an unsuitable occupation for a women. Western medicine was seen

as a colonial project that would interfere with the social and cultural norms.

Reluctance among indigenous women came from all quarters. Several social causes were pointed at, such as purdah system, early marriage and "lack of appreciations of the dignity of the medical profession as a career for women." What prevented the women entering medical institutions was the presence of male students and the male staff. The Indian women were never comfortable sharing classes with men. Hence, with the increase of demand for sub-assistant surgeons, it was necessary for them to be educated in medical schools taught by their own sex. The pressure on the government was to secure a better class of candidates for training as medical women. Respectable Indian women are not likely to be forthcoming as long as they were obliged to train side by side with male students. To support the opinion Agra, was seen as an ideal example that had a lecture room where staff room of two lady doctors were present, one of whom lectured on midwifery and the other on diseases of women. Till 1920, there were 12 medical schools established all over India for the training of sub-assistant surgeon and only two were officered entirely by medical women. Agra and Ludhiana being the two of them. The problem that lay with Ludhiana was that some women were prevented from studying medicine because the only training

27 Proceedings, Home Department, Medical & Sanitary, April 1920, p. 3
28 Proceedings, Home Department, Medical & Sanitary, April 1913, p. 2
29 Ibid.
30 Proceedings, Home Department, Medical & Sanitary April 1920, p. 3
school in the Punjab was a mission institution.' 31 The vulnerability of religion was exposed by such notions and the State came up strongly on this matter. The government intervened and made developments on 'secular lines'. The establishment of Lady Hardinge Hospital and the Dufferin fund were such establishments. (This shall be dealt later in the chapter.) In 1885, the Lahore Medical College admitted women, the majority however, belonged to hospital assistant or sub-assistant surgeon class. 32 This class was similar to that of civil hospitals' men assistants. In the first year for women, the Lahore Medical College had 10 students studying. 33 Scholarships were given by districts in the Punjab on the understanding that the students returned to work in the same district.

One of the significant institutions was the King Edward Medical College Lahore, built shortly after the death of King Edward VIII in 1910. It had a number of attached hospitals the Mayo, the Albert Victor and the Lady Aitcheson for medical relief and instruction. 34 Later, in 1920 the Medical College was separated from the King Edward College Lahore and moved to Amritsar. 35 In Lahore, a decade later Lady Hailey, laid the foundation of the Punjab Medical School that was to solve the

31 Notes on the Annual statements of Dispensaries and Charitable Institutions of the Punjab for the year 1927, p. 9
32 League of Nations, p. 81.
33 Margaret Balfour and Ruth Young., The Work of Medical Women in India (London : Oxford University Press 1929, 109).

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problem of female medical education and aid in the province.\textsuperscript{36} While at Amritsar, the college made priorities for women into medical education. The college introduced reservation on the basis of creed, sex and area. Forty percent of admission were reserved for Muslims, twenty percent for Sikhs and forty percent for other communities. \textsuperscript{37} Punjab offered the Fellow Member and Licentiate of the state medical faculty license. The licentiate/licenses having been dropped from the Punjab University, it was to be granted only by the medical schools. The University would give only degrees in any medical subject or subjects. \textsuperscript{38} To obtain the University degree and to provide a greater number of Indian medical women with the highest qualification, Lady Hardinge opened such an institution in 1912. Lady Hardinge proposed the college as a memorial of the visit of the queen-empress in India in 1911, and Delhi was chosen as the location of the school.\textsuperscript{39}

Affiliation to the Punjab University was secured and the students appeared for the M.B.B.S. degree of that University. The students of the college came from all parts of India and in 1926-27, there were 105 in residence. The Hindu community sending the largest, there were 13 Mohammedan students.\textsuperscript{40} In 1927, there were four medical colleges in India and Lady Hardinge had the largest number of students with 105 out of the total of 392 registered. Medical education was promoted through

\textsuperscript{36} Notes on Annual statements of Dispensaries and Charitable Institutions of the Punjab, year 1929, p 14.
\textsuperscript{37} Ibid
\textsuperscript{38} Proceedings, Home Department, Medical & Sanitary, April 1911, No 10-11, Med. A.
\textsuperscript{39} League of Nations Health Organization in British India Jan-Feb, 1928, p 82.
\textsuperscript{40} Ibid, p. 83
various other voluntary organizations, which is studied in the next section of the chapter.

