DISCUSSION
The chapters of this thesis have tried to look at different aspects of our problem separately only to grapple with details in a less complex fashion. Yet each chapter brings out the relationships within these aspects and their strengths. In this discussion we shall focus on the linkages of professionalisation of women medical practitioners and its politics in British India of the 19th century. We see these as social dynamics of 19th century Britain, the compulsions of British and colonial government, Indian society and political interests of the State, the process of professionalisation and professional relations with health practitioners.

Social Dynamics of the 19th Century

Our data points out that in the making of women professionals the key roles were played by the social dynamics of the 19th century Britain. Women's movement in the 1850s and 60s focused on demands for higher education, employment opportunities for middle class unmarried women and improvements in women's marital status through married women's property rights and the reform of the divorce laws. The demand for suffrage was adopted as an issue in the late 1860s. Women's movement was also questioning the dominant values of a patriarchal society, the constraints of the then existing structures of medical education and gender conflicts within the medical profession. The demand for medical education reflected and complemented the overall 19th century women's movement. The professional women doctors independently and as part of the women's movement, not only pressurised their home government to provide them with openings but also took independent initiatives by joining missionary work or seeking work individually. Thus began an interesting dialectical dialogue between the home government and its colonial wing in India concerning the structure, function and possible utility of health services - based on modern medicine - in India.

Compulsions of British and Colonial Governments

As a result of women's movement in Britain, the home government was put in an awkward situation as women's issues became a subject of debate in the parliament. There were supporters for women's cause within the government. The public opinion was also divided on this issue. The British government could not ignore one third of its members nor could it put aside the demands of women. To maintain a progressive
image of the government, the British State had to respond to these pressures to contain the growing conflicts around gender issues particularly within the medical profession. It, no doubt, had to deal with these issues without disturbing the centrality of its commercial and political interests. The dilemma was resolved by taking recourse to 'acts of welfare' for its colonies. It not only played a crucial role in shaping professionalisation among women medical graduates but also used them for its own political interests.

The demands of the women for medical education and opportunity to practice medicine were the main reasons that brought Indian women into the 'colonial project'. The entry of women into the medical field in Britain had met with opposition from the male medical professionals. The male medical professionals and the medical guild were not ready to accept women as their equals more so as their competitors. British government's concern for Indian women came up when women in Britain got into the medical field and were demanding employment opportunities. In the face of opposition from the male members of the profession and British patriarchal values, political dominance in colonies like India and the poor health status of women offered a way to resolves problems at home. Establishment of Dufferin Fund in 1885 was the first step in this direction.

The colonial government no doubt emerged as a most powerful factor in shaping the role of women medical professionals. It on the one hand responded to military, economic, social and political needs of the home government, and, on the other hand, acquired legitimacy in India. To do that it acquired a certain degree of autonomy that it used to protect the local (colonial) interests. There were times when it disagreed with the home government. The case of government's disagreement regarding merger of IMS (Indian Medical Service) and AMD (Army Medical Department) in the year 1879-80 is one such example. The proposals for amalgamation were found unsatisfactory on both sides. On the British side, because it feared that economic attractions of the Indian services would draw out most of their best men; on the Indian side, because it prevented the promotion of IMS officers to the superior medical posts. 1 "The changes actually carried out fell far short of these proposals. They amounted to partial amalgamation of the military medical administration of the two services". 2 It was only in 1905 that members of both services were made equally eligible for all senior appointments. 3 By and large the colonial government's political and military manoeuvres protected its
economic interest, and its intervention in other fields were subservient to these interests. Though by 1857 it was clear that military power alone was not sufficient to retain control, the welfare of people was not on the agenda of the colonial government. The first Act, i.e., Contagious Disease Act, that came up in the name of welfare was directed towards protecting health of the soldiers rather than for the welfare of the Indian prostitutes.

