Social History of Medicine in Colonial India

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Lecture 02

Association of Medical Women in India; Lock Hospitals; Regulation of Dais

Hello and welcome to Lecture number 27 in which we continue our discussion on women -related health issues and we have some very interesting developments and topics. we were looking at length at the Dufferin Fund in the last lecture. One of the important outcomes of the Dufferin Fund - apart from the various hospitals and the institutes they started - was the Association of Medical Women in India. One of the things we should tell ourselves when we come across these names like Associations and all that, is that, it is not just about the Association itself - it is also something which contributes to the larger culture of modern science. Modern science has got some particular characteristics like the presence of Journals, the presence of public fora like say, the Royal Society or say, the Asiatic Society here, and the starting of say, things like the Indian Science Congress. These are important landmarks - not only with regard to those particular fields but also to the larger culture of modern science and modernity, or about the encounter between the colonial power and native intelligentsia. , you should also keep that in mind.

How and why did this association start? This was basically started by the European women working in the Dufferin fund. They started it in 1907 following the one which was in Britain itself. This was basically, as you would expect, an effort to assert the female voice in the Dufferin fund - among the employees like the doctors and other health related workers (here, we are not talking about the Vicereines and the wives of the ICS and those kinds of officers who were there in the committees and in the Fund itself. Here, we are talking about the medical staff - the English women medical staff who were working as part of the various Dufferin Fund run-institutions, hospitals and other things), and to counter the male dominance in those institutions.

This Association made a petition in 1909 - calling for at least one female practitioner to be given a seat on the central committee of the Dufferin Fund and also that the post of the Secretary of Dufferin fund should be given to a woman. I was just talking about the importance of journals - these things do matter in terms of propagating your cause and asserting your rights. In course of time they started their own journal the JAMWI.

One of the things they did was, scathing attacks from within the Dufferin fund about the functioning of the Dufferin Fund. That is why, I said at the end of the last lecture there will be more criticisms coming about the Dufferin Fund - and you will see them unrolling now. For instance, they call the many provincial and local branches of the Fund as very capricious and inefficient. They complained about the waste of resources in the Dufferin hospitals - especially because of the practice of hiring medical women who were not sufficiently qualified or who they called as very incompetent. They also condemned the misuse of the authority given to IMS Civil Surgeons over the Dufferin hospitals – who had kind of a domineering attitude and many of whom were also males. That is an important point to be borne in mind. And at a larger level, beyond the Dufferin Fund – now, they are not talking just about the problems in the Dufferin Fund – as an Association with a larger purpose, they were now talking about issues of the medical care - adequate or inadequate - for women at large. In that context, they felt that the government should play a more prominent, more proactive role - rather than leaving such an important segment of healthcare to charity. And even if it was left to charity, it should not be left to Indian charity or philanthropy because Indians were incapable of independent efforts. That also we should bear in mind - because this Association though it had its own grievances and was fighting for rights, it was basically about British women. They had their own condescending attitude towards Indians. And coming back to the question of government, they saw the neglect of the government, the distance it kept from public health in general and with regard to women's health - all of that was seen as an indication of the kind of priority, low level of priority that the government had towards such an important issue as women's medical needs. They argued for greater government intervention based on several factors. First of all, they felt that it is the right of Indian women - they are speaking on behalf of the Indian women that they had a right to that kind of healthcare and there was a responsibility to reduce mortality among women and children. They were also projecting this as part of gender justice, as part of eugenics. As I was saying at the beginning of the earlier lectures, good mothers, healthy mothers and therefore healthy babies to them, produce healthy societies. From that eugenics point of view also, this segment is very important – healthcare. Therefore government should play a very prominent role - and also for its own good. The government itself will elicit lot of goodwill from the public if it is seen more proactive. And, there should be gender justice, both to patients and doctors - because this association was started basically to deal with issues that concerned them as workers, for instance, doctors and all that. Here, they were talking about gender justice to women both as patients, mostly Indian patients and also to the doctors. Government should play a proactive role - if government plays a proactive role then there is a greater chance of gender justice. Also government's role is particularly buttressed because of the 'backward' state of India - especially her healthcare as was seen by them. They basically suggested a sketch of medical reorganization. Of course, they could expect

what would be the government's excuse. Anything you ask - whether it is reorganization or better organization or new facility - the government will always give the financial excuse. That is why they gave a sketch of a medical reorganization which is possible even with limited funding, so that that does not become an excuse. Also giving those kinds of excuse does not go well with the logic of 'civilising' - if you are calling yourself as a civilising agent, as an enlightened government and all that - with a great responsibility of 'lifting people from darkness to light' and all those things - then these kinds of frequent excuses sit at odds with those kinds of tall proclamations. Quite embarrassingly, the Association pointed out to the situation in some of the princely states. (Princely states, as you know, are those kinds of territories which were allowed to be run by the local princes - but who pledged their loyalty to the colonial state which had its agent, the Resident there - in matters of general administration, they had considerable free hand and especially in matters like health). This association pointed out how some of the princely states were having far better healthcare models, and asking is the imperial government at such a pathetic state compared to even the natives. That was quite an embarrassing question. Thus, as I said, the association was campaigning beyond where it originated from - the Dufferin Fund working facilities and organizations.

