Chapter I

Introduction

The manner in which a society handles the crucial matters of birth, upbringing, sickness and health not only reflect but also reinforce the major values and institutions of that society. The same could be said about the way a society treats women and when we consider both together then the issues of female health and education assume special significance. Health of the people depends primarily upon the social and environmental conditions under which they live and work, upon security against fear and want, upon nutritional standards, upon educational facilities and upon the facilities for exercise and leisure. For the accomplishment of emancipating and educating the women of India and breaking down the barriers of social customs and prejudices, lot of patience, time and perseverance were needed. There were many failures and disappointments in this process, yet there were many encouragements and instances, which show that these efforts did not go waste.

Female education and health care occupies special place in the history of modern India. And it is striking how little consideration was given to women’s issues in colonial India. In extremely male oriented and male operated systems of education and medicine, women appeared as only adjuncts and appendages to men. A simple indication of the low level of welfare enjoyed by women in India even in the present day is that in large parts of the country the female education levels are amongst the lowest in the world and the maternal mortality among the highest. It is a known fact that the percentage of educated women in India is much lower than men and has been in need of greater attention. Health has been described on the whole as a state of complete physical, mental, social well-being and not merely the absence of disease or infirmity. As observers have shown that women make more frequent use of health services and are more prone to illness, the women’s participation in health domain is of profound and immediate concern. This work is an attempt at understanding female health care in colonial north India; especially it shall focus on the issues of medical education and the
availability of medical facilities to women. The importance of this theme to the future direction of education and health care delivery as well as to the quality of female population, mandates, a fresh historical approach to the analysis of women’s health and education issues, specially at this stage where female-male ratio is gradually lowering. There is perceived urgency of calling attention to inequitable and dehumanising conditions for women receiving health care.

**Historical Context**

In India women were traditionally denied education and were sometimes educated up to modest requirements of household. Especially among the Sikhs, Muslims and priestly Hindu classes, women were taught only reading, enabling them to read the religious scriptures. The Muslim women did receive a fair amount of literacy in their own language, as it is obligatory in their community that each boy and girl should know how to read Quran. Later on the practice of strict *purdah* prevented girls to pursue education in the schools established by the government. The General Report on Public Instruction in the United Provinces of Agra and Awadh, 1911-12 states that, a constant problem among schoolgirls was the prevalence of consumption. It further states that “often it seems that their physique is unequal to the strain of study up to the middle (vernacular) school.”

Introduction and spread of modern education by the colonial power had a larger agenda than mere academic enlightenment. East India Company officially intervened by introducing education policies through the Act of 1813. English education was not only a means of dispelling darkness and superstitions but also a means to train personnel for its administrative and commercial needs. In this larger agenda female education found an address only in 1882 Hunter Commission recommendations. The importance of girl’s education was realised by the government and local bodies which reflected in the recommendations of various commissions and committees which were appointed from time to time to review the female education system in India.

---

Robert Nathan in his comprehensive report on the state of education in 1904 notes that the number of females per 1000 of female population who could read and write in United Provinces was two and for Punjab was three.\(^2\) There were no female candidates for school final exam in 1901-2 in entire United Provinces. Only one percent of the population went to schools and these too rarely go beyond the lower primary stage. (97.6 % in 1917 and 97.3% in 1922 were dropouts).\(^3\) For the first time medical schools were opened for girls in early 1880 but there were a miniscule number of girls who were qualified to attain western medical training.