Colonial government's lack of concern for health of the Indian people was also evident from the handling of epidemics. British commercial interests were by themselves linked to epidemic of plague and malaria in India. For example, construction of irrigation canals and railways led to increase in agricultural production and transportation of raw material for economic gains. It also led to increase in the incidences of malaria among local population. Similarly, construction of railways also made it possible for locals to travel to religious places. This created a market for private railways. While canals and railways helped a few selected sections of the Indian society, for rest of the people it had adverse effects. During these epidemics and even in the interim period there was a marked difference in the way health of the European population in India and the health of the Indian people was taken care of.

Within this scenario, it is not improbable that there is little evidence of concern for the health of the Indian women in the early 19th century. Ensuring health services for Indian women did not, in any way, serve the political and military interest of the government, nor did it enhance government's economic interests. It is no coincidence that the concern for the health of the Indian women came at a time when many of the British women doctors were seeking employment in Britain, and the male members of the profession in Britain were opposing their entry into the medical field. Our analysis of evidence again reveals that State intervention in MCH services were justified because of a series of reasons inherent in the social dynamics of the Indian society and also because of the political interest of the State.

Indian Society and Political Interests of the State

By providing services to Indian women the colonial government projected its philanthropic and humanitarian image. The colonial government capitalised on the prevailing Indian social structure where women had subordinate status and were denied
privileges as available to men. In the name of philanthropy and humanitarianism, poor health status of women and high maternal mortality among them provided justification for initiating maternity care services for Indian women.

The colonial government projected its superiority of knowledge and modernity through the establishment of services for women. The image of the 'modern state' was strengthened by these health care services. The poor status of women became an instrument for establishing British superiority rather than for the welfare of women. The Indian elite too welcomed this move and contributed to this venture in the belief that it would improve the conditions of women. The welfare initiatives were thus able to muster sympathies of Indian elite and the emerging middle class. They also made financial contribution to the cause. This financial support saved state resources without compromising the progressive image of the colonial rule. Hence, local resources were mobilised rather than state investment in the health care services for the Indian women. The Indian elite were also able to further personal standing with the British through contribution to this philanthropic mission. To encourage and recognise the contribution of the Indian elite colonial government developed a system of patronage that rewarded Indians by conferring decorations and titles. Through these health services the colonial state was also able to break social barrier with the aristocracy and the upper caste, and at the same time assert moral and cultural superiority of the British. The missionaries, who initiated this task of breaking barriers with the common people through the services they provided, were seen with some suspicion by the elite. The services by the British women helped the state to counterbalance missionary religious activities and projected secular image of the British rule in India. The other important aspect of the services was that it also served the European population in India whose health was very important for the British administration. Hence, women doctors were used for various interests of the colonial government and at the same time acquired privileges of free education and private practice. The colonial government through these mechanisms not only solved the problems of the home government but also established its humanitarian, modern and secular image. It saved the governments, home government and colonial government, the embarrassment of opposing prevailing values of a male dominated British society yet upheld progressive and philanthropic image by opening up colonies for women practitioners.
The main instrument for achieving this end was the Dufferin Fund. It was set up in 1885 to take care of the health needs of Indian women. Dufferin Fund served an important political purpose for the Colonial government. Through the Fund, on the one hand the government provided a liberal platform for promotion of the interests of the women doctors and on the other, it also ensured control mechanism to not let these women's organisations become autonomous or independent. For example, the hierarchical structure of the Dufferin Fund replicated the power structure of colonial rule. All financial matters and administration rested with the European male members. No woman was member of the central committee of Dufferin Fund till 1909. All matter of appointments of female practitioner, transfers and salaries were rested with the administration where practitioners had little say. Appointments of female practitioners in different hospitals were done with the consultation of the government. Dufferin Fund's office in London exercised its discretion in offering appointments in prestigious hospitals to a few well-connected women.

The government did not want Dufferin Fund to become an organisation that could question the state's authority. It thus exerted full control and pulled up the fund for any sign of autonomy. Thus, the Fund was accused of indoctrinating data in its annual reports and for claiming credit for more work than actually done by the organisation. Dufferin Fund justified inclusion of data from other hospitals to show the extent of medical relief provided by women doctors in different hospitals even if Dufferin Fund had no financial contribution in those hospitals. It is evident that Dufferin Fund as an organisation was keen to show its usefulness in providing employment and relief to Indian women, even if the government wanted to keep it under control by pointing out shortcoming in its working.

