CHAPTER IV

MAKING OF MATERNITY SERVICES
FOR WOMEN IN INDIA
The previous chapters have already shown that the passage to India for the British women doctors and the welcome given to them by the colonial administration was not a simple social event borne out of British philanthropy. It was a much more complex social process involving the rapid changes that were taking place in the British society itself. The professional and social pressures emerging out of the interests represented by the women's movement, as well as the medical professional guild, the conflicts between the two, the need of the empire to resolve these conflicts by offering placement to the women professionals in the colonies and using them to balance their use of missionary links were crucial in the establishment of these services for women in India.

We have seen that the professional pressures and gender conflicts in Britain within the medical field forced women to look for avenues outside Britain. Some of the women had obtained medical education from Germany, France and Switzerland. It was only in 1877 that Parliament tried to extend and improve the Medical Reform Act of 1858. But here also, amendments to the bill required that all doctors be qualified in both medicine and surgery. This move to upgrade medical education concealed a threat to all women who had already received medical education. As it would automatically place women doctors in an inferior position to men in the profession since no college of Surgeons had admitted them for examination during their period of study. 1 At the same time General Medical Council proposed amendment to the new bill that would provide for a special board to examine women professionals and then place their names on a separate register. The women had to state that they had received no part of their education with men. Such a move would have disqualified all women who had received medical education in France and were undergoing medical education at that time.

The whole debate on the issue brings to light the opposition women had to face to get into the medical field and to have their names on the medical register in Britain. The women finally succeeded but their employment was yet another question that needed attention. It was possible for some of them to go abroad and study outside England, but the practice of medicine in the country by women raised many eyebrows. The professional interests of male doctors were so strong that they did not wish to share the field with women. Thus the practice of medicine in the British colonies seemed most convenient to all parties, the women, the medical men and the colonial government. The
opportunities in the colonies solved the problem for all and upheld the image of the imperial regime.

The entry of women doctors into the colony gave impetus to the emergence of a maternity service in India. This chapter explores the multiple factors that contributed to the growth of maternity services. Three broad areas are explored. Firstly, the medical opportunities for British women in India: the establishment of Dufferin Fund and the setting up of special hospitals for women. Secondly, the disease statistics about women and women's attendance in the regular hospitals before the establishment of special services for women. Thirdly, it examines the professional attitudes of British women doctors and administrators towards the traditional birth attendants who were the main practitioners of obstetrics in that period and who were seen as hindrance in the modernisation of maternity care.

OPPORTUNITIES FOR MEDICAL WOMEN IN INDIA

We have seen in Chapter I that health services in India developed in response to the military and political needs of the empire. In order to ensure a reserve of healthy soldiers, the Royal Commission was set up in 1859 to assess the health needs and suggest interventive measures. It described the venereal disease as the scourge of British troops in India, and proposed to control it through legislation. A special committee was appointed to draw rules under Cantonment Act. The act suggested stringent measures for monitoring prostitutes. This was the first time that the women in India received attention from the British rule. The prostitutes became the focus not for reasons rooted in their ill health or high levels of mortality but because they were seen as a threat to British soldiers. This has already been discussed in chapter I.

The British administration paid attention to maternity health only around 1870. This was partly due to the philanthropic concerns of some and partly due to pressures on the British government at home. British government used its colonies to reduce its internal pressures, and at the same time enhanced its public image in the colonies. The step also provided opportunity to maintain some distance from the missionary workers who were perceived by the local population to have ulterior motives. It was no accident
that the entry of British women into the medical field and the beginning of maternity services in India almost coincided.

Given the strong anti-women biases in medical profession and among general public in Britain that denied them suffrage, medical education and practice, the women had to look for opportunities outside to fulfil their professional aspirations. For making inroads into the medical field, the low status of women in India became a key argument. Taking advantage of the weaknesses of the Indian social fabric, they highlighted the desperation of women for having some trained medical help to rescue them from the miseries of sickness. The establishment of institutionalised care through western medicine was based on the understanding that the women in the colonies needed trained medical help and that in the absence of such help, the women in the colonies suffered at the hands of traditional dais during delivery and childbirth.

The concern for Indian women surfaced over the same period when a great number of British women were trained in England and they were demanding equal opportunities to practice medicine. Under the rhetoric of Indian women's needs, the colonial services provided opportunities for British women to establish themselves in medical profession and to get practical experience. This proposition is strengthened by the fact that even though women were suffering equally with malaria, cholera, gastro-enteritis etc. and were attending hospitals, the imperial focus was only on maternity care. This is not to say that maternity services were not useful or were not needed, but to argue that the services were established under pressures arising out of the conditions in Britain rather than for the welfare of Indian women. The services for women were thus started on the basis of the perceived needs of the Indian women, but as perceived by the British women doctors and the Colonial administration rather than by Indian women.

Two sets of providers of services were engaged in the delivery of maternity care and training of health workers - the missionaries and the secular professionals who came independently through Dufferin Fund and other such organisations that developed in the last three decades of the 19th century.
Medical Services for Women Started by the Missionaries

Missionaries were the first ones to get involved in the medical work. We have seen in chapter II that missionaries stationed themselves in the remotest areas of rural India and started first with the education of children and young girls. Initially their activities were confined to social services that looked after village welfare alone. Holding of regular prayer meetings was the distinct feature of their activities in these villages. Slowly they started attracting poor people of the nearby villages. The missionaries had spent a lot of time studying about Indian people, their customs, practice, and beliefs.

Special hospital and dispensaries to take care of Indian women during pregnancy and childbirth came up in the middle of the 19th century. The Medical Missions in India date from the second quarter of the 19th century. But before that some individuals had taken up the initiative to start missionary work. John Thomas seems to be the first person who made two voyages to India in 1783-84 and in 1786-87. He worked as a missionary in Malda for three years. On his return to England in 1792, he joined the newly formed Baptist Missionary Society. He came back to India in 1793 and worked as medical missionary in Malda and Dinajpur. John Taylor was another medical missionary who took medical degree at Edinburgh in 1804 and came to Madras in the London Missionary Society in 1805. He later on joined as Assistant Surgeon in the Bombay Service in 1808. The credit for establishing regular Medical Mission in India goes to mission in Southern India that was founded and supported by citizens of the United States. It established itself in 1830 in India.

Missionaries were the first ones to send women for medical work to India. Initially, medical missionaries did not have the full medical education or medical degree. Their main aim was to reach to the people and women in Indian families, who otherwise remained out of reach for the ordinary missionary workers.

It was as early as in 1866 that a Civil Surgeon, Dr. Aitchison, started a Class for dais at Amritsar. This class did not run very well initially. Miss Hewlett of the Church of England Zenana Missionary Society took charge of the training school in 1877, and it became a very successful and well known training school for dais in the 80s. Miss Hewlett was not a qualified medical person. She had obtained some training under a
doctor in Britain. Over the years she trained Indian girls as assistants in the mission work. St. Catherine’s Hospital also came up in Amritsar at that time.

Miss Rose Green Field came under the society for Female Education in the East in 1875. She started her work in Ludhiana by visiting the homes and teaching women and children. 7 She started with medical work by way of providing simple remedies and prescribing cleanliness. In 1881, a small dispensary was opened in that area. She was instrumental in opening the Women’s Medical School at Ludhiana in 1893, in association with Edith Brown, who was the first principal of the school. Both, Miss Hewlett and Miss Greenfield continued their missionary work well into the early 20th century.

We have already shown in Chapter II that Miss Bielby came to India in 1875, with some medical training. She started medical work in a place near Lucknow, by opening a dispensary. Her sister, a trained nurse joined her, but died in a few months from enteric fever. 8 Miss Bielby’s contribution to the establishment of medical facilities for Indian women is important, as she had conveyed to the Queen of England, the desire of one Maharani, on behalf of the Indian women, that trained medical help was most needed in India. Miss Bielby’s experience in India had made her eligible for medical training so she went back to England to obtain medical education. She obtained the license of the Kings and Queens College of Physicians, Ireland, and M. D. of Bern, before she came back to Lahore in 1888 and took charge of the hospital for women opened by the Lahore Municipal Committee. This hospital was known as the Lady Atichison Hospital and was formally opened by the Countess of Dufferin on 15th November 1888.

The first qualified medical women, Miss Clara Swain came from United Stated in 1869. She started with medical work in Bareilly where Mrs. Thomas, a missionary, looked after a girls’ orphanage. She opened a dispensary in 1873 and a hospital in 1874. The site for the hospital came as a gift from the Nawab of Rampur. This missionary looked after the hospital and dispensary till 1885. Later on she moved to Khetri to take up the post of physician to the Rani on the insistence of Raja, where she along with Miss Pannell opened a dispensary for women and children.
A small dispensary came up in March 1872 in Allahabad by Miss Sara C. Seward, who was sent by the American Presbyterian Foreign Missionary Society. After her death in 1891, Sara Seward Memorial Hospital was built. 9

The first qualified medical missionary from England was Miss Fanny Butler. She was sent by the Church of England Zenana Missionary Society in 1880 and was stationed first at Jabalpur. 10 In 1887, she started a hospital and dispensary in Srinagar, in Kashmir.

The missionaries had a large number of hospitals in Punjab, Kashmir and Northwest Province. These mainly belonged to the Church Missionary Society and to the Church of England Zenana Missionary Society. One of the large hospitals was in Amritsar that had about 100 beds.

American Presbyterian Mission had a hospital in Ferozpur under the charge of women missionaries. The American United Presbyterian Mission had hospitals run by women at Taxilla, Sialkot, Sargodha, Jhelum and Pasrur. 11

A hospital, with 75 beds was supported by the Danish Presbyterian Mission in the Northwest Frontier Province. In the United Province, the medical work was started by the American Methodist Episcopal Church, the Women’s Union Missionary Society and the Women’s Union Missionary Mission. The famous medical hospitals were in Bareilly and Brindaban. The other famous hospital was in Lucknow where Miss Bielby, under the Zenana Bible and Medical Mission, started medical work amongst women.

