Chapter-2
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Colonial Policies towards Women’s Health and Hygiene

The British East India Company during second half of the eighteenth century firmly established themselves as a territorial state and therefore, being a ruler of subject population had to lay down policies affecting socio-economic and political life of Indians. In the arena of health the British policy initially was confined to the British citizens and soldiers and was not guided by the force of philanthropy. The British medical policy originated from and remained subservient to the needs and expediencies of the empire. The rulers primarily concentrated on how to provide the best hygienic, sanitary, and medical facilities to the military and civil population of their own race. It was not devised as a part of welfare policy. The health policy was primarily aimed at catering to the needs of civilians and soldiers. It was mainly extended to urban areas to safeguard the Europeans in mines, plantation, factories and administrative centers. However, during the nineteenth century due to the pressure of reforms, official as well as indigenous, the colonial state had to devise and formulate a health policy with the establishment of hospitals, dispensaries and research institutes to tackle the health problems. There is a strong consensus among scholars that the effort of the British government to create public health organization was not satisfactory. This has been also argued that infrastructure of rural health care was inadequate and the colonial state failed to devise a proper executive health service of all ranks.

The development of health policy in India during colonial rule was gradual but very slow. The state recognized its responsibility for public health gradually and to begin with the preventive health measures developed the model of ‘public health

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3 David Arnold, ‘Colonizing the Body State Medicine and Epidemic Disease in Nineteenth Century India’, OUP, Delhi, 1993, p. 3.
4 Palit Chittabrata, Achintya Dutta (ed.), ‘History of Medicine in India: The Medical Encounter’, Kalpaz Publications, Delhi, 2005, p. 21
activities'. These are four landmarks in the history of public health administration in the country.  

(1) The appointment of a Royal Commission to enquire into the health of the army in India in 1859;

(2) The report of the Plague Commission in 1904 following the outbreak of plague in 1896;

(3) The Reforms introduced by the Government of India Act of 1919 and


The Royal Commission that was appointed in 1859 to enquire into the conditions of health of the army in India recommended measures not only for the army, but also for the civil population. On its recommendation, 'Commissions of Public Health' were established in the provinces of Madras, Bombay and Bengal in 1864. The Commissions in Madras and Bengal put forward far reaching recommendations, which included the employment of trained public health staff in towns and in districts. But these recommendations were not carried out and no comprehensive policy in regard to the development of preventive health services was laid down. The officers concerned were designated Sanitary Commissioners. In addition to advising Governments and local bodies on sanitary matters, these officers were entrusted with the control of vaccination against smallpox in their respective areas. In 1888, in view of the recent creation of local bodies, municipal and rural, the Government of India issued a resolution drawing the attention of local bodies and village unions to their duties in the matter of sanitation. The success achieved by such efforts was, however, negligible except in the larger cities. Each provincial sanitary Commissioner had only one assistant to work with him and, apart from this lack of adequate technical staff, the main emphasis continued to be laid, during the period, on the development of medical relief. Medical administrators did not give preventive medicine its proper place. The huge numbers of India's sick presented a field so obviously demanding attention that it was to the practice of curative medicine that, by far, the majority of the doctors in the state health service turned. Lay administrators,

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therefore, naturally tended to regard provision for hospital facilities and attention to the sick as of more importance than arrangements to meet the fundamental requirements of the community and the individual with regard to environmental hygiene. Without these requirements being met, the attempt to cure the sick of a continent, though embarked upon courageously, was doomed to failure.  

A proper Public Health Ministry came to function only after 1920 with the passage of the Local Self-Government Act. The responsibility to tackle the epidemics and funding of rural health was now put on the shoulder of the District Boards and Union Boards. But they failed to cope with the situation because of scanty reasons and scarcity of health personnel. The district dispensaries set up in rural areas were ill-equipped to tackle the health problems. Many municipalities and local boards were unable to raise sufficient revenue for vital sanitary reforms. More government aid and better supervision on the local bodies were necessary. A more concerted effort by government to assist the local bodies would undoubtedly have done much to improve the situation. Although mortality due to epidemic disease was reduced in the 20th century by the remedial measures, there was no remarkable progress in their prevention and eradication programme. What was followed regard to anti-epidemic policy and public health developments were small scale measures. In comparison of public health in western countries, India was hovering behind in public health services terrifically.  

