REVIEW OF LITERATURE AND CONCEPTUALISATION OF THE PROBLEM
There is need to understand the available literature on women's health, women medical professionals and health services and factors that influenced these in the colonial period. This will help conceptualise the role the British women doctors and their professionalisation played in the evolution of women's health services. This also requires some exploration of the social processes that prevailed in the 19th century and influenced the 20th century.

Without any attempt at a complete historical review we selectively focus on areas that are of primary interest to us (women's health, women health professionals and the emergence of health services organisation in the colonial period), and contextualise them in the political and social history of the period.

In the Indian context, colonial roots of the political and economic development/underdevelopment has been subjected to analysis by a wide range of scholars, while social history is a rather late development. Social history focuses on the importance of the experiences of different groups of people as an area for historical investigation. It covers a broad terrain that includes all aspects of society and social organisations including medical institutions and manpower.

Some of the well-known critiques of colonialism, especially its impact on the economic development help us understand the context in which women's role was shaped. These scholars have addressed the question of commerce and how it affected the cultural and socio-political matrix of the 19th century India and that influenced 20th century developments significantly. They have addressed the changes in legal and administrative structure that came up during the British rule, and how these affected different sections of the society. R.C. Dutt periodizes the British plunder into different stages, and points to the consequences of the agrarian policy. ¹ Dadabhai Naoroji's drain theory speaks of 'material and moral drain' of resources. He endeavours to prove that colonial economic drain was oriented towards capital development. The capital moved out of the country and the Indian industries were mainly confined to the production of raw material to meet the needs of the British companies. ² Rosen shows that in the post independent period market forces dominated the direction of growth. For example, expansion of textile industry took place during the Second World War in
response to the demands created by war. This expansion was followed by a decline after the war as not only the demand dropped but the government also introduced licensing policy for import of new machines and price control. 3 This shows that the economic activities of the colonial period directed economic growth in post independent India.

The construction of irrigation canals and the railway lines during the colonial rule were directed towards large-scale commercial interests. Whitcomb highlights that irrigation work was a large-scale commercial activity, the provision of protection against drought being a somewhat subsidiary consideration. 4 Water rent was calculated after each harvest, and with the increase of production the farmers were to pay correspondingly higher water rent. 5 Similarly, the introduction of railway was in the interest of Colonial rule and the interest of the British companies, as these connected interiors with the ports to carry raw material outside India. Railways not only reshaped the pattern of Indian foreign trade, these also provided a boost to the British economy. 6 Commercialisation of agriculture, with the introduction of railways and irrigation canals brought about far reaching changes in the Indian economy. It also changed the consumption pattern as the income was spent on the consumer goods. 7

Bagchi takes a much broader view and looks at the political economy of under development of the third world. His analysis points out that historical changes can not be explained without bringing in the understanding of conflicts between capitalist and workers, capitalists and landlords, national and international capitalist interests. He argues that it is important to pay particular attention to pre-capitalist relations of production even when dominant relations are capitalist in nature. 8 Irfan Habib also highlights the importance of pre-capitalist relations of production. 9 Bagchi argues that it is necessary to take into account the social and political structure of the third world countries in order to place them relative to the advanced capitalist countries with whom they have had many decades of relationships of dominance and subordination. 10 He highlights the chief methods of exploitation that have been used by the capitalists - both foreign and indigenous - in order to accumulate capital. During the colonial period, the Indian industrialisation was thwarted through the policy of 'one way trade', stunting Indian capitalist class by means of political and racial barriers against their entry into business. Bagchi also points out that the state's apparatus balanced the interests of the
landlords, monopoly of professional classes and collaborationist elements in the upper classes. Hence, government policy was never radical enough to release agriculture from the conditions of semi-feudal bondage, and lay a firm base for assured growth.

Some scholars have shown that though colonial policy had some concern for indigenous people, it did not envisage a process of economic growth for them. Colonial policies rarely proposed economic progress for the indigenous people. These aimed at the development of natural resources of the colonies for their own countries' benefits. British adopted a policy of 'discriminatory intervention' in India, in the name of laissez-faire that encouraged investments in areas that were profitable and ignored those areas that were not profitable. "The state guaranteed investment in railways and irrigation companies, the extraordinary measures were taken to provide incentive to production of raw material like cotton...", argues Bhattacharya. Whereas, "the government refused to interfere in food grain movement in a period when India was going through a cycle of famine. Mukerjee also highlights the impact of railways on Bengal economy.

Within this broader process of economic development, the nexus between science, technology and society in India is of interest to us. Scholars such as Chattopadhyay, Rahman, Sangwan and Deepak Kumar have contributed to our understanding of the role of science, technology in the social process of transformation. Others like Ramasubban, Arnold, Catanach, Harrison have focused on the history of medicine, particularly on the response of the colonial rule to different diseases and epidemics and introduction of modern medicine. Very recently feminist have started to explore the relationship between the women's movement in the west and the strength it gathered from the social reforms initiated by the western women in the colonies. All these studies point to one thing that the historical insights are very important to understand the contemporary issues.

In addition to this set that analysed the British colonial policy, social history began exploration of historical experience of various groups of people. Social reform in the 19th century, use of science and technology to fulfil imperial agendas and study of disease and response to different diseases began to occupy centre stage in historical research.
There are many historians of social legislation and educational reforms in relation to women, yet there is relatively less work on the relation between colonial intervention in the form of land revenue settlement and local patriarchal relations. The compulsion of colonial rule to extract surplus and create classes conducive to its rule led in part to an aggravation of existing unequal relations within many sections of Indian society. Bagchi has also shown that state apparatus balanced the interest of the landlords and collaborationist elements in the upper classes, the reforms also helped only certain sections of the society, especially the powerful sections. Chawdhary, taking example of Haryana, points out that there existed complex inter-relationship of contest and collusion between indigenous patriarchal norms and those held by the British administration. The interest of British administration is visible in the colonial regulation of agrarian relations while it granted certain rights to widows in the interest of revenue collection, the administration was anxious to discourage them from availing of these very rights at the same time. Telengana peasant struggle in Hyderabad also highlights the nexus between administration and the native rulers, and it replicated unequal agrarian relations.

