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Initiatives To Provide Health, Hygiene And Sanitation To Women In Colonial Punjab

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Abstract:

Gender played an important role in the articulation of social hierarchies that would assert the superiority of the British over Indian society and justified the imposition of British rule over India. James Mill, using a woman's position as an indicator of the social advancement of society, famously constructed the Indian woman as a degraded victim of her barbaric society. Although the degraded Hindu woman persisted as an index of Indian society's need of rescue through colonial rule after the Revolt of 1857, the colonial state distanced itself increasingly from active intervention. For this purpose, initiatives were taken into account to provide better health and hygiene to women in colonial Punjab. Thus, the present research paper is about the initiatives taken by the British government to provide Health, Hygiene and Sanitation to Women in Colonial Punjab.

1. INTRODUCTION:

Social welfare always was the duty of the state. The state has control over society in terms of vaccinations, control of epidemics and endemic and contagious diseases. The Indian colonial state became involved in providing medical care for its subjects from the early nineteenth century. The state's involvement in improving access to Western medical care for the indigenous population formally began with the decision in 1838 to provide Government Funding for a network of dispensaries. The development of medical care in Punjab took a peculiar trajectory which was shaped by its colonial context.[1] Many initiatives were being taken in the colonial Punjab for the protection of women health, hygiene and sanitation. Hospital and dispensaries were established by the state to act as 'public' institutions. In the 1830's, discussions were done in the public realm south to improve the sanitary state of Calcutta and to provide a medical institution for the treatment of natives. Gender played an important role in the articulation of social hierarchies that would assert the superiority of the British over Indian society and justified the imposition of British rule over India. James Mill, using a woman's position as an indicator of the social advancement of society, famously constructed the Indian woman as a degraded victim of her barbaric society. Although the degraded Hindu woman persisted as an index of Indian society's need of rescue through colonial rule after the Revolt of 1857, the colonial state distanced itself increasingly from active intervention. Saving Indian women from their plight continued to be seen as a necessary precondition for modernizing India, and a tool to legitimize colonial rule, but the rescuing was increasingly left to missionaries and white women. The practice of purdah, or female seclusion, was one of the gendered social evils that provided girst for the mill of arrange of imperial writers, increasingly becoming the focus of the 'colonial gaze'.[2] Since the male colonial gaze could not venture into the zenana of the female quarters, white women became an important part of the imperial mission to reform the zenana, which became a site for proselytization by missionaries and later, a site for educational reform.

[1] Sehrawat, S. (2013), Colonial Medical Care in North India: Gender, State and Society (1849-1920), Oxford University Press, New Delhi

[2] Janaki Nair, Uncovering the Zenana: Visions of Indian Womanhood in Englishwomen's Writings, 1813-1940, Journal of Women's History, 1990, Vol.2, No.1

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Middle class British women, keen to assert their imperial citizenship, publicized the 'plight' of these 'helpless' women and supported the emergence of the Dufferhin Fund.

2. THE DUFFERIN FUND & MEDICAL CARE

The Dufferin Fund (DF) was founded in 1885, to provide 'female medical aid to the women of India as well as Punjab'. The Fund was closely associated with a range of initiatives to improve women's health care in twentieth century India the training of indigenous midwives (dais), the opening of zenana hospitals, training and work conditions of female doctors, and later 'scientific' investigations in to Indian women's health.[3] Although the Fund's activities were meant to improve infant and maternal health, the primary emphasis of the Fund in the first thirty years of its existence remained curative, as its report acknowledged in 1924.[4] The Fund's curative activities also accounted for a large part of its expenditure initially.[5] The DF sought to coordinate the efforts of charitable institutions in different parts of India and to initiate new 'female hospitals, dispensaries, or wards in areas where they had not existed before.[6] Over fifty years after its foundation, the DF was described as 'the first national effort for the establishment of medical relief for the women of India,' and clearly played an important role in expanding medical facilities available to Indian women.[7]