By entrusting the work of women's health to Dufferin Fund, the colonial government absolved itself of the responsibility of taking care of the health needs of the Indian women. Under this philanthropic mission, the main concern was to provide employment to British women doctors in India. This is evident from Lady Dufferin's letter where she had mentioned that through the Fund gainful employment was ensured in India as not many Indian women were qualified to enter medical schools for want of basic primary education (see page 279). The colonial government's reluctance to take up additional responsibility of health care for Indian women is evident from the official
records. The government has mentioned that it has never undertaken the responsibility of taking care of the health needs of the Indian women, nor it had any intention of doing so (see page 299). The colonial government's indifference to the issue is also evident from the fact that the government had made no financial commitment to the cause. Yet, it claimed that these initiatives were the result of concerns for Indian women and their health needs.

Without having to spend much on women's health, the state managed to ease pressure on the British government, enhance humanitarian image, come closer to Indian elite, provide gainful employment to British women in India and yet save its treasury.

It is very interesting to note that financial contribution from the Indian people for the first year of the establishment of Dufferin Fund was about £9,900 whereas contribution from its office in England was only £225. Not only that, the Indian maharajas and nawabs had to contributed Rs.5000 to become life members whereas the Viceroy and the Countess of Dufferin Fund contributed only Rs.500 each (see page 287). This shows that with minimal investments the colonial government was able to optimise its political image. Possibly, the experience of Cama hospital kept government out of such commitment. In the case of Cama Hospital, that was established two years before Dufferin Fund, the government had agreed to pay salaries of two women doctors. This was a non-profitable investment for the colonial government. As far as employment of British women in India and the health needs of the Indian women were concerned, the government found it quite convenient to leave this issue to the non-governmental private organisation. It was sufficient for colonial rule to extend patronage to the cause to uphold its humanitarian image and save state resources.

The political link of the Dufferin Fund with India served several purposes for the two sides. Besides bailing out both the governments, it resolved gender conflicts that arose with the entry of women into the male dominated medical field in Britain. It also provided strength to the women's movement in Britain. Often women in Britain used the fact that married women worked in India, to their advantage. They argued that their experience improved quality of care provided by them (see page 248). Young graduates from the London School of Medicine for Women were encouraged to move to India. Dufferin Fund's office at London co-ordinated with central committee of Dufferin Fund in
India for the placement of women doctors in India (see page 284). The Fund was also created to promote indigenous professional growth, especially among women. Though the idea was preached, little was done till late 19th century to actually train Indian women. Only subordinate women workers were actually trained.

The Process of Professionalisation

The process of professionalisation thus had certain specific features for those women who chose to come to India for professional work. One, the female practitioners had state support and patronage in India. Two, they had free education and placement for practice. For example, Madras Medical College opened its door to women students in 1875, when women in Britain were still struggling to get into medical schools. Three, they had status and acceptance within the British community in India whose families they looked after.

On the other hand this support was also accompanied by certain expectations such as: 1) The services by the women doctors were to be confined only to maternal and child care. 2) The women practitioners were to work under the supervision of civil surgeon even when some of them were senior in age and experience than the civil surgeons. 3) Moreover, their placements and appointments were to be done through the government and it controlled the terms and conditions of their work.

The women doctors largely accepted these conditionalities presumably for three apparent reasons. (1) Their education had led them to believe that the place of women doctors was in caring roles. (2) Given the narrow bio-medical perspective, they confined themselves to clinical and surgical practices and had little understanding of the epidemiological issues and social roots of women's health. Thus high levels of general morbidity, malnutrition, anaemias never became central concern for women professionals. (3) They were not necessarily prepared to overcome the cultural and social barriers. In fact there is evidence to show that they had very definite and negative views about the local population.

The medical women among the missionaries were not very different in their actual medical practice and mindset even though they were more accessible and
reached out to poorer communities in far off areas. These two sets of professionals played a key role in the training of nurses and Traditional Birth Attendants (TBAs), in undermining TBAs, in projecting home delivery system as lethal and forcing hospital confinements for training purposes, and in setting up models for the training of women medical doctors.