This campaign had an impact first on the Fund itself. It recognized internally the need for relief and the need to move away from these kind of funding handicaps and also to move away from the excessive focus on urban areas. Therefore, in 1908 the Dufferin Fund formally requested for an annual grant of 15,000 from the Government of India, so that salaries could be increased - giving inflation and the difficult working conditions as a reasons - very legitimate reasons. The Fund echoed the calls given by the AMWI for greater government involvement and responsibility. The India Office, on the one hand, acknowledged the difficulties of realizing the ideal of endowments and fundraising and voluntary subscriptions in India. Yet, it advised the government not to take too much of the responsibility, not to get too involved because once the government gets involved then it would not stop with it, then there will be recurrent call for, demands for, more funds. But on the other hand, the Home Secretary here with the Government of India argued that expecting philanthropic medical care to be sufficient would be unrealistic in the Indian context where government will and should have a role - financially and otherwise. This appeal was successful to an extent and the Secretary of State Morley allowed the Dufferin Fund to be granted an amount which would be equivalent to the subscriptions it collected - so there is that binding clause - so that at the same time, the Fund did not lose sight of the focus on philanthropy and public subscriptions. Whatever the government would give would be also dependent on, proportionally dependent on - what is collected through the other route. And there were two particular conditions: it was to be provided only for five years and the maximum amount that the government could give in any particular year was 20,000. So. suppose private subscriptions in a

particular year goes to say 27,000, the government would still be giving only 20,000 that year and not matching 27,000. But sometimes because of the gradual loss of the initial enthusiasm seen in the starting years, the subscription generation was low. Though government's contribution was allowed for a maximum of 20,000, when in some years the subscription collected was low - as low as 2500 - the government's side was also only that much. There was also an interesting difficulty coming up for making the case for government support. It was discovered that the Dufferin Central Committee and the provincial branches had been receiving some kind of government support (at different levels), but which was not shown explicitly in the accounting procedure – it was concealed. Eventually (as I always say, the truth will always come out - sooner or later), when that truth was coming out, it was very embarrassing. These, again pointed to further problems of leaving medical care to voluntary bodies. These kinds of accounting and the kinds of other irresponsibilities and irregularities complicated the problem. But the Dufferin Fund continued to justify looking for more grants while trying to maintain that facade of being a non-state voluntarist vehicle for healthcare organization and provision with its ill concealed links with the state. In fact, its connections with the state kept increasing. It was very hardly concealed - but it maintained that facade that it was a non-state organization and building a case on that - that it deserves more funding.

Moving on to another topic - this is about the lock hospital, one of the most notorious institutions during the colonial era in terms of health. What was that? It is about homosexual aspects concerning the army. It is common for Indian prostitutes to cater to the sexual needs of the military men and as I said in an earlier lecture most of the colonial men across the board came alone - not with their families - especially those at the lower levels. Across the board - whether is a civil or army - and in particular the difficult conditions of the army, this was a particular issue and it was very common for them reaching out to Indian prostitutes. But then there was a medical issue here which was the spread of sexually transmitted diseases, that was causing a lot of concern. It is in this context that the lock hospitals were set up. They were set up for basically confining and treating the prostitutes who were suspected of having venereal diseases or other kinds of sexually transmitted diseases in the military cantonments all over India. They were suppressed in 1833 but again reinstated under the Contagious Diseases Act. It was a very official way of, once again, allowing prostitution but monitored through this Act. This Act of 1864, initially targeted British military stations but later extended to both the cantonments of the British soldiers as well as Indian women suspected of being prostitutes going beyond the cantonments. This, therefore introduced a new form of bodily regulation beyond the cantonments and this was also used as an instrument to depict moral division between respectable and not respectable women - now expressed through the language and idioms of medicine and healthcare concerns of western medicine. The laws allowed for the forcible examination and detention of the women suspected of carrying any kind of sexually transmittable disease. It was assumed that