The hospitals in Punjab, Kashmir, Northwest Province, United Province were exclusively for women and they were started with the objective to cater to the women of India. In the Central province and in the eastern part of India hospitals exclusively for women were not many. The hospitals in these provinces catered to the men as well as to the women. However, the Nagpur Hospital under the United Free Church of Scotland was one of the best-known hospitals for women at that time. Dr. Agnes Henderson was the woman behind the success of that hospital. She also had regular classes for the training of dais. The only hospital for women and children in the eastern part of India was in Patna. It was under the Zenana Bible and Medical Mission. 12
The South of India especially, Madras had lots of missionary hospitals. The United Lutheran Church Mission had the oldest mission hospital for women in Madras. Dr. Kugler came to India as a missionary worker in 1883 and in 1886 she was entrusted with the medical mission work. The work started from the small room, and took the shape of a big hospital in 1899. 13 The same mission had a 60-beded hospital in Rajmundry, in the Madras Presidency. 14

The other big hospital for women was started in Vellore with 120 beds. This hospital was under the American Arcot Mission. A missionary woman who had no medical training started the other hospital under The American Madura Mission. She did some hospital work in Madras. She started medical work in 1877, with the help of a male doctor who visited the place twice a week to attend to the patients. As the medical work acquired momentum, a qualified medical woman, Dr. Pauline Root came to join in 1885. This hospital became a large hospital with 110 beds having three qualified doctors.

The credit for another large hospital at Nellore also goes to the missionaries. The American Baptist Foreign Missionary Society had started this hospital and also had small hospitals in Udayagiri and Sooriket. The Presidency capital had many fine hospitals. The Rainy Hospital of the United Free Church of Scotland started medical work with the appointment of Dr. Macphail in 1888. She started a dispensary and a 12 bedded hospital in 1891. 15 By the early 20th century this hospital had 75 beds and three doctors. The hospital had antenatal clinic, maternal and child welfare centre, and regular dispensary.

There were few mission hospitals in Bombay presidency. The oldest mission hospital was in Poona, which came up under the auspicious of the Church of Scotland in 1892. It was known as St. Margaret’s Hospital. The hospital at Nasik was under the Zenana Bible and Mission. There were other hospitals run by the missionaries but these were comparatively smaller. Kolhapur had a hospital run by the American Presbyterian Mission, while the Church of the Brethren had a woman’s hospital at Dahanu. Irish Presbyterian Mission started with medical work at Borsad in 1889 and later it became a 50 bedded hospital. There was a small hospital at Baroda State that was run by the Methodist Episcopal Church.
Some of the women's hospital came up to ensure medical education for women in India. Edith Brown opened the School of Medicine for Christian women in 1894 in Ludhiana. Its objective was to train women to work for the Zenana Medical Missions. Initially, it offered a four years course - equivalent to Sub-Assistant Surgeon; but later on changed it into the five years course to the Assistant Surgeon grade.

The main features of the missionary services that evolved over the 19th century were:

1. They focused on the remote areas, away from cities. “It is noticeable that many mission hospitals which started as dispensaries or small hospitals of a few beds, moved outside the cities when the time for expansion arrived…. Little trouble is experienced in inducing women to come as in-patients though the hospital may be with in a mile or more from the centre of the town.” 16

2. They made it a point to provide extensive charity services.

3. Even though the hospital got substantial amount of income from the fees paid by the well to do patients, a large amount of income was from renting small rooms to the patients and their families. Yet, no doctors under the mission made direct demand for money for the services rendered. 17

4. The services were both medical and religious, having moral and social education as its components.

There were about 332 medical missionaries serving in India by early 20th century. 18 Though the mission hospitals rendered useful services to the local people, there were some sections in the society who preferred services run by the private institutions, or government run hospitals and dispensaries. Thus, even though the ordinary people were happy with the quality of service in the mission hospitals and dispensaries, the preaching of another religion in these places kept certain sections of the people away from the mission hospitals and dispensaries. At the same time there were places where missionary work did get support from the local people who came readily for treatment.
Governmental and Non Governmental Services for Women

In Chapter I we have seen general hospitals that were already in existence and those that came up in the 19th century. Here, we focus on the hospitals for women that came up in the 19th century.

The famous hospitals in Bombay were St George's Hospital, the Jamsetji Jibibhai Hospital that came up in 1843, Sir Cowasji Jehangir Ophthalmic Hospital that came up in 1866, the Bai Matlibai and Petit Obstetric Hospital established in 1889, and Sir Dinshaw Manekji Petit Hospital for women and children. These hospitals had female wards for the care of women. The presence of female wards in the hospitals is an indication that women came to hospitals even with obstetric problem even though there were no female doctors. It was only in the later part of the 19th century that these wards were changed into full-fledged hospitals and female doctors from Britain took charge of these special wards or hospitals.

It was in 1883 that the special hospital, Pestanji Harmusji Cama Hospital for women and children came up in Bombay. This was also the first hospital to appoint women doctors. Dr. Edith Pechey was the first woman from Britain to head this hospital. In the compound of the same hospital came up another hospital called Bomanji Edalji Allbless Obstetric Hospital in 1890. The staff of the Cama Hospital also looked after this hospital. Major contribution for this hospital came from a local rich man and the hospital was named after him. It is interesting to note that all hospitals came up with major contributions from the local elite.

General Hospital in Madras was in existence since 1842. It was for Europeans and the natives of both, civil and military services. This hospital had set apart half of the building for European women and children and the other half was for the natives of both sexes, in separate wards. Even after the renovation and expansion of the building in 1861, it had a separate place for the British, European and Eurasians. They did not mix with the natives. The women and children were taken care of in a separate building. In 1881 the women and children ward was shifted to the Old lying-in Hospital. The presence of lying-in hospitals and obstetric wards in these hospitals point to the fact that women came to the hospitals for treatment.
The Royal Victoria Caste and Gosha Hospital for women was founded in 1885 in Madras under the Presidency of Lady Grant Duff. In fact Mary Scharlieb had proposed the scheme for the provision of medical women in Madras for Caste and Gosha ladies, way back in 1875 and she had obtained the sympathy of the Governor, Lord Hobart, and the Surgeon-General Balfour. 20 But the scheme materialised only in 1885, with the contribution of one lakh rupees from Raja of Vanketgiri and of Rs.62,000 from Maharaja of Vizianagram. 21 By that time Mary Scharlieb had completed her medical education and was already engaged in private practice in Madras, when she was offered to take charge of the Caste and Gosha Hospital. A second medical woman, Miss Paithorpe, was appointed as assistant to Mary Scharlieb.

There were also hospitals outside the Madras City. The earliest mofussil hospitals in the Madras presidency seem to have been established in 1830s. 22 There were about six civil hospitals in the Presidency outside Madras. 23

In Calcutta also there were general hospitals that came up in the 18th century, but there is no mention of separate wards for women in these hospitals. In the 19th century, two dispensaries came up in connection with the native hospital. These were known as Chandni Hospital and Mayo Native Hospital. The later was named so because it received a grant of 50,000 from the Mayo Memorial Fund. 24 This hospital was opened in the year 1874. Chandni Hospital remained small with twelve beds meant for emergency cases; its out patient department was large and expanded further in the early 20th century with subscriptions from the local people, donations and government’s annual contributions. In the Native Hospital and the dispensaries there was no mention of female patients. So, it is difficult to say whether there were any female patients in the 18th century who attended any of the native dispensaries or hospitals.

The Calcutta Medical College Hospital came up in the year 1838 for the purpose of clinical teaching. 25 It was a small hospital with 30 beds and an out patient dispensary. A Lying-in Hospital was opened in early 1840, with an outpatient dispensary and a training classes for dais. 26 This was absorbed into the Medical College Hospital in later years. The hospital expanded with the contributions from the local rich and it bore the name of the donors on its out patient wing. The new hospital with big building for the medical college was completed by the year 1853. It had the provision for 500 beds in 24
wards, and one ward was reserved for women and children. This hospital admitted Europeans as well as natives. There were additions to the building of the hospital, the most famous being the Eden Hospital in 1881-82, a hospital for women. Thus, we see that in the 19th century, special wards for women were opened in the hospitals. It is interesting to note that till that time there were no women doctors attached to these hospitals, hence female patients were obviously attended to by male doctors.

Hospital for general population in the mofussil towns in Calcutta came up in the early 19th century. “Some of the best known mofussil hospitals in Bengal were founded in the thirties of the nineteenth century”. 27 By the year 1853, the government in Bengal and Northwest Province supported about fifty-five dispensaries. Though it is not clear whether these hospitals had provision for the care of women patients, the hospitals in the Presidency towns and mofussil town were opened for the general population in early 19th century. These hospitals were mostly at places where British officials resided. Giving data from the reports of medical institutions in Calcutta and Bengal Mofussil dispensaries, for the 1885, Maneesha Lal shows that women did attend these institutions and their attendance was between 15 and 20 percent. 28

The Marquis of Ripon laid the foundation stone of the Ripon Hospital at Simla that was established in 1882. At a special meeting on 21st September 1882, the Municipal Committee invited people to form a committee that would assist in all matters connected with the hospital. Public subscriptions were invited for running the hospital. Ripon Hospital had a Dufferin Block that had been opened in the early days of the Dufferin Fund, 29 and looked after by women assistant surgeon. The Dufferin Block remained under the control of the civil surgeon. This 20 bedded Dufferin block at Ripon hospital was poorly equipped and staffed. Its poor functioning had led to the establishment of Lady Reading Hospital in Simla in 1923. The Indian princes gave large donations for the building fund. 30

The history of hospitals in Bombay, Calcutta, and Madras thus shows that in the 19th century, the big hospitals and dispensaries had some provision to take care of the female patients. In other words, much before the British women doctors came from Britain to take care of Indian women these women were seeking help from the hospitals.
Most of the hospitals that came up in the 19th century were built with the contribution of the local elite. The Indian elite contributed with great willingness as it enhanced their public image and also brought them closer to British officials. We present this evidence in the following section.