In the three provinces of Madras, Bombay and Bengal the administrative officer in charge of the medical department was known as the Surgeon General, while in other provinces the corresponding officer was the Inspector General of Civil Hospitals. The officer responsible for medical administration in a district was the civil surgeon; He was the in-charge of the district headquarters' hospital, was the inspecting officer for all other public hospitals and dispensaries in the district and was, in certain provinces, responsible for public health administration also. In

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6 Ibid, p. 19  
8 Palit Chittabata, Achintya Dutta (ed.), 'History of Medicine in India: The Medical Encounter', Kalpaz Publications, Delhi, 2005, p. 23
addition, many calls were made on his time by his having to serve on various committees, official and voluntary, which were interested in health problems.

A district was divided into sub divisions which were normally run under the medical officer who held a medical degree. The hospitals and dispensaries in a sub-division were usually under the control of Government or of local bodies. The medical officers in charge of these were generally provincial service men with the qualification of licentiates.9

The history of sanitary work in British India began with the report of the Royal Commission of 1859. After it reported in 1863 on the sanitary conditions of the Army, the Commission recommended for the establishment of a Commission of Public Health in each presidency and pointed out the need to improve sanitation and prevention of epidemics in civil society for improving the health of the British Army.10

Under the Military Cantonments Act of 1864, a sanitary police force was formed under the charge of military medical officers to improve military hygiene. Sanitary boards were formed in each province to improve civil sanitary conditions in 1864. Sanitary Inspector General who was later named as Sanitary Commissioner replaced these boards and took over the charge of sanitation. In 1870, the sanitary department was merged with the vaccination department to form a central sanitary department. From 1870 to 1879, sanitary departments were set up in each province. Under the orders of the Governor General of India in 1880, Sanitary Engineers were employed in all major provinces. The Sanitary Commissioner of India and the provincial sanitary commissioners had no executive powers and were advisors to the government.11

During second half of the nineteenth century Contagious Disease Act was passed in England to keep soldiers safe from the infection of Venereal Disease (VD). The soldiers living in India were allowed to interact with Indian prostitutes to satisfy their sexual needs. The importance of catering the sexual needs of the soldiers was

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9 Annual committee report 1926 p. 31
10 Op. sits. Harrison Mark
11 Ibid
highlighted during this period. It was rarely argued to ban the commercial sexual activity. The army commandants were always careful to point out the dangers of preventing soldiers from having sex, since that would lead “to offences such as criminal assault, rape and unnatural crime against respectable women.\textsuperscript{12} In India Contagious Disease Act (XIV) of 1868 was passed which provided for the complete regulation of brothels and prostitutes, periodical medical examination and compulsory treatment for those found infected. By the end of the nineteenth century hospitals were built, popularly known as ‘Lock Hospitals’ for the diseased women through the authorization of Governor General in Council in Behrampur, Kanpur, Dinapur and Fatehgarh. Prostitutes were also required to live in specific area. The entire idea of prevention of VD was based on the idea that VD was “more a matter of police than of medicine”, rather than the abolition of prostitution.

This Act was widely opposed in England. The organized campaign against the Contagious Disease Act was started by the Ladies National Association under the leadership of Josephine Butler which resulted in the repeal of the Act by 1886. After two years i.e., in 1888 the House of Commons allowed repeal of the Act in India also. After 1888, the same invasive regime could not continue, yet women were certainly not discouraged from becoming prostitutes but only from contracting and spreading the disease. The surveillance of women catering to the troops was carried out by other means, through the use of severe and rather arbitrary punitive measures which went under the name of New Cantonment Rules. It was only after the First World War the punitive measures against prostitutes to prevent VD was replaced with a therapeutic regime of administering prophylactics to soldiers.