prostitution was the main cause for the spread of such infections, though there could be other kinds of ways in which it could spread. Women found to have any of those kinds of diseases could be detained in a lock hospital for treatment and observation till it was considered that they were disease-free and not dangerous to go out. Thus we see medicine becoming a new form of power to colonize Indian women's bodies and to discipline them - it is another kind of medicalization. In 1877 and 1878, there was a particularly high level of venereal disease among the European troops, so much so that they had to set up a special committee to investigate how effective was the Contagious Disease Act in practice. They found that there was some shortcoming in the Act - there was even not even a proper definition of what constitutes a common prostitute. There was no compulsory, mandatory registration of those prostitutes who were caught or convicted. The powers of arresting them was also seen to be insufficient - it was there but seemed to be insufficient. Therefore one government after another made its own decision: the Bengal government, for instance, decided to restrict the application of the Contiguous Disease Act based on these kinds of findings of the committee. In Bombay Presidency, again, financial constraint came as an excuse - there the Bombay Corporation allowed the Act just to lapse in 1871 and the regulations were not reintroduced until 1880. Quite expectively the Act faced criticism in Britain and in India particularly as one would expect from religious groups such as the Salvation Army - basically on religious and moral grounds because the Act was seen as condoning immoral behavior providing a system - officially sanctioned the system - of licensed prostitution,. The evangelical organizations denounced the act in the name of God and humanity and held several meetings and protests to condemn the measures. Indian nationalists and women's groups and rights activists also condemned. They also saw it as a form of racial and gender-based discrimination as they targeted only Indian women, and were often used to justify mistreatment of Indian women by British officers and soldiers. There is a colonial cultural angle also brought into it - because as I also said earlier, this offered a new way of colonizing and controlling and disciplining Indian women's bodies. Therefore when there was protest from the Indian side, there was also that angle - apart from the moral angle. There were some papers like the *Hindu Patriot* which in fact, supported the Act citing that it was very effective in improving the health of the European troops, which was the original purpose. But generally the Indian press also opposed the working of this Act. As a result of these various kinds of pressures, the Act was suspended in 1881 by Lord Rippon who was seen generally as being liberal on several fronts. But they continued, the lock hospitals continued in a covert way under new cantonment acts. The Military Cantonments Act of 1889 for instance, once again permitted the inspection and compulsory medical treatment of prostitutes who were caught. But again the government in Britain directed the Indian government in 1894 to limit the scope of the cantonment acts because through this route it was disobeying the original suspension of the Contaguous Diseases Act. Accordingly in 1895, legislation

was passed stating that no rule under the Cantonment Act of 1889 should permit that kind of medical examination or compulsory treatment of prostitutes suspected of having any kind of socially transmitted disease. But despite this kind of opposition and criticism, the CD - the Contiguous Diseases Act remained in force in India until 1914 when it was finally and formally repealed.

Yet another important topic in colonial healthcare - especially with regard to women is the question of dais. This is again one of the other ways in which the colonial state extended its medical arm into the realm of Indian women in the name of health. What is the traditional dai system? The dais are basically midwives who assisted in the childbirth. This was sought to be replaced by the colonial state by western trained midwives. Why? The reason was that the dais were basically barber's wives or lower caste women though they played a very important role in childbirth and also post-birth assistance - like for instance, helping the mother or the family, giving bath to the child and the other kinds of medical assistance, traditional assistance. But the problem is that the methods they were using were seen as a very barbaric and primitive which had fatal consequences leading to deaths of both mother or child or both - high rates of maternal and infant mortality. For instance, the census of India 1911 had this to say about the system: "It is the common habit and custom in almost all districts to hand over the women in labour to the care of one of the dirtiest, most backward, illiterate, ignorant and superstitious classes, the barber midwife. The result of this custom is that untold misery and unnumbered unnecessary deaths, are meted out to the perturient women of this country by these untrained and unclean practitioners".

Thus this issue of dai system was framed, or midwifery as such was framed, as a conflict between a progressive and humane West and a very backward, superstitious, barbaric East. But, of course, it was not always whites versus the non-whites. In course of time, Indians themselves looked at the dai system as being comparatively a bit crude and backward. They willingly supported the changes towards modern scientific midwifery. Indians, by choice themselves, chose the hospital option rather than delivery of child at home. Even to this day, there are parts of India where delivery is done at homes. But even during this time, there was this change in attitude - there were more and more of people going to hospital for childbirth This, we can see as an influence of Western medicalization - another example of medicalization, whereby childbirth - which would normally have been seen as something very private, social and done in a very indigenous way, traditional way - now became more medicalized – with the midwife being properly trained. In this context, we also have to mention that there was also a general concern about reproductive health of mothers and generally about women themselves - irrespective of the mother or young girls. Then also in the context of the fact that maternal mortality was considerably high, compared to the rates in Western countries.

This was due to effects of poverty, poor nutrition and also many social, cultural factors like say for instance, the purdah and isolation and other such things. This continued to be an important concern - the neglect of maternal health - particularly in state-funded medical research and practical measures. As we saw, the state had lot of research labs, research initiatives in fields like bacteriology, parasitology and even in nutrition and other such things, but there was not much with regard to questions of women's health in particular. As always, with regard to practical healthcare too, there was not much from the government side. This was an important criticism about the colonial healthcare.

On that note we will close this lecture. Thank you.