Chapter I: Colonial Constructions of the Indian Nurse

The contours of contemporary nursing have been shaped by both the modernisation and professionalisation of the occupation. Understanding the historical evolution of nursing therefore, becomes essential to understanding the complexities of the profession in contemporary times. Women practicing medicine during colonial India is a well researched and documented field, however, most scholarship have focused on either exceptional women, who fought against all odds to become doctors, or the hereditary midwives (dais) who became the central figure in the female medical discourse that developed from the latter half of the nineteenth century. The field of gynecology and obstetrics in both pre-colonial and colonial India was the forte of the dai. Colonial medicines attempts to infiltrate this field did not meet with much success as it could not successfully undermine the centrality of the dai in Indian women’s lives. Though women doctors, trained in western medicine attended to childbirth, it was the nurse who was responsible for postpartum care, and this directly pitted her knowledge and skills against the dai. My chapter focuses on the construction of the trained nurse, who I argue, was perceived as central to undermining the dai and increasing the sway of colonial medicine over the Indian sub-continent. European women, who functioned as nurses were far and few between and the nursing occupation, had very few takers amongst Indian women. For the smooth functioning of the colonial medicine apparatus, it was imperative that more Indian women enter nursing services. Indian nurses had limited opportunities in the field of nursing as racial prejudices of European nursing leaders and the colonial government did not allow for career growth. Early in its history in the sub-continent, the profession became associated with low-caste, working-class women and majority of Hindu or Muslim middle-class women stayed away. Coeval with this was the continuing presence of the dai in colonial hospitals and private residences. There was an ever growing social and occupational separation between trained nurses who were superior professionals, usually European or native Christian women, and the lowly dai, carrying
old associations of caste pollution and new pejorative associations of superstition and ignorance. The call for registration and professionalisation then had two aims—to disentangle and distance the trained nurse (modern, western, scientific) from the dai (primitive, eastern, superstitious) and to make nursing a respectable profession so as to attract a ‘better class’ of (and therefore upper caste) Indian women. In this chapter, I explore the emergence of the nurse within the matrix of the female medical discourse with the dai as her referent point.

**Colonial Medicine and Indian Women**

Indian women’s health was never a priority with colonial government till the 1870s. The only exception was the Contagious Disease Act of 1868, which did not focus on women’s health, but the health of European soldiers. It was brought into being for control and surveillance of Indian prostitutes, so that their European clients could be protected. Though various reasons have been cited for the growing visibility of reproductive health of Indian women in colonial medical discourse from the 1870s, it is generally accepted that this discourse was restricted only to the zenana woman; the working class was left out of its ambit.

David Arnold argued that hegemonic aspirations of the colonial medical apparatus made it imperative to include women’s health in its agenda. The zenana was perceived as an uncolonised space full of political intrigue, which needed vigilance and had to be brought under civilising rule of the British.\(^65\) Janaki Nair argues that the zenana was vulnerable to the infiltration by the white woman via education and medical help.\(^66\) Alison Bashford claims, that apart from its political significance, medicine also had a modernising mission—to civilise savages—by transforming, altering, modifying their domestic and


\(^{66}\) Janaki Nair, 'Uncovering the Zenana: Visions of Indian Womanhood in Englishwomen's Writings, 1813-1940', *Journal of Women's History*, 2, 1, Spring 1990.
intimate habits. She argues that sanitation in the realm of the domestic in the nineteenth century, and infant and maternal welfare in the twentieth century, had as its central organising node the figure of the western trained nurse.⁶⁷

Despite its hegemonic aspirations, colonial medicine initially ignored women’s bodies, especially in Bengal, where midwifery training and infant mortality rates were never given much importance. Indian women too, did not take to the colonial medical apparatus as smoothly as was expected. Roger Jeffery argues that women were induced to come to hospitals in exchange of a payment, so that there were enough maternity cases that allowed the hospitals to meet the GMC (General Medical Council) requirements.⁶⁸ Records corroborate it. The Lying-in hospital in Calcutta did see an increased number of women patients; however, indulgences like consumption of tobacco, gifts for women and their children were partially responsible for this attendance.⁶⁹

Apart from the state, missionary societies and women doctors in Britain and America took an active interest in women’s health in colonial India. The ‘white woman’s burden’ was based on horror stories of the conditions and the filth in which Indian mothers gave birth to their children with the help of the dai. Medical help for women was absent either because it was unavailable or inaccessible because of cultural codes that prevented purdahnashin women from coming into physical contact with men outside the family.⁷⁰ The figure of the suffering Indian woman legitimised the migration of British women doctors and activists, to fulfill their professional and spiritual aspirations, which were

⁶⁹ Medical College, Centenary Volume: Calcutta Medical College, Centenary Volume Sub-Committee, Calcutta, 1935.
shunned in London, with its internal hierarchical institutions and power structures.\(^{71}\) The Indian woman thus became a figure who needed to be helped and/or saved by the civilised, emancipated, white, Christian woman, whether in the name of Christ or for scientific healing.

However, the success of medical help by women for women depended on access to the *zenana* which was the privilege of the *dai*. Medical work for women could only be successfully implemented and sustained if the centrality of the *dai* could be undermined. This, as Maina Chawla Singh argues, could not be done without the help of the nurse.\(^{72}\)

The nurse emerged as an important figure in the project of increasing the sway of colonial medicine. Doctors, especially women doctors, attending maternity cases, needed nurses to visit patients at their homes for follow-up work and in the process, displace the *dai* from her privileged position. Wilhelmina Noordyk, an American nurse wrote in favour of the nurse, ‘India needs these trained women for the villages and towns to teach hygiene and sanitation and to replace the barbarous midwives who work such untold ruin. Both government and mission hospitals need them, for how can doctors carry on their work without the follow-up work of the nurse?’\(^{73}\) The figure of the nurse, though neglected in most historical studies of colonial medicine, takes on new significance when studied in context of western medical science in the colony.

**The Colonial Nurse and the Hereditary Dai**

Florence Nightingale’s detailed report ‘Suggestions on a System of Nursing for Hospitals in India’ (1865) which contained a full outline of a scheme to train Indian women in


\(^{73}\)Wilhelmina Noordyk, ‘Nursing in India’, *The American Journal of Nursing*, 21, 5, February 1921.
nursing, following the model of the Nightingale School in London, is usually considered the inception of nursing education in India. However, her offer of preparing and sending nurses and matrons trained in England to start the new system was rejected by the Government of India, which balked at the costs involved. The whole proposal was shelved by 1867.

1879 is usually considered the beginning of formal nursing services when the first contingent of British nurses arrived to staff the military hospitals in India. Around this time nurses in military hospitals were actually nonexistent; it was male attendants who nursed the sick. It was only in 1888, when Lady Roberts, the wife of the Commander-in-Chief, pointed out the need for skilled nursing for British soldiers that the Government sent for 8 fully qualified nurses under the guidance of Katherine Loch and Ms. Oxley (first name unknown). They stationed themselves in Rawalpindi and Bangalore respectively and worked on establishing the modern nursing system. The process was not smooth as the two matrons faced medical officers who did not believe that there was a need for women nurses in the army; they preferred male attendants who volunteered for it as a change from military duty.