The 'hospital assistant' class emerged within a strong framework of racism, an approach that was favoured by the missionaries and the government officials, alike. The imperialist rationale of bringing civilisation to the "non civilising" world was too strong for both to ignore. For instance, there rose a strong difference in the salaries of those who were qualified as doctors in England and the 'hospital assistants' trained to work in the dispensaries or hospitals in India. While the former received Rs 450/- the latter Rs 50/- per month. Similarly an advertisement was referred by The Tribune regarding a post of an assistant surgeon in the Indian Medical Department. Applications were invited from only Europeans and Anglo-Indians, Indians considered "ineligible" for the service. The message put forth was loud and clear that the hospital assistants were not intended to take independent charge or to be placed on an equal footing "with ladies possessing superior qualifications."  

Treatment of indigenous women was increasing steadily though slowly in response to demand. The necessity of a female hospital in Simla was demonstrated in 1907 by the number of patients treated and the dearth of wards in the Ripon Hospital. Answer to this need was the establishment of Lady Reading Hospital, Simla, which soon gained a reputation of a first grade

41 Countess of Dufferin's Fund 5th Annual Report of the National Association for Supplying Female Medical Aid to the Women of India for the year 1889, p 78.
42 Fahbar-i-Hind, NNP Vol.XXXVI No.18, upto 5th May 1923,p.257.
43 Countess of Dufferin's Fund 6th Annual Report of the National Association for Supplying Female Medical Aid to the Women of India for the year 1890, pp. 40-41.
hospital. A great deal of surgical work, especially gynaecology was done at this category of hospitals. In 1920, Lady Reading Hospital reported 1,600 operations and Aitcheson Hospital, Lahore, 1,036. As indicators of receptivity these statistics defended the old notion of fear and apprehension that indigenous women had overcome of the 'unfriendly western skills especially surgical apprentices'. From the colonial point of view, there was a clear demonstration of alternative treatment to native remedies when they stated that over every $5^{1/2}$ millions of adult women were annually treated in the hospital and dispensaries of British India.

By 1932, State public, local fund and private dispensaries numbered 42, whilst 21 women doctors were attached to the female sections of general hospitals. Though the number was small it was large enough for the colonial optimists to consider the medical profession as an 'awakening' in the province that soon saw this as an noble outlet for feminine activity. Such observations became the basis for experiments that demanded full recognition of western medical relief. The colonisers laid inherent limitations on the recipient society while understanding the local response to western medical education. For them, the object of western medical system would have to wait for the fuller emancipation of the women of the middle classes.

44 *League of Nations* p. 86
46 *Proceedings, Home Department Medical & Sanitary October 1908.*
Statement showing the number of on door and out-door patients treated in the State-Public, Local Fund and Private-aided dispensaries during 1910.

Table 7.1

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<th>Province</th>
<th>Total (Including men)</th>
<th>Women</th>
<th>Children</th>
<th>Total (Including men)</th>
<th>Women</th>
<th>Children</th>
<th>Total (Including men)</th>
<th>Women</th>
<th>Children</th>
<th>Total (Including men)</th>
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<td>Out-door</td>
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<td>612</td>
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47 Proceedings, Home Department Medical, Jan. 1912, Nos.85-96 Part A.
Providing Newer Opportunities: Dufferin Fund and Other Initiatives

