Social History of Medicine in Colonial India

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Lecture 01

Women Health: Zenana Mission ; Dufferin Fund

Hello and welcome to yet another lecture, Lecture number 26. In this and in a couple of other lectures following this lecture, we will specifically discuss about women's health issues, women healthcare and the various institutions and arrangements made specifically with regard to women. Before we go into healthcare as such, I think all of us already know - but it's important to underline - the special place of women in anything in society - because it is literally at the lap of women that a society is born. The child is born in the mother's womb and it grows up in the mother's lap. It's first intakes - whatever it takes - whether it's the milk or any kind of nutrition or any kinds of manners, any kinds of gestures, all of those things come from the mother's lap. as they say in Tamil: thaya pola pillai, noolai pola selai or the other way around - whichever way you take it - the quality of the saree is determined by the quality of the thread and in the same way the quality of a child is determined by the quality of the mother. We can extend it to say that the quality of society is to a great extent determined by its women, especially its mothers. And while that matters generally, it matters even more particularly in the arena of health.

The mother has to be healthy at every stage - when she is pregnant, when she is still giving birth to the baby, and immediately after the delivery - she should be in such a good state to bring the kind of well-fed child. Well-fed children produce/constitute a healthy society. generally speaking, (of course men's health is also important but particularly) women's health is of considerable importance to a any society. In a colonial scenario, there are particular difficulties - as we have been seeing, the colonial state from the beginning had been very cautious about intruding too much into the indigenous social, cultural systems. Of course, after a period of time - say from the 1830s, it felt confident enough to educate Indians or to reform Indians in the ways it thought best. But then after 1857, there were constant reminders of the Uprising, and therefore constant concern about not overreaching. that applies here also - reaching out to women in the particular Indian social context was a challenging thing – because, to reach out - and especially this is literally reaching out to the body of women - is breaking the privacy of

the women. But once committed to public health - coming out of the earlier -called enclavist frame, once the colonial state came into the public health mode, there's no way it could talk about the public - of that 'public' health by ignoring about 50% of that public and with regard to women (that 50% we are talking about is about women), there were particular concerns about their unsanitary conditions - for instance with regard to the conditions after delivery or with regard to the menstruation and other such things which are very particular to womanhood. there were more risks and needing more attention. But then the question is reaching out to the women. Already there is a problem with the personnel, medical personnel. As we have been saying, they tried to create as much of local personnel as possible especially at the lower levels of medical care. This very logistical issue of personnel becomes even more acute - to reach out to women even generally - because there weren't too many women: as it is, as I said - there weren't too many Europeans in the medical services - especially at the top level, IMS, and other such levels - even at the lower levels, the Europeans did not normally bring their wives - higher officers came with family, but otherwise generally there weren't too many women from among the European population here - which at least could have paved some way of reaching out to the women as it is all the more difficult for men - and white men - to reach out to the women population. Even if there were white women, since it is particularly about medical care, there is also need for particularly trained personnel. Housewives could help - whatever minimal number of white women were here - not professionals - but housewives of officials - that would have helped reach out to the women - at least to cross the cultural barriers. But in a more medical sense, in a more professional sense, it would be better to have particularly trained women health workers.

One fruitful way opened through the missionary route, especially women missionaries. On the other side, the missionaries also saw medicine as one of the very fruitful ways of doing/executing, their original mission - which is spreading the religion, spreading the gospel. Also, as we have been saying repeatedly, in the initial days, the colonial state was very concerned about not intruding too much into the social, cultural and especially the religious affairs of people and for that reason, the company in fact, banned missionaries because of the same concern about non-intrusion - because they knew if missionaries were here, then they would act with a missionary zeal, not only spreading the religion but also coming out against certain indigenous customs like say, for instance, Sati and other such things - as part of their missionary work, which would have repercussions, which they were very concerned about in the early days. But as I said, as decades passed, there was a sense of confidence and by around the 1810s, they decided and in the Charter Act of India in 1813, allowed missionaries to enter India. Among their other activities, as I said, medicine offered a particularly bright opportunity to spread the gospel. They began to involve themselves in the field of medicine. In the 1830s, one of the most famous missionary societies, the LMS, the London Missionary Society began their medical work in southern part of India and they saw the potential of using women,