In 1885, The National Association for Supplying Female Medical Aid to Women in India, popularly known as the Lady Dufferin Fund was set up under the auspices of Countess of Dufferin, the Vicerine of India. It had as its goals both medical help for women by women and medical education and training for women. The popular story

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77 Alice Wilkinson, A Brief History of Nursing in India and Pakistan, Trained Nurses Association of India, Delhi, 1958.
79 Alice Wilkinson ,A Brief History of Nursing in India and Pakistan, Trained Nurses Association of India, Delhi, 1958.
about the inception of the Fund reflects the need of the colonial power to establish itself as a maternal state concerned with the welfare of its Indian subjects, especially women.\textsuperscript{80}

The stated objectives of the fund was to provide medical tuition (training and teaching) to women doctors, hospital assistants, nurses and midwives and medical relief through construction of dispensaries, hospitals, female wards and appointment of trained female medical personnel.\textsuperscript{81} The fund had as its chief patron the Queen-Empress, and the Governors and Lieutenant Governors of the various provinces, as vice patrons. Provisions were made by which, according to the amount of money donated, other people could become Life Councilors, Life Members or Ordinary Members. There was a Central Committee which managed all affairs and coordinated with the various branches in the provinces. For all purposes, the branches had full financial and executive autonomy and in turn had to contribute a percentage of their receipts annually to the Central Fund. In those provinces where there were no branches, the Central Committee coordinated with the ruling houses to achieve their objectives. The Government, sympathetic to the Fund’s objectives, had also pointed out to the local municipalities that some of the money they had at their disposal for medical work may be given to the Fund for setting up female dispensaries and hospitals.\textsuperscript{82} However, Dufferin Fund reports complained of the unfair treatment that was meted out to the women’s hospitals and dispensaries in terms of heavy

\textsuperscript{80} The story follows that Miss. Bielby, a medical missionary took care of the Maharani of Pune, who after recovering wanted that the conditions and sufferings of Indian women be known to Queen Victoria and requested Miss Bielby to personally meet the Queen and pass on the message. On her return Miss. Bielby had an audience with the Queen who reportedly said that ‘We had no idea it was as bad as this. Something must be done for the poor creatures. We wish it generally known that we sympathise with every effort made to relieve the sufferings of the women of India.’ Margaret Ida Balfour, Ruth Young, \textit{The Work of Medical Women in India}, Oxford University Press, London, 1929, p 20-21.


\textsuperscript{82} The Countess of Dufferin’s Fund, \textit{A Record of Three Years' work of the National Association for Supplying Female Medical Aid to the Women of India, August 1885- August 1888}, Thacker Spink and Co., Calcutta, 1888.
taxes extracted and very little support, financial or otherwise, given by the Central or the Provincial Government.\textsuperscript{83}

Within the first 3 years of its foundation, the Fund was associated with 12 female hospitals and 15 dispensaries\textsuperscript{84} and by 1905, the Fund boasted of 42 lady doctors of the first grade (those who are qualified to register in England), 87 assistant-surgeons or practitioners of the second grade (those who have Indian qualifications), 274 hospital assistants or practitioners of the third grade. At that time 99 women were undergoing training as assistant-surgeons, 115 as hospital assistants and 323 as nurses, re-trained hereditary dais and compounders.\textsuperscript{85} By 1926 hospitals aided and run by the Dufferin Fund had 9 matrons, 1 nursing superintendent, 35 sisters-in-charge, 75 Indian staff nurses, 23 trained or re-trained dais who carried out the function of staff nurses, 203 Indian probationer nurses and 43 dais who worked as probationer nurses.\textsuperscript{86} Between the years 1921 to 1926, nurses under training had risen from 178 to 208.\textsuperscript{87} Rather than focusing on increasing infrastructural support for training Indian women to become nurses, most of the Dufferin Fund’s money was spent on bringing nurses from England to India to become matrons and sisters-in-charge.

The first nursing training in India, however, was not started at the initiative of either the colonial state or philanthropic organisations such as the Dufferin Fund. The Anglo-American medical missionaries stationed in India took the lead, albeit, informally and sporadically. They recruited nurses from their traditional constituency of Anglo-Indians,

\textsuperscript{83} The Countess of Dufferin’s Fund, \textit{Forty Second Annual Report of the National Association for Supplying Female Medical Aid to the Women of India}, Bengal Secretariat Press, Calcutta, 1926.
\textsuperscript{84} The Countess of Dufferin’s Fund, \textit{A Record of Three Year’s work of the National Association for Supplying Female Medical Aid to the Women of India, August 1885- August 1888}, Thacker Spink and Co., Calcutta, 1888.
\textsuperscript{86} The Countess of Dufferin’s Fund, \textit{Forty Second Annual Report of the National Association for Supplying Female Medical Aid to the Women of India}, Bengal Secretariat Press, Calcutta, 1926.
\textsuperscript{87} Margaret Ida Balfour, Ruth Young, \textit{The Work of Medical Women in India}, Oxford University Press, London, 1929.
and later Indian Christian converts. 88 In the beginning, nursing by medical-missionaries was carried out by untrained women who visited women in zenanas. A report (1867) by the Society for the Propagation of the Gospel and the Cambridge Mission to Delhi mentions that nursing work was carried out for almost 3 years before a trained woman was sent. 89

Christian evangelism in India was primarily aimed at conversion of upper-caste, middle-class zenana women. Women medical workers, specifically nurses, were able to reach them faster than lady doctors. Accounts left by missionary medical practitioners point to the twin task of healing— the body as well as the soul— which was made the special responsibility of nurses, who were trained in medical missionary establishments, as both evangelists and as medical aides. 90 Christian education and medical work could be easily intertwined and sustained. Indian women who were trained in nursing in missionary settings could become agents of evangelism themselves.

But a new day is dawning for India when nurses, trained are going out from mission hospitals, to help their native sisters in their time of labour… Our nurses trained in the mission hospitals are Christian women, mostly young women from the Christian Girls School. They also take a course in Bible study which fits them to be Bible-women as well as nurses, and in this way they have many opportunities to tell those whom they help about Jesus, the True savior and Lord. 91

90 Ethel Bleakley, Meet the Indian nurse, Zenith Press, London, 1940.
91 E.A. Foster, 'The Untrained Midwife in India', The American Journal of Nursing, 12, 1, October 1911.
Nurses were seen as more suitable to this double responsibility than white women doctors. While missionary circles in England urged women to come to India as medical women, they were encouraged to take up nursing. To become a doctor needed rigorous extended training which most women coming to India failed to complete. To go out in the missionary field without proper training in medicine could possibly lead to failed medical interventions. This would make them indistinguishable from the hereditary dai; they were urged to become nurses instead. Women who could not take training for more than 2 to 3 years were needed in missionary stations, where imbibed with Christian values and spirit, they could act as nurses.  

In the nineteenth and early twentieth century women missionaries had far outstripped men. In fact, India drew more women medical missionaries than China and Africa. In India, even as early as 1900, there were both medically trained and untrained women who were involved in medico-missionary work: 88 women and 81 male missionaries who held medical diplomas and a further 42 untrained women. In Asia in 1925, there were missionaries who had sent 596 male doctors, 321 female doctors and 640 nurses as compared to Africa which had 124 male doctors, 15 female doctors and 232 nurses or Latin America which had 24 male doctors, 6 female doctors and 42 nurses. In all the 3 continents it was nurses who far outstripped doctors, both male and female.