Chakravarti traces the colonial and indigenous construction of a Hindu-Aryan identity of women as part of her exploration of social history of the 19th century. She points out that the entire focus of 19th century was on high caste Hindu women whether it was to highlight her high status in the past or reforming her low status in the present. She situates 19th century historiography of women within cultural and ideological encounters between England and India and shows that what was gradually and carefully constituted in the interaction between colonialism and nationalism is now deeply embedded in the consciousness of the middle classes. The ideas of the past have assumed the status of revealed truths. Taking Ramabai's life as an example, she shows that in the late 19th century women who had the courage to express their views were seen as 'betrayed' of culture. Ramabai's conversion to Christianity became betrayal of 'religion' and of nation. Branding her as a betrayer was intended to marginalise her as a person as well as to suppress her critique of Hindu society. The colonial structure of power in the 19th century compromised as well as learnt from the indigenous patriarchy and upper class norms and practice.
Mani through the debate on *sati* shows that the conception of tradition that Rammohan contests, and orthodoxy defends is one that is especially 'colonial'. Through her work she shows that historical analysis of 19th century social reforms clarifies the continuation and discontinuation in the ideologies of colonial and postcolonial debate of women. She points out that it has generally been accepted that colonisation brings with it a more positive reappraisal of the rights of women but stresses that though women became critical matter for public concern, it does not signify concern for women. The women's question was a central issue in some of the controversial debates over social reforms in the early and mid 19th century, but by the close of the century there was sudden disappearance of such issue from the public debate in Bengal. Chatterjee highlights the role of nationalist agenda and the scope of women's issue within it. In order to lend force to nationalism, the ideology of motherhood was given enormous importance. The glorification of motherhood, based on the philosophy of deprivation, kept most women out of the privileges like education, etc., and made it difficult for them to exercise their choices. Sen also shows that the health needs of the Indian women were assessed from the perspective of western women and focus remained on hygiene and good mothercraft. Economic and social history review shows that the scholars have highlighted the impact of British rule on economic and social sphere. Women's issues were thus central for colonial rule to reinforce their 'moral' and 'cultural' superiority. The weaknesses in the Indian social structure, especially the lower status of women provided psychological advantage to the colonial ideology and helped the rulers to assert their moral superiority.

Within social history other than the situation of women, the place of technology and its handling by the colonial government is also of relevance to us. Science in popular tradition has been considered objective, apolitical and neutral, so is its very use, i.e., technology. It is often believed that technology is fine but it is the use we put it to that defines the outcome. This perception was legitimised for medicine too which was considered apolitical in nature and structure and not embodying any ideology. Historians and feminists have demonstrated the role of science, medicine and technology in establishing and maintaining the positions of dominant sections. Exploring literature on medicine we find that scholars like Mckeown and Rosen have questioned the use of science and technology in western context. Mckeown's study of population decline contests the role of technology against supply of food grain that led to decline in death.
rate. Questioning the use of science and technology as a part of colonial agenda, Habib and Raina point out that while focusing on introduction of modern science in India, it is important to pay attention to traditional Indian society. They argue that Modern science and the social discourse of the 19th century were infected by the scientific imperialism and there existed a close relationship between science, politics and culture. The colonisers were fully aware of the importance of science as effective instrument of colonisation and control. The scientific concepts and its use were very closely related to the need of the empire. In order to legitimise their own rule they delegitimised and condemned several pre-colonial structures. Indians were declared unscientific, superstitious, and their sense of superiority came from the western discourse on rationality and progress. Kumar highlights the use of science in different fields, such as agriculture, geographical exploration, communication, scientific education, etc., to show that these were to maintain position of dominance and for facilitation of economic gains and as well as to project an image of a progressive nation.

Roy Macleod and Milton Lewis see western medicine as a cultural force. They point out that medicine, in its conceptual, professional and political dimension, is both shaping and shaped by cultural circumstances that surrounds it. The image of medicine as morally neutral which merely uses effective techniques for curing disease and reducing suffering has been questioned.

For quite sometime, medical history dwelled upon history of disease and efforts to conquer the diseases itself, ignoring political and cultural environment of disease. Sigerist, Virchow, Dubos, Rosen and Mckeown have highlighted the importance of socio-political environment in which medicine is used and practised. Rosen shows that “the impulse to sanitary reform did not come from the medical professionals, even though some physicians played a significant part in calling attention to the community problem of ill-health. Furthermore, medicine had little real knowledge to contribute to the problem, which concerned the transmission of communicable disease....Broadly speaking, what happened was that the founders of modern public health, accepted certain postulates of economic and social policy, established institutional forms that would serve later to implement more accurate and effective medical knowledge”. 45
Medical historians have begun to move away from an exclusive attention to medical theory to, the political and economic dimension of medical activity. Medicine and the treatment of disease is seen as structurally embedded in political thoughts. Hence, 'medical imperialism' has a great meaning in the imperial history. "If imperialism means extension of international system of domination-by economic, cultural, or political means-it is clear that medicine has a place in this definition". "If the history of imperialism in medicine can be taken to comprise the expansion of medical attitudes, beliefs and practices to non-medical domain then history of medicine in empire refers to the complementary history of medical regimes as participants in the extension and consolidation of political rule". Rammsubban, Arnold, Harrison, Zurbrigg have used this premise for historical analysis of epidemics and other disease.

They all have pointed out that colonial medicine grew in direct relation to political, commercial and military expansion of the imperial rule in India. 'Colonial medicine' was the professional activity of the 'colonial medical service', which in turn formed the arm of colonial authority. The colonial medical service grew serving imperial military, political and trading interest, and only slowly did it move towards the needs of the local people. Medicine was a 'tool' of empire, a term used by Daniel Headrick, as primarily served the imperial interests.