Attempts were also made to protect factory workers through legislation especially women and children. The findings of the Enquiry Commission, 1928 observed that the condition of women and children were miserable in the unregulated factories. It was also observed that in India as in other countries, public interest and public support are necessary to countries to carry out this protection of women and

\textsuperscript{12} Kenneth Ballhatchet, 'Race, sex and Class under the Raj, Imperial Attitude and policies and their Critics', New York, 1980, pp. 60-61
children.\textsuperscript{13} Several evidences were submitted to the Enquiry Commission of both cotton and jute industries which revealed considerable strain upon women workers. The Lady Investigator of the Bombay Labour Office said: “The health of the women workers is more affected than that of the male workers by the present conditions of living. She is a wage earner as well as a domestic drudge and has to sustain the strain doubly. Her bodily strength is stunted on account of overwork.”\textsuperscript{14}

Same was the condition of women in mining industry. Though the women fought a long war in getting protection in mining industry but could not achieve much in ensuring safety and better health facilities. The Mines Act was amended in 1928 to provide for the gradual exclusion of women from underground working. It is important to note that the main reason for providing this relief was not meant to ensure personal health to women body but was due to the concern of healthy child bearing and child rearing.\textsuperscript{15}

In the early stage of the plantation economy, when large numbers of \textit{coolies} were procured by both contractors and garden \textit{sardars}, the policies towards labour remained gender neutral, as reflected by the series of acts from 1850-1900 which aimed at making the flow of labour to the area smooth and continuous. When planter's concerns shifted to making the labour force stable and permanent, the attitude to women workers changed dramatically. For the first time in 1906, the reproductive capabilities of the female labour force were viewed as seriously conflicting with their productive abilities.\textsuperscript{16} The death rate, especially among labourers recruited under the Assam Tea Labourers Act VI was very high in the 10-year period between 1895 and 1905. More worrying, given the problems of long distance sourcing of labour, was that in the rest of the province: the birth rate per mile declined steadily from 133.1 in 1882 to 79.7 in 1893.\textsuperscript{17}

Other laws were also enacted for the prevention of the spread of dangerous epidemic disease, for the segregation and medical treatment of pauper lepers, etc. The

\textsuperscript{13} Read Margaret, ‘\textit{The Indian Peasant Uprooted: A Study of the Human Machine}’, Longmans, Green and Co. New York, Toronto, 1931, p. 161
\textsuperscript{14} Ibid, p. 162
\textsuperscript{15} Ibid, p. 169
\textsuperscript{16} Nair Janki, ‘\textit{Women and Law in Colonial India: A Social History}’ Kali for Women, 1996, p.102
\textsuperscript{17} Ibid
Epidemic Diseases Act, first enacted in 1807 and still in force with amendments while the Lepers Act, 1898, was repealed and substituted by another law in early 1980s.

In the second half of the nineteenth century, as the medicine got recognized in England, it slowly started having its impact in India, too. Further, the public health campaigns, the increasing intervention of the state in the provision and regulation of health care, establishment of hospitals and above-all the development of scientific medicine gradually led to the establishment of what we know as the organized health care service systems all over western Europe. However, the colonial power was not interested in making the necessary investment in developing such well-organized health care and public health campaigns for its subjects. After 1857, the main factors which shaped colonial health policy in India were its concern for the troops and the European civil population. The genuine public health measures remained confined to the well planned cantonment areas housing British people. It has also documented that for the general population, the sanitary measures were started in commercial method for pilgrim centres, but the realization that they would be very expensive made the colonial government discard the programme under various pretexts. The era of sanitary reform was superseded by the professionalization of medicine in England; the colonial government shifted the focus from the sanitary reforms to public health research in India.\(^8\)

During second half of the 19\(^{th}\) century and early 20\(^{th}\) century number of hospitals, dispensaries and asylums came into existence. The total number of public hospitals and dispensaries under the control of the Imperial government of India was about 1200 in 1880 and in 1902, the figure raised to approximately 2,500. There was one hospital for every 330 square miles in 1902. The income of public health facilities was 3.6 million Rupees in 1880 and about 8.1 million Rupees in 1902. Patient turnover was 7.4 million in 1880; that increased to about 22 million in 1902.\(^9\)