The nineteenth century dai has not left behind any first person account, making it difficult to recover her voice. Chandrika Paul in her doctoral thesis, demonstrates that memoirs written by bhadramahilas, regarding the status, nature and extent of the dais’ work, points to her as a midwife, gynecologist, obstetrician and nurse rolled into one. These memoirs also reveal that middle class women preferred the dais’ techniques to the male doctor and commended her expertise. Paradoxically, while the dai belonged to the

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92 John Lowe, Medical Missions: Their Place and Power, F.H. Revell Company, New York and Chicago, 1892
lower castes or untouchables, they were also respected and considered figures of authority within their communities. There appears to be a contradiction here. On the one hand, the dai was seen as repository of knowledge and skills, and on the other hand, within the hierarchy of the Indian medical system, the dai ranked relatively low.\textsuperscript{94}

The Caraka Samhita and the Sushruta Samhita, mentions childbirthing processes, but mostly related to preparation of the labour room. The process of childbirthing was left in the hands of the dai.\textsuperscript{95} The dai was consulted by women for reproductive diseases, abortion, infertility, childbirth and post-partum care. She was both a doctor and a nurse. The hereditary midwives had their own internal hierarchy: the dai was at the top, then the dhorrinis or the dais’ assistant and then the narkatta dai who cut the umbilical cord and was located at the bottom.\textsuperscript{96} Rewards and payments were given according to the status of the family and the experience and the grade of the dai concerned. Supriya Guha argues that the dai could be seen as belonging to a pre-modern occupation, where the calling was hereditary, and there was no formal training or standardised remuneration.\textsuperscript{97} It is highly possible that the women of upper-caste and/or middle-class Bengali families did go to male vaids and hakims for treatment, but because of expenses involved, most women consulted the hereditary dai.\textsuperscript{98}

Margaret Balfour and Ruth Young, two women doctors who traveled in India extensively, and were active in organising medical services and education for women, left behind their impressions in a book, ‘The Work of Medical Women in India’. Writing critically about the hereditary dai they, however, admitted to her centrality in Indian

\textsuperscript{95} Roger Jeffery, Politics of Health in India, University California Press, Berkeley, 1988.
\textsuperscript{96} Supriya Guha, A History of Medicalisation of Childbirth in the late Nineteenth and Early Twentieth Century, PhD Thesis (Unpublished), Calcutta University, 1996.
women’s lives. They observed that women trained in western medicine could not gain entry into the communities due to the presence of the hereditary dai. ‘For ages the dai has been the genius presiding over childbirth and her sway was undisputed.’ By the late nineteenth and the early twentieth century the campaign against the dai intensified. Vilified by colonial medical practitioners, medical missionaries and elite Bengali reformers, she slowly started losing ground.

Nineteenth century colonial India was not unique in this respect. In Europe, from the fourteenth century continuing till about seventeenth century, a movement had begun to medicalise childbirth and wrestle it away from the midwives/lay women healers’ control. Whereas in Europe, medicalisation of childbirth meant masculinisation of the profession, in India, it meant professionalisation of midwifery trained in western medicine. The two contexts were, however, radically different. Scholars such as Barbara Ehrenreich and Deirdre English contradict the popular belief that in Europe, the first attack against women in medicine was against midwives, who were branded as witches and eliminated. Instead, they argue that preceding the witch hunt, the first target of medical male professionals, the state and the church was the urban, literate, elite woman doctor who had the same clientele as the university-bred male doctor. Subsequent professionalising of medicine meant masculinisation, as women were debarred from entering the universities. By the fourteenth century, male doctors were secure in their medical practice amongst the upper classes. The next in line were the women who functioned as lay healers, whose clients were primarily working-class people. After elite women were removed from practicing medicine, male doctors turned their gaze on working-class women. Collaborating with the state and the church, women healers were branded as ‘witches’, who were then persecuted, tortured, and burnt on the stake. By the

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seventeenth and eighteenth century, it was only the midwife who survived. Medical establishments run by male professionals, based on claims of technical superiority, labeled midwives as ‘superstitious’ and ‘primitive’ and by nineteenth century midwifery was successfully eroded.¹⁰¹

India, however, had its own specificity. We have no records of women’s large scale participation as lay healers; instead, accounts left to us point to women in medicine as midwives. All other indigenous medical practices were in the hands of male vaids and hakims. Colonial medicines’ entry into obstetrics and gynecology was through white women medics and missionaries. However, pitted against the dai she was unable to hold her ground. The Indian dai proffered not only medical aid during child birth but stayed with the mother for post-partum care; in a way she was both a doctor and a nurse. The colonial doctor, however, was unable to deal with multiple responsibilities of Indian child birth and this is how the figure of the nurse emerged as an important tool in colonial medicine. Her functions increased from just bedside care to follow up/home visits, where she came face to face with the dai.

Attacks on the dai were mounted from all corners. While the ‘primitive’ techniques and ‘unhygienic’ methods used by the dai were foregrounded, conditions and environment associated with birthing practices, as practiced by Bengali households came under criticism. The room reserved for childbirth was described as the ‘darkest and most airless room in the house’ or a ‘dark cellar like small room’ whose only source of light, whether day or night, was a ‘primitive vessel containing oil…’¹⁰² Colonial medical reports were dotted with graphic descriptions of the dai’s body as filthy and unclean that invoked repulsion and put both mother and child’s health at risk. It was reported that she attended

¹⁰² Victoria Memorial Scholarship Fund, Improvement of the Conditions of Childbirth in India: Including a Special report on the work of the Victoria Memorial Scholarships Fund during the past Fifteen Years and Papers written by Medical Women and Qualified Midwives, Calcutta Superintendent Government Printing, India, 1918.
vaginal examinations with her ‘dirty’ and ‘unclean’ hands which ‘perhaps had just been cow-dunging a floor or attending a case of puerperal fever’. Hewlett, who started the first recognised dai training course in Amritsar, wrote a paper from her own experience which was quoted at great length in medical reports. She classified dais as ‘ignorant’, ‘careless’, and with ‘vicious intentions’. She attacked the dai’s knowledge, techniques and intentions which she alleged, more often than not, led to death of both mother and child.

Carelessness led to the use of bedding so indescribably unclean that fever after child-birth is rather the rule than the exception, and carelessness about bathing causes number of lockjaws which are nearly always fatal... Amongst others the willful murder of infants in the birth by breaking their backs or twisting their necks. One old Dhai confessed in her deathbed that she had herself destroyed hundreds of children.

Infant and maternal mortality rates were truly dismal in nineteenth century colonial India. However, scholars have pointed out various causal factors—from child marriage, repeated pregnancies, poverty, imperialism, economic exploitation of working-class women, malnutrition, to other forms of gender discrimination — which were responsible for such high mortality rates of mother and child. Yet, the discourse built around the dai held her singularly responsible. It was just not just the dai’s knowledge,

103 Ibid.
104 The Countess of Dufferin’s Fund, A Record of Three Year’s work of the National Association for Supplying Female Medical Aid to the Women of India, August 1885- August 1888, Thacker Spink and Co., Calcutta, 1888.
105 Ibid.
but her filthy body and vicious mind, that was condemned. Geraldine Forbes argues that the *dai* was equated with everything that was primitive, dirty, evil, and unscientific which stood in the way of the nation’s scientific modern progress.108 Thus, medicalisation of childbirth became for the nation, a sign of modernity. Part of the responsibility of the nation’s progress shifted onto reformist Bengali men and women. While it started becoming clearer, that replacing the hereditary *dai* was becoming next to impossible, because of the patronage they received from even the wealthiest families, Bengali women started being pulled into the discourse of modernity, nationalism and the domestic within it.