Medical doctrine and public health administrators followed the policies, which sustained European control, and which primarily focused on disease which affected the economic activity of the entire population. The health of the indigenous people inevitably remained subordinate to the economic and political interests of the government. Thus, some scholars have given an account of public health in India, others have confined themselves to the study of a single epidemic, aiming thereby to expose the conflicts and tensions revealed by a society in crisis. There are still others who have framed their enquiry in terms of 'political economy' of health and disease and sought to relate incidences of disease and the allocation of health care resources to the political and economical structure of colonial rule. Demographers like Clarke presented history of Indian mortality by showing that infrastructural development for economic development paid higher human price than realised.
Harrison gives an account of public health in British India and raises a question that whether slow progress of public health in India was inevitable, given practical constraints on reforms. He stresses that the best possible was done under the circumstances. His account of public health services and Indian Medical service is extensive, but does not relate to the political economy of the time. He points out that the financial constraints were immense in the expansion of education, public health and Indian Medical Service. Jeffery recognises administrative and financial constraints of health policies in India and points to the practical and logistic difficulties. Anil Kumar's work on British health policy covers different aspects of British medical policy in India from medical education to the establishment of hospitals, to the response to different diseases and epidemics. His work explores how the new medical system made its way through new educational policies and institutions. He presents the chronology of these developments and highlights the dynamics that were at work.

Ramasubban, Arnold and Zurbrigg look at the political economy of health in 19th century India. Ramasubban points out that after independence, the challenges confronted the government were to overcome the contradictions of the colonial legacies. This historical continuity is reflected in the public health measures that were still confined to the control of epidemics and crisis management; medical research policies were ad hoc and were decided under the pressure from medical profession, hence, remained exogenous in origin. Ramasubban is critical of the government's failure to introduce sanitary reforms in India in the 19th century, as done in England. In India the new medical advancement were selectively introduced in the interest of the European population.

Arnold focuses on history of medicine and diseases in the 19th and 20th century, especially on specific diseases and medicine as a site of contact and conflict. The main concern of his work is not so much with the disease and medicine as with their instrumentality. His study shows that medical intervention against small pox in the 19th century was "expression of a colonial situation which the administration was culturally and politically remote from the lives of its subjects". Vaccination against small pox met with same kind of experience in Europe as well. Yet, the reluctance of the Indian people to seek vaccination was seen as a sign of ignorance and backwardness. Though there
were technical and practical difficulties to make vaccination operational, the administration choose to ignore them and blamed local practices.

Catanach’s study of plague epidemic in 19th century India highlights tensions of the empire as it seriously affected international trade. Plague epidemic revealed western medicine’s crisis of confidence, as it had no answer to its causation and prevention. The solutions suggested were administrative rather than medical. Enforced segregation, hospitalisation of the suspected plague case led to unrest amongst the local people. Ramabai had also criticised the government on this account. Example of small pox and plague are useful in the understanding of today’s context where government draws policies keeping in mind the professional needs and the administrative solutions to medical problems.

Disease was a potent factor in the European conceptualisation of Indian society. The Europeans were proud of their scientific understanding of disease even though, it did not help in combating disease in many cases. They saw Indian response to disease as fatalistic, superstitious and barbaric. In the wider context, disease became a part of condemnation of Indian ‘backwardness’, and growth of scientific medicine was a sign of technological superiority. Illness among local people fostered growing sense of their innate racial and physical superiority. In lunatic asylums, where Europeans were kept, a strict segregation was maintained on class lines. Discriminatory treatment for patients of different classes was one of the features of lunatic asylums. Repatriation Policy allowed transfer of mentally ill back to Europe. It was to avoid cultural mixing and also that failure in life (such as inability to earn, mixed marriages, dropping out of army etc.) was seen to have bad influence on the whites. Waltraud Ernst shows that transfer of mentally ill to Europe can be seen as a device used by colonial authorities in cases where a European’s presence in India was seen to be highly undesirable.

Indigenous people suffered as a result of the economic policies of the authorities. For example, in Punjab where Jamuna canal was built for irrigation and to combat drought, fever accounted for overwhelming majority. The highest death rates from fever were recorded in the districts of Punjab that were served by the lower reaches of western Jamuna canal. Zurbrigg has questioned this notion of deaths due to disease and argued that these were malnutrition deaths by showing that it was not availability of
quinine but famine relief measures that brought down death rate in early 20th century. She highlighted the fatal consequences of malaria during 1880s and 1890s and shows that high death rates reflect a general underlying stress from the dramatic shifts in the agricultural economy under the impact of soaring exports of food grain. The railway links helped in transportation of food grain despite fall in production due to droughts, thereby reducing the local food grains stores. The poor peasants suffered the most, as they had to go without food during bad harvest and related high prices. She quotes from the report of the Punjab sanitary commission to show that the poor and the landless were the worst sufferer. She shows that "the (high fever mortality rate)... is the result of the widespread poverty and distress for food which have reduced the bodily strength of the people to such a degree to render them incapable of resisting the assaults of any disease ...(sic)". The economic policies created more health problems for the people rather than solving the problems. Despite reminders from local officials about the need for relief, the authorities failed to take note of people's suffering till revenue from agriculture were affected. In fact tropical climate was held responsible for the diseases that occurred as a result of socio-economic policies. Famine was not so much about the shortage of food, as it was with the lack of purchasing power of labourers and small landholder due to failure of cash crops in case of droughts.

The above works highlight that western medical discourse occupied an important place in the process of colonisation. Western medicine grew in direct relation to the political, military and commercial expansion of the British rule in India. The health of the indigenous people remained subservient to the needs of the empire. "Public health services developed only because officials fostered them. Almost the whole range of municipal services were evolved in response to pressures from the British official rather than as a result of the desire of the people". Despite the medical professionals' preference for hospitals, dispensaries began to flourish in India, though they hardly met the health needs of the Indian population. This had to do with the professional needs of the newly graduated medical men and also to cater to the needs of the European officials at the smaller towns.

It is search for similar linkages in the area of women's health and the growth of professional women doctors that we extended our review. As we have already pointed out, child bearing and maternity was main focus of women's health. The studies in this
area can be classified into three categories: a) studies focusing only on evolution of MCH service, b) studies focusing on providers of health care, and c) studies contextualising services in the colonial frame.