In North India, *Arya Samaj* helped in removing some of the prejudices against women’s education among the urban middle classes and made female education respectable. It also fought against the more blatant forms of women’s exploitations and to some extent altered their status in the family. In 1889, *Stri Samaj* was found at Jallundhar, yet the women *Samajis* were treated as subordinate partners. The *Stri Samajs* established *Kanya Mahavidyalayas* for the promotion of female education. In the school instructions the main focus would often be training girls for their future roles of being wives and mothers. Thus, they tried to reform ‘women’ rather than reform the social conditions. When there was hardly any access to education for women there were but a very few women who came forward for training as doctors and the social taboo associated with medical training prevented many women to take up medical education. Thus one very important feature of women’s education was the contradictory nature in it. At one level education promised freedom, equality and was projected as a programme that would shape the child for future responsible citizen, the nature of education provided to them was to make them more fitting home makers, mothers and companions to the emerging urban middle class men.\(^4\) They were allowed to public spheres only to be better protectors of private spheres.


\(^3\) The History of Rural Education in the United provinces of Agra and Oudh (1840-1926), *The Indian Press*, Allahabad, 1930, p. 183.

The prevailing status of health care system available for women was also very limited. The only access women had was to the traditional dais. The Indian women are exposed to the same risk of diseases as the Indian men, but she has the additional handicap of the perils of child birth. The prevalence of purdah system among women kept them within the confines of zenana walls, denying them fresh air and freedom of movement. They were doomed to an appallingly high percentage of ill health and mortality as this social custom did not allow her to seek any help from male doctors. Practical midwifery was not included in the professional equipment of the hakims, vaids and women depended on the dais. From surgical point of view the typical dai is unclean, and crude in methods. The disastrous results were often due to the lack of elementary knowledge about cleanliness and hygiene. Osteomalacia was quite rife among the women observing purdah and it bears a resemblance to rickets, attacks young and pregnant women rendering the bones soft and plaint so that they bend very easily. The sufferer consequently becomes crippled and as the bones of the pelvis are specially affected, difficulty in labour is always experienced, necessitating a serious surgical operation for the delivery of the child. Lack of efficient medical help at child birth often lead to the death of mother or the child. And many women survived this ordeal to live a life of chronic invalidism as they became permanent disabled through the rough treatment to which they were subjected, infections etc.

Modern medicine was introduced in India on a very limited scale first by Portuguese in the 16th century itself. However, it was actually the British who introduced modern medical facilities as well as medical training on a larger scale and firm footing. The British doctors in charge of hospitals employed a few Indians for technical help who were known as ‘native doctors’. Though by 1875, there was a wide spread hospital network through out India run by the government, municipalities and district boards, women remained the most neglected segment of the Indian society in the matters of medical aid and attendance.
From 1860 onwards it was female missionaries who came in large numbers to promote education in the zenanas. They gradually adopted medicine as a very effective tool to enter the bastion of female hold. After 1880 medical missionaries, who were single women trained professionally in medicine, came in large numbers to India. Piecemeal and sporadic efforts to train indigenous midwives in western methods began in late 1860s by few civil surgeons and missionaries. These were the first organised medical training for women in India. From 1880s training for Indian women in medicine both licentiate and degree levels was started too. In the early decades of the twentieth century the western women physician’s efforts led to the establishment of some of the great mission hospitals and medical educational institutes in India. The small-scale training classes for Indian girls were formalized to give certificates and diplomas that equipped them to launch their own dispensaries.

The colonial state’s first intervention into the Indian women’s health care came in 1868 in the form of the Contagious Diseases Act XIII which was designed to protect the soldiers from venereal diseases by regulating the treatment of prostitutes.5 This act required registration of all women suspected of prostitution, compulsory fortnightly medical examination and the segregation of prostitutes to Lock hospitals for treatment if diagnosed for venereal diseases. A major consequence of this was women in India were detached from a sacred seclusion of home and were expressed through western medical metaphors of health and disease. Other than establishing dispensaries and hospitals there were no special initiatives for women’s health care by the government till 1885 when the Dufferin Fund was established. Government gave a fixed grant-in-aid to this organisation for maintaining the women’s health care system in the country. The Colonial Reluctance to see women’s health as a state responsibility endured well into the twentieth century.6