The question is truly one of home rule— for the woman is the heart of the Indian home, and it is she who will be the decisive factor in improving the conditions of child birth in India.109

Reforming birth practices also had a lot to do with altering familial structures and ties within the household. Much was written on the presence of the mother-in-law and older women in the birthing room and their insistence on the use of the *dai* despite western-trained lady doctors, nurses and midwives being freely available. Supriya Guha argues that medicalisation of childbirth played a pivotal role in taking away the control of birthing practices from older women of the family and placing the conjugal couple at the center of the reformed Bengali family, who displayed a commitment to a life based on scientific and a rational way.110 Scholars like Partha Chatterjee argues that the refashioning of patriarchy in the nineteenth century required the *bhadramahila* to be

inculcated with western education (scientific) and yet remain Indian (spiritual) in her values and outlook. Emancipation of women in this new patriarchy was tied to education that would impart bourgeois and modern values of discipline, hygiene and ways of running an efficient household.\textsuperscript{111}

Bengal was not unique; all over the country, middle-class women preferred the hereditary dai to the trained nurse or a lady doctor. To deal with Indian women’s preference of the hereditary dai, a two-pronged strategy was used to establish the superiority of the western trained female medical practitioner. The work of the Dufferin Fund was expanding: setting up zenana hospitals and wards, bringing women doctors and nurses from England, and training Indian women as doctors, nurses and hospital assistants. But it was soon realised that more specific and determined efforts were required that focused exclusively on the hereditary dai. The Victoria Memorial Scholarship Fund was inaugurated in 1903 under the auspices of Lady Curzon, the Vicerine of India. The stated objective was to train the hereditary dai in western medicine as against dais taken from other classes that were already being carried out by other agencies (municipals and missionaries).\textsuperscript{112}

Simultaneously, massive campaigns and organisations of baby shows, welfare exhibitions and distribution of prizes and rewards for childcare were held all over the nation. One of the largest nodal bodies that organised such events was The Lady Chelmsford All India League for Maternity and Child Welfare, which was founded in 1919. Apart from organisation of events and baby week, one of the other most important functions of the league was to publish literature on maternal and child welfare. In Bengal, in 1919, the Government formed a Child Welfare Committee by a resolution, which became permanent in 1921, which amongst other things, focused on training and education of


\textsuperscript{112} Victoria Memorial Scholarship Fund, Improvement of the Conditions of Childbirth in India: Including a Special report on the work of the Victoria Memorial Scholarships Fund during the past Fifteen Years and Papers written by Medical Women and Qualified Midwives, Calcutta Superintendent Government Printing, India, 1918.
dais. The Health Publicity and Propaganda Branch of the Public Health Department of Bengal had started extensive work through magic lantern shows and films that focused on issues of disease, hygiene, nursing, infant mortality and birthing practices. These travelling exhibitions and baby week became the medium of propaganda against the hereditary dai.\textsuperscript{113} Through the discourse of hygiene and eugenics, it was the hereditary dai, who became the marker of primitive, unhygienic and unscientific practices. To be a part of the scientific progress that the nation was making the Indian populace had to embrace colonial medicine and its personnel.

Patricia Jeffery, however, argues that at the national level, infrastructure was more towards training doctors and nurses than the hereditary dai. And, the clientele in focus was the purdanashin women.\textsuperscript{114} The training of a new class of dais by missionaries, charity funds and colonial administration was nothing but a temporary measure till professional trained nurses could replace them. Jeffery further argues that ‘attempts to train dais were sporadic, urban biased, and had little noticeable impact on obstetric practices in most of the country.’\textsuperscript{115} There are also evidences that in the Indian urban milieu, European doctors were called on only as consultants; most women preferred to employ nurses and dais.\textsuperscript{116} The nurse was an important figure in attracting more in-patients to the hospitals and along with her community visits, was to slowly but surely replace the hereditary dai. A woman doctor, writing on colonial medical practices in India, has noted that ‘a nurse also pays visits to women’s homes in the villages to deliver babies. She acts as a midwife…’\textsuperscript{117}

\begin{flushleft}\textsuperscript{113} The Countess of Dufferin’s Fund, \textit{Forty Second Annual Report of the National Association for Supplying Female Medical Aid to the Women of India}, Bengal Secretariat Press, Calcutta, 1926.\textsuperscript{114} Patricia Jeffery, \textit{Contaminating States and Women’s Status: Midwifery, Childbearing and the State in Rural North India}, Indian Social Institute, New Delhi, 1985.\textsuperscript{115} Ibid.\textsuperscript{116} Margaret Ida Balfour, Ruth Young, \textit{The Work of Medical Women in India}, Oxford University Press, London, 1929.\textsuperscript{117} Elsie Thomas Culver, ‘A Nursing School in South India’, \textit{The American Journal of Nursing}, 50, 3, 1950.\end{flushleft}
Colonial medicine, particularly obstetrics and gynecology, met with varied responses from the Indian populace. On the one hand, hereditary dais resisted easy cooption, and on the other hand, women continued to prefer the hereditary dai to the western-trained doctor or nurse. In Bengal especially, some of the women from the urban families preferred the methods of the hereditary dai to those of a trained medical woman. There were other reasons why the Indian population preferred the hereditary dai—the dai charged much less than a trained woman, she would do certain menial work like burying the placenta, washing clothes, etc, which a trained woman would not do. Most importantly, despite all attempts to vilify the dai, there were many Indian women who held her in great respect and confidence.

Dais were also employed in Lying-in hospitals to act as nurses. The Canning Nursing Institute in Kolkata, Bengal, meant for training and providing nurses to hospitals and private homes (that could afford to pay the salary and give suitable accommodation), sent retrained dais instead. A category called the nurse-dai started emerging who was the retrained dai working in hospitals till a qualified nurse could replace her. This phenomenon was prevalent in Bengal, where even medical practitioners employed retrained dais as general nurses. They were regularly employed as nurses, especially

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121 West Bengal State Archives, Calcutta, (henceforth WBSA), Finance Department, Medical Branch, Proceedings B 63, April 1914, File No. IR/33, Minutes of the Half Yearly Meeting of General Committee, Calcutta Hospital Nursing Institution, dated 1913, 27th February.
122 WBSA, Miscellaneous Department, Medical Branch, Proceedings B 52-53, December 1922, File No. N/3
123 The Countess of Dufferin’s Fund, Fifty First Annual Report of the National Association for Supplying Female Medical Aid to the Women of India, Superintendent Government Printing India, Calcutta, 1935.
for maternity cases, and replaced as soon as qualified nurses were available. This was so widely practiced that at the time of Independence, two categories of nurses were registered, which included 15,000 general nurses, who might have also had midwifery qualifications, and 500 lady health visitors. In addition, trained dais were employed as ancillary nursing staff, while some even carried out duties that could be defined as nursing.