Studies Focusing on Evolution of MCH Services

Sub Committee of the National Planning Committee (NPC) or Sub-Committee on National Health or Sokhey Committee, Health Survey and Development Committee generally referred as Bhore Committee, and scholars like Borkar, Dutt have focused on the evolution of maternal health services. The sub-committee of the National Planning Committee pointed out that infant mortality and maternal mortality in India was subject to wide margin of errors and did not reflect the real magnitude of the problem. Their focus on maternal and infant mortality was mainly in terms of damage to the future race and of continual loss of national efficiency. NPC in one of its resolutions in 1940 had urged integration of curative and preventive functions in a single state agency. The Health Survey and Development Committee submitted its reports to government in 1946 and the guiding principles adopted by the Shore committee emphasised that no individual should be denied medical care and it should be available to all. Both these committees urged a very high priority for maternal and child health services in the development of health services in India. Bhore committee pointed out that the maternal mortality in India was somewhat near 20 per 1000 live births. It estimated that in British India, maternal deaths total annually about 200,000. It also remarked that the number of women suffering from varying degrees of disability and discomfort as a result of child bearing must be very large. It estimated that number of such women could be anywhere near four millions. Having made crucial observation about the determinants of health status, the recommendations focused on essential services for women and children. The Bhore committee remarked that "the health of the people depends primarily upon the social and environmental conditions under which they live and work, upon security against fear and want, upon nutritional standards, upon educational facilities and upon the facilities for exercise and leisure. We shall not consider the problem here in this wider aspect but shall confine ourselves to the question of essential services to protect the health of mother and children". The committee emphasised the need for women health personnel to provide services to women and children in the rural population.
Dutt shows that till 1931, maternal and child health work was a totally voluntary work. In 1931, Madras was the first state to set up a special section of M& C. W (maternal and child welfare) in Public health department and appointed an Assistant Directress of Public Health. In 1931-32 Dr. A. L. Mudaliar undertook study on maternal mortality in Madras at the suggestion of the then Surgeon General of Madras. An Advisory Committee on Maternal Morbidity and Mortality was set up in association with Indian Research Fund to advise on research into the problems connected with maternal morbidity and mortality. In 1933, the All India Institute of Hygiene and Public Health at Calcutta started D.M.C.W (Diploma in Maternal and Child Welfare) course for women doctors in association with the Lady Dufferin Fund. Dutt also gives an account of committees that were set up in Madras, Bombay and Calcutta to investigate into the incidence and causes of maternal mortality. 77 He also shows that it was in 1938 that maternal and child health work was integrated into the health services and there were about 800 maternal and child welfare centres in 1938, though these remained poorly equipped. All the above studies and reports of the committees highlight evolution of MCH services.

Studies Focusing on Providers of Health Care

Arnold and Harrison have made some reference to the establishment of services for women from the 1860s. Arnold observes that "Women's health was given less consideration before 1860s and 70s, but thereafter it assumed prominent and emblematic position in debate over the nature and authority of western medicine". 78 In a male oriented and male dominated system women appeared only as adjuncts and appendages to the health of the men. Contagious Disease Act of 1868 had direct bearing on the health of women, it was designed to address the problem of venereal disease among British soldiers.

Arnold, Harrison, and Macleod and Lewis, observe that from the 1860s Christian mission were established with the aim of getting access to zenana. Women missionaries were used to enter zenana where no male outsider was allowed. Education and health services were employed as means to get access to the hearts and minds of secluded women. 79 Baru provides a list of women missionaries who came to India in the second
half of the 19th century. She highlights that missionaries’ hospitals came up in those states where there was good infrastructure support available for their activities.

The most striking feature of maternal care services was the attempt to replace or reform the traditional birth attendants. In an attempt to incorporate women into medical discourse, the women doctors defamed Indian dais. In order to get cases for medical education, first the male doctors and than the British women doctors worked towards training of dais.

From the 1870s, first through missionaries and from the 1880s, through Dufferin Fund, British women doctors came to India and set up a net work of services for Indian women. Maneesha Lal highlights the role of State in the establishment of these services. Dufferin Fund, having state’s patronage provided easy passage for British women doctors. Being a philanthropic organisation it was able to muster support from the Indian nobles who contributed generously to the cause. The state had left it to the non-governmental organisation like Dufferin fund to take care of the health needs of Indian women.

Some scholars have questioned the narrow focus of policy makers on maternal aspect of women’s health. Oakley and Graham’s work show that development of specialisation within medical science and professional interests of the medical professionals were instrumental in picking up pregnancy and childbirth as an area for medical intervention. Medicine is not simply a science, as pointed out above, it has a social context. How the scientific knowledge is used depends upon the social diversity of medical practitioners, hence involves values, argues Jordanova. Loudon shows that development of specialisation within the medical field from the 19th century brought maternity care under its fold, and development of male midwife was the first step in this direction. From the 1880s, surgical intervention or ‘operative obstetrics’ attracted medical professionals and more over attending certain number of cases became compulsory to be registered as medical practitioner, hence maternity service became important for professional reasons. We take up studies in professionalisation separately later.
There was another aspect that has been important in the establishment of maternity services i.e., women’s entry into the medical field as a result of women’s movement in the west. Drachman shows that in America women entered medical field as result of women’s movement and not for economic gains. Drachman and B. Harrison show that women doctors actively campaigned against patriarchal structure of society and stressed that 'women's nature', i.e., physical and mental weakness were socially constructed images. Brain Harrison shows that opponents took recourse to scientific explanation to dissuade women from taking up medical profession.

Lewis focuses on the child and maternal welfare movement in Britain that was endorsed by politicians from all political parties, members of the medical professionals and women's groups in early 20th century. She shows that though the women's groups, such as Women's Co-operative Guild (an organisation of married working-class women), had campaigned for paying greater attention to the needs of the women, the aims and concerns of the policy makers and of the women who used the services differed widely. Her work highlights the gap between the official policy regarding maternal and child welfare services and women’s demands. Interest in child and maternal welfare began with the recognition that infant mortality was a problem of national importance. Concern over efficiency first arose when attention was drawn to the poor quality of army recruits. The appointment of an Inter-departmental committee on Physical Deterioration that submitted its report in 1904 stands witness to this. The report devoted much attention to the welfare of infants and school children, recognising that it was in the national interest to safeguard the next generation and thereby improve the quality of the race. The loss during World War I further increased the importance of infant life, and maternal and child welfare work was extended to include antenatal care.