6 David Arnold, Colonising the Body, University of California Press, Berkley, 1993, pp. 265-266.
Further efforts to improve medical care for women were begun by the wives of viceroys and these were later on supported by the government. In 1885 at the prompting of Queen Victoria, the Vicereine Lady Dufferin launched ‘National Association for Supplying Medical Aid to the Women of India’, popularly known as Dufferin Fund. This association sought to give medical relief through hospitals and wards, constructed exclusively for women and to educate and train Indian women for medical profession. It provided medical tuition for female doctors, hospitals assistants, nurses and midwifes. Many dispensaries, hospitals and female wards were constructed which were under female doctors. The setting up of Dufferin Fund has become a turning point in the history of female health care through western medicine in India. The Dufferin Fund not only increased access to medial facilities and bringing the medical relief but also stimulated the other initiatives in women’s health and medical education including the establishment of an all India women’s medical college, i.e. Lady Hardinge College at Delhi in 1916.

However, the Dufferin fund had its own draw backs. The underlying assumption of this fund was that Indian women lacked access to medical care, which can be resolved by simply supplying western trained women physicians and by providing separate wards in the hospitals. This was a narrow characterisation of the problem and its solution had conveniently ignored the more fundamental and systematic problems of poverty, nutrition, sanitation, education and gender discrimination.7

By 1890, there were women medical students in Agra and Lahore medical schools but the conditions were far from ideal. In 1903, Lady Curzon established Victoria Memorial Scholarship Fund to train indigenous midwives. However, it was only after 1918 that some success was achieved as attempts were made to train hereditary dais, especially in Punjab. This had little success in United Province. In 1886 Madras became the pioneer in providing medical training in western medical system for women in India. By 1890 there were women students

training in medical colleges and schools at Madras, Calcutta, Agra and Lahore. Among the Indian women pioneers in medical education were Anandibai Joshi, Annie Jagannathan, Rukhmabai, Hilda Lazurus, Kadambini Basu and Hymabati Sen and their life stories stand as testimonials to the immense opposition for the entry of women into medical schools and colleges.

In 1907 Association of Medical Women of India was started and in 1914 Women's Medical Services were started. However, WMS which professed concern for Indian Women professionals by offering them to integrate through two tier system of superior and inferior grades was more beneficial to the British women doctors.⁸ By 1920s many medical institutions were open for women like lying-in-hospitals, nursing homes, dispensaries, new female wards in the old general hospitals, and institutions especially designed to train women doctors and nurses.

Missionaries, colonial government, philanthropist, nationalist and women themselves have already worked for the promotion of health care system and western medical care for women became a part of educated middle class aspirations by 1900s. Each agency, operating with in their ideologies, have played a significant role in the promotion of female education and health care and the inter play of all these agencies has effected them.

**Frame of Study**

Western education and medicine have a long and complex history in India. They did not arrive abruptly in India as a part of the 'new imperialism' in 1880s and 1890s, but had an active history stretching back into the 18th century and earlier. There was lot of contestation and negotiation for their acceptance. Both these need to be understood as an influential and authoritative vehicle, not just for transmission of western ideas and practices to India but also for generating and propagating of Indian ideas about themselves. Education and Health care were also used by the colonial state as tools of hegemony and in the process legalizing

---

the colonial rule education and health care along with law became the duties of the state.

Colonial subjection through these hegemonic tools forced an exposure on the colonised to a radically new civilization as a necessarily superior one. This induced, within the Indian intelligentsia a simultaneous attraction to it as well as a need to escape from it to one’s own past, one’s own roots. It raised many comparisons, doubts, criticisms and questioning which lead to glorifying the past and defending the traditional order. Women were always considered the carriers and reproducers of these social values, so were led into a more conservative and traditional fold. On the other hand, to overcome the domination the colonised people realised that it is necessary to learn superior techniques of organising material life and incorporate them within their own culture. In this project, the nationalists tried to rationalise and reform the ‘traditional’ culture of their people. Thus, lot of ambivalence is seen in the attitudes and approaches towards women of this period. Women were given access to education and health care but within the seclusion of purdah. The educated middle class was the first to allow their women to come out seclusion and later on it became necessary to be educated and trained in the ‘western’ knowledge to be an ideal bride and mother.