Dufferhin Fund took initiatives to provide medical care for Indian women by vicereines acting as 'incorporated wives,' by female doctors as represented by the Association of Medical women in India (AMWI) as well as in Punjab and by various provincial administrations. This should not be seen as merely 'adding' women to an analysis of medical care. Institutions associated with Indian women's health care were closely linked with the development of ideas about the role of voluntarism in medical care. For instance, the DF represented the colonial ideal of medial philanthropy – it allowed the state to distance itself from medical provision and to claim that philanthropy and private stimulus ought to provide for the medical needs of Indian society. The subscriber democracy model of the DF was meant to improve Indian conduct through participation in the public associational spaces it created. Justifications of the imposition of British rule in India had depended upon the creation of racial and gender hierarchies that contributed to pejorative characterizations of Indian society. Ideas of zenana medical care that gave rise to the DF had emphasized the need for maintaining patients' seclusion by adapting 'public' hospitals to make them compatible with institutions that screened and 'sheltered' female patients from an 'inappropriate' male gaze. However, cracks appeared in colonial constructions of zenana medical care from the very process of creating institutional spaces appropriate for it. Provincial governments responded to regional practices of female seclusion since these varied greatly, provincial definitions of zenana medical care also varied.

2.1 Constructing the Zenana Patient: Institutionalizing Zenana Medical Care

Colonial discourse on the zenana echoed essentializations about the harem in western constructions of the Orient, evoking women who were confined in their own homes, living a life of idleness and lasciviousness, capable of exercising power in 'unnatural' ways but remaining the

3 In the 1920s, doctors who were part of the Women's medical service managed by the DF mapped maternal and infant mortality rates, undertook research into the incidence of venereal diseases and links between segregation of women and occurrence of osteomalacia.

4 DFR 1924, p. 2. After the formation of the women's medical service in India (WMSI) in 1913, and the appointment of Margaret Balfour as the joint secretary of the DF in 1916, medical women played a more prominent role is shaping the agenda of the DF, with greater emphasis on preventive medicine and maternal and infant health.

5 This was due to the high startup costs of establishing 'female' hospitals and dispensaries. Hariot Blackwood, A Record of Three years, Work of the National Association for Supplying Female Medical Aid to the women of India (Calcutta: Thacker Spink and Co., 1888), pp. 38, 59.

6 DFR 1890, P. 8.

7 E.W.C. Bradfield, An Indian Medical Review (New Delhi : GoI Press, 1938), p. 171. Bradfield, then Director- Gen. of the IMS, was reviewing 'the medical organizations of all- India'.

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stronghold of superstition and stubbornly resisting 'progress'.[8] Although missionaries first sought to introduce education and medicine in the zenana in the hope of aiding proselytization, both causes were taken up by other white women.[9] It was in this context that the quasi-governmental DF was initiated wherein vicereines and other colonial officials' wives could act as rescuers of women confined to the purdah by providing them with 'modern' scientific Western medical care.[10]

The foundation of the DF and the 'Medical Women for India Fund of Bombay were central to the emergence of zenana medical' care in colonial India.[11] The emphasis in these initiative was to extend curative care to women who were prevented from seeing male physicians due to practices of female seclusion.[12] The need to provide medical care in the zenana was articulated by early pioneers of the women's medical movement in Britain, such as Frances Hoggan, Mary Scharlieb, and Elizabeth Bielby; by the National Inidan Association; and by supporters of the DF, including imperial administrators and Victorian journalist Mary Billington.[13] Despite the differing aims of these authors, their rhetorical thrust tended to paint a picture of Indian women as passive, undifferentiated recipients of medical aid at the hands of female medical professionals. The figure of the 'zenana' or 'purdah' woman who would not receive medical care from a male physician the zenana patient was given considerable prominence in this rhetoric. Lady Dufferin declared in 1888 that:

> "The foundation of our work lies in the assumption that, as a rule, Indian women will not see medical men, that many of them would rather die than do so, and that the only way of bringing professional aid to them in sickness and suffering is to create a supply of female Doctors and to establish hospitals and Dispensaries for them, officered by women".[14]

The Victoria Hospital in Calcutta was criticized for its lack of building enclosures to screen zenana patients from being overlooked by men from outside and for the employment of male staff.[15] The Bengal branch of the DF was very responsive and sought to address these issues in order to boost attendance by high caste Hindu women and purdah-nashin women observing purdah strictly. Male janitorial staff was dismissed and male children above the age of seven excluded from the Lady Dufferin Victoria Hospital, Calcutta. Nevertheless, the perception of hospitals as public spaces,

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[8] See Janaki Nair on constructions of the zenana in colonial India, Malek Alloula's analysis of the picture postcards of the colonial harem in Algeria, and Rana Kabbani's work on Western views of Eastern women, Nair, uncovering the zenana: visions of Indian womanhood in Englishwomen's Writings, 1813-1940, journal of women's History, vol. 2. no.1 (1990), pp. 8-34;

[9] For medical missionary women in a later period, see Jeffery Cox, Imperial Faultlines: Christianity and colonial power in India, 1881-1940 (Stanford: Stanford University Press, 2002), chap. 6 'Gender, Medicine and the Rhetoric of Professional expertise,' pp. 155-89.