Various types of hospitals, thus, came into existence by the middle of the nineteenth century which may, conveniently, be placed under four broad categories. First and foremost of these were the ‘military hospitals’ for soldiers; second category

comprised all such hospitals either at the metropolis or the district headquarters which exclusively attended on the European civilians. The third category comprised the general hospitals meant for all including the natives. In the fourth and last category came the charitable hospitals and dispensaries which were mostly the outcome of native efforts and were maintained by public subscriptions.\(^{20}\) By the end of the eighteenth century, Lock Hospitals were set up within the premises of most of the European regiments to protect European soldiers from venereal diseases. In the lock-hospitals Indian women were subjected to periodical medical examination and if found healthy they were to carry on prostitution with soldiers as usual, and if found infected, they were retained and treated at the hospital; and if found to be incurable, they were expelled from the regimental or cantonment premises.\(^{21}\)

In the province of Madras, where first hospital was built in 1664 for the sick soldiers and second hospital was built, between 1679 and 1688, by public subscription, at the cost of 838 pagodas (nearly Rs 3,000). In 1793, the Madras Council sanctioned the proposal of Assistant Surgeon V. Connolly for the establishment of lunatic asylums at Madras. In the category of specialized hospitals, a hospital for lepers of all races and both the sexes was set up in 1816, which later developed into the Madras Government Leper Hospital.\(^{22}\)

In Bombay as early as 1850, facilities for childbirth had been provided first time in the Jamsetjee Jejeebhoy (J.J.) Hospital and the adjacent Grant Medical College. These hospitals acquired greater acceptability in due course of time which is reflected in the continuous increase in the number of women patients visiting these hospitals. The percentage of women going to J.J. Hospital gradually increased from 13 in 1851 to 18 in 1891. In spite of these initiatives the Medical facilities established in the last two decades of the nineteenth century, exclusively for women and children were not sufficient however it may be argued that there was a marginal expansion of medical facilities for women.\(^{23}\)

\(^{22}\) Op. cit. Kumar Anil, P. 92
In the following table 8, the total number of sex profile of the Indoor and Outdoor patients treated in dispensaries of the North West Provinces are recorded. The table indicates that there was a marginal increase in the number of women visiting hospitals and dispensaries for the treatment.

Table 8: The Statistics of Life, Abstract Statement Showing: Sexes of the Indoor and Outdoor Patients Treated in Dispensaries of the North West Provinces

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Treated Women</th>
<th>Daily Attendance in Average Numbers</th>
<th>Ratio per cent of Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1890</td>
<td>577,803</td>
<td>4277.09</td>
<td>21.28</td>
</tr>
<tr>
<td>1891</td>
<td>625,456</td>
<td>4,427.73</td>
<td>21.45</td>
</tr>
<tr>
<td>1892</td>
<td>693,502</td>
<td>4,870.71</td>
<td>21.53</td>
</tr>
<tr>
<td>1893</td>
<td>726,173</td>
<td>5,183.67</td>
<td>21.48</td>
</tr>
<tr>
<td>1894</td>
<td>774,180</td>
<td>5,476.78</td>
<td>20.88</td>
</tr>
<tr>
<td>1899</td>
<td>836,917</td>
<td>6238.59</td>
<td>22.96</td>
</tr>
</tbody>
</table>

Source: Report of the Administration of the North-West Provinces and Oudh

Another record had been mentioned the total number of mental hospital and women population of each hospital in the different provinces during 1929 and the number of women discharged, cured and died. (see appendix 1, table 4)

During this period the attempts were also made to provide medical education to women also. The establishment of fully lagged medical courses for women and a hospital exclusively for women and children was due to the effort of Sorabji Shapurji Bangali and George Kittredge, who set up the Medical Women for Indian Fund (MWIF) in 1882.24

The MWIF applied to Bombay University for the admission of women to the LM&S degree and to the Grant Medical College for the granting of diplomas to women hospital assistants and apothecaries. The university responded in 1883, offering medical degrees to matriculates, who pursued a five-year course, and the GMC offered a three year certificate course to none matriculates. The candidates were required to be at least eighteen year of age. The grand medical college was opened to women in 1884 though some of the professors seemed to have been reluctant to teach certain subject to women.25

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24 Ibid, p. 183
25 Ibid, p. 185
Ferny Cama was the first woman LM&S from Grant Medical College, graduating in 1892. Besides Cama, Emmeline Da Cunha and Manak Turkhad were the other Indian women who had graduated by 1896, the other for being Eurasian. The former later qualified as the first woman bacteriologist. Between 1892 and 1915 (when the MBBS degree was awarded), 31 Parsi, 17 Indian Christians, 8 Hindu and 2 Jewish women secured the LM&S.26