There were many factors that affected women's health. Prime among them were their poverty, malnutrition and lack of access to specialised services. The undermining of TBAs as a part of modernisation of maternity services did not necessarily help Indian women at large. The impact on the health status of the process of professionalisation of British medical doctors is therefore not to be ignored. Women doctor's pre-occupation to lay claim on 'common medical knowledge', follow code of conduct of the medical guild, and distinctive ethics, all these made women doctors insensitive to the real needs of the Indian women. As Dubey has said that there are three dimensions of a profession and that earns its members special power and prestige (see page 32).

It appears then that as noted by Sharma the value of nobility and traditional of aristocracy played a key role not only as 'ideals', but also as instruments of patronage of the powerful and of professional groups. Alignment with these groups appeared to be a strong aspiration among women doctors aspiring to join the profession. The other aspect of professionalisation, i.e., knowledge, skill and expertise appeared to be less of a binding force. Thus, Sharma's two conceptions of professionalisation therefore are useful but more as phases in the process of professionalisation rather than two independent types of concepts of professionalisation.

Because of their prescribed gender roles and professional aspirations the British women doctors focused on institutional maternal care services. This was rationalised by the general impression that women in India did not seek treatment in male-staffed hospitals (It was also a reason that justified coming of women doctors to India and starting services for women). We have seen from the reports of the hospitals in Bombay and Calcutta between 1876-1900 that Indian women were coming to hospitals and dispensaries prior to the establishment of Dufferin Fund. Our data from these reports show that their attendance varied between 22% to 30.2% (see Tables 2.5, 2.6 and 2.7). We also see that even Cama Hospital, specially meant for women, had only 20%
obstetric related cases and the rest of the cases came for non-obstetric reasons. This indicates that British women doctors' services only concentrated on maternity related problems for reasons other than scientific or epidemiological. 70% of the women seeking help suffered from a variety of general ailments.

Despite the evidence women doctors stayed within the confines of maternity care or at best childcare. This had to do with their professional training and social attitudes that saw women professionals only suitable for roles that were best suited to their feminine qualities — such as care of women and children. This affected women's general health care.

The services started by women doctors were not only hospital based, but also urban centred and purely technocentric. Their belief in the superiority of modern medicine and technological intervention left no scope for appreciation of the skills of the traditional birth attendants even though their new surgical interventions did not always save the life of the women. As discussed in Chapter IV, in one of the prestigious hospitals in Bombay, between 1883 and 1888, all caesarean operation ended in death of women. This hospital was in the city of Bombay. The conditions in smaller towns and rural areas could not have been better. The women professionals criticised "cultural backwardness" of both Indian women and dais, but the poor health of women was never linked to nutritional deprivation and poverty. The professional tendency was thus to ignore social and economic aspects and even epidemiological dimensions and focus on clinical aspects of midwifery and gynaecology.

High maternal mortality among Indian women was attributed to unhygienic handling by the dais. Our data shows that even well equipped hospitals did not save life of the women (see Table 2.4, page 208). We are not against well-equipped hospitals for maternity care, we are arguing that both accessibility and skill and quality of care is important in saving life of a woman. The professional care offered by British women doctors was neither substantial nor was it accessible to majority. Perhaps the main reason of its failure was that it did not get women early enough to prevent complications rather attempted to treat complicated cases in difficult conditions. This shows that the clients became instruments of professionalisation rather than their beneficiaries.
The Dufferin Fund provided professional space to the women medical practitioners. It gave them opportunities to acquire the needed knowledge and experience to be member of medical guild. Dufferin Fund became a vehicle in the process of professionalisation. Women professionals, through Dufferin Fund, were able to lay claims on medical knowledge that had been considered the monopoly of men. This medical knowledge enhanced professional status of female practitioners, as they alone were considered competent to diagnose and treat illness among women. They thus had the opportunity to share the medical knowledge that they had with their male counterparts in Britain as well as in India.