**Special Hospitals for Women - Cama Hospital and the Dufferin Fund's Hospitals**

Cama Hospital in Bombay came up in the second half of the 19th century. The ‘Medical Women for India Fund’ established Cama Hospital that was inaugurated in 1882. An article by Dr. Elizabeth Hoggan (a medical woman) appeared in *The Contemporary Review* that stressed the need for medical department in India to take care of the needs of the women. This attracted the attention of Mr. Kittredge, an American businessman from Bombay. He planned to “raise a fund sufficient to pay fair salaries to two or three competent ladies from Europe for a short term of years, in the hope that at the end of that time they would have established themselves so firmly that their future position would be assured, or else that their usefulness would have sufficiently established to warrant the government giving them positions in the hospitals here”. 31 The management of the fund had intended to raise funds to build hospital and give under the charge of women doctors, and also intended that the government would take over the hospital. The government agreed that “the institution shall be handed over entirely to the care of women doctors, as soon as competent… doctors shall be available for its sole management, and funds are provided to pay the salaries of such staff”. 32 Mr. Cama, one of the subscribers, paid a sum of Rs.120,000 and the foundation stone for the hospital was laid by the Duke of Connaught on November.23, 1883. 33

The other agency that started hospitals for women in India was 'The National Association for Supplying Female Medical Aid to the Women of India', commonly known as Countess of Dufferin Fund. This was established in 1885 with the objective to bring female doctors from Britain to open women's hospitals and wards and train Indian women to follow in their footsteps. 34 The establishment of Cama Hospital in Bombay in 1882 and the establishment of Dufferin Fund in 1885 followed closely the entry women into the medical field in Britain.
The work of Cama hospital began in the temporary dispensary in July 1884, and Dr. Edith Pechey took charge of the dispensary and Miss Charlotte Ellaby came and joined as Junior Officer to assist Miss Pechey in November 1884. The management faced difficulty in meeting the cost of medicines at the dispensaries as the government had refused to give a grant of Rs.100 per month that was requested. The building of the hospital was completed in August 1886 and the governor opened the hospital to the public. The responsibility of providing salaries to Dr. Pechey and Dr. Ellaby was handed over to the Government that reimbursed the salaries of these doctors from the time of their appointment. The hospital committee invested this money in the formation of “Scholarship of the Medical Women for India Fund”. This scholarship of Rs.150 per year was meant for the female graduates of any medical school affiliated to the University of Bombay, who passed the final examination with the highest marks.

We see here that the impetus for the appointment of female doctors in India came on the initiative of local elite who were able to contribute money for the cause. The government was not very keen to provide employment of the women. The establishment of Dufferin Fund was also a pointer to this strategy.

The establishment of Dufferin Fund was attributed to the personal initiative of Queen Victoria, who asked Lady Dufferin to investigate the possibilities of providing medical aid to Indian women. Lady Dufferin, after her arrival in India started to survey the nature of work done by the private institutions and the government. She concluded that the Indian women were without any medical aid and that there was an urgent need for such aid. Lady Dufferin issued a prospectus on 18th August 1885, in several languages and the Fund was inaugurated.

The main objective of the Fund, as stated in its own article of association, was to bring medical knowledge and medical relief to the women of India by providing women doctors/ health workers. The aims of the National Association for Supplying Female Medical Aid to the Women of India, also promised:

1. Medical tuition, including the teaching and training in India of women as doctors, hospital assistants nurses and midwives.
2. Medical relief, including a) The establishment of dispensaries under the female superintendent for the treatment of women and children b) opening of female
wards in the existing hospitals under the female superintendent c) provision of female medical officers and attendants for existing female wards d) founding of hospitals for women where special fund and endowments were forthcoming.

3. The supply of trained female nurses and midwives for women and children in hospitals and private house. 37

The National Association was formed in 1885 and in 1886 it established independent branches in the provinces. These provincial branches were financially and administratively independent. The National Association or the Dufferin Fund was not intended to be a government organisation, so it sustained itself on the donations and subscriptions from the local people. It is interesting to note that the central committee collected Rs.148, 344 (approximately £9, 900) in India and £235 in England. 38 More than Rs.70, 000 came from the Nawabs and Maharajas, who donated Rs.5, 000 each to become of life members, whereas the Viceroy of India and the Countess of Dufferin donated Rs.500 each to become life members. This indicates that the British government and the officials contributed minimum for the Fund yet projected themselves as Saviour of Indian women.

The activities of the Dufferin Fund expanded and it set up hospitals in all major cities and established female wards in the already existing hospitals. The annual report of the Dufferin's Fund showed great extension of work, in geographical sense. 39

The main Dufferin Hospitals were established in Lucknow, Patiala, Madras, Nagpur, Calcutta, Gaya, Mysore etc. Agra Maternity Hospital came up in December 1890 with the help of Dufferin Fund's Local Association. In the same year Lady Lyall Hospital came up near Agra. Two lady doctors Miss Morice and Miss Yerbury were in charge of this hospital. 40 The Viceroy also inaugurated a hospital at Patiala in October 1890, for which Lady Dufferin had laid the foundation stone in 1888. It was known as Lady Dufferin Hospital, and Miss Crowley from Edinburgh was to take charge of the newly opened hospital. Miss Crowley was already in charge of an Edinburgh Hospital of high standing, yet she chose to take responsibility of the hospital in Patiala. This was not the first hospital in Patiala, there were already some other hospitals in Patiala. Rajinder Hospital was opened by Sir Atichnson with a government contribution of about 1 ½ lakh rupees, a Military Hospital, a Jail Hospital, a branch dispensary in the city of Patiala and
17 dispensaries in the Mofussil existed in Patiala at the time of opening of Dufferin Hospital. The Dufferin Hospital was started as the city had no hospital for women and children.

Major Dufferin hospitals were opened in the cities where the local rich gentry had offered to bear the cost of construction and had provided land as well. These were also located in the native States where ruler and chiefs obliged the Dufferin Fund by providing land or building the hospital as a gesture of friendship, as in the case of Dufferin Hospital at Patiala. Be it Lucknow, Patiala, Gaya, Agra, Rangoon or Lahore, the hospitals were built with the major contribution of the local rich gentry. In fact, it is possible that hospitals came up only in those areas where local help was easily available. Often the local support decided the location of the hospitals rather than the real problems of the women in that area or state.

The major contribution for Dufferin Hospital at Patiala came from the Maharaja of the State, for the Lady Lyall Hospital the contribution came from local gentleman Sheikh Hafiz Abdul Karim of Meerut. Lord Elgin opened Dufferin Zenana Hospital at Gaya on 30th March 1895. For this hospital also the local person donated the money. "...Rajkumari Rattan Kuar of Tikari, whose grandfather presented a quarter of a lakh originally, has now promised an annual contribution of Rs.1200, which practically secures the permanent endowment of the hospital".

In the annual meetings of the Dufferin Fund, the contribution of the local elite was recognised and appreciated. "From a hundred different quarters, both from small and from great, from the princes of the land and from individuals in more humble stations, sympathetic replies, as well as considerable material assistance, have been received". In 1890, Lord Lansdowne also appreciated the contribution made by the local people towards Dufferin Fund. On the occasion of inauguration of one of the Dufferin Hospitals in 1890, he remarked, "I am glad to have the opportunity of expressing my acknowledgement of the generous manner in which the Lady Dufferin scheme has been supported by the Princes and Chiefs of this Part of India. They were the among the first to come forward, when the movement was in its earliest infancy, and it is most satisfactory to find that many of them are now freely established hospitals in
their own dominions and making arrangement for the maintenance of those hospitals at
the cost of their states". 45

Apart from establishing independent hospital, the Dufferin Fund also provided
grant for the salary of doctors and maintained female wards in the big general hospitals.
The Dufferin fund also provided grant for training of hospital assistants and arranged for
training of nurses. There were about 11 important Dufferin hospitals staffed by qualified
medical women and administered by local committees by 1888. 46

Dufferin Fund did not always have Indian supporters. There were some that
suspected the motives behind Dufferin Fund. " The Praja Bandhu commented satirically,
'behold, how very artfully Her Ladyship has drained out the wealth of many maharajas,
Rajas, and other noblemen of India..." 47 National leaders like Balgandhar Tilak also
criticised the government for passing on the responsibility onto the public shoulder for
the maintenance of Dufferin's Fund. 48 But in its defence, one of the English ladies wrote
in Indian Spectator, "It is hard to get your people to see that we have no personal objects
to serve in promoting this scheme". 49 These, so called philanthropic activities were
successful with the help of local people, yet the British took full credit for it. Not only that,
they also expected Indian people to feel obliged for these initiatives as is evident in the
speeches delivered on formal occassions and annual meetings of the Fund.

For some of the Indians, the contribution to the philanthropic work was an occasion
to come closer to the British officials. The Indians either expressed great appreciation for
the work done by Dufferin Fund or they directly involved themselves in the work of the
Association. One of the High Priests, Sailayananda Ojha, of a Hindu Temple, Baidya
Nath, wrote to the Dufferin Fund expressing his deep appreciation for the work done by
it. 50 He not only appreciated the work, but also contributed a sum of Rs.100 to show his
solidarity to the efforts of the Dufferin Fund in India.