The penetration of western medicine for women was not only done through institutions but popularisations came through the government sponsored programmers too. To widen the area and social boundaries, the Dufferin Fund was launched in 1885. The Countess of Dufferin Fund on the National Association for Supplying Female Medical Aid to the Women of India was founded at the direct instigation of Queen Victoria who personally commended the matter to the care of the Countess of Dufferin before the latter left England for India. The Queen was to some extent moved to this action by the representations which were made to her by Elizabeth Biebly. While she was in England, Dr. Biebly had the honour of being received by the Majesty, Queen Victoria, to whom she told something of her experience in India and the terrible need of women there for skilled medical help. It was of the account of the then state of affairs that influenced the Queen to entrust Lady Dufferin (when she went to India as the wife of Viceroy) with the task of attempting to do something to meet the need.48 On her arrival in India, she concluded that "a large and sustained effort for an un-sectarian and national character was imperatively called for. The objects were medical tuition, medical relief and the supplying of nurses and midwives from hospital in private work."49 The Fund had a Central Committee at the Capital while in various provinces local

49 *League of National Health Organization in British India Jan-Feb, 1928* p. 77.
committees were established that were “allowed power to manage their own affairs and funds, but were affiliated to the Central Committee.” A strong network of hospitals were set up. The Punjab branch of the Countess of Dufferin Fund was set up in the same year as the fund’s foundation. Although grant-in-aid from the fund came to 8 hospitals, but no hospitals in the province were affiliated to the Fund. The Lady Reading Hospital, Simla was regarded as the only “Dufferin Hospital” but it had its own Endowment Fund and Managing Body.

The funds of the Association had two main aims namely medical education of Punjab women and medical relief to women’s hospitals and dispensaries in the province. Hospitals and dispensaries were classified according to the courses they offered for medical education. King Edward College too expanded by awarding stipends to the Punjabi Women studying for the M.B.B.S. classes. Although the number of students were few, they figured repeatedly in the fund reports. In 1943, 5 students of the college received grants from the fund. For the L.M.S. and L.S.M.F. classes, the Punjab Medical School for Women, Ludhiana and the Medical School, Amritsar, gave new stipends to 3 and 16 Punjabi girls, respectively.

Grants-in-aid for the maintenance was given to mission hospitals, too. Philadelphia Hospital, Ambala, regularly got monthly assistance from the Fund for the general improvement

50 Ibid.
52 Countess of Dufferin’s Fund 58th Annual Report of the National Association for Supplying Female Medical Aid to the Women of India for the year 1943 of the Punjab Branch, p. 6.
as well as rural work of the hospital and the Ludhiana Hospital too got scholarships. The fund dominated in a small way towards the scholarship to nursing and nurse-dais classes, too.  

Table 7.2

<table>
<thead>
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<th>Authority awarding the scholarships</th>
<th>MBBS Classes</th>
<th>LMS Classes</th>
<th>Dispensing Classes</th>
<th>Nurses Classes</th>
<th>Dais Classes</th>
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<td>2. Punjab Education Deptt.</td>
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The main initiative of the Fund was the involvement of the Indian staff. “We live in India, and where the thing is practicable, especially for all subordinate posts, we should employ the people of India not only from a sense of responsibility to the land we live in, but also from a matter of economy.”  

Despite its diverse approach in the field of medical education, one of the major complaints against the Dufferin Fund, however, was that it still worked in a limited way. It trained the so-called “lady Doctor” of various grades, while the rank and file of other medical professions - the nurses, midwives

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53 Countess of Dufferin’s Fund 61st Annual Report of the National Association for Supplying Female Medical Aid to the Women of India for the year 1945 of the Punjab Branch, p. 76.
54 Countess of Dufferin’s Fund 61st Annual Report of the National Association for Supplying Medical Aid to the Women of India, 1945 p. 76.

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and compounders remained almost un-catered for. “It was like training officers when there is no army.”

Another drawback of the fund was its loose financial ends. It left the fund in a rather awkward position among the government aid, private philanthropy and medical missionary arena. By 1912, the Dufferin Fund Committee in Punjab was providing female assistants to the women hospitals along with scholarships in some cases.