The women doctors’ professional experience was not totally free of gender conflicts. Dufferin Fund maintained the superiority of male professionals. The male civil surgeons supervised the work of women doctors. In some cases junior civil surgeon (both in age and experience) were entrusted with this work. This demoralised the experienced and senior women physicians. Though the number of women practitioners was very small as compared to male professionals, the male professionals rejected their competence and perhaps feared competition. Male doctors claimed in scientific journals that female patients trusted male professionals more than women doctors as far as surgical operations were concerned (see pages 243-44). Even in the case of the obstetrical operations women preferred male surgeons, claimed Lancet (see page 243-44). Gender discrimination within the medical profession was not uncommon. Medical missionary records also have the evidence of gender discrimination within missionary organisations (see pages 135-37). Male professionals in Britain and in India discouraged women from taking up medical profession. Pointing out their shortcomings and their unpopularity with patients were ways to demoralise new entrants in the profession. Lancet and the Indian Medical Gazette repeatedly expressed that women should take up nursing profession if they were really interested to help the humanity. The common argument was that the medical profession was not suited for women as they lacked mental capacity and wisdom to pursue medical profession, and patients also might not feel comfortable with women medical professionals (see page 161). The Government itself subtly supported male professionals and confined women to maternal care.
Not infrequently the professional women depended more on patriarchal structures, social connections (their husbands higher official status) rather than on the collective strength or professional pride.

An interesting aspect of their professionalisation was their own perception of themselves. Unable to break away completely from their own patriarchal value system, deeply rooted in the cultural milieu of British society where women still were responsible for children and for the care of the family as a whole, many lived with a sense of guilt. Perhaps this was a key factor in holding them back from exploring new horizons and stepping out of the prescribed boundaries.

The State as we have seen always turned these contradictions to its advantage. Thus while it let Dufferin Fund and its branches expand, it never encouraged the debates on Public Health, that were there in late 19th century Britain, to take roots in India. While nutritional services, milk supplies for children and antenatal care and post natal care were emerging as key services there, in India the women medical professionals continued to test their skills on serious cases that came in the last stages.

We thus find that professionalisation among women and gender conflicts were closely intertwined both in Britain and India. In the former, linked with the women’s movement the gender conflicts acquired a progressive form and became the impetus for the growth of professionalisation among women. Contrary to this, in colonial India the professional women who came did not become part of a collectivity, nor did they align themselves with the local people. At best they mingled with the elite or the educated middle class. Being ‘professional’ required acceptance by a section and that in itself became primary. They accepted medical definitions of their role despite being a part of broader movement that fought for women’s equality and rights. In need of security, they uncritically accepted the patronage of the state and absorbed the official attitudes towards local practitioners (ālais) and populations (rural and urban poor). As a result they could at best recreate the model of maternal health care that they had learned in their training without exploring the challenge that a totally new context offered to them.
Professional Relationship with Health Practitioners

British women doctor's professional relationship with health practitioners, i.e., TBAs, nurses and Indian women doctors, highlighted the pressing desire of British medical practitioners to establish themselves and to acquire recognition and membership of the medical guild. They adopted the scientific language of the profession, encouraged institutional care, undermined Indian health care practitioners on the basis of scientific rationality, and influenced Indian women to follow their footsteps. As Oommen has said, the manner in which the profession defines their role with other categories would generate both, competitive and conflicting relations. The relationship with TBAs was an example of competitive and conflicting relations. The Indian TBAs were from the lower social classes and the emerging professional class did not want them to be a part of health care system. The professional competition was therefore often couched in contempt for their 'backward' and 'unclean' existence. Their lower socio-economic status, cultural alienation and lack of knowledge of the "modern" became easy toll for dismissing them. It is clear however that a relationship of competition was perceived straight away and right from the beginning. Leslie has shown that association of practitioner and government agencies sponsored and regulated medical services in India in the 19th century but the Indian practitioners as well as Indian TBAs had no such sponsorship.