Though the explicit aim of Dufferin Fund was to provide relief to the women of
India, implicit in it was the desire and compulsion to provide employment to the British
women in India. This is evident from one of the letters, Lady Dufferin wrote to the Mayor
of London. " I hope that it will not only be means of bringing medical relief to many
suffering women, but that it will also open... (up a ) career (for) ...native women, and will
tend to improve the general female education throughout India. I think also that number of English lady doctors will find employment in India..." In order to fulfil the professional aspiration of the women doctors and for providing employment to them, the Dufferin Fund capitalised on the poor health status of Indian women.

Through these initiatives the British administration justified British women doctors’ employment in India. Inadequate care during pregnancy and childbirth was seen as the main reason for high mortality amongst Indian women. This limited focus on women’s health led to establishment of purely maternity services for women in India. It is true that mortality was high among women in India, but maternal services alone were picked up to reduce the suffering amongst women, ignoring other disease that caused many more deaths among them. It was also not true that women did not attend male-staffed hospitals. Data from the reports of the dispensaries and hospitals in Calcutta has shown that women did come to the hospitals for treatment. They constituted 15-20 percent of the total strength of the patients. We examine some of the reports of the Bombay and Calcutta hospitals to see the female attendance in these hospitals and also look at the reports of the sanitary commission to see what had been the reported causes of deaths among women in the 19th century.

WOMEN’S NEEDS AS ASSESSED BY RECORDED MORTALITY AND MORBIDITY AND SERVICE UTILISATION

Disease Statistics

As we have seen in Chapter I, the aim of the sanitary commission reports was to assess disease, sickness and deaths among the different segments of population and its focus was limited to the European population in India. For general population, the data represented mere compilation of figures, without much analysis. It did give death rates and birth rates in different provinces but, it did not provide age and sex wise distribution of these figures.

In spite these shortcomings, the Sanitary Commission reports pointed to the trends that gave useful indication about the deaths and their causes. We have shown from the Sanitary Commission reports that women suffered from malaria, cholera, and
gastro-intestinal problems yet, the British authorities picked up maternal mortality as the single most common reason for deaths amongst Indian women. The reports admitted that women and children were worse affected during epidemics. Even then no special attention was paid to that section of society. Selective focus on maternity was more or less arbitrary and became rationale for establishment of maternity services in the 19th century.

We note that the Sanitary Commission reports till 1890 did not give any data on maternal mortality. Whereas, as early as 1871, the Sanitary Commission report pointed out that women and children of families of the British regiment suffered in greater proportion from cholera. Cholera mortality among women and children of European population was higher as compared to the men. It recorded death rate of 2.45 among the former, and 1.0 per thousand for the later. There is little reason to believe that for the Indian women the pattern would have been different. It was only in 1891 that the special mention was made about the health status of women in the Sanitary Commission report. Here also it was the health statistics of European women that had been talked about. The report took note that among European women also cholera, fever, dysentery, puerperal diseases and rheumatism were major reasons for admission in the hospital. The report admitted that there was variation in the disease pattern in different provinces, for example, Bengal had the highest ratio for influenza, cholera, enteric fever and puerperal affection, and Madras had the highest of respiratory problems, bowel complains. The constantly sick rate was highest in Madras and lowest in Bombay. For European women population the death rate was reported as 17.30 in Bengal Presidency, 12.63 in Madras and 6.54 in Bombay.

Till 1900 these reports devoted very little attention to the male-female ratio or sex wise distribution of diseases and deaths. Till this time, the faulty registration had been the reason for not analysing the data. It was only in 1901 that the Sanitary Commission report provided sex ratio in different age groups and also mentioned regional variation in this ratio. This report not only talked about maternal mortality but also presented comparison between India and England and Wales in two decades, i.e., 1841-50 and 1886-95. Maternal mortality data was published for the first time, though the officials had been saying for more than 40 years that it was the prime cause for deaths among the women of India.
The report for the year 1901 provided mortality rates according to age group. It concluded that where there was early marriage, the female death rate was higher in 15-20 and 20-30 years of age. Drawing comparison with England and Wales it said, "the curve of female mortality rises above the curve of male mortality at the childbearing period". The report indicted that this sudden rise in female mortality curve attributed to maternal mortality, without taking note of the other major killer diseases. The report had taken two different periods for analysing the maternal mortality in these two countries - for England and Wales it was 1841-50 and 1886-96 and for India it was 1891-1900. The report shows that female mortality was higher in India during the said period and it was much higher than the maternal mortality reported in 1841-50 in Britain. The major reason for excess loss of life had been given as early marriage among the native people. This kind of analysis makes little epidemiological sense given totally different conditions of life for women in India and England. To ignore this and compare maternal mortality across countries can create the impression that rates were higher in India without giving any comprehensive explanation of the difference. The reason chosen may be one of the many and was therefore given priority arbitrarily. Secondly, without comparing the proportion of Maternal Mortality Rate with the rest of the causes of mortality, its importance within the Indian context could not be assessed.

The report for the year 1901 also shows that during infancy the male death rate was higher. In the age group of 1-5 years the male death rate was higher in all the provinces except in Punjab. But between the age group of 10-15 years, females in Punjab and Bombay had higher mortality rate than males; whereas in Madras death rate for males and females was same. In the age group of 20-30 years, the female deaths were higher in all provinces except in Bengal and central province. Between the age group of 30-40 years the female death rate higher only in Punjab and Lower Burma. After the age of 40 years, males died at greater rate everywhere, except in Punjab, where after the age of 60, female deaths were higher. This data perhaps reflects the added risks to women due to maternity as well as their inferior social status.

The report of the Army sanitary commission for the year 1885 had given death rates for women and children of the regiment. It observed that the death rate for women and children of the regiment indicated decrease between 1875-1884 (Table 2.1). Among the British women in India, childbirth and abortion had been reported as the chief cause
of death. It stated that, "Among women the chief death cause was child birth and abortion. Enteric fever caused five deaths among 3419 women" \(^{58}\) The Sanitary Commission report for 1891 also reported that mortality among European women was lower than in any year since 1885. "The chief causes of deaths were, in order, puerperal affection, cholera, enteric fever and diseases of nervous system. The chief increase of mortality was in cholera, and the chief disease in circulatory, respiratory, and bowel complaints" \(^{59}\)

Table. 2.1
Death Rate among Women and Children of Regiment between 1875-1884

<table>
<thead>
<tr>
<th>Year</th>
<th>Death Per thousand strength</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
</tr>
<tr>
<td>1875</td>
<td>25.89</td>
</tr>
<tr>
<td>1876</td>
<td>20.83</td>
</tr>
<tr>
<td>1877</td>
<td>22.50</td>
</tr>
<tr>
<td>1878</td>
<td>29.20</td>
</tr>
<tr>
<td>1879</td>
<td>25.00</td>
</tr>
<tr>
<td>1880</td>
<td>21.05</td>
</tr>
<tr>
<td>1881</td>
<td>25.93</td>
</tr>
<tr>
<td>1882</td>
<td>19.78</td>
</tr>
<tr>
<td>1883</td>
<td>21.28</td>
</tr>
<tr>
<td>1884</td>
<td>17.50</td>
</tr>
</tbody>
</table>


For general population, the reports of the sanitary commission for the year 1875 said that mortality among males exceeded than among females (Chapter I, Table 1.4, and pages 87-88). From of report of the Sanitary Commission for 1888 (as also shown in Table1.3), we see that out of the 58,677 registered deaths from cholera, 28,280 occurred among women, i.e., 48.20%; of 204, 561 fever deaths 97,759 were among women, i.e., 47.79% and of 27,721 registered deaths due to bowel complaints, 13,034 occurred among women, i.e., 47.02%. This points to the fact that almost half of the deaths occurred amongst women due to these major causes (Page 88).
The reports between 1871 and 1901, which have been reviewed (and which give only number of deaths and births in different provinces and provide causes of death in these provinces), show that the main causes of death reported were fevers, cholera, dysentery, bowel complaints, rheumatism, skin diseases among natives. The deaths due to puerperal causes were listed last in these reports, whereas for women of the regiment it has been stated as the first cause in the reports for the year 1871 and 1891, and also in the report of the Army Sanitary Commission for the year 1885. There was no special mention of maternally related causes as main reasons for deaths among the female population of India.

It appears therefore that the need to collect information on maternally mortality among general population followed then proceeded the emergence of maternity services. Secondly, the obvious mortality and morbidity among women due to other communicable diseases were sidelined. The official focus on maternity services and, to remedy the situation, efforts were directed towards replacing dais with the trained female medical help.

In fact, it was in 1938 that the Central Advisory Board of Health prepared a report on Maternal and Child Welfare work in India that also gave maternal mortality data. It stated "during 1936, maternal mortality rate recorded in the cities and larger towns ranged between 2.6 and 37.4 per 1000 births". It also stated that, "Sir John Megaw carried out an investigation into certain public health aspects of village life in India by collecting from a large number of rural dispensary doctors (and)...gave maternal mortality rate of 24.5 per thousand live births. During a more recent inquiry conducted in Calcutta, Dr. Neal Edwards found the rate there too correspond with that of General Megaw, whilst in Madras city during 1930-31 Dr. Lakshamanaswami found the rate to be 16.6 per thousand live and still births. An earlier enquiry conducted by the Madras public health department in 1927-28 in four largest municipalities of the province, excluding Madras that the rate was 18.5 per 1000 live birth". These surveys suggest that the maternal mortality rate for this country as a whole was probably somewhere near 20 per 1000 live births, as compared with the 1936 figures of 4.9 per 1000 live births in England and Wales.
A special committee was formed to investigate into the causes of maternal mortality in the city of Bombay that submitted its report in 1941. It reported that, “during the year under consideration 38,243 deaths were registered. The total number of cases of maternal mortality investigated was 525. Of these, ten were not cases of maternal mortality and were therefore omitted... Of these 340 deaths or 66.1% were strictly the result of pregnancy, labour or puerperium and the remaining fell into the ‘Associated diseases’ group. The maternal mortality rate including associated disease is 13.5 per thousand and the rate excluding associated disease is 8.9 per 1000. This figures has to be accepted with reserve for the obvious reason that the registration of births and deaths is still defective...”61 The report accepted that maternal mortality had associated diseases also. In this regard this report stated, “daily experience at medical institution for women reveal a state of malnutrition amongst majority of patients, pregnant and non-pregnant, partly due to ignorance of the principles of dietetics but largely due to poverty”62 The need for free milk supply and nutritional supplements was suggested in the report.