even local women also eventually as nurses and doctors and also the wives and daughters of missionaries could be used to reach out to the women folk first. As I said, it was also a challenge to reach out - either medically or even otherwise generally. So the missionaries' families, the women members of the missionaries' families could be used to reach out socially and then also through that, for medical purpose. In fact, an exclusive women missionary movement was started just for medical purpose. One such was the Zenana Bible and Medical Mission. Zenana basically/literally means something related to women/pertaining to women and in this case, it's also the part of the household in a Hindu or Muslim traditional family which is reserved for women. Here, the challenge is to pierce that Zenana - it's not only in the physical sense. Here in the figurative sense, it meant reaching out to the women part of the population by transcending that veil of gender, which meant that you have to cross over the the fence of the men folk, in a larger little figurative sense. Therefore, women missionaries were sent in 1840s and later specifically professional lady doctors were sent to cater to the Zenana, the inner women's quarters. This was projected also in a larger cultural sense - because we have to keep in mind constantly that all of this had a lot of social, cultural and other kinds of dimensions. I keep repeating - medicine was not just about medicine. Here, this particular missionary activity was also projected in the cultural sense as piercing the dark recesses of the Zenana with the light of modern medicine. Through that, influence is gained over the women of the colonized population and through that, the entire household, for religious purpose and of course, for medical purpose as well. Church of England Zenana Missionary Society and other Societies specifically recruited women to serve in India in the second half of the 19th century for this kind of work. The task of such women who were recruited was in fact what was interestingly thought of as a double cure - not only curing the body of a particular ailments or disease but also curing them spiritually also - from what was seen as a disease or whatever they were already following in terms of religious belief. By the end of the 19th century, there were about 50 women missionary doctors from various denominations - various Christian missionary organizations, representing two-thirds of all female physicians in India at that time. This indicates the contribution of missionaries to the entire field of medicine because. We will have a separate lecture on non-state initiatives where we will be focusing on missionaries and their diverse activities including starting of colleges and other such things. Some of them open hospitals exclusively for women and children.

Of course, this was a considerable breakthrough, that enabled reaching out to , as I said, almost 50% of the population, of that public, which would have been left out in whatever was the limited public health outreach. But the institution of purdah, the seclusion of women - more than in a literal sense, more in a figurative sense: the challenge of the men folk being too protective of their women and suspicious of any kind of exposure to the outside world - all those kinds of challenges were there. Also, even if some of these

hospitals were for women and by and large, staffed by women healthcare workers, there was a requirement that any such institution should be inspected by a male doctor. This also stood on the way and many Indian men were reluctant to allow their wives and daughters to visit hospitals - going anywhere outside can be problematic, we do not know what they are going to see, what they are going to hear, what they will learn and what they will do when they come back home – there was that fear that they will develop the signs of independence and therefore begin to challenge the authority, the masculine authority in the household. Again you see, we are talking about medicine but we have also all these kinds of other social issues.