[10] The DF implemented the colonial state's policy of religious toleration by declaring itself to be non-sectarian and emphasizing that its activities would be distinct from missionary medicine in that no proselytizing would be allowed within its hospitals.

[11] The DF has been mentioned in passing in many accounts, including those on British women in India, on the philanthropic activities of British memsahibs, and on medical women in the Victorian period-See Pat Barr, the Memsahibs: The women of Victorian India (London: Secker and Warburg, 1976); Mary Ann Lind, the compassionate Memsahibs: Welfare Activities of British women in India, 1900-1947 (New York; London: Greenwood Press, 1988); Kumari Jayawardena, The white woman's other Burden: Western women and South Asia during British Rule (New York; London: Routledge, 1995); Antoienette Burton, 'Contesting' the Zenana: The mission to make "Lady Doctors for India", 1874-85', Journal of British Studies, vol. 35, no. 3 (1996) pp. 368-97

[12] Female missionaries had provided a lead in arguing this, see, for instance, the testimony by Greenfield of the Ludhiana medical mission. M. Rose Greenfield, 'Dispensary for Women and Children in Connection' with the Ludhiana Zenana Mission, 1882, republished in PHDR 1885, p. 42.

[13] Hoggan's article on 'Medical Women for India', published in 1882, seems to have provided an impetus for Kittredge's 'Medical Women for India Fund for Bombay', begun in 1882. Witz, "Colonizing Women", pp. 25-8.

[14] Blackwood, Record of three years' Work, p. 95.

[15] Criticism by Sanjivani, 6 Mar. 1900, cited in ibid., p. 282.

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rather than a 'zenana' medical space persisted especially as Dufferin hospitals were associated with the Raj. Despite such criticism, the foundation of the DF drew attention to the need for medical institutions where female patients could receive treatment in privacy and away from men. The provincial administration at Bengal was broadly in agreement with the Fund in privileging the zenana patient in women's health care provision. The Inspector-General for Civil Hospitals for Bengal claimed in 1892 that the entire separation of male and female departments was necessary and that this would be brought about by the DF leading to an increase in female patients.[16] From 1902, Bengal hospital Reports noted a steady increase in the number of female patients using dispensaries.[17] This increase was attributed to 'separate accommodation for women having been provided in many of the dispensaries'.

2.2 Incorporated Wives, the Colonial State, and the DF as the Ideal Medical Charity

Officials serving on the Fund in an honorary capacity, its links with royalty and the viceroy, and its alignment with imperial gender ideologies that justified British rule in India all point to the quasi-governmental nature of the DF. Clearly the fund was non-governmental only in name.

Many links existed between the DF and the colonial state, reflecting the close ideological affinity of the two. The queen acted as the royal patron of the Fund, the viceroy was designated the 'patron in India', and the heads of provincial administrations were vicepatrons.[18] Viceroys regularly made speeches supporting endeavours related to the improvement of Indian women's health at the annual meetings of the Fund.[19] Such speeches, which were widely reported, allowed the colonial state to associate itself with the colonial gender ideologies propagated by the Fund.[20] Curzon, for instance, characterized the work of the DF as a boon which lifts the purdah without irreverence.[21]