One thing is clear from the official reports that general mortality was high among the Indian women, and it was not only due to high maternal mortality. The other thing that is obvious from the reports is that limited statistics for maternal mortality among Indian women became available only after the maternity services got established. Even in the 20th century, the official reports did not have the data to calculate maternal mortality. The special committees that were set up to investigate into the maternal mortality also sounded caution on the drawn mortality rates. Thus, despite all official intent to reduce maternal mortality colonial India never managed to come to grips with the extent and nature of this problem. At the same time the glaring diseases among women did not get the attention they deserved.

Reflections on Maternal Mortality in the Hospital Reports

The officials and the British women doctors stressed that “it is in childbirth that the full horror of the purdah system is seen, when women are allowed to die undelivered sooner than show themselves to a man”64 We see from the official reports that women had been coming to hospitals and dispensaries. So neither Balfour’s nor British officials’ and women doctors’ impression was confirmed.
Table 2.2.
Stated Causes of Deaths amongst In-door Patients in Two Hospitals of Bombay during 1881-85

<table>
<thead>
<tr>
<th>Year</th>
<th>European Hospital</th>
<th>Jamsetjee Jeejeebhoy Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Deaths (% to total admissions in the hospitals)</td>
<td>Main stated causes of deaths</td>
</tr>
<tr>
<td>1881</td>
<td>68 (4.67%)</td>
<td>Phthisis, disease of liver, malarial fever</td>
</tr>
<tr>
<td></td>
<td>740 (13%)</td>
<td>Cholera, Respiratory digestive problems, Hepatitis, Opium poisoning</td>
</tr>
<tr>
<td>1882</td>
<td>58</td>
<td>Causes not stated</td>
</tr>
<tr>
<td>1883</td>
<td>73</td>
<td>Cholera, Diarrhoea, Dysentery</td>
</tr>
<tr>
<td>1884</td>
<td>65</td>
<td>Fever, Phthisis, Respiratory affection, Dysentery &amp; Liver disease</td>
</tr>
<tr>
<td>1885</td>
<td>81 (5.6%)</td>
<td>21 died of Cholera</td>
</tr>
<tr>
<td></td>
<td>Male-636</td>
<td></td>
</tr>
</tbody>
</table>

Source: Data taken from the Administration and Progress Reports on the Civil Hospitals and Dispensaries under Government of Bombay. (Indian Office Records, London)

Note: The figures given in the reports do not specify anywhere the number of deaths among women patients, except reporting one or two deaths in obstetric wards. This had been attributed to the bad management of labour by the midwives, before arrival in the hospital.

# For the year 1885, total number of deaths among women was 202 or 24.1% of the total deaths. The stated causes did not indicate maternal mortality as one of the main cause of death among women patients.
Examination of reports between 1881-1885 from the two hospitals from Bombay indicated total number of deaths and main causes of death (Table 2.2). Fever, cholera, respiratory and dysentery had been shown as the major causes of mortality in European and Jamsetjee Jeejeebhoy Hospital (Table 2.2). None of these reports have mentioned mortality amongst women separately. Hence, calculating maternal mortality or general mortality for women from these figures is not possible, nor can we assess relative importance of maternal mortality and general deaths in women. Over 1881-1885 the two hospitals show pretty high rates of total mortality ranging between 12.1 to 14.0 percent among indoor patients.

Table 2.3
Stated Causes for Admission and Mortality in Cama Hospital for 1886 and 1889

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number Female admissions</th>
<th>Main causes for admission</th>
<th>Total number deaths (mortality)</th>
<th>Stated causes of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1886</td>
<td>295</td>
<td>Uterine Disease-123, Respiratory affection-37, Scrofula 24, Syphilis 18, Rheumatism 16, LiverDisease 14, Others 63</td>
<td>21 (6.2%)</td>
<td>“Chief cause being affection of the respiratory organs”</td>
</tr>
<tr>
<td>1889</td>
<td>657</td>
<td>1/3 gynaecological cases, Rest cases of digestive problems, respiratory problems and Nervous problems</td>
<td>35 (4.4%)</td>
<td>“Chief cause Tuberculosis and diarrhoea”</td>
</tr>
</tbody>
</table>

Source: Data taken from the Administration and Progress Reports of the Civil Hospitals and Dispensaries under Government of Bombay. (India Office Records, London)

Note: The hospital was meant for the care of women in India. Women were admitted to the hospital with variety of illnesses.
The data from the Cama Hospital for women that was staffed with women doctors however, is more revealing. Table 2.3 shows that this hospital received patients with variety of illnesses and obstetric and gynaecological mortality was not stated as the main cause of deaths among women. It was difficult to derive at the Maternal Mortality Rates, as complete data about deaths and its causes was not available. The obstetric cases constituted 20% of the female attendance as we show later in the next section. Table 2.2 and 2.3 also indicate that women were coming to hospitals largely with non-obstetrics conditions, and number of such cases was more than the obstetric cases. We are not arguing that maternal mortality was not high among Indian women, but pointing out that maternity care alone was picked to address the problem of Indian women, whereas the data from the hospitals indicate that women suffered from other illnesses as well.

Table 2.4.
Number of Obstetric Deaths in Jamsetji Jeejeebhoy Hospital between 1883-1889

<table>
<thead>
<tr>
<th>Year</th>
<th>Total obstetric cases</th>
<th>Natural labour</th>
<th>Unnatural labour</th>
<th>Premature labour</th>
<th>Complicated cases</th>
<th>Caesarean</th>
<th>Total Deaths amongst obstetric cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total cases</td>
<td>Forceps</td>
<td>Version</td>
</tr>
<tr>
<td>1883</td>
<td>173</td>
<td>100</td>
<td>20</td>
<td>---</td>
<td>53</td>
<td>21</td>
<td>8</td>
</tr>
<tr>
<td>1884</td>
<td>172</td>
<td>108</td>
<td>--</td>
<td>11</td>
<td>54</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>1885</td>
<td>153</td>
<td>91</td>
<td>--</td>
<td>23</td>
<td>48</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>1888</td>
<td>222</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>1889</td>
<td>275</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>17</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: Bombay medical department, Annual Administrative and Progress Reports of the Civil hospitals in Bombay presidency (V/24/697, India Office Record, London)
From the Table 2.4, we also find that those who were coming to the hospitals did not get good care. This is evident from the reports of the hospitals and dispensaries. The cases of difficult labour and caesarean ended invariably in the death of the women. We look at the stated causes of death in the obstetric cases in one of the major hospitals in Bombay (Table 2.4), and we see that the operative cases invariably ended in fatal consequences. Even though from a single hospital, the data is indicative of the quality of care. From 1885 on wards there was increase in the number of deaths in obstetric cases.

Thus even though a complete picture of maternal mortality is difficult to drive from the hospital reports yet, it is apparent that, the women came to hospitals with non-obstetric reason. Secondly, the quality of care in the hospitals for obstetric case was not very good as to attract women for treatment. The interventive obstetric care did not always save the life of woman. In fact, the number of deaths increased between 1885 and 1888 in Jamsetjee Jeejeebhoy Hospital that was one of the major hospitals of Bombay (Table 2.4). One can well image the quality of care that was available to women in smaller towns. One more thing that is significant is that Indian women did seek treatment in the hospital, for both general and obstetric help, much before, British women doctors came and started services for them.

This is not to suggest that women did not need obstetric and gynaecological service, but to show that the exclusive focus on maternal care seems arbitrary in terms of concern for women's health though not unimportant.

**Women's Attendance in Hospitals and Dispensaries**

The special services for Indian women by the British women were encouraged on the understanding that the Indian women did not attend hospitals as these were staffed by men. This was one of the main reasons for the establishment of Cama Hospital and of the Dufferin Fund. Balfour and Young had written that Indian women were reluctant to come to hospital for treatment. They had also written that the social status and class of women decided whether they would go to the male-staffed hospitals for treatment or not, but generally women avoided being attended by male professionals.
Many of the British women doctors argued that Indian women did not seek treatment in the male-staffed hospitals and thus died in greater number. They also claimed that Indian custom or religious beliefs debarred Indian women from seeking medical relief from male doctors. Mary Scharlieb remarked that the "great mass of women dislike treatment by the men doctors..." 65 Such claims were not fully true. Data from the official reports on hospitals and dispensaries in Calcutta for the year 1885 shows that "women of all "communities" and regions did seek aid in the predominantly European and male-staffed government hospitals and dispensaries... though women's attendance generally was between 15 to 20 percent of the total attendance. The percentage of population who went to the hospitals was, however, extremely low, at the very most 2.5 percent, and was limited to the urban lower classes and castes..." 66

The official records also did not support the assumption that Indian women did not attend hospitals and dispensaries run by government, and staffed by men. A question and answer session in parliament in 1912 also points out that government was not very sure about the number of Indian women who attended hospitals and dispensaries run by government. Replying to one of the questions by some Mr. Joynson-Hicks on this issue, the official reply stated, "The number of women in India objecting to treatment by male doctors in public hospitals is no doubt large, but I know of no figures by which the statement in the first part of the question can be confirmed or disputed" 67 It does confirm that Indian women came to government run hospital for treatment.