One of the most ambitious schemes that came up during the time was the suggestion of a Women Medical Organization. It was formulated on the mere survival of the Dufferin Fund. The debate had already received a good deal of attention earlier in 1910. Mary Scharlieb, M.D. and other in the medical practice in India and United Kingdom, submitted a memorial to the Secretary Of State for India for the formation of a Women Medical Service on lines mainly analogous to those on which the Civil Indian Medical Department was constituted. The main object aimed by the memorialists was to improve the status and condition of the Dufferin Fund. In reply to the above demand, the Secretary of State appeared to be disinclined for the proposed scheme. Costliness, and secondly the declared policy of the government at the present moment was to encourage the growth of an independent medical profession, the measures advocated in the memorialists would tend to move in the opposite direction. There was a clear link between the proposal of the

55 Proceedings, Home Department, Medical & Sanitary, October 1911.
56 Proceedings, Home Department, Medical & Sanitary Jan. 1911.

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women's service in medical department to that of the progress of the Dufferin Fund.

There were reasons put up for the stagnant growth of Dufferin hospitals. The fund was defectively organised, its income was inadequate, its employees underpaid and inefficient and it failed in its objects for not providing adequately for the privacy of the women for whom it works. 57 Moreover, it was stated that the salaries and conditions of service offered by the Association did not attract competent medical women on the contrary 'money was wasted in employing incompetent women...' 58 In short, the present provision for female medical aid in India lacked professionalisation under the fund. The remedy proposal was the abolition of the existing organisation and the institution in its place of a regular government service of female practitioners, working aide by side with the officers of the Indian Medical Service and spreading gradually into every district headquarters and eventually into small areas. 59

The suggestion of a Women Medical Service was not easily accepted by the Government nor the abolition of the Dufferin Fund. After all, the National Association had done notable work not only for directing attention to the special needs of the women of India but it rightly "stimulated the generosity of the classes and has enlisted the active sympathy and cooperation of Indian and European community." 60 Moreover, the various missions

57 Proceedings, Home Department. Medical & Sanitary. September 1912, Nos. 54-56, Med. A

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were already working on the same objectives as that of Dufferin Fund, that is to spread the treatment of women. But the difference was laid clearly. With the former “proselytizing was as accompaniment of medical relief” no such pressure was placed on the Dufferin Association that was “entirely secular in its origin and in its operations.” 61 This quality became an asset to the very existence of the fund. Where the Women’s Medical Service was concerned the Punjab Government “was glad as in the past to employ the members of such a service where suitable, but it must be understood that when so employed, the lady doctor should be entirely under the order of the local government without any right of corresponding with the Central Committee.” 62

Hence, Dufferin Fund continued and amidst controversial and earlier calls of rejections the Women’s Medical Service was formed in 1914. It was financed through a state subsidy to the Dufferin fund of Rs. 3,70,000 a year.63 It was received with general satisfaction by provincial governments, local bodies and medical women.64 The service, in the first instance, consisted of twenty five first class medical women or such not exceeding twenty five as the Central Committee may appoint. Recruitment of the Service was to be made in India as well as in England. Dufferin Hospitals were given assistance by making arrangements for the education in the United Kingdom for

61 Proceedings, Home Department, Medical & Sanitary, September 1912, No. 54-56. Med-A
63 David Arnold, Science Technology and Medicine in Colonial India (Cambridge: C.U.P., 2000, p. 89)
64 June 1918, No. 20-23, K.W. Med. A No. 256 dt. 28th November 1917.
undergraduate women medical students to be sent here by the Dufferin Fund authorities. Along with this, recruitment of English Women graduated for services in India was to be made under the selection committee at India House. The arrangements worked well and most of the hospitals of which members of the service had been sent, showed considerable improvement, some to a very marked extent. In 1919, there were thirty-five appointments for medical women under local bodies in the Punjab-four for women with British qualifications, six for women Assistant Surgeons and twenty five for women sub assistant surgeons. There were twenty mission hospitals of which eighteen were under medical women with British or American qualifications, and two were under sub-assistant surgeons.