One of the most important landmarks with regard to healthcare for women in colonial India was the creation of something called the Dufferin fund in 1885. It was named after the Vicerine, the wife of Lord Dufferin, the Viceroy - Lady Dufferin. It was basically the starting of an association which was the National Association for Supplying Medical Aid to the Women of India. As you can see, the focus is particularly on women's health and the personnel for women's health and which was done through raising of fund - that is why it is called the Dufferin fund. Its aim was to recruit qualified white women doctors, nurses and midwives in Britain to be sent for the relevant medical work in India. Of course, eventually the idea was to train Indian women themselves to make healthcare available to Indian women in a broader scale. What was the funding for the fund? Initially, some of the funding came from the government. But as we have been noting, the government was always reluctant to spend and was, on the other hand, eager to encourage or to find ways in which the public can be brought on voluntary level. The government always ought to bring up that culture of volunteerism as it was in Britain. Here too, the expectation was that there will be considerable donations and subscriptions - which did come from both Europeans and Indians. It did prosper with several branches - both at home as well as in different Indian provinces. The fund widened the reach of western medicine in India with a considerable leap in the overall number of patients attending hospitals and dispensaries - women patients. Of course, while doing any of these things the colonial state could not totally change things lock, stock and barrel. It had to contend with some of the social and cultural factors and limitations - for instance, seclusion - that cultural consideration for seclusion had to be maintained; that, in these new institutions/the hospitals, women were not subject to too much of male gaze. As I said, the entire broader idea of zenana was to keep the women in the house under the protective watch of their own men folk. But here going out itself is one thing and while going to these kinds of particular places, it was important that there were not too many men who see them or who come into contact with them. The local press also was constantly demanding for such kind of arrangements though the public opinion - at least elite progressive public opinion - welcomed these kinds of institutions - these kinds of new attention to women and their health. They did insist on these kinds of cultural arrangements where the privacy of women is maintained with considerable room for

seclusion. And as I said, there was a lot of local enthusiasm and some provinces, in particular, worked very proactively with the Dufferin Fund. The United Provinces and Punjab province extended special grants for the improvement of the Dufferin hospitals and they also bore some of the expenditures of some of the Dufferin Fund institutions - like whatever local dispensary or hospitals or some of the expenses associated with that was also borne by the respective provincial government. These provincial governments, also from their part, provided female branch dispensaries within the existing hospitals - but these special dispensaries with female assistants - hospital assistants for women of all classes. These kinds of arrangements had impact even on the admissions - admissions means they've been getting admitted to the ward. As we already saw, there were lots more women actually visiting - like what you call OP now - Out-patients. Apart from the increase in the number of women visiting, there was also increase in people being admitted. There was a increase in the average occupation of hospital beds by women in both these provinces. The Dufferin Fund also interestingly involved another important social and gender dimension - this is with regard to the British women themselves - because the whole thing was about health care for Indian women - supplying personnel for improvement of health facilities for Indian women. But this was also something about British women themselves - especially the special roles of wives of those in government service starting from the Viceroy. As we saw, the Fund itself was named after the name of the wife of the Viceroy Dufferin, who in fact showed her role as an extension of her feminine identity as a wife. But of course, she also rose to be a public figure in her own right - beyond the shadows of her husband or the office of the Viceroy due to her close association and very active work with the Dufferin Fund. Similarly, after that, the wives of succeeding Viceroys - the subsequent Vicereines also involved themselves in this and other kinds of a charitable initiatives - especially those related to providing better facilities for women's health. There was also a general expectation among the wives of the upper-class English - in this case particularly ICS offices and other higher level employees - their wives to be associated with some charitable cause or the other. That was seen as a kind of a social more, as a kind of social status also. On the other hand, as far as the Bodies were concerned - the particular agencies or organizations - like in this case the Dufferin Fund - it was a great advantage to them because it gave privileged access to the royalty. For instance, say, if it's the Vicereine - in fact in the case of the Dufferin Fund, the Queen Victoria herself also had a role. She in fact, impressed on the Vicereine to proactively go ahead and start this because of some representation made to her. That kind of access to - if not always to the royalty - at least to the Viceroy here, and then to the all the officials who work under the Viceroy - this kind of an arrangement gave the Dufferin Fund quasi-governmental slant - the nature of it was it became more and more of a quasi-governmental one. They projected themselves as rescuers of confined traditional women by exposing - these are all the claims - Indian women to the light of modern scientific medical care.