Though education for girls was promoted the kind of education provided to them was targeted make them better home makers. Extensive research was done on the spread of modern education system for women. However, there is very little research done on female medical education. Except for the work of Balfour and Young 9 most of works on history of medicine or history of women have a small mention on the existing opportunities for women in colonial India.10 In the present thesis medical education, right from research to nurse training, is studied extensively.

David Arnold has suggested that in 19th century, medicine remained essentially male oriented and male operated system with the primary areas of concern being

10 David Arnold, Arnold, David, Science, Technology and Medicine in Colonial India, The New Cambridge History of India, Vol. III.5, Anil Kumar, Medicine and the Raj, Geraldine Forbes, Women in Modern India etc
the army, jails and hospitals, which were exclusively male domain. Hospitals and dispensaries, both state funded and individual sponsored, were to a large extent centres for vaccination against small pox, plague and for dissemination of western ideas about sanitation and hygiene. Even when women were presented as soldiers' wives and daughters, their specific needs were largely ignored.\(^{11}\) It has been argued by scholars like Radhika Ramsubban that western medicine, as it developed at least until 1900, remained largely confined to a small enclave of white residents and soldiers.\(^{12}\) According to Mark Harrison improvement in Public Health was depended on the co-operation between colonial officials and indigenous people. This needed direction and financial aid, however, neither the key sections of the indigenous population nor the government had the commitment.\(^{13}\)

When analysing the colonial educational and medical discourse, as a set of ideas and practices which were shaped by the objectives of the various participants in the educational process either to preserve or to contest the status quo the issues of women's education and health care also come out pointing to the asymmetry within the coloniser-colonised relations. This shows the prevailing wide gap between the privileged and the unprivileged of the society. The main hurdles in the spread of female education and health care were the social customs of purdah system, early marriage, pressure of household duties etc.

A historical analysis with gender as an analysing category would help not only in bringing in the ways in which men and women were differentiated, but also show the significance of such differences in terms of the definition of power, specific to each instance. By studying the social history of medicine of the period one can have a picture of the western and native perceptions about female health care and the process of evolution of modern medical systems in India. History has shown that the educated sections in the society were the one who mostly used health

---

\(^{11}\) David Arnold, *Colonising the Body*, University of California Press, Berkley, 1993, p.234.


care facilities provided by the western medical systems. But there were hinders in the spread of education for women, like the systems of Purdah, child marriages etc. So it is necessary to see in to the social history of period. As Sangari and Vaid suggest women are not some thing framed in history but all aspects of reality are gendered. Women are not only shaped but also shaped the changing processes of the time. 14

The totality of the situation was a product of several different relational articulations. Thus a question like ‘Female Health Care in Colonial North India’ mandates an inter-disciplinary study approach for better understanding of various processes involved in the discourse on women.

**Objective**

The present study aims to examine the issues of female health care and the various medical and educational interventions during the last phase of colonial rule in India. It proposes to look into the way in which women’s education and health were perceived and examine various measures taken at the official and non-official levels in North India during 1920-1947.

- What were the ambivalences in the introduction of western health care system and medical education for women in India?
- What place did Indian women get in the larger social reformer and revivalist agenda? How did they perceive the western systems of education and medicine and their application to women’s issues?
- What was the position of women in Indian society at the dawn of twentieth century? How did women of that period perceive their status in the society?
- What was the role of various agencies like missionaries, nationalists, philanthropists, colonial state, women’s organisations etc. in promotion of

---

women’s education and health care. How did these agencies articulate the issues of medical education and health care systems for women’s cause?

- What ever has happened to the traditional dais, who were the key health care providers for women in the rural India? How was the question of dais addressed in the western medical systems and what steps were taken to tackle this issue?