In order to control and transform the TBAs the British female practitioners initiated training for TBAs based on modern medicine. Apart from a few exception they did not appreciate the techniques and skills of dais. They worked towards training an entirely new class of dais in modern methods. Instead of providing supportive services to help Indian women, they wanted to displace the already existing traditional system that had evolved for maternity care over the centuries. The colonial government supported the professionals in undermining TBAs. In some cases incentive were given to bring cases to hospitals and in other cases fine was suggested for the offenders. Educated Indian elite also shared the view that TBAs were responsible for deaths among women. Yet we know that even in post independent period the modern MCH services have not been able to do away with TBAs.
The relationship with the Nurses was that of accommodation as they were products of institutional health care system. Nurses were trained to complement the health care services, so they were expected to be part of the health care system where they carried out the order of the superiors, i.e., medical practitioners. They were also entrusted the work of training midwives hence they had higher status than the TBAs and trained midwives.

The relationship with Indian doctors brings to light both accommodative, competitive relations. Initially despite all talk of creating local professional women doctors, the Dufferin Fund actually did nothing for encouraging medical education among women. The “cultural backwardness” argument came handy to delay taking up Indian women. In the late 19th century, in any case they were very few so there was no space for conflict. However in the early 20th century conflicts surfaced between British and Indian women doctors with the formation of WMS. The conflicts emerged when issue of placement and services came to the fore.

The history of Women Medical Service and its financing is a good example of the attitudes of the State towards both professional women and public welfare. It also reveals the mindset of the British women doctors. The British women professionals as a group demanded establishment of WMS in 1910. It called for creating a cadre under the government that would employ women doctors and extend all those privileges that were available to the male doctors under IMS, such as salary, leave benefits, pension, etc. The women professionals were demanding consolidation of professional status. The issues raised by women professionals did not touch upon the problems and needs of Indian women for whom services were meant. Nor did they work towards strengthening services and referral links between services in rural areas and in the cities.

In the formation of WMS, the State once again did not want to take up the additional responsibility of women’s employment, hence it decided to provide annual grant to Dufferin Fund and left it to the Fund to draw rules and regulation for the newly created WMS. By doing so, the colonial government was able to keep its control over the service, yet kept itself out of the financial commitment.
WMS did not have much scope for Indian women doctors. The political nature of the WMS is evident in the exclusiveness of its professionals. The supremacy of British women professionals was reflected by the fact that WMS included 25 women doctors and 85% women were British. Indian women protested against this but it took another 20 years for them to create a space for themselves in WMS. Much was said for the medical education and employment of Indian women, but little was done towards this. Professional aspirations of British women doctors were central in the establishment of WMS.

The practices introduced by the British doctors had a significant influence on the education of different categories of health professionals. Indian women doctors also followed their footsteps as they were trained within the same bio-medical frame. All this led to the decline of the traditional knowledge system and a culture based practice. Instead of making it a starting point, developing systems of detecting high risk cases and providing timely support, the professional doctors undermined the skills of TBAs and used complicated cases for experimentation with newer evolving technologies.

While British women professionals criticised "cultural backwardness" of Indian dais and Indian women, the State added on its own explanation rooted in the notion of racial inferiority (see page 250). Thus instead of helping doctors to shed their biases it in fact reinforced them.

While maternity was the main area where the state provided work for women doctors in 1880s, yet for the process of control maternity care itself became the cause of derecognition of Indian medical degrees. All through 19th century, General Medical Council (GMC) had no problem as far as standard of medical education in India was concerned. But in late 19th and early 20th century, when Indian doctors started going to Britain for higher degrees and competed with British doctors in the civil services that concern about standard midwifery training arose. 9 This indicates that GMC maintained its control over medical education and sympathised with British medical professionals.

Thus we see the emergence of women medical professionals in 19th century India as a product of the dynamic interaction of British and colonial states, movements based on gender issues in the west, and state strategies to deal with the conflict around
these issues in different situations. We have shown that while the primary concern of the state remained political, military and economic to develop its capitalist economy at home, it made use of various dimensions of the colonies. It capitalised not only by transforming their economies into providers of raw material but by using its traditional feudal structures and institutions to act upon (like sati, women's status, health, etc.), it also established its cultural superiority and scientific base. The medical services and technology that they introduced in India, however, were not necessarily accessible to the vast majority of its poor. It was technocentric, rooted in bio-medical and clinical framework and therefore failed to either comprehend the totality of the medical dimensions (classical epidemiological perspective), or saw the link between poverty and disease (social epidemiological perspective). Lata Mani, through her debate on Sati, has shown that general belief that colonisation brought with it more positive reappraisal of rights of women does not signify concern for women. 10 Similarly, starting services for women does not indicate that taking care of health needs of Indian women was central to these initiatives.