The support provided by provincial governments to the Fund was most evident in the North-Western provinces and Punjab, which both supported opening women's dispensaries and hospitals five dispensaries were opened in the North-Western provinces in 1885 and twenty in 1891; and the lady Aitcheson hospital for women in Lahore was supported by the Punjab government (Rs 8,000 in 1885 and Rs 13,000 in 1886).[22] Both administrations instructed civil servants to assist in improving female medical aid and training.[23] The UP government made special grants to 'Dufferin Hospitals' in 1906 (Rs 25,000) and 1907 (Rs 18,000),[24] and from 1908 this grant (Rs 18,000) was made recurring to enable improvements in the administration of Dufferin hospitals.[25] Both UP and Punjab took over expenditure on institutions supported by the Fund.[26] The local press reported on the considerable official support that the Fund received.[27] Newspapers also reported the close involvement of some officers, including civil surgeons and collectors in raising funds for the Fund.[28]

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16 ASR, 1892, p. 27; ASR, 1893, p. 26; ASR, 1894, pp. 25-6.
17 An increase was reported in ASR, 1902, p. 26; ASR, 1903, p. 23; ASR, 1906, p. 17; ASR, 1907, p. 20; ASR, 1909, p. 16.
18 DFR 1890, p. 8; Balfour and Young, work of Medical Women, p. 36.
19 'Lady Hardinge Hospital, Opening by the Viceroy: The Viceroy's speech, JAMWI, Feb. 1892, speeches by the Marquis of Lansdowne, Viceroy and Governor Genral of India (Calcutta: SGP, 1894), vol. 2, p. 401.
20 Lord Curzon Quotes Kipling: Eulogy of Medicine at the Dufferin Fund Annual Meeting, 5 mar. 1899, The New York Times.
21 Speech at the Annual Meeting of the Lady Dufferin Fund' 25 Mar. 1899, in C.S. Raghunatha Rao (ed.), Notable Speeches of Lord Curzon (Madras: The Arya Press, 1905), p. 111.
22 NWPHDR 1889, p.2; 'Note by Lieut-Gov.' PHDR 1885, p. 2; 'Note by Lieut-Gov., PHDR 1886, p.1.
23 NWPHDR 1891, p.3; PHDR 1898, p.16; 'Note by Lieut-Gov.' PHDR 1898, p. 3.
24 UPHDR 1907, p.12.
25 UPHDR 1910, p.8.
26 The UP government took over the Dufferin hospitals at Agra (1971) and the Punjab government took over the medical college for women at Ludhiana in 1913. UPHDR 1918, p. 10; PHDR 1913, pp. 11-12.
27 See report by Almora Akhbar, 21 Sep. 1885, SVN, Punjab NWP, p. 660.
28 See reports by Najmu-l-Hind, 25 Mar. 1889, SVN, Punjab NWP, p. 201.

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2.3 Female Medical Experts and the Medical Needs of Indian Women: Appropriating Zenana Medical Care

By 1908, the number of British and American medical women employed in women's hospitals in India had increased sufficiently for them to seek a professional platform, which led to the foundation of the AMWI. The employment of British medical women to provide zenana medical care had been widely promoted by the DF as well as the London school of Medicine for Women. Medical women were only beginning to be accepted within the medical profession in early twentieth century Britain and employment opportunities were still restricted.[29] In this context strictly enforced purdah arrangements within a hospital meant the exclusive employment of predominantly British female doctors, and hence expansion in employment opportunities. British medical women had therefore benefited from the privileging of zenana patients in Indian women's medical care.

3. FOUNDING THE WOMEN'S MEDICAL SERVICE

The Dufferin Fund (DF) not only survived the Association of Medical Women in India's (AMWI) attempts to have it replaced with a state medical service of women doctors, but also assumed a new importance in the first half on the twentieth century. In 1936, the British Medical Journal (BMJ) reported its pioneering role in training midwives and female health visitors, and scientific research on women's heatlh: The Dufferin Fund has now become the head of an important all-India service, which links together women of different Provinces in carrying medical aid to the poorest and remotest parts of the country.[30]

The all India service that the BMJ was referring to was the women's Medical Service in India (WMSI), founded in 1913. This chapter analyses the events leading up to the foundation of the WMSI. The first section discusses the AMWI's challenge to the colonial state to live up to its rhetoric of benevolence by funding a women's medical service. The DF sought government aid to improve the pay of its female medical employees in 1908, which the Indian government supported.[31]

4. DEVELOPMENT OF LEGAL SYSTEM FOR THE HEALTH, HYGIENE AND SANITATION OF WOMEN

Colonial and racial hegemony in policy towards public health closely related to human lives. There were three different stages of legalization: first, public health first included in the Government of India Constitution; secondly, the laws prepared to control quacks in the medical profession for public welfare and to protect the western medical system leading the government to increase its control on the standard of medical education; and finally how the government policies penetrated social life. Laws were being prepared to eradicate social practices that directly but adversely affected the women's health, hygiene and sanitation.