One of the major issues concerning the surveillance of the hospitals was the need of an Inspector. The Punjab Government in 1913, asked the government of India to sanction such an appointment. In the following year, the Dufferin Fund appointed Dr. Balfour to the Women’s Medical Service and placed her service at the disposal of the Punjab government for the purposes of inspection of the women’s hospitals. The Central Committee advocated the appointment of a member of Women Medical Service as Assistant to the Inspector General of Civil Hospitals in each Province in India. Such an appointment

65 Correspondence from Feroze Khan Noor, High Commissioner for India to Sir G.S. Bajpai dt. 17th Feb., 1937.
66 Margaret Balfour and Ruth Young, The Work of Medical Women in India (London: O.U.P., 1929, p. 168.)
67 League of Nations Health Organization in British India, Jan-Feb. 1928, pp. 84-85
resulted in a rapid development of female aid. In this context the following remark was entered by the Inspector General of Civil Hospitals in 1917, "To Dr. Balfour who has served her connection with the Punjab Dufferin Fund, the Province owes a debt of gratitude for the increased efficiency of the female side of medical administration." The tenure of Dr. Balfour remained brief. In the same year, her services were required at the Central Committee and she was replaced by Dr. Agnes Scott, who inspected all hospitals in which women were employed and which received aid from the Punjab Government. In 1918, there were 93 such hospitals or institutions in Punjab. Dr. Agnes even served as the Secretary of the then newly formed Central Midwives Board for Punjab.

There had been a general improvement in the female hospitals of the province and a quickening of interest among the medical women employed. After the institution of the Women's Medical Service, The Lady Aitchison Hospital at Lahore increased the rate of pay to the assistant surgeon, nursing superintendent and pupil nurses. The hospitals gave full modern training in disease and midwifery to women of all naturalities and as it was the only institution in Northern India in a position to do so, this departure was of a great value to the community. Simla too, underwent a change. Since the appointment of a member of the Women's Medical Service in 1914, the Dufferin Hospital here, formerly backward became a first class institution. Nursing

69 Proceedings, Home Department. Medical & Sanitary June 1918, NO. 23
70 June 1918, NO. 20-23 KW Med. A No. 256 dt. 28th November 1917.

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managements were made in the hospital and a number of young Indian women were being trained as nurses and midwives. 71 Within no time, the government stated that 'the training of Lady Dufferin nurses and of Victoria Lady Curzon dais, and if we might add of Lady Hardinge scholars of pharmacy and district nurses, would do infinitely more to relieve suffering females and to raise the status of women in this country than will ever be done out of small grants to isolated hospitals.'72

The important feature that demanded attention was the employment of women in Punjab as medical workers. With all the social drawbacks women did not remain oblivious to the demand, a significant number figured on the education statistics of the reports. During the year 1927, out of 106 girls who passed the matriculation examination of Panjab University, 17 candidates, of whom 9 were Christians, 6 Hindus and 2 Sikhs, were admitted to the Sub-assistant surgeon class of the Punjab Medical School for Women, Ludhiana. 73 By 1933, there were 26 hospitals maintained by the Women’s Medical Service in India, with three in Punjab. 74 Through small in number, yet their presence promoted the demand of indigenous women as trained western physicians.