The argument that women shunned male medical professionals also does not stand validated when we further analyse the reports of medical department of Bombay Presidency between 1876-1896 and some of the reports of the medical department of Calcutta. There were quite a number of hospitals and dispensaries in the Bombay Presidency, but three major hospitals have been picked up for the purpose of present research, as the records for these hospitals are available. We have taken European Hospital, Jamsetjee Jeejeebhoy Hospital and Cama Hospital that came up especially for women. Cama Hospital was the first hospital to employ British women doctors. The Cama Hospital is included in the analysis to see whether this special hospital had many more female patients with obstetric and gynaecological problems.
Table 2.5
Number of Patients (In-Patients and outpatients) in Jamsetjee Jeejeebhoy Hospital, Bombay, between 1876-1905

<table>
<thead>
<tr>
<th>Year</th>
<th>Out patients</th>
<th>In patients</th>
<th>Obstetrics cases (in patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Female</td>
<td>% of females</td>
</tr>
<tr>
<td>1876</td>
<td>25494</td>
<td>12651</td>
<td>49.6%</td>
</tr>
<tr>
<td>1877</td>
<td>30975</td>
<td>16049</td>
<td>51.8%</td>
</tr>
<tr>
<td>1878</td>
<td>---</td>
<td>14195</td>
<td>---</td>
</tr>
<tr>
<td>1879</td>
<td>---</td>
<td>11373</td>
<td>---</td>
</tr>
<tr>
<td>1880</td>
<td>---</td>
<td>14266</td>
<td>---</td>
</tr>
<tr>
<td>1881</td>
<td>---</td>
<td>---</td>
<td>31.7%</td>
</tr>
<tr>
<td>1882</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1883</td>
<td>24551</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1884</td>
<td>28942</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1885</td>
<td>29025</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1886</td>
<td>28317</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1887</td>
<td>32567</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1888</td>
<td>37291</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1901</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1903</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1904</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1905</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

Source: Extracts from the Administration and Progress Reports on the Civil Hospitals and Dispensaries under Government of Bombay. (V/24/697-700, India Office Records, London)

Note: Only available data from the reports has been taken. For some the years, the reports were not extensive and did not carry break up of female/male ratio in the hospital. Percentage has been calculated for the purpose of uniformity.
Table 2.6
Female Attendance in the European Hospital, Bombay, 1878 - 1896

<table>
<thead>
<tr>
<th>Year</th>
<th>Out patients</th>
<th>In Patients</th>
<th>Obstetrics- In patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Female (%)</td>
<td>Total</td>
</tr>
<tr>
<td>1878</td>
<td>1204</td>
<td>---</td>
<td>1743</td>
</tr>
<tr>
<td>1879</td>
<td>1483</td>
<td>450</td>
<td>1384</td>
</tr>
<tr>
<td>1880</td>
<td>1395</td>
<td>500</td>
<td>1304</td>
</tr>
<tr>
<td>1881</td>
<td>1283</td>
<td>395</td>
<td>1458</td>
</tr>
<tr>
<td>1882</td>
<td>1159</td>
<td>---</td>
<td>1598</td>
</tr>
<tr>
<td>1883</td>
<td>1074</td>
<td>---</td>
<td>1415</td>
</tr>
<tr>
<td>1884</td>
<td>1415</td>
<td>---</td>
<td>1312</td>
</tr>
<tr>
<td>1885</td>
<td>---</td>
<td>---</td>
<td>1194</td>
</tr>
<tr>
<td>1886</td>
<td>1824</td>
<td>---</td>
<td>1576</td>
</tr>
<tr>
<td>1888</td>
<td>2175</td>
<td>---</td>
<td>1491</td>
</tr>
<tr>
<td>1889</td>
<td>2578</td>
<td>---</td>
<td>1461</td>
</tr>
<tr>
<td>1890</td>
<td>---</td>
<td>---</td>
<td>1233</td>
</tr>
<tr>
<td>1891</td>
<td>3609</td>
<td>1776</td>
<td>1313</td>
</tr>
<tr>
<td>1892</td>
<td>---</td>
<td>---</td>
<td>1881</td>
</tr>
<tr>
<td>1893</td>
<td>3306</td>
<td>---</td>
<td>1894</td>
</tr>
<tr>
<td>1894</td>
<td>3882</td>
<td>---</td>
<td>2039</td>
</tr>
<tr>
<td>1895</td>
<td>3749</td>
<td>---</td>
<td>2037</td>
</tr>
<tr>
<td>1896</td>
<td>3415</td>
<td>---</td>
<td>1879</td>
</tr>
</tbody>
</table>

Source: Extract from the Administration and Progress Reports of the Civil Hospitals and Dispensaries under Government of Bombay (V/24/697-700, India Office Records, London)

Note: Reports for some of the years did not carry the break up of male/female ratio, hence those columns have been left. Percentage has been calculated on the basis of available data.
Table 2.7
Attendance of Women in Cama Hospital for Women and Children, 1886 - 1896

<table>
<thead>
<tr>
<th>Year</th>
<th>Female Out-Patients</th>
<th>Female In-Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>1886</td>
<td>2242</td>
<td>295</td>
</tr>
<tr>
<td>1887</td>
<td>2242</td>
<td>809</td>
</tr>
<tr>
<td>1888</td>
<td>6953</td>
<td>761</td>
</tr>
<tr>
<td>1889</td>
<td>5529</td>
<td>657</td>
</tr>
<tr>
<td>1890</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1891</td>
<td>8761</td>
<td>1076</td>
</tr>
<tr>
<td>1892</td>
<td>9885</td>
<td>1339</td>
</tr>
<tr>
<td>1893</td>
<td>10402</td>
<td>1332</td>
</tr>
<tr>
<td>1894</td>
<td>12336</td>
<td>1381</td>
</tr>
<tr>
<td>1895</td>
<td>11342</td>
<td>1371</td>
</tr>
<tr>
<td>1896</td>
<td>10948</td>
<td>1315</td>
</tr>
</tbody>
</table>

Source: Administration and progress reports of the Civil Hospitals and Dispensaries under the government of Bombay (V/24/697, India Office Records, London)

Note: The hospital was meant only for women and children. The women came to the hospital with all kinds of ailments. Non-obstetrics causes were major reason for admission of women to the hospital.

Tables 2.5, 2.6, and 2.7 show the attendance of women patients in European Hospital, Jamsetjee Jeejeebhoy Hospital and Cama Hospital between 1876-1905. The annual reports of these hospitals indicate that there were significant numbers of women attending these hospitals as out-patients as well as in-patients. It indicates that the female attendance as in-patients varied between 13.2% to 28.5% in European Hospital (1876 to 1896) and between 22% to 30.2% in Jamsetjee Jeejeebhoy hospital (1876-1885). In the outpatient department it varied between 30.3% to 49.5% (highest in 1891) in European Hospital and between 31.75% to 51.8% (highest in 1877) in Jamsetjee Jeejeebhoy hospital. This is not an insignificant proportion.

The reports also mention that women came up in greater numbers compared to children to Jamsetjee Jeejeebhoy Hospital. Surgeon Hughes stated that in Jamsetjee Jeejeebhoy hospital the "...average daily attendance of women has been 73.27, and of children 61.26".

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Cama Hospital came up exclusively, for women and children in 1886. Its aim was to cater to the health needs of Indian women with the help of trained female medical help from Britain. The data from the Cama Hospital indicates that many more women came to hospital with other ailments rather than for obstetric reasons. This also is a pointer to the fact that women sought treatment for other diseases in this hospital, and a much larger proportion accessed services for non-obstetrics causes (Table 2.7).

The data from the hospitals also indicate that fevers, respiratory and digestive disorders were the most common causes for admission of women to the hospitals. As regards Jamsetjee Jeejeebhoy Hospital it was said, “In the women and children out patient department there were 1,263 cases of fever, which on the total 12,651 treated is only 9%. Venereal Disease would not appear to be so common on the female out patient side as on the male, only 500 cases of all cases, syphilitic and gonorrhoeal, having been treated, or 8.9%. Intestinal worms numbered 2,775 cases or 21%, Catarrh contributed 1,579 admissions, Bronchitis 330, Rheumatism 192, Scurvy 196, Dysentery 257, Phthisis 50, Scrofula 149, Constipation 472, dyspepsia 257, Diarrhoea 471, abscess 234, Ulcers 243, Scabies 1,252, Uterine complains 275”.

In fact the European Hospital and Jamsetjee Jeejeebhoy Hospital did not have women doctors in 1870s, even then women came for treatment to these hospitals. The percentage of obstetric cases in the female indoor patients varied between 10.3% to 19.5% in European hospital, 7.4% to 23.9% in Jamsetjee Jeejeebhoy Hospital and 8.3% to 27.5% in Cama hospital (Table 2.5, 2.6 and 2.7). The data points to the relevance of the treatment of other illnesses rather than of obstetric needs alone. The reports also indicate that the percentage of such cases varied between 72 % to 80%.

The report of the European Hospital for the year 1878 indicates that “There were 1,743 in-patients treated…. Of these 1,401 were males, 231 females and 111 children.” The report also indicates that the principal causes of admission were malarial fever, Syphilis, and gonorrhoea; disease of the stomach, bowel and liver; rheumatism and respiratory affection. Eleven cases of enteric fever were treated, of whom seven died. Eight admissions with Cholera reported 4 deaths. The Annual report of the Bombay medical department for the year 1880 makes a note that the number of female attendance has increase over the past year.
The report of Jamsetjee Jeejeebhoy Hospital's indoor patients for the year 1876-77 indicted that, "The proportion of females of the different classes was much larger among the native Christians, being as high as 54% ... The number of Hindu and Muslim females, in proportion to the males, did not vary greatly, being 25% for the former and 23% for the later" 73 As regards outdoor patients the report indicated while Hindu population gives the largest number of in-patients, Muslim patients predominated among the out door patient, 74 but that included male and females patients put together.