According to colonial medical reports, under the various training schemes that were initiated, three categories of nurses started emerging. First, the Indian nurse, with a training of three years in general nursing and midwifery under a missionary or a government hospital and who was employed as a staff nurse. The second category was the semi-trained dai-nurse, who had a training of two years in rudimentary nursing. They worked in the hospitals and learnt on the job. The third category was the hereditary dai who either refused to participate in any training or relapsed to their traditional means of child birthing. They were resilient to continuous attempts to replace or eliminate her.

While eliminating the dai seemed impossible, the project of retraining and co-opting her within the folds of colonial medicine was also not successful. As reports of failure of the dai training schemes started coming in from all parts of the country, including Bengal, registration of midwives seemed the only way of putting them under supervision and surveillance and forcing them to come under the colonial medical apparatus. "Registration of dais must come, as we find in many places inexperienced women offering their services for very little or nothing...they promise to cook, sweep, fetch...

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124 The Countess of Dufferin’s Fund, Fifty Second Annual Report of the National Association for Supplying Female Medical Aid to the Women of India, Superintendent Government Printing India, Calcutta, 1936
126 Victoria Memorial Scholarship Fund, Improvement of the Conditions of Childbirth in India: Including a Special report on the work of the Victoria Memorial Scholarships Fund during the past Fifteen Years and Papers written by Medical Women and Qualified Midwives, Calcutta Superintendent Government Printing, India, 1918.
127 Ibid.
water, in fact do everything that is necessary in the house and conduct the confinement too, and all for whatever the women care to give, perhaps a few annas.’ By 1920, there were proposals to standardise the training and examination of nurses and midwives in the province of Bengal. The Surgeon General with the Government of Bengal proposed to the governing body of the State Medical Faculty of Bengal to establish a regular course of instructions and a qualifying examination for nurses and midwives on the lines of the schemes in force in the United Province. Apart from the above, the proposal also included maintenance of rolls of qualified nurses and midwives in Bengal so that the Medical Faculty could regulate, restrict and supervise their practice. The proposal was passed in the same year.129

Growth of Nursing Profession: Standardisation and Registration: 1905-1947

The colonial medical structure, especially in the field of gynecology and obstetrics, found itself stumbling on the question of the hereditary dai. Despite various attempts to eliminate or reform her, she remained central to Indian women’s lives. Institutions of colonial medicine found in her a cheap and easily available alternative to the western-trained nurse. Categories of nursing staff had started emerging that blurred the boundaries between a dai and a nurse. To eliminate such confusion, the nurse had to be marked out and disentangled from the dai. One solution was to professionalise nursing. Another reason for the call for professionalisation was to attract Indian women from a ‘better class’ to join nursing services. Sarah Tooley, who left an account of nursing in India in 1906, wrote that there were strong protests that the Dufferin Fund spent too much money on constructing hospitals and bringing nurses from England. It should instead focus on training Indian women in nursing. As Indian patients did not want to take food from

128 The Countess of Dufferin’s Fund, Forty First Annual Report of the National Association for Supplying Female Medical Aid to the Women of India, Superintendent Government Printing India, Calcutta, 1925.
129 WBSSA, Local Self Government Department, Medical Branch, Proceedings A 12-19, February 1922, File N-7(1), Training and Registration for Nurses and Midwives in Bengal.
European or Christian women, a ‘better class’ (in the Indian context this also meant upper caste) of Indian women trained in nursing was required.  

Colonial administrators and nursing leaders have left behind accounts that speak of a dearth of Indian nurses. While Indian men (and handful of women) transgressed caste norms to become doctors, nursing had no takers. Indian upper-caste men were quite resistant to the idea of dissecting corpses, the core of western surgery, so much so that when Madhusudan Gupta, who came from a family of upper-caste Ayurvedic practitioners, along with four other medical students, performed dissection in Calcutta Medical College for the first time (1836), the British government saluted him with 50 cannon shots from Fort William, Calcutta.  

If it was socially difficult for Indian men to study allopathic medicine then it was doubly difficult for Indian women to do so. Yet, in the nineteenth century, we have the likes of Anandibai Joshi and Rukhmabai (who went abroad at the teeth of opposition to study medicine), Hilda Lazarus (from an Indian Christian convert family) Kadembini Basu (who pioneered the fight for women’s admission in Calcutta Medical College) and Haimabati Sen (who graduated from the less prestigious Campbell Medical College and received the degree of a Licentiate in Medicine and Surgery and served in a district hospital) who overcame all odds to become doctors. However, we have no such parallel examples when it comes to nursing. Middle-class, upper-caste Indian women were reluctant to transgress caste, class and gender norms to take up nursing as a profession. The material benefits of becoming a doctor far outweighed the dividends of becoming a nurse, and therefore for the latter, there was not much incentive in breaking class and caste norms. This was a concern shared by nursing leaders and medical administrators sympathetic to the profession; in a letter to the Government of Bengal in 1901, W. Parsons, the Secretary of Lady Canning ...
Memorial Fund lamented that ‘…if efficient and quality nurses are desired…making nursing a permanent profession and improving conditions of work is a must.’

Although missionary schools churned out a substantial number of girls trained in nursing (who were recruited from Christian schools and orphanages), they were reserved for missionary hospitals. Missionaries were unwilling to allow their trained nurses to go to Dufferin hospitals as they felt that their religious and moral training/education would suffer. While it was easier to recruit Anglo-Indian and Christian women as nurses, it was becoming very difficult to attract upper-caste, middle-class Hindu and Muslim women into the profession. This was a source of anxiety amongst nursing leaders—if nursing was to be established as a respectable profession it was essential that upper-caste, middle-class Indian women chose nursing as a career. While the senior posts in the nursing hierarchy could be occupied by women trained in England, it was too expensive to bring nurses over to fill the rank and file. To keep the colonial medical infrastructure functioning it was imperative that more Indian women take up nursing. The need for inducting Indian women into nursing reached the Legislative Council, where the question was raised more than once. It was stated that if Indian women would take nursing training, it would secure greater economy in hospital management, as they would be a cheaper alternative to European nurses. It would also secure an avenue of employment for middle-class women who were widowed or unmarried.

The clamor for professionalising nursing started gaining ground by early twentieth century. The President of the Berar Branch of the Dufferin Fund, wrote that the only ‘professional nurses’ that Indians have experienced were the hereditary dais who came

133 WBSA, Municipal Department, Medical Branch, Proceedings A 36-46, File no N/2. Letter from W. Parsons, Honorary Secretary, Lady Canning Memorial Fund to Lieutenant General, Bengal Government, dated 19th December 1901.
135 WBSA, Local Self Government Department Medical Branch, Proceedings A, 19, August 1922, File No 2-R.
from the ‘lowest class of the population’. This was the reason why nursing was not considered an ‘honourable’ profession. It was associated with working-class, low-caste women. He went on to write that ‘the prejudices against women who are unmarried or widowed and support themselves make it still more difficult for Indians to regard nurses with respect to which her profession entitles her. This reacts on the nurse herself and the result is that large proportion of them do not lead respectable lives.’

While it may be partially true, that women who worked as nurses were from working-class, lower-caste backgrounds who may have been more sexually assertive than the bhadramahila—class, caste and sexual connotations associated with nurses in the popular imagination marked it as a highly stigmatised occupation.