In 1943, there were three women doctors from the service in Lady Reading Simla and two at Lady Aitchison, Lahore. 75 By

71 Ibid
72 Proceedings, Home Department, Medical & Sanitary, October 1911, Nos. 12-29.
74 India in 1932-33, p. 175.
75 Countess of Dufferin’s Fund 58th Annual report of the Punjab Branch of the National Association for Supplying Female Medical Aid to the Women of India for the year 1943, p. 21.
1945, there was a substantial number supporting the women students studying in medical schools/colleges in Punjab. 76

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<td>Missionary Medical College for Women, Ludhiana</td>
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<td>King Edward Medical College, Lahore</td>
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<td>Glancy Medical College, Amritsar</td>
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The amount of medical aid supplied to women by their own sex varied very much from province to province. It was the greatest in North India, where in the Punjab and United Province there were in each province about 60 hospitals and dispensaries staffed by women.77 Women’s hospitals are relatively fewer in other provinces and this was due to the fact that social customs hindered many women from seeking medical aid from such doctors. In other words, the conservativeness of Punjabi women, acted as a prelude to the extension of women’s hospitals in their province.

76 Countess of Dufferin’s Fund. 61 Annual Report of the National Association for Supplying Medical Aid by Women to the Women of India, 1945, p. 122.
77 League of Nations Health Organization British India Jan-Feb. 1928, p 86.
In 1927, out of 36 female hospitals and dispensaries, 14 were maintained by the local bodies.\textsuperscript{78} Moreover, the domination of the missionaries remained well ahead in Punjab. Statistics of 1926 showed 36 female hospitals and dispensaries in the Punjab that recorded 280,000 attendances of women and girls. For 17 of these owe existence to missionary effort, 3 others are maintained from Charitable funds, Government and local bodies maintain only 16.\textsuperscript{79} The marginal function the state played here could be well seen through Foucault's notion, "if medicine could be potentially more effective, it world no longer be indispensable, medically."\textsuperscript{80}

Despite the shortcomings of colonial medicine, it ought to be stated that no branch of knowledge engraved its roots deeper than the western medical system in India. Colonial medical discourse gave birth to a new class of indigenous women. These women entered the new system of health by getting autonomy from the traditional patriarchy and gender roles. Constraints of social conservation were narrowed down and medicine was significant in opening new opportunities for women. Avenues opened with the establishment of the Women’s Medical Service. At the end of 1947, the strength of WMS cadre was 38 officers, against the sanctioned cadre of 43, of the 38 regulars officers 31 were of Indian domicile including 2 of the domiciled community and 7 of European domicile.\textsuperscript{81}

The concept and pattern of medical care seemed to have undergone a shift in India in the twentieth century. In the late nineteenth century, concentration was mainly on caring through institutions, while in the years that followed attention moved to the aspect of reaching the public through health education. Improving maternal and infant health became matters of colonial interest. Although we do see maternity work adopted by the missionaries in their hospitals right from the beginning, the difference lay in the very nature of its work. The state initiative remained educative, in brief, focus lay on prevention, whereas the mission work remained more practical.

During the years between 1915 to 1930, voluntary societies carried creative programmes for the benefit of women’s health. This comprehensive work by the Colonial Government has been described as an example of British paternalism in India. Initiatives that fell into this category were the organizations run predominantly by the Vicereines. In 1920, Lady Chelmsford established the All India League for Maternity and Child Welfare that coordinated the maternal and child benefit activities in all the provinces of British India.

The league raised a fund which bore an interest of about Rs. 50,000 yearly that was used for establishing health schools for training health visitors. Propaganda by means of travelling

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exhibitions was undertaken. Unfortunately, the government declined any financial aid as a result of which the income collected by the Lady Chelmsford Fund gave grants - in - aid to places undertaking child welfare work.

Associations affiliated with the League started at Madras, Rajputana and Punjab in the first phase. The Punjab Branch was a non - official organisation of which the wife of His Excellency, the Governor, was the patron and the Director of Public Health Chairman to the Executive Committee. Scarcity of grants, led the amalgamation of Lady Chelmsford Funds with that of the different funds, while the Secretary of the latter became the Honorary Secretary of the Lady Chelmsford League. This measure was aimed to gear the maternity and child welfare work. Growing importance was placed on publication of literature vernacular on maternity and child welfare subjects, it was the only organisation involved in this kind of work. Several publications were recorded in 1926, 'Food and Health, Organisation of Food and with Exhibition', 'A Health Dialogue' were a few that dealt with hygiene and dietary conditions of childbirth. By producing such discourses on the dietary habits the lack of knowledge among the indigenous women was put forth that 'not only caused harm to the family but even to the