The Municipal and Local Boards Act made provision for expenditure on maternity and child welfare work under the Public Health Legislation. This plan for the scheme led Local Boards to handle and expand the expedition on mother-child care schemes. It was found that many Municipal and Local Boards had no budget to provide sufficient funds from their normal revenues for public health. So the new Act encouraged Indian donors and philanthropists to give donations. The government made grants-in-aid on condition that certain standards were maintained.

In this way, maternity and child welfare work had an opportunity for development and somehow a standard would be maintained because local schemes would automatically come under the supervision and control of the official Public Health departments which would arrange to appoint women medical officer of the status of Assistant Director of Public Health."

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29 For an account of British women's struggle for medical education and professional acceptance, see Catriona Blake, The Charge of the Parasols: Women's Entry to the Medical Profession (London: Women's Press, 1990).

30 'The Countess of Dufferin's Fund', BMJ, 30 May 1936, p. 1127.

31 Sehrawat, S., Colonial Medical Care in North India with Gender, State and Society (1840-1920),Oxford University Press, New Delhi, 2013.

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The social customs and laws regarding women's status prepared by the efforts of Indian social reformers can be discussed under this heading which gave relief from adverse health hazards caused by evil practices. The rulers' were reluctant to improve the social status of Indian women and its adverse effect on their health because Indian society assumed that all these problems were closely related to their family and private, personal life. The Widow Remarriage Act, XV, 1856, Age of Consent Act, 1891, Child Marriage Restrain Act (Sarda Act) were the landmarks of the social history of India and these revolutionary steps taken by the government with the help of Indian social reformers and Indian intellegisia provided space for the Indian woman to grow as a human being.

In response to the enlightened Intellegisia of India the British rulers legislated against social evils. Revolutionary and significant legal reforms were abolition of sati in 1827, the suppression of infanticide in 1725 and 1804 and the Widow Remarriage Act XV of 1856. Though these legal reforms had not seen any positive changes and results it did succeed in creating a resurgence among Indian women.

Justice M.G. Ranade's comment on Malabari's note on Infant marriage states "...we are slowly touching the consciousness of the people, disarming the opposition of the terror of excommunication and teaching the female sex to rebel to protest.

These influences will be strengthened by our efforts to promote higher education."

In the words of O'Malley, "It brought to women a total new concept of themselves as persons "individually important and nationally needed"...a revaluation of women."

The wave of reformists surged up in different parts of the country for the cause of women. The father of the Indian Renaissance was Raja Ram Mohan Roy(1774) in Bengal who opposed the custom of sati, polygamy and encouraged widow remarriage, felt it was difficult to consider women as weak in intellect and virtue and deficient in resolution trustworthiness and control over their passion.

By Government Notification No. 8178, dated 26 May 1931, in Political department, this act was extended to the districts of East and west Khandesh, Sholapur, Dharwar, Thana, Kaira and Poona some mills gave less cost. Mr. R. S. Asavale pointed out the debate on the Bill that, "if India desires to secure her proper place among the civilized nations of the world, she cannot plead her inability to treat her women workers in the way in which civilized nations are expected to do

There is no doubt that if women continue their long and arduous work in factories and other organized industries even in an advanced state of pregnancy and immediately after confinement, their health, their children will not fail to suffer.

The Bombay maternity Benefit Act had been passed in 1929 and was implemented in 1929. It was passed by Bombay Legislature requiring that maternity benefits should be paid to all women mill-workers at confinement, the benefit was to consist of two months' wages, that is leave on full pay for a month before and a month after confinement. The woman was handed a cash benefit and no effort was made to tell her why, or to ensure that her own health or the child's will be safeguarded.

Indian Factories Act empowered Provincial Governments that a suitable room should be spared for the use by the children of women mill workers and prescribed the standards of rooms and supervision of children. The Government of Bombay had made the provision of creches in factories where one hundred women were employed.