Attempts were made by nursing leaders to professionalise nursing service and therefore make it respectable. The British tried transplanting medical practices that had evolved in an industrial society into a country which was developing differently. Attempts to regulate the profession included governing and setting up criteria for entry, a code of ethics, standardised training and examinations etc. Training and registration was one of the ways of eliminating the hereditary dai, the untrained nurse and the ayah (attendant) from the nursing profession. A similar trend had happened in the West— before the 1840s nursing was done by domestic workers and it was largely perceived as ‘a specialised form of charring’. In the latter half of the nineteenth century, nursing leaders fought for registration and standardised training, to eliminate working-class women from the nursing profession.

Either because of the paucity of trained nurses or expenses involved with hiring them, the untrained nurse or the ayah has always been an easy substitute. The call for registration was in a way to squeeze the rate of supply that would then enhance the status and pay of the trained nurse. Poonam Bala argues that in colonial

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136 Victoria Memorial Scholarship Fund, Improvement of the Conditions of Childbirth in India: Including a Special report on the work of the Victoria Memorial Scholarships Fund during the past Fifteen Years and Papers written by Medical Women and Qualified Midwives, Calcutta Superintendent Government Printing, India, 1918.
India, to eliminate competition, qualified medical practitioners insisted on professionalisation, to put an end to the practices of those who they perceived as ‘quacks’. She goes on to argue that, wherever the state controlled medical practices, training and registration became the criteria for qualification. The same logic could be applied to nurses and midwives. This call for registration and professionalisation, both in Anglo-American countries and in India, was to eliminate the working-class, lower-caste dai and the untrained nurse from nursing services. Some of the criteria for professionalising nursing were to set a standardised training and examination, forming professional associations and developing a code of ethics.

Different schools and colleges, missionary or otherwise, were following their own patterns of training. The mission hospitals were the first to try and introduce a systematic and standardised training for nurses. Till 1907, there was no uniformity of courses or educational requirements, but around this time the North India Board of Examiners for Mission Hospitals was organised. They took the initiative in organising rules for admission, standardised training and conducted public examinations. Many government hospitals joined the Board to reap the advantages of public examinations and recognised certificates and the designation was changed to ‘…mission and other hospitals.’ The minimum length of training was fixed at three years with an additional year for midwifery. This common examining board was the first step in organising and systematising nursing training in colonial India. Soon the number of Dufferin and government hospitals joining the Board also started increasing. A few years later the Mid India and South India Board was set up.

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The government also started laying emphasis on systemising nursing training and examination. In Bengal, the State Medical Faculty in 1922 gave an order giving its approval to the inauguration of a standardised course of training and qualifying examination. A Senior and Junior Certificate of Nursing was to be issued at the end of a three year course and examinations to be held at the end of the first and second year by the authorities of the institutions and the final examination by the State Medical Faculty. Initially the Senior Certificate Examination was open only to nurses being trained in Calcutta Medical College and Presidency General Hospital. Subsequently it widened its scope to include other institutions. The Junior Certificate Examination recognised nurses trained in the above two, as well as Sambhunath Pandit hospital. The training imparted at the Dufferin hospitals, although restricted to nursing of women and children would qualify nurses for the final Junior Certificate examination, if it was supplemented by a six month training in the men’s ward of any general hospital.\footnote{WBSA, Local Self Government Department, Medical Branch, Proceedings A -19, August 1922, File No 2-R.}

The movement towards registration started with the coming together of matrons and nursing superintendents of different civilian hospitals to form the Association of Nursing Superintendents in 1905 in Lucknow. It started with 9 European nurses and by 1909 the same office bearers started the Trained Nurses Association. By 1922 the 2 associations were amalgamated and The Trained Nurses Association of India (TNAI) was formed with a membership of 318.\footnote{Trained Nurses Association of India, Handbook of the Trained Nurses Association of India, The Trained Nurses Association of India, New Delhi, 2000.} However, records show that till 1948, all office bearers of the Association were European nurses.\footnote{Ibid, Appendix B.} The Association was started with the objectives of elevating nursing education by obtaining a better class of candidates, to raise standards
of training and to bring about a more uniform system of education, examination, and certification.\textsuperscript{144}

It was understood that unless nursing be converted from a ‘lowly occupation’, that was synonymous with menial polluting work, Indian women would not want to become nurses. This would mean elevating it to the status of a profession which would include better pay and other benefits. Only then would upper-caste, middle-class Indian women want to enter nursing services. The President of TNAI, in 1920, claimed that once nursing was institutionalised by introducing registration, Indian women would know that the Government supported the profession and its popularity as a career choice would increase.\textsuperscript{145} However it was only in 1936 that the word ‘profession’ was used for the first time in the stated aims of the TNAI.\textsuperscript{146}

The call for registration started gaining momentum. It was felt that as training for nurse, midwives and health visitors was progressing, registration would give it greater professional status. The Madras State was the first to form a Registration Council and by 1928 the Nurses and Midwives Registration Act was passed, and by 1934, the rest of the provinces followed.\textsuperscript{147} The Government of Bengal formed the Bengal Nursing Council in the same year (1928) to investigate the feasibility of introducing registration for nursing. In the following year, the issue reached the Legislative Council, where the demand for


\textsuperscript{147} Alice Wilkinson, \textit{A Brief History of Nursing in India and Pakistan}, Trained Nurses Association of India, Delhi, 1958.
registered nurses and the effect of registration in preventing untrained nurses from practicing was discussed. Finally, in 1934 the bill was passed.\textsuperscript{148}

It was the Second World War that acted as a catalyst to secure and establish nursing as a fully constituted and independent service in India. The Queen Alexandra’s Military Nursing Service was established in 1903 but it was only in 1926 that the service was made permanent and in 1927 it received the title of the Indian Military Nursing Services. However, only European women were initially recruited, the first Indian nurse being recruited as late as 1914.\textsuperscript{149} The colonial government did not give much importance to the IMNS and Indian women were not encouraged to join. At the time when the Second World War broke out the ratio for Indian nurses and soldiers was 1:109, while the British ratio was 1:23. Over and above, these nursing personnel were reserved for surgical and operation tables and first class military hospitals. It was understood that the rank and file of the Indian army could do without trained nurses.\textsuperscript{150}

With the intensification of the war, there was a rising need for trained nurses. The Auxiliary Nursing Services was established in 1942, which gave intensive short courses on nursing to candidates in civil hospitals, who were then either sent to military hospitals or overseas as assistant nurses. Almost 2000 to 3000 Indian women were recruited in this manner. This was the only way that the nursing profession could be protected from untrained nurses and attendants, and yet guarantee a supply of trained nursing personnel to the Indian army.\textsuperscript{151}

\textsuperscript{149} The Trained Nurses Association of India, \textit{History and Trends in Nursing in India}, The Trained Nurses Association of India, New Delhi, 2001.
\textsuperscript{150} A. Ghosh, \textit{History of the Armed Forces Medical Services, India}, Orient Longman, Hyderabad, 1988
\textsuperscript{151} The Trained Nurses Association of India, \textit{History and Trends in Nursing in India}, The Trained Nurses Association of India, New Delhi, 2001.
The Indian Nurse: Tensions of Gender, Class, Caste and Race