In 1840, a large female hospital was constructed in the Calcutta Medical College grounds by a liberal public subscription. It contained 100 beds and afforded instructions in midwifery. It seems that from the middle of the 19th century the bhadrakol in Bengal showed eagerness to few who could afford high cost. The report of the midwifery hospital stated in 1848 that all of their college graduates-six or more in number practicing in Calcutta were "habitually called to take charge of the women of the families they attend during their confinements".27

In 1876, the health officer for Calcutta presented a detailed picture of the unhealthy and unhygienic practices of the atughar and the same kind of portrayal was available in the census reports of 1911.28 The hegemonic ambitions of western medicine were represented by the activities of women missionaries from England and United States, who came to India from the 1860s, and established hospitals, dispensaries, and training centres for midwives and nurses. Dr. Humphrey, a member of the American Methodist Episcopal Church established a medical training school for women in Nainital in 1869. The school, however, did not last for more than three years. The same mission sent Dr. Clara Swain, a graduate of the Women's Medical College of Pennsylvania, to Bareilly in 1870. She started a small class with three married women and fourteen girls from the mission's orphanage. In 1873, thirteen of them passed their final examination in the presence of three doctors and were granted certificates of practice. Before long, mission on both sides of the Atlantic began to

26 Ibid, p. 185
champion the ability of women to apply the ‘double cure’: ‘healing the body while they healed the spirit’.  

The National Association for Supplying Medical Aid by the women to the women of India was founded by the Countess of Dufferin in 1885, the objective being to open women’s hospitals and women’s wards in existing hospitals; to train women doctors, nurses and midwives in India; and to bring these out when necessary from Europe. An endowment fund of about 6 lakhs was obtained by public subscription. In addition branches were formed in each province; each branch had its own funds and each having a number of local committees and zanana Hospitals affiliated to it.  

The Central Fund gave grants-in-aid to several Provincial Branches; it gave scholarships to a number of women students at the Medical schools of Bombay, Calcutta, Madras and Delhi. It had in the past brought from England a certain number of European medical women. It had assisted by grants-in-aid the building of a number of zanana hospitals in different parts of India. It had affiliated to it 13 Provincial Branches and a number of Local Committees.  

The Government of India subsidized the Countess of Dufferin Fund to the extent of Rs. 3, 44,306 per annum to maintain a women’s Medical Service for India—this service consists of 44 officers, with a training reserve of 8 doctors and a junior service of 6 assistant surgeons. Medical women either British or Indian Holding registerable British Qualifications were eligible for the senior service.  

The Women Medical Service was included in the National Association for supplying medical aid by Dufferin’s Fund and was administered by the Executive Committee and Council of that Fund. The Government of India had so far allotted the sum of $ 25,000 per annum towards its maintenance. The then sanctioned cadre was forty-four first class medical women, with a training reserve of 8 women graduates in  

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31 Ibid
32 Ibid
medicine of Indian Universities. Requirement of the service was made \((a)\) in India by a medical sub-committee of the Council which includes the Director General, Indian Medical Service, the Honorary Secretary to the Council and the Chief Medical Officer, Women's Medical Service; \((b)\) in England, by a sub-committee including a medical man and two medical women conversant with conditions in India. These sub-committees performed the duties of medical board examining candidates for physical fitness.\(^{33}\)

The Council determined what proportions of the members of the Service were to be recruited in England and in India respectively. In the original constitution of the Service, duly qualified medical women who were in the service of, or who had rendered approved service to, the Countess of Dufferin’s Fund, were to have the first claim to appointment, and thereafter special consideration was to be paid to the claims of candidates who had qualified in local institutions and of those who were natives of India.