- Which section of women in the society were affected and what were the various problems faced by women in these educational and medical institutes? The variations at the level of region, class, caste and religion shall be examined and analysed.

Area and Time

The area of the present study is north India which includes the erstwhile United Provinces of Agra and Oudh, Punjab and Delhi. Compared to other parts of India like Bombay and Madras presidencies the practice of purdha was more prevalent and these areas witnessed slow progress in terms of reforms concerning women.

The period from 1920s in India is marked with rapid changes and developments in almost all fronts. Politically this period marks the beginning of decentralisation and the local administration taking over the education and health subjects. At the same time the beginning of Non-Co-operation movement under Mahatma Gandhi marks a new chapter in the freedom struggle of India. Socially many reforms addressing women were already addressed and the ‘daughters of reform’ were now entering the public arena. The middle class educated women started coming out of private domains and started articulating women’s issues. Even western medicine itself has undergone changes by 1920s. Above all, this period witness the inter linking of all issues in a very complex and intrinsic way.

The administrative and technological limits of western medicine were becoming apparent from 1920s. There was realisation that deficient nutrition, rather than epidemics were more deterrent to the colonial development. Thus there was a shift from curative to the preventive and from epidemic to endemic ill-health. As diet, nutrition were inseparable from culture the state intervention in curative
health care was limited. Besides the large cost and man power involved in undertaking a comprehensive public health policy was beyond colonial resources and the public health policy was often sporadic and *ad hoc*.

Western Medicine in India by 1920s and 30s had an increased visibility and legitimacy after reorienting itself in areas of state policy, medical research, and sanitary practices into a more Indian oriented system of public health. Western medicine became part of Indian middle class’s aspiration for hegemony.

There was shift from curative medicine to preventive medicine by late nineteenth century. Along with the nineteenth century predominant model of hospital medicine based on pathology, surveillance medicine attained significance in the twentieth century, where in the focus was on the individual. There was also growing importance of personal or individual hygiene in place of older ideas of macro sanitation or public hygiene in public health measures. One important fall out of this hygienic model was the increased influence of eugenics societies, which put stress on biological fitness and purity of race. With the increasing prominence of the social Darwinist evolutionary movements in the late 19th century, the health and status of women became the frequently used metaphors for measuring the level of progress or degeneration of a nation. So the ideal woman espoused by reformers and women’s organizations was an educated mother aware of home science, health and hygiene, an image, in which both the traditional and modern elements were combined.

After world war-I, gender specific medical interventions in colonial India got a new direction. Besides the curative practice of hospital medicine, intrusive health education for women increased. Attempts were made to popularise health education and make individuals aware of health issues, especially of women. There were many health programmes launched earlier and these were mostly organised by missionaries or were funded by Non Government organisations run under the patronage of wives of viceroys and other European ladies. From 1920 onwards with formation of local governments, there was involvement and cooperation of the local governments in organizing health programmes for women.
After 1900 'Indianisation' became the key word in the medical profession. Indians were commonly employed as municipal Health officers and as assistant surgeons. With many Indian women qualifying as doctors there was growing demand now for equal working opportunities for them. Even among the Christian Missionaries there was demand for 'indianization of church' from 1900 onwards.

Politically, there have been major changes in the colonial administration from 1920 onwards. After passing the Act of 1919, through which the system of dyarchy was introduced, for the first time, some degree of Indian participation in policy making was allowed in matters of education and health. This brought about a new structure of relatively decentralized decision making and more active part in the promotion of female education and health care. The Non-Cooperation movement from 1920 also witnessed the beginning of women's participation in politics and women were brought out of homes into the public sphere. This marked the beginning of the culture of women's agency in the public arena for women, marking a new phase in Indian social history.