Since the British government was concerned about the need to improve the quality and quantity of the population, maternal and child welfare was measured purely in terms of mortality statistics. The demands of the women’s groups for policies to deal with low levels of nutrition and to afford medical treatment came into conflict with the perceived responsibility of the state, as state chose to concentrate on work place and schools. Attitudes and policies concerning poverty also ran counter to the demands of the women’s groups for direct economic assistance. Despite the gulf between the demands of the women's groups and the official definition of what constituted a child and
maternal welfare service, women did welcome the services that were offered. 93 Lewis also highlights that in prescribing middle class ideas of responsible motherhood, child and maternal welfare policies often discouraged already existing pattern of mutual aid between women. 94 For example, health visitors acted as advisors in place of grandmothers or elderly neighbours. Lewis also shows that professionals and policy makers have always tended to abstract childbirth from the fabric of women's lives. 95 The maternal welfare policies actually created the needs they set out to meet. For example, the professionals advocated institutional care as the best care during childbirth to lower mortality.

In the Indian context, some scholars have focused on the complementary role that western women played in the process of imperialism. Barbara Ramusack examines the activities of British women in India and highlights how categories of race and gender influenced the efforts to promote social reforms within the imperial relationships of dominance. 96 Though the British women had genuine concern for Indian women and started social reforms for them, middle class British women did not view the women of the east as equals. They viewed them as unfortunates, as those who needed help of their British feminist 'sisters'. 97 Through out middle class feminist discourse 'Indian women' served as evidence of British feminists' special imperial 'burden', and imagining the women of India as helpless colonial subjects, the British women constructed "the Indian women" as a foil against which to gauge their own progress. 98 The middle class British feminist identified with and complemented the British imperial mission. Burton in her recent work relocates British feminist ideologies in their imperial context, the language of imperialism - cultural superiority, political trusteeship, and sheer Englishness - is evident in the British feminists' projects on behalf of Indian women. 99

Studies Contextualising Services in the Colonial Context

Through linking up dissimilar areas of women's health, these studies bring out close linkages between socio-economic and political process and the emergence of women's health services. The work of Banerji, Qadeer, Sathyamala, Rao, Lal, and Doyal contextualise the development of health services in colonial context. 100 The close link between the needs of the empire, the evolution of and implementation of health schemes and the interests of the professionals and the British administration is evident
through their work. Banerji highlights the forces that led to establishment of services in colonial period and how these have influenced the establishment services in independent India.\textsuperscript{101} The infrastructure development, medical education and research, all these point to the continuing trends that have its roots in 19\textsuperscript{th} century.\textsuperscript{102} Banerji points out that the British rulers formed The Indian Medical Service to serve as the backdrop of colonial pattern of the health services. The very process of health service development based on a monopolistic control of the IMS had a contradiction built into it. The new medical graduates started to resent this as they were denied access to the key positions in the public institutions. The government in independent India decided to abolish the cadre of the IMS without having any alternative all-India cadre of health services which could effectively meet the challenge of the rapid qualitative and quantitative expansion of the health services that followed Independence.\textsuperscript{103}

Within the overall scenario the services for women came up not because of the poor state of health. It had a colonial context. Qadeer shows that the British rule was trying to resolve increasing conflicts in the colonies as well as at home, and saw maternal care services as an instrument rather an objective. These services encouraged institutional care, and marginalised traditional dais.\textsuperscript{104}

The socio-political context of population policies and birth control movement from the early 20\textsuperscript{th} century had similar moorings. Rao examines the Malthusian writings and locates the philosophy in a socio-political context. He shows that the Malthusian philosophy provides serious misleading explanation for Indian poverty. Population growth is seen as the main reason for poverty in India, and the explanation of this causal relationship had full support of the colonisers and of the leading sections of the Indian society.\textsuperscript{105} The world’s first government birth control clinic was started in 1930 with the full support of Indian elite. In 1933 birth control clinics came up in state hospitals in Madras. Bombay also followed the example and set up Family Hygiene Society in 1935. These efforts of the population lobby were consolidated in the 50s. In 1952, Margaret Sanger, founder of American Birth Control League and Lady Rama Rao of All India women Conference launched the International Planned Parenthood Federation (IPPF) in Bombay. IPPF has been major force in the population control movement across the globe. Rao shows that neo-Malthusian thrust in evident in the official policy and programmes of the government.\textsuperscript{106}
This was the socio-political context of health care professionals, especially women healers. Sathyamala shows that witch burning was a part of larger socio-political changes. The women who were seen to challenge the control of the state were persecuted. This had significant influence on women healers. From mid 19th century, the British medical professionals marginalised traditional birth attendants or dais. Their need for clinical experience and practice was so much that they could tolerate no competitor. Dufferin Fund in India was established primarily in response to the need for employment of the British women doctors that put political pressure on the establishment. The Fund not only provided employment to British women professionals, it also resolved gender conflicts at home that came in the wake of women's entry into the medical profession.

All the above work suggests that colonial health policies were guided by its own political and economic priorities. Western medicine and health services were very much a part of the colonial agenda. Western medical discourse was a tool that projected superiority of knowledge and progress made by the colonial government. Handling epidemics and public health reforms both were guided by the political and economic compulsions. The scholars who have focused on the women's question have either focused on social reform in the 19th century, or on the maternal and child welfare movement in 20th century Britain or India. They show that there was a wide gap between the needs of Indian women and the demands made by the British women's groups and the policies of the respective states. Health services and maternal health services were part of a much larger colonial agenda that needs exploration both at the country level and linkages between the two countries.