Hence, the reasons why MCH services remained restricted in India over the 19th century perhaps lay in the following:

a). The government hedged from investing in it over the 19th century. It was happy with the little that could be used for propaganda.

b). Medical education focused on bio-medical teaching with little focus on public health and organisational issues.

c). The women doctors came here and assumed "cultural superiority" and did not reach out to the people like the missionaries did. Language and cultural barriers only accentuated the gulf.

d). Last but not the least, the personal ambitions and dilemmas of the British women doctors always held them back.

This has lessons for contemporary maternity services. Except for the first two plans where the effort was to achieve universality and equity MCH became an instrument for the State to acquire family planning targets. Its access was confined and its approach purely technocentric. This reflected the vision of the upper and the middle class. With the introduction of health service reorganisation the commodification of medical services has been even more rapid. They are being transformed into tools of
profit making. Studies of privatisation show that maternity homes constitute one of the most imminent profit making institutions and therefore top the list. The concept of reproductive health care too has been decontextualised and in the new setting it has been transformed into fertility control toll rather than women’s health.

Exploring the contemporary issues of health services and women’s health we are arguing that the nature of the present crisis of health care system is rooted partly in the middle class perception of priorities in health and partly in the state policies. Given their status and position in society, where large chunk of welfare services come easy and they get used to the conveniences, such as cheap drinking water, roads, electricity, housing (for government servants), sanitation, these services are treated as rights rather than privileges. At the same time the lack of similar services for the other sections is interpreted as an outcome of their lack of education, poverty and ignorance, and their failure to access services.

The case of 19th century was not very different. The difference was that the space of the middle class was occupied by the richest sections of the Indian aristocracy and by insignificant proportion of the upcoming middle class. Our data shows that health services expanded for the rulers. Private practice was a rule even for those who worked in the state-controlled hospitals. Actual beneficiaries of the services were kings, princess and the Indian elite.

There is thus a thread of continuity in the biases that services have in favour of the upper middle class. This continuity shows the state’s affinity towards this class and sets tendency to blame the poor for its own failures. In other words not much has changed even now as the interests of the middle class and the elite dominate state policies. The visible gaps between the reality of the majority and the perception of the policy makers are rooted in the continuity of an ideological understanding and the social backgrounds of the contemporary policy makers and providers.

We have argued that the shifts in strategies of the state towards women’s health today recreates the images of the colonial past where addressing the miserable conditions of the women became instrument for the state to resolve some of its own conflicts. While colonial policies were shaped by their own political and economic
interests, the social scenario in India (the low status of women, emerging middle class and a section of Indian elite subservient to the British) made it possible for the state (the political guardians), missionaries (moral guardians), and professionals (scientific guardians) to undermine the indigenous practitioners and to supplant a service structure that refused to either recognise the epidemiological realities (socio-economic roots) and develop a modern services sensitive to women's needs or develop links with the prevailing practices of birth and delivery care to improve them. These trends need to be intercepted if change in the health conditions of women is to be visualised and benefits of development have to be shared by a large numbers.

Notes and References:
2. Ibid.
3. Ibid., p. 304.
5. Sharma, S. L., 'Trends in the Study of Medical Profession in India', In Sheo Kumar Lal and Ambika Chandani (eds.), Medical Care: Reading in Medical Sociology, (Jainsons Publication: Delhi, 1987). Sharma offers two conceptions in the emergence of professionalisation, i.e., idealistic and operational. For details refer pages 30-31.
6. Sharma also opines that two conceptions of profession emerged from two separate contexts-Western-European and Latin American. In his analysis it appears as if in the ideal conception power has no role to play. Our review and analysis show that traditional distinction between based on role and status began to break down with time, and with the establishment of institutional care.


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