Major social reform movements aiming at the emancipation of women have started in 19th century itself and it becomes necessary to see how far these reforms have contributed for their benefit by twentieth century. In nineteenth century reform acts addressing the women's issues like female infanticide, child marriage, sati etc were already passed by the colonial rulers\(^\text{15}\). But by 1920's the reforms for women were seen as originating from within the nationalist bloc itself and not as external (colonial power) interventions. Moreover quantitatively girls' schools and colleges underwent an unprecedented expansion in 1920s.

Women who have taken the advantage of the early social reforms, popularly known as the 'daughters of reforms', have started working for their promotion outside the gambit of male influence. Women started articulating for themselves for the first time in the twentieth century. In the discussions of social reform

\(^\text{15}\) Many laws were passed concerning women by the British. Sati prohibition act of 1829, widow remarriage Act of 1856, the Age of Consent 1860, 1891, Prohibition of female infanticide 1795, 1804, 1870, women's inheritance rights of 1874 etc.
issues relating to women, arguments relying on medical evidence became widespread and Indian women in both their individual and organisational capacities freely utilised medical rhetoric to support their feminist and nationalist goals.

**Methodology**

The historical method involves an intense focus on unearthing primary data. The primary data for this study was collected by studying the archival records. Official documents of that period were be studied in conjunction with contemporary tracts, pamphlets, journals, books, etc. The contemporary Hindi journals throw sufficient light on the issues raised. Examination of private memoirs, public documents, short stories, novels along with conventional prose writings gave a richer understanding of Indian medical and educational thoughts and practices. All this was analysed in terms of the recent literature available on Feminist History, Social History, and Medical History.

Women history has a dual role of restoring women to history and history to women, who like the other subordinate group in the society are among the muted or even silent voices of history. The use of gender as a category of analysis enables in understanding the relationship between men and women and the historical analysis would involve a through study of the ways in which men and women are differentiated. Gender, denotes the social differences and attributes of women and men and also recognizes the relationship between femininity and masculinity. The task of feminist historiography is to understand the complex ways in which women are and have been subjected to systematic subordination within the frame work that simultaneously acknowledges new political possibilities for women, drawing on traditions of dissent or resistance while infusing them with new meanings. This scholarship when informed by feminist perspective, contributes significantly to the production of women’s history.

When feminist historians analyse social differentiation as the contingent variable product of particular histories they provide an alternative to the categorical

---

16 Janaki Nair, 'On the Question of Agency in Indian Feminist Historiography', *Gender and History*, Vol.6, No. 1, April 1994, pp. 82-100.
histories that take differences as fixed, stable and eternal. One way of writing gender history of colonial period is focusing on the colonial structures that controlled women's lives and analysing the documents that determine the construct of women in the dominant discourse. These help in understanding how hegemonic processes work. These studies take as their subject matter not only the lives and actions of women but the way women were imagined and represented, which in turn influenced how women saw themselves and what they did. New theoretical frameworks, questioning power relationships, language, observers' gaze, the dominance of positivist notions etc have found gender a compelling subject.

Chapters

There are five main chapters in the thesis besides the introduction and conclusion chapters. The Second chapter of the thesis is an analysis of the various circumstances leading to social reforms concerning women and how the male reformers of the period attempted to bring betterment for women. Opinion of the women reformers and writers of the period are also studied to show their perceptions on the circumstances responsible for their subordinate position in the society. Arguments move around issues of the evil practise like sati, purdah, early marriage, enforced widowhood etc, and they show how many of these social practices were associated with women only and how these very social taboos denied them any access to education or even proper health care. The focus in the second part of this chapter is more significant, as it shows how women perceived their position in the society and how they understood their problems. The women's writings of this period in fact pose a serious challenge to the long-held notion of the nineteenth century 'social reforms'.