Studies on Professionalisation

To grasp the complexities of maternal health service development and British women's role in it, we also have to understand the process of professionalisation itself. The contour of professionalisation was not yet clearly articulated in 19th century India. To understand the emergence of professionalisation Sharma offers two conceptions – idealistic and operational. The idealistic conception defines professionalisation as "an occupation, altruistic orientation and a code of ethics for its practitioners."
emphasised the desirable dimensions of professionalisation. The operational conception according to him emphasised on the process of emergence of groups. It deals with the ways in which practitioners "lay claim to monopoly, autonomy and authority". These two conceptions of profession according to Sharma emerged from two separate contexts – Western-European and Latin American. Sharma argues that according to Western-European context, the professions emerged as modern substitute of values of pre-industrial code of guilds, values of nobility and gentlemanliness and traditions of aristocracy. While in the Latin American (underdeveloped societies) context, professions, class and power structures were closely linked. In this analysis it appears as if in the ideal conception power has no role to play. However, Mckeown shows that, "although the training of physicians, surgeons and apothecary changed little during the eighteenth century the traditional distinction based on role and status began to break down" with time. Originally this division had little basis in the experience or competence. "It was the building of hospitals during the eighteenth and nineteenth centuries that eroded these differences and replaced them with a new distinction between those who had a hospital appointment and those who had not", argues Mckeown. He further shows that, "by providing common basis for training and registration the Medical Act of 1858 and 1886 finally removed the long standing division between physician, surgeon, and apothecary. But by this time the new, ...distinction between consultant and practitioner was well established. It was a distinction based, not on material differences in experience or competence, but on hospital appointment". Thus the status of practitioners depended not so much on their professional qualification and experience as to the place of work and the fees they received. Mckeown also shows that, "the evolution of the relationship between GP (General Practitioner) and consultants shows that this distinction began long before it was justified by the state of medical knowledge; it also suggests that exclusion of GPs from hospital was not a logical development, but resulted from the fact that before eighteenth century almost all practice was domiciliary, and as hospitals developed there was a strong competition for appointments in which, inevitably, not all were successful. This indicates that even within Western Europe, the class and power structure had a significant role to play, and this dialectical relationship was not confined only to third world countries. This fluid nature of professionalisation within the medical field had significant role in chalking out the terrain for women medical practitioners.
The present literature on professionalisation helps define it and understand the historical roots and internal dynamics within medical profession as it evolved.

Professions are occupations with special power and prestige. According to Dubey there are three general dimensions of a profession "which may be classified as cognitive (knowledge, techniques, training and skill), the normative (service orientation, distinctive ethic, self regulation) and the evaluative (comparative status, autonomy and prestige). A profession is distinct from other occupations in that "it has been given the right to control its own work". Not all occupations are viewed as profession. Central to the concept of profession is its concern with the professional nature of an occupation. "The manner in which the profession define their role relations with colleagues and other occupational categories would give both to accommodative, avoidance, competitive and conflict relations" shows Oommen.

Moreover there seems to be substantial variation in the 'status' and style of functioning of professionals depending upon the nature of political system in which they work.

In the Indian context also, association of practitioners, i.e. of practitioners of 'modern medicine' and government agencies were formed to sponsor and regulate medical services. The institutional network of teaching, research and publications expanded in India. These expansions radically accelerated the professionalisation process based on standardisation of university education for physicians, thereby hampering the growth of indigenous medical systems.

Jeffery locates allopathic doctors in India in terms of their social organization and values and considers the attempts that were made to secure and extend their autonomy and monopoly in the early 20th century. He argues that nascent professionalisation on the model of the developed countries was discernible in India by 1920s largely as a result of sponsorship of British doctors and by the Imperial state.

The British government in India created different cadres of medical profession to draw on state resources. The licentiates trained in allopathic medicine were a product of such a policy. Murleedharan focuses on the role of imperial state in deciding the
professional identities of Indian private practitioners in the early 20th century. He points out that Madras Medical Act of 1914 aimed at improving the status of 'qualified' western medical practitioners. He argues that growth of licentiates has to be seen against this background, as it was the direct result of the government policy to develop a cheap health care. Under the policy of the colonial state, licentiates though provided cheap medical care, but were denied opportunities for promotion because they were not qualified as graduates who occupied such a position in the government. 127 "Thus, the licentiates working under sub-assistant surgeons felt not only 'overworked' but also saw themselves as being left with avenues for higher medical education closed and with stagnant status and prospects". 128 "The avowed policy of the government of Madras to develop an independent medical profession remained at best a pious hope. It left the independent medical profession, which consisted of largely licentiates, highly dissatisfied and a disgruntled lot. There was a bitter rivalry between them and graduates. The licentiates whose services were utilized to fulfill the object of minimizing the government’s expenditure on health care often found themselves highly discriminated". 129

The internal dynamics of the medical profession and supremacy of male medical professionals has marginalised midwives and their practice. Childbirth became a medical concern because it afforded medical men the opportunity to dominate the formerly female field of midwifery. 130 Loudon, Oakley and Graham have shown that development of specialisation within medical field from the 18th century brought maternity care under its fold (see page 26). Professionally, lying-in hospitals brought immediate rewards to doctors, clinical experience gained in hospitals was invaluable in man-midwives’ private work. Not only this, with the patronage of the state, these self-styled experts in childbirth demanded superordination of status. 131 As a result, the second Medical Registration Act of 1886 introduced midwifery into the basic medical curriculum. By contrast, the midwives found their subordinate status confirmed by the 1902 Midwife Act that put majority of medical men on the council responsible for training and registration of midwives. 132 DeVries’ study of contemporary midwives in Great Britain, Australia and New Zealand shows that “the current status of midwives in each country is a product not only of physicians status and interests but also of economic development, social stratification, government structure, the timing of regulation, the degree of integration with British medicine, and geographical barriers to health care delivery". 133
Carpenter focuses on the subordinate status of nurses within the British health care system, and Oommen sees Doctor-nurse relationship in India not only determined by the health care system but as a produce of wider societal attitudes towards women. Nursing profession is seen as an extension of domestic caring and loving role of women into public sphere.