In colonial India, women as medical professionals had to negotiate rough terrains. Dr. Haimabati Sen, who worked as a ‘lady doctor’ in the Hooghly district hospital of Bengal, left accounts of sexual harassment, physical assault and the disrespect she faced.\textsuperscript{152} If Indian women doctors faced such opposition within their communities, then how much more did nurses, who were much lower in the hierarchy? Association of nursing with women of lower-caste, working-class origins further put middle-class, upper-caste women, off the profession.\textsuperscript{153} These trends, however, were not unique to colonial India; even in the west, nursing has been seen as a morally suspect and menial service. Nursing leaders tried unsuccessfully to establish nursing as a skilled profession, but could not shake off its associations with feminine servile labour. Added to that, colonial hospitals generally saw low-castes, untouchables and European women—high-caste Hindu or Muslim women preferred to receive medical attention at home.\textsuperscript{154} If both patients and health care workers like the midwife and the nurse were of low-caste origins, it would further put hospitals out of bounds for high-caste women. This would defeat the very purpose of the medical apparatus to draw \textit{purdahnashin} women out in the open. Tension between high-caste patients and low-caste workers in the hospitals led to the former not wanting to return to \textit{zenana} hospitals; the need for trained upper-caste, middle-class nurses was essential if the hospitals under Dufferin fund were to become successful.\textsuperscript{155} The circle closed—if nursing was to establish itself as a respectable profession, it needed women from upper-caste, middle-class backgrounds; upper-caste, middle-class Indian women were often not available due to social conventions.

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\item \textsuperscript{152}Geraldine Forbes, Tapan Raychaudhuri (eds.), \textit{The Memoirs of Dr. Haimabati Sen: From Child Widow to Lady Doctor}, Lotus Collection, New Delhi, 2000.
\item \textsuperscript{153}Nursing training was largely an impetus of missionaries, who recruited destitute, orphans and low caste Christian convert women leading to a strong association of nursing with women of low caste, working class origins. Sreelekhla Nair, Madielaine Healey, \textit{A Profession on the Margins: Status Issues in Indian Nursing}, Occasional Paper, Center for Women’s Development Studies, New Delhi, 2006.
\item \textsuperscript{154}David Arnold, \textit{Colonizing the Body: State Medicine and Epidemic Diseases in Nineteenth-Century India}, Oxford University Press, Delhi, 1993.
\end{itemize}
women would not join nursing because of its association with low-caste, working-class women. Over and above, bad working conditions, low wages, low status of the profession did not work as an incentive for women to transgress caste, class, gender norms (unlike doctors) and enter the nursing profession.

Even for missionary setups, it was important that menial and low-caste association with nursing be broken, as it would otherwise become an impediment to evangelism. Ethel Bleakley, a British doctor working in rural Bengal in a medical missionary establishment, wrote a book on her experience of working with Indian nurses. She narrates an incident when Shoila, a converted Bengali nurse refused to do any work. On further investigation it was revealed, that the admitted patient came from the same village as Shoila, and would report home the work she does as a Christian in a medical missionary. She couched it in terms of impediments to evangelism. ‘This maternity work is considered very low, only to be done by dai and sweepers…it will hinder the spread of the Gospel…if they go home and say that being a Christian means becoming like the outcaste Hindu.’

The menial tasks that went with taking care of the sick, such as dealing with blood, body fluids and detritus, sweeping the wards, cleaning and changing dirty bandages in a casteist society like India became a reason not to take up nursing. In the eyes of society, the menial tasks reduced nursing to denigrated labour which few Indian women wanted to be associated with. Nursing was never seen as a career option for middle-class, upper-caste Indian women. Even in Bengal, women taking medicine as a career slowly started gaining ground, but only as doctors; nursing and midwifery were seen essentially as a traditionally low-caste job.

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Accounts by medical administrators spoke of the difficulty of training nurses in India. As nursing was equated with menial work, girls were encouraged to take up teaching careers.\textsuperscript{158} Nursing recruits were mostly girls from orphanages who did not have the talent to go into any other career. Dr. Hilda Lazarus, in the All India Women’s Conference, spoke about the condition of nursing and how middle-class, upper-caste Indian women were not being encouraged to take up nursing.

The best types of Indian womanhood were not encouraged to take up nursing at the very beginning. It was only the working or lower classes who were encouraged to go in for any kind of professional work. Those in charge of orphans were anxious about their future and decided thus: if a girl were pretty she was sure to get married, if good at passing examinations she was made teacher, and if she possessed neither of the former she was sent to be a nurse or midwife.\textsuperscript{159}

Even the traditional domain of missionaries— Anglo-Indians, low-castes and Christian converts took up nursing because it was the easiest way to make a living and which may eventually lead to a life of domesticity. ‘The major proportion of nurses in Government General Hospitals are Anglo Indians, the majority of whom take up nursing not as a vocation but as an easy means of livelihood…. until such time as she finds a husband and makes a home for herself and her husband. After marriage she may or may not carry on her profession…’.\textsuperscript{160}

However, it was just not the menial nature of the service that kept Indian women away from nursing; it was also ‘the unaccustomed publicity to which a nurse is inevitably faced

\textsuperscript{158} Wilhelmina Noordyk, ‘Nursing in India’, \textit{The American Journal of Nursing}, 21, 5, February 1921.
\textsuperscript{159} Hilda Lazarus, \textit{Our Nursing Services}, The All India Women’s Conference, Tract No. 5, Aundh, 1945.
\textsuperscript{160} Ibid.
by the nature of her profession.’ Sexual misconduct and immorality were allegations that dogged women in medical professions; nursing was especially targeted. While fear that economic independence and contact with the outside world would affect her morals and she would easily succumb, the call for a ‘better class’ of women became stronger. This fear and anxiety generated from caste and class prejudices of colonial administrators and representative of the Indian middle class. It was assumed that as women who came into nursing were from lower-caste, working-class origins, they would succumb much faster and in turn bring further disrepute to the profession. Dr. Lazarus argued for better pay, living and working conditions for nurses, without which the possibility of them succumbing to sexual advances in exchange of material benefits increased and that would further stigmatise nursing. ‘The strain was great and when temptation came in the guise of a kind invitation from a generous hearted man, it was accepted…How could any self-respecting parents countenance their daughter going in for nursing or midwifery!’

The anxiety about women’s sexuality and the burgeoning medical profession was an oft repeated theme. The need for supervision, to control women’s sexuality, so that they do not succumb or become easy targets for predatory men, who were not accustomed to interacting with women in public space, was often cited. Medical work for women was a fledgling field and to associate it with immorality in the eyes of society would further delegitimise the profession. Balfour and Young, very typically characterised women who came into nursing as, ‘lacking in personality’ and ‘immoral in character’ who spent working hours ‘with men, who were unaccustomed to freedom among women and whose social customs did not breed respect for those who emerged from seclusion’. They insisted that ‘supervision in hostels were not enough.’ As much as working women’s

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161 WBSA, Local Self Government Department, Medical branch, Proceedings A-19, August 1922, File No 2-R.
162 Hilda Lazarus, Our Nursing Services, The All India Women’s Conference, Tract No. 5, Aundh, 1945.
sexuality outside the family was a theme that provoked anxiety, to be associated with nursing had its own specificity.