In 1877, the obstetric department of the Jamsetjee Jeejeebhoy hospital reported 146 cases of labour, out of this 72 were of natural/normal labour. According to caste/religion, it included 54 Hindus, 42 Goanese, 31 Muslims, 8 Parsis, one native Christian and 10 Eurasian. A considerable increase was reported in the admission of Muslim women in the obstetric department. 75 These reports show that all communities including Hindu as well as Muslim women came to in-patient and out patient department.

We examine here some of the reports of hospitals and dispensaries in Calcutta to see the percentage of women patients in these institutions.

Table 2.8
Female Attendance in Medical College Hospital at Calcutta.1874-1875

<table>
<thead>
<tr>
<th>Total Patients</th>
<th>Total female patients</th>
<th>Europeans</th>
<th>Eurasians</th>
<th>Muslim s</th>
<th>Hindus</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>In patients 4349</td>
<td>1371 (31.5%)</td>
<td>145</td>
<td>441</td>
<td>103</td>
<td>529</td>
<td>153</td>
</tr>
<tr>
<td>Out patients 45,199</td>
<td>7559 (16.2%)</td>
<td>236</td>
<td>1426</td>
<td>1926</td>
<td>3621</td>
<td>373</td>
</tr>
</tbody>
</table>

Source: Calculation done on the basis of data available in the Report on the Calcutta Medical Institutions for the year 1874-75, by R. Cockburn, Calcutta, Bengal Secretanat Press 1875 (610.7 C 126 R, National Archives Library, New Delhi)
The percentage of women as in-patients was 31.5% and as outpatients it was 16.2% (Table 2.8). The reports of the Calcutta Medical College Hospital for the year 1875 indicated that there were 1004 women obstetric outpatients (not reflected in the above Table). Out of the 226 confinements in the hospital, 20 were Europeans, 58 Indo-Europeans and 148 natives. This report remarked that native women had been attending the hospital as in-patients as well as outpatients.

The Report of all hospitals in Calcutta for the year 1891 gave total number of patients in all the hospitals. The hospitals included in this report were Medical College Hospital, Presidency General Hospital, Compbell Hospital, Mayo Native Hospital, Police Hospital, Hawrah General Hospital and four dispensaries in Calcutta (Table 2.9).

### Table 2.9
Total Number of Patients (Inpatients and Outpatients) in all hospitals in Calcutta in the years 1890 and 1891

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1890</td>
<td>2,32,435</td>
<td>1,43,722</td>
<td>33,017</td>
<td>55,696</td>
</tr>
<tr>
<td>1891</td>
<td>2,45,136</td>
<td>1,53,705</td>
<td>34,678</td>
<td>56,753</td>
</tr>
</tbody>
</table>

*Source: Calculated from the data taken from Report on the Calcutta medical institutions for the year 1891. (Home, Medical Proceedings, July 1892, No. 140-143, National Archives, Delhi)*

### Table 2.10
Total number of Patients in the Charitable Dispensaries in Bengal for the year 1889 and 1890

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Patients</th>
<th>Male</th>
<th>Female</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1889</td>
<td>1,269,510</td>
<td>758,276</td>
<td>194,247 (15.3%)</td>
<td>316,987</td>
</tr>
<tr>
<td>1890</td>
<td>1,496,054</td>
<td>853,699</td>
<td>228,555 (15.2%)</td>
<td>353,390</td>
</tr>
</tbody>
</table>

*Source: Extract from the Annual Returns on the working of the Charitable Dispensaries in Bengal for 1891. (Home, Medical Proceedings, August 1892, No.23-26, National Archives, Delhi)*
The reports of these hospitals of Calcutta, (Table 2.9 and 2.10) reveal that women constituted 14 and 15 percent of the attendance at hospitals and dispensaries. The range of illnesses was like that of Bombay hospitals and obstetric related causes formed a small percentage.

Our review of hospital reports (Table 2.3 to 2.10) from Bombay and Calcutta reveals that women were coming to hospitals in significant numbers much before British women doctors arrived in India. They constituted 14.30% of in-patients and invariably, majorities of admissions were for non-obstetric causes. Obstetrics causes constituted 20-30% of the female admissions and interestingly enough this was no different in special hospitals for women as well. The other evidence of female attendance in the hospitals is from the Municipal Commissioner of Bombay. The Municipal Commissioner, Mr. Ollivant once remarked, “Some months ago, when on my morning rounds, I happened to be in the neighbourhood of the Sir Jamsetjee Jeejeebhoy Hospital, and on the invitation of Dr. Arnott, the Surgeon In-Charge, I went over the branch of the hospital set apart for the treatment of women. I must say I was shocked at the facts that were then brought to may notice – at the miserably insufficient accommodation which the place afforded: every verandah, every corner was occupied; even places which were with difficulty screened from the gaze of persons driving along the road close by.” In fact these remarks were made in response to the request made by the hospital committee of Cama Hospital for some accommodation for the proposed hospital, but they point to the fact that women sought admission in the hospitals prior to the entry of British women doctors in India.

This was the scenario in the big cities. In rural areas, where there were no medical hospitals and dispensaries, the people relied on traditional dais and other practitioners of Indian system of medicine. With the establishment of maternity services in India, the role and place of traditional dais became a challenge for practitioners of modern medicine.
THE PLACE OF TRADITIONAL DAIS IN THE MODERN MEDICAL NETWORK OF MATERNITY CARE

Indian women preferred to be attended by dais during pregnancy and childbirth. It is understandable therefore that the British women doctors in the process of establishing themselves in India tried to marginalise dais who played a significant role in the care of pregnant women in India. Training of dais was the first step in this direction. In fact before British women doctors came to India, the male doctors had also tried training dais in hospitals, but these experiments were not very successful.

The efforts in the direction of training of dais bring to light many important issues that are of interest to us. The need for cases for training of students in the medical colleges created pressures for institutionalised deliveries. Not only that, the training schools also enhanced contact with rich gentry that in turn provided opportunity for private practice for the medical men. The report of the Midwifery School at Amritsar for the year 1871 points out that the school provided very good cases for private practice and for the teaching of the students. The civil Surgeon reported, "An important element in our school is the outdoor dispensary for the treatment of females....a daily average of seven females, old and young, (are) coming for advice for general complains. The simple cases are treated by the native doctor, and Mrs. Hewlett, the Superintendent, sets apart those which are considered of more importance..." 77 The report from the civil surgeon further stated that, "These (cases) I have been accustomed to see and prescribe for, at the same time using them for instructions.... I have seen in this way most interesting cases, such as our home professors would be proud to get hold of in their hospitals, and sometimes apparently very respectable females have come seeking relief." 78

The training of midwives ensured regular contact with the cases that could be accessible for teaching medical students in India. The efforts to train midwives started in the late 1860s. In one of the letters the Surgeon General wrote to the government for training of native women in midwifery where he stated that "... A well taught midwife might be attached to a few of the largest and most important dispensaries; she should be thoroughly instructed... at one of the schools before she joins, and care should be taken by the civil surgeon, and sub-assistant surgeon that she keeps up her knowledge.
She would then be useful in assisting them to teach others and in securing bed site teaching in the neighbouring towns, if cases were not forthcoming at the dispensaries...

All the initial efforts for training of midwives were more or less for the acquisition of cases rather than upgrading the knowledge and skill of midwives in modern methods of conducting deliveries. Midwifery training classes provided handy list of cases for that purpose.

With the coming of British women doctors to India the training efforts became much more vigorous. British women doctors also began with the training of dais. but they were keen to train a new cadre of dais belonging to upper class. They believed that the dais in India were ignorant, unhygienic and their methods were barbaric. The dais were blamed for the high maternal mortality. It was most common belief that the Indian women die during pregnancy and childbirth because they have no trained medical help, and most the women avoid being attended by the male doctors in the hospita's. Yet, it was obvious that most women continued to seek the assistance of dais for delivery.

Two things are very obvious from the reports of the hospitals and official records. One, that the dais have been blamed for the mishandling the obstetric cases before these arrived at the hospital, second, that the operations were performed to acquire skills in dealing with such cases in future rather than to ensure life of patients. Table 2.4 throws sufficient light on the outcome of interventions. In 1883, the report of the Bombay Medical Department reported that, "Most of the Obstetric cases were brought to hospital in a critical condition, having been treated in their own homes for days by ignorant 'Dais' and which consequently tends to militate against a successful issue". The report from the same department in 1889 also stated that, " The number of deaths during the year was 26, of which 18 were due to labour (see Table 2.4), nearly all resulting from the late period at which the cases came to the hospital". In 1891, Cama Hospital also reported the same. The report of Cama Hospital for the year 1891 stated, "There were five deaths after parturition, four of which were due to bad treatment by unskilled midwives before admission to hospital, and one was due to embolism". All these indirectly hint that the dais were responsible for wasting useful time at home while dealing with difficult cases.
The difficult cases became case studies for the medical professionals. This is evident from one of the reports of the Jamsetjee Jeejeebhoy Hospital. It stated that it had four cases of obstructed labour in 1885, and all ended in the death of women. The report further commented that, "Dr. Arnott observes with reference to these fatal cases that however unpromising, he acted on the old maxim that no women should die undelivered and that he operated... (as)... it would have been difficult to argue that success was impossible". The experimentation with such cases contributed to the body of medical knowledge, and this is evident from the report of the hospital. The report also stated, "Surgeon Major Arnott makes remarks as regards various obstetrical operations some of which were communicated to the Obstetric Society of Edinburgh, and he observes that certain cases met within Bombay give an invaluable experience, greater perhaps than is afforded by any obstetric hospital at home. Surgeon Major also mentions all the most recently approved practice and some new instruments he has adopted (emphasis added)". There was steady increase in the reported deaths in the obstetric case (Table 2.4), it possibly, could be due to surgical intervention. The reports of the Bombay medical department also pointed out that there were more aseptic rooms in the hospitals than the labour rooms and Lying-in rooms. Craniotomy, forceps and version were quite common, and quite often, dead babies were delivered and mothers had long convalescence.