Gender typing of specialties for women professionals has been the focus of study of some scholars. Lorber points out that in US women are urged to enter specialties with higher interaction with patients such as pediatrics or psychiatry because such specialties are felt to be compatible with their interests and nature. She also observes that women physicians are underrepresented in the upper echelons of medical profession and finds that conventional explanation invariably have been their commitment or relegation to family responsibilities and their lesser motivation to achieve high status. Chidambaram observes that though the percentage of women doctors has increased in India, women are still underrepresented. She focuses on the relationship between institutional process of closure, women's preference, and shared cultural notion of femininity, masculinity and medical expertise. She highlights that sex typing of task within medical profession did not merely reflect attitudes of male colleagues and educators. Women doctors themselves advanced arguments that women were best suited to caring for women and children. Another guiding principle in the choice of specialties was the perceived capability between occupation and family role. Elston investigates how far the recent increase in women entrants has led to reduction in gender segregation within the profession in Britain. Her analysis of changes in the medical labour market constituted by NHS indicted that new cleavages and internal differentiation have been developing, some of which have different implications for women and for men. There is a real possibility of widening of the gap between ‘practitioners’ and the mainstream positions both in general practice and hospital medicine.

Our previous research shows that maternal health services in India started from the middle of the 19th century by the British women doctors who came to India to fulfil their professional aspirations. The gender conflicts within the profession in Britain did not provide opportunities for women doctors. Though the colonial state did not take the responsibility for the health of the women, the initiatives had the state's patronage. Like
in any other sphere, impressed by British achievements the Indian elite lent a helping hand to these initiatives. The process in the establishment of maternal care services involved formation of a Fund, institutionalisation of care, training of personnel, mobilisation of resources and public support. The state and the British women doctors played a key role in this process. Their role needs to be further explored and analysed to understand the continuities and discontinuities between the past and the present. It is hoped that the historical interlinkages that we are interested in will throw light on some of the problems that plagued the present services.

CONCEPTUALISATION OF THE PROBLEM

Our review and M.Phil work indicates that the policies of the colonial government were mainly in the interest of the empire. It had great influence on the social, economic and cultural life of the people. We have seen that in the field of health, the concern was mainly for the welfare of the European population in India, yet it projected an image of the well wisher of the indigenous people. In the emergence of services for Indian women in the 19th century the State had played a significant and crucial role. The state pursued policies that were in the interest of the government, helped professionals to gain experience and employment, resolved employment problems at home and yet justified presence of British rule in India. The British women doctors from mid 19th century established health services for women in India. Here was a colonial government that was politically powerful, having Indian collaborators, i.e., Indian elite. And there was home government that was put in a strange situation by pressure from the women’s groups for employment opportunities, and on the other side was equally strong opposition from the male members who did not want women to enter medical profession. The women’s movement in Britain, professional aspirations of women doctors, and the gender conflicts within the medical profession forced colonial government to use its privileged position in India and justify setting up services for women in India. The process of setting up services for women affected the traditional birth attendants who were marginalised. In the establishment of services the State, medical professionals, missionaries and the Indian elite have played a crucial role. These key actors had an important role in moulding the shape of maternal care services. Even though the roles played by these actors were not necessarily complementary, the contribution of each
was important and crucial. We propose to study each of these and see how they influenced each other. It is the dynamics of these relationships that are of interest to us.

Role of State

The British presence in India was mainly for economic gains. The policies were moulded by a combination of strategies to enhance revenue and encourage particular kind of production to maximise their profits. In the process they introduced new system of revenue collection, modified old system which in turn changed the land relations to a great extent. Their new political and economic arrangement produced a deep impact on the social life of the Indian people.

To begin with, women were of little concern to the British. Very little change took place in their favour even in the area of public sphere. In the area of personal law, many reforms were introduced, but economically and socially, women remained disadvantaged. Yet British government supported the establishment of maternity care services for women.

It would be relevant to focus on the role of state in the establishment of services. How and what did the state gain politically and economically by extending its patronage to these services. The sudden interest in the health needs of the Indian women has also to be located in the social circumstances that were putting pressure on the government at home, i.e., women's movement and gender conflicts within the medical profession that had to be resolved somehow. It needs to be explored that how much the services had to do with the real needs of Indian women and how much did social circumstances and pressures at home influenced these initiatives of the state. Very often government initiatives were meant to resolve conflicts other than those arising out of women's health. For example, professional interests of male doctors in Britain, gender conflicts within the profession and the need for expansion of medical professional groups shaped the course of events in India. It is not surprising thus that epidemiological basis for starting these services were lacking and services had very little do with the needs of the majority of women.
Role of Missionaries

Missionaries and the colonial rule had many interests in common. The two groups kept out of one another's way, yet separation could never be complete. Missionaries could not exist in India without the permission or at least connivance of the government. Missionaries had a wide range of activities from education, social welfare to the health care services. Missionaries and the State shared complementary relationship. State kept distance from the missionary's activities for political reasons yet their support was important for the colonial government. We have noticed that Christian missions were established with the aim of penetrating zenana, using women missionaries to enter that area in Indian homes where no male outsider was allowed. This, combined with the fact that women had begun to study medicine in England, induced missionaries' societies to send out medical women to India. Evangelisation was the aim, and the mission hospitals were means of opening doors that would otherwise have remained shut. It would be worth exploring the contribution of missionaries in opening up spaces for British women doctors and in the establishment of maternal care services.

Gender Conflicts within the Medical Profession

The changing social circumstances and women's movement in Britain made it possible for middle class women to seek education and demand rights such as property rights and participation in political matters. Education gave them personal confidence and economic opportunities allowed women to take advantage of the larger social changes. Some of the middle class women in mid 19th century sought admission to the medical schools. This led to opposition from the male members of the profession. Gender conflicts within the profession and the professional aspirations of the women necessitated that the government took steps to resolve these conflicts within the profession. The most practicable solution that state could come up with, was to provide opportunities for women in the colonies, where it had political advantage. The state patronage under the influence of women's movement led to the establishment of services for women in India. It would be interesting to focus on the dynamics of professionalisation that were at work in the establishment of these services.
British Women Doctors as Professionals and as Individuals

British women doctors played a crucial role in the establishment of health services for women. They were not only the key actors but also an important link between State, Missionaries and the Indian elite.