The Women's Medical Service for India had a sanctioned cadre of eight, and was open to women graduates in medicine of the Indian Universities. Salaries ranged from Rupees 200 to Rupees 300 per month, with furnished quarters or the equivalent in money, to those employed in India.\(^{34}\)

The Victoria Memorial Scholarships Fund was organized by Lady Curzon in 1903, in order to secure a certain amount of improvement in the practicing dais of India. A sum of about 6.5 lakhs was obtained by public subscription, and centres were organized in each province to carry out the objective of the Fund. An additional Rupees 1, 39,000 was allotted to the Fund from their Majesties’ Silver Jubilee Fund in 1935. Thousands of midwives had been trained in addition to large numbers who had been partially trained. Of late years the Fund had done much to pave the way for the registration and supervision of indigenous dais. It had done much propaganda work. Registration was urgently needed. The Fund was then administered by the Maternity and Child Welfare Bureau of the Indian Red Cross Society.\(^{35}\)

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\(^{33}\) Ibid p. 622
\(^{34}\) Ibid
\(^{35}\) Ibid, p. 623
Lady Hardinge Medical College was opened by Lord Hardinge on the 17th February 1916 in Delhi. It is a residential Medical College staffed entirely by women, and was founded to commemorate the visit to Delhi, in 1911, of the Queen Empress. Lady Hardinge took the initiative in raising funds by public subscription to meet the cost of buildings and equipments. Thirty lakhs of rupees, in all, have been given for these purposes, mostly by the Ruling Princes and Chiefs of India. After Lady Hardinge’s death in 1914, it was suggested by her Imperial Majesty Queen Mary that the institution should serve as a memorial to its founder, and be called by her name.\textsuperscript{36}

At present, the College and Hospital, together with separate hostels for 100 medical students and 70 nurses and residences for medical and teaching staff, occupy a site of 55 acres in New Delhi within easy reach of old Delhi city. The grounds are enclosed and adequate provision is made for the seclusion of both students and patients from outside observation. Strict observation of purdah cannot, however, be guaranteed in the case of students. As the hospital patients are all women and children, it is for example, necessary that student should, in their final year, attend a brief course of instruction on men patients at the Civil Hospital, Delhi.\textsuperscript{37}

Whilst India could not show the complete chain of efficiently-nursed hospitals which existed in England, there had been a great development of skilled nursing of recent years. This activity was principally centered in the Bengal, Madras, and Bombay Presidency towns were chief hospitals in the Presidency towns were well nursed, and where large private staff were maintained, available to the general public on payment of a prescribed scale of fees. These hospitals also acted as training institutions, and turned out a yearly supply of fully trained nurses, both to meet their own demands and those of outside institutions and private agencies. In this way the supply of the trained nurses, English, Anglo-Indian and Indian, was being steadily increased.

In Bombay, the organization had gone a step farther, through the establishment of the Bombay Presidency Nursing Association, St. George’s Hospital, and Bombay. This was composed of representative of the various Nursing

\textsuperscript{36} Ibid, p. 623
\textsuperscript{37} Ibid, p. 623
Associations in charge of individual hospitals, and worked under the Government. The principle on which the relations of this Association with the Local Associations was governed was that there would be a central examination and control combined with complete individual autonomy in administration.38

In 1906 Lady Minto’s Indian Nursing Association was inaugurated, replacing the Punjab and Up-country Nursing Association for European in India, which society, established in 1892, had accomplished much useful work in this country. The Home Committee of the existing Association, recognizing the need for expansion, consented to take over the present Association and approached Lady Minto Before she left England in 1905 for co-operation towards this project, and after much consideration and discussion with the Government of India, Lieutenant-Governors and Commissioners of Provinces, the present Association was established.

An appeal by Lady Minto addressed to the public both in most generously, and sufficient funds were collected to form an endowment fund, which has in spite of fluctuations increased a little with time. The assistance of a Government grant was much valued, as it enabled Homes for the Sisters to be kept up in six Provinces in India and in Burma. At the request of the Home Committee the enlarged Association was renamed the “Lady Minto’s Indian Nursing Association.”39

The establishments of hospitals and medical colleges led to the increase in the number of doctors and nursing staff during second half of the nineteenth century which required laws and institutional control to govern them. It was in this period that the establishment of a nationwide formal and organized health care system was started. After the enactment of the law establishing General Medical Council in 1857 in England, the British doctors employed in India were registered with the GMC and came under its disciplinary regulation. As the number of doctors qualified in Indian medical colleges increased, creation of laws for them became necessary. Similar development took place for the nursing profession.40