In the establishment of maternal care services in India, the doctors, both male and female had blamed dais for mishandling the cases. Miss Hewlett, Lady Superintendent of the Amritsar Municipal Hospital remarked, "there is annually a great sacrifice of both maternal and infant life in the province owing to the want by the Dhais, or native midwives, of a proper knowledge of even rudimentary principles of their profession. Great loss of life undoubtedly occurs from the mistakes due to ignorance". Our data shows that women died even in the hospitals in spite of having trained doctors and equipment and instruments to deal with difficult cases. We have seen that these things did not make much difference as far as saving women's life was concerned.

In fact, there were some in the medical field who had appreciated the skills of the traditional dais. Some of the professionals had said that dais were more skilful in dealing with difficult cases of labour. The civil surgeon in the annual report of the Amritsar Midwifery school for the year 1871 pointed out that 'native' dais were very competent to
conduct most difficult cases. He wrote, "I had the opportunity of being present, and saw one of the dhais (dais) conduct the case. This she did well enough, and knew the successive steps in the operation perfectly, but what stuck me was the lack of attention to what may be considered minor point, but on the proper execution of which may depend the life of the mother and child such e.g. as having hot water ready an tape and scissors, binders etc. at hand" 87

In India, the interest in the institutional deliveries was one of the reasons for targeting traditional dais. The medical professionals considered institutional care safe for women. They believed that the institutional deliveries would be able to lower the deaths amongst women. This was not true as also observed by Florence Nightingale for Britain. She estimated institutional maternal mortality as 34 per thousand deliveries, more than seven times higher than in domiciliary deliveries. 88

The training mainly emphasised the aseptic techniques that dais should observe while conducting deliveries. At the end of training each dai was provided with a kit that contained articles for delivery, and the dais had to contribute some money for acquiring the kit and they also had to replace articles after each delivery. This did not encourage many dais. As far as skills were concerned the training had nothing to offer to the experienced dais. These training efforts helped medical professionals to establish themselves and enhanced their professional image. The dais did not gain much from these training programmes, in fact it affected them adversely. They worked under fear of being deprived of their living. There were also suggestions that dais should be fined by the municipality for not reporting the cases in the hospitals. Dr. Balfour had suggested that all dais should be registered by the municipality, their work should be supervised and punishment inflicted for persistent disregard of duty. A duty assigned not for the benefit of dais but for the convenience of women doctors! This system was made operational in one of the hospitals in Bhopal, and Dr. Murphy had reported success of this experiment 89. At some places, the dais were also offered monetary incentives for bringing cases to the hospitals. Dr. Balfour reported that, "a difficulty in the way is the want of clinical material owing to the objection Indian women have for entering hospitals for confinement... (It has been) ...got over in some places by a system of paying indigenous dais 8 annas or Rs.1 for every case (that) they bring to the hospital" 90
Moreover, the *dais* in India, belonged to the lower class and the class prejudices of the British saw them unhygienic and muddlesome. They not only insisted on training of traditional *dais* but also wanted to do away with them. The medical doctors especially, women doctors wanted to train women from the upper class as *dais*. "The case for the abolition of the Indian Dai is this, she is usually ignorant, of a caste that allows her to be dirty and that does not insist on her cleaning herself, and her morals are bad - the whole calling in fact is considered so disreputable that it is difficult to get right class of women to train." 91 Not only in India, the *dais* were subjected to same kind of treatment in America as well. In 1906, a survey was commissioned in New York, which revealed that 90% of midwives were hopelessly dirty, ignorant and incompetent. 92 It is interesting to note that in America midwives were employed by Negros and by the foreign born and the midwives mostly shared the race, nationality and language with their customers.

Thus we find that the aspirations of medical professionals, especially of British women doctors and their belief in superiority of western medicine initiated the training of *dais* in India. They tried to undermine the already existing system without offering much as an alternative. In spite of recognising the skills of the traditional *dais*, the belief in the superiority of ‘western’ knowledge among doctors undermined traditional *dais’* skills and tried to thrust upon them new knowledge.

No one can undermine the importance of asepsis, skilful handling and techniques; all are important in cases of difficult labour for saving the life of women. However, we only want to highlight that the newly learned lessons in the university influenced British doctors so much that they could not appreciate that merely observing asepsis, without skill would also not save the life of a woman or her baby, if in trouble.

For providing good maternity services there were more important issues such as:
1. Tackling the weakness of the indigenous health care personnel, i.e., dais,
2. Providing better maternity care in the hospitals
3. Outreaching services for villages
4. Recognising associated causes of maternal mortality.

Instead of handling these, whatever was done undermined the already existing system. The British women doctors concentrated on clinical maternity care services. The
professional interests of women doctors could not see beyond establishing themselves in the profession. They along with the medical administration not only failed to make use of the patterns of diseases and trends of service utilisation but also interpreted issues rooted in poverty such as poor nutrition and sanitation as cultural limits of the 'natives', particularly women. Thus, while armies were well provided for, the general population was blamed for its illness and tropical climate was held responsible for high burden of disease and death. Though British women doctors came to India as campaigners for Indian women, the overriding professional aspirations made them blind to the real needs of the women and the place health care professionals (dais) had in it.

Hence, we see that the maternity services were started for Indian women, not on the basis of disease statistics that was available in the official reports, but due to other factors that guided the development of these services. The entry of women into the medical field in Britain and the need for employment was one of the major factors that gave impetus to the establishment of services in India. British women doctors not only established services for Indian women but were also instrumental in weakening the already existing system for the care of women in India. The relationship between British women doctors and traditional dais brings to light the pressing desire of the women doctors to transform these traditional dais into their subordinates. The British women doctors, who came to India under professional pressures, were too hard pressed to try out the lessons that they had learnt at the university. Their professional aspirations and personal ambitions contributed greatly in shaping the services for women in India in the 19th century. In the next chapter we focus on the professional and gender conflicts that forced them to come to India and establish these services.

Notes and Reference:

4. Ibid.

223
5. Ibid.
7. Ibid., p. 18.
8. Ibid., p. 19.
9. Ibid.
10. Ibid., p. 18.
11. Ibid., p. 79.
12. Ibid., p. 81.
13. Ibid., p. 31.
15. Balfour and young, n. 6 above, p. 32.
16. Ibid., pp. 84-85.
17. Ibid.
20. Balfour and young, n. 6 above, p. 29.
22. Ibid., p. 417.
25. Ibid., p. 427.
26. Ibid., p. 429.
27. Ibid., p. 431.
29. Balfour and Young, n. 6 above, p. 62.
30. Ibid.
32. Ibid.
33. Ibid.
34. Balfour and Young, n. 6above, p. 33.
36. Harriot Dufferin, n. 35 above, p. 259


40. Ibid., p. 258.

41. Ibid., pp. 177-78.

42. Ibid., p. 258.


44. Lord Dufferin in a General Meeting of the National Association for Supplying Female Medical Aid to the Women of India, 27th January 1886 in *Speeches Delivered in India by the Marquis of Dufferin*, (John Murray: London, 1890).

45. Lord Lansdowne on the occasion of Opening of the Dufferin Hospital at Patiala on 2nd October 1890, in n. 39 above.


47. *Praja Bandhu*, 23 March 1888, quoted in Maneesha Lal, n. 28 above, p. 54.


49. *Indian Spectator*, 4 April 1886, quoted in Maneesha Lal, p. 55.


51. Ibid.

52. Maneesha Lal, n. 28 above.


56. Ibid.

57. Ibid.


59. IOR, V/24/3644, n. 54 above, p. 45.

61. Ibid.

62. IOR, V/25/850/94 (no.29), Report on an Investigation into the Causes of Maternal Mortality in the City of Bombay by Dr. J. Jhirad, 1941.

63. Ibid.

64. Balfour and young, n. 6 above, p. 3.


67. NAI, Home, Medical, July 1912, No. 4 B.


69. IOR, V/24/697, Bombay Medical Department, Annual Administrative and Progress Report of the Civil Hospitals in the Bombay Presidency for the year 1876-77, p. 57.

70. IOR, V/24/697, Bombay Medical Department, Administrative and Progress Report of the Civil Hospitals and Dispensaries in the Bombay presidency for the year 1878.

71. IOR, V/24/697, Annual Report for the year 1877, n. 68 above.


73. IOR, V/ 24/697, Annual report, n. 69 above, p. 47.

74. Ibid.

75. Ibid.

76. Municipal Commissioner of Bombay in one of the Meetings with the Members of the 'Medical Women for India Fund' on 29 March 1883, quoted in Geo. A. Kittredge, n. 31 above, p. 20.


78. Ibid.


82. IOR, V/24/707, Administration and Progress Report in the Civil Medical Institutions in the City of Bombay for the Year 1891.

83. IOR, V/24/698, Administration and Progress Report of the Civil Hospitals and Dispensaries under the Government of Bombay, 1883.
84. Ibid.

85. Annual Reports of the Bombay Medical Department from 1876-1905, that have been reviewed, indicate that surgical interventions were very common in the hospitals, and invariably these resulted in fatal results. Some of the reports have mentioned that complicated cases provided good experience to the medical professionals and these were of great medical value as far as acquiring skills was concerned. Also refer to the quote in n. 84 above.

86. NAI, Home, Medical, December 1887, Nos. 76-78
87. NAI, Home, Public, 14 October 1871, Nos. 65-67
90. Ibid., p. 13

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