These professionals not only legitimised modern midwifery but also became emissaries of the imperial government for the princes, the Nawabs and other elite. In addition, they played a key role in giving a modern and philanthropic image to the colonial government. In this process did they succeed in changing the existing providers of maternity care, did they succeed in setting up a sound need-based service? These are the areas that our research explores. British women doctors' influence on the professional content of maternal and child health services, their influence on Indian women doctors, and their ideological vision, perceptions, and values are some other areas that we explore here. These British women doctors also played a key role in influencing the public opinion about training Indian women doctors and became instruments of training nurses and Traditional Birth Attendants (TBAs).

While British women doctors chose to move to colonies under professional pressures they were not free from personal dilemmas. It is interesting to note that a society (British) that accords secondary status to women, allowed women to move to far off places in search for experience and practical training and employment. The other pressures must have been much greater to allow women to take such a step.

This thesis locates British women doctors in the larger socio-political environment. The effort is to understand professional aspiration of women doctors and the ensuing gender conflicts that forced them to move to colonies, i.e., to India, and see their influence on the Indian women doctors, traditional birth attendant and the evolution of services for women. The dynamics of relationship between colonial government, government at home and British women doctors is the central focus but intermediaries like Indian elite, TBAs, Missionaries make important links within this complex social process. While we look at larger socio-political factors, women doctors' personal dilemmas are not overlooked. These professionals as women had been squeezed
between personal ambitions and domestic obligations and that too affects their roles as creators of maternity services in India.

**Role of Indian Elite**

Colonial rule could not survive in India without the support of Indian elite. The emerging middle class got a chance to have education in the west and they were impressed with the achievements of the British administration. Whether it was commercial activities, social reforms or the medical work, the Indian collaborators were necessary for colonial rule in the realisation of their goals.

Our review shows that Indian elite had a crucial and important role in the establishment of services for women, whether these were started by the missionaries or by the Dufferin Fund. Moral support and monetary help from the Indian elite had been very significant for all initiatives of the colonial government. Apart from this, believe in the superiority of western medicine gave boost to the services started by the women doctors in India. Indian women educated in Britain were also instrumental in propagating the need for trained women doctors. For the Indian elite philanthropy and medical patronage were means of buying influence, prestige and even political recognition from the colonial regime. Indian elite advanced their personal standing with the British by providing funds for the hospitals and dispensaries. We explore the role of Indian elite in the establishment of maternity services in India.

**OBJECTIVE OF THE STUDY**

The objective of the study is to examine the dynamics of the emergence of services for women in the 19th century India with a focus on colonial politics, professional interests of women doctors, the ensuing gender conflicts at home and in India, role of missionaries, Indian elite and traditional providers of services.

These main objectives will be divided into the following sub objectives:
1. Emergence of health services by missionaries and the State.
2. British women doctors - their medical training and entry into Indian as professionals.
3. Professional conflicts due to gender biases and personal dilemmas.
4. The intervention of the State and the influence of traditional providers of health and Indian doctors.

SOURCES OF DATA

It is a study that attempts to understand the sociological aspects of the emergence of maternal health services within a historical perspective. The research requires going through historical material, i.e., government reports, official correspondence, missionary records, private papers of government officials and of women doctors. Along with that secondary literature has been consulted.

LIBRARIES AND ARCHIVES CONSULTED

Apart from the published work in different libraries, the following libraries were consulted for primary material.

1. National Archives, Delhi
2. National Medical Library, Delhi
3. Central Secretariat Library, Delhi
4. Nehru Memorial Library, Delhi
5. National Library, Calcutta
6. State Archives, Calcutta
7. Library of Asiatic Society, Calcutta
8. India Office Records, London
10. Library at School of Oriental and African Studies, London
11. Library at School of Tropical Medicine, London
12. Wellcome Institute of History of Medicine, London
13. Library of the Royal Free Hospital and School of Medicine, London
15. National Library of Medicine, Mary Land, USA
ANALYSIS

Using our conceptual framework the analysis focuses on the processes and the determinants of Maternal Health Services in India. The primary data with the support of secondary material has been structured in the following format, which forms the chapters of this thesis.

1. Evolution of Health Services in 19th Century India
2. Missionaries and Medical Work in India
3. Entry of Women into Medical Profession in Britain
4. Making of Maternity services for Women in India
5. Professionalism and Politics of Gender in the Medical Field in the 19th Century

TIME PERIOD

It has taken two and a half years for collection of data for this research, i.e., from June 1995 to December 1997. Analysis of and writing of this thesis has taken about two years and eleven months' time.

LIMITS AND FOCUS OF THE STUDY

We are asking certain sociological questions of contemporary importance, hence the effort is to trace back the roots of our research question rather than provide full historical information of the period. We have used the historical method for analysis, but we do not claim that ours is a comprehensive historical study. The use of historical methods provided a valuable instrument for deriving sociological insights that are of interest and importance for contemporary issues in public health.

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74. Bhore Committee, n. 72 above, p. v-vi.
77. Dutt, n. 72 above, pp. 98-99.
78. Arnold, n. 70 above, p. 254.
79. Ibid., p. 256.
81. Ibid.
83. Ibid.
84. Our M. Phil Work entitled 'Women, Medicine and Society in 18th and 19th Century- A Focus on India', Jawaharlal Nehru University, Delhi, 1995, highlights that the British women doctors and the missionaries set up net work of health services for women in India in the 19th century.


92. Ibid., p. 15.

93. Ibid., p. 20.

94. Ibid.


98. Ibid., p. 137.


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104. Qadeer, n. 100 above, p. 269.

105. Rao, n. 100 above.

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108. Guha, n. 82 above.


111. Ibid.


114. McKeown, n. 112 above, p. 10.

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116. Ibid.


118. Ibid., p. 107.


120. Sharma, n. 110 above, p. 112.


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127. Ibid.


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132. Ibid.


135. Ibid.
138. Ibid.
140. Our M.Phil research highlights that the British women doctors came to India to fulfil their professional aspirations as they faced opposition from the male professionals.

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