38 Ibid, p. 623
39 Ibid, p. 624
As a part of the criminal procedures and for other purposes, the colonial government had, in 1871, enacted Coroner's Act applicable to Bombay and Calcutta. It defined role of medical professionals in the work of conducting autopsy and inquests. However, the laws for the creation of indigenous medical councils took many more years for enactment. Meanwhile, the laws were enacted for the prevention of the spread of dangerous epidemic disease, for the segregation and medical treatment of pauper lepers, etc. The Epidemic Diseases Act, first enacted in 1807 and still in force with amendments while the Lepers Act, 1898, was repealed and substituted by another law in early 1980s. The issues of regulating medical practice and registration of deaths were taken up for serious consideration in a meeting of a Committee of the Grant College Medical Society held on March 3, 1880. The meeting was called in response to a resolution passed at an earlier meeting of the society, which had asked the Committee to examine the Medical Act of the United Kingdom to understand the extent to which it might be applicable to Bombay.\footnote{Ibid, p. 51}

The Committee adopted a draft bill for such law on March 3, 1880 meeting. However on April 6, 1880, an extraordinary meeting of the members of the society formally and unanimously adopted it. The meeting also decided to approach the government with the draft for its enactment. The draft adopted by the society contained, amongst other things, the provisions such as:

(1) It may be called the Bombay Medical Act; (2) It should establish "the Council of Medical Education and Registration of Bombay" or in short, "The Medical Council; (3) The Council should appoint a registrar who would act as secretary; (4) The registrar's duty would be to maintain the Register; (5) Provisions for registration of persons now qualified and of persons hereafter becoming qualified; (6) Provisions on giving evidence of qualification to be given before registration; (7) Publication of register every year; (8) Privileges of registered persons; (9) only registered person should have right to recover charges in the Court of law; (10) The exemption to registered persons from serving on bodies such as Juries; (11) Prohibiting unregistered persons from holding certain posts or appointments; (12) Certificates signed only by registered persons to be valid; (13) Penalty for obtaining certificate by
false representation; (14) Penalty for falsely pretending to be a registered person; (15) Removal of name from register on getting convicted of felony, infamous professional conduct.\footnote{Ibid, p. 51}

The demand raised by the practitioners of modern medicine in 1880 was met only in the decade of 1910s. The Bombay Presidency enacted Bombay Medical Act in 1912. The medical acts in some other provinces soon followed. The Bengal Medical Act and the Madras Medical Registration Act were enacted in 1914. These Acts are more elaborate, but incorporate most of the recommendations made by the Bombay professionals over a quarter century earlier. They laid down procedures for controlling medical education, registration and the penal provision on removing names of professionals guilty of infamous conduct. Although we could not locate code of ethics of the Bombay Act, we could get a copy of the code of ethics used by the Madras Medical Council. Thus, the legalization had also led to codification of ethics which, was used for guiding doctors on ethical conduct and for prosecuting them for infamous professional conduct.\footnote{Ibid, p. 52}

These provincial Acts were immediately followed by the Indian Medical Degrees Act passed by the Indian Legislative Council and approved by the Governor General in 1916. The laws for nurses and midwives were enacted in few years after doctors were brought under the regulation. The nurses were trained in India from the third quarter of 19th century. In the last quarter of 19th century, there was a significant increase in their number. The early years of the 20th century saw the creation of the first professional organization of nurses in the form of the Trained Nurses Association of India (TNAI) in 1908. Then the first quasi Nursing Councils, namely, the Bombay Presidency Nursing Association (BPNA) and the North of India United Board of Examiners for Mission Hospitals, were formed in 1909. The object of BPNA was to coordinate various attempts at nursing training and to obtain a uniform system of training by inspecting schools and by prescribing the curriculum. It also conducted examinations and registered successful trainees.
The first Nursing Journal, called the "Indian Journal of Nursing" also began its publication in 1910. Thus, the pressure from the nursing professionals for the legal recognition and registration increased. The nurses in England in that time made some more concerted attempts for legal registration, and after a protracted struggle they won it in 1920. After the enactment of law for legal registration of nurses in England in 1920, the laws for legal registration of nurses were passed very quickly in India. The Madras Nurses and Midwives Act was passed in 1925 while the Bombay Nurses Midwives and Health Visitors Registration Act was passed in 1935. Thus, while it took more than a half a century for the introduction of legal registration for doctors after it was done in England, the same happened in half a decade for nurses after legal registration for nurses was introduced in England. While going through the historical documents, we also found that the select committee of the legislature had in 1924, while discussing the bill for the Madras Nurses and Midwives Act, recommended that dais should also be brought under the purview of act and thus provided registration. The Bill defined dai as an untrained woman practicing profession of midwifery. It recommended maintenance of a register for them and that no dai other than a registered dai should be employed by a registered medical practitioner subsidized by the government or local body. This provision on dais was perhaps kept simply because under the government programme for Madras Presidency providing subsidy to doctors for locating their practice in the rural areas, there was a provision for making payment to the untrained midwife or dai.\footnote{ibid, p. 54}