Maternity Benefit Acts gave maternity benefits to women in all the industrial work including plantation. It allowed the maximum period for benefit. But it was different in all provinces. The International Labour Convention recommended six weeks period. It was a great benefit and importance for the health of mother and of the child where there was high rate of maternal mortality and infant mortality rate. It was a great need for giving the period of rest to the women workers.

It did not show any decrease in number of women employed in the mills. But it was ridiculous that to obtain maternity benefit, a woman worker should produce a certificate of

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pregnancy. In a society, where women were reluctant even for ante- natal care, how could she produce a certificate of pregnancy.

The benefit provided by legislation was Rs. 21 per head. There were about 30,000 women mill workers in Bombay of whom it estimated about 10 percent bear children annually. Rs. 60,000 per year would be given by the mill-industry towards the benefit if all women who were eligible came forward for it, which it seemed decided and it was based on the enquiry. Grain shops were established in mills to ensure that they would get a good return for their money.

The expenditure was given under different items such as Rs. 3 and 7paisa for household maintenance expenses Rs. 2-11-00 for food excluding milk Rs. 2-13 -00 for Dais, Rs. 5-0-0 for clothes Rs, 5-13-00 for ceremony Rs. 1-10-00 for ornaments and Rs. 0-9-00 for medicine. Total Rs. 23-12-00 were granted slightly Rs. 21,11 paisa and 29 ana increased in 1931.

It showed the minimum amount to be given foe medicine and Rs. 5,13,00 and Rs. 1,10,00 had been given for ceremony and clothes respectively only 15 women went to their villages for confinement, 71 delivered in their homes through the helps of *dais* the nurse and 32 went into maternity homes and 28 did not receive any skilled attendance.

The mill women still relied on dais, and unskilled assistance. In 1922 Dr. Barnes found 75% mill women in Bombay had not obtained any skilled assistance.

"It is clear that maternity Benefit Act and efforts made by government and Municipality supplemented by the Wadia Hospital and voluntary efforts of the Infant welfare society have done a great deal to alleviate the lot of working women in Bombay.

A total of 5398 women took benefit for actual birth and an amount of Rs. 1,28,542, 00 was paid for it in Bombay Presidency in 1932.

This act benefitted in terms of decreasing maternity mortality rate amongst textile women in terms of rest and financial assistance AR of the 1933 showed that maternal mortality amongst textile women was very low. Sholapur mill showed only 2 deaths of mothers occurred out of 169 confinements of the 170 children bom, 3 were still bom and 16 died within a short period. Both infant morbidity and matemal mortality rates were low. Dr. Balfour's confinements were usually of a normal nature with a comparatively low maternal death rate '^' out 353 factories 348 implemented in the presidency. In smaller factories women employer not received benefit.

In the presidency it was compulsory to provide creches for the children of these female workers. The same was to be legalized for the rest India. This started fi-om 1938.

The factory Act of 1934 regulated the hours of work for women and the employment of expectant and nursing mothers only. Maternity Benefit Acts were in force in Bombay Presidency where industries had developed. It was certificate of pregnancy.

Though the Maternity Benefit Act, 1929 was applied it was essential to be carried out with proper application of legislation and regulation. "Legislative measures could not be made effective where they were almost worse than useful" The Maternity Benefit Act, for women working in mines was passed on the lines of Maternity Benefit Act, 1929.

5. OBJECTIVES

1. To study the Initiatives to Provide Health, Hygiene and Sanitation to Women in Colonial Punjab
2. To discuss about the Dufferin Fund & Medical Care for Women Health Hygiene and Sanitation in Colonial Punjab.
3. To review the founding of Women's Medical Service in Colonial Punjab.
4. To analyze the Development of Legal System for the Health, Hygiene and Sanitation Of Women in Colonial Punjab

6. RESEARCH METHODOLOGY

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The Methodology is a doctrinal research study it outlines the way in which a research is to be undertaken and among other things, and also identifies the methods to be used in it. The present research work is done with the help of secondary sources i.e. reports, books, magazines, newspapers, journals, articles, etc.

7 CONCLUSION:

The 19th Century initiated to established dispensaries in India was Borne of the reconfiguration of the relationship between state and medicine. The state's involvement in improving access to western medical care for the indigenous population formerly began with the decision in 1838 to provide Government funding for a network of dispensaries. Medical care was widely perceived as a tangible expression of imperial benevolence.

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