84 Margaret Balfour and Ruth Young, The Work of Medical Women in India, pp 146-148.
85 Annual Report of the Public Health Commissioner with the Government of India, 1921, p. 74
86 The Journal of the A.M.W.I, Aug 1926, p. 55
nation'. Hence, from the early decades of the twentieth century, focus was on the reconstruction of ideal motherhood who would nurture children to build a strong nation.

The main agenda of reform was to create awareness during motherhood for healthy infants. One of the most important activity concerning the subject was the baby week conceived in 1923 by Lady Reading. The movement owing to the unprecedented enthusiasm became 'national' in the real sense when National Baby Week was organised in different provinces. Punjab celebrated ‘Baby Week’ for the first time in January 1924. Encouraged by the efforts made by the provincial and local committees, the Punjab health week committee decided to carry an even more ambitions programme of Baby Week in the following year. A special feature of the celebration was to spread of knowledge in regard to the simple laws of health especially to make child welfare more popular. The Education Bureau of the Public Health Department undertook the preparation of lantern slides of which 5,876 were prepared. The Red Cross Society helped the Branch with financial aid by paying for the slides and supplied a number of magic lanterns for the use of local committees. Such Health Week Committees were found in various towns that numbered 29 including Lahore, Ferozepur and Ambala. In case of small centres, less ambitious

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88 Annual Report of the Provincial Health Week Committee on the combined celebration of Health and Baby Week, 1925, Lahore, 1925, p. 2.
89 Ibid.
programmes suited to the local needs and resources were revised. It was a matter of achievement to note that practically every district of Punjab arranged the health week and in many cases preceded by an intensive period of preparations. Opinions differed widely regarding the manner in which the work was propagated. The material was poor and badly thought out and many of the Baby and Health Weeks were little more than 'tamashas'. This was all the more regrettable when one realised that these could be made real stimulating and educative. 90 Amidst the debate on the quality adopted for prevention work, the movement gave a new meaning to the notion of western medical practice.

Events like Baby shows indicated that the imposition of health education was a part of the surveillance medicine that brought government control over the patients body.

Intensive arrangements were introduced that ensured the full utilisation of the child welfare programme. One such change that altered the policy of the Lady Chelmsford League most radically was the entry of the Indian Red Cross Society into the field of child welfare work. In 1930, the voluntary work became centralized by the establishment of the Maternity and Child Welfare Bureau under the Red Cross Society. The latter was already contributing towards the goodwill for western medicine among Indians and with the above amalgamation the Red Cross Society broadened its paradigm of activity. To meet the demand


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for maternal and infant benefit, a director for the Bureau was appointed.\textsuperscript{91}

In the Punjab, the work had passed largely into the Government hands as regards provincial organisation. The appointment had been made of a woman officer, under the Director of Public Health for the purpose of organising and inspecting the work.\textsuperscript{92} In 1931, Dr. Ruth Young, the Director worked for the development of this Branch.\textsuperscript{93}

The scope of the Bureau included training school for health visitors, the work of instruction of indigenous dai, the supervision of infant and child welfare work and the assisting and advising of centres for the sepoy’s wives and children.\textsuperscript{94} The grants given to the health schools enabled the Bureau to keep up the standards of training as well as supplying much needed financial aid. The existing finance was provided by local bodies, the Lady Chelmsford League, the Red Cross Society and independent local committees.\textsuperscript{95} On 1\textsuperscript{st} April 1927, the Punjab Health School was taken over by the government from the Lady Chelmsford League whilst the staff of the School, comprising the principal, the superintendent who were engaged on a three-year contract in the first instance.\textsuperscript{96} In other words, the Punjab Health School became a provincial school supported entirely by