Missionary doctors, be it through the church or mission hospitals, Dufferin fund, or the state sponsored hospitals, have contributed immensely for the promotion of western medical systems for maternal health care in India. By the late nineteenth century across India missionaries provided more female medical care

by qualified medical practitioners than the state. Chapter three is a modest attempt at understanding the role of church focusing on the contributions made by the female medical missionaries. Modern Missionaries were not merely religious agents but were also cultural and social agents too and their role gain more significance when set in the colonial context. This chapter will try to place growth of single or professional medical missionaries in West within the larger discourse of western feminist movements. It will also discuss questions like the motive behind the female medical missions, relation between the church and the colonial rulers, the attitude of missionaries towards Indians women and health systems, the response of the Indians, especially Indian Christians, success of missionaries at evangelisation, Indianization of church, and church institutions, etc. Besides this it will also trace the genesis and growth of two famous missionary medical institutes i.e. Christian Medical College (CMC) at Ludhiana and St. Stephen’s Hospital at Delhi. Both these institutes were started by efforts of missionary women, who had no formal medical training, they gradually grew into huge medical institutions, which are surviving to this day.

Chapter 4 and 5 are interlinked discussions of imperial contributions in public health policy of government and medical education institutes which were also mostly run and regularised by the Government. The role of state in the promotion of maternal health care system in India is studied in chapter 4. This chapter first traces briefly the beginning of public health policy in India and then studies the development of the medical administration from 1920. It traces the development of the health organisation under the Government of India Acts of 1919 and 1935 and how the central and provincial medical administration was co-ordinated with the creation of Central Advisory Health Board (CAHB). Focusing on the theme of the present thesis, the state sponsored maternal health programmes administered by Dufferin Fund, Women’s Medical services is studied. The functioning of the state sponsored hospitals, dispensaries and maternal and child welfare centres (MCW) in Punjab, United Provinces and Delhi are also analysed.

In Chapter 5 attempt is made to study the training of women in medicine and various issues related to it, focussing on the exclusively ladies medical
institutions. By 1920 there were many institutes providing medical education for women in India. The various levels of training like research, post graduate training, degree studies, diplomas, health visitor training, nursing training etc are studied. A detail analysis of the working of All India Institute of Public Health and Hygiene, Lady Hardinge Medical College and Ludhiana Medical School is done in the chapter. Some of the issues studied are the establishment of the ladies institutes, the struggles they faced and the growth of these institutes and finally the short comings in the trainings. Not only higher education and degree training is studied but also the training of nurses is included in this chapter.

Chapter 6 studies how in twentieth century women started articulating demands for themselves for the first time. It shows how the image of ‘new woman’ of the nineteenth century percolated into their demands also. In the issues of women’s health care and higher education this emblems of gender continued so much so that women accepted that they were the nation builders and protectors of home. In this chapter attempt is made to understand how women started to form pan Indian organisations and sought improve the conditions of women in India. The concept of ‘new women’ is analysed and it is shown how it was perpetuated by the Women’s organisations and their activities in early twentieth century. This also shows how the women’s movement got intertwined with the national movement as both sought to achieve the ultimate goal of political autonomy and national building through this ‘new women’. The study of the vernacular ladies journals of the period also shows the extent to which the ‘new woman’ image got permeated and accepted in to the popular notion.

Many issues will be left out or not addressed in this study. Some of them are as follows

- There was lot of debate and contestation for accepting the western medical system. Nationalists have tried to revive the indigenous medical systems Ayurveda, Sidda, Unani etc. In this research the question of revival movements of the native medical systems and how did the women’s health care feature in their discourse is not discussed.
• The situation of women in the princely states like the Rajputana States of that period is not addressed and it is mainly about the women in the British India provinces.

• The study treats women as a homogeneous whole, yet it is a known fact that it is not so. Women in the lower sections of the society were the least effected. History by its very nature has been the history of success and successful. So women in general and lower section women in particular were invisible in history. But an attempt would be made to cull out the possible data from the contemporary literary writings of the period.

• The main focus of women's health care in the present study includes about maternal health care which is specific to women. The question of women during the epidemics like plague, small pox, leprosy, tuberculosis, malaria etc. requires a separate research and is not included in this study.