Officials, that is male officials, also served on the Dufferin Fund in honorary capacities. But again, as they had those other official positions and links, there was that advantage to the concerned organization in practical terms - they may be honorary post-holders but because they had those other posts in the government service, the benefits of those links were available for the particular agencies.

As I said, the volunteerism is something which the colonial state tried to bank on, to a great extent, because it was an important aspect of health care in Britain itself. Here in this case the Dufferin Fund tried to foster that culture - especially in the light of the continued reluctance of the colonial state to fund extensive public health measures. And of course, when you are doing it for women's health care, it was expected that the benefactors, the philanthropists, will have a special sense of belonging considering the special place, the central place that women have in society, as I said earlier. The fund itself was modeled on the subscriber-democracy model as in the British Voluntary Hospital System and which the British tried their best to replicate wherever possible in the Indian context. The newspapers at that time, in fact, talked about the very generous contributions made by the public. For instance, in 1886 the *Bombay Gazette* expressed satisfaction at the contributions from wealthy representatives - even among the Indians. The *Hindu Patriot* lauded Lady Dufferin for opening up this avenue which gave the opportunity for Indians to show their magnificence for this very important cause - both the social as well as a medical cause. Naturally, because of this kind of - at least in the early stages - this kind of a generosity the DF was itself was quite 'healthy' - in its financial state. For instance, in 1891, we have the statistics that it had 11 lakhs of rupees invested which gave it an annual income of rupees 50,000. The private donations and subscriptions for 1891 - for that particular year itself - totaled about 1 lakh of rupees and with that they could think of employing appropriate trained medical personnel. For instance, 13 female practitioners with higher qualifications and the LMS degree were employed. Then there are 27 assistant surgeons with other levels of qualifications certificates and diplomas and 21 of them were Indians at that level. It also sponsored people who are still getting trained as the students in the various colleges and institutions - working for their various diplomas or certificates or degrees.

In all, about 400,000 women had received medical aid at DF's hospitals and dispensaries – these are people who are attending - the patients. By that time - around the 1890s - this was a considerable thing - it was just about five-six years. By 1892, there were 10 provincial branches in India and 120 local and district associations overseeing as many as 48 hospitals especially meant for women. All of this was supervised at an overall level by a central committee operating from London. And as in anything in life, there is criticism and there was criticism directed towards the Dufferin fund also. It was seen as a kind of an example of British paternalism - all the kind of language, the kind of projection of 'rescuing' Indian women, taking them from 'darkness to light' or even

more - saving them - saving Indian women from their own men folks. Those kinds of imperial gender ideologies were sought to be perpetrated. Another important criticism is about the inadequate employment of Indians. Of course, Indians got cured, Indians had better facilities at the dispensaries - at the ward and bed level and all that. But to what extent, were Indians employed especially at the higher levels? We saw just now there were Indians - but there was disappointment particularly with employment of Indians at a higher supervisory level. This, in spite of the fact, that there were several Indian Christian women who had obtained medical degrees. In spite of that, only 11 fully qualified doctors were employed by the Association - that is 11 who were Indian. The central committee of the Fund defended the exclusion of Indian women. It was not apologetic - it said there are problems of age, there are problems of experience and then we have our own reasons - we can't entrust such higher level jobs to Indian and Indian women. So, they had their own justifications for that. The number of Indian women opting for training as hospital assistants and apothecaries was very low. Of course, this was related to financial reasons because their pay was low and they found themselves as too inadequate in proficiency in English. Also in due course (as I said, when the Dufferin fund apart from providing healthcare, also later on went into the realm of training people within India, there was a criticism of that training - it was deemed to be a very defective education and in course of time), the financial health of the Dufferin fund was not as good as it was in the beginning. There was concern and criticism of worsening financial position. Also there was the important question of privacy in the hospital, because as it is, there was that standing requirement that there should be at least one male doctor overseeing the functioning of any of these institutions.

And, as we will see, there are other criticisms which were being expressed subsequently. We will see them in another lecture. On that note we will close this lecture. Thank you