Undoubtedly, this provision gave an excellent opportunity for retraining or further training of traditional birth attendants. However, this provision of recognizing dais's services to the society was dropped in all subsequent legislation on nurses. The subsidy programme in the Madras Presidency also suffered setbacks in a few years after the act was passed due to Economic Depression and the Second World War.

Interestingly, even in 1970s when the government, under the high sounding orientation to community health, launched a massive programme for the training of traditional birth attendants, the dais, not even lip-service was given to the issue of some kind of registration for them. They were just trained and left to fend for
themselves. The non-government organizations which pioneered the training, on the other hand, did not take up the issue of properly linking the daish to the government health infrastructure or made any demand for their registration.45

While laws for creating provincial councils were passed, the creation of Medical Council of India looks longer time and more efforts by doctors. As Jeffery (1988: 160-73) has suggested, before 1920, there were very few doctors in the nationalist movement. The main concern of those and of other doctors till 1920 was with the access of Indians to the Indian Medical Service and with its reforms. However, after the arrival of Gandhi in 1920 in the leadership of the nationalist movement, the focus changed to two main issues. The first of them was the recognition of Indian medical degrees abroad and the second about the systems of medicine the government should be supporting.46

The issue of recognition of Indian medical degrees immediately brought into focus the fact that constitution of provincial medical councils had still not created uniformity in the standard of medical education across the country. It was realized that in order to achieve that, the legal constitution of a medical council of India was a must. The constitution of the provincial medical councils had also given lots of privileges to the doctors of modern system of medicine at the detriment of the practitioners of Indian system who lacked any firm legal status. Thus, it was expected that the practitioners of Indian systems of medicine would make their own efforts to elevate their position, and their concerns were articulated strongly in the nationalist movement. These concerns brought about a movement for the establishment of colleges for training in the Indian systems and for the legal recognition of doctors trained in the Indian systems of medicine.47

The Medical Council of India, a national level statutory body for the doctors of modern medicine, was constituted after the enactment of Indian Medical Council Act, 1933. The first legal recognition and registration for the Indian Systems of medicine came when the Bombay Medical Practitioners' Act was passed in 1938. It

45 Ibid, p. 54
46 Ibid
was only after independence that the practitioners of Indian systems of medicine and homeopathy could have their own separate national Medical Councils.

The fate of the nursing profession was the same. While the colonial government began the province level registration for nurses and midwives in 1920s, no prompt actions were taken for establishing such legal framework at the national level. The Indian Nursing Council Act was passed only in 1947. Thus, the legal registration and regulation of health care professionals took long time.48

The colonial state initially was mainly concerned with the health and hygiene of the officials of company and British residents. They initially promulgated law to curb the infectious diseases through preventive measures and sanitization. By the second half of the nineteenth century there was shift in policy leading to the development of institutional set up of health services. Consequently, number of hospitals and dispensaries started increasing. The exclusive hospitals for women and children also came into being through private and government initiatives. To provide these hospitals with women doctors and nursing staff medical colleges for the women were established and their number increased.

These health facilities did not adequately serve the purpose of Indian population. Nevertheless, these played an important role in the development of public health services in India after Independence. The expansion of medical services required legislations to control and regulate the different category of medical staffs for which laws were enacted.

48 Ibid, p. 55