Indian women were absolutely essential for the medical profession to be helpers, assistants and nurses for the economic viability of the hospitals; and women of upper caste, middle classes were desired as staff to ensure female patients from similar socio-economic strata. While colonial administrators and nursing leaders emphasised that caste, class and gender acted as barriers for Indian women to take up nursing, scholars like Madeline Healey argue that racial discrimination also acted as disincentive for Indian women who contemplated a career in nursing.\textsuperscript{164}

Indian women were considered lazy, apathetic, childlike and primitive who were not capable of hard work and did not have the cognitive capacity to enter a profession like nursing. In debates about nursing education and training, it was agreed that Indian women needed more years of training than European women, especially as the former was not a ‘well educated girl with good home influence.’\textsuperscript{165} ‘Things need to be repeated over and over again, even to senior girls and to graduates. They are like children and need to be guided.’\textsuperscript{166} Race, caste, class and gender intersected to justify why Indian woman could not come into nursing and even if they did, they deserved subordinate positions in the nursing hierarchy; as staff nurses accountable to a European sister-in-charge.

Static racial projections of Indians as people who lacked rules and discipline were cited as reasons why it was difficult to train them into professional nurses. Duties like sweeping of wards, washing soiled bandages, and bedside care of patients was something

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no upper-caste, middle-class Indian woman—Hindu, Muslim or Christian—would do.\textsuperscript{167} A European nursing superintendent shared her experience in a conference held in Lucknow in 1905, about how she convinced an Indian nurse to do work, which in Indian standards was considered menial and not respectful. When faced with refusal by a converted Christian Punjabi nurse about sweeping wards, the superintendent did it herself saying that ‘well if it’s beneath you, it’s not beneath me.’ Six months later, the same Indian nurse reported that she had told her Indian patients that she did not mind doing ‘the work of a low caste’, because ‘we are Christians, no work was beneath us. We did it all for Christ’s sake.’ The European superintendent reported in the conference, ‘I felt this to be a real conquest’.\textsuperscript{168} The trained European nurse was given the responsibility to teach the Indian nurse through her own example. The Indian nurse had to be ‘shamed’ into doing menial work through the cause of Christian service and by the example of someone who was racially superior. The European nurse thus became an agent of the civilising mission.

The colonial bias of European nursing leaders was reflected in their essentialist understanding of the Indian women. She was essentially a caregiver—a trope of Mother India—a domicile woman who could only excel in her familial role. But being inherently narrow in her worldview she was unable to provide and bestow the same care and affection outside the family. ‘The average Hindu woman will make a capable nurse, deft with fingers, clever and full of resources…we see Hindu mothers and wives as most devoted and self-sacrificing nurses at sick bed of their parents, husbands and children: but ask them to bestow a little of this wealth of affection on outsiders and they will generally be unresponsive.’\textsuperscript{169} Brought outside the familial setting she did not have the capability to be a good worker. ‘To be reliable and punctual in every matter comes not naturally to

\textsuperscript{168} Ibid .
them; everything is done in a casual way.\textsuperscript{170} Her potential outside the familial setting therefore needed to be examined, and her services within the family be brought into the colonial market of hospital settings, where she would then excel because of her very essential nature of a caregiver and subsequent superior European training. \textquote{The Hindu woman can learn much from her European sisters...patient training at home and at school, and thorough instructions in private classes, above all by good and practical example, the Hindu woman will find one of her chief vocations in the sick room, in the nursery, orphanage or other charitable institutions.}\textsuperscript{171} There was a need to bring her out of the domestic sphere into the public space. With the equation of nature, primitive and woman, her body needed to be disciplined, to be colonised and only then could she become a productive worker in the colonial labour economy. This, however, also had other implications: this discourse on femininity and domesticity and its linkages with nursing which was actively deployed to encourage Indian women to become nurses resulted in nursing increasingly getting constituted as a feminised, domestic labour which in the subsequent years came in the way of attempts to professionalise the service.

Apart from caste, class and gender associations with nursing, bad working conditions, and racial bias towards Indian women reflected in low pay and inferior appointments. Indian nurses were considered and appointed as Group D staff or were given junior grade nursing training, which in turn excluded them from all positions of power and authority.\textsuperscript{172} European nursing leaders also tried to protect their privileges by setting up criteria for admission in nursing training that Indian women would find difficult to fulfill. Women had to be unmarried, preferably between the age group of 18 to 35. In the beginning, English language was medium of instruction for nursing and midwifery training; such standards were difficult for Indian women, who got married and had

\textsuperscript{170} Ibid.
\textsuperscript{171} Ibid.
\textsuperscript{172} Sreelekha Nair, Madielaine Healey, \textit{A profession on the Margins: Status Issues in Indian Nursing}, Occasional Paper, Center for Women’s Development Studies, New Delhi, 2006.
children at a much earlier age than their European counterpart. Further the certificates issued to trained Indian nurses were not recognised in England and it was difficult for trained nurses of Indian origin to gain entry into the coveted and well-paid military nursing service. Along with rigorous training and high standards of education that was required, racial bias against appointments, low pay scale and lack of future prospects played a role in discouraging Indian women from taking up nursing. In fact, the Dufferin hospitals preferred European and Eurasian nurses to Indians. In Bengal, in 1905, complaints were received that the European superintendents of the Dufferin hospital in Calcutta was dismissing Indian nurses in favour of Eurasian nurses. Even the colonial Government admitted that nursing was not a coveted profession for Indian women due to lack of opportunities. ‘The candidate for the nursing profession does not however have bright futures. They can become staff nurses….or may undertake private nursing. They may find employment in moffusil hospitals but the latter hospitals are in dire financial straits and are unable to meet the costs of engaging trained nurses.’

Upper-caste, middle-class Indian women did not take to nursing services despite it being given the contours of a profession. Apart from caste, class and gendered associations with nursing as a menial and immoral profession, the prospects of an Indian nurse in colonial India were not promising. Colonial administrators and European nursing leaders either laid the blame on the deeply casteist and feudal nature of Indian society which was not accustomed to seeing the bhadramahila in paid employment or the primitive, child-like nature of Indian women who were not capable of entering a modern profession.

176 WBSA, Local Self Government Department, Medical branch, Proceedings A -19, August 1922, File No 2- R.
Conclusion

The question of colonial medicine, at least in the field of gynecology and obstetrics, was embedded in the figure of the *dai*. As much as it was perceived that western trained nurses along with women doctors could undermine the importance of the *dai* in the lives of the Indian populace, it was also acknowledged that nurses had to come from the local population. On top of that, as representatives of colonial medicine, an Indian nurse had to be middle class and/or upper caste as opposed to the *dai*. However, racism along with class, caste and gender constituted nursing as a low career option for respectable Indian women. The association with low caste and sexual impropriety continued well after India gained Independence. Even after Independence, following the trends set by the colonial government, nursing was not given the resources needed to promote it. In its bid to become a global player in the field of health, India preferred to emphasise on urban infrastructure, imported drugs and technology and scientific knowledge. Nursing, perceived as a feminine skill, was placed as a low in priority in its budgetary allocations. In the next chapter I shall explore, how nurses operating within the hierarchical binaries of cure/care, reason/emotion, masculine/feminine, are constituted as docile ancillary workers within the health care workforce.