\textsuperscript{92} League of Nations Health Organisation in British India, Jan – Feb, 1928, p. 91.
\textsuperscript{93} Ibid.
\textsuperscript{94} India in 1932-33, No. 1124, p. 177.
\textsuperscript{95} Report on the Punjab Health Administration of the Punjab for the year 1925, p. 18.
the provincial government. There were four training centres in India under the grant. In Punjab, the centre was at Lahore. The work of the health visitors undoubtedly gave a dimension of professionalism to the movement. In the United provinces and the Punjab, the greatest amount of welfare work was carried on, that it to say, it was found that these provinces had more health visitors at work in paid posts. The number of health visitors involved in the maternal and child welfare efforts meant an indication of constructive approach of the province. And proudly enough, Punjab could claim the distinction of being the first province in India to recognise the importance of maternity and child welfare by providing facilities for the training of health visitors.

Maternity and child welfare work had taken its place as an essential part of the various departments of Punjab and great importance was attached to this work. In 1931, 37 welfare centres functioned, 8 new centres being opened by district boards in Hissar, Kangra, Jandiala, Nurmahal, 3 by the Red Cross Society and by an Infant Welfare Centre committee at Jullundhur. Such a fusion of different bodies re-emphasised the necessity of the work. Responses to these sections were reflected in the gradual strengthening of statistics. By the end of

1930, 37 welfare centres functioned in Punjab, 8 new centres opened by the district Boards. Over 20,000 mothers were advised, 7337 expectant mothers visited the centres, whilst 3198 labour cases were attended by health visitors and 9832 confinements were conducted by the dais. 101 It was noted that behind the efficiency with which the infant welfare centres in the Punjab ran was largely due to the constant visits of the Inspectress and the interest of the whole department in this branch of work.102

In order to give widespread interest to maternity and child welfare, certain amount of all India organising work was carried out in the office of the Countess of Dufferin Fund. The All-India Maternity Exhibition and the beginning of a quarterly journal for maternity and child welfare was initiated in 1920 and 1921, respectively. This was followed by the All- India Conference of Health Welfare in 1927. 103

Although limited was the task yet awareness was extended in the rural areas. Out of 42 Health centres in the Province 17, were actually situated in rural areas, while 12 functioned in areas partly urban and partly rural.104

Such reports gave recognition to western medicine. Somewhere, it yet again extended the claim over indigenous

society through their response over health awareness issues. Western medicine facilitated medical relief in the process of 'colonizing' indigenous women. Within a few years of its discourse, it became an integral part of the indigenous society and was no longer merely a colonial project.\textsuperscript{105}

CONCLUSION

The practitioners of the colonial medical service were under pressure to justify and defend their professional performance to the colonial government. They, therefore, put tremendous pressure on the government to increase its commitment arguing that only by legislating for, and funding increased hospital provision would the situation improve. For the colonial government, the Dufferin Fund offered an example of this. The Fund had not only defended the treatment but also professionalisation of the native women, that could bridge the gap between Britain and India within Dufferin fund rhetoric. The impetus behind this scheme and others was not only the humanitarian side to provide medical relief to the women but to inculcate the western values of hygienic education, and mother and child care. Punjab was quick to grab the medical benefits offered by the state hospitals. Statistical returns could boast that. Yet, the number of mission hospitals remained far ahead. If on one hand, Christianity was a threat to the non-heathen society, on the other hand it gave a humanitarian touch to the

\textsuperscript{104} The Journal of the A.M.W.I, Aug. 1932, p. 52.
healing work carried in the mission hospital and added to the efficiency of the staff, an asset over the ‘secular’ hospitals run by the government. There never came a point of rivalry between them. For both worked in their own separate parameters, giving space to the other to reach out to women, medically. The State institutions worked in a limited way if speaking of them as instruments of social control. For the local women there always was a choice between the mission hospital, the state hospital and indigenous traditional medical treatment.